

COMPREHENSIVE REPORT
ON THE REVIEW OF THE WHITE PAPER
FOR SOCIAL WELFARE, 1997



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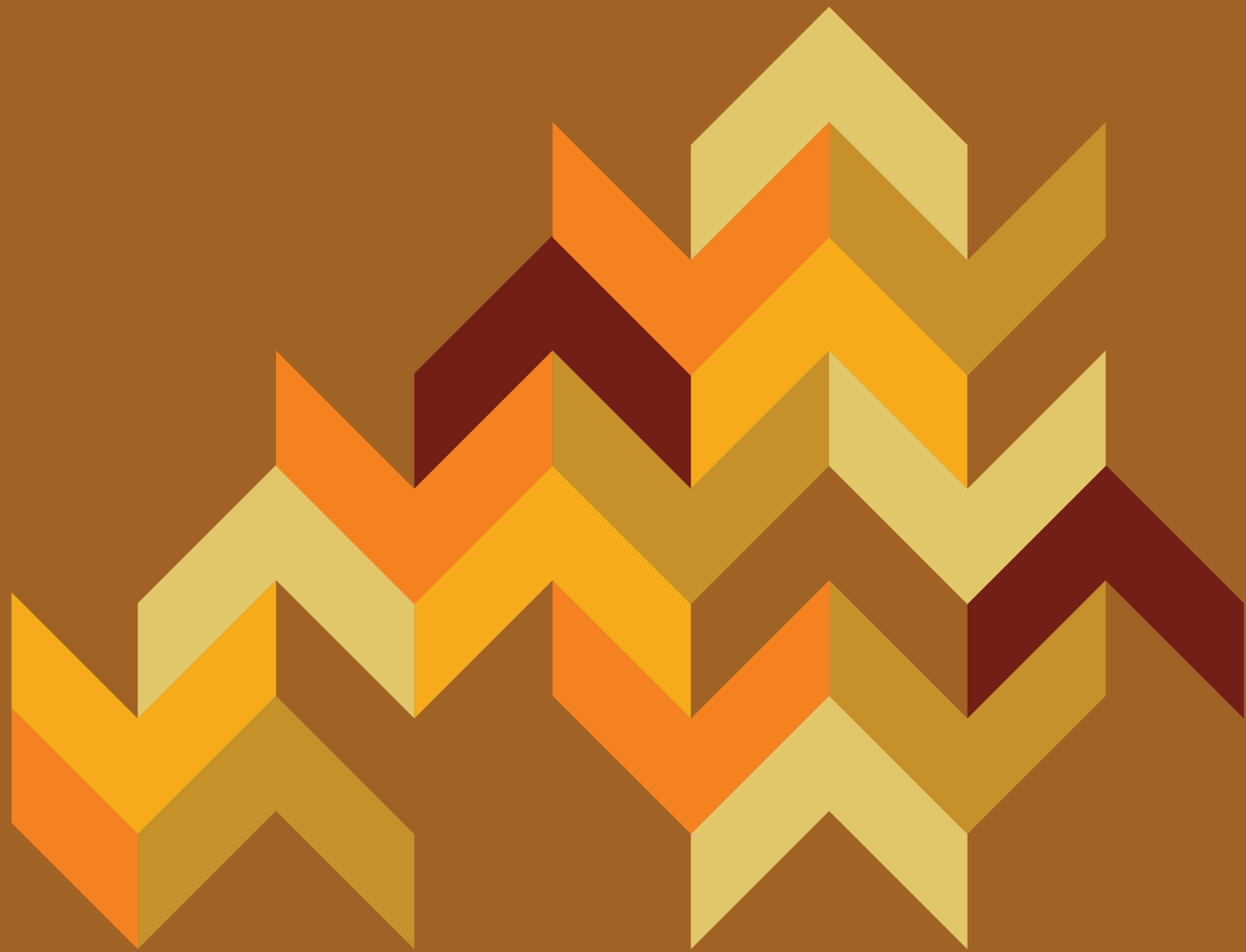
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Foreword by the Minister

It has been 19 years since Government adopted the White Paper for Social Welfare (1997) to guide the transformation of the social sector from welfare to social development services that seek to improve the quality of life of all South Africans. The White Paper linked the mandate of the Department of Social Development to Section 27 (1) (C) and Section 28 (1) of the Constitution of the Republic of South Africa. This means seeing the provision of social development services not narrowly as a matter of charity, but as giving effect to the Government's Constitutional obligation to human rights.

Since the adoption of this policy document, the Department of Social Development and the social sector as a whole has undergone major changes. We have witnessed a growing number of challenges that requires the intervention of the Department and the sector such as the increase in the levels of alcohol and substance abuse, violence against women and children and the declining moral fibre of our society which has given rise to many other challenges. Alongside these challenges, we have also witnessed encouraging progress in the sector such as the de-racialisation and expansion of the social assistance programme which to date reaches over 17 million eligible beneficiaries.

We also recorded notable progress in the general provision of social services to vulnerable groups, in particular women, people with disabilities, older persons and children. Over the years, Government has made significant investment in key sectoral programmes such as Early Childhood Development (ECD) with particular focus on children from poor households. Indeed we have made progress, but much more still need to be done. It is in this context that I appointed the Ministerial Committee to Review the implementation of the White Paper for Social Welfare under the leadership of Professor Vivienne Taylor. In the entire Government there is no department which connects with as many people at important milestones of their lives such as in childhood, youth and adulthood like the Department of Social Development. For this reason, it is important to assess that the services and interventions that we provide are responsive to the need of those we serve all the time. The aim of the review was twofold, namely to identify key achievements or areas where we are lagging behind and to make recommendations, particularly in the context of the envisioned role of the Department in the context of the National Development Plan.

The review report contains key observations and proposals from the beneficiaries of social services and the broader voice of the sector represented by non-governmental organisations, institutions of higher learning that produce social service professionals as well as social service professionals themselves.

This report is the first and a very important publication that makes an invaluable contribution to Government's social transformation agenda in key areas such as resource allocation for the social sector in terms of personnel and finances, establishment and enforcement of simple, effective and standardised data collection as well as analysis of developmental social welfare trends.



As we embark on a process to implement the proposals contained in this report, we seek the support of the sector and key partners who have keen interest in this field. Special acknowledgement go to the Ministerial Committee under the able leadership of Professor Vivienne Taylor who worked tirelessly and conducted consultations throughout the country.

We also express special acknowledgements to community and faith based organisations, and civil society at large, social service professionals, academics, our development partners, and all individuals and groups for their valuable time and contribution to this report.

We look forward to your continued contribution and partnership as we embark on this ambitious challenge of building the future we want for our children and many generations to come



Ms Bo Dlamini, MP

Minister of Social Development
Republic of South Africa

Message by the Chairperson of the Ministerial Committee on the Review of the White Paper for Social Welfare(1997), Prof V Taylor

*The Honourable Minister of Social Development
Minister Bathabile Dlamini
Government of the Republic of South Africa*

Minister,

We are pleased to submit to you the findings and recommendations of the Review of the implementation of the White Paper for Social Welfare (1997). There are two products of the White Paper Review that arise from a rigorous process of engagements with the entire social development sector. These are a ***Comprehensive Report on the Review of the White Paper*** and an abbreviated version of the report in the form of a Summary Report which provides an overview of the main findings and the recommendations.

After its establishment in September 2013 the Committee conducted a systematic and focused review of the state of social development service provision at national level and across all nine provinces with both government and non-governmental sectors. The main purpose of the review was to assess how the White Paper for Social Welfare is being implemented and to determine the lessons of experience for ongoing transformation of social development in the context of South Africa's National Development Plan (Vision 2030) (NDP). The Committee presented its findings and preliminary proposals to you and representatives from the entire sector including the National Planning Commission, UN representatives and related national government departments at a national summit in September 2015. The findings and preliminary proposals were debated and discussed in commissions at this summit. Participation from the social development sector at the summit and throughout the review was significant. During the period October 2015 through to February 2016 we tested the feasibility of key proposals and engaged with government departments that collaborate with social development in rendering primary or secondary social services to South Africans.

The report provides the first comprehensive and most up to date national assessment of progress, gaps and key challenges in the implementation of the White Paper for Social Welfare since 1997. It contains the latest quantitative and qualitative analysis of national and provincial trends in implementing the WP and the policy and programme responses in reducing issues of poverty, vulnerability and risks. Using national and provincial submissions from the broad social development sector as well as site visits, the Committee was able to assess the state of social development provision and the extent of transformation with "on the ground" engagements in all nine provinces and district engagements with service providers and service users and beneficiaries. We note in the

Message by the Chairperson of the Ministerial Committee on the Review of the White Paper for Social Welfare(1997), Prof V Taylor (continued)

report the achievements made since 1997 and the changing demographic and social and economic context especially with regard to poverty, inequalities and vulnerabilities of people through the life cycle. In addition, the lessons of experience, challenges and gaps in social development services when it comes to Constitutional and legislative mandates are highlighted. Recommendations and proposals in the report focus on the priorities contained in the NDP related to social protection and developmental social welfare as pathways to achieving social development. There are 16 major proposals in the report that, if implemented, can improve social development incrementally. Among these proposals is the urgent need for a National Social Development Act that provides overall direction and guidance on the place, role and functions of social development in South Africa.

This report will be a key reference for amendments to the White Paper for Social Welfare and for overarching national legislation to provide a framework on the functions, scope, size and shape and types of provisions in social development. Importantly, it provides an implementation framework for social protection and developmental welfare services to achieve social development while responding to the needs of those living in poverty and who are vulnerable and at risk. The report can also be used by government in national and provincial spheres and the non-governmental sector as well as other stakeholders to monitor the implementation of Constitutional mandates and the priorities in the National Development Plan as well as the process of achieving the country's 17 sustainable development goals.

Our findings highlight that since 1997 national government has achieved significant progress in certain important areas of social development. Notable among these is the establishment of a unified system of social development with national and provincial departmental structures to carry out the functions of social development. Changes to policies and legislation to promote transformation in social welfare and social development are also evident. Such policies and legislation align with the Constitution of the Republic of South Africa of 1996 (Act 108 of 1996). The introduction of new pieces of legislation and amendments to existing legislation is intended to create an enabling environment for the delivery of social development services. Our findings show, however, that enabling legislation and policy for social development services are undermined because resources to translate legislative mandates into operational effect lag far behind.

An outstanding achievement of government is in the area of social security, and specifically in social grants, to income-poor individuals and households. Both in the administration of social grants as well as in the distribution and reach of grants since 2003 South Africa is used as a best practice model internationally. Across all nine provinces the social grant programme was rated the best performer and evidence of its impacts on poverty, on the nutritional status of children, on gender and income

inequalities is positive. Yet a significant gap exists in the provision of social protection to indigent unemployed individuals between 18 and 59 years.

While there is significant progress in some areas, there are huge gaps in social welfare service provision in critical areas affecting the wellbeing of children, of youth in trouble with the law, of the elderly, of people with disabilities and of those who are experiencing substance addictions and violence. These gaps in services leave the poorest individuals and households in extreme distress and undermine the transformation and change agenda identified in the NDP (Vision 2030). With the exception of the programme on social grants and HIV and AIDS services, all other social welfare programmes had ratings below half of the possible score in relation to access to services, quality of services and distribution of services. This is not surprising given that the proportion of resources to fund social welfare services has remained static over the years. The Report provides 16 proposals to address the need for overarching national legislation, the critical inclusion of basic social welfare provision in a nationally agreed social protection floor, proposals to address gaps in social welfare services, alongside an incremental phased increase in funding of welfare services. Proposals to strengthen institutional arrangements and that focus on the need for ongoing generic and specialist education and training of social service professionals by the tertiary sector is also included.

Minister, it has been a privilege to serve the country through this national review process and to work with committee members and your staff as well as a wide range of individuals who are committed to a social transformation agenda in South Africa. It has also been a special privilege to work with you, the Deputy Minister and provincial representatives of government and the non-governmental sector during the review process to ensure that the needs of the most vulnerable and poorest people remain on the national agenda.

We believe that through the review process the social development sector has already begun to align its objectives with the NDP and is working towards achieving basic social protection and developmental welfare services for the poorest citizens. The report also highlights the links between the attainment of the 17 Sustainable Development Goals and the social development programmes and priorities. The momentum built through the review process of the White Paper for Social Welfare can be used to ensure that society collectively agrees on a social floor that protects the most vulnerable and enhances the welfare and life chances of all in South Africa.



Vivienne Taylor

Chairperson

31 March 2016

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* Ms Mohale was unable to participate in the meetings of the Committee after February 2015 owing to other commitments.

** Professor Patel resigned from the Committee in April 2015 owing to other commitments.

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- Research administrative assistant to Professor Taylor (Crystal Kleinhans);
- The portfolio committee on social development in the national parliament;
- Officials of the DSD and associated entities – in particular, the National Development Agency and South African Social Security Agency – at national, provincial and district level who made presentations, submitted documents, and participated in Committee meetings and events;
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- Heads of departments or their representatives of the social work and social development education sector, who made presentations, submitted reports, and participated in Committee's meetings and events such as the round table on education and in commissions during the national consultative summit;
- Researchers who participated in the Committee's work directly and/or on whose work the Committee drew;
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Table of contents

Foreword by the Minister	1
Message by the Chairperson of the Ministerial Committee on the Review of the White Paper for Social Welfare(1997), Prof V Taylor	3
Committee members	6
Acknowledgements	7
Acronyms and abbreviations	18
Background to the Review of the White Paper	21
Introduction	22
Process and methodologies used in the review	22
Structure of the report	24
Part I: Historical overview and social welfare context	26
Developmental social welfare and social protection: paths to social development	27
Equity and transformation	30
Fragmentation and data	34
Participation rates in decision-making	35
Fragmentation, specialisation and approach	35
Transformation of funding patterns in Social Development	36
Part II: Social protection in the Constitution and the National Development Plan	40
Social protection and social development	41
The NDP and the social protection floor	42
The sustainable development goals and social development	43
Part III: Welfare policy and legislation	46
New legislation and policies	47
Policy coherence	49
Consultation	50
Underlying values and principles	51
Roles of different spheres of government	51
Part IV: Socio-economic context	54
Economic growth and income distribution	55
Employment	58
Socio-economic context	59
Family and household composition	60
Migration	71
Part V: Financing and budgets	74
Department of Social Development budgets	75
The overall size and shape of DSD budgets	75
Funding of services: Changes since 1997	77
Inequities in funding of services	78
Fiscal space for expanding and equalisation of services	80

Data sources used in budget and beneficiary analysis	82
Cost of service delivery	82
Government revenue	85
Taxation	85
Tax expenditures	85
Special purpose funds and accounts	87
Part VI: Review of welfare and community development services	98
Introduction	99
Older persons	101
Updating the White Paper	102
Other findings of the Ministerial Committee	103
Budget analysis	105
Additional evidence	108
Roles and responsibilities	116
People with disabilities	118
Updating the White Paper	118
Other findings of the Ministerial Committee	122
Budget analysis	125
Additional evidence	127
Legislation and policy	133
Roles and responsibilities	136
HIV and AIDS	138
Updating the White Paper	139
Other findings of the Ministerial Committee	141
Additional evidence	143
Families	145
Updating the White Paper	146
Other findings of the Ministerial Committee	148
Budget analysis	149
Children	150
Updating the White Paper	151
Other findings of the Ministerial Committee	154
Budget analysis	159
Additional evidence	163
Crime prevention and support	169
Updating the White Paper	169
Other findings of the Ministerial Committee	170
Roles and responsibilities	172
Victim empowerment	173
Updating the White Paper	173
Other findings of the Ministerial Committee	173
Budget analysis	175
Additional evidence	176
Roles and responsibilities in respect of gender-based violence	177

Table of contents (continued)

Substance abuse prevention and rehabilitation	180
Updating the White Paper	181
Other findings of the Ministerial Committee	181
Budget analysis	183
Additional evidence	183
Roles and responsibilities	199
Poverty reduction, community development and sustainable livelihoods	202
Findings of the Ministerial Committee	202
Budget analysis	207
Roles and responsibilities	207
Youth development	209
Updating the White Paper	209
Other findings of the Ministerial Committee	209
Budget analysis	211
Roles and responsibilities	213
Women development	213
Updating the White Paper	214
Other findings of the Ministerial Committee	215
Budget analysis	216
Roles and responsibilities	216
Departmental initiatives and campaigns	218
Part VII: Social security	221
Updating the White Paper	222
Other findings of the Ministerial Committee	227
Additional evidence	231
Roles and responsibilities	244
Part VIII: Review of current institutional issues	246
Policy framework, functions and structures	249
Developmental welfare services and the capable developmental state	249
Policy and legislative mandates	250
Planning, monitoring and evaluation	250
DSD functions as outlined in guidelines, models and frameworks	251
Organisational design	252
Human resources	254
Updating the White Paper	254
Findings of the Ministerial Committee	256
Additional evidence	258
Human resource planning	278
Staff shortages	280
Workload management	282
Non-profit organisations	283
Updating the White Paper	284
Findings of the Ministerial Committee	285

DSD transfers to NPOs	287
Other government funding sources	310
Corporate funding	312
Pay and conditions of work	315
NPO regulation	321
NPO registration	323
Public Benefit Organisations	327
Education, training and skills development	329
Updating the White Paper	329
Findings of the Ministerial Committee	330
Social work and social development qualifications	330
Inadequate funding of social work and social development	331
The sector education and training authorities and social development	332
Social development and social work professional education and the NDP	333
Partnerships	334
Partnership with NPOs	335
Partnerships with donors	338
Partnerships with other government agencies	339
Partner structures	344
Planning and information systems	347
National Information System for Social Welfare	347
Matching need for and supply of services in Western Cape	350
Information systems	351
Part IX: Policy and legislative options for change	353
Proposal 1: Establish a social protection floor that includes social welfare	354
1. The issue, condition or problem addressed by the proposal	354
2. The proposed action/s	354
3. Alignment with the NDP	354
4. The delivery agents / partners	354
5. Resource implications	354
6. Timing and sequencing of the recommended actions	354
Proposal 2: Develop a national social development act	355
1. The issue, condition or problem addressed by the proposal	355
2. The proposed action/s	355
3. Alignment with the National Development Plan	355
4. The delivery agents / partners	355
5. Resource implications	355
6. Timing and sequencing of the recommended actions	356
Proposal 3: Include a social development component in the provincial equitable share formula or increase the poverty component to fund welfare services	356
1. The issue, condition or problem addressed by the proposal	356
2. The proposed action/s	356
3. Alignment with the National Development Plan	356
4. The delivery agents / partners	356

Table of contents (continued)

5. Resource implications	357
6. Timing and sequencing of the recommended actions	357
Proposal 4: Increase DSD welfare budgets incrementally	357
1. The issue, condition or problem addressed by the proposal	357
2. The proposed action/s	357
3. Alignment with the National Development Plan	358
4. The delivery agents / partners	358
5. Resource implications	358
6. Timing and sequencing of the recommended actions	358
Proposal 5: Strengthen national planning and standardise service offerings across provinces	358
1. The issue, condition or problem addressed by the proposal	358
2. The proposed action/s	359
3. Alignment with the National Development Plan	359
4. The delivery agents / partners	359
5. Resource implications	359
6. Timing and sequencing of the recommended actions	359
Proposal 6: Establish and enforce simple, effective and standardised data collection	359
1. The issue, condition or problem addressed by the proposal	359
2. The proposed action/s	360
3. Alignment with the National Development Plan	360
4. The delivery agents / partners	360
5. Resource implications	360
6. Timing and sequencing of the recommended actions	360
Proposal 7: Integrate youth development and women development into other programmes	361
1. The issue, condition or problem addressed by the proposal	361
2. The proposed action/s	361
3. Alignment with the National Development Plan	361
4. The delivery agents / partners:	361
5. Resource implications	361
6. Timing and sequencing of the recommended actions	361
Proposal 8: Focus the responsibility of the Department of Social Development in respect of disability	362
1. The issue, condition or problem addressed by the proposal	362
2. The proposed action/s	362
3. Alignment with the National Development Plan	362
4. The delivery agents / partners	362
5. Resource implications	362
6. Timing and sequencing of the recommended actions	362
Proposal 9: Coordinate with other departments and agree on roles and responsibilities	363
1. The issue, condition or problem addressed by the proposal:	363
2. The proposed action/s	363
3. Alignment with the National Development Plan	364
4. The delivery agents / partners	364
5. Resource implications	364
6. Timing and sequencing of the recommended actions	364

Proposal 10: Policy on orphans living with relatives	364
1. The issue, condition or problem addressed by the proposal	364
2. The proposed action/s	365
3. Alignment with the National Development Plan:	365
4. The delivery agents / partners	365
5. Resource implications	365
6. Timing and sequencing of the recommended actions	366
Proposal 11: Accelerate NPO funding reform process	366
1. The issue, condition or problem addressed by the proposal	366
2. The proposed action/s	366
3. Alignment with the National Development Plan	366
5. Resource implications	366
6. Timing and sequencing of the recommended actions	367
Proposal 12: Institutional reforms	367
1. The issue, condition or problem addressed by the proposal	367
2. The proposed action/s	367
3. Alignment with the National Development Plan	368
4. The delivery agents / partners	368
5. Resource implications	368
6. Timing and sequencing of the recommended proposal	368
Proposal 13: Human resource reforms	368
1. The issue, condition or problem addressed by the proposal	368
2. The proposed action/s	369
3. Alignment with the National Development Plan	370
4. The delivery agents / partners	370
5. Resource implications	370
6. Timing and sequencing of the recommended proposal	370
Proposal 14: Education, training and skills development	371
1. The issue, condition or problem addressed by the proposal	371
2. The proposed action/s	371
3. Alignment with the National Development Plan	372
4. The delivery agents / partners	372
5. Resource implications	372
6. Timing and sequencing of the recommended proposal	372
Proposal 15: Community development and sustainable livelihoods	373
1. The issue, condition or problem addressed by the proposal	373
2. The proposed action/s	373
3. Alignment with the National Development Plan	373
4. The delivery agents / partners	374
5. Resource implications	374
6. Timing and sequencing of the recommended proposal	374
Proposal 16: Comprehensive social security	374
1. The issue, condition or problem addressed by the proposal	374
2. The proposed action/s	375
3. Alignment with the National Development Plan	375

Table of contents (continued)

4. The delivery agents / partners	375
5. Resource implications	375
6. Timing and sequencing of the recommended proposal	375
Part X: Conclusion and next steps in achieving social development and vision 2030	376
Conclusion	377
Next steps	377
Appendix 1: Terms of reference	378

List of Tables

Table 1.	Examples of social development interventions by category	36
Table 2.	Population by age and sex and number of generations in household	50
Table 3.	Population by race and number of generations in household	50
Table 4.	Population by geo-type and number of generations in household	51
Table 5.	Population by age and sex and whether in skip-generation household	51
Table 6.	Population by geo-type and whether in skip-generation household	51
Table 7.	Population by age and sex and whether part of nuclear family household	52
Table 8.	Population by race and whether part of nuclear family household	53
Table 9.	Population by geo-type and whether part of nuclear family household	53
Table 10.	Population by constancy of household composition 2008 and 2011	55
Table 11.	Population by constancy of household size, 2008 and 2012	57
Table 12.	Distribution of individuals in households with less than 10 members by size of household in 2008 and 2012	58
Table 13.	Population by splitting of households between 2008 and 2012	58
Table 14.	Doubling welfare services allocations through annual 1,9% increase: National and provincial Social Development combined (Rm)	68
Table 15.	Equalising 2015/16 allocations per poor person to Northern Cape level (R000s)	68
Table 16.	Monthly full cost and cost to be subsidised per beneficiary, selected programmes – KPMG costing, August 2013	69
Table 17.	Monthly full cost and cost to be subsidised per beneficiary, selected programmes – adjusted to April 2015	70
Table 18.	Electricity levy collections (Rm)	74
Table 19.	Components of fuel tax per litre, 2011-2015	75
Table 20.	UIF transfers received (Rm)	76
Table 21.	Amounts paid in benefits (R000)	76
Table 22.	Assessment revenue (R bn), 2011/12-2017/18	77
Table 23.	Compensation claims, 2012/13-2014/15	77
Table 24.	Active financial commitments as at February 2015	79
Table 25.	Previous and active in-kind commitments as at February 2015	79
Table 26.	Key performance indicators for older persons for 2014/15	90

List of Tables (continued)

Table 27.	KPMG costs compared with 2015/6 budget allocations for older persons services using 2014 performance indicators (R'000)	91
Table 28.	Distribution of DSD-registered old age homes by province	93
Table 29.	Distribution of residential facilities by managing entity	94
Table 30.	Key performance indicators for persons with disabilities for 2014/15	111
Table 31.	KPMG costs compared with 2015/6 budget allocations for persons with disabilities using 2014 performance indicators (R'000)	111
Table 32.	Location of residential facilities for people with disabilities	112
Table 33.	Prevalence of severe depression by demographic factors, population 15+, 2012	117
Table 34.	Availability of facilities by province	118
Table 35.	Mental health roles and responsibilities	122
Table 36.	Needed funds compared with 2015/6 budget allocations for ECD using 2015 performance indicators (R'000)	146
Table 37.	KPMG costs compared with 2015/16 budget allocations for child and youth care centres using 2015 performance indicators (R'000)	147
Table 38.	Number of orphans and vulnerable children receiving psychosocial support services	148
Table 39.	Facilities accommodating children awaiting trial	151
Table 40.	Number of existing and planned facilities for children awaiting trial	152
Table 41.	Western Cape facilities registered to provide secure care	153
Table 42.	KPMG costs compared with 2015/6 budget allocations for substance abuse using 2014 performance indicators (R'000)	169
Table 43.	Prevalence of ever having had alcoholic drink (%)	171
Table 44.	Prevalence of ever having had alcoholic drink by province and sex (%)	171
Table 45.	Prevalence of ever having had alcoholic drink by race and sex (%)	171
Table 46.	Prevalence of every having had alcoholic drink by age group and sex (%)	172
Table 47.	Prevalence of frequency of drinking (%)	173
Table 48.	Prevalence of frequency of binge drinking on one occasion (%)	174
Table 49.	Distribution by AUDIT score (%)	175
Table 50.	Distribution by AUDIT scores within province and sex (%)	176
Table 51.	Distribution by AUDIT scores within race and sex (%)	176
Table 52.	Distribution by AUDIT scores within age group and sex (%)	176
Table 53.	Use of substances over past three months by sex	177
Table 54.	Number of substances used by sex	178
Table 55.	Number of substances used by race, age, province and geotype	178
Table 56.	Failure to perform responsibilities among cannabis users	179
Table 57.	Frequency of failure to perform responsibilities among substance users	180
Table 58.	Substance abuse facilities by province, funding and managements	182
Table 59.	Responsibilities of government agencies in respect of substance abuse	186
Table 60.	Comparison of 2012 and 2015 papers on comprehensive social security reform	222
Table 61.	Institutional arrangements for social security in South Africa	228
Table 62.	Social security benefits offered by different entities	229
Table 63.	Service points of social security agencies, 2012	230
Table 64.	Frontline social workers as percentage of all social workers by province and programme	248
Table 65.	Percentage of employees who are frontline workers by sub-programme (excluding EPWP)	252
Table 66.	Number of posts for service occupations by province, 2015	261
Table 67.	Service delivery occupations in national DSD	263

List of Tables (continued)

Table 68.	Social work and related professionals	263
Table 69.	Funded NPOs per province, 2012	278
Table 70.	NPO allocations by service area, Free State	279
Table 71.	Funded NPOs by service area, 2014/15, Gauteng	280
Table 72.	Funded NPOs by service area and district, 2014/15, Limpopo	281
Table 73.	Funded NPOs by service area and category, 2014/15, Western Cape	281
Table 74.	Monthly per-child subsidy for child and youth care centres (CYCCs)	289
Table 75.	Daily per-child subsidy for ECD centres	289
Table 76.	Monthly subsidy for drop-in centres for children	290
Table 77.	Monthly per-resident subsidy for homes for people with disabilities	290
Table 78.	Monthly per-resident subsidy for old age homes	291
Table 79.	Subsidy for day care/service centre for older persons	291
Table 80.	Annual subsidy for social workers	293
Table 81.	Annual subsidy for chief social worker / social work supervisor	293
Table 82.	Annual subsidy for social auxiliary worker	294
Table 83.	Transfers by broad category, 2012/13-2014/15 (R000s)	296
Table 84.	Social service categories of ICNPO	313
Table 85.	SAASWIP membership numbers, September 2015	333

List of Figures

Figure 1	Conceptual framework for the report	22
Figure 2	Focus group ratings of the four aspects of transformation	27
Figure 3	Comparative provincial social welfare expenditure per poor person, 2000 and 2015	28
Figure 4	District distribution of DSD personnel, Eastern Cape	29
Figure 5	District distribution of DSD personnel, Limpopo	30
Figure 6	Functional classification of consolidated budget, 1997/8-2017/18	63
Figure 7	Comparison of KPMG and Afrec costing estimates	70
Figure 8	Composition of tax expenditures, 2005/06-2012/13	73
Figure 9	Focus group ratings of service areas	84
Figure 10	Focus group average ratings of services by province	85
Figure 11	Per capita allocation for older persons by province, 2015/16	90
Figure 12	Number of subsidised homes for older persons, 1996/97 and 2010	96
Figure 13	Subsidised users of homes for older persons per 100 000 population aged 65 years and above	97
Figure 14	Comparison of need and capacity: Older persons homes	99
Figure 15	Comparison of need and capacity: Older persons' centres	101
Figure 16	Persons with disabilities allocation per disabled person aged 18-59 years by province, 2015/16	110
Figure 17	Subsidised homes for persons with disabilities, 1996/97 and 2013	113
Figure 18	Subsidised users of homes for persons with disability per 100 000 estimated population with disabilities	114
Figure 19	Comparison of need and capacity: Homes for persons with disabilities	115
Figure 20	Changes in number of foster child grant beneficiaries by province, 1997-2015	129
Figure 21	Children and families allocation per child by province, 2015/16	134

List of Figures (continued)

Figure 22	Comparison of need and capacity: Early childhood development centres	140
Figure 23	Child care and protection allocation per child by province, 2015/16	144
Figure 24	ECD and partial care allocation per child aged 0-4 years by province, 2015/16	145
Figure 25	Per capita allocation for community-based care services for maternal orphans, 2015/16	148
Figure 26	Victim empowerment allocation per sexual offence case reported in 2013/14 by province, 2015/16	161
Figure 27	Comparing need and capacity: Shelters for abused women	162
Figure 28	Comparing need and capacity: Substance abuse treatment centres	183
Figure 29	Poverty alleviation and sustainable livelihoods allocations per poor person by province, 2015/16-2017/18	193
Figure 30	Youth development allocation per NEET by province, 2015/16-2017/18	198
Figure 31	Comparing need and capacity: Youth development centres	199
Figure 32	Presidency organogram for youth development	200
Figure 33	Social grant amounts 1999-2015 (December 2013 rands)	209
Figure 34	Uptake of old age grant among population 60 years and above	210
Figure 35	Total DSD employees by department, 2015	241
Figure 36	DSD employees by department and population group	242
Figure 37	DSD employees by salary level	243
Figure 38	DSD employees by salary band and province	244
Figure 39	Key service delivery jobs	245
Figure 40	Length of service by employee category	246
Figure 41	Social workers by province and programme	247
Figure 42	Frontline social workers by province and programme	247
Figure 43	Social auxiliary workers by province and programme	249
Figure 44	Frontline community development workers by province and programme	250
Figure 45	Frontline child and youth care workers by province and programme	251
Figure 46	Social workers employed and subsidised by DSD	253
Figure 47	Social auxiliary workers employed and subsidised by DSD	254
Figure 48	Compensation of employees as percentage of expenditure	255
Figure 49	Administration programme as percentage of provincial DSD expenditure	256
Figure 50	Administration programme as a percentage of provincial DSD budget, 2011/12-2017/18	257
Figure 51	Population per post, filled position and total staff	258
Figure 52	Population per social worker posts, filled and staff	259
Figure 53	Filled and additional staff as percentage of approved posts	260
Figure 54	Service workers as percentage of all and filled posts	262
Figure 55	Administration as percentage of national DSD budget	263
Figure 56	Service delivery staff per director/manager	265
Figure 57	Population per government social worker, 1996/7 and 2015	266
Figure 58	NPO transfers as a percentage of provincial DSD budgets	286
Figure 59	Provincial subsidies for 2014/15 and Afrec 2011/12 costs for residential services	287
Figure 60	Provincial subsidies for 2014/15 and Afrec 2011/12 costs for other services	288
Figure 61	Capacity per 100 000 target population: Children's homes and residential facilities for people with disabilities, 1996/97	335
Figure 62	Capacity per 100 000 target population: Early childhood development centres and homes for older persons, 1996/97	336
Figure 63	Welfare case services, 1996/97	337

Acronyms and abbreviations

ARV	Anti-retroviral
ASASWEI	Association of South African Social Work Education Institutions
AUDIT	Alcohol Use Disorders Identification Test
BEE	Black economic empowerment
BRRR	Budgetary review and recommendation report
CBIMS	Community-based Interventions Monitoring System
CBO	Community-based organisation
CCG	Community caregiver
CCMA	Commission for Conciliation, Mediation and Arbitration
CCOD	Compensation Commission for Occupational Disease
CCW	Community care worker
CESM	Classification of Educational Subject Matter
CF	Compensation Fund
CIDA	Canadian International Development Agency
CPD	Continuous professional development
CSG	Child support grant
CSI	Corporate social investment
CSM	Continuing survey member
CSO	Civil society organisation
CWP	Community Work Programme
CYCC	Child and youth care centre
CYCW	Child and youth care workers
DCOG	Department of Cooperative Governance
DCS	Department of Correctional Services
DOD	Department of Defence
DOH	Department of Health
DOJ&CD	Department of Justice and Constitutional Development
DOL	Department of Labour
DRDLR	Department of Rural Development and Land Reform
DSD	Department of Social Development
DSW	Developmental social welfare
DVA	Domestic Violence Act
EC	Eastern Cape
ECC	Employment Conditions Commission
ECD	Early childhood development
EPWP	Expanded Public Works Programme
FAMSA	Families South Africa
FS	Free State
GCBS	Government Capacity Building Systems
GDP	Gross domestic product
GHS	General Household Survey
GT	Gauteng
HAT	Harmonised assessment test
HCBC	Home-and community-based care
HSRC	Human Sciences Research Council

Acronyms and abbreviations (continued)

HWSETA	Health and Welfare Sector Education and Training Authority
ICROP	Integrated Community Registration Outreach Programme
ID	Identity document
IDP	Integrated development plan
IDT	Independent Development Trust
ILO	International Labour Organisation
IMC	Inter-ministerial Committee
IMST	Information management systems technology
ISDM	Integrated Service Delivery Model
KZ	KwaZulu-Natal
LM	Limpopo
MinComm	Ministerial Committee
MP	Mpumalanga
MPRR	Mineral and Petroleum Resources Royalty
MTEF	Medium-term expenditure framework
MTSF	Medium-term strategic framework
NACOSS	National Coalition of Social Services
NASW SA	National Association of Social Workers (South Africa)
NC	Northern Cape
NDA	National Development Agency
NDMP	National Drug Master Plan
NDP	National Development Plan
NEET	Not in employment, education or training
NEHAWU	National Health Education and Welfare Union
NFD	Non-financial data
NICC	National Interim Consultative Committee on Developmental Social Services
NICRO	National Institute of Crime Prevention and Rehabilitation of Offenders
NIDS	National Income Dynamics Survey
NISWEL	National Information System for Social Welfare
NLDTF	National Lottery Distribution Trust Fund
NPA	National Prosecuting Authority
NPO	Non-profit organisation
NSSF	National Social Security Fund
NW	North West
OAG	Old age grant
OSD	Occupation-specific dispensation
OVC	Orphans and other vulnerable children
PBO	Public benefit organisation
PEPFAR	US Presidential Emergency Plan for AIDS Relief
PFA	Policy on Financial Awards to Service Providers
PoA	Programme of Action
PPP	Public-private partnership

RAF	Road Accident Fund
RAR	Reception, assessment and referral
RSA	Republic of South Africa
SAASWIPP	South African Association of Social Workers in Private Practice
SACENDU	South African Community Epidemiology Network on Drug Use
SACONO	South African Congress of Non-profit Organisations
SACSSP	South African Council for Social Service Profession
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SANGOCO	South African Non-governmental Coalition
SAOPF	South African Older Persons Forum
SAPS	South African Police Service
SASSA	South African Social Security Agency
SAVF	Suid Afrikaanse Vroue Federasie
SDIMS	Social Development Information Management System
SETA	Sector education and training authority
SLA	Service level agreement
SOA	Criminal Law (Sexual Offences and Related Matters) Amendment Act
SPC	Severe psychiatric condition
SROD	Social relief of distress
Stats SA	Statistics South Africa
TSM	Temporary survey member
UIF	Unemployment Insurance Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VAT	Value-added tax
VEP	Victim empowerment programme
WC	Western Cape



1. Background to the Review of the White Paper

1.1 Introduction

In September 2013 the Minister of Social Development, Honourable Bathabile Dlamini, appointed a Ministerial Committee which she tasked with a review of implementation of the White Paper for Social Welfare of 1997. The key question to be answered by the Committee was: “To what extent has the implementation of the White Paper for Social Welfare transformed and restructured social welfare / social development services in South Africa?”

The overall goal was to assess how all social welfare service providers, including government, non-government organisations (NGOs) and private providers have implemented the White Paper and the associated issues, challenges, and gaps in service delivery. The review will both inform production of a revised White Paper for Social Welfare/Development, and recommend changes to legislation, policies and programmes in line with government’s medium-term strategic framework (MTSF) and the National Development Plan (NDP).

The Minister appointed fifteen individuals from across South Africa with experience and knowledge relevant for the task at hand to be the members of what was constituted as an independent expert Committee. Professor Vivienne Taylor was appointed as chairperson, and Dr Thami Mazwai as deputy chairperson.

1.2 Process and methodologies used in the review

There were five phases to the Committee’s work, as follows:

- Phase 1: Setting up operational systems and assessing scope (September 2013-March 2014)
- Phase 2: National and provincial reviews of existing services (April 2014-December 2014)
- Phase 3: Research and consultations (January 2014-July 2015)
- Phase 4: Roundtables with experts, dialogues and a national consultative summit on findings of the review (June 2015-September 2015)
- Phase 5: Drafting, testing proposals and finalising report (August 2015-March 2016)

The review process began with presentations and written submissions from national DSD and its entities (South African Social Security Agency (SASSA) and National Development Agency (NDA)). In these and subsequent engagements, the Committee in some cases requested that participants submit follow-up information.

Thereafter, the Committee travelled to the nine provinces, in each of which there were two days of presentations from DSD and its entities and NPOs. Across the nine provinces combined, 151 government officials and 188 NPO representatives participated in these meetings. The dates of the provincial meetings were as follows:

- Eastern Cape: 9-10 February 2015
- Free State: 8-9 September 2014
- Gauteng: 20-21 October 2014
- KwaZulu-Natal: 27-28 August 2014

- Limpopo: 19-20 June 2014
- Mpumalanga: 15-16 April 2014
- Northern Cape: 27-28 March 2014
- North West: 12-13 March 2015
- Western Cape: 17-18 November 2014.

The provincial meetings were followed by a further two days spent in selected districts in each province by Committee members. Two districts were sampled in each province. In each of the selected districts, separate focus groups were held with users (beneficiaries), service providers, and practitioners, with a target of 30 participants for each of the three categories. Practitioners included social workers, child and youth care workers, community development practitioners, caregivers and probation officers. Across 17 districts¹, 127 DSD officials, 441 practitioners, 427 service providers, and 314 users of services participated. Some of the practitioners and service providers were DSD employees.

In addition, Committee members visited approximately eight service sites in each district. The sites visited included DSD's facilities and sites of (mainly subsidised) NPOs. Altogether 143 sites were visited. The Committee was supported in the provincial and district review process by a contracted secretariat (SEAS) and the DSD staff team.

On completion of the provincial and district visits, the Committee organised three roundtable consultations with experts to discuss challenges, gaps and future directions in social development. The first, attended by 49 representatives, focused on NPOs and the disability sector. The second, with 39 representatives, provided for engagement with higher education and training institutions and providers, and professional associations. The third, with 30 invitees participating, involved presentations from and discussions with experts on livelihoods, the Expanded Public Works Programme (EPWP) and community development.

In addition to these larger forums, the Committee invited specific government officials, experts and others to make inputs on key issues related to developmental social welfare and related themes at some of its meetings.

In September 2015 the Committee hosted a summit to share preliminary findings with the social development sector, and to consult on proposals for advancing priorities identified through the review and in the National Development Plan. The summit programme included a set of plenary presentations, including a keynote speech by the Minister of Social Development and a presentation of the processes and methodologies used in the review and, importantly, a detailed comprehensive presentation of the preliminary findings by the chairperson of the Committee. The presentations were followed by work in six commissions which subsequently reported back to plenary. A total of 464 people representing the social development sector attended the summit.

The findings from the review process and other engagements provided a rich picture of the state of social development services in the country. The primary data received in the form of oral and written input through this process was supplemented by secondary data

¹ The attendance register for one of the Northern Cape districts was mislaid, and the participants in those meetings are therefore excluded.

sources as well as some primary data collection and analysis. The additional information and analysis served both to fill gaps in our evidence and data and to triangulate and verify the data received through the primary engagement.

1.3 Structure of the report

The Committee has produced two versions of its report. A full comprehensive report, of over 350 pages, includes all the evidence gathered by the Committee. The summary report draws out the main findings that inform the Committee's proposals. The two reports have a similar structure, so as to allow policy makers and other readers of the summary report who would like further information on a particular aspect to find this in the full report.

Both reports are structured into nine parts, some of which are further sub-divided into chapters. The ninth part contains the Ministerial Committee's broad proposals for reform and amendments.

Many of the sections of the report begin with an italicised extract from the White Paper on Social Welfare of 1997. The discussion that follows these extracts, entitled *Updating the White Paper*, updates the situation described in the White Paper.² This discussion draws on information gathered during the review process as well as evidence from secondary and some further primary research. Because this is a review of the White Paper, the discussion is located similarly to where it was in that document. In a revised White Paper the location and content is in some cases likely to be different.

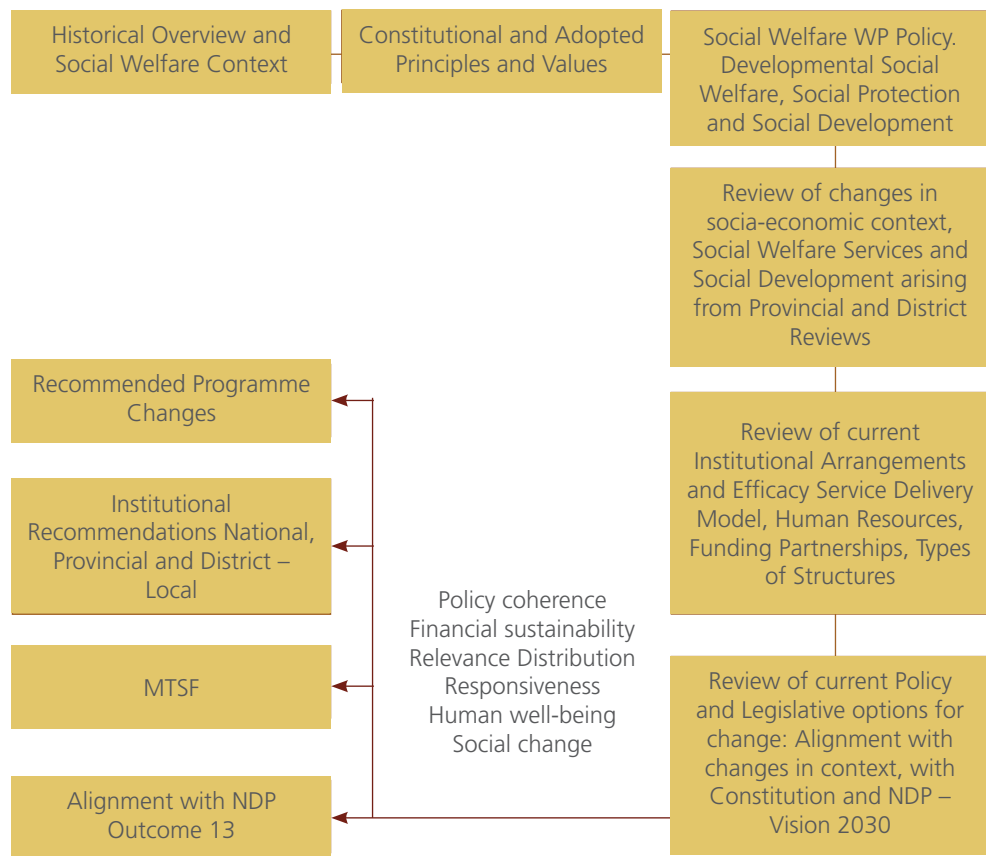
The information updating the White Paper is typically followed by a section titled *Other findings of the Ministerial Committee*. This section highlights issues that were not necessarily raised in the White Paper of 1997, but that emerged during the Committee's review process. It draws primarily on evidence gathered during the review process and, in particular information gathered during the national, provincial and district engagements.

This sub-section is followed, where relevant, with a discussion titled *Budget analysis* that explores the shape and size of the relevant budget allocations and expenditure for the issue under discussion.

On some issues there are further sub-sections. Additional evidence presents further information gathered primarily through secondary research and some primary research. The functions assigned to DSD and other roleplayers are discussed under *Roles and responsibilities* and issues which clearly require multi-sectoral responses are highlighted.

² From this point forward, the term "White Paper" refers to the White Paper on Social Welfare unless otherwise indicated.

Figure 1: Conceptual framework for the report – V. Taylor 2013





PART 1:

2. Historical overview and social welfare context

The White Paper on Social Welfare identified the lack of a national consensus on a welfare policy framework and its relationship to a national reconstruction and development strategy as the first “critical problem” within South Africa’s welfare system.

The White Paper characterised past (apartheid-era) welfare policies, legislation and programmes as “inequitable, inappropriate and ineffective in addressing poverty, basic human needs and the social development priorities of all people.” It noted the past and ongoing racial, gender, sectoral and geographic biases in access to, and delivery of, services.

The White Paper observed that the fragmented and incomplete nature of information resulted in an inability to assess need for and impact of welfare spending. The White Paper noted limited participation by citizens and “stakeholders” in decision-making related to social welfare policies, programmes and priorities, resulting in a lack of legitimacy of the system.

The White Paper observed that the social service delivery system was organised along specialist lines and fragmented between different fields of service, which made a holistic approach difficult. Further, while some social workers had community development skills, the approach was still largely rehabilitative and institutional rather than preventive and developmental.

The White Paper observed that in the past social welfare programmes were not seen as “critical social investment priorities” and were therefore under-resourced. Taxation and other finance-related legislation and policies were not “welfare-friendly”.

2.1 Developmental social welfare and social protection: paths to social development

The National Development Plan (NDP) provides the long term vision for development and an agenda until 2030 for South Africa that replaces that of the Reconstruction and Development Programme (RDP) of the nineties. There is a need to reach consensus on what this vision and agenda means for social development in terms of the proposals put forward in the White Paper of 1997. In particular, there is a need to explore the concept of developmental social welfare (DSW) that served as the underlying concept for the White Paper’s proposals. This is especially necessary given widespread agreement that the concept is interpreted in many different ways. Concerns are expressed about the vagueness of the concept and confusion about what changes in traditional methods of social welfare lead to DSW (see box). Questions are also raised about what the specific added value of developmental social welfare as a concept is within the broad vision of social development and social protection reflected in the NDP.

How is developmental social welfare understood?

The vagueness in prevailing understandings of the concept was typified by the wide range of responses offered in the Ministerial Committee's round table with non-profit organisations (NPOs) and the disability sector. When asked to describe developmental social welfare, participants offered a long list of characteristics. These included: grassroots not institutionalised; equity and equality; inclusion; not top-down; human rights-based; empowerment; people-centred; moves away from charity; active citizenry; advocacy; paradigm shift; accountability; transformation; opportunities; capacity building; social justice, strength-based perspective; people-centred; change; emancipatory; creates space and frees people to participate; provides for prevention and early intervention; celebrates diversity; organic and responsive; protects the vulnerable, encompasses progressive realisation; and inter-sectoral collaboration in place of a silo approach. In particular, participants emphasised the focus on poverty eradication and alleviation, and that it was also important to consider – and have information on – the full range of deprivations and ensure that services addressed these.

Participants in the round table for higher education and professional associations argued that developmental social welfare did not mean that social workers must develop economically-related projects at community level but the concept instead referred to the way in which social workers did their work. They agreed further that, while historic patterns of social and economic underdevelopment in South Africa created a range of different vulnerabilities, even when these were addressed, vulnerabilities and risks would continue to exist and would need to be addressed, through social work and specialised professionals.

The White Paper's introduction of the concept of developmental social welfare (DSW) was an important advance that situated the problems of individuals and families within South Africa's unique socio political context of institutional racism and socio-economic inequality. The Committee's understanding is that the concept of DSW places emphasis on the need to ensure that the psycho-social trauma and social alienation caused by structural inequalities during apartheid required a different approach to mainstream understandings of social work and social welfare. According to the Committee DSW recognises that outcomes of social alienation and the multiple deprivations of the majority of black South Africans contribute to social conditions which continue to make individuals, families, households and communities vulnerable. With high levels of poverty and inequality continuing in South Africa today (see further discussion below), this recognition remains important.

An evaluation of a reorientation training programme for social workers and other social service workers³ conducted soon after the White Paper was launched highlights confusions and challenges that still continue today. The programme was motivated by the sense that existing education and training prepared practitioners for therapeutic and restorative work, but "did not equip graduates to respond appropriately to the most

³ Southern Hemisphere. 2000. Evaluation of reorientation programmes for social service workers: Final report. Prepared for Independent Development Trust.

important social development needs in South African communities.” The evaluation found that while the programme provided participants with the theory of DSW, it did not give them the skills and support to implement DSW. Limited focus was given to how a shift in paradigm translates into changes in how social welfare is practised and the methods through which individuals and communities are enabled to reduce poverty related to structural conditions, risks and vulnerabilities. The professional practice implications of developmental social welfare were not clarified. This weakness was perhaps exacerbated by the fact that the trainers were all university lecturers.

Further, the evaluation found that there was a “misconception” among some participants that DSW was equivalent to community work. The participants – and evaluators – seemed to understand DSW as involving communities to be self-reliant as evidence, in particular, in promotion of (income-generating) projects. The evaluation therefore noted that the programme did not impart fundraising skills as a problem. The evaluation also cited the problem in Mpumalanga that social service workers were assigned to different programmes (such as children and families, substance abuse, or poverty alleviation), and this resulted in their entering communities with a specific agenda rather than utilising a “holistic” approach. The compartmentalisation also resulted in the poverty alleviation focus “running parallel” to other work. A further challenge specific to the course was that the materials referred only to social workers, thus excluding or marginalising other categories of social service workers.

The Committee finds a diversity of understandings of the concept of DSW within the government sector, the non-governmental sector, practising social development professionals, academics and researchers creates confusion. There is a need for further clarity to translate the concept into operational practice to better link DSW with poverty and vulnerability and takes into account the psycho-social trauma that individuals and households experience through their life cycle.

Chapter 11 of the NDP places emphasis on a social protection function within social development to address the needs of people who are vulnerable and who are at risk through their life cycle. The preventive and generative functions of social protection are designed to enhance individual and community coping in dire circumstances and links with effective community development processes. DSW is a path to ensuring that the most vulnerable and at risk in society have comprehensive social protection (including social welfare services) that covers them throughout their lifecycle. Together social protection measures, developmental social work and welfare services as well as community development processes provide the paths to social development. Social development is an outcome of protecting people who are vulnerable and at risk using both social assistance and social welfare services. It is also an outcome of processes that enable communities to overcome structural conditions such as poverty and unemployment through strategies designed to promote capabilities, social infrastructure and effective participation in local governance.

2.2 Equity and transformation

The White Paper proposed changes that are necessary for a more equitable welfare system and these changes are referred to by the term “transformation”. The Committee finds that overall equity in employment practices has improved across the sector. However, transformation of the sector in relation to the distribution and access to services for all who need them has been slow.

During the district reviews, the Ministerial Committee used a quantitative tool that assessed aspects of transformation. When completing the quantitative tool, district participants in the review (service providers⁴, practitioners and beneficiaries/users) were asked whether transformation was being addressed in the district in respect of four different aspects, namely racial integration, service delivery to other communities, integration of services, and employment equity. For this question the possible responses were yes, no, and “NA” (not available or not applicable).

Overall, perceptions of users and providers of services are that racial equity in the distribution of services and in employment practices has improved.

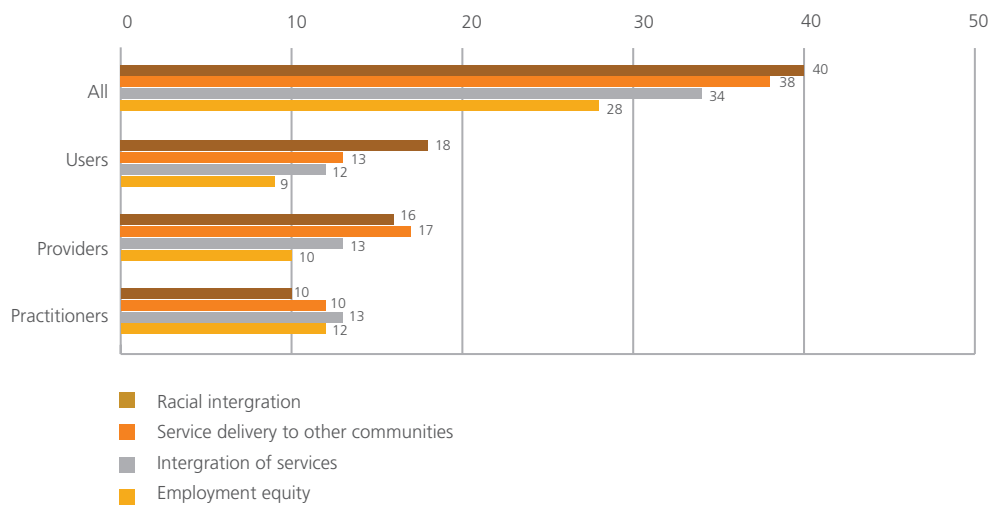
The scores reflected in **Figure 2** show the number who answered Yes for each of the four aspects. On the overall combined scores, the maximum possible score is 54 (18 districts x 3 stakeholder groups per district). Racial integration – referring to users – was scored highest overall, with 40 of 54 (74%) Yes answers. In some cases a No score here could reflect the fact that the geographical community served was not racially integrated. Employment equity – which should refer to those employed to deliver services – was scored lowest, but even here more than half of the responses are Yes.

For each of the three stakeholder groups the maximum possible score is 18 (one per district). In all districts service users reported that there was racial integration. Providers felt that both racial integration and service delivery to other communities were present in 16 or more of the districts. The practitioners gave lower scores for racial integration of delivery of social welfare to racially diverse communities than the other two groups, but a slightly higher score for employment equity. None of the groups gave fewer than half of the districts a Yes response on any of the four aspects.

Northern Cape emerged in first place at 5,3 of a possible 6, tied with KwaZulu-Natal. Gauteng scored slightly lower at 5,0. At the other end of the scale, Mpumalanga scored only 2,8 – less than half of the maximum possible, and a full unit below the next lowest-scoring provinces of Free State, Limpopo and North West.

⁴ In most provinces, DSD officials constituted a large proportion of the service providers who participated. DSD and SASSA officials were also included in the practitioner groups in most provinces.

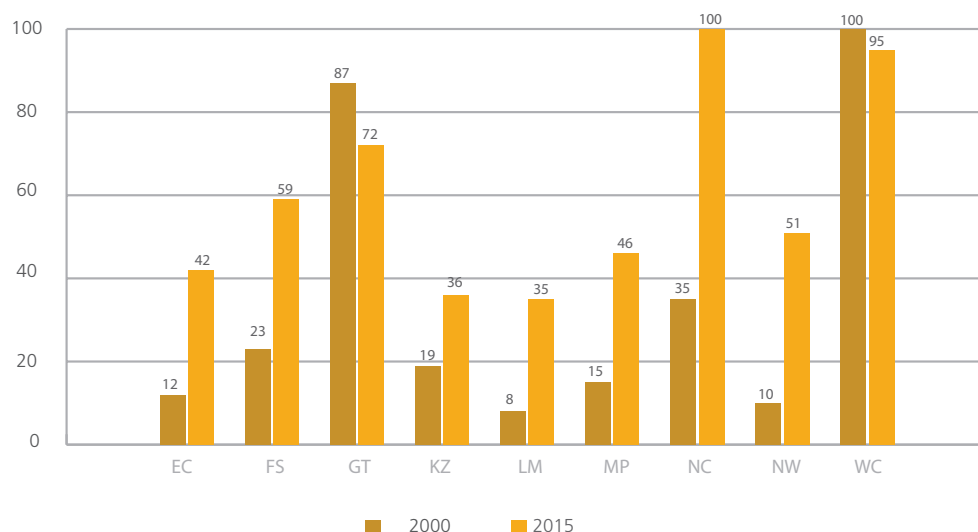
Figure 2: Focus group ratings of the four aspects of transformation



The Review finds that improvements in budget allocations have reduced geographical disparities. The Committee’s analysis of provincial budgets revealed that geographical disparities in financial provision for welfare services are less substantial than in the past. For example, **Figure 3** shows that while in 2000 the province with the lowest expenditure (Limpopo) allocated only R8 per poor person for every R100 allocated by the most well-provisioned province (Western Cape), by 2015 Limpopo was still the worst performing in terms of provisioning but its allocation per poor person now represented R35 for every R100 of the most well-provisioned (Northern Cape).⁵ Nevertheless, the gap between the worst- and best-provisioned provinces remains large, as do the differences in relative need for services across different areas.

⁵ 2000 estimates for welfare services from National Treasury. 2000. Intergovernmental Fiscal Review: 64; 2015 estimates calculated on the basis of full provincial DSD budgets. The nominal amounts per poor person were R41 for Limpopo and R503 for Western Cape in 2000, and R517 for Limpopo and R1 491 for Northern Cape in 2015.

Figure 3: Comparative provincial social welfare expenditure per poor person, 2000 and 2015



There are further disparities within provinces. The provincial budgets are not easily disaggregated to show the amount spent per district. An alternative indicator of disparity is the distribution of human resources, in the form of DSD employees.

Figure 4 uses Eastern Cape as an example and compares the distribution of government-employed social workers (SWs), social auxiliary workers (SAWs) and child and youth care workers (CYCWs) across districts with the distribution of the population (the blue bars). The numbers are derived from a provincial profile compiled by the provincial DSD in late 2014. Overall, the profile tool records 1 996 social workers, 416 SAWs and 174 CYCWs i.e. the number is highest for the most highly-paid cadre of worker and lowest for the lowest paid (who are, arguably, the most community-based and –oriented).

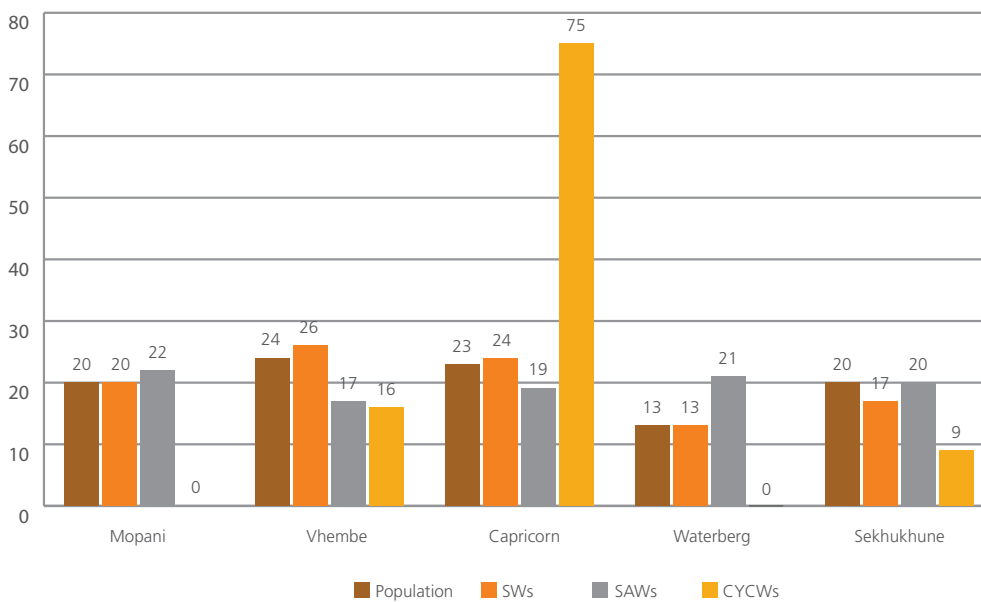
The figure shows that 75% of all government-employed CYCWs are in Nelson Mandela Metropole, while this district accounts for only 18% of the population. The distribution of social workers has the closest match to the population distribution, but even for social workers there is sometimes a five percentage point difference (for example, OR Tambo and Joe Gqabi) between the two distributions. Social auxiliary workers are generally less well distributed and CYCWs worst of all.

Figure 4: District distribution of DSD personnel, Eastern Cape



In Limpopo, as seen in **Figure 5**, the profile tool recorded 1 526 social workers, 190 SAWs and 77 CYCWs i.e. the number is again highest for the most highly-paid cadre of worker and lowest for the lowest paid. The most striking message is that 75% of all government-employed CYCWs are in Capricorn district, while this district accounts for only 23% of the population. The distribution of social workers shows a very close match to the population distribution. The social auxiliary workers show a close match for some provinces, but Vhembe is noticeably under-provided when compared to the population while Waterberg is over-provided.

Figure 5: District distribution of DSD personnel, Limpopo



2.3 Fragmentation and data

Today the social development system is less fragmented and simpler to the extent that there are fewer administrations involved than during the apartheid era, and services and the related data collection and indicators of services are to some extent standardised. Nevertheless, substantial challenges remain in relation to data. There has been a range of attempts to improve information, but these attempts have generally been expensive and over-ambitious and/or poorly implemented.

Further, the Ministerial Committee found inconsistencies in coding and recording and missing information even in the transversal (i.e not DSD-specific) databases such as PERSAL, the government employee database used, among others, for salary purposes.

Within DSD, the Social Development Information Management System (SDIMS) was first developed in the Eastern Cape, and from 2007 onwards was rolled out to all provinces. SDIMS includes modules on community-based services, foster care, RAR (reception, assessment, referral), and registers for case tracking and child protection. Further modules are planned. National DSD's annual report for 2014/15 noted that the "first phase"⁶ of SDIMS involved integration of (a) Victim Empowerment and Older Person Register; (b) Probation Case Management System; (c) Child Youth Care Application; (d) Accreditation of diversion programmes and services; and (e) Intake module. The list of aspects integrated also does not show an exact match with modules referred to elsewhere.

Across provinces the Ministerial Committee heard that SDIMS was not working well, if at all. Some of the problems appear to be related to the design (such as the inability to capture information off-line), some to availability of the necessary tools and infrastructure such as computers and electricity, and some to reluctance on the part of staff (primarily social workers) responsible for using the system to record data. Provinces struggle to produce basic performance delivery statistics, and use a large number of different paper-based or spreadsheet-based data collection instruments for the different service areas. Gauteng has replaced SDIMS with another system, Supatsela. In some cases the response has been to develop a replacement system which is equally complex and difficult to implement.

In terms of general population data, Statistics South Africa (Stats SA) now places decision makers in a much better position than before (although data at the level of small geographical areas is not reliable). However, challenges remain in respect of some important data elements, such as those relating to some aspects of disability. Beyond government's need for information for planning and monitoring, there was a constant refrain in the district reviews that ordinary people do not know what services are available.

DSD does not have reliable statistics and other information easily available on key operational issues essential for planning purposes. For example, provinces do not have readily at hand the number of posts that they fund in non-profit organisations (NPOs) despite the key role played by these organisations in delivering services for which DSD is responsible.

⁶ It is not clear why/how a first phase can be reported on in 2014/15.

2.4 Participation rates in decision-making

Participation rates of people in the sector have increased. Unlike pre-1994 a large number of forums for citizen participation exist today. Some sectors do however report that they are not adequately consulted, and would like to participate more. Others who participated in the Ministerial Committee's reviews observed that they spent too much time going to meetings, leaving too little time for managing or "doing" welfare service delivery. The forums for participation also impose financial and other costs on both government and other entities.

Some participants at the round table with NPOs and people with disability reported that they had, in a short space of time, attended a series of meetings with substantial overlap of content. In this instance, and perhaps others, one of the underlying reasons for the plethora of meetings is the large number of different but related policy processes ongoing at the time.

In addition, several of the policies and some pieces of legislation developed over the years since the White Paper mandate creation of issue-specific multi-stakeholder, multi-sectoral forums at multiple levels. Some forums are mandatory and permanent, but that does not necessarily mean that they work well or that the necessary resources are allocated for them. Overall, it seems there is a need to assess whether each of the existing forums serves a purpose that warrants the time, money and other resources devoted to it.

2.5 Fragmentation, specialisation and approach

Specialisation and service fragmentation remain a challenge. Subsequent to the publication of the White Paper, DSD developed the Integrated Service Delivery Model (ISDM) in an attempt to provide for integration of services across programmes. Nevertheless, programmes continue to be determined by target group (often related to life cycle stages) or issue. Services continue to be delivered primarily by target group/issue-specific NPOs although some NPOs have expanded their scope, and many are now working in a more holistic way. Within government, staff are often allocated to programmes designed to address specific social conditions of people. Some of these conditions cut across a range of interventions and require better integration at the point of service delivery.

Further, complicating the issue is that the various official documents that prescribe norms and standards do so at the generic level in terms of the ISDM, at the service-area specific level, and also in terms of different types of office arrangements. These different specifications are not easily reconciled and inevitably result in frustration in planning processes.

There is also growing recognition that there is need for specialised skills to deal with particular groups and issues. Two important findings on fragmentation of social welfare services and specialisation are highlighted. First the response to fragmentation of services has been to create models for integrated service delivery and interventions. The

challenge, however, is not one of integrating service interventions but rather ensuring that people can access services without having to be referred from place to place. The use of multipurpose facilities rather than “single-use” facilities would provide better integration at the point of delivery. The issue is one of providing a range of services within a single facility.

The second finding is that integration of services is assumed to address the need for specialised services. It does not. As noted in the NDP the structural inequities contribute to complex social conditions including substance abuse, abuse of children and elderly, violence, trauma and social isolation. These conditions require specialised social welfare services. They require expert knowledge and treatment interventions that existing social development professionals generally do not have.

Another finding relates to the shift in approach to social welfare that was recommended in the White Paper. This shift was characterised by a process of deinstitutionalising people who required long-term residential care. The shift to community-based care using a DSW approach requires additional resources and infrastructure within communities. These resources are not present. Community-based care systems require more planning, resources and infrastructure to be effective.

Institutional and residential services continue to be offered, but many community- and home-based programmes have been developed and some institutional and residential services now incorporate a more developmental approach. The cost of these services is not included in the transfers received by NPOs from government. What also emerged clearly from the Committee’s engagement is that a developmental approach does not remove the need for rehabilitative and institutional services. Further, those managing institutional services would be acting unethically if they released beneficiaries into the community without the necessary aftercare services being in place.

2.6 Transformation of funding patterns in Social Development

Disparities in funding in social development services continue and funding remains inadequate to meet the needs. Funding allocations for social welfare services have remained static. Analysis of current provincial DSD budgets reveals that inadequate funding remains a problem, especially in respect of NPOs who are the main delivery agents. There are also many operational problems, such as late notification about transfers, and delayed signing of contracts, and late payments. These inefficiencies, which are discussed further below, are probably more easily addressed than the size and extent of transfers. The inadequacies are illustrated by the substantial provincial variation in the financial allocations per member of the relevant target group of different service areas. For example, in 2015/16, in respect of the full allocation for government and NPO services, the range between the most and least generous per capita allocations is as follows:

- Limpopo allocated only R209 per year for older persons services per poor person aged 60 years and above, while Western Cape allocated R1 448
- Northern Cape allocated only R115 per year for disability services per severely disabled person, as against R1 584 in Western Cape

- Eastern Cape allocated only R264 per year for children and families services per poor child, as against R1 323 in Gauteng
- KwaZulu-Natal allocated only R2 per year for the poverty alleviation programme per poor person compared to R79 in Northern Cape.

These examples suggest that while the disparities in some cases reflect historical differences in wealth and availability of services, sometimes there are other factors at play. Expressed differently, the budget allocations reflect policy decisions rather than only available funds. A contributory factor to the disparities is the fact that – unlike in respect of subsidies to schools in education – national DSD does not currently prescribe the amounts to be paid to NPOs that provide statutory services, although standardised amounts were previously specified.⁷ The problems in this respect are discussed further below.

The budget allocations are insufficient even in the provinces with higher per capita amounts. This is illustrated by the fact that the total budget allocation for various service areas does not cover the core costs of delivering the relevant services even to those who are already being reached. Yet the performance monitoring data reveal that only a small proportion of the target group is currently being reached. The shortfall would thus be much larger if access was improved to acceptable levels.

Legislation and policy-making in respect of NPOs and NPO funding are a source of ongoing tension, and has in some cases provoked litigation. The funding challenges for NPOs are exacerbated by the drying up of other sources of funding because South Africa is no longer seen as a priority recipient for aid, and because the international global financial crisis, and general austerity have reduced both international and local potential sources of funding. International funders generally feel that a middle-income country such as South Africa should be funding its own service delivery.

Added pressure has resulted from DSD's endeavour to shift funding away from traditional welfare organisations, many with their origins in white Afrikaner churches in the cities and white towns – to community-based or “emerging” organisations. A static budgets inevitably results in funds being diverted away from the organisations that have experience, skills and expertise in delivering services. The Committee found that historically white organisations are making attempts to expand the geographical scope of their delivery as well as the racial representation of beneficiary profile. Meanwhile many of the emerging organisations may be more firmly located in poor areas and communities, but lack the expertise to provide quality services. While there have been initiatives to provide management, financial and similar generic organisational support alongside funding, these initiatives generally do not address weaknesses in professional service-related skills.

A review of budget allocations shows that within government, social development is accorded low priority in both national and provincial level. At provincial level, there is no social development component in the formula for the equitable share which accounts for a major part of provincial budgets. The absence of a social development component

⁷ Standardised amounts are specified, for example, in the Report of the Welfare Reprioritisation Committee, 31 March 1996, to then Minister of Welfare and Population Development Geraldine Fraser-Moleketi.

or share sends a message that this is not a key area that requires substantial resources. The Financial and Fiscal Commission and National Treasury have argued that the poverty component of the formula caters for social development, as the underlying indicators would be the same for poverty and social development. While the point about similar indicators has some validity, the fact that the share of the poverty component has not increased despite new social development legislation and obligations having come into force undermines the argument.

At national level, national DSD has over the years submitted several bids for additional funds to be allocated to provinces for particular social welfare purposes. These bids have often been refused on the grounds that DSD has not made a convincing case. Challenges that prevent this happening include poor data and information on the demand or need for services as well as on the costs of service delivery (and of non-delivery). This is not a recent problem. In this respect, already in 1992 Francie Lund's research into the multiple welfare bureaucracies then operating in South Africa noted that welfare is less able than a sector such as health to "argue its case" because it does not have similar tools to measure impact, activities and service delivery.⁸ Where additional funds are provided, provincial treasuries do not always make the extra funds available to the provincial DSD, and the provincial DSD may itself divert the funds for other purposes.

As discussed elsewhere in this document, a range of new laws and policies have been developed since 1997. For some of these – such as the Child Justice Bill, Children's Bill, Programme of Action for Early Childhood Development (ECD), social welfare services registration processes, and NPO registration processes – cost estimates for implementation have been developed. However, it seems that these "costings" have not necessarily been adopted and used in planning, implementation and budgeting, and none has been updated over time. Different methodologies have been used for the various "costings", and questions are asked as to whether the "costings" are based on realistic minimum norms and standards or, instead, sometimes idealistic levels. In many cases the financial estimates focus on the unit cost of delivery without attempting to estimate how many units are needed i.e. how many people are in need of the particular service.

Taxation laws provide some relief for donors and for some NPOs, as discussed elsewhere in this report. The Davis Commission is looking at these issues as one part of its larger investigation into taxation policy and legislation.

⁸ Lund FJ. 1992. The way welfare works Structures, spending, staffing and social work in the South African Welfare bureaucracies. Human Sciences Research Programme: Pretoria: 21.

Historical overview and social welfare context:

Summary highlights

- The concept of developmental social welfare is now widely accepted as the underlying approach to social development, although there are differences in how it is understood.
- Institutional arrangements for social development have transformed with a single national department of social development and nine provincial departments.
- Equity in employment practices across government and non-governmental sectors has improved.
- Service delivery to previously disadvantaged areas has expanded and services are now more integrated, but there are still clear imbalances in access.
- The need for social welfare services in critical areas such as child protection, violence prevention, substance abuse, trauma counselling and in mental health as well as in the care of the elderly far outstrips current levels of provision.
- The policy development process is far more consultative than previously.
- South Africa still does not have a national social development act, and this contributes to lack of uniformity across provinces in funding, staffing and prioritisation of different service areas and services
- The funding available for social development, particularly social welfare services, remains limited.



PART II:

3. Social protection in the Constitution and the National Development Plan

Section 27 of the South African Constitution establishes legally enforceable obligations on government that encompass every aspect of a system of social protection. The section states that all South Africans “have the right ... to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.” Section 27(2) goes further to state that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to social security and social assistance. Section 28(1) (c) of the Constitution provides for the right of children to social services. These rights are immediately realisable rather than subject to progressive realisation within available resources.

3.1 Social protection and social development

In line with the Constitutional obligation, social protection is one of the key priorities identified in the NDP and is central in ensuring the links between social and economic policy goals. Social protection is envisaged as ensuring inclusive social development by ensuring that protective, preventive, transformative and generative measures are in place for human well-being across all sectors of society. **Table 1** below provides some examples of social development interventions that fit into the various categories.

Table 1: Examples of social development interventions by category

Category	Objective	Social development examples
Protective	Aims to protect the most vulnerable and at risk individuals and households from further exposure to poverty and deprivation and to provide prompt assistance when exposure has happened	Residential facilities for care of vulnerable Food parcels Social relief of distress Safe houses for survivors of violence Substance abuse treatment & care
Preventive	Aims to prevent people from falling into (deeper) poverty and vulnerability by promotional activities in communities, schools and employment spaces in which formal and informal sector workers receive income	Social grants Food gardens Active aging Teenagers Against Drug Abuse Comprehensive social security (including social insurance measures).
Promotive	Aims to enhance the capabilities of individuals, communities and institutions to participate in all spheres of activity through developmental, rehabilitative and therapeutic services	Protective workshops Early childhood development Stimulation centres Skills training for prisoners Aftercare services

Category	Objective	Social development examples
Transformative	Aims to reduce inequities and vulnerabilities through systemic and redistributive changes that provide an enabling environment for broadening access and quality of social development services	National legislation for social development Legislated social protection floor including welfare services National minimum wage National reform of NPO funding
Developmental and generative	Aims to promote local economic development and enable poor and vulnerable people to access economic and social opportunities	Social grants Expanded public works programme Community work programme Expansion of services to under-served areas (ICROP, Isibindi)

3.2 The NDP and the social protection floor

Chapter 11 of the NDP positions social protection as a critical part of public policy which provides support that reduces vulnerability, alleviates and ultimately prevents poverty, and empowers individuals, families and communities through a range of social development services. The goal is to create a caring nation, that has a defined social minimum or social floor that prescribes a standard of living below which no one should fall – this should include access to basic social welfare services. Social protection measures cover the entire life cycle of individuals from conception (by ensuring that pregnant mothers have adequate nutrition) up to old age. The measures include developmental strategies to promote social and economic integration throughout the lifecycle of those who are vulnerable and at risk.

Implementation of Chapter 11, which focuses on social protection, links with objectives in other chapters in the NDP that also address elements of social protection. These include the economy and employment, education, health and infrastructure as all of these contribute to the social protection floor (or parts of the social wage). The welfare of people is a primary function of social development and a secondary function of many other departments across government.

The NDP envisages the social protection floor as specifying a minimum guaranteed level of entitlements to social benefits, including social welfare services. It would provide for a set of norms, standards and criteria for the basic level and types of social development services and specify who would benefit. Achievement of this protection floor by 2030 will require incremental improvements to the human resources required, as well as the funding and institutional arrangements.

3.3 The sustainable development goals and social development

While the NDP sees the social protection floor as being achieved only by 2030, the needs of vulnerable groups would need to be prioritised on the path to this end goal. Further, while the NDP envisages a “mixed economy” of social development which combines state and market-based provision, and utilises the services of non-profit institutions, government would bear responsibility for ensuring that the needs of the most vulnerable and those at risk are met through either funding provision by others or providing services itself. The social protection floor aims to improve the quality of life of all and advance achievement of the sustainable development goals (see box).

Prioritisation of the needs of the most vulnerable is in line with the underlying principles proposed for the social protection floor, namely solidarity; social cohesion; social and economic inclusion; promotion of active citizenship; capacity enhancement; equity; and distributive justice.

Sustainable development goals and social development

South Africa was among the many countries that participated in the United Nations Sustainable Development Summit of 25 September 2015, where the 2030 Agenda for Sustainable Development was adopted. The Agenda includes a set of 17 Sustainable Development Goals (SDGs) to end poverty, fight inequality and injustice, and tackle climate change by 2030. The goals are as follows:

1. Poverty - End poverty in all its forms everywhere
2. Food - End hunger, achieve food security and improved nutrition and promote sustainable agriculture
3. Health - Ensure healthy lives and promote well-being for all at all ages
4. Education - Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
5. Women - Achieve gender equality and empower all women and girls
6. Water - Ensure availability and sustainable management of water and sanitation for all
7. Energy - Ensure access to affordable, reliable, sustainable and modern energy for all
8. Economy - Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
9. Infrastructure - Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
10. Inequality - Reduce inequality within and among countries
11. Habitation - Make cities and human settlements inclusive, safe, resilient and sustainable
12. Consumption - Ensure sustainable consumption and production patterns
13. Climate - Take urgent action to combat climate change and its impacts

Sustainable development goals and social development

14. Marine-ecosystems - Conserve and sustainably use the oceans, seas and marine resources for sustainable development
15. Ecosystems - Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
16. Institutions - Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
17. Sustainability - Strengthen the means of implementation and revitalize the global partnership for sustainable development

The vision statement of the Agenda explicitly envisages, in clause 7, that in 2030 we will have a world with equitable and universal access to social protection and, in clause 24, that everyone should enjoy “a basic standard of living, including through social protection systems.” Both social protection and social development more broadly defined are linked to many of the 17 goals, with especially strong links to four goals.

Both social grants and activities related to sustainable livelihoods and poverty alleviation make clear contributions to goal 1 on poverty alleviation. To the extent that social development services address hunger and food security, it is linked to goal 2 on food.

Many of the welfare services, and in particular those relating to children, older persons and persons with disability, link to clause 5.4 of goal 5 on gender equality and women’s empowerment. This goal calls for recognition and valuation of unpaid care through the provision of public services, infrastructure and social protection policies. The strong link with gender equality and women’s empowerment exists because, where accessible public services are not available, it is women who bear the primary responsibility for doing this work unpaid in their homes.

Social development, with its strong focus on equity highlighted throughout this report, also contributes to goal 10, which focuses on reduction of inequality within and among countries. Clause 10.4 of this goal refers explicitly to social protection policies.

Social protection in the Constitution and the National Development Plan:

Summary highlights

- The Constitution of 1996 proclaims the right of all to social protection, and provides especially strong rights for children.
- Chapter 11 of the National Development Plan also identifies social protection as a critical part of public policy, and provides for a social protection floor.
- The NDP conceives social protection as extending beyond social security and social assistance
- A social protection floor would promote achievement of the Sustainable Development Goals, in particular goal 1 on poverty alleviation, goal 2 on food, and goal 5 on gender equality and women's empowerment.



PART III:

4. Welfare policy and legislation

The White Paper noted that most of the legislation governing social welfare and related services had been passed by the previous government including the “independent” homelands, as well as the separate departments for the different race groups. It noted further that the welfare sector is directly influenced by legislation of other ministries, whether through affecting welfare services, target groups or alleviation of poverty (which the White Paper saw as in part as a welfare task). It observed that the legislation in existence at the time it was drafted was generally not developed through an inclusive and consultative process. As a result it tended to reflect the choices and values “of an elite group of politicians, public servants and opinion makers”, and did not enjoy broad public support, or even support from other government sectors.

The White Paper noted that the existing legislation was not based on planning and evaluation, but instead reflected “ad hoc and partial reactions” to different needs at different times. It noted further the lack of adequate policy guidelines in respect of the values and principles that should underlie welfare services and the extent of government responsibility. It observed that while there was a new Constitution in place, the criteria for distinguishing the roles and powers of national and provincial government were open to interpretation and could result in confusion or even conflict.

4.1 New legislation and policies

In the period since 1997, several new social development policies have been developed and laws enacted, while some of the existing laws have been amended. New policies developed since 1997 include the White Paper on Families, the National Drug Master Plan (which is reviewed every five years); the Anti-substance Abuse Policy; National Policy Guidelines for Victim Empowerment; the South African Older Persons Policy; Policy on Services for People with Disability; Policy on Financial Awards; the Integrated Social Crime Prevention Strategy; and the Policy framework on accreditation of diversion service providers in South Africa. New legislation includes the Older Persons Act, 2006; Prevention of and Treatment for Substance Abuse Act, 2008; Social Service Professions Act, 1978 as amended; Probation Services Act, 1991; Child Justice Act, 2008; and Children’s Act 2005 as amended.

Draft policies and legislation in process in April 2015 included second and third amendment bills to the Children’s Act; the Non-profit Organisations Act (process at the policy framework stage); Victim Empowerment Services Bill; Draft Policy on ECD; Older Persons Draft Amendment Bill; Policy Framework on Social Service Professions; and amendment of the Social Assistance Act.

In the area of disability, DSD’s role expanded when the Department of Women, Child and People with Disabilities became the Department of Women and responsibility for transversal issues in respect of children and people with disabilities was relocated to DSD. DSD has developed a draft bill on social development services to people with disabilities as well as a national policy on the rights of people with disabilities. Development of the bill, which relates to DSD’s core functions, has been put on hold until the disability rights policy – which relates to government as a whole – is finalised.

In addition to the legislation and policies, a large number of supporting documents have been developed. For example, in respect of families, where a White Paper was released in 2013 after a multi-year process, the supporting documents include the 2007 Manual for Marriage Preparation and Marriage Enrichment, Department of Social Development; 2010 (Revised) Manual on Family Preservation Services; 2012 Guidelines on Reunification Services for Families; 2012 Norms and Standards for Services to Families; 2012 Framework on Mediation for Social Services Professionals Mediating Family Matters; 2013 Keeping Families Together Customised Manual on family preservation services for emerging organisations including faith-based and emerging community-based organisations; 2013 Fatherhood strategy, as well as an undated Training Manual on Families in Crisis and undated Integrated Parenting Framework.

The Committee finds that a proliferation of supporting documents is often stimulated by donor funding. In the area of victim empowerment, for example, the following enumeration shows the proliferation of documents in the period 2009 through 2011 when there was donor funding for this area of work. The documents produced for this service area include the 2003 Policy Framework and Strategy for Shelters for Victims of Domestic Violence in South Africa; undated National Policy Guidelines for Victim Empowerment and Victim Empowerment Programme (VEP) Cluster and Technical Support; 2009 Integrated Indicator Set for the National Victim Empowerment Program; 2010 Social Development Guidelines on Services for Victims of Domestic Violence; 2010 Shelter Strategy for Victims of Crime and Violence in South Africa; 2011 Working with Victims of Human Trafficking: Training manual on Restoration and Healing Programme; 2011 Manual on the Establishment of a Khuseleka One Stop Centre Model; 2013 Mentoring and coaching model for emerging CSOs [civil society organisations] [on VEP]. There are also several undated documents related to human trafficking, including Intake officers/ social service providers: Identification of victims of trafficking; Human Trafficking: DO's and DON'Ts; Guidelines for Service Providers to Victims of Trafficking in Persons in South Africa; and Trafficking in Persons Policy Framework.

As noted above in terms of setting norms and standards for resources to implement policies, the different documents in some cases seem to contradict each other. In the victim empowerment area, three strategies have been developed, but none properly implemented. Thus the first national strategy (2002-06) for the VEP management team was developed but never implemented, a second strategy (2006-8) was developed and partially implemented, and a third strategy (2009-12) was developed and partially operationalised with support from the European Union bilateral agreement of 2007 but when funding ended, so did implementation.

More generally, while NPO participants in the round table organised by the Ministerial Committee commended the new legislation and policies, they observed that there was a "massive chasm" between these and implementation. Participants suggested that some of the legislation was a "dream", in that it was not immediately achievable.

The Committee finds that the absence of an over-arching social development act similar to the overarching acts in sectors such as higher education and health, undermines the objectives of different pieces of legislation and undermines policy coherence. The absence of such legislation hampers coordination and standardisation and development of a truly national and equitable social development system.

4.2 Policy coherence

The welfare system is now unified and is administered by nine provinces, all of whom have more or less the same approach in terms of broad programmes, some activities, budget structures and indicators, alongside new national legislation and policy, has contributed to standardisation. The White Paper itself is instrumental in promoting a unifying (but reportedly confusing) concept of DSW. Nevertheless, there are still problems in terms of some provinces (Western Cape, in particular, is named in this respect, and Gauteng in respect of its management information system) developing their own policies and approaches, and districts within provinces sometimes developing their own approaches. Non-standardisation is promoted by the fact that provincial DSD organograms provide for multiple planning posts in the form of social work policy managers and policy developers and include policy development among provincial functions within the different service areas, sometimes even down to district level.

The social development sector continues to be influenced by legislation enacted in other sectors across government. This is inevitable as different sectors of society and people's lives do not operate separately. There are, duplications arising from overlaps in, or confusion about, the boundaries of the mandates of the different agencies. There are also important areas that fall between the different sectors or departments and these are not covered well, or not covered at all.

In terms of inter-sectoral collaboration, the most commonly voiced concerns were about the relationships with the Department of Justice and South African Police Service (SAPS) in the area of children in conflict with the law; the Department of Health in the areas of old age, detoxification, mental health and disability, and Home Affairs for access to grants and other services.

Duplication and/or lack of collaboration across government agencies seemed to be particularly problematic in respect of community development (where local government has a similarly named cadre to community development workers), and sustainable livelihoods (where there is a multitude of agencies, including some affiliated to DSD) doing many, sometimes small, overlapping, and uncoordinated interventions.

Youth development and women development are further areas in which roles and responsibilities are unclear with overlaps possible even within DSD. For substance abuse, DSD is designated as the lead agency but has limited functions beyond awareness raising and coordination.

While policy coherence within social development is improving, there is confusion over roles and responsibilities of social service professionals exacerbated by the fact that different agencies may not always use terms in exactly the same way. For example, the community development worker handbook developed for local government workers envisages these workers as serving as a link between government and communities, informing people about available government services, increasing accessibility of services, and by so doing improving the impact of service delivery and achieving four objectives of "assisting in the removal of development deadlocks; strengthening the democratic social contract; advocating an organised voice for the poor; and improved government

community network.” While community development workers within social development are seen as a professional cadre with a four-year Bachelor of Community Development degree, the local government describes community development workers as:

community-based resource persons who collaborate with other community activists to help fellow community members to obtain information and resources from service providers with the aim of learning how to progressively meet their needs, achieve goals, realize their aspirations and maintain their well-being. They are cadres of a special type, participatory change agents who work within communities from where they are selected, where they live, and to whom they are answerable for their activities... Although specifically trained and certificated for their role, they have a shorter training than professional development workers who receive tertiary education.⁹

The Committee finds that the role of community development in the White Paper has not been clarified and the roles and responsibilities of community development practitioners and other social service professionals lack policy and programme coherence and integration. There is an urgent need to review the role, place and functions of professional community development workers within the social development sector.

4.3 Consultation

Participation has increased significantly in policy processes. Virtually all the new legislation and policy that has been developed since 1997 has been developed through a more consultative process than in the past. This has inevitably prolonged the development period. As one example, the development of the Children’s Act took ten years before legislation was passed. During subsequent implementation, the need for amendments has emerged, with further consultation ensuing.

The consultative process typically involves consultation in all provinces, as well as with representatives of all relevant government and related agencies. With a diverse population of approximately 55 million people, and the attendant diverse interests, needs and opinions, any legislation or policy will inevitably not satisfy everyone. Further, those who are less “connected” are less likely to be reached by consultations. In addition, realistically, many people may not have the knowledge, inclination or time necessary for meaningful participation. Nevertheless, despite these inevitable challenges, the consultative approach is likely to produce legislation and policy that is more appropriate and “owned” than was the case previously.

The fact that any legislation that affects provinces must be considered by the National Council of Provinces as well as the National Assembly aims to ensure that provincial needs and situation are taken into account in national legislation. Some provinces have developed their own policies in addition to the national ones. The danger here is that such policies could deviate from the NDP vision and reproduce inequalities.

⁹ A Handbook on Community Development Workers in South Africa. Undated.

4.4 Underlying values and principles

The new legislation developed since 1997 largely reflects new values and principles, including those embodied in the country's Constitution. However, as noted above, the social development sector still lacks national overarching legislation on social development. Further, some of the existing legislation – such as that governing NPOs – does not contain adequate guidelines necessary to achieve the values and principles reflected in the White Paper. As a result, implementation of these values and principles lags behind the intention.

Over the years, litigation has in some cases clarified how legislation should be interpreted, and in other cases highlighted the need for new or amended legislation. Litigation in the area of social security, but also in respect of some welfare services, has led to improvements. For example, in respect of the Children's Act there have been challenges relating to sections 151 and 152 that relate to removal of a child and placement in alternative safe care, and in 2012 and 2013 there were two judgements on the meaning of “without visible means of support” in respect of foster care.

In addition to alignment with the Constitution, legislation passed or amended since 1997 has often been aligned with international conventions and protocols. In particular, South Africa signed the International Covenant on Economic, Social and Cultural Rights in 1994, and ratified it in 2015. It ratified the Convention on the Elimination of All Forms of Discrimination Against Women in 1998, and the Convention on the Rights of the Child of 1993 in 1995, and has also ratified associated Optional Protocols on involvement of children in armed conflict; and the sale of children, child prostitution and child pornography.

It has not ratified the associated Optional Protocol on a communications procedure. It has, however, signed the Hague Convention on the Protection of Children and Cooperation in respect of Inter-country Adoption and the Hague Convention on the Civil Aspects of International Child Abduction. The country ratified the Convention on the Rights of Persons with Disabilities of 2006 in 2007, as well as the related Optional Protocol. It has not ratified the Convention on the Protection of the Rights of All Migrant Workers and Members of their Families of 2003.

Important regional instruments which South Africa has ratified include the African Charter on the Rights and Welfare of the Child and the African Charter on Human and Peoples' Rights and the associated protocol on establishment of an African Court on Human and Peoples' Rights.

4.5 Roles of different spheres of government

In 2015, there is more clarity on the roles and responsibilities of the national and provincial spheres of government in respect of social development than there was in 1997. There is still little clarity on the roles and responsibility of local government in respect of social development, and also differing views on what ought to be the roles and responsibilities of local government. An important challenge if responsibilities

are to be conferred on local government is the very varied levels of competence and resources between metropolitan and other municipalities, as well as within each of these categories.

Whether or not local government is given direct responsibility for core social development services, there are some municipal mandates, for example those relating to management of public space which impacts on people living and working on the streets, and those relating to zoning and health and safety requirements for buildings, which have clear links with social development services.

In the absence of clear social development obligations for local government, DSD seems to have interpreted the need to decentralise and be “close to communities” as an impetus for decentralisation of functions to DSD district and local office level. While this may have brought some officials closer geographically, it can also cause problems if staff of local offices lack the competence to do tasks assigned to them, and/or if they are allocated or assume an inappropriate degree of autonomy on the basis of needing to address local needs. In terms of efficiency, the multiple layers can result in duplication and delays associated with extended bureaucracy.

On the social security side, since 1997 the responsibility for administration of grants has been centralised in a new agency, the South African Social Security Agency (SASSA), rather than each province having the responsibility for administration within its borders. The establishment of SASSA as a centralised unit has brought multiple benefits both for government and the fiscus and for beneficiaries.

Welfare policy and legislation:

Summary highlights

- A range of new social development policies have been developed since 1997.
- There has also been a range of new legislation and amendments to existing legislation, as well as secondary legislation in the form of regulations, norms and standards, and the like.
- The new and amended legislation is aligned both to South Africa’s Constitution and to international and regional instruments
- Both new and old policies have generated challenges related to lack of clarity of roles and responsibilities of DSD and other agencies in various service areas, especially in respect of the roles of DSD and the national and provincial Departments of Health.





PART IV:

5. Socio-economic context

The White Paper reported that over the previous two decades, gross domestic product (GDP) had grown more slowly than the population, resulting in a decrease in per capita income, increasing poverty, and very limited ability of poor individuals and families to save. It illustrated the extreme inequality in South African society with the fact that the poorest 40% of households accounted for less than 6% of total national income, whilst the wealthiest 10% accounted for more than half of national income. Over a third of all South African households – equivalent to 18 million people – were living in poverty, with rural households dependent on women the worst affected. More than half (54%) of children lived in poverty. African people were most likely to be poor, and rural households were primarily reliant on remittances and social grants from government, with many households without access to remittances, wages or other earnings-related income.

The White Paper noted the presence of large-scale unemployment in South Africa, with the formal sector creating far too few jobs to cater for the growth in the labour force. As a result, unemployment had increased over time, and large numbers of people were working in the informal sector or attempting to make a living from subsistence agriculture. Unemployment rates were particularly high among women, rural people, young people, and black people. The White Paper noted that the formal sector had a decreasing need for less skilled workers, pointing to a need for a more skilled and educated workforce.

The White Paper referred to the social costs imposed on individuals, families and communities by the economic crisis at the time alongside the political and social changes. It saw these as having resulted in “social disintegrations” characterised by “family disorganisation, domestic violence, mental health problems, rising crime, illegal drugs, substance abuse and an illicit arms trade which contributes to growing societal violence.” Poverty and the burden of care for affected households increased financial and psychological vulnerability. The vulnerable and/or marginalised groups identified included children, youth, the elderly, women, persons with disabilities, offenders and their families, and HIV-infected people.

The White Paper noted that the increase in migration from rural to urban areas, as well as from neighbouring countries and beyond that followed the ending of apartheid posed challenges for social welfare services.

5.1 Economic growth and income distribution

In this part of the report the Committee examines what socio-economic conditions have changed and what remains the same or has worsened. Gross domestic product (GDP) per capita increased each year between 1997 and 2013, except for 1998 and 2009, implying that economic growth outpaced population growth over the period. GDP per capita reached a growth rate of more than 4% per annum in 2006 and 2007. However, South Africa was severely affected by the global economic and financial crisis, and the

increase in GDP per capita has continued on a downward trend since 2010. In 2014 GDP per capita increased only marginally, if at all.¹⁰

South Africa is still characterised by high levels of poverty and high income inequality. Calculations based on three large national household surveys found that the Gini coefficient, the most common indicator of income inequality, increased from 0,66 in 1993 to 0,70 in 2008.¹¹ Statistics South Africa's calculation, using the 2010/11 Income and Expenditure Survey, found that the poorest 20% of the population accounted for less than 5% of all expenditure, while the wealthiest 20% accounted for more than 61%.¹² The agency's calculations based on the 2005/06 Income and Expenditure Survey found that if social grants and taxation were not taken into account, the Gini coefficient of the time would have been 0,80 rather than 0,72.¹³

Other analysis suggests that the South African fiscal system, through a combination of progressive taxation and pro-poor social spending, reduces income inequality in the population to a greater extent than in twelve comparable middle-income countries.¹⁴ In 2010, the reduction was from a Gini coefficient of 0,77 for "market" income to a coefficient of 0,59 for income after transfers. Expressed differently, before transfers the richest 10% of the population has an income more than one thousand times the poorest 10%, while after transfers their income is 66 times that of the poorest 10%. The social grants for which DSD is responsible, through SASSA, account for a large part of these transfers.

The analysis of changes in the Gini coefficient does not take into account some taxes and expenditure which are difficult to allocate to households but are likely to benefit the wealthy households more than poorer ones. Examples include corporate income, property taxes, and infrastructure investments.¹⁵ The analysis is also generous in that it includes the monetary value of basic services such as water and electricity and spending on education and health when calculating transfers. Despite the generous approach to analysis, income inequality after tax, government transfers and spending is more unequal in South African than in all the other countries. Indirect taxes are usually found to be regressive. In South Africa, this is true for excise taxes on alcohol and tobacco. It is not true for fuel taxes and VAT, because of the zero rating of basic food items and VAT exemption for public transport.

Both poverty and inequality continue to have clear race, gender, age and geographical dimensions. For example, while Statistics South Africa found an overall headcount poverty rate of 46% for the population as a whole in 2011, the rate among Africans was 67% versus less than 1% for white people; the male rate was 55% compared to

¹⁰ GDP per capita calculated based on Statistics South Africa P0441 series for GDP, and the UN Population Division's World Population Projections 2015 for population. Use of Statistics South Africa's P0302 series of mid-year population estimates produces a very similar trend.

¹¹ Leibbrandt, M.; Woolard, I.; Finn, A.; Argent, J. 2010. Trends in South African income distribution and poverty since the fall of apartheid, OECD Social Employment and Migration Working Paper No 101. OECD, Paris.

¹² Statistics South Africa. 2014. Poverty Trends in South Africa: An examination of absolute poverty between 2006 and 2011 / Statistics South Africa. Pretoria: Statistics South Africa: 14.

¹³ Statistics South Africa. 2007. Income and Expenditure of Households: Analysis of results Pretoria: 3.

¹⁴ Woolard I, Metz R, Inchauste G, Lustig N, Maboshe N and Purfield C. 2015. How much is inequality reduced by progressive taxation and government spending? <http://www.econ3x3.org/node/328>, accessed 10 November 2015

¹⁵ Bond P. 2014. "Tokenism in South African Social Policy" in Transformation 86: 48-80.

59% for females; the rate for children under the age of 18 years was 56%; and the rural rate was 81% as against 41% for urban areas. At household level, using a crude measure based on “household head”, 11% of income of “female-headed” households took the form of pensions, social insurance and family allowances, while this was the case for only 3% of “male-headed” households. Conversely, the share of work-related income of these two household types was 63% and 76% respectively.¹⁶

South Africa does not have a single official poverty line against which poverty levels can be monitored. In addition, changes in methodology have resulted in large fluctuations in the percentage of the population that is poor. These fluctuations call into question the comparability of the different estimates (see box). Statistics South Africa’s most recent re-basing of the poverty line suggests that in 2011 more than a fifth (21,7%) of the population experienced extreme poverty, but 53,8% were poor when using the upper-bound poverty line of R779 per person per month.¹⁷

Understanding poverty measures

Statistics South Africa uses a set of three poverty lines, namely the food, lower-bound, and upper-bound poverty lines. These are derived using what is known as the cost of basic needs approach. The food poverty line is the estimated cost of a “basket” of food that meets the minimum recommended caloric requirement, using a choice of food that matches that consumed by poor people as shown in their expenditure patterns. The lower bound is derived by adding to the basic food amount the amount spent on non-food items by households whose total expenditure is equal to the food line. At this poverty line, households will not meet their basic food requirement as they will spend some of what is needed for food on other goods and services. The upper-bound is calculated by adding to the basic food amount the average non-food amount spent by households whose food expenditure is equivalent to the amount needed for the minimum caloric requirements. This upper line is therefore the only one of the three at which households have enough to eat. The National Development Plan (NDP) targets are based on the lower-bound poverty line, which had a value of R419 per person in 2009 prices.

Statistics South Africa’s calculations done in 2008 (the ones used in the NDP) produced noticeably lower values for the three lines than the calculations done by the agency in 2015, even after adjusting for inflation. Using 2011 prices, the food poverty line changed from R321 to R335 per person in the new calculations, the lower bound poverty line from R443 to R501, and the upper-bound from R620 to R779 (R923 in 2015 rands after adjusting for inflation). The estimates from the 2008 calculations were still, however, noticeably lower than the first cost of basic needs estimates, derived by Hoogeveen and Ozler, for South Africa.

¹⁶ Statistics South Africa. 2014. Poverty Trends in South Africa: An examination of absolute poverty between 2006 and 2011 / Statistics South Africa. Pretoria: Statistics South Africa.

¹⁷ Statistics South Africa. 2015. Methodological report on rebasing of national poverty lines and development on pilot provincial poverty lines – Technical Report. Pretoria:13.

¹⁸ Statistics South Africa. 2015. Methodological report on rebasing of national poverty lines and development on pilot provincial poverty lines. Technical Report. Pretoria: 11.

Understanding poverty measures

More recent detailed calculations which attempt to address methodological weaknesses in Statistics South Africa's 2008 and 2015 implementation of the cost of basic needs approach produced lines for 2011 at R337, R534 and R1 042.¹⁹ For 2015, the upper bound line is R1 307.

5.2 Employment

In 2015 challenges in respect of jobs and employment remain. In early 2015, the official unemployment rate among the working age population (15-64 years) stood at 26% – 24% for men versus 29% for women; 26% in urban as against 31% in former homeland rural areas; and 30% among Africans versus 23% for coloured, 16% for Indian and 7% for white people.

The patterns in terms of education might seem counter-intuitive as while the rate was lowest (13%) for those with tertiary education, it was higher among people with some secondary education than among those with primary schooling or less. Even among those with completed secondary, the unemployment rate was slightly higher than for those who had not completed primary schooling. These counter-intuitive patterns are explained by the fact that younger people tend to have more formal schooling than older, but have a much higher unemployment rate. Thus the unemployment rate for young people age 15-34 years was 37% – 34% for young men and 41% for young women. The unemployment patterns in respect of education suggest that the main issue is not inadequate education, but instead that the economy is not creating the needed jobs.

All the estimates above reflect the official unemployment rate. In early 2015 the expanded unemployment rate – which takes into consideration discouraged workers who have given up looking for work in the belief that there are no jobs available – stood at 36% – 32% for men and 40% for women. The official unemployment rate yields an absolute number of approximately 5 million unemployed people. The expanded unemployment rate yields an absolute number of 8,7 million unemployed people. These numbers must be compared against the approximately 1 million work opportunities, equivalent to 387 278 full-time equivalents, created by government's Expanded Public Works Programme (EPWP) in 2014/15.²⁰

South Africa's population structure – with people aged 15-64 years accounting for 65,9% of the population, and an age-based dependency ratio that fell from 56,0 to 51,7 between 2007 and 2014 alone²¹ – might suggest that it is well placed to benefit from the demographic dividend. The logic behind the demographic dividend is that with a large share of the population in the prime productive years, there will be relatively more earnings available to support the population, including those who are younger and older. However, the high rate of unemployment, especially among youth, limits

¹⁹ Budlender J, Leibbrandt M & Woolard I. Forthcoming. South African poverty lines: a review and two new money-metric thresholds. Southern Africa Labour and Development Research Unit, University of Cape Town.

²⁰ EPWP presentation to round table on sustainable development, July 2015.

²¹ Lehohla P. April 2015. Statistics South Africa's presentation to the Ministerial Retreat.

any potential benefit that South Africa might have gained from the age structure of its population.

Of those who are employed, 70% work in the non-agricultural formal sector, 16% in the non-agricultural informal sector, 6% in agriculture, and 8% in private households. The latter category is made up primarily of (usually low-waged) domestic workers and accounts for 15% of all employed women and 3% of all employed men. In terms of population group, 90% of employed white people are in the formal sector as again 65% of employed Africans. One in every ten African employed people (and 18% of employed African women) work in private households.

If one uses the broader notion of formal and informal employment (where employees in the formal sector and private households who are not entitled to basic benefits from their employer such as a pension, medical aid and who also do not have a written contract of employment are considered informal alongside workers in the informal sector), 66% of employed South Africans are in formal employment, with the female percentage (68%) somewhat higher than the male (64%). In terms of race, coloured workers do best with 78% formal while Africans fare worst, at 63%.

The relatively high number of employed people in informal employment in part reflects the expansion in externalisation of production over the past two decades, through processes such as outsourcing, sub-contracting and use of labour brokers. In terms of the absolute number of jobs, there has been a substantial reduction in the agricultural workforce over the past two decades. The mining workforce has also contracted and mining companies are currently in the process of either planning or effecting massive retrenchments. Loss of jobs in these two sectors, which have traditionally provided jobs for many poorer black men (and also women in agriculture) will have particularly serious implications for poverty levels.

On the more positive side, the years since the White Paper was written have seen sectoral and ministerial determinations introduced which specify minimum wages and conditions for vulnerable workers. Domestic and agricultural workers, in particular, now enjoy protection after having been excluded from most labour legislation during the apartheid years. However, attempts to establish a sectoral determination for the social welfare sector have not yet borne fruit. Such a determination is unlikely to be feasible until the problems relating to funding of NPOs that employ many workers in the sector have been addressed.

5.3 Socio-economic context

Two decades after the end of apartheid, the legacy of poverty, inequality and structural unemployment continues and is exacerbated by new factors. These include the global financial and economic crisis of 2007 onwards from which the global economy has not recovered. South Africa has been hit particularly hard, including in industries – such as mining and agriculture – which formed the backbone of the economy and provided jobs for many poor rural people for many decades. The HIV and AIDS pandemic is a further aggravating factor. While South Africa, after a long delay, now has the largest anti-retroviral (ARV) programme in the world, it also confronts the challenge of large

numbers of children who have lost parents, and large numbers of other family members caring for children as well as other family members who are ill. South Africa has had impressive success in reducing mother-to-child transmission of HIV, but HIV infection levels among adults remain unacceptably high. While ARV transforms HIV infection into a chronic disease rather than a death penalty, it imposes financial, resource, time and other burdens on the individuals affected as well as the health and financial system of the country more generally.

The HIV and AIDS pandemic contributed to increased global awareness of the burden of unpaid care work that is borne primarily by women, and in particular by poor women. This burden does not relate only to care work done in respect of HIV and AIDS, but also to the housework, care of persons and community-based work done on a daily basis by most women. This work, among others, reduces the ability of women to engage in income-earning activity. Statistics South Africa's Time Use Survey of 2010 revealed that women spend an average of 229 minutes per day on unpaid care work, compared to the 97 minutes per day spent by men on this work.²² While there is greater awareness of this burden than before, little – if anything – has been done to address it.

5.4 Family and household composition

Developmental social welfare places great emphasis on the family, which it sees as the/a core unit of society. It is, therefore, important to understand the composition of families and households in South Africa as a core part of the social system in the country. Analysis of Statistics South Africa's General Household Survey (GHS) of 2014 provides insights in this respect. The analysis is presented in terms of an age and sex categorisation (adult men, adult women, and children, with 18 as the cut-off age for adulthood); race and geo-type (urban formal, urban informal, former homeland, and rural commercial).

For the generational analysis, each member of the household is categorised into a generation based on their relationship to the household "head". The heads, their partners and siblings are Generation 0; grandparents are Generation -2; parents and aunts and uncles are Generation -1; children are Generation 1; and grandchildren are Generation 2. Other relatives, non-related persons and those for whom relationship is not specified cannot be classified. These three categories make up only about 9% of the total population and thus should not cause much bias in the results. Arguably, it is only the 7% who are "other relatives" who are relevant for the analysis below.

5.4.1 Generational analysis

Table 2 shows almost half (49%) of the population living in two-generational households, with a further third (33%) in three-generational households. The negligible number (less than half a percent) recorded as living in 0-generational households result from there being no household head for a few households in the dataset.

They are shown in the tables for completeness of reporting. Children are – as expected – far less likely than adult men or women to live in one-generational households (4% for

²² Statistics South Africa. 2013. A Survey of Time Use, 2010. Report 02-02-20, Pretoria: A-9.

children versus 24% for men and women adults combined). The percentage of children in this situation would be even lower if there were not some individuals who cannot be categorised into generations. Women (at 19%) are also far less likely than men (at 30%) to live in one-generational households. This is expected given women's traditional role of caring for children – as well perhaps as caring for the older generations. Almost a third (31%) of the one-generation households consists of a single person.

Table 2: Population by age and sex and number of generations in household

Generations	Man	Woman	Child	Total %	Total n
0	0%	0%	0%	0%	4844
1	30%	19%	4%	17%	9332482
2	44%	47%	55%	49%	26376291
3	25%	34%	40%	33%	17800809
4	0%	0%	0%	0%	186577
Total	100%	100%	100%	100%	53701003

Table 3 shows white people are far more likely than those in other groups to live in one-generation households, and coloured people least likely. White people are also far less likely than others to live in households with more than two generations. Africans are least likely to live in two-generation households, with fewer than half in this situation, while more than a third (36%) of Africans live in three-generation households.

Table 3: Population by race and number of generations in household

Generations	African/B	Coloured	Indian	White	Total	Total n
0	0%	0%	0%	0%	0%	4844
1	17%	10%	15%	30%	17%	9332482
2	47%	57%	65%	58%	49%	26376291
3	36%	33%	20%	11%	33%	17800809
4	0%	0%	0%	1%	0%	186577
Total	100%	100%	100%	100%	100%	53701003

Table 4 shows that close on half (47%) of people in former homeland areas live in three-generational households, compared to fewer than 30% in all other types of areas. Conversely, only 12% of people in former homeland areas are in one-generational households. One-generational households are most common in rural commercial (previously white farming) areas. More than half (54%) of people in urban formal areas are in two-generational households.

Table 4: Population by geo-type and number of generations in household

Generations	Urban formal	Urban informal	Former homeland	Rural commercial	Total %	Total n
0	0%	0%	0%	0%	0%	4844
1	19%	22%	12%	26%	17%	9332482
2	54%	49%	41%	45%	49%	26376291
3	26%	29%	47%	27%	33%	17800809
4	0%	0%	0%	1%	0%	186577
Total	100%	100%	100%	100%	100%	53701003

A multi-generational household may consist of people from contiguous generations, or may be a “skip generation” household in which there are members from one generation, no members in the next generation, but again members from the following generation. A household consisting of grandparents and grandchildren, without the parents, is a common example of a skip-generation household. However, such a household would not be classified as skip generation if an aunt or uncle of the grandchild/ren was in the household.

Table 5 shows 6% of people living in skip-generation households. Children are more likely than adults to be in such households, and adult women more likely than men. This matches the common perception that such households commonly consist of grandmothers and their grandchildren.

Table 5: Population by age and sex and whether in skip-generation household

Skip generation	Man	Woman	Child	Total %	Total n
Yes	4%	6%	7%	6%	3035636
No	96%	94%	93%	94%	50665367
Total	100%	100%	100%	100%	53701003

In terms of race, 6% of African people live in skip-generation households, as against 3% for all three other race groups. This pattern is, in large part, explained by the fact that 9% of households in (African-dominated) former homeland areas are skip-generation households, as seen in **Table 6**.

Table 6: Population by geo-type and whether in skip-generation household

Skip generation	Urban formal	Urban informal	Former homeland	Rural commercial	Total %	Total n
Yes	4%	3%	9%	3%	6%	3035636
No	96%	97%	91%	97%	94%	50665367
Total	100%	100%	100%	100%	100%	53701003

5.4.2 Nuclear family households

A nuclear family household is defined as one that consists of a mother-and-father dyad, their children, and no other members. These households are identified by first identifying all members of the population who are living together with their mother and father. The overwhelming majority of these are in the generation following that of the household head. For these individuals, we then disqualify all households in which there are more than two generations and/or in which there are any individuals in the children's generation who are not living with their mother and father. We also disqualify households with individuals in the "head's" generation who are not either the head or their partner. For the extremely small number of people who live with their mother and father and are in the "head" generation, we exclude those households who have any other members in that generation other than siblings, as well as those households which do not have exactly two individuals in the older generation.

Individuals living in nuclear family households will be either the "parent" or the "child" in the parent-child dyad that underlies a nuclear family. Some of the "children" in nuclear families will, in fact, be adults in terms of age, and it is also possible for some of the "parents" to be children in the sense that they are under 18 years of age.²³ The "parent" and "child" as defined by the nuclear dyad are labelled as "NuclearParent" and "NuclearChild" in the tables that follow.

Only 18% of the population lives in nuclear households as shown in **Table 7**. This portion of the population is made up of almost equal numbers of nuclear parents and children. This implies that, on average, there are two children per nuclear family as, by definition, each nuclear family household has two parents. About 20% of age-defined children are nuclear children, with a minimal number being nuclear parents. Among the age-defined adults, 5% of men and 3% of women are nuclear children. In absolute terms, more than 780 000 adult men live with their parents, as compared to just over 480 000 adult women. Also in absolute terms, the number of adult men and women who are nuclear parents are very similar (approximately 2 493 000 and 2 482 000 respectively). The fact that this category accounts for a smaller percentage of adult women than adult men is explained by the fact that there are more adult women than adult men in the population as a whole.

Table 7: Population by age and sex and whether part of nuclear family household

Nuclear status	Man	Woman	Child	Total %	Total n
NuclearChild	5%	3%	20%	9%	5021095
NuclearParent	15%	14%	0%	9%	4977317
Not nuclear	81%	84%	80%	81%	43702591
Total	100%	100%	100%	100%	53701003

Table 8 reveals that only 14% of African people, as compared to 27% of coloured, 40% of white and 45% of Indian people live in nuclear family households. The fact that the

²³ In respect of the latter, the dataset suggests that there are 35 000 households headed by children. However, some of these are almost certainly mistakes as one of the "heads" has age specified as low as three years, and some of these households have other members who are not children – even in their fifties.

percentage of the white population who are nuclear children is less than the percentage who are nuclear parents points to below-average family size for this population group.

Table 8: Population by race and whether part of nuclear family household

Nuclear status	African/B	Coloured	Indian	White	Total %	Total n
NuclearChild	7%	14%	22%	19%	9%	5021095
NuclearParent	7%	13%	23%	21%	9%	4977317
Not nuclear	85%	73%	55%	61%	81%	43702591
Total	100%	100%	100%	100%	100%	53701003

Table 9 shows nuclear family households as most common in urban formal areas, and least common in former homeland areas. In the latter areas, only 9% of the population lives in nuclear family households.

Table 9: Population by geo-type and whether part of nuclear family household

Nuclear status	Urban formal	Urban informal	Former homeland	Rural commercial	Total %	Total n
NuclearChild	12%	9%	5%	10%	9%	5021095
NuclearParent	12%	9%	4%	10%	9%	4977317
Not nuclear	76%	82%	91%	79%	81%	43702591
Total	100%	100%	100%	100%	100%	53701003

If one measures in terms of households rather than individuals, 17% of the 14,5 million households in the country are nuclear families. Of the nuclear households, 97% are headed by men.

5.4.3 Changes in household composition over time

Data from the National Income Dynamics Surveys (NIDS) of 2008 and 2012 allow exploration of changes in household composition over time. Changes in composition are important from a policy perspective especially where, as is the case within parts of the South African government as well as among donors, there is increasing emphasis on interventions that target the “family”. In South Africa the emphasis on the family is seen, among others, in the development of the Green Paper on Families, in discussions on the possibility of a family grant (rather than individually-targeted) social grants, and the promotion of parenting programmes by government, donors and other development partners. The perception that families take the form of typical nuclear families delinks social welfare interventions from the social realities in South Africa. It reduces the possibility of strengthening and supporting households that do not fit the traditional notions of family. Such thinking influences policy and programme design objectives and reinforces the exclusions that result from apartheid and discriminatory thinking about family, household types and the social status of people.

Households are not synonymous with families. Further, households as defined for the purpose of a survey may not always be the same as households as socially conceived and understood. Nevertheless, government and donor interventions that target families

will often, in practice, intervene on the basis of the household because that is the practical and visible manifestation of a family. With social grants, in particular, one expects a family grant to be targeted at the grouping of people who live together and pool resources. These two characteristics – co-residence and pooling of resources – underlie the definition of a household for most surveys.

NIDS and technical considerations

NIDS is ideal for this exploration as it is a longitudinal survey that attempts, every two years, to follow up on the individuals who were surveyed in the first wave, which was conducted in 2008. The exercise is funded by the Presidency and is large-scale. The first wave covered over 30 000 individuals in close on 7 300 households. Households were sampled in all nine provinces, in urban and rural areas, and the sampling was designed so that the results could be representative of the full population.

In all waves of the survey, NIDS distinguishes between continuing survey members (CSM) who are people who were targeted and surveyed in the first round and then followed up in further rounds, and temporary survey members (TSM) who are individuals who at some point are in the same household as a CSM, but were not a permanent resident of a targeted household in the first wave. The CSM category also includes babies born to CSM mothers subsequent to the first wave of the survey.

NIDS further distinguishes between resident and non-resident members. The former are those who live in the household at the time the survey is done. The latter are those who spent more than 15 days of the last 12 months in the household but are not living in the household at the time the survey is done.

For the analysis presented here, the focus is on the CSM in Wave 3 who were also surveyed in Wave 1. The analysis thus excludes those who died between Wave 1 and Wave 3. It also excludes those Wave 1 CSM whom NIDS did not manage to locate for Wave 3. If these two groups are included, the extent of change in household composition would be even larger than reported below. Some parts of the analysis include the new CSM in the form of babies born to CSM mothers, while other parts of the analysis exclude the babies. If the babies are included, the population covered in the analysis is estimated to represent 45 million people. The 45 million people are found in approximately 15,8 million households. If the babies are excluded, the population covered in the analysis is estimated to represent 41 million people.

For the most part, the analysis is reported using the weights supplied by NIDS i.e. giving a sense of the extent of the phenomena discussed for the population as a whole. Where characteristics might vary between 2008 and 2012, for example with marital status, the tables reflect the situation for the individuals in 2012.

The first test examined whether all CSMs for whom there were successful interviews in Wave 3 were living with the same other CSMs as in Wave 1. This comparison included babies born after Wave 1 to CSM mothers. The household was considered to have an identical match if all members were the same. (For households with ten or more members, in which about 10 per cent of the CSMs lived, the household was considered the same if there was a match for the first ten members checked.)

Table 10 reveals that, overall, less than half (45 per cent) of CSMs covered by the survey in 2012 were living with exactly the same individuals with whom they lived in 2008. The percentage was somewhat higher for men than women. This may reflect a greater tendency for women than men to move at the time of marriage, a greater likelihood that men will control the property of the household, and a much greater likelihood for women than men that they will live with young children. In terms of race, a much larger proportion of white people (70 per cent) were living with the same people, with less than half in this position for all other groups.

Birth year is obviously a proxy for age. The percentage living with the same people as in 2008 tends to increase with age. However the pattern changes from 1990s onward. The low percentage for those born in the 2000s is at least partly attributable to some of these having been born after wave 1 of the survey was done i.e. some of this group were not living in any household in 2008! On marital status, widows are more likely than other groups to have been living with the same people in 2012 as in 2008. Those who are never married are least likely to be in this position. This matches the pattern in terms of age.

Northern Cape has the highest percentage (48 per cent) of people living with the same people in 2012 as in 2008 and Limpopo (38 per cent) the lowest by some margin. The fact that Gauteng has one of the highest percentages while Western Cape's is one of the lowest suggests that these patterns are not explained simply by migration. In terms of geotype, more than half of the relatively small share of the population living on farms in 2012 was living with the same people in 2008, while this is the case for only 39 per cent of people living in traditional (former homeland) rural areas.

Table 10: Population by constancy of household composition 2008 and 2011

Category	Group	Different	Same	Total	% same
	Total	25360277	19740315	45100592	44%
Sex	Male	11768374	10208662	21977036	46%
	Female	13591903	9531652	23123556	41%
Race	African	21136497	14359617	35496114	40%
	Coloured	2330713	1937347	4268060	45%
	Asian/Indian	625068	565328	1190396	47%
	White	1260917	2878024	4138941	70%
Birth year	Pre-1940	401876	574685	976562	59%
	1940s	727949	1123402	1851351	61%
	1950s	1335102	1937840	3272942	59%
	1960s	1868089	2825650	4693739	60%
	1970s	3286000	3181949	6467948	49%

Category	Group	Different	Same	Total	% same
	1980s	5097449	2920020	8017469	36%
	1990s	4955483	4005947	8961430	45%
	2000s	5672705	3170563	8843268	36%
	2010+	2009005	0	2009005	0%
Marital status	Married	4140556	5064014	9204570	55%
	Living with partner	924348	873159	1797507	49%
	Widow/ Widower	809871	1143258	1953129	59%
	Divorced/ separated	400168	467765	867933	54%
	Never married	10225789	7996673	18222462	44%
Province	Eastern Cape	3183921	2458052	5641972	44%
	Free State	1437512	971465	2408977	40%
	Gauteng	5823212	5165073	10988284	47%
	KwaZulu-Natal	4808809	4006842	8815651	45%
	Limpopo	2766181	1694888	4461068	38%
	Mpumalanga	1988990	1442471	3431462	42%
	North West	1665141	1404147	3069288	46%
	Northern Cape	534729	488095	1022824	48%
	Western Cape	3151785	2109282	5261067	40%
Geotype	Traditional	9251028	5802066	15053093	39%
	Urban	14861047	12557654	27418701	46%
	Farms	1248203	1380595	2628798	53%

A second, less onerous, test looks as whether the overall size of the household, in terms of number of members, was constant between 2008 and 2012, without considering whether the actual people were the same. This test might be relevant, for example, for a benefit that was based on household size, such as a grant calculated per person, without regard to the characteristics of the individual household members. As with the other tests, this one ignores those who died between 2008 and 2012. This particular test also excludes young children and babies born after the 2008 wave. It is thus more relaxed than the previous test in terms of both specifying the individuals and exclusion of new-born members. However, it is stricter in that the size test is applied to all households with more than ten members whereas the previous test only tested the first ten members of larger households. The test also includes considers non-CSM who are present in (and thus “permanent” members of) the household in 2012 as these people would need to be considered for benefits calculated on household size.

Table 11 shows that only 42 per cent of the 2008-2012 CSM members were in a household of the same size in 2012 as in 2008, even after disregarding births and deaths. The fact that this is lower than for the previous test suggests that many of the households which had more than ten members did not have identical membership despite the first ten members matching. With race, white people are again the most likely to be in the same households as previously, and African the least likely. On this measure coloured people do better than Indian. However, this finding should be treated

with caution as the Indian sub-sample is small. Nevertheless, the gap between white and coloured is much smaller than before, and the percentage of white people in “same” households in 2008 and 2012 is lower than before.

With age (birth year) there is a less clear pattern than before, but overall those born in the 1980s and later are less likely than those who are older to be in a same-sized household. With marital status, married people are most likely to be in same-sized households, while the likelihood is much lower for widows. The latter pattern could be the result of widows living in very large households.

Provincially, those living in Western Cape were most likely to be living in same-sized households and those in Eastern Cape least likely. Generally, those living in 2012 in the poorer and more rural provinces are less likely than those in wealthier, more urban provinces to be living in same-sized households in 2012 and 2008. The same pattern is seen in terms of geotype, where urban areas have the highest proportion of individuals living in same-sized households and traditional areas the lowest.

Table 11: Population by constancy of household size, 2008 and 2012

Category	Group	Different	Same	Total	% same size
	Total	24244630	17341737	41586367	42%
Sex	Male	11628680	8579827	20208507	42%
	Female	12615950	8761910	21377860	41%
Race	African	20253866	12301943	32555808	38%
	Coloured	1851247	2112267	3963514	53%
	Asian/Indian	645805	462345	1108150	42%
	White	1491523	2462865	3954388	62%
Birth year	Pre-1940	479532	497030	976562	51%
	1940s	940521	910830	1851351	49%
	1950s	1753306	1519636	3272942	46%
	1960s	2304485	2389254	4693739	51%
	1970s	3625295	2842653	6467948	44%
	1980s	5273088	2744381	8017469	34%
	1990s	5421493	3539936	8961430	40%
	2000s	4441443	2898016	7339459	39%
Marital status	Married	4259085	4945484	9204570	54%
	Living with partner	1016596	780911	1797507	43%
	Widow/Widower	1203150	749979	1953129	38%
	Divorced or separated	532656	335277	867933	39%
	Never married	11515400	6707062	18222462	37%
Province	Eastern Cape	3364550	1867298	5231848	36%
	Free State	1289232	938473	2227704	42%
	Gauteng	5614885	4554324	10169208	45%

Category	Group	Different	Same	Total	% same size
	KwaZulu-Natal	5131527	3001210	8132737	37%
	Limpopo	2486310	1558116	4044426	39%
	Mpumalanga	1761280	1377714	3138994	44%
	North West	1707479	1144737	2852216	40%
	Northern Cape	525483	428546	954028	45%
	Western Cape	2363886	2471320	4835206	51%
Geotype	Traditional	8925867	4818040	13743908	35%
	Urban	13850136	11535475	25385611	45%
	Farms	1468627	988222	2456849	40%

Table 12 shows the percentage of the CSMs who lived in households with fewer than 10 members in both years in each combination of 2008 and 2012 sizes. The shaded cells, which together add up to 48% of these CSMs (36,4 million in total) are those where the size was the same in 2008 and 2012. The grey cells are the most common cells for each row and column, but still add up to less than half of these individuals.

Table 12: Distribution of individuals in households with less than 10 members by size of household in 2008 and 2012

2008	2012									Total
	1	2	3	4	5	6	7	8	9	
1	5%	3%	2%	1%	1%	1%	0%	0%	0%	13%
2	1%	6%	3%	2%	1%	1%	0%	0%	0%	14%
3	0%	1%	8%	4%	2%	1%	1%	0%	0%	17%
4	0%	0%	2%	10%	4%	2%	0%	0%	0%	18%
5	0%	0%	1%	2%	8%	3%	1%	1%	0%	16%
6	0%	0%	0%	1%	2%	5%	3%	0%	1%	11%
7	0%	0%	0%	0%	1%	1%	2%	1%	0%	6%
8	0%	0%	0%	0%	0%	0%	1%	1%	1%	3%
9	0%	0%	0%	0%	0%	0%	0%	0%	1%	2%
Total	6%	11%	16%	19%	17%	13%	8%	6%	4%	100%

Household composition can change through birth, death as well as people joining and leaving households. In some cases, those leaving form a new household while in others they join an existing household. A third way of testing changes is therefore to consider how many people in a particular household in 2012 have at least one other member of their 2008 household who is, in 2012, living in a different household. We refer to these as people from “split” households. This test considers only CSMs surveyed in 2012 who were alive and surveyed in 2008.²⁴

Table 13 shows 35% of 2012 CSM having lived in 2008 households whose members by 2012 were found in more than one household. There is very little gender difference on this measure, but Africans are again the most likely to have changes in their households and white people the least likely.

²⁴ There is also a very small proportion of CSMs – less than half a percent of the 2012 CSMs – in the converse position i.e. who were living in the same household in 2012, but different surveyed households in 2008.

Age-wise, it is middle-aged people who are most likely to be in 2008 households that subsequently split. Older people are, presumably, more likely to have settled into a household, while younger ones may not yet have left their childhood home. However, with marital status, it is the never married category – which includes all the children, which is most likely to have been in a household that subsequently split.

Table 13: Population by splitting of households between 2008 and 2012

Category	Group	No split	Split	Total	% diff
	Total	27092276	14494091	41586367	35%
Sex	Male	13081997	7126510	20208507	35%
	Female	14010278	7367582	21377860	34%
Race	African	20075282	12480526	32555808	38%
	Coloured	2843787	1119727	3963514	28%
	Asian/Indian	801781	306369	1108150	28%
	White	3369109	585279	3954388	15%
Birth year	Pre-1940	679276	297286	976562	30%
	1940s	1322194	529158	1851351	29%
	1950s	2332998	939943	3272942	29%
	1960s	3469315	1224424	4693739	26%
	1970s	4312118	2155830	6467948	33%
	1980s	4391347	3626123	8017469	45%
	1990s	5739768	3221662	8961430	36%
	2000s	4844411	2495048	7339459	34%
	Marital status	Married	6713515	2491055	9204570
Living with partner		1218336	579170	1797507	32%
Widow/Widower		1413962	539167	1953129	28%
Divorced/separated		547878	320055	867933	37%
Never married		10906549	7315913	18222462	40%
Province	Eastern Cape	3119769	2112079	5231848	40%
	Free State	1269018	958687	2227704	43%
	Gauteng	6852183	3317025	10169208	33%
	KwaZulu-Natal	5422017	2710720	8132737	33%
	Limpopo	2439958	1604469	4044426	40%
	Mpumalanga	2225670	913324	3138994	29%
	North West	1873063	979152	2852216	34%
	Northern Cape	643694	310335	954028	33%
	Western Cape	3246904	1588301	4835206	33%
Geotype	Traditional	8379119	5364789	13743908	39%
	Urban	16921843	8463768	25385611	33%
	Farms	1791315	665534	2456849	27%

Province-wise, Free State has the greatest degree of splitting and Mpumalanga the least. Excluding Free State, it is the two poorest provinces – Eastern Cape and Limpopo – that have the highest degree of splitting. With geotype, farms again appear to have the most stable households and traditional (former homeland) areas the least stable.

The analysis presented above suggests substantial changes in household membership over a very short period of four to five years on all three measures used. All these measures probably under-estimate the extent of change by excluding deaths, and by focusing on CSMS covered in both the 2008 and 2012 surveys i.e. those could be located both at the start of NIDS and some years later. The findings suggest that any government or other development interventions that assume a stable family will not be suitable for the South African context.

5.5 Migration

The extent of migration has increased substantially since the 1997 White Paper was drawn up. In particular, immigration from other parts of Africa has increased, but migration within the country has also continued. Both types of migration are driven, in large part, by the search for work.

The 2011 Census suggested that approximately 3,4 million people moved into or out of South Africa's nine provinces between 2001 and 2011.²⁵ Approximately 340 000 South Africans left South Africa over this period, but a much larger number of people entered South Africa. This resulted in a net influx from outside South Africa (the number who had moved into South Africa less those who had left) of about 651 000. A larger number – 2,17 million – of people in South Africa in 2011 were recorded as having been born outside the country. However, many of these would have moved to South Africa before 2001. About 1,32 million people born outside South Africa were recorded as having immigrated between 2001 and 2011. Of these, nearly three-quarters were from other Southern African Development Community (SADC) countries – with Zimbabwe and Mozambique dominating.

If both international and provincial migration are included, Gauteng showed the largest net gain, of 917 000 migrants, while Western Cape gained 244 000. Eastern Cape experienced the largest loss, at 351 000, followed by Limpopo's 183 000. Migration was concentrated among people in the age group 15 to 39 years, confirming that migration mostly occurs on economic grounds. However, migration to Western Cape had a larger proportion of older people, many of whom would have moved to retire in that province. International migration was heavily male-dominated, with 154 male migrants into South Africa for every 100 female migrants.

The employment rate is higher and the unemployment rate lower among international migrants than among South Africans. A perception that foreign migrants are filling some of the limited number of work opportunities available has fuelled waves of xenophobia.

For social welfare services, migration patterns and the increasing numbers of migrants raise a number of issues. The courts have ruled that registered asylum seekers and refugees must be eligible for the same services, including grants, as citizens and permanent residents. Children, from whatever category, must be provided with protection and other services. This raises, among others, challenges in respect of identity documents as well as funding to meet increased demands. The challenges are exacerbated by the weaknesses in the operations of the Department of Home Affairs.

²⁵ Estimates sourced from analysis undertaken by R Dorrington, T Moultrie and D Budlender for the African Centre for Migration Studies, University of Witwatersrand.

Of concern, is that a national DSD presentation to the Committee claimed that South Africa is “home to five million illegal immigrants, including some three million Zimbabweans”. Such unsubstantiated claims can fuel xenophobia and also results in misinformed policy making.

Access to grants by permanent residents and refugees

In 2003, in the case of *Khosa and Another v Minister of Social Development* (CCT 13/03), the Constitutional Court directed that the law be changed so as to allow permanent residents to access social assistance. This was achieved through the Social Assistance Act 13 of 2004.

Care dependency grants were the first type of social grant to be made available to refugees, as a result of court action brought against DSD by the Scalabrini Centre (assisted by Legal Resources Centre) in Cape Town. The case settled out of court and resulted in an amendment to the 2008 Regulations so as to provide access for refugees for the care dependency grant.

Josephine Sango (assisted by Lawyers for Human Rights) brought a case to court which caused DSD to urgently amend regulation 2 of the 2008 Regulations, and this extended social assistance coverage to refugee older persons with effect from 1 April 2012.

SASSA’s 2013 booklet entitled ‘Social assistance for refugees’ makes it is clear that all grants are available to South African citizens, permanent residents and refugees.

Socio-economic context:

Summary highlights

- Decrease in poverty rates, although this is now under threat because of declining economic growth and employment opportunities and impacts of the global recession.
- Substantial and effective social grant system reduces poverty and protects the most vulnerable but does not remove those in income poverty from below the poverty line.
- South Africa remains among the most unequal societies in the world.
- Poverty and inequality continue to have clear race, gender, age and geographical dimensions.
- Unemployment rate remains stubbornly high.
- Sectoral and ministerial determinations provide some protection for vulnerable workers, but some sectors – including welfare – are not fully protected.
- Unusual social structure and diverse family setups place a particular burden on women.





PART V:

6. Financing and budgets

6.1 Department of Social Development budgets

The White Paper noted that in 1995/6 the welfare budget stood at R13,4 billion, equivalent to 8,7% of the consolidated national budget and 2,7% of the gross domestic product (GDP). The White Paper of 1997 noted that the share of the national budget going to social security and welfare service had increased over the previous five years, while the shares of education and health had remained more or less constant. The growth in welfare's share resulted primarily from equalisation across races of social grant amounts, which had already happened by 1994.

At the time of the White Paper, social security accounted for 88% of the total budget and welfare services for 8%, leaving 4% allocated to capital expenditure. About 60% of the grant expenditure went to the elderly, 24% for people with disabilities, and 14% for state (child) maintenance grants. The White Paper observed that because social security and welfare services were in a single parliamentary vote, and social security was a statutory benefit, any shortfalls in social security funding were addressed by diverting funds from welfare services.

An input paper prepared for the White Paper on fiscal considerations found that, excluding the homelands (which would have increased the extent of disparities), per capita expenditure on substance abuse and care of the disabled was twice as large for white people as for the population as a whole. In respect of older persons, per capita spending for white people was twenty times as large as for black people, or seven times if the calculation was adjusted to account for the higher share of older persons in the white population.

The White Paper stated bluntly that “[w]elfare services are inadequately funded”, noting further that government’s contribution to these services was “far smaller” than that of formal (i.e. state-subsidised) and informal (non-subsidised) organisations. It observed that because social security and welfare services were in a single parliamentary vote, and social security was a statutory benefit, any shortfalls in social security funding were addressed by diverting funds from welfare services. It proposed that all provincial disparities in funding of welfare services be removed within five years.

6.1.1 The overall size and shape of DSD budgets

In 2015/16, social protection has a budget of R206,4 billion, equivalent to 15,3% of consolidated government expenditure, and 4,9% of GDP²⁶. (The category social protection consists entirely of expenditure found in DSD national and provincial budgets.) Social protection expenditure has increased since 1997 both in real terms and as a share of the total government budget. However, the share of the consolidated budget allocated to social protection (or social security and welfare) has remained more or less constant over the last ten years i.e. between 2005/06 and 2015/16 (see figure²⁷). Thus in 2005/06, this category of expenditure already accounted for 15,9% of consolidated government expenditure, and 4,7% of GDP²⁸. Social grant expenditure as a percentage of GDP reached its peak of 3,7% in 2010/11, and had fallen to 3,6% by 2013/14²⁹.

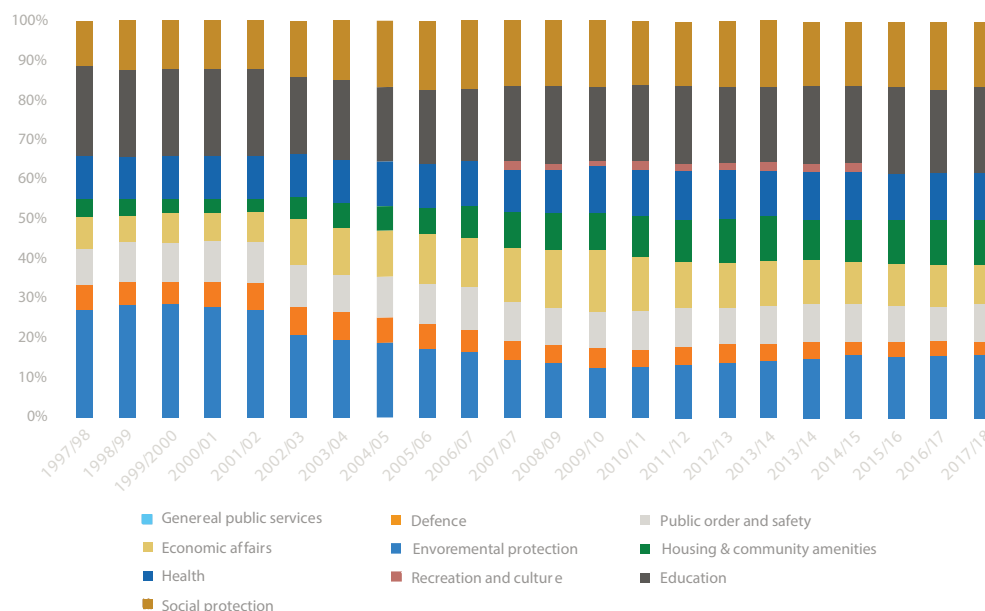
²⁶ National Treasury. 2015. Budget Review 2015: 201-203

²⁷ The fluctuations in the share going to economic affairs and housing to some extent reflect changes in the classification of particular expenditures, and water in particular. The general public service category includes servicing of debt.

²⁸ National Treasury. 2006. Budget Review 2006: 161; 179

²⁹ SASSA presentation to Ministerial Committee, November 2013.

Figure 6: Functional classification of consolidated budget, 1997/18-2017/18



Sources: Budget Reviews 2002; 2006; 2015

The increase in social grant expenditure since the White Paper reflects both the introduction of new grants (such as the child support grant (CSG), for which the target group and coverage were expanded incrementally over time as an outcome of the proposal in the Report of the Committee on Comprehensive Social Security in 2002), and substantial expansion in coverage of existing grants. In particular, coverage of the foster child grant (FCG) is substantially broader than previously after being made available to orphans, including those living with relatives, rather than only children in need of care for child protection reasons other than poverty. The increase also reflects an increase in allocations for social development services. Allocations and expenditure on children’s services, in particular, increased after the Children’s Act came into operation. Nevertheless, even after the expansion the allocations for children’s services remain only a fraction of the amount estimated in a government-commissioned costing of the Act at the time the legislation was being developed.

The Committee finds that, currently, the social security component of the budget is located in the budget of national DSD. In 2015/16 the allocations for social assistance and social security amount to R136,85 billion. The welfare and other social development service components are located in part in the budget of national DSD, which is primarily responsible for policy development and coordination, and in part in the budgets of the nine provincial DSDs. National DSD has an allocation of R1,02 billion, and the nine provinces combined allocate R14,05 billion, giving a combined total of R15,07 billion. National and provincial DSD together allocate R2,66 billion for administration. These amounts yield a breakdown of 88% for social assistance and security, 10% for welfare and related services, and 2% for administration. The breakdown is thus very similar to the one prevailing at the time the White Paper was drawn up. However, over the 2015/16-2017/18 medium-term expenditure framework (MTEF) period, 41,5% of the social assistance budget is destined for the old age grant, 36,4% for the CSG, 15,4% for the disability grant, and 4,2% for the foster child grant. This is a very different breakdown from that of the late 1990s and reflects a positive redistributive outcome for poor households.

6.1.2 Funding of services: Changes since 1997

An input paper on fiscal considerations for the White Paper reported that, of all budgeted expenditure for services provided or subsidised by government, 41% went to child and family care, 39% to older persons, and 12% to persons with disabilities³⁰. The same paper³¹ found that, excluding the homelands (whose inclusion would have increased the extent of disparities), per capita expenditure on substance abuse and care of the disabled was twice as large for white people as for the population as a whole. In respect of older persons, per capita spending for white people was twenty times as large as for black people. If the calculation was adjusted to account for the higher share of older persons in the white population, per capita expenditure on whites was still seven times that of black older persons.

Care of older persons also had the largest provincial disparities, with Western Cape spending ten times per capita more than Mpumalanga. The paper on fiscal implications proposed this service as the only one where there should be scaling down of provision – in Western Cape, Northern Cape and Gauteng – but urged caution that this should not result in the “collapse of functioning institutions and services.”

Unsurprisingly given the past domination of services for older people, many of the statistics in the White Paper related to these services. The White Paper noted that there were only 13 government-run old age homes as against more than 7 500 private residential and non-residential facilities. Of the private facilities, fewer than half were managed by government-subsidised organisations. Most of the facilities were old age homes with white residents.

Currently, many of the services delivered previously continue to be delivered because they remain necessary to meet needs. However, a range of new additional services and programmes have been developed and are currently delivered. These include, for example, active ageing, drop-in centres, home- and community-based care services, stimulation centres, diversion, shelters and prevention and early intervention programmes such as Isibindi. Provinces continue to fund the old fields of service, but several new fields – such as youth development, women development, victim empowerment and HIV and AIDS – have been added.

If one combines national and provincial allocations for all the core service areas³² (excluding social assistance, analysed above), 62% of the 2015/16 total is allocated for children and families, 11% for older persons, 8% for HIV and AIDS, 6% each for people with disabilities and substance abuse, 4% for social crime prevention and victim empowerment, and 3% for youth development.

At provincial level, which is where service delivery is funded, the Children and Families programme alone accounts for 38% of combined provincial budgets, and 75%³³ or

³⁰ Van der Berg S. August 1995. “Fiscal Implication of the White Paper on Social Welfare” in *Social Work* 34(1), March: 35-43.

³¹ Van der Berg S. August 1995. “Fiscal Implication of the White Paper on Social Welfare” in *Social Work* 34(1), March: 35-43

³² Substance abuse, older persons, people with disabilities, children and families, social crime prevention and victim empowerment, youth development, and HIV and AIDS

³³ 25% of the programme’s budget is allocated for Child Care and Protection Services, which includes – but is not limited to – child and youth care centres, the residential component of children’s services.

more of this programme's budget is allocated for non-residential services. More generally, many NPOs across the service areas are now funded for non-residential programmes.

6.1.3 Inequities in funding of services

Fairly substantial progress has been made in extending services beyond formal urban areas. However, analysis of the results of rating exercises conducted by the Ministerial Committee found that in all but one service area services were rated as somewhat more accessible in urban than rural areas. The exception was HIV and AIDS services, where rural participants rated accessibility higher than urban participants. Residential services, in particular, continue to be concentrated in formal urban areas.

The country remains heavily dependent on NPOs for service delivery, especially in respect of services for children. Thus, in 2015/16 the share (54%) of the provincial children and families budget programme allocated for NPO transfers was higher than the NPO shares for welfare services (46%), restorative services (26%) and development and research (10%). However, the NPO share of the children and families budget programme falls 12 percentage points, from 65% to 53%, over the period 2011/12-2017/18. Within the welfare services programme, the share going to NPOs in the welfare services and development and research programmes increases slightly over the same period, but the NPO share in the restorative services programmes decreases.

Despite the White Paper's commitment to provincial equity within five years, in 2015/16 the budget allocations per target population differ substantially across provinces for different provincial sub-programmes, suggesting serious inequities in available services across provinces. Gauteng and Western Cape, the wealthier provinces, generally top the rankings, as follows:

- In respect of services for older persons, in 2015/16, Western Cape has by far the highest amount (R1 448) per poor person aged 60 years and over, and Limpopo the lowest (R203). Western Cape's allocation per poor older person is more than six times as large as the Limpopo allocation.
- With services for people with disabilities, the amount per capita ranges from R115 per person aged 18-59 years in Northern Cape to R557 in Western Cape. When analysis is restricted to the severely disabled, the range is from R654 in Northern Cape to R1 585 in Western Cape.
- For the children and families budget programme as a whole, Gauteng has by far the highest amount per poor child, at R1 323 per annum, while Eastern Cape again has the lowest, at R264. The Eastern Cape amount is only one-fifth of the Gauteng amount.
- For the child care and protection sub-programme. Gauteng remains by far the best performer, with Western Cape and Northern Cape following quite far behind. Limpopo is by far the worst performer, with only R3 allocated per child whether calculating for all children or only for poor children.
- For ECD and partial care, Western Cape is the top performer at R1 369 per poor child aged 0-4 years, with Free State second and Gauteng a close third. North West and Eastern Cape are the worst performers, at R339 and R345 per poor child respectively.
- For poverty alleviation and sustainable livelihoods, the allocation per poor person ranges from less than R10 in Eastern Cape, KwaZulu-Natal and

- Limpopo to R79 per poor person in Northern Cape.
- For youth development, the amount for youth aged 18 to 29 years who are not in employment, education or training (NEET) ranges from only R7 in Limpopo to R208 in Free State.

Comparison of the cost of providing services to current beneficiaries with the allocated budget for a service area produces worrying results³⁴.

- For older persons, covering NPOs' core costs in respect of residential and home-based care exceeds the total budget for older persons in all provinces except North West. In six provinces the budget is less than half of the costs of service delivery to current beneficiaries.
- For persons with disability, NPOs' core costs in respect of residential care and protective workshops amount to more than the total disability sub-programme budget for five provinces. In Northern Cape, even the monthly amount is more than double the annual budget allocation.
- For community-based services for children (primarily Isibindi and drop-in centres), the Gauteng allocation per maternal orphan is R2 516, with the next most generous province, Limpopo, recording a much lower R951. Eastern Cape and Free State each allocate R145 or less per year per maternal orphan.
- For substance abuse, the budget is much larger than the NPO core costs for in-patient and out-patient services. This seemingly optimistic result in fact reflects the small number of beneficiaries reached through these services, as well as the focus within this service area on other services, such as the Ke Moja school-based awareness programme.
- For child and youth care centres, three provinces – KwaZulu-Natal, Limpopo and Mpumalanga – the core NPO costs amount to more than the budget. In KwaZulu-Natal and Mpumalanga the needed amount is more than three times the budget.

The discussion of different DSD service areas above, and further analysis presented elsewhere in this report, draws on budget information from the nine provinces. The focus is on the provincial budgets because the provinces bear the primary responsibility for service delivery³⁵.

As already seen above and further seen in the discussion of the different service areas in the next part of the report, combining available population data showing the extent of need for various services with information on budget allocations exposes enormous variation in “per (relevant) capita” allocations across provinces. In many cases

³⁴ The comparisons use beneficiary data from provinces' non-financial (performance monitoring) data standard indicators (which include delivery by funded NPOs), and the recurrent core costs (excluding overheads) of service delivery calculated by KPMG for the Free State DSD for the NAWONG court challenge. The amounts are substantially more than the transfers currently paid to NPOs, but were deemed by KPMG as necessary for NPO delivery of the different sources, and are likely to be substantially lower than the government costs of providing the same services.

³⁵ In addition to the provincial estimates of expenditure, the main sources for the budget analysis are: Budlender D and Francis D. 2014. Budgeting for social welfare in South Africa's nine provinces, 2010/11-2016/17. www.ci.org; Linström, Johannes. August 2013. Affidavit. National Association of Welfare Organisations and Non-governmental Organisations & Other vs Member of the Executive Council for Social Development, Free State & Others. Case No 1719/2010. Free State High Court; National Treasury. 2015. Annexure W1: Explanatory memorandum to the division of revenue. Website annexure to the 2015 Budget Review. <http://www.treasury.gov.za/documents/national%20budget/2015/review/default.aspx>; Statistics South Africa. 2013. Men, Women and Children: Findings of the Living Conditions Survey, 2009/2009. Pretoria.

the resultant patterns confirm the relative advantage of the more wealthy provinces, Gauteng and Western Cape. These provinces tend to have more established services, a larger number of NPOs available to deliver services, and a smaller proportion of their populations in need, all of which help to explain relatively better provision – although the provision is still inadequate in absolute terms.

Nevertheless, the variation found across the provinces in provision cannot be explained only by these factors. Northern Cape, in particular, has patterns that are unexpected when compared to those of other provinces. Further, the fact that the extent of provision relative to need varies across services, with a province that performs well in respect of one service performing poorly for another service, suggests that the patterns reflect political choices. Choice also seems evident when patterns change for a particular province across the years. Some of the reported patterns suggest that the performance indicators reported to DPME (previously reported to National Treasury) may be quite badly wrong. Virtually all the comparisons of allocated budget with the true subsidy cost for existing beneficiaries show budgets that are too small, even if all other services and costs in each of the sub-programmes are ignored. The exception is substance abuse, where the seemingly adequate budget hides sometimes large capital allocations and a very low level of provision of services.

6.1.4 Fiscal space for expanding and equalisation of services

Currently, the budget for social assistance is located in the budget of national DSD (and then transferred to SASSA). In contrast, responsibility for social welfare service delivery remains with the provinces. Funding of welfare services remains extremely small because direct service provision is funded through provincial budget allocations and not the National DSD.

The paper on fiscal issues prepared during the development of the White Paper noted that because social security accounted for such a large part of welfare spending, an increase of only 1,6% per year in total welfare spending would allow for a doubling of welfare service expenditure in five years if social security expenditure did not change. The paper noted further that expenditure would need to increase by less than two-thirds in five years to allow all other provinces to reach Western Cape's level in all services except older persons. Additional funds might be needed to cover the additional costs of providing services in remote areas, addressing new and increased need for services resulting from HIV and Aids, and compensating for cutbacks in private funding to NPOs.

Using calculations based on the 2015/16 budget the Committee finds that an annual increase of 1,9% per year in social development spending for five years would more than double welfare service spending (i.e. the total less social security and administration). Table 14 shows the relevant estimates for the broad categories of administration, social assistance/security, and welfare services for such a five-year phase-in across national and provincial DSD combined.

Expenditure category	2015/16	Year 1	Year 2	Year 3	Year 4	Year 5
Administration	2954	2954	2954	2954	2954	2954
Social Assistance/ Security	136850	136850	136850	136850	136850	136850
Welfare Services	15070	18013	21011	24067	27180	30353
Total Social Development	154874	157816	160815	163870	166984	170156

Table 15 shows that this increase would more than allow for all provinces to achieve the level of DSD spending of Northern Cape per poor person, as it requires an increase, over the five year period of 95% rather than the 100% implied by doubling. Northern Cape, is in 2015/16, the province with the highest allocation per poor person. This incremental and gradual increase to social welfare financing would assist in reducing the crises in the sector and would promote equity and access to services.

Table 15: Equalising 2015/16 allocations per poor person to Northern Cape level (R000s)

	2015/16 budget	Northern Cape equivalence	Increase from actual 2015/16
Eastern Cape	2230784	5265760	3034976
Free State	1019233	1720953	701720
Gauteng	3975875	5559544	1583669
KwaZulu-Natal	2630481	7225320	4594839
Limpopo	1537756	4438091	2900335
Mpumalanga	1367074	2979606	1612532
Northern Cape	709856	709856	0
North West	1343637	2626169	1282532
Western Cape	1899985	1993860	93875
South Africa	16714681	32519160	15804478

When the White Paper was developed it drew on a paper that explored the fiscal implications of proposals and this paper noted that the decisions of other departments could have implications for Welfare's budget³⁶. The examples given are health norms and standards for welfare institutions, regulations in respect of preservation (or not) of occupational pensions, and the way in which public works programmes are designed and targeted. All these issues remain relevant in 2015.

6.1.5 Data sources used in budget and beneficiary analysis

6.1.5.1 Cost of service delivery

Some of the analysis presented in this report compares the cost of providing services to current beneficiaries with the allocated budget for a service area. In order to make these comparisons, one needs an estimate of the costs of delivering the different services. In the course of the court challenge by the National Association of Welfare Organisations and Non-Governmental Organisations (NAWONGO), NG Social Services Free State and Free State Care in Action against the MEC for Social Development in Free State, the Head of the Free State Department of Social Development, and the National Minister of Social Development³⁷, the Free State Department of Social Development (DSD) commissioned KPMG to develop a model for costing of welfare services and distribution of available funds.

Table 16 reflects the per beneficiary “core” costs computed by KPMG, in consultation with both DSD and NAWONGO, as recorded in an affidavit submitted on behalf of Free State DSD in August 2013 for the NAWONGO case³⁸. These are the costs that were proposed as the basis for transfers to NPOs delivering these services. The table shows both the full estimated cost of delivering the service, and the (smaller) subsidy amount proposed to be paid as a transfer by DSD, less any amount that the NPO was deemed able to raise from other sources for this service.

The difference between the full costs and the costs to be subsidised reflects various costs which NAWONGO argued were necessary, including vehicle maintenance and replacement, bank charges, accounting and audit fees, equipment insurance, and medical equipment. In respect of staff, government salary rates were used for the costing but the subsidy costs excluded a 13th cheque, pension fund and medical aid contributions, and housing allowance. The subsidy costs also do not make allowance for a share of the overall management of the NPO. Even the full costs shown in the table below are likely to be substantially lower than the government costs of providing the same services. Nevertheless, the amounts shown in the table below are substantially more than the transfers currently paid to NPOs.

³⁶ Van der Berg S. August 1995. “Fiscal Implication of the White Paper on Social Welfare” in *Social Work* 34(1), March: 35-43.

³⁷ National Association of Welfare Organisations and Non-Governmental Organisations and Others vs the Member of the Executive Council for Social Development, Free State and Others. Case no: 1719/2010. Free State High Court.

³⁸ Linström, Johannes. August 2013. Affidavit. National Association of Welfare Organisations and Non-governmental Organisations & Other vs Member of the Executive Council for Social Development, Free State & Others. Case No 1719/2010. Free State High Court.

Table 16: Monthly full cost and cost to be subsidised per beneficiary, selected programmes – KPMG costing, August 2013

Sub-programme	Service	Full cost	Subsidy
Children	Children's home	6 044.59	5 178.56
Older persons	Residential facility	6 489.63	4 570.43
Persons with disabilities	Residential facility	6 512.79	4 651.98
Substance abuse	Inpatient treatment centre	6 617.78	3 738.84
Substance abuse	Outpatient treatment centre	1 443.80	1 175.61
Persons with disabilities	Day care services	2 271.93	2 113.00
Older persons	Home based care	1 558.58	1 011.40
Persons with disabilities	Protective workshops	4 186.15	640.03

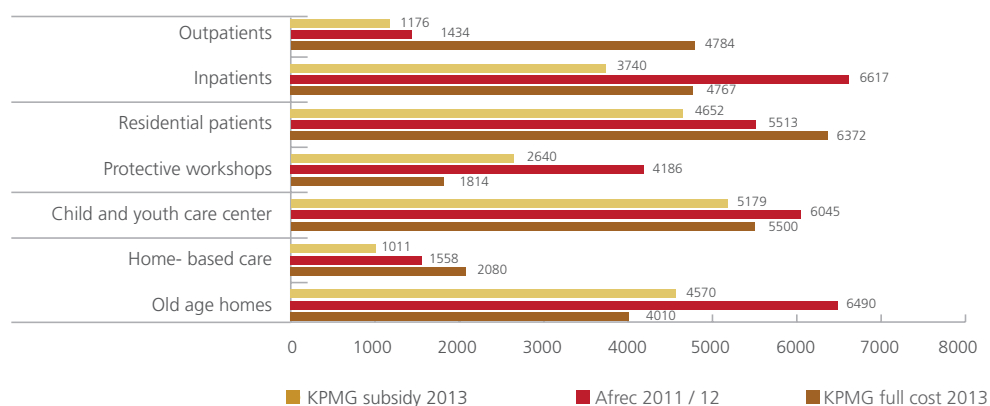
The above estimates are for August 2013. The NPO transfers reflected in the 2015/16 budget are for the period April 2015 to March 2016, and inflation will have increased the costs over the intervening period. Table 17 below therefore provides the full cost and subsidy as at April 2015, using Statistics South Africa's consumer price indices for the two dates (104,2 and 114,0 respectively). This is a conservative measure as the price is inflated only to the first month of the financial year, whereas the same subsidy amounts are paid for the full period from April of one year to March of the next year.

Table 17: Monthly full cost and cost to be subsidised per beneficiary, selected programmes – adjusted to April 2015

Sub-programme	Service	Full cost	Subsidy
Children	Children's home	6 613.08	5 665.60
Older persons	Residential facility	7 099.98	5 000.28
Persons with disabilities	Residential facility	7 125.32	5 089.50
Substance abuse	Inpatient treatment centre	7 240.18	4 090.48
Substance abuse	Outpatient treatment centre	1 579.59	1 286.18
Persons with disabilities	Day care services	2 485.60	2 311.73
Older persons	Home based care	1 705.16	1 106.52
Persons with disabilities	Protective workshops	4 579.86	700.22

The KPMG costing is not the only one available. Prior to the KPMG costing, former staff of the Applied Fiscal Research Centre (Afrec) were commissioned by the United Nations Development Programme to estimate the costs of delivery of the different services. The cost estimates were derived for the financial year 2011/12. Figure 7 shows the differences in the estimates for selected services (without any upward adjustment of Afrec to bring it to KPMG's 2013 base year). The figure shows both the full cost and subsidy cost for KPMG. The six services are evenly divided between those where Afrec estimated a higher amount than the KPMG full cost and those where it estimated a lower amount. There are only two cases where the KPMG subsidy amount is more than the Afrec estimate, despite the Afrec estimates relating to an earlier year. The KPMG costing is thus more conservative if one uses the subsidy amount, but is used here because KPMG took the Afrec costing into account when developing its own costing.

Figure 7: Comparison of KPMG and Afrec costing estimates



6.1.5.2 Beneficiary numbers

Some of the analysis presented in the report is based on actual beneficiary numbers. Other parts of the analysis are based on the number of potential beneficiaries in the population.

The actual beneficiary numbers are derived from the standard non-financial data (NFD) indicators that each provincial DSD is required to report on every quarter. The indicators, developed in collaboration with National Treasury, were previously reported to National Treasury but are now reported to the Department of Performance Monitoring and Development (DPME). Provinces can also develop further province-specific indicators but are obliged to report on the standard set, which consists of approximately three indicators per budget sub-programme.

This paper uses the unaudited results of the provincial NFD reporting for 2014/15. As will be seen below, there are some cases in which there is nothing reported for a particular province where there is no doubt that the province does fund this service. In other cases, a number is reported but seems questionable. Unfortunately, there was no way of correcting these apparent errors for this analysis. The fact that the obligatory indicators are imperfectly reported is, in itself, cause for concern.

For potential beneficiaries the estimates are derived from, among others, Statistics South Africa’s mid-year population estimates for 2014³⁹, its Quarterly Labour Force Survey and General Household Survey, and its poverty estimates. The source and approach is explained in each case below.

6.2 Government revenue

This section of the report highlights existing sources of government revenue. It also highlights the extent and limits of donor funding for broad social service categories.

6.2.1 Taxation

The main sources of government revenue are company income tax, personal income tax, and value-added tax (VAT). By 31 March 2014 there were 1.4 million individuals registered for tax (although not all would be liable to pay tax), 2.7 million registered companies (of which about 800 000 likely to submit income tax returns, with the remainder inactive/dormant) and nearly 700 000 registered for VAT (of which just over 420 000 were active). Company income tax's share of total tax revenue decreased from 22,9% in 2009/10 to 19,9% in 2013/14; personal income tax's share was 34,5% in 2013/14, and VAT's share was 26,4%.

The overall tax-to-GDP ratio in South Africa increased from 22,9% in 1994/95 to 26,1% in 2013/14⁴⁰. The 2013/14 is slightly higher than the 25% that the South African government has sometimes proposed as the ceiling. However, research by the Alternative Information Development Centre suggests that if government had since 1990 adjusted the tax brackets only for inflation rather than sticking to this rule, government would have collected R125 billion (16,5%) more than the R757 billion total revenue of that year⁴¹. The tax: GDP ratio would have been 29%, more or less the level recommended by the Macro-Economic Research Group in the years preceding the 1994 first democratic election. The extra revenue would have reflected the fact that more people were paying tax and incomes of the highest income earners were increasing faster than inflation.

In addition to ordinary taxes, SARS also collects the Mineral and Petroleum Resources Royalty (MPRR), Road Accident Fund (RAF) levies and social security contributions such as Unemployment Insurance Fund (UIF) payments on behalf of other agencies. SARS also collects the Skills Development Levy, a tax on payroll. The MPRR compensates government for permanent loss of non-renewable commodities and is therefore not regarded as a tax.

6.2.2 Tax expenditures⁴²

The diesel refund is one example of where government exempts particular categories either partially or completely from a tax or levy that applies to others. These exemptions are often referred to as "tax expenditures" because they can be seen as equivalent to government first collecting the tax or levy and then paying back all or some of it to the payer. Tax expenditures effectively reduce the funds available to government for other purposes.

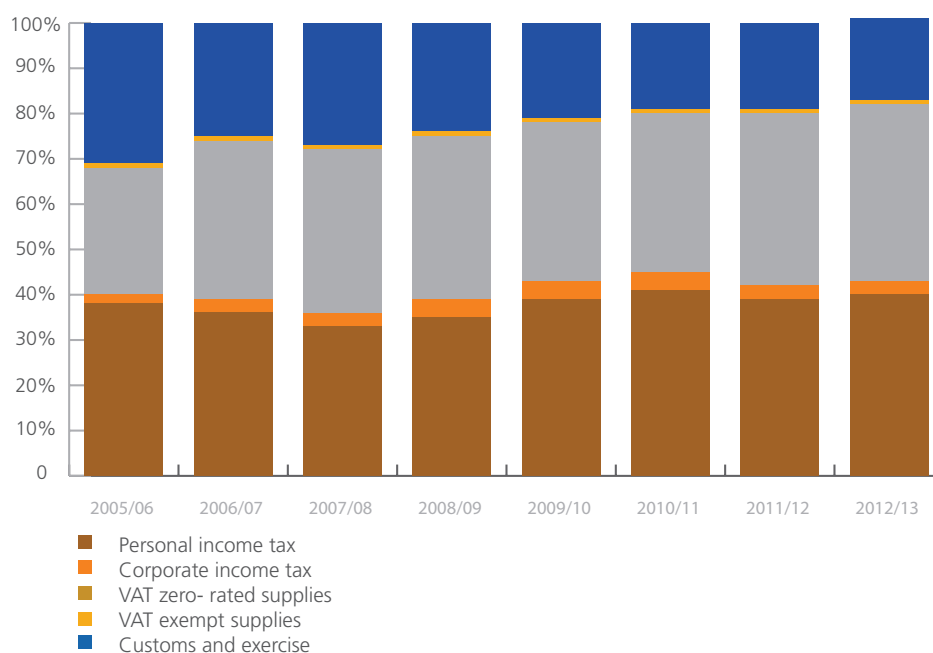
³⁹ Mid-year population estimates for 2015 are not available at the time of writing, but should not differ substantially from those for 2014.

⁴⁰ National Treasury and South African Revenue Service. 2014. Tax Statistics 2014. Pretoria.

⁴¹ Forslund D. 2012. Personal Income Taxation and the struggle against inequality and poverty: Tax policy and personal income taxation in South Africa since 1994. Alternative Information Development Centre: Cape Town.

Tax expenditures amounted to a total of R119,76 billion in 2012/13, equivalent to 14,7% of total gross tax revenue. The graph below shows the composition of the expenditures in broad terms over the period 2005/06 to 2012/13. The share relating to customs and excise declines markedly over the period, while the share for VAT zero-rating increases. Exemptions relating to personal income tax account for the largest share of tax expenditures over the full period.

Figure 8: Composition of tax expenditures, 2005/06-2012/13



More detailed analysis highlights the patterns for sub-components of the broad categories:

- Exemptions relating to pensions amount to 20% of total tax exemptions, and exemptions for medical contributions to a further 17% in 2012/13. The medical share increases from 14% in 2005/06 to the 17% in 2012/13.
- Exemptions for zero-rating of basic foods amounts to 16% of the total, zero-rating of fuel to 13%, and zero-rating of municipal property rates to 8%. The latter is 0% in 2005/06.
- The diesel refund amounts to 3% of total tax expenditure in 2012/13, up from 1% in 2005/06.

6.2.3 Special purpose funds and accounts

There are many ring-fenced or special purpose funds or accounts which are allowed to retain tariffs or fees of various sorts⁴³. The dedicated taxes and levies are probably of most interest to the Ministerial Committee. In assessing the amounts involved, one can compare with the more than R6 billion allocated for transfers to NPOs by provincial DSDs in 2015/16.

The large special purpose funds are the RAF levy, the skills levies, the UIF and compensation fund assessments. The latter is arguably not a tax as the assessments are risk-based. These levies are described in more detail below. However, they are not the only levies imposed by government. The following examples illustrate the broader range of levies but also show that with some levies the revenue is not ring-fenced for particular purposes:

- The Water Research Commission is funded by a levy paid by water utilities;
- Many regulators, such as the National Electricity Regulator, the nuclear regulator, and various professional councils, are funded by statutory levies;
- The Telecommunications Act provides for a mechanism that is supposed to fund universal service programmes and may be used to fund the set top box subsidy;
- Asset forfeiture proceeds are allocated to specific purposes in the relevant legislation
- The law provides for an equalization levy that used to subsidise Sasol and Mosgas and something similar is under consideration for biofuels;
- Television licences and other license fees sometimes are dedicated, including the transaction charge attached to road traffic management penalties.

The electricity levy is one of several environmental taxes, with the other environmental taxes being the international air passenger departure tax; plastic bag levy; incandescent light bulb levy; and the carbon dioxide tax on motor vehicle emissions. The electricity levy is the only environmental tax that includes some ring-fenced funding. The levy was introduced in July 2009. It is charged on electricity generated from non-renewable sources. When it was first introduced, the funds were not ring-fenced. From April 2011 some of the revenue from an increase in the levy was intended to fund rehabilitation of roads damaged by the haulage of coal for electricity generation. From 2012, revenue from a further increase has been used to fund energy-efficiency initiatives such as the solar-water heater programme.

Table 18 shows the revenue from the electricity levy increasing from R3,34 billion in 2009/10 to R8,82 billion in 2013/14.

⁴³ Andrew Donaldson and Cecil Morden, National Treasury, provided guidance on this issue.

Table 18: Electricity levy collections (Rm)⁴⁴

2009/10	2010/11	2011/12	2012/13	2013/14
3342	5103	6323	7984	8819

The fuel levy and alcohol taxes are not dedicated, apart from the RAF levy component of the fuel levy and a small levy in respect of paraffin.

Skills levies have always been collected by SARS. UIF is now mainly collected by SARS. However, employers who are not on the SARS register (e.g. households) pay directly to the UIF. The RAF levy has been collected by SARS as part of the fuel levy since April 2006. Previously the fuel levy, including the RAF component, was collected by the Central Energy Fund. The compensation funds collect their own funds.

6.2.3.1 Road Accident Fund⁴⁵

The RAF receives the RAF fuel levy net of diesel refund after it has been collected by SARS. Fuel levies accounted for 99% of the RAF's total revenue in 2014/15. In 2014/15 the net amount of the levy was R22,61 million, as against R20,28 million in 2013/14. For 2015/16 the amount should be substantially higher after the Minister of Finance announced an increase of 50 cents per litre, a 48% increase, in his budget speech of early 2015. In the second half of 2015 the levy amounted to approximately 9% of the total fuel price "at the pump".

In 2014/15 the amount received by the RAF was insufficient to cover claims, with payments equivalent to 124% of fuel levy income. The shortfall was covered by reserves, and the RAF was technically insolvent. The sharp increase was intended to promote sustainability under the new Road Accident Benefit Scheme for which legislation was to be introduced during 2015/16.

National Treasury sets the fuel levy per litre each year, taking into account the request of the RAF based on its financial model and calculation of costs. Generally National Treasury sets a levy rate lower than that asked for by the RAF. SARS collects the fuel levy and pays it to the RAF in terms of the Customs and Excise Act (91 of 1964) and the RAF Act (56 of 1996).

A diesel refund system was introduced in July 2001 and is funded from fuel levy collections. The diesel refund was initially intended to promote the international competitiveness of fishing, farming, forestry and mining. From October 2007 it was extended to electricity generation by large plants using distillate fuel. The refund is administered through the VAT system. The rates are revised each year based on revision to the fuel levy and RAF rates. Diesel refunds increased to R6,2 billion in 2013/14 from R3,3 billion in 2012/13. The steep increase reflected large claims relating to use of diesel generators to buffer electricity production. By 2014/15 the diesel refund amounted to 12% of the RAF's fuel levy income, having increased particularly sharply in recent years.

⁴⁴ National Treasury and South African Revenue Service. 2014. Tax Statistics 2014. Pretoria.

⁴⁵ Road Accident Fund. 2015. Annual Report 2014/15.

Table 19 shows the fuel tax charges per litre over the period 2011-2015. In 2015, after the 50c increase, the RAF levy constitutes 37% of the total fuel tax, as compared to 30% or less in previous years.

Table 19: Components of fuel tax per litre, 2011-2015

Year	RAF levy	Basic fuel levy	Total fuel tax
2011	80	177.5	261.5
2012	88	197.5	289.5
2013	96	212.5	312.5
2014	104	224.5	332.5
2015	154	225.0	413.0

Sources: Road Accident Fund. Annual Report 2014/15; National Treasury. Budget Review 2013; 2015.

6.2.3.2 Unemployment Insurance Fund⁴⁶

SARS is responsible for collection of most UIF contributions. The main exception is households employing domestic workers, from whom the Fund collects contributions directly. The contributions represent 2% of employee wages and salaries, with 1% deducted from the wage or salary and an equivalent amount paid by the employer. Currently, government employees do not contribute to the fund.

Employer-employee contributions are the main source of the Fund's revenue, and were expected to account for 62% of revenue over the 2015/16-2017/18 MTEF period. The remaining revenue comes primarily from investments.

Table 20 shows the amount transferred from SARS to the UIF increasing from R12,28 billion in 2011/12 to R16,42 billion in 2014/15.

Table 20: UIF transfers received (Rm)

2011/12	2012/13	2013/14	2014/15
12284.3	13498.5	15077.3	16420.5

Source: National Treasury. 2015. Estimates of National Expenditure.

The UIF's annual report for 2014/15 shows a total of R16,65 collected in 2014/15, confirming that the proportion of contributions collected by the Fund rather than SARS is very small.

While SARS is responsible for most collection, all employers and employees are registered with the Fund. As at 31 March 2014, a total of 53 312 employers and 1 526 416 employees were registered by the fund. A total of 667 009 domestic employers were registered as against 905 445 commercial employers and 7 234 taxi employers. On the employee side, there were 664 866 domestic employees as against 8 802 350 commercial, 6 470 taxi employees on the UIF's database.

⁴⁶ Unemployment Insurance Fund. 2015. Annual Report 2014/15.

The Fund hoped that an amendment to the UIF Act would be approved by parliament in the third quarter of the 2015/16 financial year. The amendment would improve benefits and include a new category of beneficiaries.

Table 21 shows the amounts paid out in benefits over the period 2004/05 to 2014/15.

Table 21: Amounts paid in benefits (R000)

Year	Amount
2004/05	2 475 506
2005/06	2 933 425
2006/07	2 837 851
2007/08	2 921 460
2008/09	3 846 618
2009/10	5 709 393
2010/11	5 548 979
2011/12	5 738 001
2012/13	6 122 212
2013/14	7 185 591
2014/15	7 210 370

In addition to administering benefits, the UIF also has some other roles. In particular, the Fund provides funds for the training layoff scheme managed by the Commission for Conciliation, Mediation and Arbitration (CCMA) and has a Labour Activation Programme which funds skills training. These activities fall under the strategic outcome “creating and sustaining decent employment”.

Expenditure by the UIF on this outcome is much smaller than on benefits. A total of R93 million was spent in 2014/15 against an original budget allocation of R550 million for the outcome, and a total of 105 “distressed” companies assisted. The UIF is not the only funder of the training layoff scheme. In particular, in 2014/15 the National Skills Fund committed R1,2 billion for training allowances alongside the R1,2 billion allocated by the UIF. The Fund explained that failure on the part of the sector education and training authorities (SETAs) to endorse some of the training contributed to its own expenditure shortfall. Productivity SA, which was allocated R58,5 million from these funds, was paid only half of this amount “due to the timing of the request”.

The Fund’s annual report states that it hoped to develop a business case for the establishment of a training academy for unemployed beneficiaries.

6.2.3.3 Compensation Fund⁴⁷

The Compensation Fund, which reports to the Department of Labour, is responsible for workers’ compensation outside of the mining industry. The latter is covered by different legislation and structures. In addition, the iron and steel “class” of employers was to be transferred to the Rand Mutual Association in April 2015, together with the capitalised value of pensions.

⁴⁷ Department of Labour. 2015. Annual Report of the Compensation Fund 2014/15.

The Compensation Fund collects its own revenue, with payments (assessments) by employers based on the risk of a particular industry. Table 22 shows assessment revenue increasing from R5,3 billion in 2011/12 to R10,0 billion in 2017/18, the outer year of the current MTEF. The Fund's MTEF shows total revenue growing by an average of 2,8% per year while benefits increase at an average of 5,5% per year.

Table 22: Assessment revenue (R bn), 2011/12-2017/18

2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
5.3	7.1	8.2	8.6	9.0	9.5	10.0

Source: National Treasury. 2015. *Estimates of National Expenditure*.

The amounts recorded in the table above, which are sourced from National Treasury's Estimates of National Expenditure, are higher than the amounts recorded in the Fund's 2014/15 annual report. The latter has, for example, R8,2 billion in levy income recorded for 2014/15, and R7,0 billion for 2013/14. The annual report notes that the Fund's debt book stood at R9,4 billion in 2014/15 – an increase of 41% on the previous year.

Table 23 shows the number of claims registered, accepted, repudiated and with outstanding information for each year. As can be seen, the number accepted can exceed the number registered in a particular year. This reflects backlogs, which the Fund refers to as the "legacy system".

Table 23: Compensation claims, 2012/13-2014/15

	Registered	Accepted	Repudiated	Outstanding information
2012/13	196509	129405	356	63226
2013/14	310710	260253	86	50369
2014/15	225511	6140475	155	n/a

There are several indications of poor management in the annual report. For example, the report notes that in 2013/14, the Auditor-General issued a management letter for the Fund with 317 findings. By end March 2015 the Fund considered 53 of the findings to be "resolved", but the Auditor-General considered only 36 as resolved.

The Compensation Fund is decentralising claims processing services to provincial level and by end March 2015 had filled the positions of relevant managers in six of the nine provinces. The Fund's new assessment model will include a direct link with the UIF and Companies and Intellectual Properties Commission to ensure that all active employers are registered.

6.2.4 Donors

Each year national DSD receives both financial and in-kind donations from a number of different bilateral and multilateral donors. Relatively limited funds come in the form of direct financial contributions, where funds come into the government financial

system. Far more donations are in-kind, where donors pay consultants and other service providers or buy goods on behalf of the department. Unfortunately, DSD and National Treasury do not have a record of donations that the bilateral, multilateral and other donors contribute directly to other actors, and to NPOs in particular.

Table 24 shows the active financial commitments as at February 2015, while Table 70 shows previous and active in-kind commitments. Previous commitments are included because accurate information on in-kind commitments, in particular, is often available to government after some delay. As a result, the information on current commitments is probably incomplete.

More generally, the information in the tables is not comprehensive. Firstly, there is some missing information, including in respect of amounts. Secondly, the International Development Cooperation Unit of National Treasury is not informed by donors (and/or recipient departments) of all commitments and transactions. The Unit should be informed about the limited funding that comes through the Reconstruction and Development Programme Fund channel (only the German funding in the tables below), but has to source information on other monies as best it can. The Unit is fully aware that it does not have information on all funding. Examination of DSD's annual reports already reveals some missing items, such as a child protection surveillance study and related conference funded by the Canadian International Development Agency (CIDA). Further, there are likely to be donor contributions to other government agencies, such as the National Prosecuting Agency in respect of Thuthuzela Centres, which indirectly contribute to DSD activities. Donors beyond bilaterals and multilaterals may also contribute. For example, DG Murray Trust is funding research and analysis to support National Treasury and DSD in developing a sustainable way of funding social development services, as well as in respect of funding of early childhood development services.

The available information suggests a strong bias towards activities relating to children – and orphans and vulnerable children (OVC) in particular, and also a strong emphasis on monitoring (as evidenced, for example, by information systems and audits) and capacity building (as evidenced, for example, by tools and training).

Table 24: Active financial commitments as at February 2015

Donor	Project Name	Purpose	Period	Value (R)
Canadian International Development Agency (CIDA)	Child Protection register	Awareness raising, capacity building, proposal for surveillance system	Jun 2008-Mar 2015	35 000 000
Health and Welfare Seta	Population and Development	Various training programmes	Mar 2013-Dec 2015	R9 989 550
Global Fund		Strengthening M&E systems for OVC	Apr 2014-Mar 2015	R6 944 000
Cara Fund	Victim Empowerment	Support VEP organisations	Apr 2014-Mar 2015	26 000 000

Source: International Development Cooperation, National Treasury

Table 25: Previous and active in-kind commitments as at February 2015

Donor	Project Name	Purpose	Period	Value
German Development Bank	OVC Care and Support	In KwaZulu-Natal, Limpopo & North West: Construction, refurbishment, extension & equipment of community care centers; Development and implementation of skills development programme for OVC	2013 to 2016	R2 419 476
Japan International Agency	Services to people with disabilities	Training for officials and people with disabilities, M&E and networking activities related to mainstreaming	Dec 2012- Dec 2018	Not specified
Japan International Agency	Home Community Based Care: HIV and AIDS	Strengthen data quality of HCBC M&E in North West and Northern Cape	Apr 2013- Mar 2014	
United States Agency for International Development (USAID)	Child Protection	Verify safety and risk assessment tools and training materials	Mar-July 2013	
USAID		Roll out of safety and risk assessment tool to social workers.	Oct 2013- Feb 2014	
USAID	Child Protection	Sustainability of children services directory	2012-2015	USD4 920 684
USAID	Thogomelo	Training of community caregivers on psychosocial wellbeing and development of curriculum and training on supervision.	Sep 2013- Jun 2016	R8 337 195
USAID	HIV and AIDS: M&E	Placement of 2 contract workers in DSD to provide technical support for M&E system.	Apr 2012- Aug 2014	R2 708 107
USAID	HIV and AIDS: M&E	Miscellaneous	Apr 2014- Mar 2015	

Donor	Project Name	Purpose	Period	Value
USAID	OVC Care and Support	Hosting and development of Community-based Interventions Monitoring System (CBIMS)	Aug 2013-Aug 2014	R503 356
USAID	Gender Based Violence	Gender Based Violence Command Centre	Apr 2014-Mar 2015	R4 205 000
USAID	HIV and AIDS: M&E	DSD Temporary staff travel costs	Aril 2014-Mar 2015	R81 000
USAID	Child Protection: Development of Induction Manual	Development and piloting of new Induction Manual for social workers	2014-2016	R400 000
USAID	Home Community Based Care	Impact assessment of Home Based Care support programme of DSD	2013-2015	R2 877*
United Nations Children's Fund (UNICEF)	Child Protection	Development of ECD Policy	Jun 2013-Apr 2014	R849 548
UNICEF	Child Protection	Unspecified	Jun 2013-Apr 2014	R1 295 886
UNICEF	Child Protection	Testing, training of master trainers, and layout of assessment tool for children in alternative care	Jun 2014-Dec 2014	R501 800
UNICEF	Child Protection	Audit of unregistered CYCCs and situational analysis of Safe Houses	Jun 2013-Apr 2014	
UNICEF	Child Protection	Finalisation of ECD Policy and Comprehensive ECD programme.	Jan-Dec 2014	R610 000
UNICEF	Child Protection	VAC Surveillance system	Dec 2014-May 2015	R807 270
UNICEF	Child Protection	Structural analysis of causes of VACW	Feb 2014-Apr 2015	R1 601 446
UNICEF	Child Protection	Child Protection Provincial Profiling	Jul 2014-Apr 2015	R885 620
UNICEF	Child Protection	Evaluation of Safer South Africa for Women and Children Programme	Dec 2014-Sep 2015	R1 813 300

Donor	Project Name	Purpose	Period	Value
UNICEF	Child Protection	Printing of testing tools for children entering alternative care		
UNICEF		IMC Technical Support		R237 855
PACT / United States Agency for International Development	Chief Operations Officer	Government Capacity Building Systems	Sep 2014-Mar 2015	R33 616 278
United Nations Population Fund	Capacity Building project	Sexual and Reproductive Health Advocacy	Feb 2015	
United Nations Population Fund	Capacity Building project	Intergenerational communication on Adolescent Sexual Reproductive Health and Rights Study tour to Brazil	Apr 2013-Mar2017	USD 44 000 USD 44 000

* This amount appears questionable.

The largest single amount is the more than R33 million provided in respect of the 2014/15 financial year for the Government Capacity Building Systems (GCBS), which is funded by USAID but managed by PACT SA. It is a multi-year support programme.

DSD's annual report for 2014/15 has an amount of R21,9 million for this programme. The report notes that the programme includes a number of organisational reviews, which it says will be aligned to the ISDM review process. The reviews named as already finalised include the review of the White Papers on Social Services, the Organisational Capacity Assessment and the Organisational Network Analysis, but the report notes that these are not the only reviews ongoing within the GCBS and more generally within DSD. The report also records plans to collaborate with UNICEF on a study of tax options or scenarios to fund the universalisation of the CSG given that universalisation had been put on hold primarily for financial reasons.

While some of the funding can be seen as one-off in that it relates to establishment of systems and policies and training on new systems, other programmes involve recurrent expenditure that will need to be taken over by government when donor funding comes to a halt. Examples of such programmes include the provincial data capturers for CBIMS funded by the Global Fund, and the operational costs of the Gender-Based Violence Command Centre.

Funding by the UN agencies is often subject to the interests of those agencies' donors as the UN is often a conduit for other funds. For example, UNICEF has served as the conduit for funds from the United Kingdom's Department for International Development in respect of violence against women and children, and such funds are unlikely to be available going forward as the UK moves away from funding South Africa. The current

USAID grant to the National Prosecuting Authority in respect of Thuthuzela centres provides funding for services only for four new centres, with nothing for services at the 42 existing centres⁴⁸. DSD meanwhile subsidised stipends of care workers at only 13 of the 27 NPOs providing post-rape services at these centres.

The Committee finds that it is not only the availability of sources of funding for developmental social welfare that is a problem, but also how existing funds are used.

Financing and budgets:

Summary highlights

- South Africa's social protection budget amounts to 15,3% of consolidated government expenditure, and 4,9% of gross domestic product (GDP).
- Approximately 88% of expenditure on social protection relates to social assistance, which is funded within the national sphere.
- Very limited funding is provided for other social development services, especially for social welfare services, which are funded primarily by provinces through the equitable share formula that provinces receive for all provincial functions.
- Since 1997, there has been a clear shift in prioritisation away from services for older persons and towards children.
- Currently a wider range of services is funded than in 1997, but most services are funded inadequately.
- There are substantial provincial differences in levels of funding relative to need across all service areas.
- An annual increase of 1,9% per year in government's social development spending over five years would more than double welfare service spending, and allow for all provinces to be aligned upwards. It would improve access to critical welfare services prioritised in the NDP.

⁴⁸ Shukumisa. 2015. 15DaysOfDiscontent: Day 7: Undervaluing care work.





PART VI:

7. Review of welfare and community development services

7.1 Introduction

The discussion below of welfare and community development services utilises the categories and follows the order of the provincial budgets. This is done, firstly, because provinces bear the main responsibility for delivery of services and, secondly, because budgets can be considered a reflection of where and how legislation and policies are carried forward into implementation. One deviation from this approach is that all children's services are discussed together rather than, as in the budget structure introduced for the 2014/15 financial year, having them separated into different sub-programmes.

For each service area, the relevant section first updates the observations of the 1997 White Paper, and then presents Ministerial Committee's findings that go beyond issues discussed in the White Paper update. The discussion of the Committee's findings in respect of each service area draws on the quantitative tool administered during focus groups in the 18 districts, as well as on the focus group discussions in the districts and the presentations and submissions made at provincial and national level.

The main part of the quantitative tool required that focus group participants agree, for each of a number of pre-specified services in each service area, whether the service was available in the district and, if so, the extent to which it was available. The rating for the latter was from 1 to 5, with 1 indicating very poor availability, and 5 indicating very good availability. A rate of zero was (presumably) used for whether the service was deemed not available at all. However, the zero rating was not used consistently in that in some cases the lack of any score may also indicate complete lack of availability.

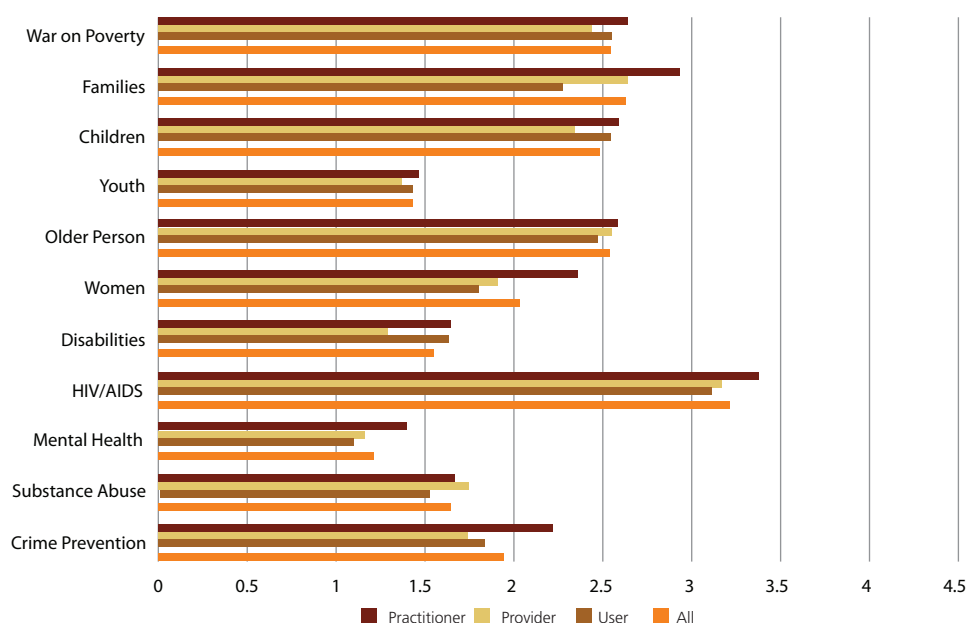
The discussion below refers to the mean (average) rating given for the various services provided by the three stakeholder groups, followed by mean ratings across all services within a particular service area. The scores and patterns must be treated as indicative, reflecting perceptions rather than objective fact. In particular, perceptions of accessibility will be influenced by the particular composition of the focus groups in each province. For example, if the beneficiary focus group in a particular district had a larger number of older people, they might be more likely to know about the services related to this group.

A mean score can be calculated for stakeholder groups and provinces in respect of each service area by averaging the scores for all services in that particular area. If this is done, HIV and AIDS emerges clearly as the most highly-rated service in terms of availability, with a mean score of 3,2 where the maximum possible is 5. In the focus group discussion, participants spoke primarily about the rollout and accessibility of ARV. It is, therefore, possible that the high rating given relates to this rather than to services delivered by DSD. Other services which scored 2,5 (half of 5) or more were War on Poverty (which included social grants, the highest-scoring service across all service areas), families, children, and older persons. Mental health was rated least available, with a rating of 1,2, followed by youth development at 1,4.

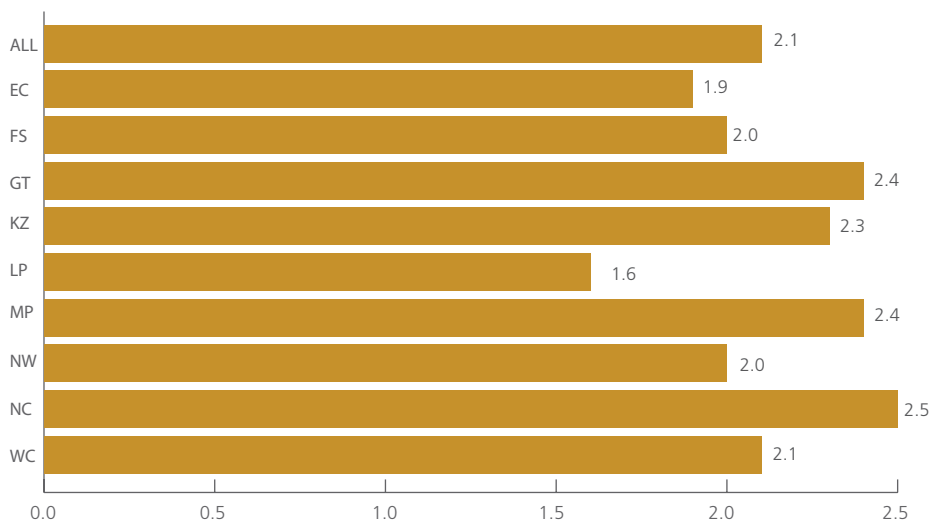
Practitioners gave higher ratings than the other two groups for all services except substance abuse. Families, women development and crime prevention showed relatively

large differences between the ratings provided by the three stakeholder groups. Older persons and youth development showed the greatest agreement on ratings across the three groups, at least at this level of aggregation.

Figure 9: Focus group ratings of service areas



The mean rating for the various service areas across provinces was 2,1 – less than half of the maximum score of 5,0. Provincially, only one province – Northern Cape – achieved a score of 2,5, half of the maximum. Northern Cape’s high score probably in part reflects the legacy of service delivery patterns during the apartheid era as the coloured share of the population is higher than in many other provinces, and welfare services were more readily available for coloured than for African people (but less available than for white people). There is a fairly clear pattern of the relative wealth of a province and its inhabitants influencing availability. Gauteng and Western Cape, the wealthiest provinces, followed 0,1 points behind Northern Cape, at 2,4. At the other end of the wealth-poverty continuum, Limpopo had the lowest overall score, at 1,6, followed by Eastern Cape at 1,9. While the rating is indicative, the top (Northern Cape) and bottom (Limpopo) scorers match those presented above in terms of provincial DSD spending per poor person.

Figure 10: Focus group average ratings of services by province

Rural-urban disparities can be explored by classifying all districts as rural or urban based on the percentage of their population classified as urban in Census 2011. (The weighted 10% sample provided by Statistics South Africa is used for this purpose.) For the country as a whole, 63% of the population was classified as urban in Census 2011. For this exercise, eight of the 18 districts visited by the Ministerial Committee were classified as rural on the basis that 63% or less of their population was not urban. The mean rural scores were lower than the urban scores for all services except disabilities. The rural-urban gap was widest in respect of older persons and mental health.

7.2 Older persons

The White Paper predicted that by 2015 there would be 3,4 million older persons in South Africa. It noted further that the percentage of persons aged 80 years and above was increasing, and that this age group, was particularly vulnerable.

The White Paper highlighted the “unrealistic emphasis” on institutional care for older persons among the white population, as well as the high cost of this service, making it unaffordable if expanded to all parts of the population. It highlighted racial and geographic (urban-rural) disparities in respect of provision of services for older people, and especially in respect of old age homes and services centres. It also highlighted the lack of affordable housing in “developing and underdeveloped communities”.

The White Paper reported that social support systems for the care of black older people had “disintegrated” in some communities as a result, among others, of violence and displacement. Recreational services were unavailable, inadequate and/or unaffordable in “disadvantaged communities”. It highlighted that older people – and particularly those over 80 years of age – were often nutritionally vulnerable.

The White Paper noted the “unfavourable” economic conditions, and limited job opportunities available. It noted that those employed informally, at low wages, or unemployed were not in a position to save for their retirement, while many of those in formal employment had inadequate or no provision.

7.2 1 Updating the White Paper

In 2014, the population aged 65 years and above was estimated to account for 5,3% of South Africa's population⁴⁹, or just under 3,0 million people. Those aged 80 years and above numbered 54 000, 0,8% of the total population⁵⁰. The old age dependency ratio – calculated as the number of people aged 65 years and above divided by the number aged 15-64 years – has increased steadily each year, increasing from 7,3 in 2007 to 8,0 in 2014. Women increasingly outnumber men in each older age group.

In 2011, more than 580 000 (14%) of the 4,05 million non-institutionalised people aged 60 years and above lived in households made up only of older people. Of these, 71% - more than 400 000 – lived alone – a marked increase on approximately 280 000 in this position in 2001⁵¹. In the same year, about 87 000 individuals aged 60 years and above – about 2% of all in this age group – were enumerated in collective living quarters, most of which were likely old age homes. Only 1% of African older people were in collective living quarters, as against 5% of white older people. Expressed differently, there were 1,3 white older people in institutions for every African older person, while for the population of this age group as a whole, there were only 0,3 white people for every African older person.

During the Committee's engagements in provinces and districts concerns were repeatedly expressed about the unavailability of residential care for older people. Where services are available, they are usually privately provided and unsubsidised by government except for some frail care services. The private, unsubsidised nature of the service makes it unaffordable for most older people and their families. Unregistered services were reported to have "mushroomed" to fill the gap, with such services unregulated and often not complying with minimum standards.

Residential services for older people were repeatedly named as among the most untransformed areas of social welfare service delivery. This is explained, at least in part, by the unaffordability of the services. It also reflects where the services are located given ongoing racial segregation in residence for large parts of the population. Beyond old age homes, there is very little government support for assisted or independent living.

In some provinces informants reported on nutritional interventions in respect of poorer older people. However, it seems that the nature and extent of the services differ across provinces and districts. Meals on Wheels was consistently rated low by participants in district focus groups during the Ministerial Committee's review process.

In respect of financial provision for retirement, the situation has not changed much since 1997. In 2007 Cabinet appointed an Inter-Ministerial Committee (IMC) on comprehensive social security reform. This is discussed in more detail below. Progress to date has been slow, but in January 2016 President Zuma signed legislation restricting the portion of provident fund savings that can be withdrawn as a lump sum to a third of the total savings. The announcement generated a wave of opposition from trade unions.

⁴⁹ Statistics South Africa. April 2015. Demographic indicators and shifts in South Africa since 1996. Presentation to Ministerial Committee Retreat.

⁵⁰ Statistics South Africa. 2014. Mid-year Population Estimates 2015. Statistical release P0302. Pretoria.

⁵¹ Calculated from the 10% sample datasets of the 2001 and 2011 censuses.

7.2.2 Other findings of the Ministerial Committee

The quantitative tool used by the Committee in the district engagements identified four services for older persons, namely residential facilities, frail care facilities, service centres, and active aging. On the quantitative tool, frail care facilities were scored lowest overall, and also scored lowest by all three stakeholder groups. The differences between stakeholder groups in the scores for the other three older persons' services were relatively small, although residential facilities were rated slightly lower than service centres and active ageing both overall and across all three stakeholder groups.

Gauteng was amongst the best performers on three of the services, but only just above average on frail care facilities. Western Cape performed especially well on both frail care and residential facilities, but was a relatively low scorer on active ageing. Limpopo performed noticeably less well than other provinces on frail care and residential facilities, and about average on the other two services.

In the discussions, there were many mentions of residential facilities, but these were generally negative. There were complaints about the lack of such facilities in previously disadvantaged areas, and also lack of provision for older persons with disabilities. Further, it seems that in most provinces DSD now only provides subsidies for frail care. This is in line with the proposal of the Report of the Welfare Reprioritisation Committee to then Minister of Welfare and Population Development Geraldine Fraser-Moleketi in 1996.

Providers in Mpumalanga noted that the exclusive focus on frail care meant that service provision was more costly and required additional staff. In North West, service providers reported that the frail care facilities were often not available for older persons as they were serving younger frail persons. In Eastern Cape beneficiaries reported that frail care centres were "running empty". However, service providers in the same district reported that the "huge gap" between demand and supply for frail care was increasing. In one of the Western Cape districts visited, a residential facility had a waiting list for older persons who needed their services. Initially the staff at this facility attempted to do outreach services to older persons in their homes, but this service was discontinued because of lack of resources and staff.

In Gauteng, service providers said there was only one government-run old age home, and the monthly fees in "semi-private" (presumably subsidised) institutions were R4 000. The old age grant in 2014 stood at R1 350 per month – not even half of the monthly fee for the home. Other evidence revealed that when utilising services, older people who receive the old age grant are sometimes required to pay over to the institution part or the whole of the grant, but that the approach differs across facilities.

There were many observations that residential facilities for older persons was the least transformed service across all service areas, reflecting the fact that residents were still largely white. This was attributed to costs of the service, but could also be related to ongoing racial segregation of residential patterns as well as what a Western Cape non-profit organisation (NPO) termed "cultural differences".

Participants reported that there was little or no residential provision for people suffering from dementia and Alzheimers – the prevalence of which is increasing as longevity

increases. More generally, there was very little provision for older people needing psychiatric care and services. However, a Northern Cape NPO noted that psychiatric treatment was available, but only in residential facilities.

The question of the respective responsibilities of DSD and Department of Health in respect of frail care facilities arose repeatedly during the Committee's engagements. In some provinces the failure of Health to provide funding was said to be diverting DSD funds that could be used for other purposes. In some provinces NPOs reported receiving funding from DSD in respect of home-based caregivers providing psychosocial services to older persons who were less mobile or even bed-ridden. It was suggested that nurses were needed to visit bed-ridden older people and thus avoid hospitalisation. A KwaZulu-Natal NPO commented that community caregivers provided information for older persons, but not hands-on care.

Concerns were raised about the lack of respite care, despite provision for this in the Older Persons Act of 2006. There was reported to be little or no support for assisted and/or independent living, or for subsidised rentals for older persons. However, the Suid Afrikaanse Vroue Federasie (SAVF) in Mpumalanga reported that close on 400 older people were accommodated in their housing scheme and there are, no doubt, other examples, some of which might receive some government assistance. For example, the Western Cape government recorded an amount of close to R1 million allocated to two NPOs in respect of independent living for 2014/15, and a further amount of R0,83 million allocated to four NPOs in respect of assisted living. The Older Persons Act does not provide for assisted or independent living.

In the Ministerial Committee's consultations, all provinces and districts reported the expansion of community-based services for older people since the 1997 White Paper. All provinces reported, in particular, on active ageing initiatives. One or two mentions suggested that the Department of Health collaborated with social welfare services in the active aging area. Service providers in a North West district said that active ageing was the only service available for older persons. North West practitioners categorised active aging as "community-based care".

Several provinces referred to the "flagship" Golden Games when reporting on active ageing. National DSD's presentation to the Ministerial Committee revealed that (only) 30 000 older people participated in active ageing initiatives in 2012. Older people receive stipend payments when participating in recreational activities organised by DSD. Western Cape stopped implementing Golden Games in 2009 with the change in administration. Attendance at service centres has reportedly subsequently fallen.

Luncheon clubs and service centres were noted as achievements in some provinces, but elicited little further discussion.

NPOs reported several intergenerational initiatives, generally in residential homes, where older people interacted with younger ones. These included the "Pretty Things for Little Things" competition in which older persons make toys for disadvantaged children; the "Gogo-gethers" where older persons provide support to children and adults infected

and affected by HIV and AIDS; a programme where school learners provide computer training for the elders and through this learn communication skills and respect for older persons; an “In-Generation” project in Eastern Cape in which old and young come together around the playing of indigenous games; and a Library Chest project in which older people read to children and/or children read to older persons and assist with literacy.

The issue of elder abuse was raised across provinces, with a widespread perception that this problem was rampant. The abuse was sometimes characterised as attempts by the abusers to get access to old age grants. Abuse can also occur when behaviour linked to dementia and Alzheimers is seen as reflecting bewitchment of the older person. Elder abuse was also raised in relation to the scarcity, or complete lack of, safe beds in residential facilities. Age-in-Action, which presented in several provinces, reported on their Careline service, which investigates alleged cases of abuse, and explores possible action including – as a last option – placements outside the family and community.

In some provinces, perhaps in line with avoidance of “dependency”, there were reports of attempts to involve older persons in income-generating projects. In Mpumalanga, an NPO reported that many older persons who attended the service centre did not want to participate in the projects. They reportedly responded: “We are old now, we want to rest...”

In several provinces there were reports around initiatives related to “voice”, such as older persons’ forums and a “parliament” for older persons. In several provinces NPOs suggested that special courts, similar to children’s courts, be established for older persons to provide a friendlier, and less intimidating, atmosphere. It is not clear that this falls within the ambit of social development services.

7.2.3 Budget analysis

Figure 11 shows the per capita allocation for older persons by province, using both the full population aged 60 years and above, and an estimate for poor elder people. The full population in this age group is derived from Statistics South Africa’s 2014 mid-year estimates⁵². The estimate of the poor uses the same poverty rate for older people as for the population as a whole for each province, namely the poverty rates used by National Treasury in calculating the poverty components in the equitable share for 2015/16⁵³. (The use of the same poverty rates as for the full population for older people is in line with the finding for the Living Conditions Survey that the population aged 65 years and above has a poverty level that is similar to that of the population as a whole.

Using the full elderly population, Free State has the highest allocation per person (R424). Limpopo has the lowest, at R107, only about a quarter the size of Free State’s allocation. If analysis is restricted to poorer elderly people, Western Cape has by far the highest amount (R1 448) and Limpopo the lowest (R203). Western Cape’s allocation per poor older person is more than six times as large as the Limpopo allocation.

⁵² Statistics South Africa. 2014. Mid-year population estimates 2014. Statistical release P0302. Pretoria,

⁵³ National Treasury. 2015. Annexure W1: Explanatory memorandum to the division of revenue: 20

Figure 11: Per capita allocation for older persons by province, 2015/16

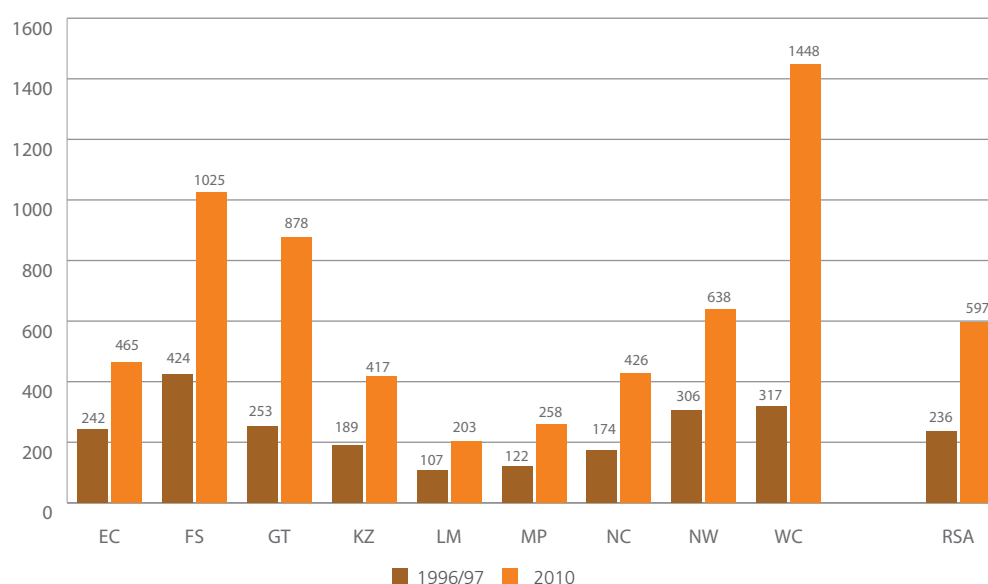


Table 26 presents the unaudited key performance indicators reported by provinces to DPME for this budget sub-programme for 2014/15. Northern Cape’s number for older persons accessing funded residential facilities seems highly unlikely, as it is higher than for all but one of the other provinces despite Northern Cape having a much smaller population than other provinces. It is possible that Northern Cape may have “multiple-counted” beneficiaries by adding together beneficiary numbers for different quarters or months without taking into consideration the fact that the same beneficiary will be counted many times. The very small number accessing community-based services in North West is surprising as for all other provinces the number for these services is larger than that for residential care. There may well be other anomalies in the data for other provinces.

Table 26: Key performance indicators for older persons for 2014/15

EC	FS	GT	KZ	LM	MP	NC	NW	WC
Older persons accessing funded residential facilities								
2 336	2 228	6 361	2 586	617	1 352	6 593	1 581	8 992
Older persons accessing community based care and support services								
13 131	8 169	19 579	20 350	15 549	5 006	7 390	542	13 410

PART VI:
Review of
welfare and
community
development
services

The performance indicator for care relates to unspecified community-based care and support, whereas the KPMG costing used here refers to home-based care. The Afrec costing suggests that day care is more expensive than home-based care. The comparisons below might therefore be inexact.

Despite these concerns about quality of the data, these indicators and the KPMG costing are used to assess the budget allocations. In this and the following similar tables the proposed subsidy amount recorded in Free State DSD’s affidavit⁵⁵ is used rather than the full cost so as to arrive at a conservative estimate. The estimate is also conservative

⁵⁵ Linström, Johannes. August 2013. Affidavit. National Association of Welfare Organisations and Non-governmental Organisations & Other vs Member of the Executive Council for Social Development, Free State & Others. Case No 1719/2010. Free State High Court.

in assuming that all the services are provided by NPOs. If some services are provided by government, the sub-programme would still need to cover it, but the per beneficiary cost would be quite a bit higher.

The adjusted monthly KPMG per-beneficiary subsidy for residential care is R5 000,28. This is reduced to R3590,28 on the assumption that beneficiaries are required to pay over to the service provider the full amount of the old age grant, which is R1 410 per month in 2015/16. In reality, residents may not be required to pay over the full amount, in which case the analysis will under-estimate the extent of the budget shortfalls. The adjusted monthly per-beneficiary subsidy for home-based care is R1 106,52.

The derived subsidy amounts are multiplied by the number of beneficiaries recorded for each of the services for a particular province and then multiplied by 12 to get the annual subsidy amount. The total for the two services is added together to get the amounts in the "Subsidy p.a." column. This is compared this with the amount in the 2015/16 budget. For all provinces except North West, the required annual subsidy amount is larger than the allocated budget. Disregarding Northern Cape where, as seen above, the beneficiary numbers are questionable, Limpopo shows the most severe under-provision, with a budget less than one-sixth of the required subsidy amount.

The final two columns in the table show the number of beneficiaries (users) for both services combined and what percentage this constitutes of the poor population aged 60 years and above in each province. If Northern Cape is again disregarded, Western Cape is the best performer, followed by Free State. North West reaches only 1% of its elderly poor.

Table 27: KPMG costs compared with 2015/16 budget allocations for older persons services using 2014 performance indicators (R'000)

	Residential	Home-based care	Subsidy p.a.	Budget	Subsidy as % of budget	Total users	As % poor
EC	100 643	174 357	275 000	136 491	201%	15 467	5%
FS	95 990	108 470	204 460	102 725	199%	10 397	10%
GT	274 053	259 975	534 028	297 622	179%	25 940	8%
KZ	111 414	270 213	381 626	154 975	246%	22 936	6%
LM	26 582	206 464	233 046	47 396	492%	16 166	7%
MP	58 249	66 471	124 720	36 378	343%	6 358	5%
NC	284 048	98 126	382 175	19 849	1 925%	13 983	30%
NW	68 115	7 197	75 312	92 192	82%	2 123	1%
WC	387 405	178 065	565 470	185 179	305%	22 402	18%

7.2.4 Additional evidence

7.2.4.1 Elder abuse

In 2014 the South African Human Rights Commission (SAHRC) published its report on hearings held after receiving numerous complaints about abuse of older persons.⁵⁶ The complaints included one from the South African Older Persons Forum (SAOPF) relating to delays in implementation of the register of persons convicted of abusing older person in terms of chapter 4(31) of the Older Persons Act (13 of 2006). The register is intended to prevent such persons from operating or being employed at any residential facility, or providing any community-based care and support to older persons. DSD is responsible for establishing the register. In 2012, a mini-study was conducted to ascertain the possibility of aligning the child protection register, sexual offences register and this register. In March 2013, the Department set up a task team into the matter. DSD said that the register would be implemented in October 2013 and “set aside” funds in 2013/14 to do this. However, SAHRC reported that DSD used a manual register to record reports of elder abuse.

The portfolio committee’s budgetary review and commendation report on 2014/15⁵⁷ states that DSD trained 408 service providers on implementation of the electronic elder abuse register in the 2014/15 financial year. This was not mentioned by participants in the Ministerial Committee’s review. The Gender-Based Violence Command Centre, which is funded by USAID, also reportedly accepts cases of elder abuse and refers them to the relevant NPOs.

The SAHRC reported that a national helpline had been established to handle complaints of abuse and receives an annual subsidy of R660 000. The SAHRC was almost certainly referring to the helpline established by NPO Age-in-Action in June 2014. The helpline is managed from the national office in Cape Town by a qualified social worker who serves as the national coordinator⁵⁸. The helpline operates from 08h30 to 16h30 [on weekdays?] with plans to divert calls to mobile phones over holiday periods. Age-in-Action is a national organisation which has “response units” across the country and 24 satellite offices in rural areas. Calls are referred to the province where the caller is situated, investigated and feedback given to the coordinator on outcomes. Age-in-Action did not provide statistics but call numbers are reportedly highest in Western Cape and the main form of abuse reported is financial.

7.2.4.2 Old age homes

The SAHRC reported that DSD funded 412 residential facilities managed by NPOs. The 412 does not exactly match the 8 government and 410 NPO-managed facilities recorded elsewhere in the SAHRC report. The latter reference notes the absence of DSD-managed old age homes in Mpumalanga, Northern Cape and Western Cape.

⁵⁶ South African Human Rights Commission. 2015. Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons.

⁵⁷ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015,

⁵⁸ Information provided by Charlotte Fairbridge, Age-In-Action

In 2009/10 DSD commissioned an audit of residential facilities for older persons⁵⁹. Umhlaba Development Services succeeded in surveying 405 of the total of 426 homes for which they were provided with information. The shortfall was explained by some homes having become “private” (presumably meaning that they were no longer subsidised) and others refusing to be audited. The survey covered services, policies and procedures, management and governance, staff and volunteers, building and facilities. The report notes that “often” the homes had clearly prepared for the audit by cleaning, grooming residents and briefing those who would be interviewed. The audit would to this extent be biased.

The audit report notes that while older persons are over-represented in the most rural and poorest provinces, 79% of the residential facilities are found in metropolitan formal areas or small urban formal areas, only 5% in informal settlements, and 16% in rural areas.

The Eastern Cape is shown as the province with the largest elderly population (9,2%) in proportion to the total population in the province, following the Northern Cape (8,2%) and the Western Cape with the third largest elderly population (7,8%). A DSD report from two years later⁶⁰ gives the provincial distribution shown in Table 28, with 29% of homes in Western Cape and a further 21% in Gauteng, while Mpumalanga has only 4% and North West 6%.

Table 28: Distribution of DSD-registered old age homes by province

Province	Number of homes	% of total
Eastern Cape	49	12%
Free State	33	8%
Gauteng	85	21%
KwaZulu-Natal	44	11%
Limpopo	7	2%
Mpumalanga	18	4%
North West	26	6%
Northern Cape	25	6%
Western Cape	120	29%
Total	407	100%

Table 29 shows the extent to which, according to the survey report, management of the homes is concentrated among a relatively small number of NPOs, many of which are faith-based organisations, which manage multiple homes.

⁵⁹ Umhlaba Development Services. 2010. Final Report: Audit of Residential Facilities. [for older persons]. Department of Social Development.

⁶⁰ Department of Social Development. 2012. 58 Old Age Homes National Report.

Table 29: Distribution of residential facilities by managing entity

Entity	Number	% of total
NPOs managing a single facility	170	42%
Afrikaanse Christelike Vroue Vereniging	50	12%
Barmhartigheid, Diens, Saam	40	10%
Suid-Afrikaanse Vroue Federasie	32	8%
NG Maatskaplike Dienste	13	3%
Sinodale Kommissie vir Diens	11	3%
Methodist Homes for the Aged	9	2%
Residentia Foundation	7	2%
Other	73	18%

Over a third (38%) of the homes provided home help services, 36% provided a soup kitchen, 43% provided training in care for the elderly, 55% provided subsidised emergency beds (for example, for cases of abuse), and 62% provided respite care to give a break to household caregivers in the community. The NPOs usually did not receive help in providing these services although DSD's guidelines state that services should be offered "in conjunction with relevant departments". Further, the NPOs generally did not have the necessary resources to meet the norms and standards for the various services offered as funding based on the number of residents does not take outreach services into account.

In ten homes white and black residents were physically separated at the time of the audit, and the residents did not seem to receive the same quality and standard of service. In some cases the families indicated that they would not let their relative stay in the home if it became racially integrated. Some better-established homes had partnered with "sub-economic" homes near them, but others wanted DSD to facilitate such partnerships so that the better-off home was not seen as imposing and so that the relationship was a formal one. The report suggested that government support black (assumed poorer) people applying to "white" homes with a sliding scale subsidy. This is, in fact, already practice at least in some provinces (e.g. Western Cape).

Most homes reported that in the past a district surgeon had visited to attend to the medical needs of residents. In most cases this no longer happened, but in some cases the Department of Health still provided the service. At the time of the audit, 16% of home never had visits by any doctors, while at the other end of the spectrum 4% had daily doctor visits. More than a fifth (21%) of homes never had access to a nurse's services, with the percentage without such services reaching 65% in North West. The report cites a previous study which found that, on average, nurses in old age home received only a third of what nurses employed directly by the Department of Health earned. The deficits in professional staff extended beyond nurses. Under half (41%) of home had a social worker. While 77% said residents could get counselling, in many cases this was provided by church leaders rather than social workers or psychologists. Staff in 61% of the homes did not know whether there was a register to report cases of abuse, and residents in only 36% of homes knew about a register.

The audit report makes several suggestions as to how funding shortages can be alleviated. These include greater effort being put into recruiting, training and placing volunteers in “black” areas (which raises a question as to whether one can expect poor people to work for nothing), creating a special fund for repairs and equipment for sub-economic category homes, and subsidising less expensive home-based care services as a way of reducing the need for frail care in residential settings.

On the issue of frail care, the report notes that DSD’s guidelines adopt a developmental approach which motivates for people to remain in the community as long as possible. It posits a percentage of 2-3% of older persons needing frail care either in residential homes or in the community through day care and home-based care.

DSD’s national report on old age homes of two years later⁶¹ focuses on the 58 homes which the audit found to be in a particularly bad physical state. The re-examination of these 58 homes found that:

- 24% had more than four issues that needed immediate attention
- 15% had 3-4 issues in need of immediate attention
- 55% have 1-2 issues needing immediate attention
- 7% had no high risk issues.

The priority areas were then costed. The costing suggested that:

- R36,9 million was needed to address priority 1, namely electrical problems
- R115,5 million was needed for priority 2, sewage and water-related problems
- R170,2 million was needed for priority 3, other “non-critical risks”
- R326,0 million was needed for renovations
- R87,2 million was needed for replacement of three facilities where the cost of repair would have amounted to more than 70% of the cost of replacement.

It is not known whether any steps were taken to provide the funds needed for these actions.

In terms of availability of residential services, Figure 12 shows a decrease of nearly a third (31%) from 1996/97 to the time of an audit in 2010.⁶² Yet, as shown below, older persons’ share of the total population increased over the time period, as did the size of the total population. Gauteng again shows a substantial decrease in availability of subsidised homes. Western Cape and KwaZulu-Natal are the only provinces with more funded old age homes in 2010 than in 1996/97.

⁶¹ Department of Social Development. 2012. 58 Old Age Homes National Report.

⁶² Umhlaba Development Services. 2010. Audit of Residential Facilities: Final report. Department of Social Development: Pretoria.

Figure 12: Number of subsidised homes for older persons, 1996/97 and 2010

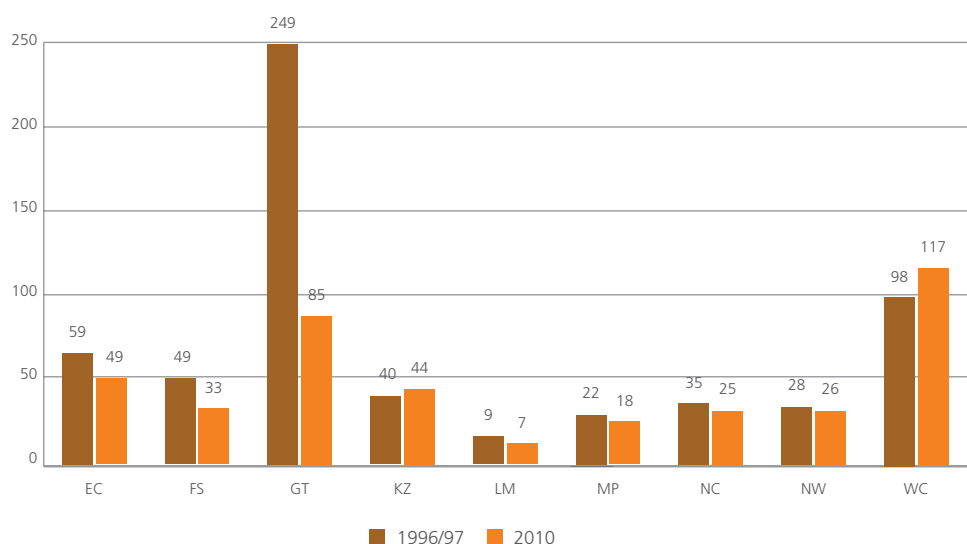
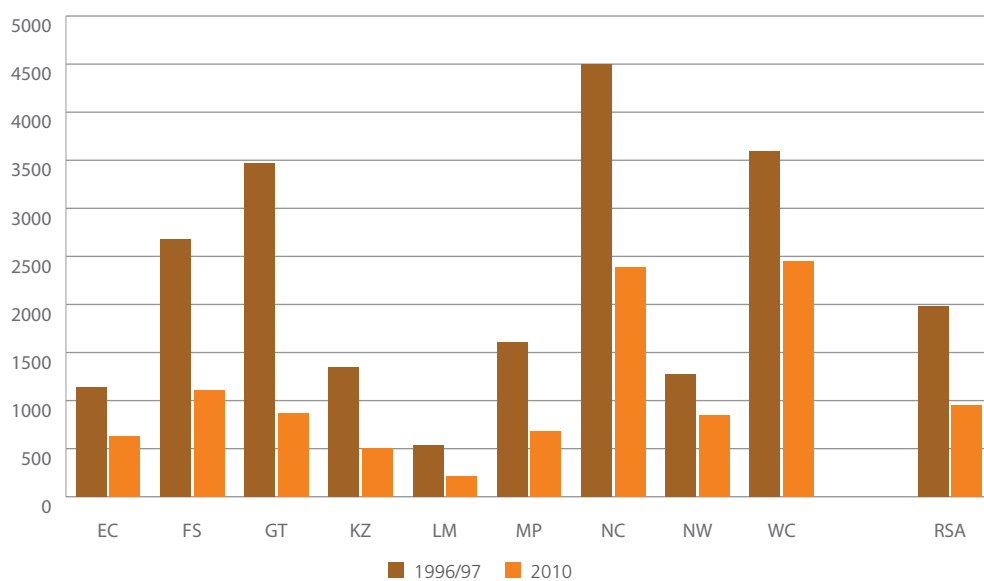


Figure 13 shows that for older persons, subsidised provision per 100 000 of the population aged 65 years and above falls below half of what it was in 1996/97. All provinces show a decrease, and Gauteng’s decrease is again the largest of all provinces. By the end of the period Limpopo has only 213 funded spaces for every 100 000 people aged 65 years and above as against Western Cape’s 2 446.

Figure 13: Subsidised users of homes for older persons per 100 000 population aged 65 years and above



The reduction in the reach of subsidised old age homes results from both an absolute reduction in subsidised places (from 33 854 in 1996/97 to 27 428 in 2015) and an increase in the population aged 65 years and above (from 1,9 million in 1996 to 2,9 million in 2015). The increase in the population of this age reflected both the increase in the overall population, and an increase in the share of this age group from 4,8% to 5,2% of the population. This is in line with Statistics South Africa's mid-year estimates publication for 2015 which suggests that life expectancy in South Africa increased from 54,6 years in 2002 to 62,5 years in 2015.

The shares of this age group differ substantially across the four race groups, ranging from 4% among Africans to 16% among whites. However, in absolute terms there are more than twice as many African people aged 65 years and above than white people (1,8 million as against 0,7 million). While it is often argued that African older people are cared for by their families, analysis of the General Household Survey of 2014 suggests that more than 200 000 African people aged 65 years and above are living either alone or only with other older people. This is also the case for more than 400 000 white people, and smaller numbers of coloured and Indian people.

DSD's Generic Norms and Standards for Social Welfare Services state that all old age residential facilities should establish facilities for independent and assisted living as well as for respite care; and that older people should live independently in the community and only be moved to a frail care facility where needed.

The compilers of the 1996/97 DSD statistical report attempted to collect information on both old age homes and housing schemes for older persons, although they noted that the latter fell under the Department of Housing. The statistical report noted that most beneficiaries of the old age homes were white, and that many did not need "specialised care at all". It noted further that the new policy was that only frail older people who could not be cared for by their families and/or through community facilities would be accommodated in (subsidised) homes. Others who could not stay with families should be accommodated in "less costly" (for government) housing schemes. Subsidies for older persons' homes had therefore already been cut by 1997. Housing schemes were described as privately established facilities which might attract (once-off) financial assistance from government if there were "enough sub-economical aged persons to warrant the establishment of such a facility." The facilities would not, however, receive a regular subsidy.

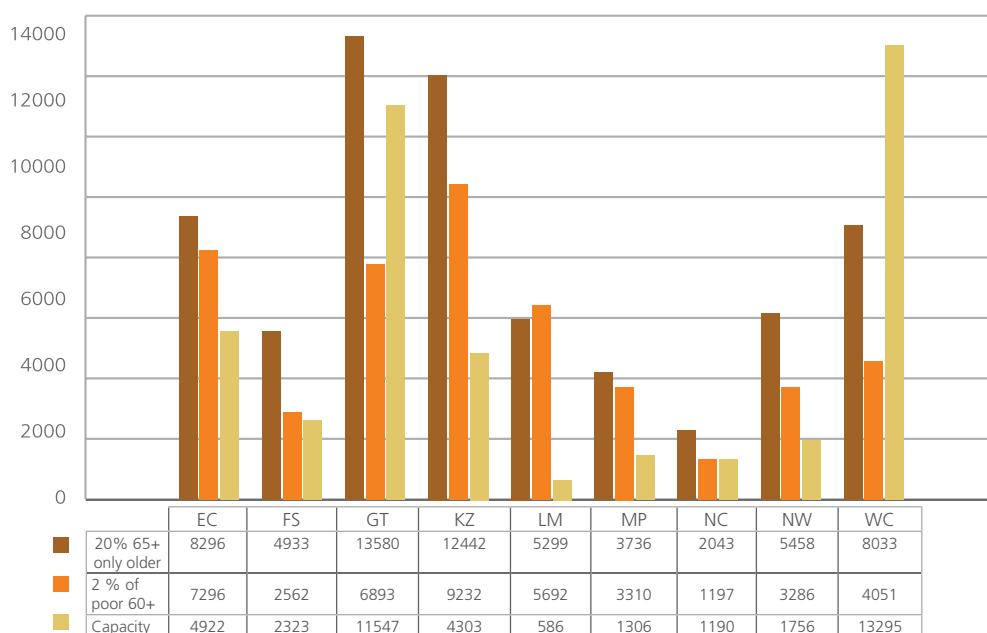
Against this background, a further measure of the adequacy (or otherwise) of services for older persons can be derived by comparing the capacity⁶³ of services recorded on national DSD's infrastructure database with the estimated size of the target population for the particular service. DSD's database includes government-owned, private and NPO facilities, registered and unregistered, and funded and unfunded. The comparison thus over-estimates provision as the target reflects those for whom government should provide while capacity includes those who are able to provide for themselves.

⁶³ For this and other similar graphs, where a relatively small number of facilities have capacity information missing, they are assigned the mean (average) value for facilities which do have capacity information.

The graph below uses two alternative measures of the need for residential services for older persons. Both measures take into account that current DSD policy is to subsidise residential care only for frail older persons. The first measure, derived from GHS data of 2014, reflects 20% of older persons aged 65 and above who are living alone or only with other people of this age. This measure assumes that other frail older persons will be cared for by the younger people with whom they live. The second measure, also from GHS 2014 data, represents 2% of the poor population aged 65 years and above⁶⁴. This is the lower end of the norm used by DSD.

For all provinces except Western Cape and Gauteng, Figure 14 indicates that capacity is less than either of the measures. For Gauteng capacity is less than one of the measures, while for Western Cape capacity is greater than both measures. Limpopo is worst off, with the two measures close on ten times capacity.

Figure 14: Comparison of need and capacity: Older persons homes



7.2.4.3 Non-residential services

The SAHRC reported that DSD funded 994 service centres managed by NPOs. In 2009, the Community Agency for Social Enquiry was commissioned to investigate the needs and access to services of older persons.⁶⁵ The investigation included a series of in-depth interviews with service providers, a national household survey of 1 355 older persons, and a survey of elderly beneficiaries (226 in total), care-workers (1 per site) and managers (1 per site) at 80 (randomly selected) of the 1 350 luncheon clubs and service centres in the nine provinces.

The report characterises service centres as typically operating five days per week and offering primary services (such as health care and a main meal) and secondary services (including social activities). Luncheon clubs offer a midday meal, social activities and sometimes skills development. Many luncheon clubs are attached to residential facilities.

⁶⁴ For this and similar graphs elsewhere in the report, “poor” represents the bottom two quintiles i.e. the poorest 40% of the population.

⁶⁵ Mudzingwa E, Mabena M, Glencross M, Ramkisoan Y and Moller V. 2009. The Status of Older Persons in South Africa: A national study on the needs and access to services of older persons. Community Agency for Social Enquiry.

Nearly two thirds (62%) of the older persons interviewed had the old age grant (OAG) as their main means of support. However, 16% of the household sample and 12% of visitors were not OAG recipients. Of the 80 facility managers interviewed, five were social workers. None of the staff had received any geriatric training. Many were dissatisfied with their work situation, citing inadequate equipment, low salaries and poor benefits.

The majority (82%) of household respondents said that they were not aware of service centres, luncheon centres or other non-profit centres for older persons in their communities. Of those who were not aware, about two-fifths said that they would use the services if they knew about them. About 25% said they would go for a meal, 23% would go for health education, and 19% for recreation. Among the actual visitors, the most used service was a meal, followed by physical exercise. This is similar to the ranking of household respondents when asked what the most useful service was, with 46% choosing meals, 38% exercise, and 19% health education. Visitors' ranking was somewhat different with meal at centre (52%) first followed by income-generating activities (38%) and physical exercise (37%). The overwhelming majority of respondents – 83% of household and 78% of visitors – said they would not consider living in a residential facility. However, 11% of visitors had previously applied for a place at a residential facility.

Those in households who used centre services reported payments of between R5 and R250 with a mean of R36. Participants in the survey of visitors reported payments of between R2 and R400 with a mean of R29 and a median of R12. The payments were made for food, membership and transport. Some (8%) of the visitors said that they had, on occasion, been turned away from the centre, as the centres were multi-purpose community centres and being used for something else on that day.

About 28% of household respondents and 38% of visitors knew of some older person who was being abused at the time of their interview.

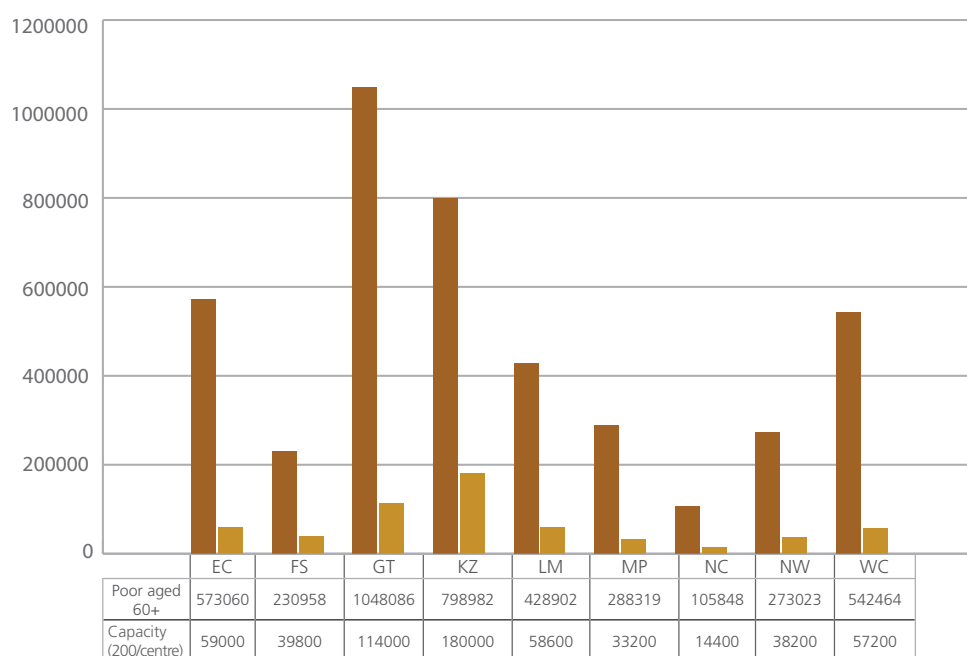
The graph below compares availability of service centres recorded on DSD's infrastructure database with the number of poor people aged 60 years and above in each province. DSD's infrastructure database does not record capacity for these centres, but it is assumed that each centre can serve 200 older persons.

Figure 15 shows a clear picture for all provinces of need far exceeding capacity. KwaZulu-Natal is relatively best off, with need "only" four times capacity. In Eastern Cape need is close on ten times capacity.

Section 11 of the Older Persons Act states that community-based programmes with specific focus on older persons should be aimed, among others, at economic empowerment of older persons. Somewhat less ambitiously, DSD's Generic Norms and Standards for Social Welfare Services states that older people should be involved in programmes that promote independent living such as gardening and sewing or knitting projects⁶⁶. The norms and standards further include several provisions in respect of "rehabilitation and re-integration" programmes for older people. Re-integration may refer to attempts to de-institutionalise those who are already in facilities. The meaning of "rehabilitation" is less clear.

⁶⁶ Department of Social Development. 2014? Generic Norms and Standards for Social Welfare Services: Towards Improved Social Services

Figure 15: Comparison of need and capacity: Older persons' centres



7.2.5 Roles and responsibilities

The Department of Social Development is identified as the lead agency in respect of older persons in the Older Persons Act (no 13 of 2006). During the SAHRC hearings, DSD informed the Commission that it had fully implemented 60% of the Older Persons Act. It is not clear how the percentage was calculated. DSD reported further that National Treasury had, due to “competing priorities”, not provided the funds indicated as necessary by a costing of the Act.

In March 2013 the Presidential Coordinating Committee approved the establishment of Older Persons Desks in all provinces. These desks were to be responsible for coordinating actors and activities in respect of older persons. DSD was given responsibility for implementing this decision. There was little, if any, mention of the desks in the Committee’s review process.

The SAHRC played a key role in establishing the SAOPF to serve as the voice of older persons in engagement with government. SAOPF subsequently participated with DSD in drafting the Older Persons Charter, and DSD provides funding to the Forum.

PART VI: Review of welfare and community development services

As in other service areas, there are difficulties in respect of older persons around the respective roles of DSD and the Department of Health (DOH). These difficulties originate, in part, from the fact that these two functions were previously combined in a single department of health and welfare at both provincial and national levels. When the departments were split into two, the functions had to be divided. DSD became responsible for older persons and substance abuse. Both of these areas have both health and social development elements, but the budgets largely followed the allocation of responsibilities. Health therefore now understands DSD as being responsible for health care of people in residential facilities.

Health's understands its responsibilities as relating to ensuring that health standards are met and provision of health care to older people if they become ill. This is in line with the National Health Act (61 of 2000) which defines DOH's responsibility as provision of free health care to all indigent individuals, both in the community and in residential care facilities. Where older persons cannot access health establishments, health care should be provided in the residential care facility. In practice, in some districts where DOH has sufficient resources it may send staff to older persons facilities at primary care level, but this is not done everywhere. Meanwhile DSD often feels ill-equipped to deal with frail care health issues within its facilities. It would prefer DOH to play a larger role, but DOH's stance is that this is provided for within DSD's budget.

A further complication is that DOH cannot take disciplinary action against nursing staff employed in residential facilities if these staff are not DOH employees. Allegations of abuse must be reported to the South African Nursing Council or criminal charges can be laid with SAPS. Meanwhile, the South African Nursing Council removed gerontology from its new nursing qualification which is registered on the National Qualifications Framework.

The condition of dementia⁶⁷ is understood by DSD to be a medical condition and as such the Department of Health is expected to play a bigger role in serving the needs of people with dementia. However, the DOH's response is that currently there is very little in the way of medical interventions available for the condition. Globally there is a new realisation that the risk factors for dementia are very similar to risk factors for other non-communicable diseases such as heart disease, stroke and diabetes. DOH is trying to deal with those as part of dementia prevention. DOH also recognises the need for health and social care to be coordinated. In particular, DSD (and related NPO) staff need to be able to identify and refer medical problems among people with dementia because the affected person will often not identify the problem, and then will be neglected in terms of medical care. Resolving the issue of roles and responsibilities of DOH and DSD – and similar problems in relation to substance abuse – would require engagement between high-level officials within both departments as well as with Treasury officials.

The Skweyiya Commission report recommended that DSD and DOH share the costs of subsidies to older persons in residential facilities. The SAHRC claims that the Public Finance Management Act (1 of 1999) does not allow for more than one department to be funded to implement a single Act, and therefore states that both cannot subsidise older persons in residential care facilities. This statement is questionable as many Acts allocate responsibilities which would imply funding to more than one agency.

DOH also sees itself as having responsibilities in respect of elder abuse. In 1997 it published National Guideline on the Prevention, Early Detection, Diagnosis and Intervention of Physical Abuse of Older Persons at Primary Level (1997); in 2000 it published the National Strategy on Elder Abuse (2000); and subsequently the Elder Abuse Screening Tool.

⁶⁷ While some texts refer to "Alzheimer's and dementia", Alzheimer's is – alongside vascular dementia – one of the two most common forms of dementia rather than a separate condition (World Health Organisation. 2015. Call for Action by the participants of the First WHO Ministerial Conference on Global Action Against Dementia (Geneva, 16-17 March 2015).

Retirement villages fall under the Department of Trade and Industry (DTI) and are not subject to DSD's annual registration and ongoing monitoring processes. However, DSD is responsible for intervening in instances of complaints and abuse.

7.3 People with disabilities

The White Paper estimated that South Africa had about 3,4 million people – equivalent to 8,5% of the total population – living with physical and/or mental disabilities, but acknowledged that accurate estimates were not available. It recorded that 1,6% (2% if rounded) of the total population received a disability grant. It noted that the uptake rates for the grant were highest in those provinces – Eastern Cape, KwaZulu-Natal and Limpopo – with high unemployment rates and limited facilities for people with disabilities.

The White Paper suggested that a low level of skills and training among people with disabilities was a “significant” cause of unemployment for this group. It recorded serious deficiencies in respect of schooling available for children with disabilities, especially in rural areas. It reported that there were only 92 schools nationally for black children with disabilities, of which less than a third were secondary schools. This situation resulted in children being cared for at home, which in turn prevented mothers from being employed, and thus also affected household poverty and stress.

The White Paper noted that “inaccessibility of the outside world” was a “critical” problem facing people with disabilities. It referred, in particular, to challenges related to buildings, communications for deaf and blind people, public transport, and sport and recreation. It cited “paternalistic attitudes”, a “piece-meal approach” to addressing needs, and a focus on limitations rather than capacities as factors hampering integration of people with disabilities into society.

The 1997 White Paper included a separate discussion of mental health, which it defined as referring to “the total well-being of the individual, that is physical and psychological health as well as healthy social functioning.” It provided some estimates of the prevalence of mental “handicap”, as well as some indications of the extent of psychiatric health services. It recorded that 155 social workers and eight social auxiliary workers were employed by mental health societies across the country. The societies provided therapeutic and counselling services, group work, home-based training, public education, grant administration services, social relief, support groups, skills training and a few income-generating projects.

7.3.1 Updating the White Paper

Statistics South Africa currently uses the internationally accepted questions to enquire about disability for its surveys. These questions enquire about ability to do various tasks. They may not adequately capture people who can function well with assistive devices, and people with health conditions such as epilepsy, mental health or mild intellectual disability. The questions may also not capture conditions such as albinism, which is

increasingly categorised as a disability⁶⁸, except to the extent that they are accompanied by other disabilities. Albinism, for example, is often accompanied by visual problems.⁶⁹

A national DSD presentation to the Ministerial Committee in late 2013 suggested that there were more than three million people with disabilities in South Africa, of whom the majority were women. The GHS gives a total of 5,6 million across all ages (10,5% of the population) with any disability, and 1,7 million (3,1% of the population) with severe disability. With both measures there are more females than males but the gender gap is not large.

The reach of the disability grant remains more or less the same in proportion to the population as in 1997, in that currently 2% of the population receives a disability grant, or 4% of the relevant age group of 18-59 years. In addition, in June 2014, more than 120 000 children were beneficiaries of the care dependency grant. At this same date, of the 1 122 204 disability grant recipients, 295 221 were in KwaZulu-Natal, 180 738 in Eastern Cape, and 150 630 in Western Cape.⁷⁰ A high rate of unemployment and limited facilities, as suggested in the White Paper, cannot explain the fact that Western Cape ranks third in terms of absolute numbers.

During consultations, representatives of people with disability informed the Ministerial Committee that access to education became increasingly more difficult at higher levels of education, and access to vocational training and education was particularly difficult. Statistics South Africa data suggest that employment rates among persons with disability broadly defined are similar to rates for people without disabilities, but persons with severe disabilities are noticeably less likely to be employed. Further, people living in households with people with disability are less likely to be employed than those in other households.⁷¹ This could perhaps reflect other household members needing to provide care to those who are disabled. In addition to disability's impact on employment, people with disabilities face costs that others do not in terms of assistive devices, health care, personal assistance, housing adjustments, and transport education. The costs of reasonable accommodation in the workplace should be borne by the employer, but this is not always the case.

White Paper 6 on Inclusive Education of 2001 provides the current overall framework in respect of education for persons with disability. The White Paper envisages a dual strategy in which special schools will be strengthened so as to provide improved services for learners with severe disabilities, while "ordinary" educational institutions are adapted so as to provide adequately for learners with moderate and mild disabilities. The White Paper envisages, in particular, the conversion of some ordinary schools and colleges into "full-service" institutions. In addition, it envisages special schools becoming resources for all other schools through improved district support services.

⁶⁸ Violence against people with albinism is also a focus of the Programme of Action addressing Violence against Women and Children.

⁶⁹ The exact prevalence of albinism is unknown but a study of Africans in Soweto in 1982 put the prevalence at about one in 3 900 people. A later study in South Africa put the prevalence at 0,66 in every 1 000 live births, slightly higher than 1 in 3 900. (Hong ES, Zeeb H and Repacholi MH. 2006. "Albinism in Africa as a public health issue". *BioMedCentral Public Health* 6: 212.)

⁷⁰ SASSA presentation at Ministerial Committee Round Table on Sustainable Livelihoods, 23 July 2015.

⁷¹ Hanass-Hancock J & Deghaye N. Presentation to Ministerial Committee, August 2015.

⁷² Budlender D. 2015. Budgeting for Realising the Right to Basic Education for Children with Disabilities in South Africa. Researched for Section 27. Unpublished.

In 2012, the number of learners in public special schools stood at 111 598, while the number of special schools stood at 444.⁷² This represents a 9% increase in the number of schools together with a 58% increase in the number of learners over the period 2001 to 2007, followed by lower increases of 6% and 9% respectively between 2007 and 2012. In addition to those in special schools, 25 213 children with special needs were enrolled in 791 full-service schools in 2014. Availability of facilities remains highly skewed. For example, in 2012 Free State accounted for 32% of all special needs enrolment in full-service schools, despite being one of the smallest provinces population-wise. As a result, parents of children with disabilities are forced to spend unnecessary money on fees and transport – expenses that they would not incur if public no-fee schools were available nearby. In some cases parents are required to cover costs, such as for nappies or special food, that the schools do not cover. Sometimes, these expenses are paid for using the care dependency grant, leaving it unavailable for other expenses.⁷³ There are also serious inequities in funding with the amount allocated by provincial Departments of Education per learner in 2013/14 ranging from R39,797 in Limpopo to R86,025 in Eastern Cape.

The Ministerial Committee’s consultations confirmed that challenges with inaccessibility of services persist, including in some cases in respect of DSD’s own local service points. The Committee was informed about the particular challenges faced by those, such as deaf and blind people, who need assistive services rather than only assistive devices. While some progress – although not enough – has been made in respect of provision of assistive devices, less has been made in respect of such assistive services. One of the reasons for this is the greater, and recurrent, cost attached to assistive services.

Nearly two decades after the White Paper was published, people with disabilities and their organisations have a louder “voice” and presence than previously. This reinforces their point that they have the capabilities to represent themselves. There is, however, regular under-performance and non-compliance in respect of provisions for people with disabilities in policies and legislation such as the Employment Equity Act.

Participants at the round table with NPOs and people with disabilities highlighted a range of challenges related to service delivery, including lack of appreciation of the different types of disabilities each with different needs; problems with SASSA’s disability assessments; need for funding and provision of personal services alongside assistive devices; confusion around, and changes in, institutional arrangements (including “merging” of the former Department of Women, Children and People with Disabilities and DSD) and policy development processes; poor linkages between DSD and the Departments of Health and Education leaving people – and particularly children – with disabilities “falling through the cracks”; and lack of recognition of the expertise required to deliver services to people with disabilities. The group had several specific suggestions for edits to the White Paper, including removal of the assumption that people with disabilities should not be economically active. Finally, the group recommended that the revised White Paper include a separate chapter on disability.

PART VI:
Review of
welfare and
community
development
services

⁷³ Human Rights Watch. 2015. “Complicit in Exclusion” South Africa’s Failure to Guarantee an Inclusive Education for Children with Disabilities: 26.

Indicative rating of accessibility

The quantitative tool used for the Committee's district review process included a section on accessibility which included probes on accessibility related to office infrastructure (4 items), people with disabilities (3 items), and access to the broader public (4 items). The overall means showed the highest scores for access to the broader public, followed by office infrastructure, with the scores for the three items on access for people with disabilities ranked much lower, with scores ranging between 0,3 and 0,9. These patterns were repeated within each of the three stakeholder groups, although the relative rating of the different items sometimes differed across groups. Language was consistently scored highest, and sign language interpreters and Braille were consistently scored lowest.

Patterns across provinces were very varied. For example, Eastern Cape scored highest on payment for services and second highest on mobile service delivery units, but lowest on turn-around times, Braille and sign language. Limpopo was amongst the highest scorers on outreach services points, mobile service delivery units, service offices, payments, and language, but had among the lowest scores on the three disability items as well as on turn-around times. The wealthiest provinces did not always perform well on office infrastructure.

The overall accessibility score on the quantitative tool was slightly higher for rural than urban districts, at 2,0 versus 1,9. Rural areas were scored noticeably higher than urban on office infrastructure. This is pleasing, but also understandable to the extent that outreach service points and mobile units might be less necessary in urban areas. For the three disability items there was little difference between urban and rural. On access to the public, rural districts performed noticeably better than urban on payments, but urban districts clearly out-performed rural ones on turn-around time and awareness about services.

The current DSD structure and budget do not treat mental health as a distinct area. The issue is therefore discussed here under disability. In practice, however, the term "mental health" is commonly used to refer to two relatively distinct conditions. The first refers to intellectually challenged people, and could be seen as a form of disability. The second refers to psychiatric illness. While chronic or severe psychiatric illness constitute a form of disability if it impairs the person's functioning, a clear distinction needs to be made between intellectual disability and psychiatric disability in terms of the differences in approach and support needed, as well as the roles of different agencies.⁷⁴

There are suggestions that South Africa has substantially higher prevalence rates of common mental disorders than any other African country affiliated to World Mental Health, and "mental disorders" are the third highest contributors to South Africa's burden of disease, lower only than HIV and AIDS and other infectious disorders. Yet 75% of those affected do not receive the care that they need.⁷⁵

⁷⁴ Cape Mental Health categorises its beneficiaries into three groups: (a) persons with intellectual disability (2 039 = 47,5% of beneficiaries in 2014/15); (b) persons with psychosocial/psychiatric disabilities (1 855 = 43,1%); and (c) persons with emotional adjustment problems (405 = 9,4%). (Cape Mental Health. 2015. Dignity in Mental Health: Annual Review 2014/2015. Cape Town.)

⁷⁵ South African Federation for Mental Health. April 2013. Making Mental Health a South African Priority. Randburg.

7.3.2 Other findings of the Ministerial Committee

Persons with disabilities had a relatively strong voice in the provincial and district engagements. They and NPOs working in this area made it clear that there were still many inadequacies in service provision.

The quantitative tool identified eight different services for disability, namely public education, community-based rehabilitation, stimulation centres, protective workshops, community-based personal support (caregivers), sign language interpreters, personal skills development, and public education. These services are those which directly target people with disability.

Analysis of data from the quantitative tool revealed substantial variation in availability of services for people with disabilities, with overall mean ratings varying from 0,8 for sign language interpreters to 2,4 for community-based personal support. There were also quite large differences in the scoring across the three stakeholder groups on some services. For public education, the ratings ranged from 1,6 for beneficiaries to 2,7 for practitioners; for stimulation centres from 1,3 for providers to 2,1 for beneficiaries; and for community-based personal support from 1,3 for providers to 2,4 for beneficiaries. These differences may, at least in part, reflect the knowledge of the particular people who participated in the focus groups.

There was noticeable variation over provinces. Eastern Cape, for example, had the highest score by far on public education but performed worst on community-based rehabilitation (and had no score at all on sign language interpreters and personal skills development). KwaZulu-Natal and Mpumalanga were often among the best performers. North West, like Eastern Cape, did well on public education but performed poorly on most of the other services.

North West DSD's submission gave some sense of the extent of the different services. It reported 3 119 people benefiting from statutory services (which includes and is probably primarily grants); 722 people using 20 day care centres; 309 people housed in six residential facilities; 87 people in protective workshops, and 50 using the assistive device banks in four districts. A subsequent submission from North West DSD included two examples of best practice in providing holistic services for people with disabilities. The depth of the information from North West suggests that special efforts have been made in this province in respect of disability.

In addition to views heard about targeted services for people with disabilities, provincial and district engagements elicited many concerns related to experiences in accessing general services. The fact that these issues were raised in part, no doubt, reflects the fact that DSD became the central government agency for disability after the Department for Women, Children and People with Disabilities' scope was reduced to Women. However, many of the concerns related to general services for which DSD is responsible. These included concerns around the lack of provision for people with disabilities in the various institutions, such as child and youth care centres (CYCCs) and facilities for older persons. There were concerns across provinces that ECD centres did not cater for children with disabilities. There were also concerns about inaccessibility of DSD service

centres. In this respect, North West service providers noted the difficulties caused when the centres were in facilities rented from private owners. The absence of Braille and officials and practitioners competent in sign language was reported across provinces.

In terms of the targeted services, there were more mentions of stimulation centres and protective workshops than of other services. The discussion also sometimes went beyond protective workshop to initiatives aimed at empowering people with disabilities economically.

The availability of stimulation centres for young children with disabilities was noted as an achievement in many provinces. These centres aim to facilitate children with disabilities being kept within the home environment during the pre-school phase. Ideally the centres should serve a similar purpose to that served by special schools at a later stage of education, serving those children with severe disabilities who cannot be accommodated by ordinary ECD services. In practice, because so few ECD centres accommodate children with disabilities, some children with less severe disabilities may be accommodated in stimulation centres, many of which were established by parents. Older children with disabilities, who are past school entrance age, may also attend stimulation centres while they wait for years for a school placement.

Concerns were raised across many provinces that there were not sufficient stimulation centres. Mpumalanga informants noted that this was another area in which DOH assistance was needed, in that centres should benefit from the services of occupational therapists who could ensure that each child had an appropriate rehabilitation plan and that caregivers received guidance on stimulation techniques. Generally, stimulation centres in urban areas were reported to have more resources than those in rural areas.

Availability of protective workshops was noted in all provinces, although the workshops were said to be situated primarily in urban areas. There were some calls (for example, in KwaZulu-Natal) for stipends to be paid to workers in such workshops. There were also calls for an “exit strategy” for those working in these workshops – a call that may not be realistic for many beneficiaries if they have permanent disabilities. There were no explicit references to the sheltered workshops supported by the Department of Labour, but it is possible that some references to protective workshops included the Department of Labour ones.

In addition to protective workshops, in some provinces there were reports of business and other work-related training provided to people with disabilities. In some cases, such as Free State, NPOs received EPWP funding for employment of people with disabilities alongside their subsidy funding. In one of the round tables, the South African Disability Development Trust, which was established by the disability movement, described its three programmes which focus on economic development of disabled people.

In terms of institutions, as in other service areas there were some concerns about “mushrooming” of unregistered facilities given the extent to which need outpaced supply of affordable registered facilities. In the case of disability, the shortage of registered institutions was also attributed in part to lack of cooperation between DSD, DOH and local government. A related concern was the absence of health personnel in residential institutions. For children with learning difficulties in both these and other institutions, there were concerns about the shortage of special schools and difficulty in

finding placement in other schools. This is again not a DSD responsibility, but instead an area where cross-sectoral collaboration is needed. Beyond schools, opportunities for young people with all forms of disability were said to be scarce, including in technical and vocational education colleges (formerly known as further education and training colleges).

There were concerns about particular types of disability being less well catered for than others. For example, in Eastern Cape participants observed that people with hearing and sight difficulties were less well catered for in terms of assistive devices than those with other physical disabilities who needed crutches, wheelchairs, and the like. Some participants reported on various initiatives to provide assistive devices, including “banks” for this purposes. However, in Western Cape a participant noted that there was a two-year waiting period for assistive devices to be issued by DOH at Red Cross Children’s Hospital. This is an especially long and damaging period in the life of a child. A Western Cape participant noted that as the life expectancy of people with disabilities increased, they were more likely to be “left destitute” as their parents aged and/or died and were thus unable to care for them.

Across provinces, there were concerns expressed during the review process around poor provision for people with mental health problems. One participant observed that intellectual disability was one of the most overlooked disabilities in terms of service provision. Mental health was treated as a separate service area in the quantitative tool although it is not considered a separate area in the DSD organisational structure or budget.

The quantitative tool named only two services in the area of mental health, namely mental health promotion programmes and social support services. Availability of these two broad service areas was consistently rated low, with means of 1,2-1,3 overall. Practitioners were slightly more optimistic about the availability of these services than providers and beneficiaries. Beneficiaries were particularly negative about availability of mental health promotion services.

Eastern Cape had no score for mental health promotion while Limpopo had no score for social support services. The absence of any score could well indicate the absence of any services. Mpumalanga had the highest or second highest rating for both the services, but the highest ratings remained low in absolute terms. Limpopo was the worst performer, with no score for one service and a score of 0,4 for the other.

In the discussions, mental health was named as a problem area across all provinces. One of the few positive comments came from service providers in a North West district, who felt that service provision was satisfactory. However, practitioners and beneficiaries in the same district said there was no provision. Mpumalanga DSD claimed to have all sorts of support for mental health. Western Cape service providers also reported that there was a focus on mental health services.

PART VI:
Review of
welfare and
community
development
services

⁷⁶ Human Rights Watch. 2015. “Complicit in Exclusion” South Africa’s Failure to Guarantee an Inclusive Education for Children with Disabilities: 34.

7.3.3 Budget analysis

Figure 16 compares the 2015/16 provincial budget allocations per capita using the disabled (those with at least some difficulty in respect of seeing, hearing, walking, remembering and concentrating, self-care, and communication) and severely disabled (a lot of difficulty or no ability at all in respect of the above tasks) population numbers reported in the GHS of 2014 for the age group 18 to 59 years. Children under 18 are excluded to avoid double-counting as they may be provided for under the children and families budget sub-programme (see below), while those aged 60 years and above are excluded to avoid double-counting with the sub-programme for older persons. The population estimates captured by the GHS will be an undercount because the survey does not sample institutions such as homes for the disabled. However, it is an over-count to the extent that the survey captures disabilities that might not require intervention from DSD.

On a provincial basis, the proportion of the population aged 18-59 reported to have at least one disability ranges from 5% in Limpopo to 12% in Free State, North West and Northern Cape, with a mean of 8%. These percentages include those for whom a severe disability is reported. The proportion reported as having at least one severe disability is 2% overall, and 2% in all provinces except Gauteng and Limpopo, where it is 1%.

Figure 16 shows the amount for all disabled of this age ranging from R115 per person in Northern Cape to R557 in Western Cape. When analysis is restricted to the severely disabled, the range is from R654 in Northern Cape to R1 585 in Western Cape. KwaZulu-Natal performs second best on this measure.

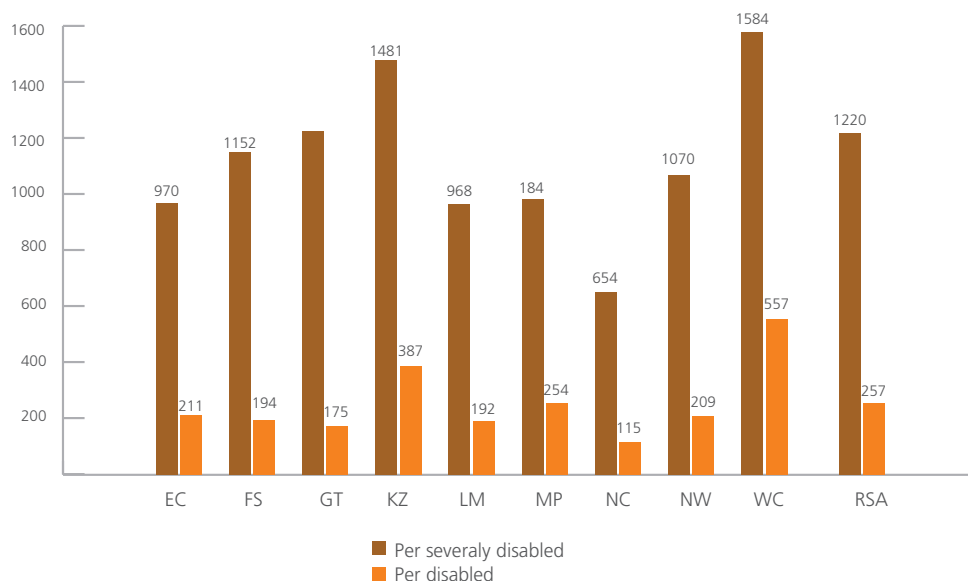
Table 30 shows the two performance indicators for persons with disabilities reported to DPME. The numbers for Northern Cape – as for other service areas – seem unusually large, given the small size of the provincial population, when compared to those for other provinces. This is probably due to double-counting over the three-month periods for which reports are required. In most provinces the number of beneficiaries of funded protective workshops is much larger than the number in residential facilities. However, this pattern is reversed in Eastern Cape, Northern Cape and North West. North West's number for protective workshops stands out as exceptionally low compared to other provinces.

Table 30: Key performance indicators for persons with disabilities for 2014/15

EC	FS	GT	KZ	LM	MP	NC	NW	WC	SA
Persons with disabilities in funded residential facilities									
976	719	1 903	966	294	709	3 589	305	1 414	10 928
Persons with disabilities accessing services in funded protective workshops									
680	895	4 183	2 392	2 725	2 236	2 163	83	2 530	16 147

Table 31 presents similar costing and budget comparisons for people with disabilities as presented above for older persons. The per beneficiary subsidy cost for residential care for disabled was estimated by KPMG at R4651,98 per month, reducing to R3 391,98

Figure 16: Persons with disabilities allocation per disabled person aged 18-59 years by province, 2015/16



per month if we assume that the disability grant is used to cover part of the cost. The per beneficiary subsidy cost for protective workshops is R640,03. The combined costs, multiplied by 12 months, amount to more than the total disability sub-programme budget for five provinces. In Northern Cape, even the monthly amount is more than double the annual budget allocation. The final column suggests that apart from Northern Cape, other provinces provide these services for at most 10% of the severely disabled population aged 18 to 59 years. North West, where the KPMG costing amounts to only 28% of the budget, covers only 1% of the severely disabled through these two services. This raises questions as to how the rest of the sub-programme budget is spent or, alternatively, about the extent of the under-count of beneficiaries.

Table 31: KPMG costs compared with 2015/16 budget allocations for persons with disabilities using 2014 performance indicators (R'000)

	Residential	Workshops	Subsidy p.a.	Budget 2015/16	Subsidy as % budget	Total users	% severely disabled
EC	43 094	5 714	48 808	63 970	76%	1 656	3%
FS	31 747	7 520	39 267	38 335	102%	1 614	5%
GT	84 025	35 148	119 174	113 729	105%	6 086	7%
KZ	42 653	20 099	62 752	127 249	49%	3 358	4%
LM	12 981	22 897	35 879	29 706	121%	3 019	10%
MP	31 305	18 788	50 094	49 474	101%	2 945	6%
NC	158 469	18 175	176 644	8 702	2 030%	5 752	43%
NW	13 467	697	14 164	50 552	28%	388	1%
WC	62 434	21 259	83 693	129 001	65%	3 944	5%

7.3.4 Additional evidence

7.3.4.1 Residential facilities for people with disabilities⁷⁷

In 2012, Lindandanda Consulting was commissioned to conduct an audit of subsidised residential facilities for persons with disabilities. The audit focused on institutions subsidised by DSD and thus did not cover children with mental disabilities accommodated in facilities falling under DOH in terms of the Mental Health Act, or under Departments of Education in terms of educational residential facilities. (The latter presumably do not provide 365 days of accommodation per year.) The audit was undertaken by two teams of fieldworkers – one from the consultancy and the other from DSD.

The report on the audit notes that the terms of reference included a long list of ways in which the right to “appropriate” residential facilities was being undermined, including insufficient and inadequate facilities, lack of provision for particular disabilities, limited or poor services and care within facilities, and lack of transformation. The report also notes disparities in subsidy amounts between residential facilities for people with disabilities and those for older persons or for children, for which it cites higher amounts than for disability.

A total of 126 of the 137 subsidised facilities were audited. Table 32 shows the dominance of urban facilities, and also a clear concentration of facilities in Gauteng, Western Cape and Eastern Cape.

Table 32: Location of residential facilities for people with disabilities

Province	Urban	Semi-urban	Rural	Total
Eastern Cape	6	9	7	22
Free State	3	2	21 ⁷⁸	7
Gauteng	30	7	0	37
KwaZulu-Natal	10	3	3	16
Limpopo	2	0	2	4
Mpumalanga	1	1	2	4
Northern Cape	2	1	0	3
North West	5	0	1	6
Western Cape	19	2	6	27
Total	78	25	23	126

Of the 126 facilities, 106 accommodated only adults, 10 accommodated only children, and the remaining ten accommodated both children and adults. The children-only facilities were concentrated in four provinces – Eastern Cape (with 6), Free State (2), Limpopo (1) and Northern Cape (1). A smaller number of facilities for children than adults may be partly justified by the fact that DOH has responsibility for children with severe intellectual disability, as well as the fact that families (especially parents) may be

⁷⁷ Lindandanda Consulting. 2012. Audit of Residential Facilities for Persons with Disabilities: Final Report.

⁷⁸ Two includes one adult only residential facility, established in 2000 called Victoria Care Centre which is found in a small holding in FezileDabi district.

better able and more prepared to care for children with disability than adults. However, the report noted long waiting lists for children at the residential facilities.

Overall, the 125 facilities accommodated 6 514 people (whereas people with severe disability in South Africa number more than a million), of whom 3 299 (51%) were female. Close on half (46%) of the residents were white, 39% African, 8% coloured and 7% Indian, showing serious under-representation of African and over-representation of white and Indian people. Children accounted for 10% of residents, youth (19-35 years) for 31%, those aged 36-59 years for 44% and pension-age (60 years and above) for 15%.

The most common types of disabilities were reportedly mental/intellectual. Unfortunately many of the questions in the audit were not answered by about half of the facilities, and findings – including on programmes offered – are therefore not reliable enough to be reported here.

All residential facilities in six of the nine provinces were privately owned. Eastern Cape, KwaZulu-Natal and Gauteng had some government-owned facilities. In addition to receipt of DSD subsidies, 48 facilities reported receiving government grants. This probably relates to disability grants paid to the institution rather than to the resident. However, only 38% of audited facilities indicated that residents received government grants. Just over 100 of the facilities reported some revenue from non-government sources. Overall, 12% of the facilities were established between 2001 and 2012 i.e. after publication of the White Paper.

Comparison of the audit findings with the 1996/97 statistical report produced by the then Department of Welfare in Figure 17 shows an overall rate of increase of 23%, from 111 facilities in 1996/97 to 136 in 2013. Eastern Cape and Western Cape show large increases, while KwaZulu-Natal shows a substantial decrease.

When provision is assessed against the target population, there is a small increase overall, from 239 to 290 places per 100 000 people with disabilities (assuming 5% of the population is disabled). Northern Cape's provision doubles over the period although in 1996/97 it already had the best provision. Eastern Cape, Free State and Western Cape also have clear increases over the period. Gauteng and North West have the greatest relative decreases in availability of spaces.

Comparison of capacity as recorded on DSD's infrastructure database with need, as shown in Figure 19 below, suggests that Gauteng has more than enough capacity and Western Cape is not too badly under-provided. Limpopo, in contrast, has only 152 spaces for the 5 287 who are estimated to need services. However, the measure of need is conservative, representing only 10% of people aged 18-64 years with severe disability as recorded in GHS 2014.

7.3.4.2 Mental health prevalence and services

The Rural Mental Health Campaign released a report on World Mental Health Day in October 2015 describing mental health services in small towns and rural areas as “unsupportive, inadequate and desert-like”. The campaign was launched in late 2014 out of frustration that the National Mental Health Policy Framework 2013–2020 was

Figure 17: Subsidised homes for persons with disabilities, 1996/97 and 2013

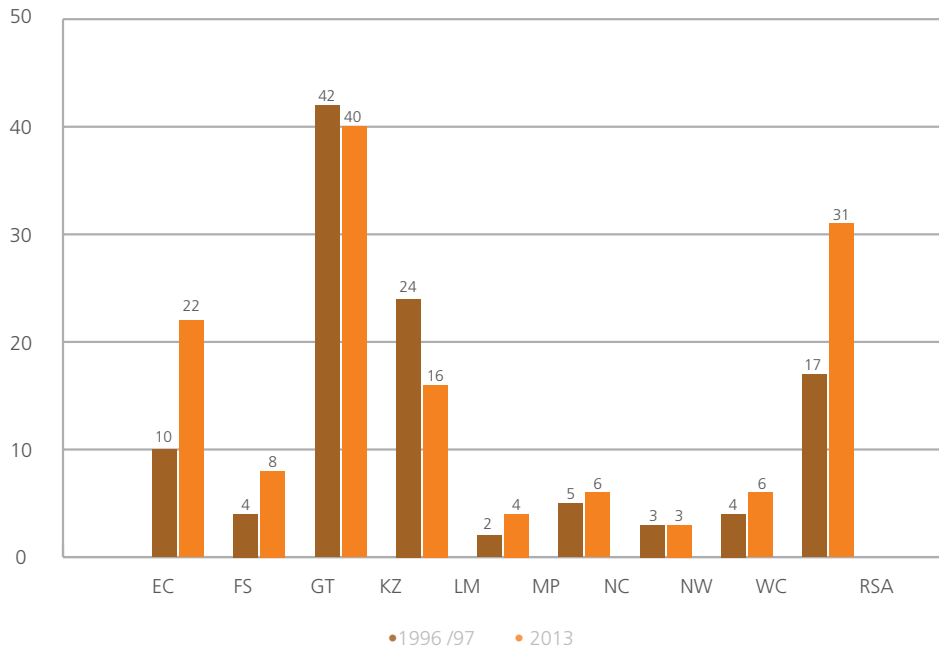
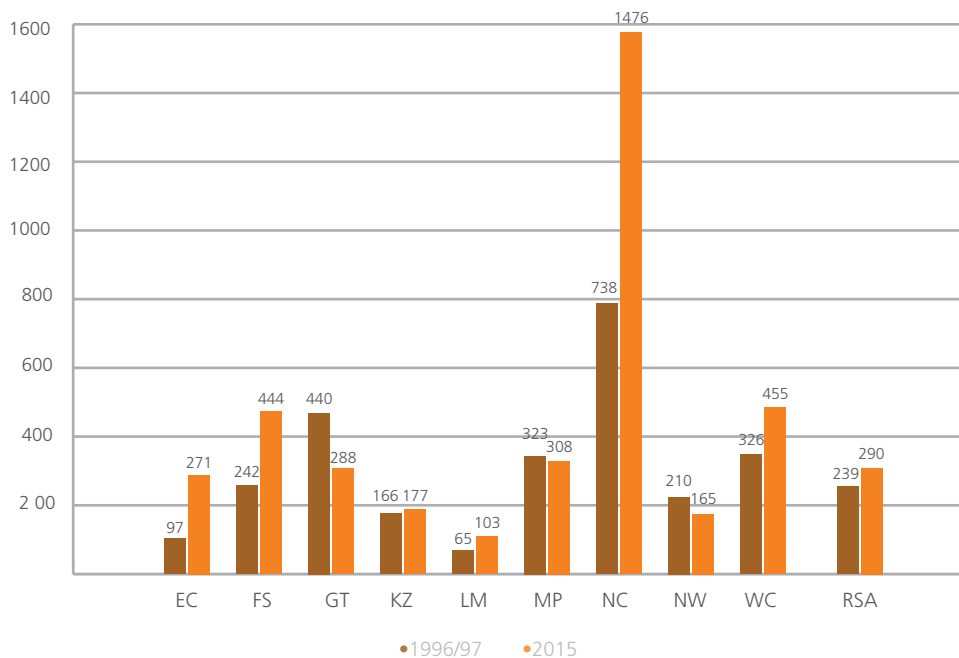


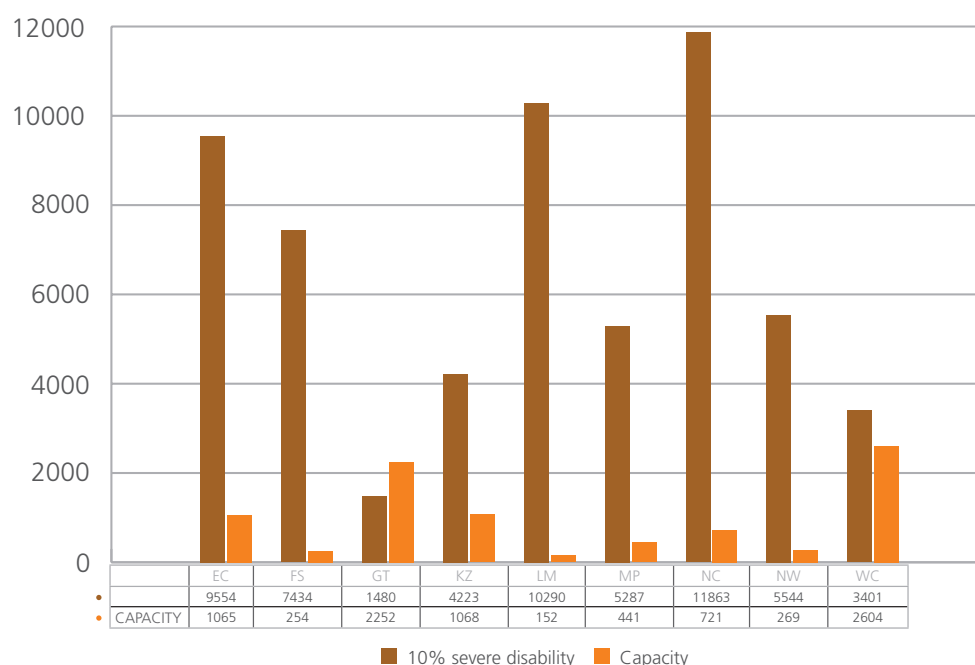
Figure 18: Subsidised users of homes for persons with disability per 100 000 estimated population with disabilities



⁷⁹ Health-E News: Mental health – the poor, crazy stepchild http://www.dailymaverick.co.za/article/2015-10-12-health-e-news-mental-health-the-poor-crazy-stepchild/?utm_source=Daily+Maverick+Mailer&utm_medium=email&utm_campaign=First+Thing+with+John+stupart%3A+Tuesday%2C+2+September+2014&utm_term=http%3A%2F%2Fwww.dailymaverick.co.za%2Farticle%2F2015-10-12-health-e-news-mental-health-the-poor-crazy-stepchild%2F#.VhtUgjihfIU, Accessed 12 October 2015.

⁸⁰ Rural Mental Health Campaign. 2015. A call to action.

Figure 19: Comparison of need and capacity: Homes for persons with disabilities



not being implemented. Partners in the campaign are Rural Doctors Association of South Africa, Rural Health Advocacy Project, Rural Rehab South Africa, the Professional Association of Clinical Associates in South Africa, and the Federation for Mental Health.

The Rural Health Campaign highlighted some of the key challenges in relation to mental health as follows:

- One in every three South Africa will have a mental disorder during their lifetime, with anxiety and substance abuse the most common disorders. One in every six South Africans will have a mental disorder in a 12-month period.
- Only 28% of people with severe disorders and 24% of people with mild disorders receive treatment. Middle-class people who have medical aid cover are far more likely than poorer people to receive treatment.
- On average, provinces spend less than 3% of their health budgets on mental health. Most of the funds go to psychiatric hospitals rather than to more community-based services.
- The South African Depression and Anxiety Group receives about 400 calls, e-mails and SMSes every day.
- In February 205, there were 800 registered psychiatrists and almost 8,000 registered psychologists in the country. The number of psychologists in private practice – serving 16% of the population – was more than seven times the number in public health.
- A national survey found one in five teenagers reporting that they had considered suicide at some point.

PART VI:
Review of
welfare and
community
development
services

⁸¹ Baron E and Lund C. 2015. Validation of the 10-item version of the Centre for Epidemiological Studies Depression Scale in Low and Middle Income Countries: Review and recommendations for NIDS. See also Tomitai A and Burns JK. 2013. "Depression, disability and functional status among community-dwelling older adults in South Africa: evidence from the first South African National Income Dynamics Study". International Journal of Geriatric Psychiatry. DOI: 10.1002/gps.3954.

- A person living with HIV & AIDS is 36 times more likely to commit suicide than the general population.
- 10% of reported medication stock outs between January and July 2015 involved psychiatric medications.

The adult questionnaire for the National Income Dynamics Survey (NIDS) includes the 10-item version of the Center for Epidemiologic Studies Depression Scale (CES-D). The ten items consist of questions addressed to the interviewees in relation to their feelings in the past week. Eight of the questions relate to negative feelings. For example, the first item is "I was bothered by things that usually don't bother me". Two of the items relate to negative feelings. For example, the first of these is "I felt hopeful about the future".

The four valid response options for the items range from "rarely or none of the time" to "all of the time". The responses to the ten items are scored between 0 for the most positive to 3 for the most negative option and the ten scores are added. The total possible score is thus 30. The fact that the questions relate only to the past week suggest that the questions record the prevalence of depression at any point in time rather than the proportion of the population that might suffer from depression – and perhaps need services – over a given period.

Unfortunately, the 10-item CES-D has not yet been validated for South Africa and the cut-off value indicating a severe depressive episode is thus not certain. Baron and Lund⁸⁰ cite previous studies that have used cut-offs varying from 4 to 16, with both of the studies with extreme cut-offs having been conducted in the United States. They suggest that in the South African context higher cut-offs than used in some studies elsewhere might be more appropriate, but motivate for a study that can confirm this.

In the absence of such a study, the analysis below uses two cut-offs – 10 and 15. From a Social Development perspective, the more conservative measure might provide an indication of those needing more intensive services, while the broader measure might include those who need early intervention services at community level. The analysis explores prevalence of poor mental health by sex, population group (race), age group, province and geotype.

The NIDS dataset used is from the third wave of the longitudinal survey, conducted in 2012. Of the 22 481 individuals in the dataset for "adults" (household members aged 15 years and above), valid CES-D scores can be calculated for 18 710, 83,2% of the total. The survey is designed to be representative of the total national population and the dataset thus contains weights, used in the analysis below, which allow statements to be made about the full South African population aged 15 years and above,

Table 33 gives an overall prevalence of 24% if the lower cut-off is used⁸², and 5% using the higher one. In absolute terms these percentages translate into absolute numbers of 7,6 million and 1,7 million respectively. (These numbers exclude the non-respondents who, when weighted, account for a further 1,7 million people.) Women are somewhat more likely than men to be depressed on both measures.

⁸² The estimates shown for 1–14 and 15+ appear to sum to 23% rather than 24% but this is due to rounding.

Table 33: Prevalence of severe depression by demographic factors, population 15+, 2012

	<10	10-14	15+
Total	76%	18%	5%
Sex			
Male	78%	17%	5%
Female	75%	20%	6%
Race			
African	74%	20%	6%
Coloured	80%	13%	6%
Asian/Indian	89%	9%	2%
White	91%	7%	2%
Age group			
Age 15-24	80%	16%	4%
Age 25-34	76%	19%	5%
Age 35-64	75%	19%	6%
Age 65+	69%	24%	7%
Province			
EC	67%	27%	6%
FS	73%	20%	7%
GT	82%	13%	5%
KZ	68%	27%	5%
LM	81%	15%	4%
MP	88%	7%	5%
NC	83%	13%	4%
NW	80%	16%	5%
WC	72%	20%	8%
Geotype			
Traditional	73%	22%	6%
Urban	78%	17%	5%
Farms	79%	16%	5%

In terms of population group, white and Indian individuals are noticeably less likely than African and coloured to appear to be depressed whichever measure is used. If the broader measure is used, more than a quarter of Africans show signs of depression against a fifth of coloured people.

The results in respect of age group show the likelihood of depression increasing with age on both the narrow and broad measures. About 7% of the oldest group, those aged 65 years and above, are found to be depressed using the more conservative measures, and nearly a third (31%) using the broad measure. Among younger youth (15-24 years), 4% are depressed using the more conservative measure and 20% - one in five – using the broader measure.

The worst affected provinces appear to be Eastern Cape and KwaZulu-Natal, in both of which close on a third of adults show signs of depression. While these are among the poorer provinces, the fact that Limpopo has lower apparent levels of depression

suggests that the link with poverty is not simple. Mpumalanga fares best, with “only” 12% of the adult population showing signs of depression. Western Cape has the highest prevalence – at 8% of the adult population – using the more conservative measure, while Limpopo and Northern Cape score best on this measure. Western Cape’s high apparently level of depression again contradicts a simple link with poverty and wealth.

People living in traditional (former homeland) areas have the highest prevalence of depression using both the more conservative and broader measures. There is minimal difference between the recorded prevalence in urban areas and commercial farming areas.

Table 34 shows the availability of facilities by province, derived from a map in the document. The spread is very uneven. For outpatient clinics, Eastern Cape has 700, while Northern Cape has only six. Eastern Cape also has more mental hospitals than any other province. For child outpatients five provinces have no facilities yet the document states that approximately 50% of mental disorders begin before the age of 14 years. With day treatment centres, give provinces have two or fewer, while Limpopo has 29.

Table 34: Availability of facilities by province

	EC	FS	GT	KZ	LM	MP	NC	NW	WC
Outpatient clinic	700	670	107	314	464	196	6	448	455
Child outpatient		2	10	4	0	0	0	0	4
Day treatment centre	1		14	22	29	12	0		2
Psychiatric inpatient unit	4	2	8	11	9	2	0	0	6
Residential facility	10		24	13	3	4		0	9
Mental hospital	5	2	3	4	3	1	1	3	3

Source: *National Mental Health Policy Framework and Strategic Plan 2013-2020: 17.*

7.3.5 Legislation and policy

When the Department of Women, Children and People with Disabilities was replaced by the Department of Women after the 2014 elections, DSD became responsible for the children and people with disability aspects. DSD already was responsible for social development services for these two target groups, but the transfer of functions from the other department added coordinating and oversight responsibilities. A new branch was established within national DSD. The name of the branch, Disability Welfare Services, suggests that the focus remains on DSD-specific responsibilities.

DSD’s current work in the area of disability includes development of a draft bill on social development services to people with disabilities and a national policy on the rights of people with disabilities. Development of the bill, which relates to DSD’s core functions, has been put on hold until the overarching disability rights policy is finalised.

The preamble to the draft Bill on Welfare Services to Persons with Disabilities states that the bill aims to “to improve the well-being of persons with disabilities through the provision of protection, care, empowerment and other forms of support, in order to enable them to live independent lives and to provide for matters connected therewith.” One of these “matters” is the proposed establishment of a national advisory/ coordinating

structure to guide the department and sector on issues relating to disability. Clause 47, which specifies membership of the board/structure, lists only directors-general of various national departments, but clause 49 refers to the “elected” Committee.

The draft bill provides that provincials MECs “may” provide “financial assistance” to service providers. This is weaker language than that of the Children’s Act in respect of key services. (The Children’s Act states that the MEC “must provide” certain services, with this phrase interpreted as meaning that the MEC must ensure that either government or others provide the service, a requirement that would include funding.) However, clause 33(b) states that the state is obliged to fund respite care for caregivers “through direct running and/or NGOs supported.”

Community-based services relevant to persons with disability include “awareness and advocacy, day care centres that cover stimulation programme, protective workshops, psycho-support support, skills development and economic empowerment, life skills, as well as respite care that form part of home-based care.” Residential facilities are defined to “include traditional residential facilities that include respite care such as Cheshire homes, group/ cluster home, as well as assisted or supported living” and the list of possible services at such facilities is (a) 24 hours care and support services to people with severe disabilities; (b) care and support services; (c) rehabilitation services; (d) provision of assistive devices; (e) counselling services to persons with disabilities and their family members who need these services; (f) awareness raising, outreach and education on disability issues; (g) provision of respite care services; (h) independent living; (i) training of volunteer caregivers to deal with persons with disabilities; (j) re-unification and reintegration programmes; and (k) sport and recreation activities.

The bill requires that all persons “alleged” to have a disability must be assessed by a social service professional and referred for “diagnosis”. Clause 44 provides for a national database for persons with disabilities that would include personal details of each individual, the type of disability, social development and other services required, and personal details of the caregiver. Those on the database are required to notify the Director-General of any “substantive changes”. Some of these clauses suggest that the bill will undergo important amendments before it can be passed by parliament.

The mental health area is, like some others, complicated because while DSD is the lead department for all types of disability, mental health services are also funded by DOH, and DOH is arguably the lead agency. Thus the main legislation governing mental health is the Mental Health Care Act (17 of 2002), which falls under DOH. The preamble to the law states, among others, that it provides for the “care, treatment and rehabilitation of persons who are mentally ill”. The body of the legislation includes provision of care and rehabilitation centres for people with intellectual disabilities. However, the thrust of the legislation is towards deinstitutionalisation.

The National Mental Health Policy Framework and Strategic Plan 2013-2020, also developed by DOH, recognises the challenges in this area as being a high prevalence of mental disorders (linked, among others, to poverty, unemployment, violence, and substance abuse); high co-morbidity (simultaneous occurrence) of mental and other diseases; a “substantial gap” between demand and supply for services; and inequities and weaknesses in the system.

The framework's definition of mental health care practitioner includes social workers trained on mental health alongside health professionals. However, the definition of mental illness does not cover intellectual disability as it refers to a mental health-related "illness". Instead the scope includes intellectual disability (and substance abuse "disorders") only insofar there is also a mental health "disorder" (i.e. co-morbidity). The framework specifies further that DOH is responsible for the provision of health care to people with severe and profound intellectual disabilities. For those with mild and moderate intellectual disability, the Departments of Education and Labour are responsible for the educational and training while DSD may provide other services. For example, to the extent that severe behavioural problems are considered a psychological or mental health issue, DSD's responsibility for child and youth care centres for children directed by the courts for behavioural problems represents a mental health service.

Departments of Education are responsible for the education of children under 18 years in health facilities and rehabilitation centres for the severely affected (which fall under DOH). In respect of education and training, a 2010 Western Cape court challenge brought by the Western Cape Federation for Intellectual Disability⁸³ established that the resources allocated by government for a child with intellectual disability must, at the least, equal the resources allocated for a child without disabilities. Health has a responsibility for children and adults with mild and moderate intellectual disability only where there is co-morbidity.

Of direct relevance to DSD, DOH's framework document states that by 2013, DOH "will liaise with the Department of Social Development and other relevant departments to include the poverty-mental health link on the policy agenda. This focus area will be integrated into policies and programmes of all sectors involved in poverty alleviation and community upliftment." Of potential relevance to DSD interventions, the document notes that stigmatising beliefs include beliefs that mental illness is due to bewitchment or other causes which can result in fear, ridicule, neglect, isolation, rejection and abuse.

DSD's ISDM states the following on mental health promotion: "These include family preservation and family reconstruction services (which are aligned to the Moral Regeneration Movement), marriage and family counselling/guidance, family counselling services in respect of divorce and mediation services." This description does not seem to relate neatly to what is generally conceived as intellectual or psychiatric disability. This again raises the question as to DSD's specific role in respect of mental health.

A norms manual for severe psychiatric conditions (SPC) produced for the Directorate: Mental Health and Substance Abuse of the national Department of Health⁸⁴ produces estimates for medium stay (up to three months) in hospitals, not for residential care. However, it notes that the latter is "crucial" for long-term care in the community and suggests that 20 residential beds are needed for every ten beds recommended in the model.

People with SPC are defined as having an "absolute need" for care and include:

- People with severe chronic psychiatric conditions such as schizophrenia and bipolar affective disorder who usually require short-term admission

⁸³ Western Cape High Court, Cape Town, Case no:18678/2007, 11 November

⁸⁴ Department of Health. Undated. Norms Manual for Severe Psychiatric Conditions

followed by ongoing support and management in the community. A small percentage requires long-term inpatient care.

- People who require short-term hospitalisation for the management of acute psychiatric problems such as suicide attempts, brief psychoses or panic attacks. These are assumed, on the basis of available evidence, to account for about 3% of the population aged 15 years and above. (Non-affective psychosis is estimated to affect 0,5% of the population aged 15 years and above is a twelve-month period, bipolar affective disorder 1,3%, severe major depression 2,1% and severe anxiety disorder 0,9%.) However, the 3% is an under-estimate in that it excludes substance-induced psychotic disorders, brief psychotic disorders, mental disorders due to a general medical condition and severe cases of posttraumatic stress disorder.

If community beds (which are probably the responsibility of DSD) are not available, the manual suggests that these should be provided in the interim in hospitals. The manual prescribes staff norms for the non-community beds (a) per population, (b) per bed, (c) per DPV (daily patient visit) – ambulatory. Baseline norm for social workers (who would be employed by Department of Health) per 100 000 population is 0,7 and the target norm is 2,2. Per bed the norms are 0.01 and 0.03 respectively, and per DPV 0,01 and 0,08 respectively.

The need for complementary community-based services is highlighted by ongoing moves by DOH to reduce the number of psychiatric patients in health facilities. For example, in November 2014 the MEC of Health in Gauteng announced that the department was terminating its contract with Life Healthcare Esidimeni Hospital in Randfontein in respect of inpatient care, treatment and rehabilitation for people with chronic psychiatric disorders and severe intellectual disability. The termination was said to be in line with subsection 6(8) of the Mental Health Care Act (no 17 of 2002) which provides for treatment in the least restrictive environment. The move would also result in a substantial saving for the department which had spent more than R323,7 million on private hospital treatment for around 2 378 patients. The funds “saved” were to be reprioritised, with the danger that they would be lost to care of those with psychiatric problems. The department was hoping to collaborate with NPOs in “managing” the released patients.⁸⁵ Past experience suggests that the process of deinstitutionalisation is not simple.⁸⁶

7.3.6 Roles and responsibilities

The Mental Health Framework document notes that Section 43 of the Mental Health Care Act (17 of 2002) makes DOH responsible for regulation (including licensing) of NPOs that provide community-based mental health services, including community residential care, day care services, and halfway houses.

The framework’s delineation of “intersectoral” (seemingly relating to agencies other than DOH) roles and responsibilities in respect of the strategic plan divides these into

⁸⁵ South African Government New Agency. 2015. Improving psychiatric patients to be discharged <http://www.sanews.gov.za/south-africa/improving-psychiatric-patients-be-discharged>, accessed 30 November 2015.

⁸⁶ Lazarus R. 2005. “Managing deinstitutionalisation in a context of change: The case of Gauteng, South Africa” in *South African Psychiatry Review* 8(2): 65-69; Janse van Rensburg B. 2005. “Community placement and reintegration of service users from long-term mental health care facilities” in *South African Psychiatry Review*, 8(3): 100-103.

those relating to promotion and prevention and those relating to removal of barriers, as shown in Table 35.

Table 35: Mental health roles and responsibilities

Sector	Promotion and prevention	Removal of barriers
Education	Support such as counselling to children and adolescents with mental and related learning disorders School-based mental health promotion programmes Employee assistance programmes for educators with work-related and other mental health conditions Mental health literacy education in the curriculum	Integration of people with intellectual disabilities into the system Collaboration with DOH in respect of learning during and after periods of illness and management of children and adolescents with severe disorders. Collaboration with Labour to coordinate basic education with skills development and vocational training opportunities
Social Development	Targeting of people with mental disabilities in poverty alleviation programmes. Awareness of the mental health benefits of being a recipient of poverty alleviation strategies, including social grants. Awareness of early childhood intervention as mental health promotion programme.	Clarity on the roles, responsibilities and service interface of Health and Social Services Guidelines to facilitate access to social grants for people with mental or intellectual disabilities
SAPS	Early identification and referral of mental health care users in terms of s40 of the Mental Health Care Act	Guidelines for implementation of s40 relating to transporting persons to health facilities.
Correctional Services	Early identification and referral for treatment of prisoners.	Guidelines for management of prisoners with mental health conditions, substance abuse and suicidality
Justice	Early identification and referral for treatment of those awaiting trial.	Special courts for those with intellectual disability or impaired decision-making skills Supporting equality under the law for people with mental and intellectual disability
Housing	Awareness of mental health benefit of provision of adequate housing	Review of special housing needs policy to accommodate subsidisation of people with mental and intellectual disability

Sector	Promotion and prevention	Removal of barriers
Local Government	Agreement on responsibilities of Human Settlements, municipalities, NPOs and DSD in housing provision Review of special housing needs policy to accommodate subsidisation of people with mental and intellectual disability	Clarity on the role of local government in provision of community and municipal services to disabled people Including the needs of people with mental disability in accessibility plans
Transport	Promotion of mental wellbeing through a safe and effective public transport system	Travel pass or benefit for people with disabilities to increase access to work, hospital services and social supports.

As with some other service areas, there are challenges around the respective roles of DSD and DOH⁸⁷.

DOH feels that many, if not most, of the people currently in DOH facilities should ideally be in community facilities if there were good ones available. In line with the general principle that money should follow the patient, DOH would be comfortable with some of the funding currently used for inpatient care in facilities being redirected to DSD if the latter could provide, or fund NPOs to provide, adequate services. However, DOH states that it cannot do this until it is confident that the people concerned will have proper care in the communities. DOH is also reluctant to transfer funds because the demand for DOH facilities is unlikely to decrease. As for other service areas such as older persons, if transfer of funding is needed, this requires decision-making at the highest level and needs to involve Treasury.

Currently DOH funds some NPOs in respect of community care. Some of these facilities may also receive partial funding from DSD. While the NPOs are sometimes accused of “double-dipping” the combined funds of the two departments generally do not cover the full costs of the service. Sometimes the funded services are referred to as “halfway houses”. However, in many cases people will live in these facilities for the rest of their life. During this period they will need visits by both health and social development practitioners, as well as access to other resources such as grants.

7.4 HIV and AIDS

The White Paper highlighted the sharp increase in HIV infection rates in South Africa in the 1990s, with the HIV infection level estimated to be 7,6% of the population in 1994. KwaZulu-Natal, Mpumalanga and Gauteng were identified as the worst affected provinces. Heterosexual transmission was recognised as most common mode. The White Paper cited projections that infection rates would plateau by 2010 at the latest, with 18-27% of the population infected at that point. The urban poor and young adults were identified as particularly vulnerable. The pandemic was envisaged as having substantial impact on individuals and families, as well as on “social and economic resources” more generally.

⁸⁷ Information from Melvyn Freemand, national Department of Health.

The White Paper pointed to the financial vulnerability of individuals and families resulting from HIV and AIDS when “breadwinners” lost formal jobs, as well as the increased costs individuals and families incurred as a result of HIV and AIDS. It notes that there would also be indirect impact on households who “receive” orphans or provide caregiving. It highlighted the “considerable” psychological stress experienced by HIV-infected people, as well as their families. In particular, it pointed to the impact on children who lose parents, and older relatives who take on the care of those who are ill and orphaned. It suggested that customary marriages increased the vulnerability of women and children affected by HIV and AIDS because of female disadvantage in respect of property, inheritance and access to land.

The White Paper’s discussion of chronic illness focused primarily on cancer, epilepsy and tuberculosis. It notes that chronic diseases can “impact on the individual and family’s capacity to function optimally. It observes that while the health system provided for people who were hospitalised, the departments of welfare, welfare organisations, religious organisations and community networks, as well as social workers employed by the provincial departments of health, were “called upon” to provide support once patients were discharged.

7.4.1 Updating the White Paper

In line with the White Paper’s predictions, the number of new HIV infections in South Africa had begun falling off among younger people by 2008⁸⁹. AIDS mortality has also declined noticeably as a result of the availability of ARV. However, South Africa continues to hold the unenviable distinction of being the country with the largest number of HIV-infected people in the world, and the number has grown despite the decrease in the number of new infections. Thus, the 2012 Human Sciences Research Council (HSRC) survey produced an estimate of 12,2% of the population – equivalent to 6,4 million people – being HIV-positive, compared to the 10,5% and 5,2 million people of 2008. KwaZulu-Natal, at 16,9%, had the highest prevalence, followed by Mpumalanga at 14,1%. Western Cape, at 5,0%, had the lowest prevalence. Among women, prevalence was highest in the 30-34 year age group, while for men the 35-39 year age group was worst affected. Among teenagers, young women were eight times more likely than young men to be infected. People living in rural informal (former homeland) areas were significantly more likely than those in other types of areas to be infected. In 2012, just over 30% of infected people were estimated to be on ARV therapy.

The HSRC survey of 2012 identified the most at-risk groups in terms of infection as being African women aged 20–34 years, people who co-habited, African males aged 25–49 years, people with disabilities aged 15 years and above, high-risk alcohol drinkers aged 15 years and above, and recreational drug users. The Recognition of Customary Marriages Act of 1998 has to some extent reduced the vulnerability of women who have married in this way. Research in three diverse areas of South Africa also suggests that customary law and practice has adapted over the years in terms of the extent to

⁸⁸ Health-E News: Mental health – the poor, crazy stepchild http://www.dailymaverick.co.za/article/2015-10-12-health-e-news-mental-health-the-poor-crazy-stepchild/?utm_source=Daily+Maverick+Mailer&utm_medium=email&utm_campaign=First+Thing+with+John+stupart%3A+Tuesday%2C+2+September+2014&utm_term=http%3A%2F%2Fwww.dailymaverick.co.za%2Farticle%2F2015-10-12-health-e-news-mental-health-the-poor-crazy-stepchild%2F#.VhtUgjjihfIU, Accessed 12 October 2015.

⁸⁹ Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. 2014. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

which single women with children can access land and probably other resources⁹⁰. Nevertheless, vulnerability persists.

The high prevalence levels of HIV infection should mean that there is less chance of stigmatisation and discrimination in South Africa than in some other countries. Nevertheless, stigma and discrimination remain as challenges. Reduced official high-level attention paid to HIV and AIDS in recent years could also result in less awareness and greater stigmatisation.

ARVs often return infected people to a state of health in which they are able to work. ARVs should also be provided free by the state to those who are unable to afford them, thus not imposing a direct cost. Nevertheless, HIV infection hampers income-earning because the infected person needs to take off time to collect medication (a process that can be very time-consuming where clinics are under-staffed and sometimes do not have the necessary stocks) and incur costs, such as for transport, for these visits. Infected persons also incur other costs, including in ensuring that they eat healthily. In a situation of high unemployment, employers may also discriminate against people known to be infected when hiring staff.

The current provincial DSD structure and budget do not provide separately for people with chronic illnesses. The issue is discussed here because HIV and AIDS can, with the availability of ARVs, be seen as a chronic illness rather than the death sentence that it was previously. The issues raised will thus often be similar.

South Africa continues to have very high rates of tuberculosis infection, and these rates are exacerbated by the high HIV infection rate in the population. As noted above, with ARV available, HIV infection itself can be seen as a chronic condition – and one that will require lifelong medication – rather than an incurable disease that effectively imposes a death sentence. Cancer remains an important cause of death in the country and will continue to do so with the (relatively slow) ageing of the population. Advances in medical knowledge have resulted in more people surviving cancer, but generally with periods during which they are unable to work and need intensive care, and also only if they receive expensive treatment.

At the height of the HIV and AIDS pandemic, before ARV became fairly widely available, a large number of home-based carers provided palliative and related care to the AIDS-sick, as well as practical, emotional and spiritual support to their families. Some of these workers worked unpaid, while others received (small) payments through funding provided by government and other funders. With ARV therapy now available, the type of care and assistance needed has to some extent changed. However, while care and related services are still needed, funding is scarcer than previously.

The extent to which non-health services are needed is increased when the policy approach is to avoid institutionalisation (including in hospitals), and also to shorten hospital stays. The economic arguments for this approach, at least in terms of savings to government, are clear. There can also be social arguments, in terms of a preference for people who are ill to be with their loved ones. However, the costs imposed on the families and on community members and organisations (and, in most cases, women within these categories) that provide care are often not taken into account.

⁹⁰ Budlender D, Mgweba S, Motsepe K & Williams L. 2011. Women, Land and Customary Law. Community Agency for Social Enquiry: Johannesburg.

Rose Parent Project

The Rose Parent Project is a community-based foster care programme for psychiatric and intellectually disabled clients of Lentegeur Hospital in Cape Town. More than 200 patients have been placed with over 100 families. Rose Parents are not paid for their contribution. Mental health clients in the care of the Rose Parents seldom require re-admission to Lentegeur Hospital and many have successfully re-established relationships with their family members. This model may not work well in rural areas where households struggle to take care of their own families and may well not have the resources to take on others, especially those needing special care such as people with mental health problems.

7.4.2 Other findings of the Ministerial Committee

Many of the achievements noted by participants in the Ministerial Committee's processes in respect of HIV and AIDS related to the widespread availability of ARV. ARV provision does not fall within DSD's scope of responsibility, although in Gauteng DSD was said to provide both ARV and food parcels throughout the province.

Even without DSD bearing responsibility for ARV provision, there could be links to DSD. For example, community-based workers who previously provided home-based care for the seriously ill and dying now might monitor compliance with medication and provide assistance with access to ARV. There was, surprisingly, no discussion in the submissions, presentations or discussions of how the role of caregivers had changed over time in response to the availability of ARVs. In Limpopo, beneficiaries expressed concern about the lack of follow-up on progress of HIV and AIDS patients on medication – a complaint that might be better directed at DOH rather than DSD. Eastern Cape service providers felt there were gaps in government provision for children born HIV-positive.

In some provinces participants reported that people affected or infected with HIV and AIDS were assisted through food parcels or involved in food gardens. This would, at least in part, be motivated by the need for people on ARVs to have proper nutrition. In Mpumalanga, school uniforms, clothing and blankets were said to be provided to families in need on account of HIV and AIDS. It is likely that some other provinces provide similar support. This can happen, among others, through the drop-in centres which are discussed under Children below, but which were probably often established with the aim of serving orphans and other children made vulnerable by AIDS (OVC). In Limpopo, for example, practitioners noted as an achievement that drop-in centres provided school uniforms and food to OVC. In Eastern Cape practitioners noted as an achievement that child-headed households were provided with school "gear" and food parcels. Gauteng's Bana Pele programmes is more extensive than in other provinces, and provides, among others, school uniforms, dignity packs and other benefits to OVC as well as to other categories of children.

In North West and Eastern Cape participants noted that HIV-positive people received support on the basis of their CD4 count. They did not specify the type of support to which they referred, but it is possible that the reference was to disability grants. The

participants said that some people defaulted on their medication so as to be ill enough to receive support.

The four services named in the quantitative tool for HIV and AIDS were home- and community-based care (HCBC), social relief and concessions, prevention programmes, and care and support programmes or services.

There was limited variation in the overall scores for the four HIV and AIDS services, although social relief and concessions scored somewhat lower than the other three services. HCBC and prevention programmes were the highest scorers across all three stakeholder groups, although practitioners felt that the latter was less available than the former. Overall, the scores for HIV and AIDS were higher than for many other service areas.

Gauteng was top or second highest performer on all four of the services, while North West was top or second highest performer on three services. At the other end of the scale, Limpopo was consistently the worst performer in all four services.

In several provinces there were reports that the number of infected people was increasing, as well as reports that the number of orphans and child-headed households was increasing. No statistics were offered to support the claims. There were, pleasingly, comments that there was far less stigma than previously, although some participants noted that the problem of stigma persisted.

Comments on HCBC tended to focus on the caregivers rather than the services provided. This focus reflects the fact that this area of work can have a substantial number of volunteers working on a regular basis. It could also reflect participation by caregivers in engagements with the Committee. The service was noted as an achievement in terms of job creation, with government support provided in particular through the EPWP. However, there were also many concerns expressed about the caregivers (with some lack of clarity as to whether the references were to caregivers supported by DSD or caregivers supported by DOH). Some submissions called for volunteers to be paid, suggesting that there are still many true “volunteers” in the sense of people doing work without any monetary reward. There were also calls, in respect of those who were paid at the EPWP minimum rate of R1 600 per month, for an increase in the rate. One of the motivations for this call was the high rate of dropout and turnover among caregivers which was reported across provinces. Government submissions suggested that these workers should be incorporated in government. In KwaZulu-Natal, EPWP workers are placed on the government payroll (rather than funded through transfers to NPOs, as in other provinces), although the KwaZulu-Natal workers are not on standard government pay scales.

Both government and NPO submissions noted the volatility of funding for HCBC and for HIV and AIDS more generally. This volatility is exacerbated by the fact that much of the funding has come through conditional grants. The EPWP grants, in particular, are allocated for a year at a time. The Eastern Cape reported that the budget for HCBC had decreased from R64 million to R18 million, while the Free State reported that after the

HIV and AIDS-specific conditional grant of earlier years ended, the province's allocation for HIV and AIDS had remained constant. Western Cape does not have a separate budget allocation for HIV and AIDS, having incorporated this service into the children's service area. Service providers in Western Cape said that support for HIV and AIDS had been "scaled down", with donors no longer interested in the area. This reference could include the US Presidential Emergency Plan for AIDS Relief (PEPFAR), which now focuses its funding on supporting "systems strengthening" rather than service delivery.

Children's sector organisations described a range of different programmes to provide services to OVC. These perhaps correspond with the quantitative tool's "care and support services", although there is variation across provinces as to whether these services are managed under Children or under HIV and AIDS. Many of these children's programmes had received funding from PEPFAR, and some continued to do so. The named community-based services for OVC developed by NPOs included, but were not restricted to, Isibindi (developed by the National Association for Child Care Workers (NACCW) and now being rolled out under DSD auspices) and Isolabantwana (developed by Child Welfare). Some of the concerns raised in respect of caregivers are likely to have referred to the situation of the caregivers who work within these programmes rather than those providing HCBC for people who are ill.

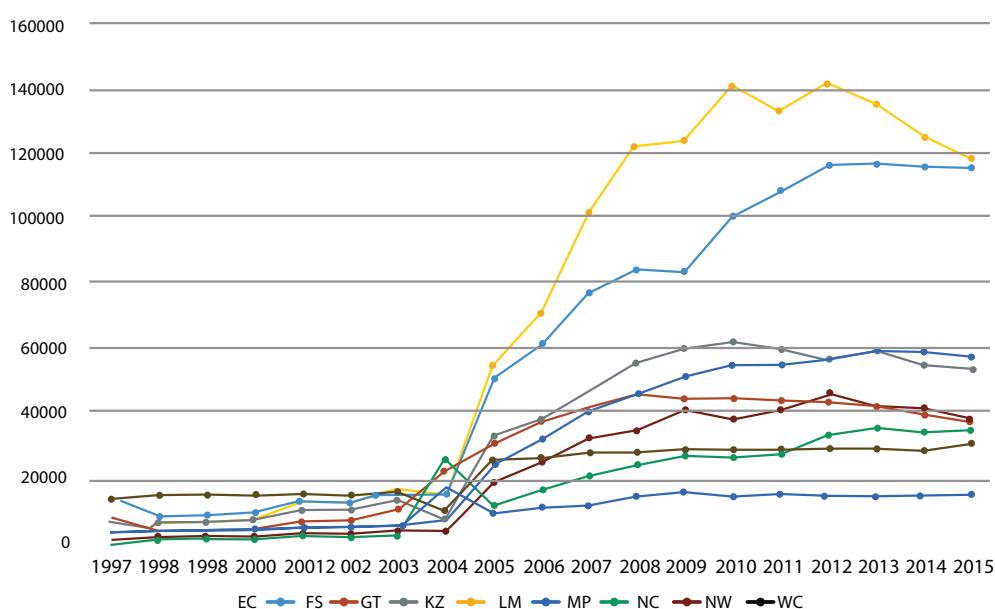
7.4.3 Additional evidence

While DOH bears the main responsibility for health-related treatment and care, DSD's responsibility lies chiefly in the area of mitigation of the impact of HIV and AIDS on families and, in particular, on children. The foster child grant has been promoted by government as financial support for adult caregivers who take on the responsibility of replacing deceased parents. However, the substantial expansion in the numbers of children who qualify if the purpose of foster care is understood in this way has placed considerable burden on the system and resulted in a range of negative side-effects.

Figure 20 shows the number of FCG beneficiaries as fairly static over the period 1997 to 2003, after which there were increases in all provinces. The graph shows KwaZulu-Natal and Eastern Cape having far more beneficiaries than other provinces. This is in part explained by the size of their population. For KwaZulu-Natal, the province with the highest HIV prevalence rate, it is in part explained by the fact that the increase came about when government promoted the FCG for caregivers of orphans and, in particular, for caregivers of children orphaned through HIV and AIDS. The graph shows an evening out, or even decline, in the number of FCG beneficiaries in recent years except in Mpumalanga and Limpopo. The decline is sharper in KwaZulu-Natal than in other provinces.

Participants in the NPO round table convened by the Committee noted that the foster care system was designed to provide for 55,000 children in need of care but was currently expected to deal with more than 500,000 children. Most of these children had poverty-related needs rather than those related to the specialised child protection needs envisaged in the design of the foster care system. One of the results of over-burdening

Figure 20: Changes in number of foster child grant beneficiaries by province, 1997-2015



the system was that children in need of specialised care and protection were not getting the services they required.

In 2009, the foster care system began to collapse, with recipients falling off the grant system due to lapsed orders. In early 2011, when the number of lapsed orders had reached over 100 000, an urgent court application was brought by the Centre for Child Law. The application resulted in a court order that allowed administrative extensions of placements in order to allow the system backlogs to be cleared. Three years later, at the end of 2014, DSD asked for the order to be extended because no systemic solution had yet been found.

Concerns about the foster care system are supported by the terms of reference of the foster care committee established by the Minister of Social Development to investigate challenges in the foster care system. The terms of reference note that while in 2000 approximately 200 000 children benefited from the grant, by August 2014 the number stood at 548 421. About 80% of the children were cared for by family members. This situation had developed in part because of the substantial increase in the number of orphans as a result of the HIV and AIDS pandemic – an increase that the Children’s Institute put at 853 000 over the period from 2002 to 2011. In 2006, provincial DSD reallocated social workers from other work to foster care to deal with the large backlogs of pending cases. Some provinces also employed additional social workers and social auxiliary workers to assist with investigations, compiling reports and finalising children’s court enquiries. By late 2014, the terms of reference of the committee estimated that the work of more than 5 300 social workers and more than 1 600 social work supervisors was focused on foster care.

DSD’s Welfare Services has, over the years developed a range of plans to improve foster care service delivery and address the backlogs. To date, these plans and strategies have not been successful. During 2014/15, 499 774 foster care grants were processed rather than the target 533 885⁹¹.

Finding a solution is complicated by the fact that two separate pieces of legislation and two separate units within DSD are involved. Participants in the NPO round table argued that in terms of social security, South Africa should be looking at progressive realisation of rights, while in the service area children had a constitutional right to immediate services. Based on this recognition, the group proposed that the proposed extension of the CSG to young people aged 18 years and older be put on hold; that grandparents, aunts and other relatives caring for orphaned children should be eligible for a higher-value CSG rather than the foster child grant unless the child was in need of specialised care and protection; and that over time, the CSG amounts for non-orphaned and orphaned children could be progressively equalised. A further proposal was that social auxiliary workers and child and youth care workers be trained and authorised to do assessments of children, freeing social workers to do therapeutic work.

7.5 Families

The White Paper discussed families in a section dealing with “Families, Children, Youth and Ageing”, in line with the Paper’s overall emphasis on the life cycle. It acknowledged the “social, religious and cultural diversity” of families, as well as the impact of social change and social, economic and political policies – including apartheid-related policies such as influx control and the migrant labour system – on families and the “traditional roles” of women and men. It observed that factors such as divorce and desertion and lack of housing had “redefined household structures in South Africa”.

The White Paper cited increasing economic stress as an important contributor to problems in functioning of families. It suggested that poor families, and those within which there were single parents, were the worst affected (presumably by economic stress, rather than necessarily family functioning). It suggested that the well-being of children, in particular, depended on effective family functioning.

The White Paper pointed to the “new demands and challenges” that families faced in meeting the needs of their members. It referred, among others, to substance abuse, relationship problems, parenting problems, family and community violence, weak support networks, and natural disasters. It pointed to economic need forcing more women to join the labour market and rely on child care outside the home. It pointed to factors such as lack of housing and a range of basic services and facilities that had contributed to an increase in the number of people and families living on the streets.

7.5.1 Updating the White Paper

South Africa continues to have a diverse, and unusual family structure. For example, fewer than 40% of children under 18 years live with both their parents, with more than this number living only with their mother. The majority of women have children, but many do so outside of marriage and with different fathers. Close on one fifth of children have lost at least one parent. Only about one third of households are nuclear in the sense of consisting only of children and parents. About a fifth of households have three or more generations or more present. Many children live with and care cared for by grandmothers rather than their parents⁹². Culture, religion, and other factors continue to influence the diversity of family forms in the country.

⁹¹ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015.

Isibindi

The Isibindi programme has objectives related to three serious socio-economic problems that face South Africa, namely unemployment (especially high among youth, women and rural people), skills deficits, and high levels of HIV prevalence and HIV-related illness and death contributing to large numbers of children whose wellbeing is threatened, including those whose wellbeing is threatened by the absence of “normal” parental care.

The Isibindi programme addresses these problems by providing high quality training to unemployed people (with a focus on youth, women and rural people) (thus addressing the skills deficit), who are employed within their communities as CYCWs (thus addressing the unemployment problem) to provide skilled care and services for vulnerable children in the community (thus addressing the threats to child well-being).

By end March 2015, after two years of national roll-out supported by national and provincial DSD, 309 projects distributed across the nine provinces were implementing the Isibindi model, and 4 485 had started (and some had finished) their accredited training as CYCWs. The two-year training course combines practical and theoretical elements, and after the initial two weeks, trainees spend 30% of their time in training and 70% of their time in practice, i.e. servicing children. In the 2014/15 financial year, more than 100 000 children were enrolled on workloads of these and already trained CYCWs in Isibindi projects. If children reached through safe parks and other outreach services in the community are included, the number reached was more than 150 000.

The fact that many children live with mothers, but not fathers, places the burden on the mothers of alone fulfilling roles of both provision of emotional and physical care and provision of financial means. This burden is particularly heavy in a situation of high levels of unemployment and where female earnings are, on average, less than male earnings even after controlling for factors such as education. The burden is increased where there are children or others in the household who have special needs, such as needing 24-hour care.

In contradiction to what might be implied by the White Paper, women have been part of the South African labour market for many decades, although the extent to which this was the case was not always captured in statistics, which tended to ignore or under-count subsistence-type work as well as informal work. Today, some working women and men can rely on unemployed family members for child care purposes. However, this is in a sense a perverse benefit of the high levels of unemployment in the country as many of those who do the child care would prefer to do paid work if it were available. Home-provided child care also may not provide some of the benefits that children gain through participation in formal ECD programmes.

⁹² Budlender D and Lund F. 2012. “South Africa: A Legacy of Family Disruption” in Razavi Shahra (ed) *Seen, Heard and Counted: Rethinking Care in a Development Context*. Wiley-Blackwell and United Nations Research Institute for Social Development: Chichester: 51-72.

The lack of jobs as well as the lack of a safety net – and in particular the absence of any grant other than the disability grant – for individuals aged 18-59 years contributes to the large number of individuals and families living on the streets. There are no national statistics available on this phenomenon, but a recent survey conducted by the City of Cape Town estimated that there were more than 7 000 homeless people in that city alone (and excluding those living in the mountains), of whom only about 2 500 slept in shelters.⁹³

7.5.2 Other findings of the Ministerial Committee

For Promotion of Family Life, the quantitative tool used by the Committee named four services. These were empowerment and support to families; family-centred crisis intervention; family group conferencing; and family preservation.

There was very little variation in the overall mean ratings for family life, with a range from 2,5 for crisis intervention to 2,8 for empowerment and support. Users gave lower ratings than the other two groups for three of the services, and tied for last place with

International concerns about a focus on family protection

In July 2015 the Human Rights Council of the United Nations General Assembly passed a resolution on Protection of the family⁹⁴. Similar to the South African White Paper, the resolution acknowledges the family as “the natural and fundamental group unit of society” and sees it as “entitled to protection by society and the State”. Also similar to South Africa, various clauses of the resolution recognise that families can take diverse forms.

The resolution requested that the High Commissioner prepare a report on whether member states were meeting their obligations in this respect. Many national, multi- and inter-national civil society organisations (CSOs) made submissions to the Council raising their concerns as to how the obligations might be interpreted. Several themes emerged repeatedly in the submissions. These included the following:

- that protection of the family is prioritised over the rights and needs of individual members who are the envisaged rights holders in respect of international human rights;
- that the resolution, in seeing the family as “a strong force for social cohesion and integration, intergenerational solidarity and social development”, did not recognise the extent to which families could support and promote power structures that undermined the rights of groups such as women, the elderly, children, persons with disabilities, and queer and transgender youth;

⁹³ http://groundup.org.za/article/over-7000-live-streets-cape-town_3190?utm_source=GroundUp+Newsletter&utm_campaign=c9d2c9decf-GroundUp_Newsletter_6_August_2015_6_2015&utm_medium=email&utm_term=0_21dfb9ddb-c9d2c9decf-147406029, accessed 10 August 2015

⁹⁴ Human Rights Council. July 2015. Resolution 29/22 Protection of the family: contribution of the family to the realization of the right to an adequate standard of living for its members, particularly through its role in poverty eradication and achieving sustainable development. United Nations General Assembly.

International concerns about a focus on family protection (continued)

- that the focus is on families that uphold traditions, with likely disadvantage or neglect resulting for non-traditional families, and that discrimination, disadvantage and marginalisation can also result from use of concepts such as “morals”, “heritage” and “values”;
- that the notion of the family should be conceptualised around the concepts of care and nurturance rather than particular institutional forms.

Underlying these concerns is the understanding that the family should be supported and protected only to the extent that it supports and promotes the rights of its members. Further, states must establish laws and policies that counter violations of rights that occur in the family context, including domestic violence and child abuse.

providers for the fourth service (crisis intervention). The range in scores was particularly large for family group conferencing. It is possible that many participants did not know what this is.

Northern Cape had the highest rating for all services except crisis intervention. North West also tended to have better scores than other provinces. KwaZulu-Natal was rated lowest on crisis intervention, while Free State, Gauteng and Limpopo were among the lowest scorers on the other three services.

Families South Africa (FAMSA) presented and made submissions in many of the provinces. An Eastern Cape participant commented that the organisation had previously been known primarily for its marital counselling, but that this was no longer the case. FAMSA's submission suggested a very wide range of activities, including, for example, trauma debriefing and home-based care for HIV and AIDS, services that one might not have expected to find with the families service area.

More generally, this area seems to be one of the least neatly defined, with many overlaps with other service areas. This was seen, for example, in the focus groups where North West practitioners reported on community mobilisation to encourage women to register cooperatives when asked to rate the families services. Gauteng discussed the lack of collaboration and a coherent approach between the SAPS and the Departments of Health, Justice and DSD in respect of domestic violence under this programme area. Promotion of families can be seen as central to developmental social welfare if the term “family” is understood to refer to a range of different family forms, without privileging one or other form. However, the service area has traditionally been a small one, as evidenced by very small budget allocations. There were some signs of increased interest in the area. The finalisation of the policy on families was named as an achievement several times during the Committee's engagements. As a more concrete indicator of increasing interest, North West reported that the number of funded NPOs providing family services had increased from three to ten over the last five years, with organisations funded in both urban and rural areas.

In the focus groups there were concerns around accessibility of services. In Free State service providers reported that churches provided services only to their members rather than to the broader community. In KwaZulu-Natal beneficiaries said that FAMSA fees were unaffordable for some people.

Many comments emphasised the importance of families. However, in Free State a potential conflict was noted between partnering with families to prevent the removal of children while also addressing concerns about the safety of family members.

Many NPOs reported on the various parenting programmes in which they were involved. There were also repeated comments on the need for parenting skills to be imparted to recipients of the child grants. Those offering these comments did not explain why poor parents might lack parenting skills more than wealthier ones, rather than lacking the financial means to provide good parenting.

7.5.3 Budget analysis

In other service areas, the budget analysis in this report generally focuses on budget sub-programmes. This short sub-section focuses on a budget programme (children and families) with some of the subsequent analysis focusing on sub-programmes within the programme. The fuller analysis for this area of work is added in recognition of the fact that the allocations for children account for a large share of the DSD provincial budgets – a share that has grown since the Children’s Act of 2005 (as amended) came into operation. It was in recognition of its importance that the separate budget programme was introduced in 2014/15, rather than having a single sub-programme in the general welfare services budget programme.

Figure 21 shows the allocation per child for the children and families programme as a whole using both the total child population per province and poor children per province. The total child population is based on the 2014 mid-year estimates. The estimate for poor children is derived by applying the provincial rates for child poverty using the upper-bound poverty line reported for the Living Conditions Survey of 2008/09⁹⁵ to the 2014 mid-year estimates.

For the measure using all children, Northern Cape has the highest allocation per child, at R530 per year, and Eastern Cape and KwaZulu-Natal the lowest, at R205 – about two-fifths of the Northern Cape amount. For the measure using poor children, Gauteng has by far the highest amount, at R1 323 per annum, while Eastern Cape again has the lowest, at R264. The Mpumalanga amount is only one-fifth of the Gauteng amount. KwaZulu-Natal, Limpopo and Mpumalanga also have very small amounts per poor child in the population.

⁹⁵ Statistics South Africa. 2013. Men, Women and Children: Findings of the Living Conditions Survey, 2009/2009. Pretoria: 42.

7.6 Children

The White Paper identified children in a range of different challenging categories and situations. It stated that about 60% of children of preschool age lived in “impoverished circumstances”, with African children more likely to be in this situation. Only one-tenth of preschool children were in ECD programmes at the time, with younger children and children with disabilities least likely to be benefiting. Further, the quality of available services were generally inadequate.

The White Paper recorded 29 000 children in residential care and 39 024 in foster care. Foster care was provided at a cost of R130 million per annum, but the child grant system was highly inequitable, benefiting mainly coloured and white children. While numbers on adoptions were not available, the option was seen as under-utilised and the services provided as problematic.

The White Paper noted the discrimination experienced by children with disabilities in respect of education, recreation and public transport. It also noted lack of support facilities, such as day care, to enable families with severely disabled children to keep them “in the home environment” as long as possible.

The White Paper reported that in 1994 the SAPS Child Protection Unit dealt with 22 911 cases of child abuse, reflecting a 36% increase over the number for the previous year. These numbers were known to be an under-count of actual cases of child abuse due to under-reporting as well as poor record-keeping. There was no policy, protocol or strategy to deal with child abuse and neglect.

The White Paper cited an estimate of 10 000 street children in South Africa in 1993, with a widespread belief that the number had increased “substantially” since that time. It suggested that although employment of children under 15 years of age was

Figure 21: Children and families allocation per child by province, 2015/16



prohibited, children as young as five years were “exploited”. It noted, however, that there had been no systematic research on the problem.

The White Paper reported that substance abuse was increasing among school children, and especially boys, and was also common among street children. It also noted the social, economic and emotional harm suffered by children with parents who abuse substances. It identified children of divorced and divorcing parents as needing special attention.

The White Paper found that of the 2,3 million South Africans estimated to be nutritionally vulnerable, 36% were children aged 6 months to 5 years, 56% were children aged 6 to 12 years and 8,3% were pregnant or lactating women.

7.6.1 Updating the White Paper

Most, but not all, of the challenging categories and situations of children identified in the White Paper are addressed in the Children’s Act of 2005, as amended. However, many children remain vulnerable and in need of assistance. As just one indicator, Statistics South Africa’s Living Conditions Survey of 2008/09⁹⁶ found a poverty rate of 64% among children, higher than the poverty rate for the population as a whole.

In terms of preschool children, Census 2011⁹⁷ found that the 6,7 million children under six years of age again accounted for 13% of the population, the same share as in 1997. About 39% of these children lived in “traditional” areas, i.e. former homelands. African children accounted for 85% of the total, coloured children for 8%, Indian for 2% and white for 5%.

Analysis of data from the GHS of 2014 suggests that at least 50% of children under five years of age do not attend any type of ECD, including services offered by day-mothers or “gogos”. About a third (32%) of the age group were reported to be in Grade R, an ECD centre, crèche or preschool. Non-attendance decreased from 71% among those under one years of age, to 25% under those four years of age. Among five-year olds, 85% were attending some sort of educational institution. These statistics reveal a noticeable increase on the situation reported by the White Paper. A national DSD presentation to the Committee reported that close on 1 million children were accessing ECD services by end 2012, of whom close on half were supported by government subsidies. The number of registered ECD centres had increased from 4 612 in 2004/05 to 19 971 by 2012.

There were, however, repeated comments in the Ministerial Committee’s district and provincial reviews about the failure of ECD centres⁹⁸ to accommodate children with disabilities. A national audit of ECD centres conducted in 2013/4 found multiple other weaknesses and challenges in the services offered, many of which related to lack of resources of various kinds.

⁹⁶ Statistics South Africa. 2013. Men, Women and Children: Findings of the Living Conditions Survey, 2009/2009. Pretoria: 42.

⁹⁷ Estimates calculated from Census 2011 10% sample provided by Statistics South Africa. The 2001 Census recorded a smaller percentage of children of this age, and the reason for the change in trend is not known.

⁹⁸ Economic Policy Research Institute. 2014. Audit of Early Childhood Development Centres: National Report.

According to the unaudited provincial DSD performance indicators for 2014/15 for eight of the nine provinces⁹⁹, there were approximately 12 577 children in funded child and youth care centres (CYCCs) in the 2014/15 financial year. There are some unregistered and thus unfunded centres, but the Children's Act requires that provincial DSD fund all registered CYCCs. Comparison with the statistics in the White Paper suggests that the use of residential care for children has decreased since 1993, despite an increase in the population. One could argue that further support for a decrease is found in the audit of registered centres conducted in 2010, which found that funded children's homes, shelters and places of safety were registered to accommodate a combined total of just under 17 500 children, but at the time of the survey accommodated only about 82% of this number¹⁰⁰. However a subsequent survey of unregistered and unfunded CYCCs found further children in these institutions, including children who had been referred by the courts.¹⁰¹

By end June 2014 there were 537 150 children in foster care and receiving foster child grants (channelled through 378 718 foster parents). Here there is a substantial increase in the number of children over time. As expected, this is reflected in a much increased budget allocation – R5,5 billion for 2015/16.¹⁰² There is no longer the previous racial bias in terms of foster child grants. Analysis of data from the General Household Survey of 2014 suggests that 93% of child beneficiaries are African, 55%, 2% white and less than 1% Indian. These patterns reflect a combination of the population distribution and relative rates of orphaning.

While government policy aims to increase the number of adoptions, the number of adoptions has fallen sharply over the past ten years, from 2 840 in 2004 to 1 448 in 2014, according to one source.¹⁰³ DSD's annual report for 2014/15 states that 1 651 adoptions were registered during the reporting period, of which 1 402 were national adoptions¹⁰⁴. In 2007, when there were about 2 500 local and 200 inter-country adoptions finalised each year, DSD estimated that there were approximately 20 000 adopted children in the country.¹⁰⁵ At this point, there are probably fewer.

Children with disabilities continue to be denied opportunities. For example, analysis of attendance at an educational institution (such as a school) for children aged 6-17 years by degree of disability as recorded in Census 2011 shows patterns for children with "some difficulty" are very similar to those for children with no difficulties. However, attendance drops – from 93% to 91% and then 83% - as the degree of disability increases. Stimulation centres have been set up in all provinces to cater for pre-school age children with disabilities. However, there are insufficient such centres for cater for the needs, and the centres do not have all the resources – including staff who can provide therapeutic services – required to serve the needs of the children.

⁹⁹ 2013/14 data used for Northern Cape because of the absence of an estimate for 2014/15

¹⁰⁰ Community Agency for Social Enquiry. 2010.

¹⁰¹ Community Agency for Social Enquiry. 2012. Unregistered Child and Youth Care Centres and Temporary Safe Care. Department of Social Development & UNICEF: Pretoria.

¹⁰² National Treasury. 2015. Estimates of National Expenditure 2015. Baseline Study on Registered Child and Youth Care Centres. Prepared for United Nations Children's Fund and national Department for Social Development. Community Agency for Social Enquiry: Johannesburg.

¹⁰³ Wolfson R. 7 September 2015. "The great power struggle over adoptions", Daily Maverick. http://www.dailymaverick.co.za/article/2015-09-06-op-ed-the-great-power-struggle-over-doption/?utm_source=Daily+Maverick+Mailer&utm_medium=email&utm_campaign=First+Thing+with+John+stuart%3A+Tuesday%2C+2+September+2014&utm_term=http%3A%2F%2Fwww.dailymaverick.co.za%2Farticle%2F2015-09-06-op-ed-the-great-power-struggle-over-adoption%2F#.Ve19bzigVjIU

¹⁰⁴ Department of Social Development. 2014. Annual Report 2014/15. Pretoria

¹⁰⁵ Department of Social Development. 2007. Alternative Care Strategy

The real extent of child abuse and neglect remains unknown as a result of under-reporting and uncoordinated record-keeping. Attempts to set up a central register of offenders have not gone as smoothly as hoped. Services have been extended to previously under- and unserved areas over the period since the White Paper was issued. This has happened, among others, through existing organisations in urban areas extending their services to outlying areas. However, rural areas continue to have fewer services and resources than more urban areas, and allocations for service provision generally do not cover the extra costs involved in providing services in rural areas. Informal settlements in urban areas are also under-served. The Children's Act sets out a comprehensive and progressive framework in respect of child protection, including dealing with child abuse and neglect. Budgets and human resources are, however, insufficient to implement the Act and the related regulations.

The number of children "on" and "of" the street is unknown, but is certainly much more than 10 000 nationally. One challenge is that, by definition, children "of the street" are not captured in standard household surveys, and are also difficult to capture in a census. The Children's Act provides that shelters for street children constitute a form of CYCCe. The shelters should thus be registered and receive funding similar to that of other child and youth care centres. However, the way in which shelters operate does not fit well with the payment framework, which is based on the number of children accommodated, as street children tend to move in and out of the shelter, especially in the first period after they make contact with the shelter. Further, per capita funding of street shelters by provinces is generally lower than that for other child and youth care centres.

There was some concerted action around street children and adults around the time of the World Cup in 2010. The action was, however, not sustained. Some municipalities have developed their own strategies in respect of street children and adults. These strategies are not uniform, and do not always encompass a human rights approach.

Subsequent to the White Paper, the International Labour Organisation (ILO) supported a substantial multi-year programme in South Africa in respect of child work and labour entitled Towards the Elimination of Child Labour. The programme supported a range of research studies. Statistics South Africa now includes questions about child work and labour in its Quarterly Labour Force Survey on a periodic basis. These surveys suggest that a relatively small number of children are working as employees or in self-employment in a way that contravenes labour legislation. This is not all that surprising given both high rates of enrolment in education and high levels of unemployment among adults. There are, however, worrying numbers of children involved in types of "non-employment" work that are considered child labour according to international definitions. In particular, the number of children involved in commercial exploitation of children is a concern.

Motivated by the ILO-supported project, South Africa has tightened up the legislation governing child work and labour. There is, for example, a ministerial determination that governs work done by children in the performing arts. There are also special regulations in respect of children in employment to protect their health and safety.

The 2008 South African youth risk behaviour survey among learners in Grades 8 to 11 found that 13% reported that they had at some point used cannabis, 7% mandrax,

and 7% crystal methamphetamine (“tik”).¹⁰⁶ Substance abuse is discussed in further detail below.

With more than half of all babies in South Africa born outside of marriage, divorce might constitute less of a problem than in many other countries. Instead, the concern should perhaps be focused more generally on the possible negative impact on children of their parents having unstable and/or acrimonious relationships. Attention to this issue must take into account the extent to which relationships break up on account of domestic violence. In such cases, parents remaining in a relationship may be more harmful to children than a break up. The complexities relating to this issue highlight the importance of in each case considering the best interests of the particular child.

In terms of children affected by divorce, the services of the Family Advocate’s Office have been extended substantially since the White Paper was issued. In particular, while the Family Advocate’s services were previously available only for the relatively small number of divorces handled by the High Court, the services are now available for all divorces in magistrates’ courts. The increased burden on the Family Advocate has resulted in delays in finalising matters, with resultant negative impact on children and their families.

The GHS of 2014 found that, of the 8,6 million households with children under 18 years, 1% had at least one child who always was hungry over the past 12 months, 3% often had a child in this situation, 8% sometimes did, and 7% seldom did. The percentage of the households that never had a hunger child ranged from 78% in commercial farming areas to 84% in urban formal areas.

7.6.2 Other findings of the Ministerial Committee

The quantitative tool had more services listed for child development, care and protection than for any other service area. This area of work has also traditionally attracted more government funding than many other areas, and its share has increased since the coming into effect of the Children’s Act of 2005 (as amended in 2007). The services listed on the quantitative tool were ECD, drop-in centres, home-based care, aftercare centres, play parks, Isibindi programme, places of safety, foster care services, and CYCCs.

ECD was a clear “winner”, with an overall mean rating of 4,0 and top rating among each of the three stakeholder groups. Foster care services were rated second overall, and home-based care third. Practitioners rated foster care higher than home-based care, while provider ratings went in the opposite direction.

Play parks were rated lowest overall in terms of availability, and were also rated lowest by providers and practitioners. Beneficiaries, in contrast, rated the Isibindi programme as less available than play parks. (In reality, play parks often form part of Isibindi projects.) Provincially, Gauteng and Limpopo tended to be amongst the higher scorers on children’s services. There was, however, substantial variation across the services. At the opposite end of the scale, Eastern Cape and North West were amongst the lowest scorers on most children’s services.

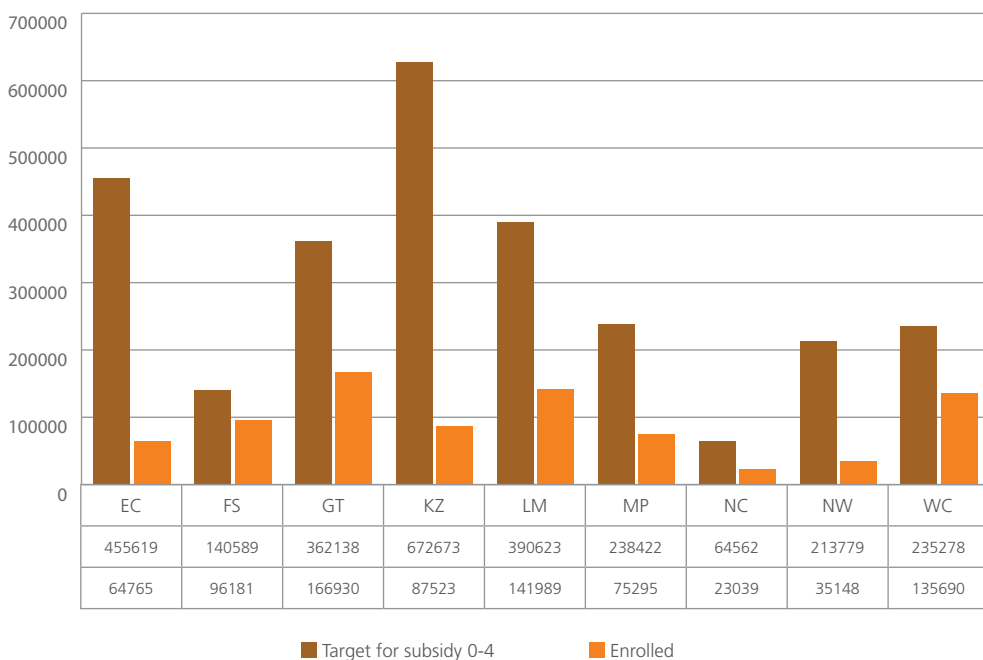
¹⁰⁶ Cited in Central Drug Authority, 2013, The National Drug Master Plan 2013-2017, Department of Social Development, Pretoria

During the Committee’s engagements, ECD regularly appeared in submissions, presentations and discussions as an area of significant achievement since 1997. The number of centres has increased, as has the number funded, the amount of funding, and number of children reached. There were, however, still many concerns. Participants noted, among others, that the reach was still inadequate, especially in rural areas; that the per-child-per-day amount subsidy was inadequate; that infrastructure was highly inadequate; that municipal regulations varied across the country and were often unhelpful; that municipalities did not provide or facilitate acquisition of premises; and that ECD centres generally did not accommodate children with disabilities. Across provinces there were concerns about the “mushrooming” of unregistered ECD centres, and the fact that most of these centres could (and/or should) not be registered because they did not meet the minimum norms and standards. Gauteng suggested that seed funding should be provided to allow ECDs to move from conditional to full registration.

Figure 22 compares capacity as recorded in DSD’s infrastructure database with need for this service. For the need indicator, GHS 2014 data are used, with the number representing 100% of poor 3-4 year olds, 75% of 2 year olds, 50% of 1 year olds, and 25% of poor children under one year of age. The capacity numbers are over-optimistic as they included unregistered and unfunded centres and are thus not all necessarily targeted at poor children. Nevertheless, there are shortfalls in all provinces, with only Western Cape having capacity that is even half of need. Eastern Cape and KwaZulu-Natal perform especially badly on this measure.

The National Development Agency (NDA) has had ECD as one of its three focus areas over recent years. Across all provinces the NDA reported assistance to ECD centres in respect of infrastructure (although in each case to a relatively small number of centres), and capacity building and training of various kinds. In some cases equipment was also provided. The NDA also brings together two of its three focus areas – ECD and nutrition – by supporting the establishment of food gardens at ECD centres, as well as in some

Figure 22: Comparison of need and capacity: Early childhood development centres



cases facilitating provision of food to ECD centres by cooperatives and other food-growing projects. However, the NDA official in the Northern Cape acknowledged that “it is certainly not feasible to expect a small vegetable garden to feed the children at an average ECD centre on a daily basis. The key objective is rather to promote good nutrition among the children and in the community to encourage a culture of producing for self-consumption.”

Across some provincial NDA offices, provincial governments and NPOs there was reported to be some exploration of different ways of providing non-centre-based ECD. However, the extent of this was much less than for centre-based ECD.

There was very little mention of aftercare centres (which would provide care for school-going age children after school hours) as such in respect of children. Instead most comments on aftercare related to the absence of such services for beneficiaries of other services, such as treatment for substance abuse. In Limpopo beneficiaries in both districts sampled noted the need for aftercare for children.

There was relatively frequent mention of drop-in centres, and often relatively substantial numbers of these being supported by provincial DSD, although far fewer than ECD centres. This service seems to have expanded substantially after being included in the Children’s Act. The centres are intended to cater for the emotional and physical needs of children who are vulnerable. At least some of the drop-in centres could serve as a form of aftercare where children can spend time after school and – depending on the particular centre – benefit from various services and facilities. However, the discussion of drop-in centres tended to focus on services to OVC, usually understood as those made vulnerable by HIV and AIDS. Mpumalanga reported that existing multi-purpose centres had been “transformed and expanded” into drop-in centres for OVC.

As noted above, drop-in centres can be used for channelling other benefits, such as school uniforms. In a district in Eastern Cape service providers reported that the Jerusalem Ministry provided uniforms to school-going children. They did not say if these were subsidised in any way by DSD, or if they were targeted at HIV-affected children, but said that some of the children did not benefit from grants because their caregivers did not have enough money to access service points.

Home-based care was seldom named as such in respect of children. However, some of the OVC initiatives referred to above under HIV and AIDS include home visits and care. These were proudly claimed by NPOs and some provincial governments as examples of developmental social welfare. Play parks were seldom mentioned apart from in response to the explicit prompt in the quantitative tool. Implementation and expansion of the Isibindi programme was claimed by provincial governments, by NPOs acting as implementing partners, as well as in some of the focus groups. However, there was no knowledge of the Isibindi programme in some focus groups.

Childline presented in several provinces, and raised the issue of child abuse, as did some other organisations. Childline’s raising the issue is not surprising as the organisation was established especially to deal with child abuse. However, Childline’s presentations in the various provinces showed an organisation that – somewhat like FAMSA – had branched out into other areas of activity, perhaps partly in search of funds.

Much of the discussion of abuse focused on deficits in the process and, in particular, the difficulty of getting swift action from social workers (especially after hours) and the criminal justice system. Childline went as far as to say that the protocol was “not implementable”. Others bemoaned the lack of follow up by social workers once abused children had been placed in alternative care.

There were many comments on the foster care system. These included references across provinces to substantial backlogs, despite various initiatives to address these; long delays in the process; the fact that foster care work was consuming much of the available social worker capacity leaving little time for anything else; and new social workers not gaining rounded experience because of having to focus all their attention on foster care. These problems were reported across the nine provinces, despite national DSD reporting that in 2011 a project plan for foster care management has been developed to address the backlog of expired foster care orders and to establish systemic mechanisms to sustain and manage the programme effectively.

Concerns were raised about the difficulties in obtaining birth certificates and identity documents from the Department of Home Affairs. These documents are necessary in order to gain access to grants. The difficulties were said to be exacerbated when children were orphaned (and the needed supporting documents were sometimes not available) as well as where children and/or parents were not South African. Both NPOs and beneficiaries in several provinces raised concerns about officials losing foster care files. The above issues relate to deficiencies in the system. There were also some comments that suggested that grants were too easily available. Thus some participants observed that some caregivers saw the foster grant as an “income opportunity to care for the family” and a “source of income”. Others suggested that the caregivers should be directed to “development projects”, presumably in the hope that they would then not claim or need the grant.

The emphasis in discussions on grants on avoiding dependency and promoting self-sufficiency was less evident in the children service area than in most others. This is to be expected as children should not be expected to support themselves. However, even here there were some signs of the tendency to see promotion of self-sufficiency as the answer to most problems. For example, KwaZulu-Natal service providers referred to the Sinamandla self-help saving scheme run by the Thandanani Children Foundation, which encourages savings as the basis for accumulation of business capital, as a great community development scheme. Child Welfare reported that their Girl and Boy child project for 13-17 year olds included entrepreneurship.

CYCC is a broad category, ranging from what were previously known as children’s homes to secure care centres, schools of industry and reform schools. With the latter two, there were several provinces (Free State, North West, perhaps others) where the institutions were noted as not yet having been transferred from the Department of Education to DSD, or, as in Eastern Cape, where challenges arising from the transfer had still not been dealt with. With all three forms of CYCC concerns were raised that such facilities did not exist in a particular district or even province, requiring that children be sent far away from their homes.

For CYCCs more generally there were complaints about lack of provision for children with disabilities. However, in Limpopo participants noted that children with disabilities were sometimes abandoned by their caregivers once placed in CYCCs. There were also many concerns about children with behavioural and emotional problems, both in respect of the needs of these children in terms of care, support and schooling, and in terms of the safety and wellbeing of other children if these children were accommodated within CYCCs.

Many participants were concerned about what happened to young people when they reached the age of 18 and could no longer be accommodated in the CYCCs. Some participants commented on the need for further transformation of CYCCs in order to be in line with the requirements of the Children's Act, and noted the April 2015 deadline for registration. From the side of the CYCCs, there were concerns about the limited funding available, and in particular lack of coverage of costs involved in adopting a more developmental approach inside the institution, in the broader community, and in reunification of children with families.

Services and initiatives in respect of street children were discussed in both NPO and government presentations in the Western Cape, and also noted by Mpumalanga DSD. The latter reported that although they had fewer street children than some other areas, the province had developed programmes through which children could receive food, have laundry done, and benefit from life skills, homework assistance, and holiday programmes. Northern Cape participants noted that there were insufficient facilities for street children. Eastern Cape service providers noted that the White Paper was silent on the issue of street children.

The term place of safety encompasses both institutions and places where individual children can be placed in an emergency. In terms of institutions, there were similar concerns as with other CYCCs in terms of catering for children with disabilities. KwaZulu-Natal reported that they had five places of safety (four of which were in Durban) and although the facilities were not allowed to turn away children with disabilities, there was staff resistance to dealing with such children, especially when they were older. Similar challenges were reported in finding individual places of safety for children with disabilities, special needs and/or behavioural problems. In Mpumalanga difficulties were reported in obtaining temporary safe care fees. In Eastern Cape Dalindyebo Hospital was reported to have a partnership with Protea Hotel whereby the hotel housed people deserted by their families until appropriate housing was identified for them or there was an opening at the Erica Place of Safety. This reference might have referred to a broader age group rather than children in particular.

Adoption was not listed in the quantitative tool but was raised as an issue in several provinces. Some commentators noted that potential adoptive parents were too poor to be accepted. This is a worrying observation as economic means is not meant to be a deciding factor in approving prospective adoptive parents. In Eastern Cape beneficiaries reported that people with disabilities were not considered appropriate adoptive parents. The adoption process was noted to be costly especially when done through a private agency. The process was also reported to be lengthy, with the duration lengthened by the time needed for a check against the child protection register. The deficiencies of the child protection register were also noted in other contexts.

7.6.3 Budget analysis

Figure 23 presents similar per child analysis as shown above for the children and families programme as a whole, but this time for the child care and protection sub-programme. Gauteng remains by far the best performer when analysis is restricted to poor children. Following quite far behind are Western Cape and Northern Cape. Gauteng is still the best performer when all children are considered rather than only poor children, but Western Cape drops to third lowest. Limpopo is by far the worst performer, with only R3 allocated per child whether calculating for all children or only for poor children.

Figure 24 shows the per capita allocations for ECD and partial care derived using the 2014 mid-year population estimates for children aged 0-4 years. Two measures are shown for each province – one for all children of this age, and one for the number estimated to be poor using the results of the Living Conditions Survey. The poor child measure is probably the more appropriate one as DSD’s per-child-per-day centre subsidy which accounts for a large proportion of this sub-programme’s funds is meant to be targeted at centres serving poor children.

If all children are considered, Free State leads on this measure, with North West, Eastern Cape and KwaZulu-Natal as the worst performers. When only poor children are considered, Western Cape is the top performer, with Free State second and Gauteng a close third. The same three provinces are the worst performers.

ECD is not covered in the final KPMG costing for the NAWONGO case as Free State DSD suggested ring-fencing (and prioritising) this category of NPO funding rather than including it in the prioritisation exercise covering all other welfare services. Table 36 therefore uses the standard R15 per-child-per-day subsidy and the norm of 264 funded days per year (or R330 per month) to compare with the actual allocations. In practice, some provinces may deviate from what is meant to be the national norm in terms of

Figure 23: Child care and protection allocation per child by province, 2015/16

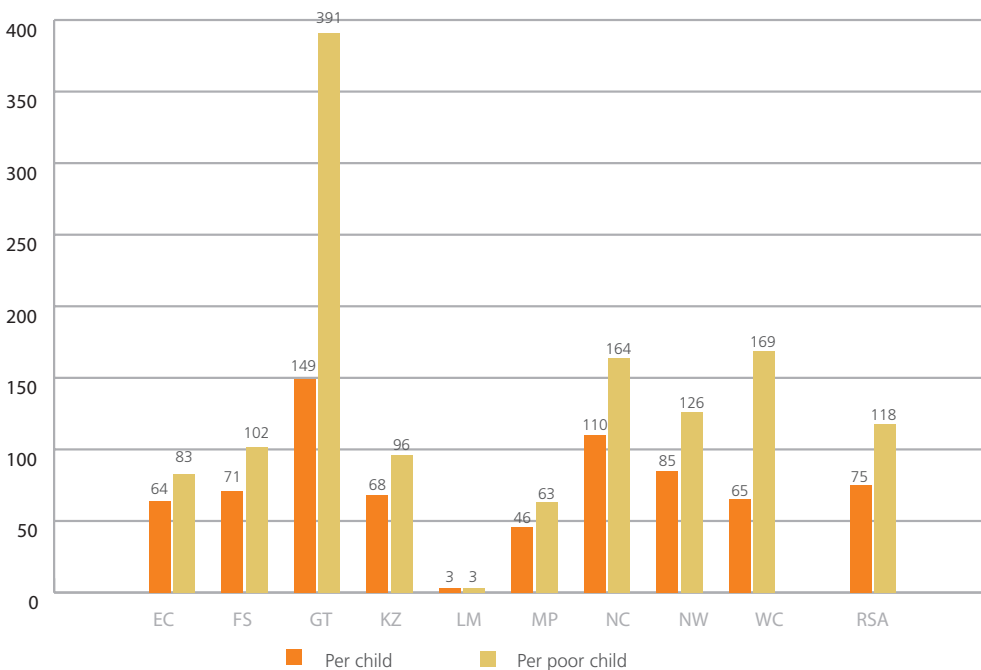
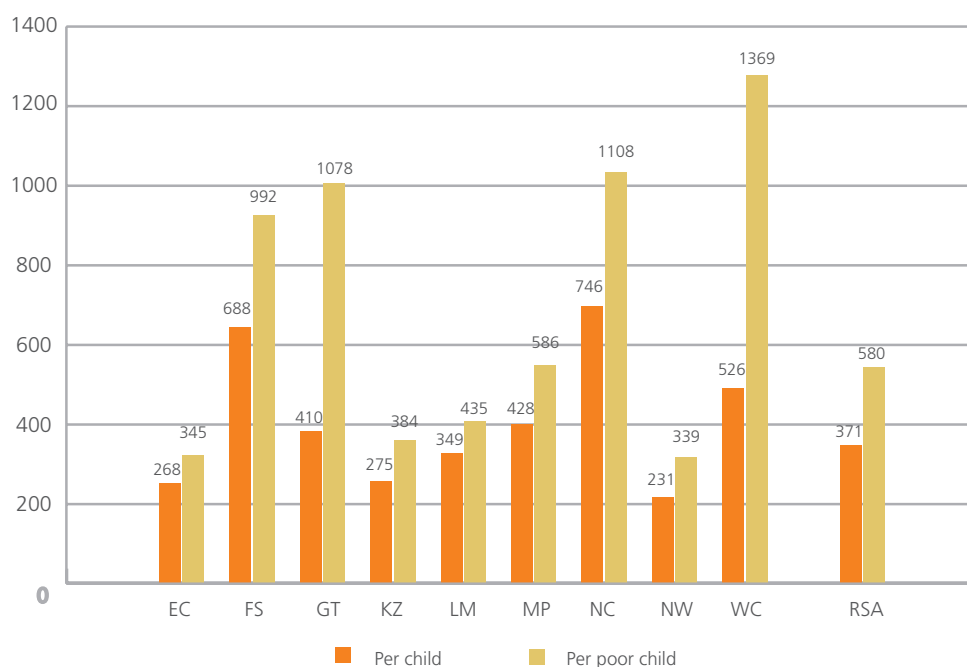


Figure 24: ECD and partial care allocation per child aged 0-4 years by province, 2015/16



amount and days. Already in 2014/15, KwaZulu-Natal was paying R16 per child per day, and several provinces were not providing for the full 264 days.

The standard performance indicator reported to National Treasury relates to children in registered ECD centres rather than to children who are in funded centres. All funded centres must be registered, but not all registered centres are funded. The standard indicator is therefore not an ideal measure for our purposes, but is the best available. The fact that it is an over-count of funded children is to some extent balanced by the fact that the budget is also meant to provide for other partial care. The total reported children for registered partial care other than ECD in 2014/15 was 81 711, equivalent to 14% of the 558 251 reported for registered ECD centres. The number reported for other partial care is much less than that for ECD centres in all provinces except North West, which records 77 144 children for other partial care against 16 486 for ECD centres. The reason for the very different picture in North West is not clear.

Table 36 shows subsidy exceeding the budget for three provinces (Free State, Limpopo and KwaZulu-Natal). The needed subsidy also exceeds budget for the country as a whole despite no subsidy amount being included for Western Cape because there is no performance indicator number for this province. For Northern Cape the needed subsidy amount is only 26% of the budget. This is at least in part explained by the reported number of beneficiaries amounting to only 6% of the poor children aged 0-4 in the province.

Table 36: Needed funds compared with 2015/6 budget allocations for ECD using 2015 performance indicators (R'000)

	Subsidy p.a.	Budget	Subsidy as % of budget	Children in registered centres	As % poor 0-4
EC	179 546	228 357	79%	45 340	7%
FS	386 607	186 702	207%	97 628	52%
GT	330 319	435 782	76%	83 414	21%
KZ	430 155	352 281	122%	108 625	12%
LM	599 584	237 000	253%	151 410	28%
MP	198 800	208 599	95%	50 202	14%
NC	20 378	79 832	26%	5 146	7%
NW	65 285	94 150	69%	16 486	6%
WC	0	298 072	0%	0	0%
	2 210 674	2 120 775	104%	558 251	15%

Child and youth care centres constitute a separate budget sub-programme within the children and families programme. Table 37 presents the cost comparison for children placed in funded children's homes, which are the most common type of CYCC. It implicitly assumes that all CYCCs are NPO-run children's homes whereas, in reality, some of the centres – including the reform schools and schools of industry – are government-run at a much higher per beneficiary cost. Some, with secure care programmes, may be outsourced to for-profit companies.

The comparison uses the adjusted KPMG estimate of R5 665,60 per child per month. For three provinces the needed funds are more than the total allocated budget for this sub-programme. In KwaZulu-Natal and Mpumalanga the needed amount is more than three times the budget. At the other end of the scale, the very low percentage of the budget needed in Free State is at first surprising. The likely explanation is that this province interpreted the indicator – phrased as “number of children in need of care and protection placed in child and youth care centres” – very literally (and perhaps correctly!) as the number of children newly placed during the year. It seems that the Western Cape number of beneficiary is also probably incorrect as for 2013/14 the province reported 724 children in children's homes.

Table 37: KPMG costs compared with 2015/16 budget allocations for child and youth care centres using 2015 performance indicators (R'000)

	Beneficiaries	Subsidy p.a.	Budget	Subsidy as % of budget
EC	1 305	88 723	95 215	93%
FS	70	4 759	66 552	7%
GT	3 900	265 150	496 547	53%
KZ	3 999	271 881	116 588	233%
LM	949	64 520	37 329	173%
MP	940	63 908	25 112	254%
NC	0	0	32 473	0%
NW	613	41 676	123 979	34%
WC	277	18 832	113 091	17%

Allocations for the Isibindi programme should be recorded in the Community-based services for children budget sub-programme, as should allocations for drop-in centres. Both these initiatives were initially conceived as interventions in respect of OVC. Per capita allocations per maternal orphans can therefore serve as a crude indicator of relative adequacy of provision across provinces.

Figure 25 presents this comparison, using maternal orphan estimates for children under 18 years derived from the GHS of 2014. The percentage of children recorded as having a deceased biological mother ranges from 2% in Western Cape to 8% in Eastern Cape and KwaZulu-Natal. The country-wide average is 6%.¹⁰⁷ (Only children where the mother is reported definitely deceased are considered orphans, although others where the status of the mother is unknown are effectively maternal orphans. These children account for just under half a percent of all children.)

Figure 25 shows that provision in Gauteng dwarfs provision in all other provinces. Gauteng's per capita allocation is more than 2,5 times the size of that of Limpopo, which is the next best performer on this measure. Gauteng's per capita allocation is 17 times that of Free State, the worst performer.

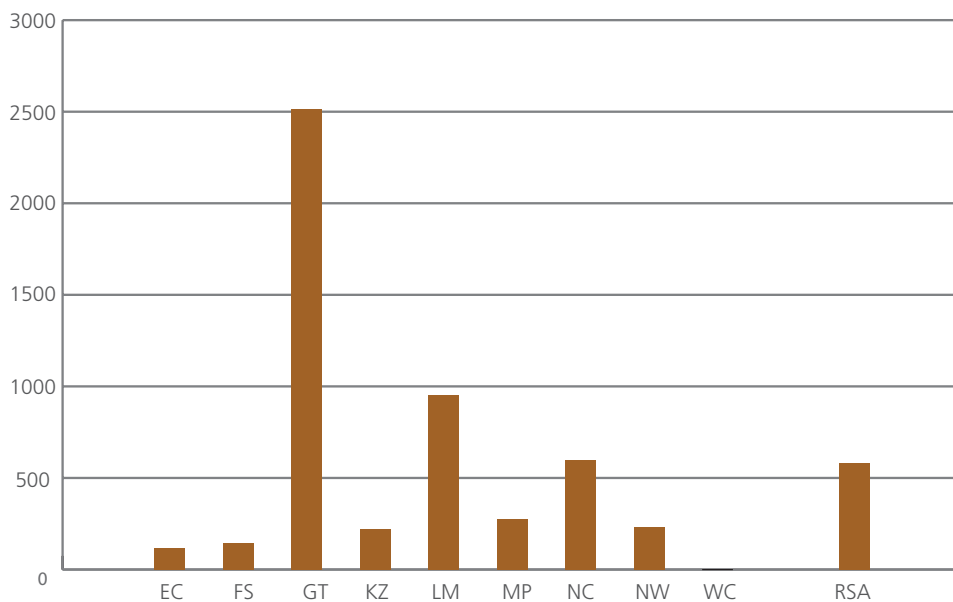
Table 38 shows the number of OVC recorded as receiving psychosocial support services in the 2014/15 financial year by province. The zeroes recorded for North West and Western Cape are not accurate as all provinces have rolled out the Isibindi programme. The Eastern Cape indicator also looks smaller than one would expect.

Table 38: Number of orphans and vulnerable children receiving psychosocial support services

EC	FS	GT	KZ	LM	MP	NC	NW	WC	SA
16 010	2 320	47 799	34 736	50 015	34 979	7 368	0	0	193 277

¹⁰⁷ Only children where the mother is reported definitely deceased are considered orphans, although others where the status of the mother is unknown are effectively maternal orphans. These children account for just under half a percent of all children.

Figure 25: Per capita allocation for community-based care services for maternal orphans, 2015/16



7.6.4 Additional evidence

7.6.4.1 ECD and partial care

A comparison of the number of subsidised crèches in 1996/97 with the number of subsidised ECD centres recorded in the national audit conducted in 2013/14¹⁰⁸ shows – as expected – a substantial increase for most provinces. The relative increase is particularly large for Gauteng and Free State. However, for both KwaZulu-Natal and Western Cape the number decreases. Nationally, the number increases from 3 897 to 7 116, an increase of 83%.

7.6.4.2 Child and youth care centres

For children's homes, there is a 26% increase overall, from 169 in 1996/97 to the 213 homes registered at the time of an audit in 2010.¹⁰⁹ Free State shows by far the biggest increase. Western Cape again shows a decrease, as does North West. The latter decreases off what is already a very low base. These numbers do not include places of safety, where the number seems to have moved from 37 with total capacity of 2 960 in 1996/97 (as reported in the Department of Welfare's statistical report) to 41 with total capacity of 2 445 when the Community of Social Enquiry was commissioned to conduct an audit of CYCCs in 2009/10. However, the audit found that in some cases children's home were filling the gap caused by the shortage of places of safety. A survey conducted in 2012 found that there were more than 100 further institutions that were effectively CYCCs although not registered as such. The unregistered institutions surveyed were accommodating more than 2 000 children at the time the survey was done.¹¹⁰

The Children's Act uses the term CYCC to cover all residential facilities for children.
¹⁰⁸ Economic Policy Research Institute. 2014. Audit of Early Childhood Development Centres. National Report. Department of Social Development: Pretoria.

¹⁰⁹ Community Agency for Social Enquiry. 2010. Baseline Study on Registered Child and Youth Care Centres. Department of Social Development & UNICEF: Pretoria.

¹¹⁰ Community Agency for Social Enquiry. 2012. Unregistered Child and Youth Care Centres and Temporary Safe Care. Department of Social Development & UNICEF: Pretoria.

The Minister and the MECs are required by section 192 to have a strategy to ensure provision of CYCCs. These strategies have not to date been published.

Secure care is a programme rather than a category of child and youth care centre although the term “secure care centre” is often heard. The CYCCs that provide secure care may receive children from the children’s court and from the child justice court. However, as the Ottery judgment described below shows, the children referred by the children’s court should not be mixed in the same facility as children referred by the child justice court.

The full list of programmes that may be offered in CYCCs are specified in section 191(2). The relevant ones for secure care are:

- (h) the reception, development and secure care of children awaiting trial and sentence
- (i) the reception, development and secure care of children with behavioural, psychological and emotional difficulties
- (j) the reception, development and secure care of children in terms of an order-
 - (i) under section 29 or Chapter 10 of the Child Justice Act
 - (ii) in terms of section 156(1)(i) placing a child in a child and youth care centre which provides a secure care programme
 - (iii) in terms of section 171 transferring a child in alternative care.

The secure care programme caters for children who have been referred either by a children’s court (under the Children’s Act) or by a child justice court. In the past, the children referred by the children’s court children would have been sent to the old school of industries, which the Children’s Act covers in subsection (i) referring to behavioural, emotional, psychological difficulties). The children who are referred under the Child Justice Act are either awaiting trial or sentence, or have already been sentenced i.e. those who would have been sent to the old reform schools.

Reform schools and schools of industry previously fell under the provincial Departments of Education. The Children’s Act required that both categories be transferred to provincial DSD by 31 March 2012 at the latest. However, it is only Eastern Cape and Mpumalanga DOE that have officially handed over their reform schools. A few schools of industry have also been transferred, but others have instead been converted into special schools and kept under DOE, while yet others still await transferral.

As discussed below, in Western Cape the government approach resulted in a court challenge for which the appeal is still ongoing. The Department of Basic Education is reportedly reluctant to hand over the facilities as this would mean de-registering them as schools, with resistance for the affected educators and principals.

National DSD has separate staff (Child Justice and Probation Services) responsible for CYCCs providing secure care for children in trouble with the law. The department has developed blueprint minimum norms and standard for secure care.¹¹¹ One of the requirements is that, where such centres were built before the norms were developed, a wing should be made available for sentenced children. Similarly centres that did not previously provide space for girls should now do so. DSD’s approach is that it should not

¹¹¹ Information from Steven Maselesele, national DSD.

build new centres before ensuring that the available spaces are fully used. This position is informed by the finding of an audit of reform schools and schools of industries several years ago which found that they were far from full. The provincial visits of the Ministerial Committee found this still to be the case.

Table 39 shows all facilities that can accommodate children awaiting trial. The capacity numbers reflect the total capacity of each facility rather than the capacity in respect of children awaiting trial. In most, if not all, cases other categories or children are also accommodated in these facilities.

Table 39: Facilities accommodating children awaiting trial ¹¹²

Province	Facility (location)	Capacity
Eastern Cape	Enkuselweni Secure Care Centre (Port Elizabeth)	60
	Erica Child and Youth Care Centre (Port Elizabeth)	50
	Protea Child Care Centre (Port Elizabeth)	5
	John X Merriman (East London)	50
	Sikhuselekile SC (Umthatha)	50
Free State	Bloemfontein Secure Care	50
	Matete Matches Secure Care Centre in Kroonstad	40
Gauteng	Mogale City Youth Centre	500
	Walter Sisulu CYCC (Noordgesig)	110
	Fr Smangalis Mkhathswa Protem Detention Centre (Cullinan)	120
KwaZulu-Natal	Excelsior Place of Safety (Pinetown)	74
	Valley View Place of Safety (Durban)	20
	Ocean View Place of Safety (Durban)	15
	Greenfields Place of Safety (Greytown)	10
	Pata Place of Safety (Pietermaritzburg)	35
	Newcastle Secure Care Centre	27
Limpopo	Polokwane Secure Care	120
	Malamulele Mavambe Secure Centre	70
Mpumalanga	Hendrina Child and Youth Care Centre (Hendrina)	60
Northern Cape	Molehe Mampe Secure Care Centre (Kimberley)	60
	Marcus Mbetha Sindisa SCC (Upington)	70
	Lerato Place of Safety in Kimberley	60
	Namaqua Secure Centre	51
North West	Reamogetswe Secure Care Centre (Britz)	35
	Mafikeng Secure Care	48
	Matlosana Secure Care	48
	Rustenburg	60
Western Cape	Bonnytoun House (Cape Town)	190
	Outeniequa House in George	77
	Horizon Youth Centre (Faure)	185
	Vredelust House (Elsies River)	30
	Lindelani Place of Safety (Stellenbosch)	60
	Clanwilliam Secure Care Centre	60

¹¹² Information provided by Steven Maselesele, national DSD.

Table 40 gives the count of current facilities as well as the number (and location) of additional facilities planned for the MTEF period in each province. It is not clear why extra facilities are planned when, as noted above, DSD reports that, given under-utilisation of existing facilities, construction of additional facilities is not appropriate.

*Table 40: Number of existing and planned facilities for children awaiting trial*¹¹³

Province	Current	Planned for MTEF
Eastern Cape	5	4 (East London, Qumbu, Grahamstown, Aliwal North)
Free State	2	1 (Qwaqwa)
Gauteng	3	
KwaZulu-Natal	6	7 (Ladysmith, Durban, Pietermaritzburg, KwaMbonambi, Harding, Vryheid, Jozini)
Limpopo	2	1 (Waterberg)
Mpumalanga	1	2 (Ekangala, Ehlanzeni)
Northern Cape	4	1 (De Aar)
North West	4	1 (Bophirima (Vryburg))
Western Cape	6	2 (Worcester, Beaufort West)

The Ottery case¹¹⁴ in Western Cape involved an application for “proper interpretation” of sections of the Children’s Act with respect to the Ottery Youth Centre and three other CYCCs. Three of the centres had been established as schools of industry and the third as a reform school. At the end of 2000 the Western Cape government closed all the schools of industry and reform schools in the province, but re-established these four as public schools. Despite this change in status, they continued with their previous functions until 2013 when the Western Cape “repurposed” the centres to be schools for children with special educational needs in terms of the Schools Act. The applicants in the court case argued that this could not be done until, at the least, strategies were in place in respect of the categories of children catered for by the CYCCs. The Western Cape government planned to transfer and refer these children to other CYCCs, most of which were high security facilities and geographically distant. The judgment found that it was inappropriate to place the children in need of care but not in trouble with the law together with criminal offenders in high security centres with “a cold and harsh atmosphere”.

The Western Cape government argued that they could not draw up a provincial strategy until a national strategy was in place. The national government, which was also a respondent in the case, did not submit the national strategy as ordered by the court by 31 July 2014. The judge found in favour of the applicants, but government is appealing this decision.

Moving beyond children in trouble with the law, national DSD does not have consolidated information on which CYCCs are registered to accommodate children referred by the courts for behavioural, psychological and emotional difficulties.

¹¹³ Information from Steven Maselesele, national DSD.

¹¹⁴ The Justice Alliance of South Africa and the Governing Body of Ottery Youth Care and Education Centre vs the Minister of Social Development Western Cape & Others. Case No: 20806/2013. Judgment delivered on 31 August 2015.

Western Cape¹¹⁵ has defined three “levels” of alternative care, reflecting differences in associated risk levels which, in turn, means a higher cost of service. The levels are as follows:

- Level 1 – community-based alternative care such as safety parents and foster care
- Level 2 - CYCCs for children in need of care and protection excluding secure care in terms of the Children’s Act
- Level 3 - CYCCs (secure care) for placement in secure care programme in terms of the Children’s Act : equivalent to old schools of industries
- Level 4 - CYCCs (secure care) for placements in terms of the Child Justice Act for those awaiting trial and sentenced youth.

Ottery is currently the only functional “school of industry” in the Western Cape. It will remain under the Department of Education pending the appeal by the Western Cape Departments of Social Development and Education against the Ottery judgement. DSD has meanwhile “taken the services in-house” in their own and “outsourced centres” through their multi-programme model which sees each CYCW providing a range of programmes. A list of CYCCs providing secure care programmes in the province includes a total of 41 facilities serving a total of 2 260 children as at 12 October 2015, as summarised in Table 41. However, this number reflects all children accommodated in these centres rather than only those with severe problems requiring secure care.

Table 41: Western Cape facilities registered to provide secure care

	Centres	Registered capacity	Actual capacity
Managed by DSD	4	423	416
Outsourced (for-profit)	2	255	256
Funded NPO:			
Cape Winelands	7	503	500
Eden Karoo	4	159	121
Metro East	5	248	200
Metro North	10	536	436
Metro South	7	294	251
West Coast	2	87	80
Total	41	2505	2260

Two provinces report plans to “insource” secure care facilities in their 2015 estimates of expenditure. Eastern Cape notes that it has decided to insource John X Merriman. Gauteng notes completion of the Soshanguve Secure Care Centre in March 2014. While Gauteng DSD initially planned to fund an NPO to manage the centre, it subsequently decided to run it in-house. It motivates this decision as follows: “The objective of the department is to build internal capacity to respond to Social Welfare services demands from communities and minimise reliance on NPOs to render services that are constitutionally mandated to the department.”

Finally, the Children’s Act classifies street children shelters as a form of CYCC. DSD’s 2013 status report on social welfare transformation recorded a total of 60 registered shelters, with a total of 4 462 resident children.

¹¹⁵ Information provided by Leana Goosen and Aubrey Mitas, Western Cape DSD.

7.6.4.3 Adoption

The number of adoptions has declined by 50% since 2004. One of the factors discouraging adoption, but not the only one, is that an adoptive parent can, at best, receive a child support grant for an adopted child, and the amount of the CSG is much less than the amount of the FCG (R330 as against R860 per month in mid-2015). DSD's alternative care policy of 2007 notes that subsidised adoption has been used successfully in some other countries for older children who are difficult to place on account of disability, medical problems, and chronic illness. However, DSD's 2013 status report on social welfare transformation for the Ministerial Committee notes that "subsidised adoptions was considered but not supported as it would change the whole nature of adoption and have many unintended consequences."

Adoption fees to professional service providers are regulated, and in 2015 the maximum fee for an adoption was R36 000.

The South African Council for Social Service Professions (SACSSP) is currently reviewing the regulations for adoptions. As for other specialties, the person must have a recognised qualification in social work, be registered with SACSSP as a social worker, and must have the necessary experience and/or qualifications. (In respect of the last, there is currently no honours or master qualifications in adoption available at South African universities.) As at end 2015, 75 social workers were registered with SACSSP as having a specialty in adoption. Of these 65 were in private practice, and 10 work for NPOs accredited for adoption work. No DSD employees had a specialty in adoption registered with SACSSP. Proposed amendments to the Children's Act include provisions that would allow social workers employed by DSD to do adoptions. This would have implications for specialisation and accreditation for compliance purposes.

Currently DSD is responsible for accrediting social workers. In 2011 there was a suggestion that SACSSP participate in the accreditation process, but this has not happened. SACSSP's Professional Conduct Division reportedly receives many complaints about the processing of applications for accreditation by DSD. Delays in accreditation result in delays in approval of adoptions.

Isolabantwana

Isolabantwana, meaning "Eye on the Children", is an approach to community-based services for OVCs initiated in 2003 by Cape Town Child Welfare and subsequently rolled out to other provinces by Child Welfare South Africa. "Natural helpers" in the community are identified and trained by the organisation as "eye volunteers" to be alert for abuse, family crises and to provide preventative and early intervention services for children and families through events, talks and workshops. Other training areas include counselling, statutory intervention, children's rights, parenting skills, domestic violence, HIV and AIDS, substance abuse and the role of stakeholders such as SAPS. "Eye volunteers" assist by removing abused, neglected and exploited children from danger and placing them in short-term emergency safe houses with place of safety parents until social workers can intervene. The Isolabantwana model aims to support social workers, promote community participation and to create a sustainable awareness and responsibility within the community to care for children.

7.6.4.4 Registers

The Child Care Act (no 74 of 1984) and subsequent Children's Act (no 38 of 2005) provided for a national child protection register. The register is divided into Parts A and B. Part A records details of the child and the abuse suffered. It is intended for monitoring, service delivery, planning and budgeting, and research purposes. Part B records details of abusers, and serves as a record of persons who are unsuitable to work with children. During 2014/15, 63 607 people were screened against the register.¹¹⁷

The Directorate Adoptions and International Social Services has developed and manages a Register on Adoptable Children and Prospective Adoptive Parents.¹¹⁸

7.7 Crime prevention and support

The White Paper pointed to crime as a "serious impediment to sustained harmonious development." It cited 1994 statistics which suggested an annual average of 7 177 serious offences per 100 000 of the population. It observed that there were far too few people, and in particular far too few probation officers, to provide the necessary services to offenders.

The White Paper reported that crime by children and youth was increasing, and pointed to the need for transformation of the system dealing with children at risk of getting into trouble with the law.

7.7.1 Updating the White Paper

In 2013/14, the South African Police Service reported a total of 3 448 serious crimes per 100 000 of the population if the 17 most serious crimes are aggregated, and a total of 4 101 if the 20 most serious crimes are considered.¹¹⁹ This suggests a reduction in the crime rate since 1994 if the numbers for both years are accurate and the term "serious crime" had the same meaning in both years. However, it is well known that many types of crime are under-reported, and the extent of under-reporting can in part reflect a perception on the part of victims that nothing will be done. Further, even if the statistics are accurate, with a total of 32 per 100 000 for murder, and 118 per 100 000 for sexual offences (a crime particularly notorious in terms of under-reporting, and one on which victim empowerment focuses), and 1 171 per 100 000 for all contact crimes combined, South Africa cannot be complacent.

The Ministerial Committee was informed that the number of youth offenders had declined since the coming into operation of the Child Justice Act. While at first glance this might seem good news, it seems that the reduction may be overstated. Instead, at least part of the decrease may reflect the unwillingness of many police officials to follow the requirements of the Act in respect of child offenders.

¹¹⁷ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015.

¹¹⁸ Parliamentary Monitoring Group. 2015. Children's Second Amendment Bill [B14-2015]: public hearings https://pmg.org.za/committee-meeting/21539/?utm_medium=email&utm_source=transactional&utm_campaign=minute-alert

¹¹⁹ beta2.statssa.gov.za/publications/Report-03.../Report-03-40-022011.pdf

The Child Justice Act emphasises diversion as a way of addressing offending by children. It thus builds on the work done in earlier years by NPOs such as the National Institute of Crime Prevention and Rehabilitation of Offenders (NICRO). Diversion has been rolled out nationally, but the services – and organisations providing the service – remain under-resourced.

Many social workers have been employed as probation officers, and have usually received some training to enable them to perform their duties. There are also some special provisions in respect of probation officers to recognise the particular conditions under which they work. Nevertheless, the Ministerial Committee was strongly urged to recommend recognition of probation work as a specialist area.

The White Paper referred at several points to the concept of restorative justice. It stated that the department would collaborate with other departments to develop an “integrated programme for crime prevention and restorative justice”. However, while one of the current DSD budget programmes is named “restorative services”, the Committee heard little mention of the term “restorative justice” during the review.

7.7.2 Other findings of the Ministerial Committee

The quantitative tool listed six services in this service area, namely advocacy, diversion, community supervision, retraining programmes for ex-offenders, support for awaiting trial (suspected) offenders, and secure care centres.

The overall mean ratings within crime prevention and restorative justice ranged from 1,1 for retraining programmes for ex-offenders to 2,6 for diversion programmes. Diversion, advocacy and community supervision were the top three scorers across all three stakeholder groups although the gaps between the scores for these and the other three services varied across groups. Retraining for ex-offenders was consistently scored lowest, at 1,1 or 1,2.

Eastern Cape performed best in respect of advocacy and diversion, and also performed well on community supervision. However, it was rated second lowest on secure care centres. North West was also generally among the better performers. Western Cape was the worst performer for all services except community supervision, where it was second worst.

Across provinces there were reports that the number of child offenders had decreased. KwaZulu-Natal attributed this to prevention and awareness programmes and campaigns. In other provinces it was attributed to deficiencies in implementation, understanding and commitment by SAPS officers to the Child Justice Act. Gauteng DSD organised for a study to be done, including a survey of SAPS officers, to investigate the drop in numbers of children in facilities after the Child Justice Act came into operation in April 2010 from 14 287 in 2008/09 to 3 546 in 2012/13 (and even lower in 2011/12).

The SAPS deficiencies in some cases result in child offenders not being brought into the system at all, but in other cases result in children not benefiting from the special provisions. However, the number of children held in correctional facilities dropped significantly after the Act came into operation and has remained at low levels. For example, Western Cape

reported to the Ministerial Committee that collaborative service delivery had reduced the number of children in correctional facilities to 20 children per month.

In terms of DSD's own service provision, there were complaints across provinces about the lack of availability of probation officers after hours. Limpopo reported that 83 probation officers had been placed across the various magistrates' offices as well as some in police stations. These officers had been provided with a standby allowance and cell phones so as to be accessible 24 hours a day.

In several provinces there were concerns about the lack of aftercare services for people who had been in conflict with the law, including those who had been institutionalised. Mpumalanga reported in this respect that it had developed an aftercare and reintegration programme that would be implemented in the districts, and was organising training for all probation officers. Free State was reported to have an aftercare programme for children aged 14-17 years in conflict with the law.

KwaZulu-Natal reported linking youth in conflict with the law with skills development programmes, including through SETAs. North West service providers observed that training provided for convicts was not accredited, and therefore the certificates provided were "useless". Similarly, in Eastern Cape practitioners felt that the training provided to ex-offenders should be, but was not, accredited. More generally, participants in several province noted the difficulties faced by those who had been in conflict with the law in obtaining employment, even if they had skills, given the high unemployment rate in the country. NICRO suggested that this and other challenges facing young people who had been in conflict with the law while children could be lessened by expunging their criminal records when they turned 18.

As suggested by the above discussion, much of the crime prevention work focuses on children and youth. In part this reflects the development and coming into effect of the Child Justice Act in respect of children. Further, prevention and early intervention when people are young and sufficiently malleable to change their patterns of behaviour is likely to be more effective than interventions with older people. Despite the apparent focus on children and youth, participants expressed concern about the lack of therapeutic programmes for children under ten years who were in conflict with the law. At the other end of the age spectrum were concerns about the lack of support for adults awaiting trial. Khulisa noted the lack of diversion for adults in Mpumalanga but was funded to provide this service in North West. Mpumalanga's non-provision in this area is interesting in that Mpumalanga DSD noted that the social crime prevention programme is also known as "probation services" and aims to provide services to children, youth and adults at risk and/or in conflict with the law.

NICRO presented at the Ministerial Committee's review sessions in many of the provinces. The organisation can take much of the credit for introducing diversion in the country, although government now often funds Khulisa for such services and has cut back on funding for NICRO. More generally, this service area is one in which service delivery is less likely than in others to be outsourced to NPOs although NPOs do play an important role. There were concerns that diversion services were not available in rural areas. In Gauteng there were concerns about children not completing diversion programmes.

As noted above, secure care centres are a form of CYCC. As with other specialised forms of CYCC, there is unequal distribution of these centres across the provinces despite a fairly energetic construction programme over the last few years. The result is that in some provinces there are complaints about lack of secure care centres while in others (such as Eastern Cape) a centre might be more than half empty. There was particular concern about limited geographical spread of specialised centres for girls. The Bhisho CYCC has repeatedly come to the attention of the courts. A 2014 judgment painted a dire picture of under-utilisation and over-staffing but with insufficiently trained and experienced personnel and a lack of programmes.

Bosasa, a private for-profit provider contracted by DSD to run secure care centres, noted that most young people referred to the centres did not have the care plans which legislation required that probation officers draw up before children were placed. Probation officers were also said to be flouting other legislative requirements, for example by not checking availability of space and by placing children under age 14 in the centres rather than in places of safety. In some cases SAPS officers brought children to the centres in marked vehicles without going through probation officers, again in contravention of the law.

There were several comments on the need for more coordination between this and other service areas such as substance abuse and mental health. In the Western Cape there was a disturbing suggestion that practitioners in the secure care centres receive a danger allowance.

7.7.3 Roles and responsibilities

The White Paper for Safety and Security of 1998 defines social crime prevention as all efforts “to reduce the social, economic and environmental factors conducive to particular types of crime”. DSD’s 2011 Integrated Social Crime Prevention Strategy¹²⁰ notes that although the emphasis of the strategy is on primary and secondary prevention, tertiary prevention is also necessary to avoid recurrence of criminal activities.

The strategy defines the different levels as follows:

- Primary prevention is defined as interventions that address risk factors in the population as a whole that are known to be associated with crime, such as youth unemployment or lack of economic opportunities for women. Such interventions can include (but is not restricted to) public education and awareness campaigns, community-based responses, and ensuring that children remain in school alongside social grants and EPWP.
- Secondary prevention is defined as interventions that target people or neighbourhoods which are particularly at risk. Here interventions include (but are not restricted to) helping youth at risk and providing extra public health nurses for teenage mothers, services that assist at-risk children before they require intensive statutory services.
- Tertiary prevention is defined as interventions that prevent repeat criminal activities by offenders, as well as assistance to reintegration of offenders.

¹²⁰ Department of Social Development. 2011. Integrated Social Crime Prevention Strategy. Pretoria.

7.8 Victim empowerment

Victim empowerment was not discussed explicitly in the White Paper, perhaps because the service area was only identified in subsequent years. However, the section of the White Paper dealing with women development highlighted the negative psychological and physical impacts of violence for the victims. It cited a police estimate that 966 000 women were raped in 1993.

7.8.1 Updating the White Paper

The points raised in the White Paper are relevant because victim (survivor) empowerment services have had violence against women as a central focus. Further, violence against women has remained a major problem in South Africa. Cases are still severely under-reported, but a number of studies have been done that give some sense of the extent of the problem. For example, a study in 2010 found that more than half of all women had experienced gender-based violence at some point; a study conducted in 2009 found that half of all female murders resulted from intimate partner violence; and a 2006 study found that 42% of Cape Town municipal workers admitted to having physically violated their partner in the previous ten years.¹²¹

7.8.2 Other findings of the Ministerial Committee

The quantitative tool identified five services in the women development service area, namely women empowerment programmes, shelters for abused women, court preparation and support, victim offender mediation, and capacity building and education. At least three of these services – shelters, court preparation, and victim offender mediation – could be seen as relating to victim empowerment.

The scores for the women development services were relatively low, with little difference between the overall mean scores for the five services. When disaggregated by stakeholder group, both providers and practitioners rated women empowerment programmes highest among the five services, but beneficiaries rated these programmes second lowest. More generally, practitioners tended to give higher scores for this service area than the other two groups.

The patterns across provinces showed no clear pattern. KwaZulu-Natal was the only province that led (in one case tying with another province) in more than one service area. Similarly, a different province at first glance appeared to perform worst in each service. However, if one considers the fact that Eastern Cape is not scored at all on victim-offender mediation, this province became the worst scorer for two services.

In several provinces participants noted that provision had diminished in respect of some of the “women” services. The recommendation in KwaZulu-Natal that victim empowerment sites be “revived” in all police stations suggested that there had been movement backward from a previous situation. In Western Cape service providers noted that NICRO (which in the past had specific women-targeted services) had scaled down its activities significantly because of lack of funds, while the Rape Crisis Centre had closed. (Rape Crisis is, in fact, still operating in Cape Town after surviving a period with

¹²¹ Cited in KPMG. 2014. Too costly to ignore – the economic impact of gender-based violence in South Africa. Johannesburg.

minimal funding.) The providers said that women were thus “worse off now compared to the past”. In Free State beneficiaries noted that VEP shelters had closed due to lack of funding. Practitioners said, more specifically, that the only women’s shelter, run by an NPO, had closed because of lack of finances. The practitioners said court preparation was available only for children, not for women, while victim offender mediation was previously available, but no longer.

Northern Cape’s submission, while not noting backward movement, reported in respect of VEP that statutory services were prioritised over services to victims. The province said it did not have dedicated personnel at district level to implement VEP, but relied on social workers, probation offices, court support workers and VEP volunteers to do the work. Northern Cape DSD funded two NPO shelters, while national DSD had provided funding to three VEP NPOs that focussed on awareness raising. The national funds were sourced from the Criminal Asset Recovery Fund.

Limpopo service providers reported that victim support accommodation was inadequate in terms of the number of victims that could be accommodated, housing of male and female in the same centre, the length of stay allowed, and safety of staff transporting the victims.

Northern Cape’s submission noted that while the White Paper was “very vocal” about violence against women, it was silent on gender-based violence, crimes against lesbian, gay, bisexual, transgender and inter-sexed people, ex-combatants, victims of hate crime (including xenophobia), and human trafficking. Nevertheless, in several provinces there were reports of activities related to trafficking. A North West NPO reported that “victims of trafficking often turn out to be illegal immigrants who need to be deported to their country of origin.” The NPO said that this was expensive and not covered by their funding.

Many concerns were raised about the weakness of inter-agency collaboration in the area of victim empowerment. Western Cape noted that there should be collaboration between the Departments of Human Settlements, Justice, Health, Education, Correctional Services, and Public Works in the case of shelters, but that this was lacking. In Gauteng an NPO reported lack of collaboration between SAPS, DSD, Health and Justice in relation to domestic violence, with police dropping victims off at the centre without providing the necessary information either then or later. Similarly, when the centre concerned provided shelter for witness protection victims, the Department of Justice did not provide background information that would facilitate appropriate services for the victim. Perhaps reflecting such lack of collaboration, there were comments from other participants on the lack of funding for second-phase housing for victims of domestic violence, as well of lack of funding for a resident nursing sister in shelters.

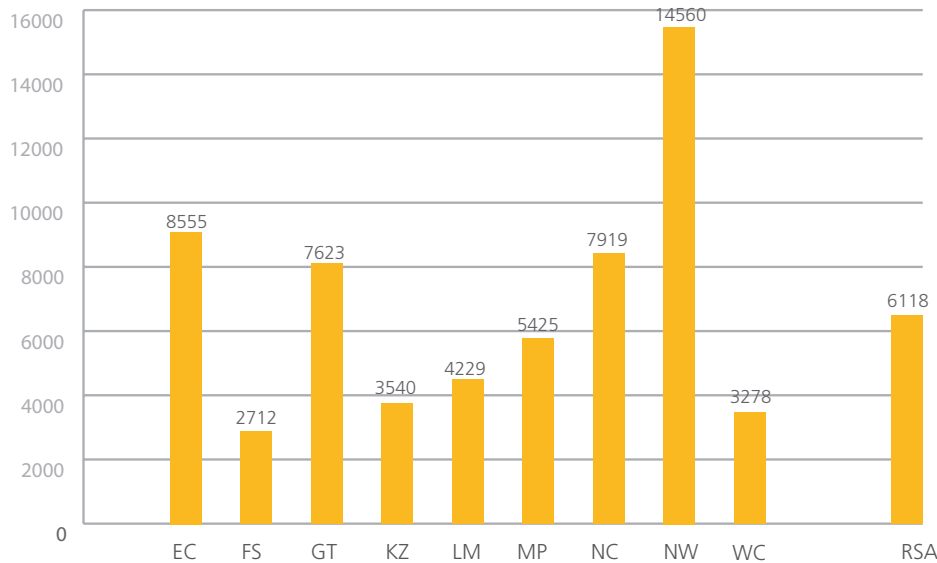
On a somewhat more positive note, Free State beneficiaries expressed appreciation for the 24-hour services available for victims of rape. Eastern Cape reported that EPWP funding was provided for employment of VEP volunteers.

7.8.3 Budget analysis

Figure 26 attempts to assess the relative size of the provincial budget allocations against the need in each province. The number of reported sexual offence cases in 2013/14 is used as an indicator of need. The number is not a full reflection of need given that victim empowerment is not intended only for victims of sexual abuse. Further, it is widely acknowledged that reported cases represent only a small fraction of actual cases of sexual offences. The fact that the extent of under-reporting probably varies by province means that the comparison must be taken only as a broad indication.

The figure suggests, that provision is most generous in North West. Free State has the least generous provision. The relative gap between North West’s allocation per incident and that of other provinces is large, but smaller than in 2014/15.

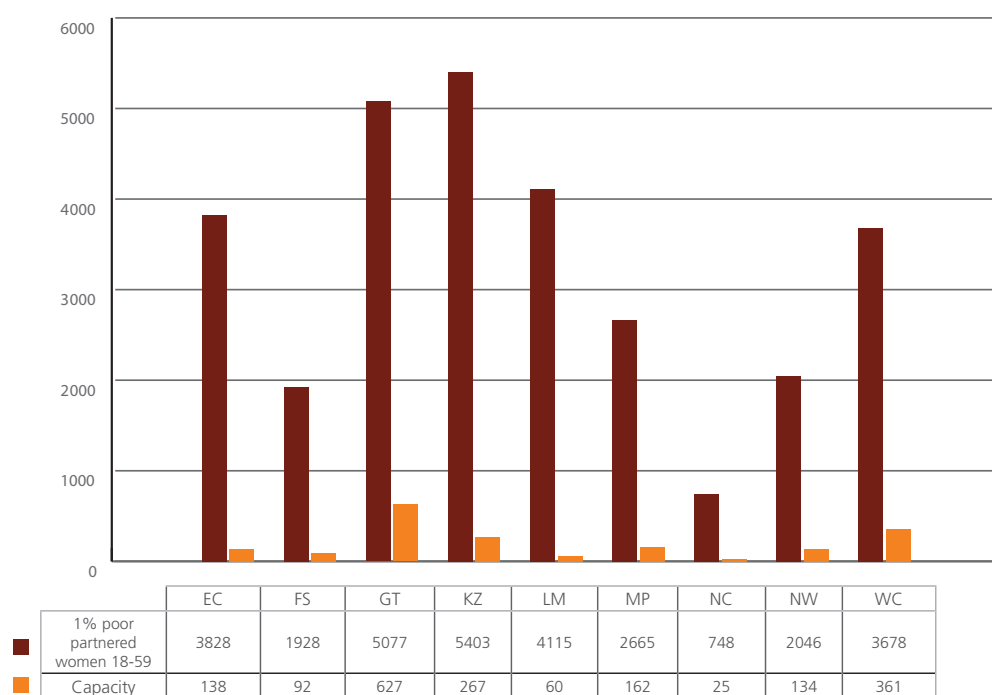
Figure 26: Victim empowerment allocation per sexual offence case reported in 2013/14 by province, 2015/16



7.8.4 Additional evidence

Figure 27 compares current capacity of shelters for abused women as reflected on DSD’s infrastructure database with need for this service. The proxy used for need is 1% of poor women aged 18 to 59 years who are either married or cohabiting. This arbitrary percentage is used in the apparent absence of evidence-based estimates or norms. The figure suggests that capacity is very seriously inadequate across all provinces. Gauteng and Western Cape have more capacity than other provinces but need is eight and ten times respectively of capacity even in these two provinces. In Eastern Cape there is one space for more than 30 women who need the service.

Figure 27: Comparing need and capacity: Shelters for abused women



The Thuthuzela Care Centres constitute one of government’s key interventions in respect of violence against women. The centres fall under the National Prosecuting Agency (NPA), and 55 were operational by late 2015, with a further four in the process of being established.¹²²

Although managed by the NPA, the centres are located in public hospitals where they offer a 24-hour service. Each centre is linked to a sexual offences court. Services offered include initial reception of the victim; history-taking and a medico-legal examination; prophylaxis and treatment for pregnancy and sexually-transmitted infections; bath/shower, refreshments and a change of clothing; and transport home or to place of safety, referral and follow-up support. Each centre is meant to be staffed, at the least, by a case manager, victim assistance officer and site coordinator, NPO or DSD counsellors,

¹²² Shukumisa. 2015. 15DaysOfDiscontent: Day 10: The investigation and prosecution of sexual offences.

trained detectives and officers competent to take statements and SAPS or emergency medical service personnel able to transport victims. The Centres currently provide services primarily to victims of sexual offences, and to children more than women. They generally do not provide services to victims of domestic violence. Assessments suggests that some centres provide noticeably better services than general health facilities, while others do not.¹²³

Recent research that includes case studies of ten NPOs offering post-rape services at these centres found that while many of them received EPWP funding from DSD, the funding did not create new jobs but was instead often accessed in desperation when previous sources of funding were no longer available. In several organisations, workers who previously were employed on standard salaries and conditions of services were now receiving only the EPWP minimum in temporary EPWP jobs.¹²⁴

DSD also supports and provides funding to Khuseleka one-stop centres which are managed by NPOs, and in which a range of different NPOs provide services associated with crime and violence, including accommodation/shelter. The 2013-2018 Integrated Programme of Action addressing violence against women and children envisages the establishment of 52 government-supported “halfway houses” using the Khuseleka model with links to existing Family Violence, Child Protection and Sexual Assault units, Thuthuzela centres and other one-stop response services. However, the Programme records a baseline of only five Khuseleka “safe house centres” in 2013. The logframe in the Programme document has a target of 80%, rather than 100%, for this strategy by end March 2018.

DSD is in the process of developing a Draft Bill on Victim Empowerment Services. DSD’s annual report for 2014/15 states that, among others, the bill will ensure that the victim empowerment services are regulated and rendered by professionals, especially shelters for abused men [sic] and children.

National DSD’s annual report for 2014/15 states further that many emerging CSOs that are providing services to victims in underserved and poor areas. In the last two years, the Department has been rolling out two interventions to build the capacity of these organisations, namely providing technical capacity building for these CSOs in lay counselling and awareness raising, and secondly, rolling out a mentoring and coaching model for emerging CSOs.

7.8.5 Roles and responsibilities in respect of gender-based violence

The Domestic Violence Act (no 116 of 1998) (DVA) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act (no 32 of 2007) (SOA) constitute the key legislation governing gender-based violence. SAPS and the Department of Justice and Constitutional Development (DoJ&CD) – and the NPA within the latter – bear the main responsibility for implementing the legislation. DOH, DSD and the Departments of Correctional Services (DCS) also have roles to play.¹²⁵

¹²³ Shukumisa. 2015. 15DaysOfDiscontent: Day 10: The investigation and prosecution of sexual offences.

¹²⁴ Vetten L. Forthcoming. Who cares? Post-rape services and the Expanded Public Works Programme in South Africa. Heinrich Böll Foundation: Cape Town.

¹²⁵ Vetten L, Le T, Leisegang A and Haken S. 2010. The Right and the Real: A Shadow Report Analysing Selected Government Departments’ Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act. Johannesburg: Tshwaranang Legal Advocacy Centre,

SAPS has both administrative and recordkeeping responsibilities, and responsibility for providing policing services to victims/survivors under the DVA. Under the SOA it has responsibility for issuing of national instructions on reporting and investigation and related procedures, as well as training of police. Meanwhile SAPS' Family, Child and Sexual Offences (FCS) Units have special expertise and responsibility in respect of sexual offences.

DoJ&CD has limited responsibilities under the DVA but is the chief custodian of the SOA. Its responsibilities under the latter include developing regulations on provision of post-exposure prophylaxis to victims and compulsory HIV testing of alleged rapists, and establishing the National Register for Sex Offenders and developing related regulations. The register is meant to record the details of persons convicted of, or alleged to have committed, any sexual offence against a child or person who is mentally disabled. The DoJ&CD is also responsible for the establishment and management of the Intersectoral Committee for the Management of Sexual Offence Matters, which includes the Directors General or equivalent officials of the key institutions.

DOJ&CD's Chief Directorate: Promotion of the Rights of Vulnerable Group's within DoJCD is responsible for supporting implementation of legislation and programmes that protect and promote the rights of the vulnerable in court, for monitoring and evaluating the impact of the court-related policies and legislation; and for developing information systems.

The NPA has no responsibilities under the DVA other than to manage prosecutions, as for any other law. In contrast, the SOA gives several specific responsibilities to the NPA. These include developing directives to guide prosecuting, sentencing and forwarding of names to the Register and developing training courses for officials. In implementing the Act, the NPA provides special Court Preparation Officers, while DOJ&CD more generally has provided Sexual Offences Courts which have witness testifying rooms, one-way mirrors, anatomical dolls, and court intermediaries to assist victims. In addition to the legislative mandates, the Sexual Offences and Community Affairs unit within the NPA has been the lead player in establishment and management of the Thuthuzela Care Centres,

The DVA states that police must assist complainants to find a suitable shelter and obtain medical treatment. However, it does not oblige DSD to ensure that shelters are available and does not oblige health providers to do anything more than they would do for any other victim of assault. Despite the lack of a legislative obligation, DSD has created various policies and related documents, including the 2003 Policy Framework and Strategy for Shelters for Victims of Domestic Violence in South Africa, the 2010 Social Development Guidelines on Services for Victims of Domestic Violence and the 2009 Strategy for the Engagement of Men and Boys in Prevention of Gender-based Violence. The DSD is also the lead actor for VEP. While the latter is meant to provide services to victims of any type of violence, it is often understood to have a focus on gender-based violence.

DSD's approach to funding shelters differs across provinces in terms of both the type of costs covered, and the amount provided for each of the different types of costs. A case study by the Shukumisa Campaign of 17 shelter organisations found that they had been forced by cutbacks in funding to reduce staff numbers by 100 between 2010 and 2013 and also forced to stop offering a range of key services

The DSD has very limited responsibilities under the SOA but did, in 2010, publish Guidelines for Services to Victims of Sexual Offences. The original bill drafted by the South African Law Reform Commission provided for a range of psycho-social services to victims and their families, but Cabinet dropped these clauses on the basis that they were too expensive.

The DVA does not explicitly place obligations on the health sector. The issue is, however, touched on in various health policies and documents, such as the Primary Health Care Package for South Africa, the National Guideline on Prevention, Early Detection/ Identification and Intervention of Physical Abuse of Older Persons at Primary Level; and the HIV & AIDS and STI National Strategic Plans.

Under the SOA, the DOH is responsible to provision of medico-legal services, including designation of public health establishments for PEP and submitting to the Registrar of the National Register of Sex Offenders the names of all those found unfit to stand trial for psychiatric reasons. DOH has established Clinical Forensic Medicine Centres which provide specialised services in respect of sexual offences.

DCS has no responsibilities under the DVA, but has obligations under the SOA, including submission of names for inclusion on the register.

DOJ&CD's 2012 amended National Policy Framework Management of Sexual Offence Matters notes that in 2012 membership of the Intersectoral Committee for the Management of Sexual Offence Matters was extended to the directors general of the (then) Departments of Women, Children and Persons with Disabilities and Basic Education (DBE), Legal Aid South Africa, and the National House of Traditional Leaders on the basis that they had important roles to play in implementation and monitoring of the SOA.

The 2012 National Policy Framework details the responsibilities of each of the agencies, going beyond the agencies represented on the Intersectoral Committee and providing more detail than the summary of key responsibilities presented above.

Given the clear need for action from multiple agencies, there have been proposals and attempts in respect of establishing a coordinating structure and plan for violence against women and children. Shukumisa's 2015 assessment of achievements to date suggest that the initiatives have been "costly and ineffective". The assessment notes the launch of the 365 Day National Action Plan to End Gender Violence in 2011. The official end date¹²⁶ for the plan was 2011 but it "limped" on until 2013 when it was put on hold pending review. Three reviews of the plan in 2012-14 found that it did not achieve anything that would not have been achieved in terms of the relevant departments' pre-existing policies and obligations.

In 2011, the then Department of Women, Children and People with Disabilities established the National Council on Gender-Based Violence.¹²⁷ Cabinet approved the establishment of the Council in December 2011, and it was officially inaugurated in December 2012. The Deputy President Kgalema Motlanthe was appointed as chairperson but withdrew soon after. About a year later the Council appointed a research agency to guide development of a national strategic plan. However, in February 2015 the Minister of Women informed parliament that the Council had been put on hold because there were concerns about the process of its establishment.

¹²⁶ Shukumisa. 2015. 16DaysOfDiscontent: Day 6: National structures, strategies and plans.

¹²⁷ Commission for Gender Equality. (2013). Expectations Unfulfilled? Assessing the Effectiveness of the National Council on Gender-based Violence. [Online]. Available at: <https://drive.google.com/file/d/0B43RY8hVdugGN2x1MTdMOE9wdEE/view>

Meanwhile in May 2012 an Inter-Ministerial Committee (IMC) was convened to investigate the root causes of violence towards women and children. The IMC was chaired by DSD. Shukumisa notes that this effectively created a situation of two rival structures within government on the same issue. Several studies were commissioned, but before these were completed the IMC finalised its Integrated Programme of Action (PoA) for 2013-2018. The PoA was approved by Cabinet in September 2013, but adjusted in August 2014 after the May elections saw changes in ministries. The PoA consists of 57 actions, for each of which target/s are set and responsibility assigned. A review of the Safer South Africa Programme found that by September 2015 the PoA had not been discussed with civil society groupings, or provincial and district level government officials, and had also not been officially launched.

Shukumisa notes that the Safer South African Programme, funded by UNICEF, United Nations Population Fund, Save the Children South Africa and the United Kingdom's Department for International Development provided most of the funds for the Council and IMC. The estimate that about R8,4 million was spent over the past three years, with little beyond two documents (the PoA and the "Know Your Epidemic – Know Your Response" report) to show for this funding.

7.9 Substance abuse prevention and rehabilitation

The White Paper noted wide-ranging negative consequences of substance abuse, and that the phenomenon was recognised "as one of the greatest health and social problems in South Africa." It stated that alcohol was still the most commonly abused drug, and was "growing in popularity, especially in informal settlements and rural areas" However, abuse of other substances, including medication, was on the increase.

Triologue's 17th report includes a case study of Netcare's Sexual Assault Centres, which were awarded the Inaugural Triologue Strategic CSI Award

Prior to Netcare's establishment of these centres, victims of rape had to be medically examined by a district surgeon to obtain forensic evidence. Many victims were forced to wait for many hours in public facilities for this service. In 1998, in response to journalist Charlene Smith's rape, Netcare developed sexual assault centres in its hospitals. By 2015 Netcare had 37 such centres across the country.

When they arrive at the centre, victims are taken to a private room with a private bathroom and given a 'dignity pack' tailored to their needs. They are treated as "Priority 1" and the forensic examination is done immediately. Victims with physical injuries receive medical care, and all victims receive advice and counselling, including HIV testing and antiretroviral treatment where needed.

Partner NPOs provide psychological counselling for the victims and families or loved ones. All cases involving minors are reported to SAPS and older victims/survivors are also encouraged to report to SAPS. On average, 78% of cases are reported to SAPS. The availability of forensic evidence reduces the chance of cases being dismissed. Netcare has also helped train government staff and awareness raising on sexual assault for communities and organisations. In 2012/13, the Netcare Sexual Assault Centres assisted 949 survivors at a total cost of R1,9 million.

The White Paper pointed to the “grossly inadequate” services available in townships, informal settlements and rural areas across services such as detoxification in hospitals, community-based services, treatment and aftercare. It identified “primary prevention” programmes as a priority. It acknowledged a network of specialist welfare organisations that worked with the departments of welfare on substance abuse, but noted that they were more visible in urban than rural areas.

7.9.1 Updating the White Paper

The World Health Organisation ranked South Africa 47th out of 189 countries in 2003 in terms of alcohol consumption per person 15 years and older. The Mental Health Policy Framework and Strategic Plan states that South Africa has the second-highest prevalence of alcohol use, after Ukraine. The 2003 South African Demographic and Health Survey found that 13% of adults who had used alcohol in the past 12 months reported “hazardous/harmful” amounts of alcohol consumption, with harmful drinking occurring mostly over weekends. In the 2008 South African national HIV survey, 10% of respondents admitted to binge drinking in the past month. Binge and harmful drinking were more common among men than women.¹²⁸

In all the provinces the Ministerial Committee heard about the problems of substance abuse, with references in particular to youth abusing a range of different drugs across the provinces. Alcohol was referred to far less often, perhaps because consumption is legal and seen by so many people as an acceptable aspect of socialising. However, in Northern and Western Cape the high rate of foetal alcohol syndrome – the highest rate in the world – was raised as a challenge. (In Western Cape, 70-80 of every 1 000 babies born has foetal alcohol syndrome.¹²⁹) The patterns in terms of use of other drugs has shifted over time, with tik (methamphetamine), for example, now being a drug of choice in Western Cape. While there is national liquor legislation, provinces are responsible for developing provincial legislation on this issue. When legislation is drawn up, there is often a conflict of interest between the interests of beer producers and sellers and the proposals of those who would like to see use (and abuse) of alcohol decline.

7.9.2 Other findings of the Ministerial Committee

The quantitative tool listed five services in the area of substance abuse – prevention programmes, community-based treatment, in-patient/centre-based treatment, out-patient services, and aftercare and reintegration services.

Prevention programmes clearly out-performed the four other services for substance abuse, presumably in part reflecting Ke Moja (see below). This pattern held across all three stakeholder groups. There was less unanimity on the relative scores for the other four services. Perhaps surprisingly, beneficiaries rated the availability of in-patient treatment higher than the other two groups.

Northern Cape was a strong performer in this service area, with the highest score (sometimes tied with other provinces) for three of the services. This could reflect the seriousness of the problem of substance abuse in the province, as reflected in the high level of foetal alcohol syndrome. Mpumalanga was first or second highest scorer for four of the services. At the other end of the spectrum, Eastern Cape had no score for

¹²⁸ Cited in Department of Social Development. 2013. National Drug Master Plan 2013-2017: 27.

¹²⁹ Human Rights Watch. 2015. “Complicit in Exclusion” South Africa’s Failure to Guarantee an Inclusive Education for Children with Disabilities: 38.

three of the services, suggesting complete lack of availability and/or lack of knowledge as to what constitutes these services. Limpopo had no score for two services, and the lowest score for a further two services.

In the submissions and presentations, Ke moja was probably the most reported service in this area. The programme has been operating across all provinces for some years. For older children and youth, some provinces reported having Teenagers Against Drug Abuse, a programme in which volunteers receive stipends. There were also reports across virtually all provinces about establishment of provincial drug action forums, as well as local drug action committees. However, while these are provided for in the legislation and policy, participants reported that the necessary funding was not allocated.

Virtually all provinces reported an increase in substance abuse among youth. In doing so, they generally mentioned the particular substances for which usage was on the increase in their province. Northern Cape noted the particular problem of foetal alcohol syndrome, a problem that affects people from when they are in the womb and for the rest of their lives.

Across many provinces participants expressed concern about the scarcity of detoxification services other than privately provided (and expensive) ones. This service should be provided by the Department of Health. Gauteng service providers reported that Bosasa had been funded to provide the services, but “there were no patients and the programme was not a success.”

More generally, there was a reported shortage of treatment centres in most, if not all, provinces. As discussed below, a conditional grant was provided for this purpose in 2014/15 for those provinces without any such government-owned facility but this alone will not address the need, especially for rural areas. Where centres existed, they were said to have insufficient beds. Participants said that both in- and out-patient services were not decentralised, and thus not available in all districts.

Geography was not the only reported basis of exclusion from substance abuse services. A Western Cape NPO observed that none of the rehabilitation centres in the country used indigenous languages such as Xhosa or Zulu. KwaZulu-Natal reported that rehabilitation centres were not accessible for women. Beneficiaries in Western Cape said that the South African National Council on Alcoholism and Drug Dependence worked only with certain organisation, such as Youth for Christ. A subsequent comment that Youth for Christ employed only coloured and white staff suggests that the complaint was at least partly about racial bias. An NPO observed that co-payment fees restricted access for services, with the situation exacerbated by people who could afford to pay accessing services intended for poorer people because of inadequate assessment of their ability to pay.

A North West NPO said that South African “values”, which favoured “quick fixes”, immediate results, and new endeavours and high numbers over maintenance were in contradiction with seeing addiction as a chronic disorder. Along the same lines, there were comments on the absence of aftercare and support services after treatment. As in other areas, there were calls for a more multidisciplinary professional approach. In particular, there was a call for health practitioners to work in the area of substance abuse alongside social workers.

7.9.3 Budget analysis

Table 42 presents the costing comparison for two substance abuse treatment services, namely in-patient and out-patient. (No delivery is reported for Western Cape, which seems unlikely.) For this costing each in-patient beneficiary is assumed to receive services for one month, while each out-patient beneficiary receives services for three months. The estimated per-beneficiary cost for in-patient treatment is R3 738,84 per month, and for out-patient treatment R1 175,61 per month. This comparison presents a more optimistic picture than all preceding costing comparisons in that the budget allocation in all provinces is more than sufficient to cover the recorded patient numbers. This optimism must be tempered by the fact that several provinces received funding, starting in 2014/15, to establish new centres. At least some of the provincial allocations thus include substantial capital amounts not related to immediate service delivery costs. Further, to the extent that the treatment is provided in government-run facilities, it will be more expensive than the KPMG costing. A pessimistic reading of the low percentages is that they reflect the low level of provision of in-patient and out-patient services. The service delivery number for 2014/15 record a total of only 2 597 in-patients and 19 460 out-patients for the full year.

Table 42. *KPMG costs compared with 2015/6 budget allocations for substance abuse using 2014 performance indicators (R'000)*

	Inpatient p.a.	Outpatient p.a.	Total subsidy p.a.	Budget	Subsidy as % of budget
EC	1 064	1 875	2 939	50 514	6%
FS	434	1 513	1 946	37 841	5%
GT	5 457	65 734	71 191	126 129	56%
KZ	1 333	1 470	2 804	73 639	4%
LM	0	1 269	1 269	7 800	16%
MP	1 313	3 226	4 539	31 388	14%
NC	683	0	683	44 211	2%
NW	340	0	340	93 103	0%
WC	0	0	0	95 684	0%

7.9.4 Additional evidence

7.9.4.1 Prevalence of alcohol and substance abuse

The third national Youth Risk Behaviour Survey of 2011¹³⁰ provides substance abuse prevalence statistics for young people in grade 8 through 11 across the nine provinces. Nationally, 49,2% of the youth had drunk alcohol in their lifetime – 53,8% male versus 44,9% female. In terms of population group, the percentages were white 77,6%, coloured 65,9%, Indian 68,9% and African 45,7%. Overall, 32,3% had drunk alcohol in the month preceding the survey – 36,6% male and 28,2% female, and ranging from 51,7% for coloured youth to 29,6% for African.

¹³⁰ Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omardien RG. 2011. Umthenthe Uhlaba Usamila: The 3rd South African National Youth Risk Behaviour Survey 2011. South African Medical Research Council: Cape Town.

Nationally, 12.8% reported ever having used dagga – 16.4% male versus 7.2% female, and ranging from 27.1% for coloured youth to 11.3% for Indian youth. Close on a tenth (9.7%) had ever used another drug – male 11.6% and female 7.9%.

The most recent national data come from the fourth South African national prevalence, incidence, behaviour and communication survey conducted by the Human Sciences Research Council, who kindly provided raw data to allow analysis for the Ministerial Committee. The questionnaire for the survey included a set of questions on alcohol use, and another set of questions on use of other substances. These questions were addressed to all respondents aged 15 years and above (N=32284) – representing a total of 37 million individuals after weighting. The results for both alcohol and other substances are reported below. However, the results for other substances are too low to be credible. It seems likely that many users were not prepared to report what is an illegal activity despite being promised confidentiality.

The questions on alcohol used the international Alcohol Use Disorders Identification Test (AUDIT). This test consists of a series of ten questions for which the responses are scored. The maximum possible score is 40. The HSRC categorised all those scoring eight or more at “at risk”. In the analysis below, we categorise all those with scores of 20 or more as having possible alcohol dependency. The analysis first focuses on responses to some of the key individual questions, and then analyses patterns in respect of the AUDIT score.

The first question in the alcohol section asked whether the respondent had ever had a drink containing alcohol. A response was recorded in respect of the first question for almost all (98%) of respondents. The analysis of this question below excludes those who did not respond.

Table 43 shows an overall prevalence of 45% i.e. a little under half of respondents report ever having had an alcoholic drink. Men are almost twice as likely as women to report ever having had a drink (59% versus 31%). In terms of age groups, the differences are relatively small, but those aged 25-34 years are more likely than older or younger people to report ever having had an alcoholic drink. White people (83%) are more than twice as likely as African people (38%) or Indian people (40%) to report having drunk alcohol, with coloured people about halfway between the two extremes.

Provincially, the reported prevalence of drinking is highest in Western Cape (63%) and Northern Cape (60%) and lowest in KwaZulu-Natal (27%) and Limpopo (28%). Drinking is most common in rural formal (including former “white” commercial farming) (57%) and urban formal (56%) areas, and least common in rural informal (former homeland) areas.

Table 43: Prevalence of ever having had alcoholic drink (%)

Variable	Category	Prevalence
	Total	45
Sex	Male	59
	Female	31
Age group	15-24	41
	25-34	49
	35+	45
Race	African	38
	White	83
	Coloured	63
	Indian	40
Province	EC	39
	FS	50
	GT	56
	KZ	27
	LM	28
	MP	41
	NC	60
	NW	51
	WC	63
Genotype	Urban formal	56
	Urban informal	38
	Rural informal	28
	Rural formal	57

Table 44 shows female prevalence lower than male prevalence across all nine provinces. The male-female gap is largest in KwaZulu-Natal and Limpopo, where more than 40% of men but only 15% or fewer women reported having ever had an alcoholic drink.

Table 44: Prevalence of ever having had alcoholic drink by province and sex (%)

Province	WC		EC		NC		FS		KZ		NW		GT		MP		LM	
Sex	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Prevalence	73	53	56	21	71	49	64	35	42	14	63	39	70	43	54	27	45	15

The same pattern of much lower rates for women than men is found when the data are disaggregated by race. This time the relative gender gap is much larger for the African group than for whites. The coloured group is somewhere in between in terms of the relative gap.

Table 45: Prevalence of ever having had alcoholic drink by race and sex (%)

Race	African		White		Coloured		Indian	
Sex	Male	Female	Male	Female	Male	Female	Male	Female
Prevalence	54	23	89	77	75	53	51	29

Table 46 shows a smaller gap between male and female for the youngest group – those aged 15-24 years – than for older people. However, the gap is substantial in all age groups.

Table 46: Prevalence of every having had alcoholic drink by age group and sex (%)

Age group	15-24		25-34		35+	
Sex	Male	Female	Male	Female	Male	Female
Prevalence	51	30	66	32	61	32

Subsequent questions were asked only of those who responded positively to the first question i.e. who had ever had an alcoholic drink. The question asked how often they had a drink containing alcohol in the past 12 months. For this question we report percentages for the full sample. For example, the percentage shows what proportion of all respondents drank alcohol four or more times a week, rather than the proportion of drinkers who drink this often. This allows easier comparison across groups with different percentages of drinkers. The table does not, however, include a column for those who have never had an alcoholic drink.

Overall, 3% of respondents said that they drank four or more times a week during the past year, a further 4% drank 2-3 times a week, 12% drank 2-4 times a month, and 16% drank once a month or less. About a twelfth of the sample (8%) had had an alcoholic drink in their lives but had not done so in the past year.

Table 47: Prevalence of frequency of drinking (%)

Variable	Category	Not in past year	Once a month or less	2-4 times a month	2-3 times a week	4+ times a week
	Total	8	16	12	4	3
Sex	Male	9	19	19	7	4
	Female	8	13	6	2	2
Age	15-24	9	17	10	3	1
	25-34	7	18	15	5	3
	35+	9	15	12	5	4
Race	African	7	15	10	3	2
	White	10	20	27	12	11
	Coloured	15	21	17	6	3
	Indian	8	17	9	3	2

Province	EC	9	15	9	3	2
	FS	6	19	15	4	4
	GT	8	21	16	6	5
	KZ	6	8	7	3	1
	LM	5	10	7	3	2
	MP	7	17	10	4	2
	NC	15	22	15	5	3
	NW	9	21	13	4	2
	WC	13	19	18	7	3
Genotype	Urban formal	10	20	15	6	4
	Urban informal	7	14	10	4	2
	Rural informal	6	11	6	2	1
	Rural formal	7	17	21	7	3

There was only a one percentage point difference between women and men in terms of heavy drinking (4+ drinks per week). The largest difference between women and men was among those drinking 2-4 times a month.

The likelihood of drinking heavily showed a clear increase by age, from 1% among the youngest group to 4% among the oldest. The youngest group also had a smaller percentage than older groups in each of the next two categories.

White people were noticeably more likely than others to report drinking four or more times a week (11%), versus 2% or 3% for other groups. Gauteng (5%) had the highest percentage in this position, and KwaZulu-Natal the lowest (1%). Urban formal areas had the highest proportion of heavy drinkers (4%), and rural informal the lowest (1%). These patterns suggest that there might be a relationship between income and drinking more frequently.

The next question asked how often the respondent had five or more (for men) or four or more (for women) drinks on one occasion. This question provides an indication of binge drinking. Again, the percentages below are calculated across the full sample (or sub-group of the sample). The table does not, however, include a column for those who have never had an alcoholic drink.

Very few respondents (1%) reported binge drinking daily or almost daily. However, 4% said that they did so weekly, with a further 6% saying that they did so monthly. Only 4% of women said that they did so monthly or more often, as against 18% of men. About one in six of those aged 25-34 years (16%) binge drank monthly or more often, as against 9% of older people and 10% of younger people. Coloured people – at 17% – were most likely to indulge in binge drink, and Indians (7%) least likely. Province-wise, Free State and Western Cape had 17% reporting relatively frequent binge drinking, while KwaZulu-Natal had only 6%. Rural informal areas had only 5% of respondents reporting relatively frequent binge drinking.

Table 48: Prevalence of frequency of binge drinking on one occasion (%)

Variable	Category	Never	Less than monthly	Monthly	Weekly	Almost daily
	Total	17	8	6	4	1
Sex	Male	21	11	9	8	1
	Female	13	5	3	1	0
Age group	15-24	13	8	6	4	0
	25-34	17	9	8	7	1
	35+	19	7	4	4	1
Race	African	13	8	5	4	0
	White	48	9	8	5	1
	Coloured	19	10	8	8	1
	Indian	18	5	3	4	0
Province	EC	15	6	5	3	0
	FS	16	10	9	6	1
	GT	25	9	6	6	1
	KZ	7	7	4	2	0
	LM	10	5	4	3	0
	MP	17	6	5	4	1
	NC	23	8	6	6	1
	NW	19	9	7	4	1
	WC	22	11	8	7	1
Genotype	Urban formal	22	10	7	5	1
	Urban informal	11	9	5	4	1
	Rural informal	10	5	3	2	0
	Rural formal	26	7	8	7	0

The final set of tables on alcohol record the AUDIT scores explained above. Table 49 shows 86% of respondents having AUDIT scores below 8, 9% with AUDIT scores between 8 and 19 and thus "at risk", and a further 1% with scores of 20+ and thus with a possibility of alcohol dependency. Men (2%) are more likely than women (0%) to have a possibility of dependency, and also much more likely than women (16% as against 3%) to be at risk. Age-wise, the 25-34 year old group is both more likely to have a possibility of dependency and also more likely to be at risk than the other two age groups. The youngest age group is more likely to be at risk than those aged 35 years and above.

Table 49: Distribution by AUDIT score (%)

Variable	Category	<8	8-19	20+	Unknown
	Total	86	9	1	3
Sex	Male	79	16	2	3
	Female	94	3	0	2
Age group	15-24	87	10	1	2
	25-34	82	13	2	3
	35+	90	7	1	3

Race	African	87	9	1	3
	White	89	7	1	3
	Coloured	81	15	2	2
	Indian	94	5	0	2
Province	EC	89	7	1	4
	FS	80	14	2	4
	GT	84	12	1	3
	KZ	91	6	1	3
	LM	90	6	1	3
	MP	87	8	1	4
	NC	83	12	2	3
	NW	82	12	1	4
	WC	85	11	2	2
Genotype	Urban formal	84	11	1	3
	Urban informal	85	9	2	4
	Rural informal	91	6	1	2
	Rural formal	81	12	1	5

Indian people appear to have the least problems, with less than half a percent having a possibility of dependency and only 5% at risk. Coloured people are worst off, with 3% having a possibility of dependency and a further 15% at risk. This pattern helps to explain the fact that Northern Cape and Western Cape – both provinces with a greater proportion of coloured people than the other seven provinces – have 2% of their population aged 15 years and above with a possibility of dependency and a further 11% or 12% at risk. In terms of genotype, the possibility of dependency is highest in urban informal areas. However, a larger percentage of the populations of rural formal and urban formal areas are at risk than in urban informal areas. The relatively positive picture in rural informal areas is explained, in part, by the extent of female dominance in the province, with 54% of respondents in this genotype being female, as against 52% for the sample as a whole.

The table above includes (among those not at risk) the 3% of the respondents for whom an AUDIT score cannot be calculated because some of the relevant questions are not answered. The tables that follow exclude these respondents.

Table 50 confirms that the pattern of the percentage of women with a possibility of dependence as well as the percentage of women at risk being lower than those of men holds across all provinces. Similarly, men are more likely than women to show a possibility of dependence across all provinces.

Table 50: Distribution by AUDIT scores within province and sex (%)

	EC		FS		GT		KZ		LM		MP		NC		NW		WC	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
<8	87	97	73	93	77	96	87	98	85	99	84	97	78	93	77	95	80	93
8-19	12	2	23	6	21	4	11	2	13	1	14	2	19	7	20	5	17	6
20+	2	0	4	1	2	1	2	0	2	0	2	1	3	1	3	0	3	1
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Table 51 confirms this finding when the disaggregation is by race and sex. It also shows clearly that both coloured men and women are more likely than those in other groups to show a possibility of dependence.

Table 51: Distribution by AUDIT scores within race and sex (%)

	African		White		Coloured		Indian	
	Male	Female	Male	Female	Male	Female	Male	Female
<8	81	97	87	97	73	92	91	99
8-19	16	3	12	3	24	7	9	0
20+	2	0	1	0	4	1	1	0
Total	100	100	100	100	100	100	100	100

Table 52 again shows women in a less negative position than men, this time across all age groups. Among women aged 35 years and above, less than half a percent have a possibility of dependence and only 2% are at risk. Among men aged 25-34 years, more than a quarter have a possibility of dependence or are at risk.

Table 52: Distribution by AUDIT scores within age group and sex (%)

	15-24		25-34		35+	
	Male	Female	Male	Female	Male	Female
<8	83	95	73	95	85	97
8-19	16	5	24	4	13	2
20+	2	1	3	1	2	0
Total	100	100	100	100	100	100

The HSRC questionnaire also included two series of questions about (a) use of a range of named substances over the past three months, and (b) how often the respondent had failed to perform their responsibilities because of their use of the named substances over the past three months. The instructions noted that use of medication prescribed by a doctor should not be reported in response to these questions. As noted above, the responses to these questions will almost certainly produce an undercount of actual use of substance given that the practice is illegal. Unfortunately, the extent of underreporting is unknown.

Table 53 has cannabis and the “other” category as the only substances where less than 98% of respondents report never having used it in the past three months. All substances except cannabis and the “other” category also have less than half a percent of women and men reporting each of the specified frequencies. For cannabis, reported use is much higher for men than women, with 3% of men reporting almost daily usage, 1% weekly, 1% monthly, and 2% once or twice in the three months, as against 1% of women reporting use once or twice and fewer than half a percent in each of the other frequency categories. The limited use of individual substances does not merit more disaggregated analysis by individual substance as the results are unlikely to be reliable.

Table 53: Use of substances over past three months by sex

Substance	Group	Never	Once or twice	Monthly	Weekly	Almost daily
Cannabis	Total	94%	1%	0%	0%	2%
	Male	91%	2%	1%	1%	3%
	Female	98%	1%	0%	0%	0%
Cocaine	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	98%	0%	0%	0%	0%
Amphetamine	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	98%	0%	0%	0%	0%
Inhalant	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	99%	0%	0%	0%	0%
Sedative	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	98%	0%	0%	0%	0%
Hallucinogen	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	99%	0%	0%	0%	0%
Opiate	Total	98%	0%	0%		0%
	Male	98%	0%	0%		0%
	Female	99%	0%	0%		0%
Whoonga	Total	98%	0%	0%	0%	0%
	Male	98%	0%	0%	0%	0%
	Female	99%	0%	0%	0%	0%
Other	Total	91%	0%	0%	0%	1%
	Male	91%	0%	0%	0%	2%
	Female	93%	0%	0%	0%	1%

The questionnaire asks about nine different substances if the category “other” is counted as one substance. A count of the number of substances used in the past three months by each respondent can be derived by including in the count any substance for which the response is not “never”. Table 54 confirms that extremely few respondents reported using more than one substance. Among men, 1% used two substances, but

less than half a percent more than this. In addition 9% of men used one substance. Among women, 2% used one substance and less than half a percent more than this.

Table 54: Number of substances used by sex

No. of substances	Male	Female	Total
0	90%	98%	94%
1	9%	2%	5%
2	1%	0%	0%
3	0%	0%	0%
4	0%	0%	0%
5+	0%	0%	0%
Total	100%	100%	100%

Table 55 shows that there are very few subcategories of respondents – white and coloured people, and residents in Gauteng and Western Cape – where more than half a percent of the group reports use of 3 or more substances. Use of two substances is reported by more than half a percent of 15-24 year olds (reflecting an age of experimentation?), coloured and Indian people, residents of Northern Cape and Western Cape, and people living in urban formal areas.

Table 55: Number of substances used by race, age, province and geotype

Group	None	1	2	3+
Total	94%	5%	0%	0%
15-24	93%	6%	1%	0%
25-34	92%	7%	0%	0%
35+	96%	4%	0%	0%
African	95%	5%	0%	0%
White	95%	4%	0%	1%
Coloured	87%	10%	1%	1%
Indian	96%	3%	1%	0%
EC	94%	6%	0%	0%
FS	93%	7%	0%	0%
GT	94%	5%	0%	1%
KZ	96%	4%	0%	0%
LM	96%	4%	0%	0%
MP	95%	5%	0%	0%
NC	94%	4%	1%	0%
NW	95%	5%	0%	0%
WC	90%	8%	1%	1%
Urban formal	93%	6%	1%	0%
Urban informal	94%	5%	0%	0%
Rural informal	96%	4%	0%	0%
Rural formal	94%	6%	0%	0%
Total	94%	5%	0%	0%

Table 55 also – if one combines all columns other than “None” – shows differential reported use of substances across categories. In terms of age, people aged 35+ are less likely than younger ones to report using substances. Race-wise, use of substances is noticeably more common among coloured people than among other groups. In Western Cape, one in every ten people reported using substances. This pattern in part mirrors the relatively high usage among the coloured group. In terms of genotype, rural informal areas again – as with alcohol – report lower usage than other areas. The other three genotypes show similar usage patterns.

The second set of questions asked how often respondents had failed to perform their responsibilities because of their use of a specified substance. This question did not generate meaningful numbers for any substance other than cannabis. For cannabis, 1% of all male respondents (including non-users) reported a negative effect once or twice in the past three months and a further 1% reported that this happened almost daily.

Table 56 confines analysis to those who reported using cannabis. Of these users, more than three quarters (28%) of the men reported failure at some point to perform responsibilities, as did 8% of the women. Among the men, 11% reported such failure almost daily, but none of the women reported such frequent failure.

Table 56: Failure to perform responsibilities among cannabis users

Frequency	Male	Female	Total
Never	72%	92%	74%
Once or twice	11%	4%	10%
Monthly	2%	1%	2%
Weekly	4%	2%	4%
Almost daily	11%	0%	10%
Total	100%	100%	100%

A combined performance measure for all substances can be derived by taking the response, across all substances, that records the greatest frequency of failure to perform responsibilities. Unfortunately, when this is done about a fifth of those who reported substance abuse do not have any responses in respect of performance of responsibilities. Using the derived measure, Table 57 shows at least 9% of substance users (and possibly more given that for 21% there are no responses on effect of substance use) reporting that they failed almost daily to perform their responsibilities. Among women, more than a quarter (26%) of users report this, as against just under a fifth (19%) of men. It is not clear if those whose performance is not affected would be more or less likely to respond to these questions. It is also not clear whether those whose performance is affected would be more or less likely to report use of substances in the first place. One could argue that those whose performance is affected are less able to deny that they use substances.

Table 57: Frequency of failure to perform responsibilities among substance users

Frequency	Male	Female	Total
Never	57%	61%	58%
Once/twice	9%	6%	8%
Monthly	1%	0%	1%
Weekly	3%	1%	3%
Daily	10%	5%	9%
Unspecified	19%	26%	21%
Total	100%	100%	100%

7.9.4.2 Foetal alcohol syndrome

With alcohol as the most common primary substance of abuse and a South African rate of alcohol consumption that is among the highest in the world, foetal alcohol syndrome is a serious problem in South Africa – perhaps more serious than anywhere else in the world.¹³¹ The syndrome is characterised by birth defects involving physical and neurodevelopmental impairments and results in low intelligence, behavioural disorders, poor social judgement and general difficulty in performing everyday tasks. In Western and Northern Cape, between 5% and 10% of children entering school have foetal alcohol syndrome.¹³² In Gauteng, one in every 40 children entering schooling have the syndrome, and some areas record double this rate.¹³³

Foetal alcohol syndrome results from the mother drinking during pregnancy. Research conducted on a sample of 1 201 HIV-positive pregnant women enrolled in prevention of mother-to-child transmission programmes at eight clinics in KwaZulu-Natal gives an indication of levels of alcohol consumption in this province, which is not one of the worst affected by foetal alcohol syndrome.

Overall, 18% of the women reported drinking during pregnancy, of whom nearly three-quarters reported drinking only before they knew they were pregnant. Two-thirds (67%) of drinkers usually had three or more drinks in one sitting and did this twice a month or more. Women living in urban and peri-urban locations were more likely to drink, as were those with higher economic status and greater social engagement. Married women were less likely to drink, while those with poorer mental health, who used tobacco, or who had a greater history of sexual risk-taking were more likely to drink. The educational levels of the sampled women tended to be higher than those for KwaZulu-Natal women as a whole, which limits the extent to which these findings can be generalised.

The authors of the KwaZulu-Natal study refer to studies that have substantially higher estimates for Western Cape – 34% in urban and 46–51% in rural areas for drinking during pregnancy. Other national research cited found 13% of pregnant women

¹³¹ London L. 2015. 1 September 2015. Government fails to tackle its high foetal alcohol syndrome rate.

¹³² May PA, Brooke L, Gossage JP, Croxford J, Adnams C, Jones KL, Robinson L, Viljoen D. Am J Public Health. 2000 Dec;90(12):1905-12, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446431/>

¹³³ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5228a2.htm>

¹³⁴ Katherine Desmond K, Milburn N, Richter L, Tomlinson M, Greco E, van Heerden A, van Rooyen H, Comulada WS, Rotheram-Borus MJ. 2011. "Alcohol consumption among HIV-positive pregnant women in KwaZulu-Natal, South Africa: Prevalence and correlates" in Drug and Alcohol Dependence 120 (2012) 113-118.

¹³⁵ Chersich MF, Urban M, Olivier L, Davies L, Chetty C and Viljoen D. 2012. Universal Prevention is Associated with Lower Prevalence of Fetal Alcohol Spectrum Disorders in Northern Cape, South Africa: A Multicentre Before-After Study. Alcohol and Alcoholism 47(1): 67-74.

reporting alcohol use in the past month. The various studies differ as to whether drinking is more common in urban or rural areas.

A “before-after” study conducted in Northern Cape in respect of foetal alcohol syndrome found that community- and facility-led interventions led by community health workers achieved a reduction in the syndrome.¹³⁵ The researchers argue that the syndrome is most common in pregnant women who indulge in binge drinking, and that this drinking pattern is more easily changed by interventions than patterns associated with alcohol dependence.

7.9.4.3 Treatment centres

The Department of Welfare’s statistical report for 1996/97 reported that there were then 24 treatment centres in the country, with a combined capacity of 1 311. All provinces except Northern Cape – which “ironically” had 5 910 people seeking help for substance abuse-related problems – had at least one treatment centre, although these were not necessarily government-owned centre. Gauteng had eight centres.

Table 58, compiled from a recent DSD database, records a total of 38 in-patient centres, 15 out-patient, and 15 combined in- and out-patient centres if all facilities – government, NPO and private – are included. Limpopo records only a single outpatient centre which is managed by an NPO.

Table 58: Substance abuse facilities by province, funding and managements

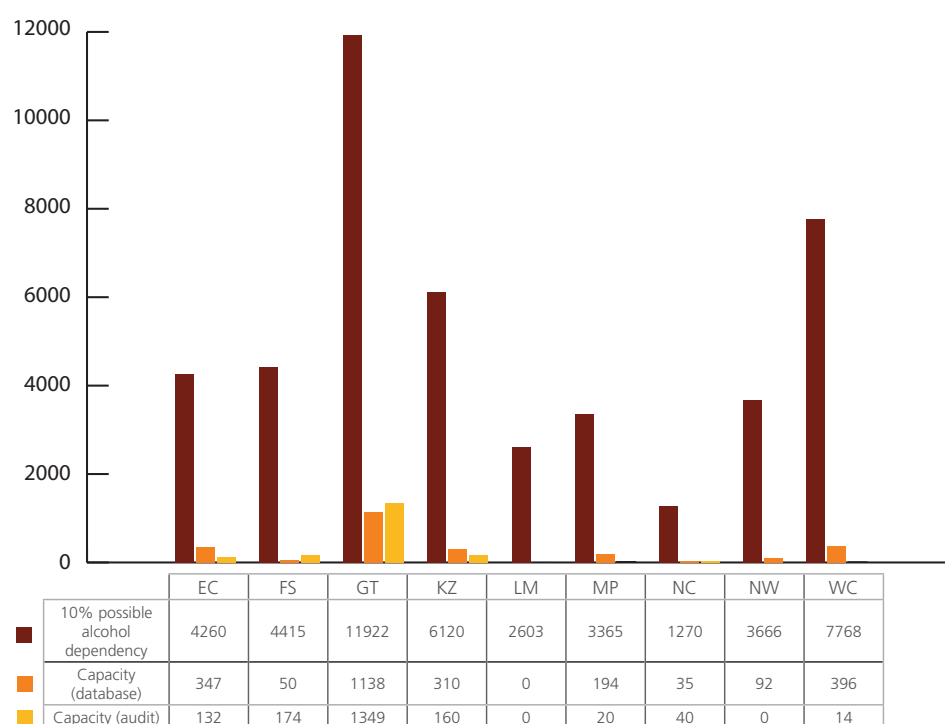
Province	Type of facility	Capacity	Funding	Owner/management
EC	2 in/outpatient	?	1 funded	1 NPO, 1 private
	7 inpatient	?	2 funded	1 NPO, 6 private
	3 outpatient	?	1 funded	2 NPO, 1 private
FS	1 in/outpatient	50	Funded	NPO
	2 outpatient	90	Funded	NPO
GT	5 in/outpatient		3 funded	3 NPO, 2 private
	14 inpatient		6 funded	1 state, 8 NPO, 5 private
	27 outpatient		27 funded	26 NPO
	1 halfway house		1 funded	1 private
KZ	2 in/outpatient	?	Funded	NPO
	2 inpatient	127	1 funded	1 NPO, 1 private
	6 outpatient	?	1 funded	NPO
	1 halfway house	50	Funded	?
LM	1 outpatient	100	Funded	NPO
MP	6 inpatient	214	1 funded	1 state, 1 NPO, 3 private
	4 outpatient	221	Funded	NPO
NC	1 inpatient		0 funded	Private
	1 outpatient		0 funded	NPO
NW	4 inpatient	131	1 funded	1 state, 1 NPO, 2 private
	2 outpatient	40	Funded	NPO
WC	5 in/outpatient	?	2 funded	1 PPP ¹³⁶ , 2 NPO
	4 inpatient	204	1 funded	1 PPP, 1 state, 1 private
	9 outpatient	?	6 funded	8 NPO

¹³⁶ Public-private partnership

Figure 28 compares the capacity of in-patient treatment centres, including both funded and unfunded, with an estimate of need. Two estimates of capacity are used. The first is derived from DSD’s infrastructure database. The second reflects the results of an as-yet-incomplete audit. The estimate of need used is 10% of people aged 15 years and above who are potentially alcohol dependent as measured on the AUDIT scale. The percentage chosen – 10% - takes into account that an individual will need a space in the centre for a limited time – typically three months or less – as well as the fact that not all those potentially dependent are, in fact, dependent.

The comparison yields a picture that is even more worrying than that for other services. Gauteng is best served, but also has more than double the number of people in need when compared to every other province except Western Cape and KwaZulu-Natal. Limpopo has no in-patient centres recorded.

Figure 28: Comparing need and capacity: Substance abuse treatment centres



Government has recognised the need for more in-patient treatment centres. In the 2014/15 budget National Treasury introduced a conditional grant to fund establishment of such centres in the four provinces – Eastern Cape, Free State, Northern Cape and North West – which did not have a government-owned centre. The first quarter expenditure report for 2015/16 shows only 1,5% of this particular conditional grant having been spent by end June 2015. DSD explained the limited expenditure to date as having been spent on professional fees with construction of the centres still to commence.¹³⁷ The portfolio committee’s budgetary review and recommendation report¹³⁸ reveals that in Northern Cape the estimated cost of a centre, at R97 million, was far more than the R42 million of the grant. The estimate was subsequently reduced to R67 million, but with the implication that the centre would have 40 rather than 60 beds.

¹³⁷ Gernetzky K. 27 August 2015. “Provinces slower in spending budgets” in Business Day: 2.

¹³⁸ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015

In the absence of government-funded centres, poorer people are excluded as the private sector centres charge unaffordable fees. Even where centres exist, across provinces the Ministerial Committee heard concerns expressed about the lack of after-care services, reflecting lack of acknowledgement about the time needed to address addiction.

The South African Community Epidemiology Network on Drug Use (SACENDU), for which the Medical Research Council acts as coordinator, is one of the few available sources of detailed information in respect of treatment for substance abuse. In 2013 SACENDU published the findings of the Phase 33 report back meetings which covered the second half of 2012.¹³⁹ The findings cover 66 treatment centres spread (unevenly) across the nine provinces. The 66 centres probably account for about 65% of treatment centres that see at least 30 patients in a six-month period, and probably about 80% of patients as the focus is on the larger centres.¹⁴⁰ The 66 on their own represent a substantial increase on the 24 centres reported to be in existence in the Department of Welfare's 1996/97 statistical report.

Free State, Northern Cape and North West are combined by SACENDU for reporting purposes as Central region while the single centre in Limpopo is included with Mpumalanga as Northern Region. The numbers per province are: Western Cape (26); KwaZulu-Natal (6); Eastern Cape (6, but recorded far fewer beneficiaries than in the previous period); Gauteng (16); Mpumalanga (6); Limpopo (1); and Central (5).

Key findings included the following:

- First-time admissions accounted for about three-quarters of all admissions, more than previously. Heroin, over-the-counter or prescription medicines (OTC/PRE) and cocaine had the highest proportions of readmission.
- Across all sites between 75% (in Western Cape) and 90% (KwaZulu-Natal) of patients were male. WC has seen a gradual increase in the proportion of female patients, perhaps because a higher proportion of methamphetamine, heroin and cocaine patients are female than for many other substances.
- Race: In Gauteng 73% and Northern Region 78% of patients younger than 20 years were African. Overall, however, African people were under—represented among patients.
- Employment status and education: Between 19% (Western Cape) and 40% (Central) of patients were employed fulltime. The student proportion ranged from 16% in Western Cape to 28% in KwaZulu-Natal. More than 70% of patients in all sites have some secondary school education. Most patients younger than 20 years are students/learners.
- Age: Across sites the average age was 29-31 years. Patients whose primary substance of abuse is alcohol or OTC/PRE, are much older than for other substances, while patients whose primary substances are cannabis, heroin or methamphetamine tend to be younger than for cocaine.
- Sources of payment: Government was the most common source of payment for treatment in Western Cape (34%), Gauteng (28%) and Central (34%), and “family” in KwaZulu-Natal (42%), Eastern Cape

¹³⁹ Dada S, Burnhams NH, Parry C, Bhana A, Rule C, Kitshoff D, Nel E and Weimann R. 2013. Monitoring Alcohol and Drug Abuse Trends in South Africa (July 1996 – December 2012). SACENDU Research Brief 16(1), 2013. South African Community Epidemiology Network on Drug Use, Medical Research Council: Cape Town.

¹⁴⁰ Information provided by Charles Parry, Medical Research Council.

(43%) and Northern (33%). These patterns reflect relative availability of government-funded centres and of inpatient centres, which medical aids are more likely to cover.

- Alcohol is the most common primary substance of abuse except in Western Cape and Northern. Alcohol accounts for 55% of admissions in the Central Region. (In the 1996/97 Department of Welfare statistical report Free State reported that 66% of substance abuse cases related to substances other than alcohol.)
- Cannabis was the most common primary substance of abuse in Northern Region, where it accounted for 33% of admissions. It was the second most common in Gauteng (26%), Central (20%), Eastern Cape (24%) and KwaZulu-Natal (25%).
- Eastern Cape had highest cocaine percentage, at 7%.
- Between 2% (Central) and 22% (Northern Region and Western Cape) had heroin as their primary drug of abuse.
- Only 1-2% had OTC/PRE as their primary substance of abuse, but these substances are more common as secondary drugs of abuse
- In Western Cape 33% have methamphetamine ("tik") as their primary substance of abuse.
- Between 1% (Western Cape) and 14% (Gauteng) reported tobacco as their primary substance of abuse.
- Between 45% (Eastern Cape) and 65% (KwaZulu-Natal) reported more than one substance of abuse.

7.9.4.3 Ke Moja

Ke Moja is the most widely reported substance abuse intervention across provinces, and the one that reaches the largest numbers. The initiative was launched by the Minister of Social Development in 2003 as a national campaign. The health awareness programme which forms the core of Ke Moja was piloted in Western Cape in later 2007, with support from the United Nations Office on Drugs and Crime (UNODC).

A 2009 evaluation of the Ke Moja programme in Western Cape¹⁴¹ highlighted some worrying weaknesses in the early years of implementation. The identified weaknesses included that the programme was unable to provide the necessary psycho-social support to learners because the facilitators lacked counseling skills, that the programme did not include teachers and parents, that some schools were not doing the full six weeks of the programme and thus not covering all the content, that there was lack of ownership on the part of the Department of Education despite the programme being school-based, that some schools already had similar programmes that competed for class time, and that there were delays in DSD funding.

The main change in learners' behaviour was that they shared information they had received with their family and friends, while educators and principals also increased their knowledge. This suggests very limited impact. The evaluators recommended that content be expanded to include themes related to substance abuse, such as HIV and AIDS and teenage pregnancy, and that further alternatives (beyond sports and indigenous games) be offered as alternatives to drug taking. National DSD's annual

¹⁴¹ Southern Hemisphere. 2009. Draft Report for the Evaluation of the "Ke Moja, I'm fine without drugs" Programme. Submitted to Western Cape Department of Social Development: Cape Town.

¹⁴² Central Drug Authority. 2013. National Drug Master Plan 2013-2017. Department of Social Development: Pretoria

report for 2014/15 notes that a further evaluation of the Ke Moja “campaign” had been commissioned.

The National Drug Master Plan 2013-2017¹⁴² (NDMP) includes matrices that summarise the findings of global research on the effectiveness of various interventions in different areas, such as education and persuasion, research and the like. Taxation, restrictions on physical availability and limits on hours and days of purchase are all found to be effective in respect of alcohol. Findings are less conclusive in respect of other substances. School-based, family and community prevention programmes – which is where Ke Moja would be categorised – are found to have a “modest impact, the value of which is appraised differently by different stakeholders.”

7.9.5 Roles and responsibilities

The National Drug Master Plan 2013-2017 (NDMP) is framed around three broad strategies of demand reduction, supply reduction and harm reduction. This reflects a global shift from a previous emphasis primarily on supply reduction. UNODC and the World Health Organisation emphasise primary prevention – more or less equivalent to demand reduction – in particular.

The NDMP envisages all national and provincial government departments incorporating substance abuse problems in their planning and budgeting, and submitting drug master plans to the Central Drug Authority (CDA) each year. The CDA, in turn, must submit an annual report that the Minister of Social Development must submit to Parliament before end September each year. The CDA itself consists of 13 experts on substance abuse appointed by the private sector, and representatives of 18 national departments and three other national government entities. The CDA is based in, and funded by, national DSD. There is also an Inter-Ministerial Committee on Alcohol and Drug Abuse.

The NDMP identifies a relatively large number of departments as “pivotal in the fight against drugs”. Table 59 summarises the responsibilities described in the NDMP for each agency.

Table 59: Responsibilities of government agencies in respect of substance abuse

Agency	Responsibilities
DSD	Lead in the action against substance abuse. Technical and financial support to the CDA and its Secretariat. Develops generic policy on substance abuse. Provides treatment centres at community and tertiary levels in collaboration with the Department of Health.
Arts and Culture	Support to occupational groups at risk, such as artists, musicians and others. Using the arts to provide alternative development among the youth and learners, as part of the prevention of substance use and abuse.

Agency	Responsibilities
Correctional Services	Prevention of drugs entering the correctional centres, reducing demand among offenders by means of educational programmes and implementing harm reduction strategies and rehabilitation programmes for offenders suffering from substance abuse, in line with Department of Health protocols.
Basic Education	Using the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions... The prevention aspects of the policy are largely implemented through the life skills programme... supported by peer education strategies that aim to change social norms about high-risk behaviours.... random search and seizure as well as drug-testing procedures in schools Implementation Protocol (2011) with the South African Police Service ... with schools linked to local police stations.
International Relations and Cooperation	Bi-lateral and multi-lateral agreements with other countries and international agencies for the effective management of substance abuse and ensure compliance with international obligations
Health	Development of legislation and policy guidelines for early identification and treatment. Collaboration with the Departments of Basic Education, Higher Education and Training, and Social Development on national awareness. Support for treatment centres through advising on detoxification programmes, the appointment and support of medical personnel, capacity building and supervision.
Higher Education and Training	Prevention.
Home Affairs	Dealing with drug abuse by deportees at deportation facility.
Justice and Constitutional Development	Refers offenders that require drug-related treatment to treatment through a variety of mechanisms. Asset forfeiture of the gains/property that came about as a result of crime as well as through deterrent sentences in the courts.
Labour	Development of workplace policies on substance abuse.
Medicines Control Council	Applying standards to govern the manufacture, distribution, sale and marketing of medicines.
National Youth Development Agency	Youth development policy to include substance abuse and related issues.
SAPS	The Directorate of Priority Crime Investigation (or Hawks) combats drug trafficking organisations; National Chemical Monitoring Programme prevents diversion of precursor chemicals and laboratory equipment for illicit drug production
South African Revenue Service	Controls cross-border movement of goods including prohibited and restricted goods.

PART VI:
Review of
welfare and
community
development
services

Agency	Responsibilities
Sport and Recreation	The Drug-Free Sport Act (no 14 of 1997) outlaws doping practices, establishes the South African Institute for Drug-Free Sport and empowers it to conduct a national drug-testing programme.
Trade and Industry	Administers and enforces the Liquor Act (no 59 of 2003) through the National Liquor Authority. The Department's International Trade Administration Commission issues import and export permits for certain controlled precursor chemicals used in the production of illicit drugs.
Transport	Co-ordinates the activities of provincial and local authorities through the Road Traffic Management Corporation.
Cooperative Governance and Traditional Affairs	Combat substance abuse at the provincial and local government level.
National Prosecuting Authority	Partners with other law enforcement agencies.

Focusing on the key actors, national-sphere responsibilities can be summarised as follows.¹⁴³

- DSD focuses on treatment;
- Department of Health focuses on detoxification and cases where there is psychiatric morbidity, is responsible for some laboratory work (toxicology), and reports to the International Narcotics Control Board on certain medications manufactured in or imported into South Africa;
- The Medicines Control Council focuses on control of medicines;
- SAPS focuses on crime and forensic testing of drugs seized;
- Sport is concerned with drug use in sport;
- Foreign Affairs reports annual to the United Nations;
- Education manages drug testing in schools;
- The Departments of Agriculture, Trade and Industry and Transport have roles in respect of alcohol. For example, DSD, DOH and Trade and Industry worked together on developing the draft bill on the content of alcohol marketing which has been approved by Cabinet.

While the documents appear to delineate clear roles, there are similar challenges for substance abuse as for older persons in terms of delineating the roles of DSD and DOH. As with older persons, the challenges in part reflect the fact that social development (then welfare) and health were previously combined in a single department at provincial and national levels. The substance abuse function was allocated to DSD, which is responsible for running and/or funding treatment centres. The related health issues, including co-morbidities, detoxification and some similar medical interventions must be provided by health practitioners. DSD currently employs and pays for (some of) those practitioners.

Both DOH and DSD favour a move towards a community-oriented model instead of two months of inpatient treatment.¹⁴⁴ This approach requires more cooperation between the two departments. The detoxification element will still probably need to happen within a health facility and would be DOH's responsibility. However, DSD would then

¹⁴³ Summary provided by Charles Parry, Medical Research Council

¹⁴⁴ Information from Melvyn Freeman, national Department of Health.

need to be responsible for a community programme as otherwise there would not be long-term impact. This model is already working in some places but not as effectively as it should. It places additional burdens on treatment facilities because when it does not work, people get sent to the facilities. The division of responsibilities has not yet been agreed on for the more community-based model. Part of the problem is that DOH is very short-staffed on substance abuse (and older persons) because these functions were taken over by DSD. So, for example, there is a single deputy director in the national DOH on substance abuse (and an assistant director for older persons).

7.10 Poverty reduction, community development and sustainable livelihoods

The White Paper did not include a focussed discussion of services in respect of poverty alleviation, community development and sustainable livelihoods. This presumably reflects the fact that this type of service was far less common at that point before the concept of developmental social welfare emphasised the economic aspect. The only aspect that was specifically discussed in the White Paper was the grant system that already in 1997 was a key element in South Africa's social security system. The grants are discussed in a separate section on social security below.

7.10.1 Findings of the Ministerial Committee

Poverty alleviation, community development and sustainable livelihoods services were reported on and discussed extensively in the provincial and district engagements. Submissions and presentations on Community development within provincial DSD and by the provincial NDA, in particular, focused on this area. Many of the NPOs, as well as government submissions on other service areas, referred to support for income generation, cooperatives and other "livelihood" activities that would fall within this category. This is not surprising given that poverty alleviation and sustainable livelihoods are often seen as emblematic of the difference between developmental social welfare and traditional social welfare.

The Committee finds that in all spheres of government, as well as in the community sector itself, there is a lack of clarity about the place, functions, processes and programme activities that constitute community development. This lack of clarity and understanding creates a disabling environment for community development practitioners.

The Committee recommends that at national, provincial and local levels within DSD the concept of community development needs to be clearly defined, its links with poverty and sustainable livelihoods identified and the series of activities that lead to building community resilience requires urgent attention. If the objective of community development is to strengthen community resilience and coping in situations of poverty and deprivations then programmes or activities designed to do this should include a number of processes. These could, for example, include the facilitation of adult education, the sharing of knowledge on how to access resources, and developing structures for community decision making on community issues and community planning for social welfare services.

A key issue that was identified is the lack of recognition of community development practitioners as a professional category, the lack of appropriate education and training for professional community development practitioners and absence of appropriate provision of workplace supervision by supervisors with appropriate knowledge and skills in professional community development practice.

In a round table on community development and sustainable livelihoods convened by the Ministerial Committee, there were presentations from a range of different actors who link community development to job and enterprise creation and skills development of young unemployed individuals. In many cases employment generation is combined with an endeavour to produce socially useful assets, goods and services that are of benefit to poor communities. The presentations included examples of corporate social investment, youth academies, EPWP and the Community Work Programme, the National Youth Development Agency, the Independent Development Trust, the social enterprise work supported by the ILO, and university community engagement initiatives.

The Committee found that most participants in community development and enterprise development came from outside of the social welfare field. This illustrates the need for DSD's sustainable livelihoods and community development programme to clarify its place, role and functions in relation to other sectors also working to achieve community development. Currently a multiplicity of actors reinforces the danger of duplication and lack of coordination. One of the strong calls in the round table was for an inventory to be established of all relevant initiatives. Given the wide range of different initiatives, ranging from small local initiatives involving a few people to the nation-wide EPWP, and given the short lifespan of many initiatives and multiplicity of government and non-government actors involved, such an inventory, although important, is unlikely to be delivered.

While participants in the round table welcomed some impressive achievements in community and social enterprise, they also reflected on the many challenges that affected these initiatives. The challenges included that the performance of the cooperatives and small businesses supported had been less good than hoped; the paucity of innovative business ideas and low levels of entrepreneurship; the limited types of skills training provided in the various initiatives; and the difficulty in finding employers for the beneficiaries of the different programmes. These challenges were not surprising given the current economic context in South Africa.

The round table included a presentation and extensive discussion of social grants. Participants recognised that the grants did not target a large proportion of the population who were poor and might need some sort of assistance, namely those aged 18-59 years who were without vocational education and without access to decent paid work. While the grants are targeted at older people, people with disabilities and children, all of whom are not expected to work to support themselves, they had become de facto poverty grants that supported other members of the household. In so doing, the impact of the grants for the targeted individuals was diffused. For this and other reasons, the round table proposed that the focus for the 18-59 year olds must not be only on delivery of welfare services, but also on understanding how those without access to decent paid employment can begin to gain access to skills and income-earning work through different initiatives.

In a presentation on this area of work, national DSD categorised the different interventions in the livelihoods area into five categories using the functions highlighted in the NDP, as follows:

- Protective: Food and nutrition security through FoodBanks, community nutrition development centres, and household food production; and facilitation of EPWP and Community Work Programme;
- Preventative: Social audits through household and community profiling; community and youth mobilisation programmes; and the sustainable livelihoods programme targeted at youth, women and people with disabilities;
- Promotive: Capacity development and management for youth, women, people with disabilities, communities, institutions and practitioners; coordination of Community Development services, and youth leadership [development];
- Transformative: Review and development of policies, strategies and programmes for communities, youth and women; facilitation of the social transformation process; and promotion of asset-based community development;
- Developmental and generative: Community economic analysis for local economic development, strengthening of assets of households for sustainable development; establishment of and support to cooperatives facilitation of social enterprise initiatives; and community savings.

Partly mirroring what was reported in the round table, most of those who reported in provinces and districts on livelihood activities noted achievements of various kinds. Sometimes this was expressed in general terms, but often specific projects were named as successes. For example, service providers in KwaZulu-Natal reported that active support, including funding, for community projects was beginning to show positive results with projects becoming self-sustaining. They pointed to a Lamontville food gardening and sewing project as evidence. In Gauteng, the NDA noted that a few projects had been successfully moved from “welfare” to “development” through assistance with products and equipment. Two projects in particular were named, one producing school shoes and the other vegetables. However, as in other provinces, many projects had failed to become sustainable. In Western Cape, movement from “welfare” to “development” was hoped for in targeting beneficiaries of food parcels and CSG recipients when selecting beneficiaries for Taiwan-funded projects and other DSD ministerial interventions.

Overall, however, the reach and impact of livelihood initiatives were relatively small compared with the extent of poverty and joblessness, and also compared with the reach of other assistance. Eastern Cape, for example, reported financial support for [only] six income generation and four women’s cooperatives encompassing food gardens, poultry, crop production, bakery, leather works, bead work, sewing, candle making, catering skills, computer training and life skills. The province claimed that the support enabled the beneficiaries “to be self-sufficient and restoration of self- dignity.” In North West, the NDA reported that it had funded a maximum of 12 project in any one year since 2006/07, and a maximum of eight per year since 2007/08. Funding had decreased from R12 million in 2007/08 to R3,8 million in 2014/15

In Northern Cape DSD reported that 325 grant beneficiaries had been linked to sustainable livelihoods initiatives through various other government-related agencies, and about 403 project members had received stipends. However, of the 190 projects reported, 109 related to soup kitchens, alongside 26 food gardens, six crop production projects, and 17 “socio-economic” projects. The soup kitchens and drop-in centres had reached 32 487 households in 2013/14. The extent of funding support since 2009/10 amounted to R33 million for soup kitchens; R41 million for drop-in centres; R8 million for socio-economic projects; and R5 million for food security. In Free State the NDA proposed that household food garden programmes “must be rolled out en masse to create a culture of being able to produce for self-sustenance” but reported that currently only 500 households were involved in food garden programmes.

There were some indications across provinces of reluctance to engage in projects on the part of community members. As seen above, Northern Cape provided stipends for project members. In North West and some other provinces beneficiaries and other participants expressed unhappiness about the lack of such stipends. In the Eastern Cape, an NPO that had experimented with a food-growing project concluded that while there was a range of different challenges, the main reason the project had stopped functioning was that in informal settlements on the outskirts of cities “youth want gainful employment and the older persons probably have their hands full with caring for grandchildren etc.” She concluded: “Not every perceived good idea is a good one. Lesson learnt.”

Across provinces, officials in charge of this area of work noted the lack of markets as a barrier to the success of cooperatives. They suggested that government should favour cooperatives when procuring goods, such as food for ECD centres or uniforms for OVC. There were some examples cited where this was happening. The NDA in Western Cape suggested that a percentage of goods and services procured by government and public enterprises be ring-fenced for local cooperatives and small and emerging enterprises.

A potential contributing factor to success was where other agencies collaborated with DSD and/or the NDA to provide support. Northern Cape NDA reported that an “important reason for the success and viability of Cooperatives is because of the plethora of inter-governmental support programmes directed at Cooperatives. Therefore, in most instances NDA funded Cooperatives have been able to attract other government programmes in a partnership that makes these ventures more sustainable over the long term.” On the negative side, drawing support from multiple points is sometimes seen as “double-dipping” in other contexts, and limits the overall reach of assistance in terms of number of beneficiaries.

In light of ongoing project failures, especially if success is assessed in terms of sustainability, several submissions noted new approaches. KwaZulu-Natal NDA said that their new funding model, introduced in 2014/15, included small grant allocations to existing projects to allow them to consolidate and improve sustainability and job creation. Limpopo DSD said it had moved away from small grant funding to larger amounts so as to encourage sustainability, job creation and improved “livelihood conditions of poor households.” In Gauteng the NDA had established advisory centres in all districts. In a new advisory centre in Maponya Mall, interns and unemployed graduates were providing information, references, and assisting with applications, compliance and compilation of business plans.

As seen above, Northern Cape commented positively on the existence of a “plethora” of different supporting actors. The same province commented on collaboration with the Departments of Agriculture, Education, Health and Water and Affairs and Forestry in the establishment of community food gardens. In 2012/13 responsibility for the gardens was handed over to Agriculture. Northern Cape also reported that the Independent Development Trust had channelled funds from its Poverty Relief Programme to provide start-up capital for income-generating opportunities to NPOs. In other provinces there were sometimes concerns about overlap between agencies. In particular, there seemed to be concerns that the NDA was being allocated funds that should instead be given to DSD for either similar or other services.

Across all provinces, DSD reported profiling as a key activity within Community development. The profiling occurs at various levels – household, community and district. The activity creates temporary stipended jobs and imparts some skills or experience to the (usually young) unemployed people who visit households. Thus, for example, Free State DSD reported that young women accounted for more than 50% of the EPWP-funded “Door Knockers Project” initiated in 2014. The door knockers received R1 500 per month and assisted with profiling and identifying child-headed households.

The intention behind the profiling is that it will allow targeting of assistance to individuals, households and communities in need. North West reported that the household profiling had generated referrals for interventions by other actors and facilitated development of community-based plans for household and community interventions, programme design and municipal integrated development plans. In Free State, 101 young people, identified through household profiling, were placed in accredited skills development training, and 27 “change agents” identified through profiling were assisted with studies or in establishing their own businesses.

There are, however, concerns about the reliability of the information generated by the profiling exercises. In Northern Cape, the Balelapa Household Profiling Status study of 2012 identified more than 48 250 “no-income” households in the province, compared to the 36 039 households living in chronic poverty enumerated in the 2011 Census. However, the report on Balelapa noted that sample realisation was low, and the province commented that a non-interviewed household could be just as poor as those identified as poor. Information from profiling will also quickly become outdated unless regularly updated giving migration and other frequent changes in circumstances. Further, the extent to which the exercise has been undertaken varies substantially across provinces, and it is not clear if the information gathered is actually used in all provinces.

EPWP does not fall under the sustainable livelihoods budget sub-programme. Instead, it spans other sub-programmes within DSD (and beyond) which may fund employment of workers. The sub-programmes that do this differ across provinces and also across years within a particular province. EPWP is discussed here in the absence of another appropriate location in this report given its poverty alleviation focus.

Several provincial DSDs reported that EPWP was being used in different areas, including home-based care, ECD, youth development, Isibindi, and VEP. There were, in particular, reports that EPWP was used to provide opportunities for youth. Several NPOs reported that they had received some EPWP funding. There were indications, however, that the

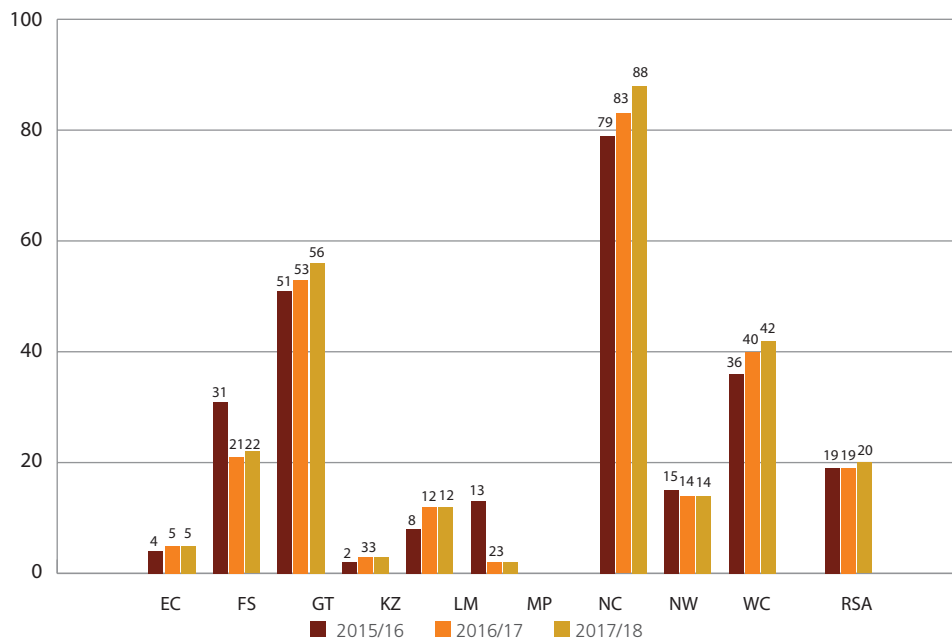
funding and use of it was erratic, both for the provinces and for the NPOs. This reflects in part the way in which EPWP is budgeted, one year at a time.

NPOs were generally grateful for EPWP funds received. However, one Free State NPO felt that payment of stipends (presumably whether through EPWP or other means) was problematic in that it created the perception that individuals should receive compensation for voluntary work.

7.10.2 Budget analysis

Figure 29 shows the poverty alleviation and sustainable livelihoods allocations per poor person for each of the nine provinces and for the country as a whole for each of the three years of the 2015/16-2017/19 MTEF. (The mid-year population estimates for 2014 are used as the basis for population estimates for all three years.) For the country as a whole, the nominal amount increases very slightly in each year. However, for Free State and Mpumalanga the 2015/16 amounts are larger than for each of the following years, even in nominal terms (i.e. before adjusting for inflation). In absolute terms there are massive differences between the amount per person across the provinces. Northern Cape has an allocation of R79 per poor person in 2015/16 while at the other end of the scale the allocations for Eastern Cape and KwaZulu-Natal, and Limpopo, which are among the poorest provinces, are less than R10.

Figure 29: Poverty alleviation and sustainable livelihoods allocations per poor person by province, 2015/16-2017/18



7.10.3 Roles and responsibilities

National DSD serves as the lead for social sector EPWP. DSD’s role as the lead is housed in the department’s Special Projects and Innovation. A national DSD presentation to the Ministerial Committee noted that provincial budget cuts hampered the meeting of EPWP targets. The same presentation and other reports noted that lack of dedicated EPWP coordination personnel in KwaZulu-Natal, Mpumalanga and Western Cape negatively affected DSD’s ability to play the lead role assigned to it.¹⁴⁵

¹⁴⁵ Critical Balance Report to the Minister – EPWP – February 2013 update.

The Community Work Programme (CWP) was first piloted in 2007 under the auspices of the Presidency and DSD. In 2008 it became part of the EPWP, and was subsequently placed under the Department of Cooperative Governance (DCOG) because of the key role of municipalities in the programme. However, a Cabinet lekgotla instructed that DSD should work together with DCOG on implementation.¹⁴⁶ The two departments defined their respective roles and responsibilities as follows:

- DCoG: Responsible for the overall implementation of the programme
- DSD: Facilitate provision of integrated social development services in all CWP sites (148 by early 2013); registration, monitoring and support of NPOs.
- DCoG and DSD: Prepare and present reports to steering committee and Inter-Ministerial Committee; resource mobilisation.

Signing of a memorandum of understanding to this effect was delayed by the restructuring process within DCOG, but such a memorandum finally came into effect in October 2014. A DCOG-DSD forum was also established to discuss relevant issues. The memorandum provided, among others, for development of joint implementation plans for collaboration on identified projects, strengthening of community development approaches in identified sites by DSD, and facilitation of delivery of integrated social services in the sites.

After signing the memorandum DCOG and DSD embarked on a series of road shows which focused mainly on DSD-related types of work that might be done within CWP sites, such as home-based care, psychosocial support, ECD and partial care. DSD used the opportunity to highlight the relevant policy frameworks, norms and standards, training and skills required for the relevant services.

¹⁴⁶ Critical Balance Report to the Minister – CWP – February 2013 update.

7.11 Youth development

The White Paper noted inconsistency in how the South African legal system defines children and youth. It recorded that there were close on 11 million people in the country between the ages of 16 and 30, representing 33% of the working age population. Problems affecting this group included unemployment, school dropout, teenage parenthood, “delinquency”, crime, and exposure to sexually transmitted infections and violence. It suggested that nearly 75% of young people “of all races” were marginalised or at risk of marginalisation.

7.11.1 Updating the White Paper

Currently, youth are often defined in South Africa as young people between the ages of 15-34 years, in line with practice in other countries in Africa. There is, however, increasing acknowledgement that this definition is not always appropriate for policy making and design and implementation of programmes as the group encompasses people in very different circumstances. For example, people at the bottom end of this age range are, or should ideally be, in school or further education. In South Africa even school education can extend into the early twenties. Those at the other end of the age spectrum will ideally be employed. Many will themselves be parents in families established apart from their parental family.

Currently, young people aged 15-24 years account for 19,4% of the population, while those aged 25-34 years account for a further 16,7%. Together these two age groups account for 36,3% of the total population, and 56,0% of the working age population (those aged 15-64 years).¹⁴⁷ The unemployment rate in these age groups is much higher than for their older peers – at 51,3% for those aged 15-24 years and 30,1% for those aged 25-34 years. Expressed differently, youth account for about two-thirds of unemployed people in the country. The large numbers of especially younger youth who are still studying full-time are not included in these computations. Close on two-fifths of youth are not in employment, education or training (NEET).¹⁴⁸

A wide range of youth programmes and services has emerged over the years, offered by a wide range of different agencies, including government, government-related, non-profit and corporate. These services are seldom coordinated with each other, resulting in duplication alongside huge gaps. While all the needs noted in White Paper 1997 remain, the need for employment and related education and training has emerged as one of the most pressing.

Much of the discussion of youth refers to (poor) youth in general, and does not adequately consider the different needs of young women and young men. This often results in more focus on young men and their needs than on young women, perhaps because the consequences of ignoring the needs of young men are seen as more threatening to society in general. The lack of consideration of young women’s needs ignores, in particular, needs related to their reproductive and unpaid care work roles.

7.11.2 Other findings of the Ministerial Committee

Five services for youth development were identified in the quantitative tool. They were youth development centres, life and personal skills development, work skills development, leadership development, and Masupatsela youth pioneers.

¹⁴⁷ Statistics South Africa. April 2015. Demographic indicators and shifts in South Africa since 1996. Presentation to Ministerial Committee Retreat.

¹⁴⁸ Calculated from Quarterly Labour Force Survey 2015:1.

Youth development services scored low overall, with means of between 1,4 and 1,9 for four of the services, and a mean score of only 0,6 for Masupatsela youth pioneers. The Masupatsela score was lower than for any other service across all service areas. Life and personal skills development scored highest overall, and was also scored highest by users and providers. Leadership development was scored second lowest by all three groups.

Masupatsela was scored lowest of all youth services across all provinces, although the score for Masupatsela was noticeably higher in Mpumalanga and Northern Cape than in other provinces. These two provinces were also scored noticeably higher than other provinces for leadership development. Eastern Cape and Free State tended to be among the lowest scorers on the various youth services.

In the submissions and discussions during the Ministerial Committee's engagements, many of the mentions of youth related to employment creation. Some of these mentions related to other service areas. However, there is an overlap with work and skills development to the extent that employment opportunities, even without training, provide work experience to youth, and probably also provide skills even if there is no explicit training component. Masupatsela is also an employment creation programme to the extent that youth earn stipends while on the programme.

Masupatsela was reported on by many of the provincial DSDs, at least in passing, but was not mentioned by NPOs. The overall picture was diverse and confusing. In the Cape Town district focus groups in Western Cape none of the three stakeholder groups was aware of Masupatsela. However, Western Cape DSD reported that they were establishing youth focal points and working with job seekers under the Masupatsela umbrella. It seemed that the programme was also still in place in Eastern Cape, Gauteng and Mpumalanga. In Gauteng, service providers said it was part of the EPWP. The programme seemed to have disappeared in some other provinces. In Limpopo, for example, the termination of Masupatsela was reported to have been "negative to the up-scaling of youth services in the province."

In Free State and North West, (some) Masupatsela youth had been absorbed within government. In North West beneficiaries and practitioners in one district reported that the Masupatsela programme had been available in 2010/11, but was no longer available. In the other district beneficiaries reported that pioneers had been absorbed by government as auxiliary community development practitioners. Eastern Cape similarly reported that 341 pioneers were employed as auxiliary community development practitioners in 2011/12. These youth had assisted with household profiling and facilitation of community development. The change had increased the youth's monthly income from R1 500 while they were in Masupatsela to the much higher government salary level 5. Eastern Cape DSD had subsequently recruited a further 611 young people into Masupatsela. Eastern Cape practitioners reported that the pioneers received training through learnerships. This implies that they received accredited training. There were no references to accredited training in other provinces.

The Masupatsela work opportunities are by no means the only ones that are provided for youth. Mpumalanga, for example, reported that more than 1 200 "temporary work opportunities", with stipends, had been created for young people. Mpumalanga also recorded the negative impact for the (DSD) youth development service area of the transfer of the National Youth Service to the Department of Education.

There were several negative comments about youth initiatives in North West. Firstly, North West DSD felt that “high-risk interventions for youth-led initiatives” had been funded whereas the focus should have been on structured skills development programmes. North West service providers cited the Deputy Minister’s Review of the youth policy which reportedly found the internship programme to be a “cheap labour strategy”. The service providers felt that NPOs and the private sector were the only ones doing something about the situation, while government “has abdicated completely.”

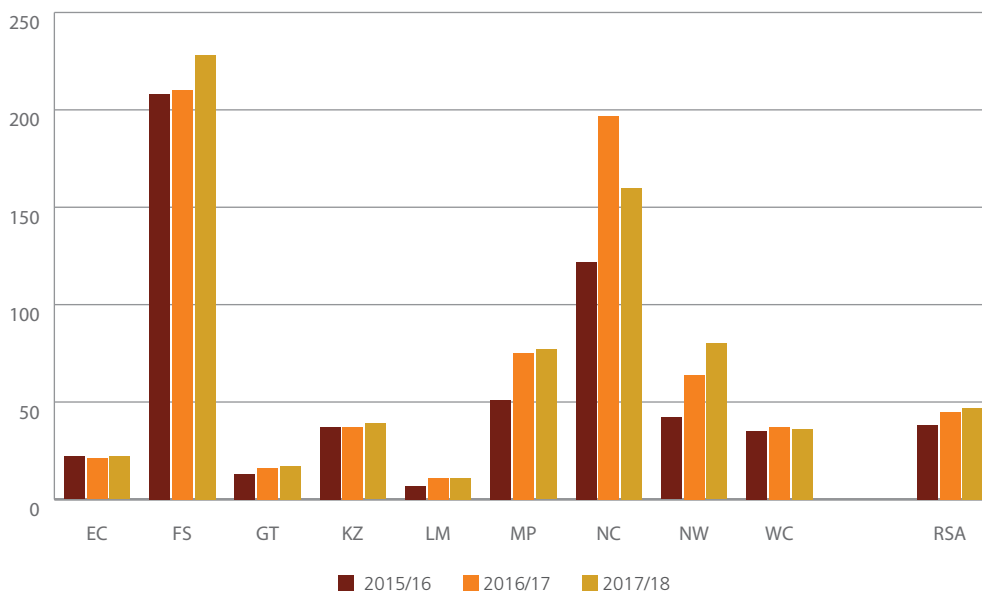
Limpopo NDA noted that youth were not interested in community development programmes especially when they related to agricultural activities. Somewhat similarly, in the round table on sustainable livelihoods, one of the agencies reported that they had discovered “through bitter experience” that youth were not homogeneous and were not necessarily interested in “pick and shovel” jobs.

National DSD’s annual report for 2014/15 describes DSD’s mandate in terms of contributing to the National Youth Development Agency strategy as being to mobilise young people, contribute to their life skills and (employment-related) skill development and to enhance their livelihoods. Reported activities for 2014/15 included youth dialogues, establishment of youth clubs, skills development programmes, and a National Youth Leadership Camp hosted in collaboration with the Department of Defence.

7.11.3 Budget analysis

Figure 30 shows the per capita allocations for youth development over the MTEF, with the allocations divided by the number of youth aged 18 to 29 years who are not in employment, education or training (NEET). This denominator is chosen as an approximate representation of the target group for this sub-programme. The NEET estimate is derived from the Quarterly Labour Force Survey 2015, first quarter data. As a proportion of all young people in this age group, NEET vary between 36% in Western Cape and 55% in Northern Cape. Eastern Cape, North West and Northern Cape all have 50% or more of this age group recorded as NEET.

Figure 30: Youth development allocation per NEET by province, 2015/16-2017/18

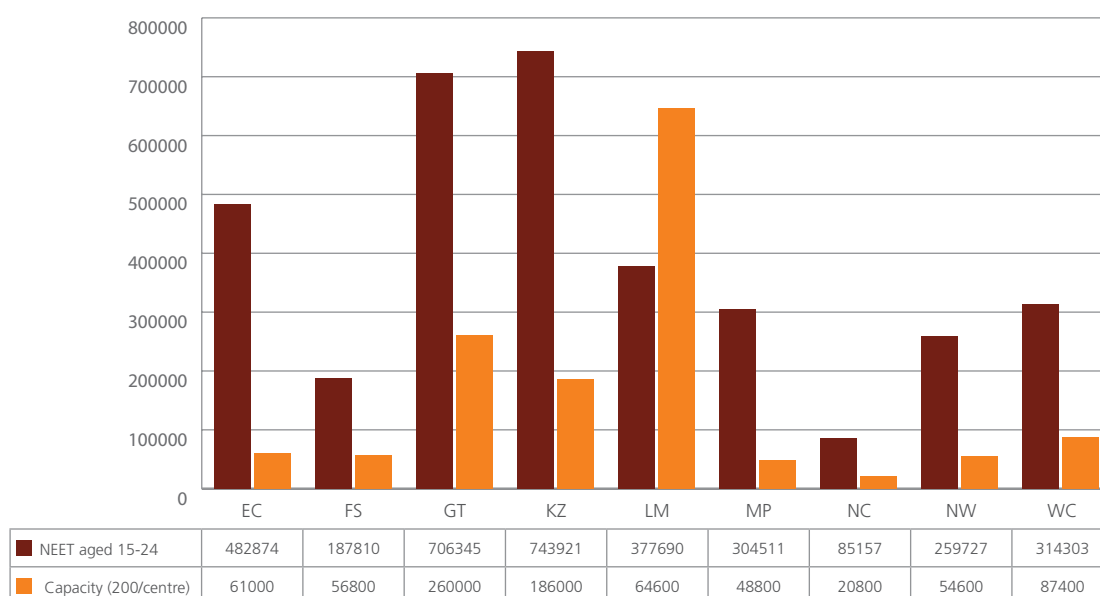


The per capita amount ranges in 2015/16 from only R7 in Limpopo to R208 in Free State. Northern Cape stands out as having a particularly volatile allocation. North West shows a sharp increase over time. For the country as a whole, there is a small increase over time in the nominal amount. The increase would be smaller if adjusted for inflation.

Figure 31 compares the reach of service delivery through youth development centres with the need for such services. It uses data from national DSD’s infrastructure database on the centres, and GHS 2014 data for an estimate of the number of young people aged 15-24 years who are not employed and also not in education. In the absence of information on the reach of each centre, it is assumed that a centre can serve 200 young people.

The figure shows the number of youth needing services clearly outnumbering the number that can be served by centres across all provinces. Gauteng is best served on this measure. This can be at least partly explained by both more work and more educational opportunities being available in this province. However, even in Gauteng more than half of young people in need will not be able to be services. Eastern Cape is particularly poorly served.

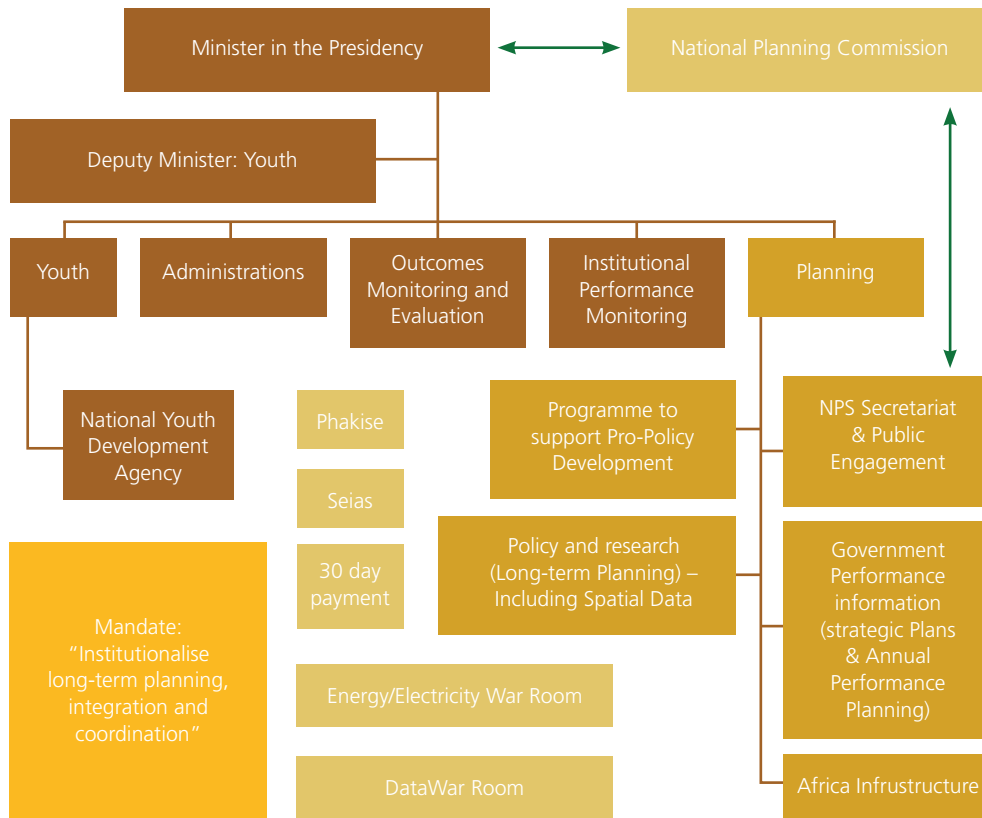
Figure 31: Comparing need and capacity: Youth development centres



7.11.4 Roles and responsibilities

The Deputy Minister for Performance Monitoring and Evaluation has overall national responsibility for youth and, in particular, is responsible for the National Youth Development Agency and youth policy. The Presidency does not currently have a dedicated departmental unit responsible for youth. Instead, staff from other branches of the Presidency and the Director-General's office support the deputy minister as necessary. The organogram below shows the lines of responsibility graphically.

Figure 32: Presidency organogram for youth development



The linkages between the work of the Deputy Minister in the Presidency responsible for youth and the DSD activities and funding related to youth need to be clearly understood so that the various arms of government work together in the allocation and use of resources.

7.12 Women development

The White Paper notes the diversity among women in South Africa, especially in respect of race, class and location (rural-urban), but also noted that there were "commonalities" in respect of gender inequality. It highlighted illiteracy and poverty as "major obstacles to women's advancement".

The White Paper highlighted the challenges imposed by customary marriages not having the same legal status as civil marriages. It suggested that this was a more serious problem for women in urban areas "where traditional community systems protecting women have broken down". In a paragraph on care-giving roles, it noted that women provided the bulk of "social care" to people who are ill, disabled, young or elderly, and that this contribution is "unacknowledged". It elaborated on reproductive needs, pointing in particular to both teenage pregnancy and unsafe abortions.

7.12.1 Updating the White Paper

The rate of female unemployment remains higher than the male rate the population as a whole as well as for all population groups. Women account for 51% of the working age population (15-64), but only 44% of all employed people, 49% of unemployed people, and 59% of the not economically active. Women account for 42% of people employed in the non-agricultural formal sector, 38% of those in the non-agricultural informal sector, 32% of those in agriculture, and 77% of those in private households. Approximately a million women work in private households, with these mainly domestic workers accounting for 15% of all female employment. While there is now a minimum wage for domestic workers, the minimum wage is lower than for any other sectoral determination. On a more positive note, levels of illiteracy are less of a challenge than before, with 7% of adult women (18 years and above) categorised as illiterate in the General Household Survey of 2014 as compared to 5% of men.

The Recognition of Customary Marriages Act addressed some, although not all, of the problems associated with customary marriages. There has, however, not been the expected take-up in terms of registration of such marriages. Problems remain in respect of recognition of Muslim and Hindu marriages. Lack of recognition places the women involved in a vulnerable position economically as well as in other ways.

The importance and contribution of unpaid care work is more recognised than it was previously both in South Africa and beyond. Recognition has not, however, necessarily been accompanied by the other two "R"s, namely redistribution of the work (for example, to men, government or other actors) and reduction of the work (for example, through labour-saving devices, or availability of public or private services).

The rate of teenage pregnancy has remained high in subsequent years, although it is not necessarily increasing. Fears that the availability of the CSG would encourage teenage pregnancy have been disproved by the lower rates of take-up of the grant among younger than older mothers as well as several studies. Branson et al¹⁴⁹ analyse data from six large national household surveys conducted over a 14 year period. Because the surveys ask about the birth history of women, the data can be used to produce a picture of teenage childbearing since 1980. The paper usefully disaggregates results for adult teenagers (those aged 18 and 19 years) and child teenagers (under 18 years of age). The analysis finds that in the period 1985-89 more than 30% of women gave birth during their teens. The rate was 34% for African women. By 2004-08, the percentage had fallen to 23%, with most of the decline happening in the late 80s and early 90s. The rate for African women has remained at about 30% since the early 1990s. For all race groups combined, the percentage of women who gave birth before age 18 declined from 14% to 9.7% between 1980-84 and 2005-08, while the percentage of women who gave birth while 18-19 years old showed little change (15.6% to 14.0%). Mpumalanga and Limpopo were found to have higher levels of teenage childbearing throughout the period. All provinces except KwaZulu-Natal and Northern Cape showed a decline in teenage childbearing over the period. Further, Department of Health data do not show an increase in the share of teenage women presenting at ante-natal clinics. In addition, the majority of teen births are to young women who are 18 or 19 years old, and thus adults.¹⁵⁰

¹⁴⁹ Branson N, Ardington C and Leibbrandt M. 2013. Trends in teenage childbearing and schooling outcomes for children born to teens in South Africa. A Southern Africa Labour and Development Research Unit Working Paper Number 98. Cape Town: SALDRU, University of Cape Town

Despite this solid counter-evidence, DSD's 2011 Integrated Social Crime Prevention Strategy¹⁵¹ cites an Umsobomvu Youth Fund document as claiming that the "average" South African teenager has sex before reaching 14 years of age, and that 20% of all young women who become sexually active become pregnant within the first month of sexual activity, and 50% within the first six months. These questionable statistics are mirrored by scaremongering statistics on teenage pregnancy found elsewhere. More evidence-based sources confirm high rates of teenage childbearing, but substantially lower than many of the oft-cited statistics. For example, countering the claim about the "average" South African teenager, the third national Youth Risk Behaviour Survey of 2011¹⁵² found that 44,4% of male and 28,6% of female learners – all of whom would have been 14 years or older – had ever had sex.

Legally, schools are not permitted to exclude any young women on the basis of pregnancy. Nevertheless, teenagers who fall pregnant face many challenges both during the pregnancy and young motherhood, and subsequently. The Termination of Pregnancy Act of 1996 is progressive. However, implementation has been inadequate and even regressed over the years in terms of the number of facilities able and willing to provide abortions. Unsafe abortions and the attendant negative consequences thus persist.

National DSD's annual report for 2014/15 reports that 460 women were trained in business management (Limpopo: 140; Free State: 120; Mpumalanga: 91; Western Cape: 109)¹⁵³, and 356 women trained on legal rights awareness (97 in KwaZulu-Natal; 50 in Eastern Cape; 71 in Western Cape, 58 in Limpopo, and 80 in Mpumalanga).

7.12.2 Other findings of the Ministerial Committee

The quantitative tool findings in respect of the women development service area are discussed above, under victim empowerment.

The provincial and district engagements suggested that the women development area is poorly defined. One of the confusing factors is that services such as victim offender mediation could fall under the crime prevention service area, while women empowerment overlaps with sustainable livelihoods. However, this is not the only source of confusion. There are also confusions as to DSD's focus. For example, KwaZulu-Natal DSD understood women development as encompassing gender mainstreaming and equity targets in employment alongside improvement of the capacity to service women. A North West NPO reported that they engaged in "gender-related initiatives (UN CEDAW¹⁵⁴)" without further clarification.

Mpumalanga's Research and Development submission included a justification for a "developmental focus on women". It noted that an argument based on women's engagement in the labour market, facilitated by relieving the burden of care through

¹⁵⁰ Ardington C, Branson N, Lam D, Leibbrandt M, Marteleto L, Menendez A, Mutevedzi T & Ranchhod V. 2011. Revisiting the 'crisis' in teen births: What is the impact of teen births on young mothers and their children? Southern Africa Labour and Development Research Unit, University of Cape Town; see also Makwane M, Desmond C, Richter L & Udjo E. 2006. Is the Child Support Grant associated with an increase in teenage fertility in South Africa? Evidence from national surveys and administrative data. Human Sciences Research Council, Pretoria.

¹⁵¹ Department of Social Development. 2011. Integrated Social Crime Prevention Strategy. Pretoria.

¹⁵² Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omdardien RG. 2011. Umthenthe Uhlaba Usamila: The 3rd South African National Youth Risk Behaviour Survey 2011. South African Medical Research Council: Cape Town.

¹⁵³ Department of Social Development. 2014. Annual Report 2014/15. Pretoria

¹⁵⁴ Convention on the Elimination of All Forms of Discrimination Against Women.

services such as ECD and publicly provided care for the elderly, was a more “compelling” argument than one that focused on “protection” of women on account of their disadvantage. This argument would favour a focus on economic empowerment within women development. In contrast, a Northern Cape NPO wrote that the White Paper focused on women and the girl child because they were most affected in terms of sexual and reproductive health, and also bore the main burden in raising and caring for children.

Across several of the provinces the question was raised as to why there was no special attention paid to men. For example, North West providers observed that there were “no services for men; everything is about supporting women”. Limpopo providers, similarly, noted that there were no programmes targeting men, and fathers in particular. Eastern Cape service providers observed that the White Paper was silent on the issue of support services for men. However, practitioners in the same province noted as an achievement that there was more focus on fathers than previously. Several provinces reported initiatives targeting men and boys. North West noted that men’s forums had been established in all municipalities. Eastern Cape and Free State reported initiatives in respect of men and boy role models.

In several provinces participants noted that provision had diminished in respect of some of the “women” services. Eastern Cape DSD reported that they were collaborating with private sector actors on a Sanitary Dignity Programme that had provided a year’s supply of sanitary pads to school girls and poor unemployed young women. Gauteng provides sanitary pads to girls through Bana Pele, which falls under the children services programme.

Participants in the NPO round table convened by the Committee agreed to disagree on whether women and youth development should be treated as a distinct service area, or the necessary initiatives and gender perspective be integrated into other service areas.

7.12.3 Budget analysis

At the time of the White Paper there was not a separate programme or budget for women development. Since 2014/15, the provincial budget structure includes a sub-programme for women development. In 2015/16, six of the provinces (all except Mpumalanga, Northern Cape and Western Cape) included (generally small) allocations for this sub-programme.

7.12.4 Roles and responsibilities

As seen both in the absence of a separate budget allocation in some provinces and the views of stakeholders cited above, there are different views as to whether women should be regarded as a separate area within DSD or whether, instead, gender and women’s concerns should be mainstreamed within all other service areas. The latter approach has some appeal if DSD’s services are conceived primarily along a life cycle approach as gender is relevant at all stages of the life cycle rather than constituting a stage of the life cycle in its own right.

At the level of generalisation, the following gender issues arise in the other key service areas within social development:

- Women dominate among older persons, and especially among those needing services, because biologically they tend to live longer than men, because their partners (if they are in a married or in a stable relationship) tend to die before them, and because they tend to be poorer than men in old age, amongst others because they are less likely to have private pensions or have smaller pensions because of lower earnings earlier in their life, time off for childbearing and rearing, and concentration in lower-paid jobs.
- Girls and women who are disabled can face additional challenges to those faced by their male peers. In particular, women with disabilities are at higher risk of sexual assault.
- Prevalence of HIV infection is higher among women than men, and particularly so among younger women. Women also dominate among those who provide care in the household and community, and thus bear the burden when government and other services are inadequate.
- Within families, women predominate in the parental role. This pattern is particularly marked in South Africa where more children live with their biological mother but not their biological father than live with both biological mother and father. Among the substantial number of children living with relatives other than their parents, grandmothers and aunts predominate.
- Gender issues are important for children, among others because it is during these years that gender norms and values are established.
- The patterns in respect of crime are different for men and women. Men account for the majority of criminals, as evidenced by their domination in the prison population. However, women account for the majority of certain types of crime, and of gender-based violence in particular. Women are more likely to be violated and murdered by their intimate partners, while men are more likely to be violated and murdered by people outside the family.
- Men and boys are more likely to abuse alcohol and other substances than women and girls. However, the abuse by men and boys affects women and girls negatively in multiple ways.
- In terms of poverty alleviation, women are more likely to be living in poor households than men. There are many reasons for this, including higher unemployment levels, generally lower pay for the same level of education, and domestic responsibilities alongside explicit discrimination. Women are also more likely than men to live in the poorest areas, the former homeland areas, where economic opportunities are scarcest.
- Among youth, women face particular problems than men do not face in the same way. In particular, youth development programmes often ignore the fact that many young women are mothers, with all the challenges that

entails for their own development and well-being. While public concern is often expressed about teenage pregnancy, this does not often translate into programmes and support for young women who have had children.

7.12.4 Departmental initiatives and campaigns

DSD's Special Projects and Innovation section is responsible for flagship projects, including Kwanda (a multi-media communication platform that showcases government initiatives), Military Veterans and Mikondzo. Mikondzo and Kwanda are two of a series of initiatives that DSD has developed over the years in its efforts to have integrated services and development at community level, with a focus on the poorest areas. Such initiatives and campaigns also provide opportunities for public participation and outreach by the Minister and Deputy Minister, who achieved 51 and 33 such engagements respectively in 2014/15.¹⁵⁵

Mikondzo is a series of activities designed to increase the "footprint" of DSD (including SASSA and the NDA) in 1 300 wards in the 23 poorest municipalities alongside informal settlements in Western Cape and Gauteng. Mikondzo was not mentioned by any non-government actor during the Ministerial Committee's engagements, and was also not mentioned by many government officials in provinces. The portfolio committee's budgetary review and recommendation report for 2015¹⁵⁶ notes that R50 million was reprioritised (shifted) from SASSA to DSD over the 2015/16-2017/18 MTEF for the rollout of Mikondzo. In total, Mikondzo was allocated R75 million over the MTEF period.

A lengthy report¹⁵⁷ of 2015 assesses social development delivery in each of the nine provinces, using data collected through Mikondzo and community dialogues conducted by DSD. The report classifies the types of issues raised by communities. The "emerging classification" consists of (a) material wellbeing and social economic issues; (b) behavioural issues; (c) Community Development issues; (d) multi-sectoral and co-ordination issues. The report assesses interventions against the issues raised, among others by examination of municipal integrated development plans (IDPs).

The exercise focused primarily on 23 districts (and 1 300 wards) targeted by Cabinet as most afflicted by poverty. DSD designed the tools, and conceived the exercise – and perhaps Mikondzo more generally – as action-research because Mikondzo is designed to "take Social Development practitioners to the communities' in the name of research." The report notes that: "This aspect of taking managers and officials out of their offices to engage face-to-face with recipients of Department of Social Development (DSD) services seems to have had an impact on some of these officials."

The problems raised in the engagements did not necessarily fall within DSD's mandate. For example, in Bushbuckridge water and sanitation was the most named problem by far, while in Ga-Magara municipality in Northern Cape the lack of a secondary school

¹⁵⁵ Department of Social Development. 2015. Annual Report 2014/15. Pretoria.

¹⁵⁶ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015.

¹⁵⁷ Department of Social Development. 2015. Project Mikondzo: An Investigation into a Social Development Service Delivery Model for South Africa: The Province as a Case Report. Final Report Two (of Phase One).

was the most commonly voted problem. The report also notes that DSD forums are not the only ones seeking to have community participation in identifying issues, with other departments and agencies (including the legislature) also mandated or encouraged to organise for community participation. The section on Mpumalanga notes that the fact that participation is mandated for municipal IDPs or by other policy as strategy documents, including the Provincial Growth and Development Strategy, “does not necessarily mean it is inadequate or superficial.” However, “[p]articipation can be unruly and citizens do not conform to the long-term templates required by these processes. That is why in some cases public participation in these processes is simply a garment to put on the body of decisions, plans, and budgets that municipalities have in mind already.”

The section of the report on the North West observes that the reports produced by the action-researchers in the different provinces “have an alienating sense of ‘scoping and stock-taking orientation’ to them” and do not consider how decision-making and “authority” (power) happens and how actors deal with the social challenges named. The suggested solutions then also tend to be “generic”. The section on Limpopo suggests that the “normative ‘social work’ model of life-cycles” results in even community development involving the community being “acted upon”. In terms of mismatch between issues identified by “communities” and interventions, across provinces the report observes that behaviour issues (where the most commonly cited issues are substance abuse and teenage pregnancy) do not receive adequate attention.

Kwanda focuses on HIV prevention, alcohol abuse, violence, crime, livelihoods and support to vulnerable people. It was first introduced in 2009, and DSD had utilised the services of Soul City in implementing the programme. The portfolio committee’s report notes that DSD failed to establish any of the nine planned new Kwanda sites during 2014/15. The reason given for this failure was lack of “sustainable funding”. Implementation continued in the existing five Kwanda communities, namely Lephepane in Limpopo, Pefferville in Eastern Cape, Tjakastad in Mpumalanga, Kwakwatsi in Free State and Umthwalume in KwaZulu-Natal.

The Committee finds that while women play a fundamental role in the care and reproduction of society, their needs, rights and responsibilities often take second place because of their locations within households, communities and nationally. Since 1997, however, progress has been achieved in raising awareness of women’s rights and needs.

Review of welfare and community development services:

Summary highlights

- Older persons: Since 1997, support for residential services for older persons has been scaled back while the rollout of community-based services for the elderly is inadequate to meet the extent of need of large numbers of elderly black citizens. There are widespread concerns about abuse of older persons.
- Disability: Access challenges remain for persons with different forms of disability in respect of service areas within and beyond DSD. Mental health remains an under-recognised and under-serviced area, with lack of clarity about roles and responsibilities of DSD and Health.
- HIV and AIDS: While the number of new HIV infections in South Africa is falling as a result of widespread availability of antiretroviral therapy, the need for services for affected individuals and families remains. Use of the foster child grant as the instrument of choice for orphaned children has placed strain on both human and financial resources and placed children in need of care at risk.
- Families: The service area for families is poorly defined, and policies and interventions may not adequately take into account the diverse nature of families in South Africa.
- Children: The Children's Act has resulted in increased resourcing for, and understanding of, children's rights and needs, although service levels are still uneven and far below what is provided for in the Act. ECD receives a disproportionate share of resources, but even this service is under-resourced.
- Crime prevention: The Child Justice Act has introduced needed reforms in the area of crime prevention, but implementation of the provisions has been very uneven.
- Victim empowerment: This is a new service area and has focused primarily on violence against women, but the related services have been heavily reliant on external donor funding with resultant volatility in funding.
- Substance abuse: Interventions in the area of substance abuse, including development of National Drug Master Plans, have been unable to reduce high levels of alcohol abuse and abuse of other substances is widely perceived as having increased.
- Community development and sustainable livelihoods: Community development and sustainable livelihoods constitute a new service area for DSD. While the area encompasses a diverse range of activities, the reach and impact of community development and livelihood initiatives is small when compared with the extent of poverty and joblessness in the country.
- Youth development: This is another new area, and activities have been primarily employment-related, resulting in overlap with work of other agencies as well as with other DSD service areas.
- Women development: This new service area is poorly defined and also has serious overlaps with work of other DSD service areas.



PART VII:

8. Social security

The White Paper defined social security as encompassing “a wide variety of public and private measures that provide cash or in-kind benefits or both, first, in the event of an individual’s earning power permanently ceasing, being interrupted, never developing, or being exercised only at unacceptable social cost and such person being unable to avoid poverty and secondly, in order to maintain children.” The South African social security system was characterised as made up of four elements, namely private savings, (contributory) social insurance, (non-contributory) social assistance, and (short-term) social relief. The White Paper suggested that there was “little understanding of the significant role played in the past by social assistance money in alleviating poverty.”

At the time the White Paper was written, the old age grant was estimated as having 80% coverage overall. It suggested that the “majority” of poor people lived in three-generation households, which resulted in the grant potentially reaching 7,7 million people. It noted that 1,6% of the population were recipients of the disability grant, and went on to highlight challenges in respect of training, the means test which penalised those who tried to obtain other sources of income. It commented on the “great racial inequity” in child and “family-care” benefits, alongside serious problems with the private maintenance system, with particularly negative impact for poor black women. It noted that the state maintenance grant accounted for only about 15% of the social assistance budget, although 2,8 million women might be eligible. It predicted increased demand for the disability grant, foster care and a range of other services as a result of HIV and AIDS.

The White Paper commented on the fragmentation, inefficiency and potential for corruption in the grant administration system. It suggested that outsourcing of payment “increases the distance between the state and beneficiaries if things go wrong”. It noted that social relief in the form of cash, vouchers, rental payments, and the like primarily benefited coloured and white people, while the short-term nature of the relief was inappropriate given the long-term nature of poverty.

Finally, the social security section of the White Paper pointed to non-coverage of millions of migrant workers by work-related benefit funds, suggesting that this resulted in reliance on social grants. It also noted non-coverage of domestic and farm workers and people in the informal sector.

8.1 Updating the White Paper

South Africa’s social grant provision is an area in which the highest numbers of poor people receive direct benefits. A number of policy and legislative reviews were undertaken that led to social security improvements and that better aligned social provision with the Constitution of 1996 (Act 108). These reform initiatives took place through the Lund Committee of 1997, the Taylor Committee on Comprehensive Social Security Reform of 2002 and subsequent interdepartmental task teams and committees. Social grant provision was expanded as an outcome of 2002 proposals that recommended the phased extension of the CSG to children up to the age of 18 years. Today social grants are the most highly rated social provision by beneficiaries, service providers and practitioners. In 2015 grants reached about 16,7 million people in South Africa, or

¹⁵⁸ Information from presentation by R Ramakgopa of SASSA at Ministerial Committee Round Table on Sustainable Livelihoods, 23 July 2015.

about 32% of the population¹⁵⁸ as compared to 2,8 million people, or 7% of the population at the time of the White Paper. The percentage of the provincial population currently benefiting from grants was highest in KwaZulu-Natal (at 43%) and Eastern Cape (42%) and lowest in Gauteng (19%) and Western Cape (25%).

The old age, disability and care dependency grants are all set at the same monthly amount. The monthly amounts for these grants are higher than for any other grant, but are still not sufficient on their own to lift recipients out of poverty. The amount in 2015 is R1 410, which may be slightly larger than the lower-bound per capita poverty line used in the NDP. However, the amount falls below this poverty line when – as is generally the case – the grant must provide for other household members as well. While this sharing results in benefit for more people, it reduces the direct benefit to the targeted individual. The extent of the reduction for the beneficiary is increased to the extent that poor people tend to live in larger households.

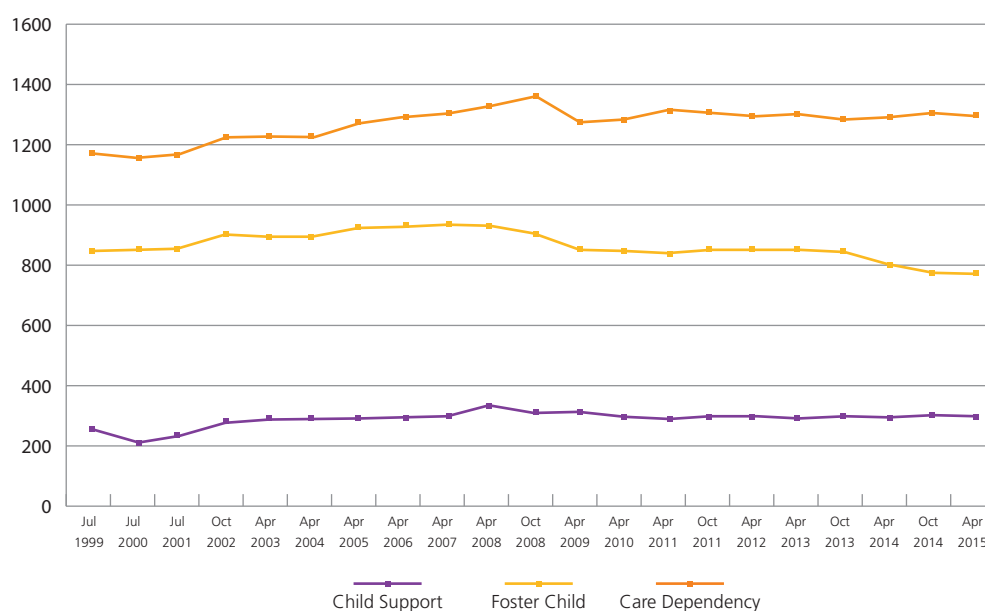
Even without sharing with other household members, the grant amount certainly does not provide enough for a person to live comfortably, especially as people age and as health-related and other needs increase. In an ideal situation, many people would also be able to draw on other sources of provision for their retirement. However, unfortunately, many of the challenges described in the White Paper in respect of retirement provision remain. The challenges are exacerbated by high unemployment rates, because the term “retirement” assumes the person was previously employed. National Treasury and DSD started collaborating on reform of the retirement system in South Africa about a decade ago, but the reform proposals have not yet been finalised and agreed upon. Preservation of savings – probably mandatory – is one of the elements foreseen for the retirement reforms.

Upward adjustments to the grants are announced each year in the Minister of Finance’s budget speech. The adjustments generally come into effect in April, although in some cases a partial adjustment happens in April followed by a further adjustment in October of the same year. As Figure 33 shows, the amounts for the old age, disability and care dependency grants as well as for the CSG have more or less kept pace with inflation over the period 1999 to date, and even increased in the early years.¹⁵⁹ The exceptions are in 2009 and again in the latest increases announced in early 2015. The value of the FCG has continued to fall over time. This probably represents an attempt to narrow the gap between the FCG and the CSG, but – unlike the alternative route of increasing the CSG amount to reduce the gap – makes many children worse off than they were before.¹⁶⁰

¹⁵⁹ Grant amounts are delated using Statistics South Africa’s headline inflation for December of the previous year.

¹⁶⁰ The amounts for the old age and disability grant are the same and therefore do not show separately in the graph.

Figure 33: Social grant amounts 1999-2015 (December 2013 rands)



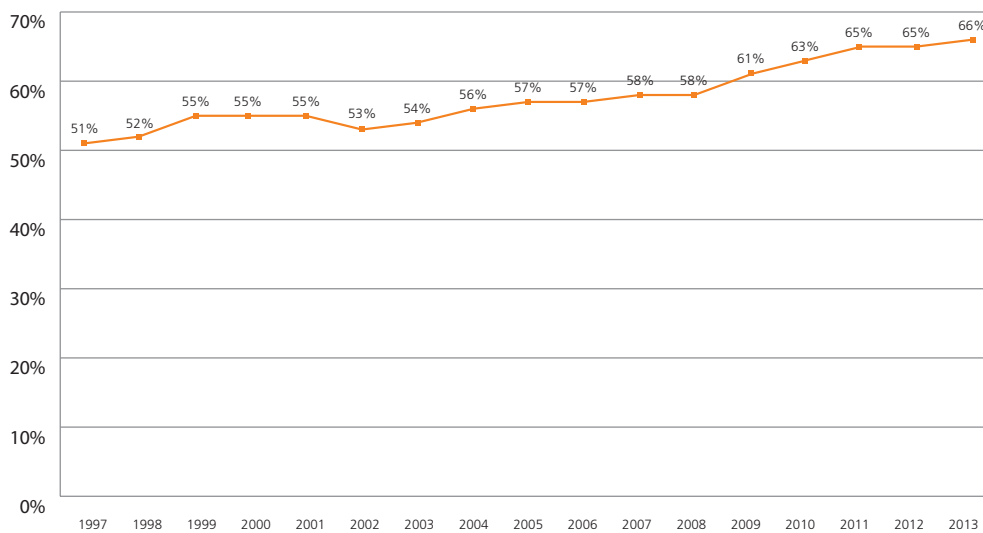
There is nevertheless widespread recognition of the role played by grants in reducing the depth of severe poverty. In 2012/13, 75% of grant beneficiaries were children (71% CSG), 18% older people, and 7% people with disabilities. Expressed differently, in 2012/13, approximately 65% of all children under the age of 18 years were grant beneficiaries¹⁶¹. Research studies have confirmed the role of grants in mitigating child poverty, contributing to child development, improving health and education outcomes, and reducing risky adolescent behaviour. Grants can also contribute to local economic development, although the impact is not as great as it might be given the high levels of commercialisation and domination by big business in the South African economy.

Figure 34 shows uptake of the old age grant as a percentage of the population aged 60 years and above increasing fairly steadily over the period March 1997 to March 2013.¹⁶² The sharper increase over the period 2009 to 2011 reflects the phased lowering of the eligibility age for men from 65 to 60 years. The equalisation was phased in over a period of three years, with men aged 63 and 64 years qualifying as from 1 April 2008; men aged 61 and 62 years qualifying as from 1 April 2009 and men aged 60 years from 1 April 2010. The figure calls into question the White Paper’s claim of 80% as even if the population figures for the period prior to 2008 were adjusted downwards to exclude men aged 60 to 64, that would not result in an increase to anywhere near 80%. It is possible that the 80% referred only to older people who had passed the means test. Further, reliable population figures for particular age groups are still not available for the 1990s.

PART VII:
Social Security

¹⁶¹ Estimate derived using population estimate generated from General Household Survey 2012.

¹⁶² Grant uptake numbers are as provided by SASSA to the Ministerial Committee in November 2013. The population estimates are the alternative mid-year estimates developed by the Centre for Actuarial Research at University of Cape Town as Statistics South Africa’s mid-year estimate series goes back only to 2002.

Figure 34: Uptake of old age grant among population 60 years and above

In absolute terms, the number of old age grant beneficiaries has increased from 1 911 378 in 1997 to more than 3 million in 2015. Government has committed to universalising the grant. However, while a deadline of 2016 was previously given for this move, it now seems unlikely.

The disability grant targets individuals aged 18-59 years of age who are unable to support themselves through work on account of disability. Analysis of data from the General Household Survey of 2014 suggests that 7,7% of this age group has some disability, with 1,6% having at least one severe disability. Combining this with SASSA statistics for 2012/13 suggests that just over half (51%) of all people with disabilities in this age group receive a disability grant (4% of all people in this age group, and 2% of the full population). This is, however, a very rough estimate as the definition of disability in the survey does not neatly match the eligibility criteria for the grant. Further, while there have been changes to the approach, process and actors responsible for assessing eligibility, these issues have remained contentious.

As noted above, today there are some initiatives to support training and rehabilitation of people with disabilities to facilitate their earning income. This has happened both through the sheltered employment and protective workshops which existed in the apartheid years but were racially segregated, and through support for other more recent initiatives, some of which are managed by people with disabilities. Nevertheless, the initiatives are nowhere near meeting the need. Further, the disincentives for engagement in attempts to earn income for fear of losing the disability grant remain. A further perverse disincentive exists for people who are HIV-infected or have other chronic conditions which can be controlled with medication, but where use of the medication can result in access to the disability grant being forfeited.

The child grant system has changed radically in the period since 1997. In particular, the state maintenance grant was phased out and replaced by the CSG. The new grant, while a smaller amount, does not have the narrow and culturally biased assumptions that underlay the child maintenance grant. The reach of the child support grant has been incrementally increased since it was first introduced in 1998 to the point where there are more than 11 million child beneficiaries each month. The World Bank's The

State of Social Safety Nets 2014 ranked the CSG amongst the top five programmes across the world, and first in Africa, in terms of the absolute numbers as well as the percentage of the population covered.

In terms of operations, there is now much less use of manual systems in accounting, and there is a single national social grants register maintained by SASSA and a single national ID system managed by the Department of Home Affairs. Difficulties arise with the latter in respect of those who do not have official identification documents (IDs), including people from outside the country and those who have lost their IDs or have had their IDs stolen.

The payment system for social grants is still outsourced, but is now managed by a single company for the whole country. Investigations are ongoing as to the feasibility and desirability of SASSA insourcing the function. The experience for beneficiaries has been transformed by the introduction of alternatives to monthly queuing for cash at paypoints. About four-fifths of all beneficiaries now have their payments effected electronically, receiving their payments into their own bank accounts or through presenting their smart cards at vendors. This change has, among others, freed beneficiaries up to receive their grant in any part of the country rather than only at the paypoint for which they are registered.

Social relief of distress (SROD) is currently among the most problematic aspects of the social assistance system. The grant is intended for people “in dire need” who are awaiting payment of an approved social grant; are medically unfit to do remunerated work for a period of less than six months; are not receiving maintenance from a parent, child or spouse; have a breadwinner deceased or admitted to a government-funded institution; are affected by a disaster as defined in the Disaster Management Act or Fund Raising Act; and/or are not receiving assistance from any other organisations. The grant is available for a maximum of three months, which may be extended for a further three months in exceptional cases.

One example of the problems with SROD is perceptions across all provinces of food parcels being used as a vote-catching mechanism at election time. The social relief allocations are also, from the financial side, treated as a residual, in part because unlike the other grants they are not statutorily defined as a constitutional right in the same way. As a result, the amounts available for SROD can be increased when there are “savings” (expenditure less than allocations) on other grants, but SROD payments may also not be provided at all in the final months of a financial year if the budget is exhausted. Another complication with SROD is unclear delimitation of roles and responsibilities between SASSA and provincial DSD. A further challenge is that SROD is not well suited to address disasters as it is targeted at individuals rather than at larger groups, such as geographical communities.

As predicted in the White Paper, the HIV and AIDS pandemic has resulted in increased demand for disability grants, and a massive increase in the demand for foster child grants after then Minister Skweyiya announced that these grants were available for those, including grandparents and aunts, caring for orphaned children. On the services side, several programmes have been developed to address the need for community-

based care, including support for older people and other relatives caring for those infected and affected by HIV and AIDS. Funding for these initiatives has, to a large extent, been dependent on external donors, and PEPFAR in particular. Changes in the focus of these donors have put many of the initiatives under threat.

Currently, South African migrant workers are covered by the same laws and policies as non-migrant workers. They may, however, experience more difficulties in claiming their benefits. There have, for example, been several court cases in which former mineworkers as well as those living in communities that were negatively affected by mining and other operations have attempted to claim compensation. Domestic and agricultural workers, including seasonal workers, are now covered by the UIF, and the Department of Labour plans to extend coverage of the Compensation Fund to domestic workers over the next few years. Self-employed workers remain without coverage.

8.2 Other findings of the Ministerial Committee

The quantitative tool listed five areas for the War on Poverty, namely meals on wheels, food security – food gardens; social assistance and relief – food parcels; social grants; and community nutrition and development centres. Although not all of these fall under social security, all the ratings are discussed here so as to allow comparison across the various services categorised under War on Poverty.

Under the War on Poverty, the quantitative tool saw social grants emerge as the clear winner in terms of accessibility across all three stakeholder groups as well as across all provinces. Indeed, social grants achieved the highest score across services in all service areas. The overall mean score for social grants was 4,5, as against 2,6 for social assistance and relief (food parcels), 2,3 for food security (food gardens); 2,0 for community nutrition and development centres, and 1,5 for meals on wheels.

Providers and practitioners were more likely than users (beneficiaries) to feel that food parcels were available, while the opposite pattern held for food gardens. KwaZulu-Natal achieved the highest mean score on three of the five services – meals on wheels, food gardens, and social grants. Northern Cape was the highest scorer on food parcels, and Mpumalanga on community nutrition and development centres. Limpopo was the lowest scorer (sometimes tying with other provinces) on meals on wheels (with an extremely low score in both absolute and relative terms), food gardens, and food parcels. North West was perceived as the poorest performer on community nutrition and development centres, and Mpumalanga and Gauteng on social grants.

As already suggested above in the discussion of other service areas, food is made available through multiple channels and to diverse categories. Examples that illustrate the diversity as well as the differences across provinces include soup kitchen vouchers for people who are infected by tuberculosis in Western Cape; meals on wheels for specified organisations and services in Gauteng; DSD food banks (serving, among others, those on ARV) and food parcels for pensioners in Gauteng. National DSD's annual report for 2014/15 reports that DSD established provincial food distribution centres in each of the nine provinces as well as 140 community nutrition development centres. More than 400 000 households accessed food through the Food Security Programmes and DSD

distributed more than three million kilograms of food supplies to more than 615 898 beneficiaries.¹⁶³

On the negative side, food parcels were reportedly not available for child grant beneficiaries and for either old age grant or CSG beneficiaries in Free State, in North West food parcels were said to arrive only in December and be unevenly distributed across districts, while NPOs in Free State complained that they were not subsidised to provide food parcels. In several provinces there were accusations that politics was driving food-related initiatives as evidenced, for example, by a “spike” in food parcels around election time, and/or that food parcels were being allocated “to those who [were] not legitimate”¹⁶⁴.

There were relatively few mentions of community nutritional development centres in the provincial and district engagements. Northern Cape reported that during 2013/14, two drop-in centres and one soup kitchen had been converted into centres, and that these formed part of food banking in the province. As discussed below, national DSD’s planned funding of such centres did not proceed as smoothly and speedily as planned.

SASSA is responsible for virtually all tasks associated with social grants other than policy making. SASSA, which presented in all provinces, also sometimes gets involved in other services, such as food parcels. There is overlap – and some confusion – between DSD and SASSA’s responsibilities in respect of social relief of distress, and between DSD and the NDA in respect of nutrition. One difference between SASSA and the other agencies is that they do not employ social workers. In Gauteng there was the suggestion that SASSA should employ this cadre of workers.

Social grants is one service within social welfare that is now nationally governed, rather than provincially. It is also the service area where the same basic service is provided across all provinces. Free State suggested that the establishment of SASSA as a separate entity to manage grants had allowed clearer emphasis by provincial DSD on social welfare. However, there is still some variation in SASSA’s operations beyond the basic grant, as illustrated further below.

Across provinces, districts and stakeholders there was acknowledgement that the expansion of the grant system and the eradication of past racial and geographical bias in the system were significant achievements. There was acknowledgement, in particular, of the importance of the introduction of the CSG in place of the maintenance grant. There was also acknowledgement of the progress made in providing grants in ways that did not require monthly queuing at paypoints. There can, however, be problems with the new systems. For example, beneficiaries in KwaZulu-Natal said that it cost more to receive grant money through automatic teller machines than through shops, presumably referring to bank charges. The Black Sash has led research and advocacy in respect of illegal deductions from grants, often working in cooperation with SASSA.

The extent of SASSA’s accessibility is illustrated by the fact that, in addition to the head office, it has nine regional (provincial) offices, 44 district offices, 335 local offices, 917 service points, and 9 937 pay points. In addition, the 40 mobile offices of its Integrated Community Registration Outreach Programme (ICROP) reach under-serviced

¹⁶³ Department of Social Development. 2014. Annual Report 2014/15. Pretoria

¹⁶⁴ These particular words were used in Limpopo.

or unserved areas across the country. ICROP also utilises the general-purpose Thusong Centres and community facilities in some communities.

Despite acknowledged progress, there are still problems with the grant system. Concerns were repeatedly raised during the Ministerial Committee's engagements about long queues, lack of adequate provision for frail and sick applicants, and lack of ablution and other facilities and water at service points. The concerns raised perhaps related to applications and queries more than to receipt of grant money now that most beneficiaries receive payments electronically. One comment suggested that a public health risk was present if tuberculosis defaulters accessed grant at paypoints. There were also complaints that, unlike DSD, SASSA service points did not operate every day. In Free State there were reports that people "slept over" at paypoints because they were "overcrowded".

Concerns raised in relation to poor service included SASSA officials not providing information to applicants unless they were accompanied by a social worker from an NPO, rural applicants with disability being turned away because the doctor would only attend to a limited number of people each day, and delays in review of grants pushing beneficiaries into debt. Delays in review of grants also affects NPOs when part of the grant is used to contribute towards the cost of residential accommodation. In Free State it was suggested that SASSA needed more doctors, presumably for disability assessments.

Concerns were raised across provinces about deficiencies in the assessments for the disability grant. These included the fact that the doctors' assessment was privileged while the social worker reports were not (adequately) taken into account, that new criteria were perceived to exclude more people than before, and the silence of the criteria in relation to mental health. A further problem with the disability grant – raised in the round table on sustainable livelihoods – was the perverse incentive implied by taking away the grant as soon as the beneficiary attempted to earn income.

SASSA officials reported progress in tackling fraud, particularly at the individual level. However, there is still concern around fraud perpetrated through syndicates.

There were many people who were concerned about dependency on grants. Some of these comments could be interpreted as reflecting the view that ideally grants should not be necessary because economic opportunities should be readily available. Expressed differently, it is poverty, rather than social grants that cause dependency, and grants are a constitutional right. However, there were also some – particularly in Northern Cape and North West – who seemed to oppose widespread grants in principle. These comments did not acknowledge that the grants focus on groups – older people, people with disabilities, and children – whom one would not expect to provide for themselves. Where concerns were expressed in relation to child grants, the expectation seemed to be that the caregiver (grant recipient) should provide for the child themselves. There were some suggestions that seem inappropriate about working towards exit or weaning people off grants. In the case of older people, for example, it is not clear what (apart from death) the commentators were hoping could allow exit from old age.

At both national and provincial level, SASSA presentations took issue with claims that grants encouraged dependency, or that the grant system was unaffordable. Claims

about dependency were also strongly challenged in the round table on sustainable livelihoods, in which participants acknowledged that the grants were targeted at older people, children and people with disabilities – all groups whom one would not usually expect to support themselves.

There were many mentions of teenage pregnancy in the provincial and district engagements, although most were not directly linked to grants. In two cases – North West beneficiaries and Western Cape practitioners – there was the suggestion that the availability of the CSG encouraged teenage pregnancy (a claim that, as noted above, has been disproved, including by research commissioned some years ago by DSD¹⁶⁵).

There were many participants who expressed concern that grants were not monitored. It seems that at least some of these participants felt that there should be monitoring of how grant money was spent, similar to the monitoring of NPO funds. In other cases monitoring was said to be needed to ensure that grants went to the correct beneficiaries. This might have referred, among others, to a concern that mothers were receiving grants when it was grandparents who cared for their children on a daily basis. It might have also referred to what others named as abuse, where non-beneficiaries within the family gained control of the grant money and used it for their own needs rather than that of the beneficiary.

There were concerns about what happened to young people when they became too old to benefit from the child grants. One suggestion was that the young people be channelled to developmental programmes, although other participants noted that many young people were still attending school at the time the grant ended.

In the focus groups there were some appreciative mentions of the concessions available to grant beneficiaries. For example, North West beneficiaries were pleased about discounts available from the South African Broadcasting Corporation, while Gauteng service providers noted the availability of SASSA food vouchers. In Eastern Cape the waiving of school fees and provision of feeding schemes for grant beneficiaries were welcomed.

Across provinces SASSA reported ways in which it had expanded and improved its services. These included mobile trucks and ICROP. The mobile units and services in farms do not have the same level of automation and sophistication as those offered at regular SASSA offices, but do make the services more accessible. In Eastern Cape, SASSA was reported to do home visits for older people where necessary.

SROD emerged as an area in which there was more variation across provinces in what was done than in other areas of social assistance, and some tension between SASSA and provinces. North West reported that in that province SROD provided for food parcels and school uniforms, but expressed concern that both DSD and SASSA had budgets for social relief of distress allocated to them and went to the same communities to render the same service. Mpumalanga reported that the budget for SROD was cut when there were financial difficulties in the Department and/or province, suggesting that it is regarded as a residual not only in respect of the grant budget, but in terms of DSD or provincial budgets more generally. Eastern Cape practitioners noted as a problem that social relief of distress was only allocated once every quarter.

¹⁶⁵ Steele M. 2006. Report on Incentive Structures of Social Assistance Grants in South Africa. Kesho Consulting and Business Solutions (Pty) Ltd: Pretoria.

Lessons of experience: Initiatives to improve SASSA's service delivery

North West SASSA named a wide range of ways in which the agency was attempting to improve its services. For many of the ways the submission noted that the attempt was "work-in-progress", suggesting that implementation might be limited to date. Nevertheless, the proposed avenues illustrate the opportunities as well, implicitly, as the challenges that still exist. The avenues included placing suggestion boxes at local offices; queue walking (meet-and-greet); sign language training for staff; appointment of staff as commissioners of oaths to minimise delays in the application process; making drinking cups and water dispensers available for users; and providing ablution facilities suitable for people with disabilities.

North West SASSA reported that they were paying, or planning to pay, monthly stipends to dikgosi (traditional leaders) for use of "tribal halls", and also paid a small fee for use of other facilities, such as those of churches. As in other provinces, a large number of paypoint sites had been renovated, with the overwhelming majority in rural areas.

In terms of job creation, North West SASSA planned to procure social relief of distress goods from local cooperatives, and was collaborating with the NDA, DSD and the Canadian International Development Agency to build the capacity of cooperatives for this purpose. SASSA also employed approximately 30 EPWP workers to assist at local offices, had an agreement with Disabled People of South Africa for placement of 26 interns across the different offices, and had provided veterans employment opportunities in line with section 5(1)(e) of the Military Veterans Act of 2011.

8.3 Additional evidence

8.3.1 Grant administration and payment

The R9-billion monthly social grant payment has been outsourced to Net1, which owns the companies that pay out the grants (Cash Paymaster Services), facilitate grant payments through retailers (Easypay) and provide loans targeted at grant recipients (Moneyline). Net1 also has a close relationship to Grindrod, the default bank for social grant recipient accounts.¹⁶⁶ The system currently works well in terms of grant recipients now having bank accounts, as well as access to credit in the form of loans from Moneyline.

Nevertheless, questions must be asked about several aspects of the contract. The Constitutional Court declared invalid the tender that resulted in the contract with Net1. It seems that the different Net1 companies may also be sharing confidential information about recipients. There have been many complaints, and much advocacy, around money being deducted from the accounts of social grant recipients before they receive their money. Further, Moneyline is charging a management fee for its loans that effectively translates into a very high rate of interest despite the extremely low risk that Moneyline faces that the money will be paid back. The portfolio committee's budgetary review

¹⁶⁶ Goundup staff. 7 October 2015. Spotlight on social grants: The good, the bad and the confusing www.goundup.org.za, accessed 11 October 2015.

and recommendation report¹⁶⁷ notes SASSA's observation that the issue is difficult to manage because the deductions happen within the banking system, which is not under SASSA's control. SASSA had, however, established a "payment resolution mechanism" to which beneficiaries could report unauthorised deductions and was working on the issue together with the National Credit Regulator. SASSA had also requested the insurance companies provide information on insurance deductions.

Academics such as Keith Breckenridge¹⁶⁸ and Kevin Donovan¹⁶⁹ acknowledge that the biometric system has assisted with standardisation and also allowed for easier accessibility of grants. Donovan, however, suggests that the introduction of the electronic system has depersonalised the system and made it more difficult to query payments. Ethnographic research conducted in Bushbuckridge by Natasha Valley has exposed other difficulties, such as that beneficiaries who collect their grants from supermarkets but do not plan to buy any goods from the supermarket are required to queue separately, extending their waiting time. While such difficulties are real, the time spent waiting is almost certainly less than was the case previously when all grants had to be collected in person from the paypoint at which the beneficiary was registered.

8.3.2 Accessibility of services¹⁷⁰

Thusong Service Centres were first introduced in 1999 as a way of bringing together key public services in a single location. The "anchor" services for such centres were identified as SASSA, Departments of Labour and Home Affairs, and SAPS. For the latter, the Thusong Centre would serve as a "contact point" rather than deliver services. In addition to the anchor services, some centres would also house other government services.

The plan was that there would be at least one Thusong in each district by December 2004. In early 2016, there were 178 Thusong centres, of which 98 were in urban areas. In addition, there were 165 of what can be recorded as Thusong "clusters", where the anchor services are housed separately but in fairly close proximity to each other. A total of 165 such clusters existed in early 2016, of which the overwhelming majority (143) were in urban areas. 54 of the 234 municipalities in the country had neither a centre nor a cluster. More than half (56%) of the population estimated to be covered had access through a cluster rather than a centre. Further, 21 facilities served a population of 300 000 or more.

8.3.4 Harmonised assessment test

Representatives of the disability sector expressed concern during the Ministerial Committee's engagements at the fact that the long-promised Harmonised Assessment Test (HAT) was not yet in place. The Committee was told that plans to move to a new standardised and internationally accepted test that is not "elitist" (because reliant on medical doctors) had not yet been finalised.

¹⁶⁷ The Budgetary Review and Recommendation Report (BRRR) of the Portfolio Committee on Social Development, on the performance of the Department of Social Development and its entities for the 2014/15 financial year, dated 21 October 2015,

¹⁶⁸ Breckenridge K. 2005. The Biometric State: The Promise and Peril of Digital Government in the New South Africa, *Journal of Southern African Studies*, 31:2, 267-282,

¹⁶⁹ Donovan KP. 2015 "The Biometric Imaginary: Bureaucratic Technopolitics in Post-Apartheid Welfare", *Journal of Southern African Studies*, 41:4, 815-833.

¹⁷⁰ Department of Public Service and Administration. 2016. Geographic Accessibility Analysis in respect of Thusong Service Centres: Provisional Report. Pretoria.

Government reported that the HAT was completed and approved by Cabinet in 2007, but could not be implemented without amending the Social Assistance Act so as to have a clearer definition of disability.¹⁷¹ Cabinet approved the Social Assistance Amendment Bill in November 2009. The bill was accompanied by a memorandum that noted a possible constitutional implication in that people with chronic conditions would no longer receive disability grants once the HAT was implemented. A DOH presentation to the parliamentary portfolio committee in May 2010 indicated that they were not yet ready to implement HAT because of a shortage of health professionals trained in its use. The HAT aims to assess the impairment of the applicant, including but not limited to the medical condition. The HAT thus relies on assessment by medical officers as well as other health professionals such as occupational therapists, but SASSA has reportedly insisted that the form must be signed by a medical doctor. In the portfolio committee meeting, the Department of Health said further that they would need three years to strengthen provision for chronic conditions within the primary health system.

The portfolio committee agreed not to proceed with the inclusion of the definition of disability and related clauses in the Social Assistance Amendment Bill and implementation of HAT therefore could not proceed. Training of SASSA officials on the HAT has meanwhile proceeded, and SASSA is exploring options for addressing the issue of chronic conditions.

In the current approach, SASSA uses DOH where the resources (clinics and hospitals) are available. Where this is not the case, SASSA contracts private medical officers directly. Even where DOH resources are used, in some provinces SASSA pays for the time the medical doctors spend on the assessments.

The HAT will be used only for assessments for disability and care dependency grants. The term “harmonised” refers to the fact that the tool takes into account all the health professions, and provides an opportunity for the different disciplines to input before a final recommendation is made. This moves the assessment from a purely medical model to one which considers the impact of the impairment as being the determining factor for a grant.

8.3.5 Private maintenance

One of the reasons why so many children and their caregivers are reliant on grants is the limited extent to which parents who do not live with their children can and/or do make financial contributions for them. Legislative amendments as well as other reforms to the private maintenance system have brought about some improvements since 1997. Advances include the possibility of electronic payment and increased possibilities of use of attachment orders on earnings. These reforms do not, however, address one of the most important underlying challenges, namely high unemployment rates and low earnings among fathers. Further, some reforms, such as the introduction of family courts, have not been rolled out to the extent initially planned. Overall, the system still does not work well. This is a serious problem in a situation where the General Household Survey of 2014 suggests that close on six million children under the age of 18 years live with their biological mother but not with their biological father.

¹⁷¹ Information from Johanna Sekele, DSD and Dianne Dunkerley, SASSA.

8.3.6 Unemployment Insurance

Unemployment insurance is especially important in a situation where there is no grant – other than the disability grant – for poor individuals aged 18 to 59 years. The White Paper noted that the Unemployment Insurance Board had stopped granting extended unemployment benefits and that this had resulted in increasing reliance of unemployed people on welfare. (In reality, however, this would have had to be primarily through grants of other members in the household given the absence of grants other than the disability grant for working age people.) It contrasted the less than R200 million spent in 1990 on work-related disability and illness compared to the R223 million spent on disability grants in 1995 in a single province, Gauteng.

In contrast to the situation in 1998, the Unemployment Insurance Fund has had a surplus in recent years. This is, in part, due to changes in the unemployment insurance system, including requiring contributions from higher-paid workers. This allowed, in 2014, for the extension of the maximum benefit period from eight to twelve months in a four-year period. This extension, while welcome, is only of benefit to those who have contributed to the fund for a sufficient length of time. It does not help unemployed people who have never been in formal employment. It also does not help with the increasing number of employees whose work has been informalised through various forms of externalisation. Further, it does not help the self-employed, who are currently not eligible to join the Fund.

8.3.7 Compensation for work-related death, disease and injury

The disability grant targets those who are unable to work on account of disability. Worker compensation schemes target those who are injured or suffer from diseases arising from their work, as well as dependents of those who have died from work-related accidents or diseases. These schemes are not available to those who have never worked, but constitute a possible alternative source of income to the disability grant for those whose disability was caused by their work.

The White Paper noted the weaknesses in the scope and operations of the Workmen's Compensation Act, 1941, especially in rural areas. It also noted that the Act transferred costs from industry to government welfare and health services. The Compensation for Occupational Injuries and Diseases Act of 1993 replaced the former Workmen's Compensation Act. Reforms have included the opening of provincial offices and computerisation of systems. However, despite these and some subsequent amendments to the Act, problems remain in the compensation system.

In 2013/14 the Compensation Fund paid a total of R2,7 billion¹⁷² in compensation, as against the R17,8 billion paid out in disability grants. (The Compensation Fund also provides financial support to NPOs to train shop stewards, workers and community members on the underlying legislation as well as the Occupational Health and Safety Act.)

There are particular problems related to workers' compensation in mining. These arise, among others, from the fact that historically different agencies have been responsible for mining and other parts of the economy. For example, currently the Departments

¹⁷² Compensation Fund. 2014. Annual Report 2014: 6.

of Mineral Resources and Health are involved for mining workers whereas for other industries the Department of Labour is responsible. Further, in mining many of the cases relate to silicosis, a disease that manifests only 15-20 years after the worker is exposed to unhealthy working conditions, at a time when a migrant worker may no longer be at the mine. The numbers affected are substantial, with 1 500 to 2 000 applications from those still working at gold mines alone in respect of compensation of silicosis and tuberculosis.¹⁷³ The estimated number of medically certified, but as yet uncompensated, claims stands at 104 000. The cost is also substantial despite the level of under-performance suggested by the large backlog. Administration costs of the Medical Bureau for Occupational Diseases amount to about R55 million annually – an amount that is borne by the fiscus rather than by the mining industry.

8.3.8 Nutrition and food security

As seen above, one of the foci of social security relates to food security. Malnutrition is particularly serious when it affects babies and young children as it has lifelong consequences for the young person's development. Stunting – characterised by low height for age – has particularly serious consequences as it can permanently delay cognitive development, affect physical growth, and increase the risk of poor health.

Unfortunately, the stunting data for South Africa are sparse and there is no firm evidence as to whether levels have fallen or increased over the last two decades¹⁷⁴. The data from the 2012 South African National Health and Nutrition Examination Survey can be questioned on the basis of the poor response rate for the biological measures, for which respondent was not done in the home at the time the survey was administered but instead respondents were asked to go to a clinic or other facility for the test, and only about half did so.

A systematic review¹⁷⁵ of studies and surveys published between 1970 and 2013 on stunting of children under six years of age in South Africa found that the national prevalence of stunting decreased. Marked disparities on provincial, age and race groups remained, but unlike elsewhere in sub-Saharan Africa, there were no significant differences between boys and girls and between rural and urban.

In 1995 the Department of Health established a Directorate of Nutrition and the Integrated Nutrition Programme was launched in 1996. Nevertheless, available data suggest that the national prevalence of stunting increased between 1993 and 2008, after which it decreased to a level lower than in 1993 by 2013. The authors suggest that the decrease in the latter period could reflect “trickling down” of economic growth that allowed for improved mother and child nutrition, and reduction in mother-to-child transmission of HIV. Nevertheless, prevalence rates of 26,9 % in boys and 25,9 % in girls between 0 and 3 years of age remain a serious problem. Stunting levels are highest in more rural provinces with higher levels of unemployment, poverty (such as Eastern Cape, Northern Cape, Free State, North West, Limpopo) as well as in informal settlements with poor water and sanitation services.

¹⁷³ http://groundup.org.za/article/sick-miners-time-mines-share-burden_3087, accessed 13 August 2015

¹⁷⁴ Information provided by Debbie Bradshaw, Medical Research Council

¹⁷⁵ Said-Mohamed R, Micklesfield LK, Pettifor JM and Norris SA. 2015. Has the prevalence of stunting in South African children changed in 40 years? A systematic review. *BMC Public Health* (2015) 15:534.

The 2013 Saving Babies report records that 15% of all live births in South Africa have a low weight at public healthcare facilities.¹⁷⁶ Low birth weight is found in the majority of babies within the first 28 days of life. One of the main causes of low birth weight is poor nutrition of the mother, especially around the time of early pregnancy. Other common contributing factors are hard physical labour, substance abuse, HIV and other sexually transmitted infections.

Moving beyond the first four week, Statistics South Africa's Mortality and Causes of Death 2013 notes intestinal infectious diseases as the most common cause of death for children under five, followed by respiratory and cardiovascular disorders, and influenza and pneumonia. Poor nutrition is often a contributory cause. Exclusive breastfeeding for the first six months serves as a protective factor, but only 8% of babies in South Africa are exclusively breastfed for this period – the lowest known rate in the world.

Key contributors to stunting include smoking during pregnancy (which affects birth weight) and lack of breastfeeding together with inappropriate weaning foods, often linked to poverty.

8.3.9 Reform proposals

There have been a number of different reform proposals in the social security area over the last decade or so. Some are firmly part of a comprehensive social security reform agenda that spans the whole of government. Other proposals are more specific to DSD. This section discusses some of the key proposals.

8.3.9.1 Comprehensive social security reform

In 2007 Cabinet appointed an Inter-Ministerial Committee (IMC) on social security reform. In the same year, DSD established a new unit to focus on social insurance policy. The IMC, which is led by the Minister of Finance, is assisted by an Inter-Departmental Task Team that includes directors-general from National Treasury, Social Development, Labour, Transport, Health, Public Service and Administration and the Presidency. The reform agenda includes extension of the social assistance net; introduction of a compulsory pension system; improved unemployment insurance and better linkage to labour market policies; reform of the Road Accident Fund; National Health Insurance; alignment of social insurance benefits provided by the Road Accident Fund, Compensation for Occupational Injuries and Diseases, and the UIF; social security governance and institutional restructuring; and fiscal and financial aspects. Progress to date has been slow, but in April 2015 DSD reported to parliament that the Consolidated Comprehensive Social Security Reform proposals had been completed.

The first step was to be a Cabinet paper to secure inside-government agreement. By 2012 there was enough consensus for this step, although none of the agencies was comfortable with all aspects. Cabinet asked for further explanations and engagement on the proposals put to it through workshops with the relevant sectors.

Activities to further the reform of comprehensive social security were renewed under the 2014 administration by Ministers of Finance and Social Development who met

¹⁷⁶ Furlong A. 2 October 2015. South Africa's real nutrition policy. www.groundup.org.za, accessed 11 October 2015.

and agreed to revive the process. A more recent paper retains a lot of the work from the original, but reflects a new view in Treasury. Instead of a firm single proposal, the new paper presents two options. It also no longer provides for the same degree of coordination by a single agency. A further element that fell away was income support for people aged 18-59 years. Other differences between the two papers reflect the fact that some proposals in the first version have already been taken forward. These include reforms in respect of UIF and the Road Accident Fund.

Table 60 below compares some of the key proposals presented in the 2012 and 2015 discussion papers.¹⁷⁷

Table 60: Comparison of 2012 and 2015 papers on comprehensive social security reform

Issue	Paper 1, 20 March 2012	Paper 2, 26 August 2015
Main identified gap	Absence of a public fund that provides pensions and life insurance to the workforce as a whole.	Absence of mandatory social insurance cover to provide pension, death and disability benefits to the workforce as a whole.
Pillar/ tier approach	3 pillar approach	4 tier approach
Social insurance	<p>Establishment of a social security fund</p> <p>Introduction of a NSSF, a centrally managed public fund to provide pensions, death, disability and unemployment benefits.</p> <p>All employers and employees to contribute at a combined rate of 12% of qualifying earnings up to a ceiling aligned with the UIF earnings threshold.</p> <p>Employees earning below an agreed threshold not obliged to contribute to the NSSF for retirement or risk benefits but will continue to contribute to the UIF.</p>	<p>Establishment of a mandatory social insurance system for pensions, death and disability benefits</p> <p>Two options proposed:</p> <p>Option 1: Establishment of a National Social Security Fund to which all employers and employees would contribute at an agreed combined rate sufficient to cover the proposed benefits. Contributions payable on qualifying earnings up to the UIF earnings threshold. Unemployment benefits will continue to be provided by the UIF.</p> <p>Option 2: Creation of a default fund or funds for currently excluded or poorly served workers by current arrangements, while strengthening the regulation of existing funds to ensure that mandatory pension, death and disability cover assured in all approved funds. Death and disability benefits provided through a single risk pool underwritten by government</p>

¹⁷⁷ Table based on more detail comparison developed by Anthony M Makwiramiti of DSD.

Issue	Paper 1, 20 March 2012	Paper 2, 26 August 2015
Contributions	<p>Contributions to unemployment insurance will be included in the 12% NSSF contribution, and unemployment benefits will be paid out from the NSSF. However, contributions to the UIF will not be pooled with the pension and risk contributions, and its funding arrangement will remain as it is at present.</p> <p>The compensation funds will continue to rely on a separate revenue stream alongside the NSSF, funded by levies on employers.</p>	<p>Funding streams of existing social insurance funds will continue. The UIF will be funded via a combined employer and employee contribution. The compensation funds will continue to be funded by levies on employers.</p> <p>To the extent that standard benefits are paid out from the NSSF or the group life-scheme (covering a portion of the obligations of the other funds) contributions to the other social security funds should be aligned accordingly.</p>
Contribution subsidy	<p>Government will pay all or a portion of the NSSF contribution for low-income employees. This subsidy will be paid from the fiscus.</p>	<p>Government will cover part of the contribution costs of workers, whose earnings are below the tax threshold. Payment of the subsidy will be deferred until triggered by retirement, death or disability.</p>
Funeral benefit	<p>The NSSF will pay a flat rate funeral benefit.</p>	<p>The NSSF will offer a flat rate funeral benefit to all its members. A similar benefit will be provided for social assistance beneficiaries.</p>
Automatic enrolment	<p>Employers will be obliged to enrol employees in a retirement fund unless an explicit choice to opt out is exercised.</p>	<p>Automatic enrolment in supplementary arrangements.</p>
Social assistance	<p>Gradual elimination of the means tests for the old age, disability and child support grants.</p>	<p>Gradual elimination out of the means tests for the old age, disability and child support grants</p>
	<p>Grants for people below tax threshold mirrored by rebates in tax system</p>	<p>Grants for people below tax threshold mirrored by allowances or rebates in tax system</p>
		<p>Possible creation of survivor (orphan) benefit as reform of foster care grant</p>
		<p>Possible indexing of grants to consumer prices index</p>

Issue	Paper 1, 20 March 2012	Paper 2, 26 August 2015
		Possible progressive alignment of child support grant to food poverty line
		Possible enhanced social relief of distress and other support programmes for households affected by unemployment
	Standardisation of disability assessments	Standardisation of disability assessments
Enhancing social insurance arrangements *Reform Initiatives	Institutional consolidation across new and existing social security arrangements	Institutional coordination across new and existing social security arrangements
	No-fault Road Accident Benefit Scheme reform approved by Cabinet in September 2011.	No-fault Road Accident Benefit Scheme reform already in process
	COIDA: Amendments in process to include vocational rehabilitation and reintegration	COIDA: Amendments in process to include vocational rehabilitation and reintegration.
	Government employees to be brought into UIF and COIDA	UIF Bill to include government employees, learners and contract workers
		Mine compensation: Measures announced to address backlogs
Regulatory reform of pensions and life insurance industry	Funds framework with stringent standards to determine which funds eligible for tax-incentivised supplementary savings	Funds framework to determine which funds eligible for tax-incentivised supplementary savings. Simplification ongoing to encourage savings and restrict tax benefit to high income-earners
	Preservation of retirement savings until the end of a worker's career compulsory, except under clearly specified circumstances.	The social security and retirement funding system should promote preservation of retirement savings
	Substantial improvements to the regulation of the retirement and life insurance industries are also proposed.	Consolidation of the private retirement fund sector into a smaller number of large employer-based retirement funds

Issue	Paper 1, 20 March 2012	Paper 2, 26 August 2015
Annuity provider	Government investigating whether it can provide an annuity product that pools mortality across working population, with same benefits for women and men	Government investigating whether it can provide an annuity product in respect of [portion of] mandatory contributions, with same benefits for women and men
Strengthening links between social security and labour	Closer policy coordination between the consolidated department of social security and the Department of Labour. Social security agencies and labour centres will share facilities and infrastructure.	Closer policy coordination between the consolidated policy authority for social security and the Department of Labour. Social security agencies and labour centres should share facilities and infrastructure.
Improved employment benefits	UIF: Faster accrual of benefits and extension of period covered. The long-term unemployed will receive a continuation benefit.	UIF has proposed an extension of the benefit for unemployed workers who remain out of work after the exhaustion of their 238 credit days. A moderate flat-rate unemployment allowance paid to those whose credit-based unemployment benefits are exhausted, linked to participation in labour activation and placement services.
Unified policymaking	A single department with oversight for social security	A single authority for social security policymaking.
Contribution collection	Collection of contributions from employers and individuals will be undertaken by SARS	Collection of contributions is likely to be best performed by a single collection agency.
Low-cost fund	Government will give consideration to establishing a low-cost pension fund to run alongside the NSSF and the approved funds. Such a fund would be run on a defined-contribution basis and without Government underwriting.	In option 1, government will give consideration to establishing a default pension fund to run alongside the NSSF and the approved funds, operating on a defined contribution basis.

DSD bears the responsibility for finalising the proposals together with the Minister of Finance. Issues that need to be considered include the fiscal implications, the role of the private sector and the governance of new arrangements for social insurance. In 2016 legislation was signed restricting the portion of provident fund savings that can be withdrawn as a lump sum to a third of the total savings. This legislation was later amended in the face of strong opposition from the union movement. The amendment provided for a delay of two years in implementation of the restrictions relating to withdrawal of savings.

After careful consideration of all the factors involved, the Ministerial Committee on the Review of the White Paper supports the proposals on comprehensive social security reform, and is of the view that the proposals taken to Cabinet in 2012 are more aligned to the Constitution and the NDP than the subsequent proposals. The 2012 proposals are supported over those of 2015.

Gaps in social grant provision include income support to working-age adults between 18-59 years who are not in employment.

8.3.9.2 Planned reforms for child grants

The current comprehensive social security draft paper does not include any specific provisions in respect of youth. However, the youth wage subsidy grew in part out of discussions around a jobseekers' grant at the African National Congress Mangaung Conference in 2013. The same grant was referred to by DSD as a "youth grant", which would provide support beyond 18 years if the young person remained in education or training. The DSD proposal would have doubled SASSA's budget so as to enable case work alongside supplementary income for youth. The current alternative proposal is to extend the CSG to youth. Treasury is supportive of this proposal, but concerned around the fiscal implications.

The current comprehensive social security draft paper provides for universalisation of both the old age grant and the CSG. DSD has completed a discussion paper on universalisation of the CSG, as well as a costing of universalisation. There is also a draft discussion paper on universalisation of the old age grant. It is proposed that universalisation be achieved by aligning the current means threshold with the income tax threshold ensuring that all receive benefits either through the tax system or through a cash grant.

In relation to the challenges around foster child grants going to relatives, the Forum of South African Directors-General has approved an extended CSG. This went to Cabinet in late 2015 for approval. Implementation depends on availability of finance. The proposal is that the expanded CSG will be 50% higher than the CSG, and children currently receiving the FCG will continue to receive it.

Proposed amendments to the Children's Act provided for a means test to be added to the FCG. This was done in response to the court judgement. However, it seems that the amendments will not go through in the proposed form.

8.3.8.3 Family grant

In 2012 DSD commissioned a study into the feasibility of introducing family benefits rather than the current system of individual social grants. The report¹⁷⁸ on the study saw the motivation as lying primarily in the fact that South Africa's current system of grants does not address the needs of the "able-bodied working-age poor", except to the extent that some members of this category may receive grants that assist them in providing care to children.

¹⁷⁸ Samson M, Meth C, Khadka A, Koh K, Miller E, Moorhead T, Renaud B with Carnes RD, Dayton WT and Lauten P. 2012. A Study on the Feasibility of Introducing Family Benefit(s) instead of the Existing Individual Social Grants. Prepared for Department of Social Development. Economic Policy Research Institute: Cape Town.

The report presented five country case studies – of Brazil, Mexico, Armenia, United Kingdom, Australia – which reveal that there is no single model for a “family grant”. However, one commonality is that all five countries base the size of the benefit in part on the number of children in the household but do not necessarily take the number of working-age poor into account. Further, comparison of South Africa’s CSG with the family grant programmes reveals that the former already includes some aspects of a family grant programme.

The study notes that it bases its analysis on DSD’s definition of the family. This is, however, questionable as the report proposes that the recipient unit would be the household whereas DSD’s definition of family members is not necessarily linked to physical residence.

The study proposes three models for determining the amount of the family grant benefit:

- a lump-sum grant i.e. a standard amount – the same in all cases – paid to a designated recipient in eligible households;
- a size grant, calculated on the basis of all individuals within eligible households who are not already receiving a grant other than the CSG. The CSG is excluded because the family grant replaces it. The size grant would be paid to one designated recipient in each eligible household; and
- an adult grant, calculated on the basis of all adults between the ages of 18 and 59 years within eligible households who are not currently receiving a grant. The adult grant would be paid to one designated recipient in each eligible household.

All three models are designed in a way that should ensure, in line with the principle of progressive realisation, that no household receives less after the reform than before it is introduced. All household members currently eligible for what the report terms “non-family vulnerabilities” grants (disability, old age, foster care, for each of which the value is greater than the proposed family grant per person) would continue to receive these but would not be considered when calculating the size of the grant.

Across all simulations, the size grant performs best in reducing the poverty gap. It also reaches about 100 000 more households than the lump-sum grant, and nearly 140 000 more households than the adult grant. The lump-sum grant performs best in reducing the poverty headcount and is also the largest and most expensive grant. The adult grant performs best in reducing the depth of poverty per unit cost, but has less impact on poverty and inequality than the other two grants.

The authors note that the fact that taxation in South Africa is imposed on individuals creates challenges if one wants to use the tax threshold for targeting (determining eligibility for) a family-based grant. Further, the fact that household composition changes over time due to mobility, death, movement of orphans between households, and other reasons, will make a family grant more difficult and costly to implement, and could also result in unforeseen consequences where individuals (such as abused women) are pressured to remain in unhealthy families in order not to lose access to the grant.

Analysis of changes in household composition over time using data from the NIDS of 2008 and 2012 suggest that such changes in household composition are frequent in South Africa. The analysis focuses on continuing survey members (CSMs), namely people who were targeted and surveyed in the first round and then followed up in further rounds. (Temporary survey members (TSMs) are individuals who at some point are in the same household as a CSM, but were not a permanent resident of a targeted household in the first wave.) The CSM category also includes babies born to CSM mothers subsequent to the first wave of the survey. The analysis excludes people who died between Wave 1 and Wave 3. If they were included, the changes would be even greater.

Overall, less than half (45 per cent) of CSM covered by the survey in 2012 were living with exactly the same individuals with whom they lived in 2008, even after excluding any new births. The percentage was somewhat higher for men than women, and much higher for white people than the other population groups. Northern Cape had the highest percentage (48 per cent) of people living with the same people in 2012 as in 2008 and Limpopo (38 per cent) the lowest by some margin. The fact that Gauteng had one of the highest percentages while Western Cape's was one of the lowest suggests that these patterns are not explained simply by migration. In terms of geotype, more than half of the relatively small share of the population living on farms in 2012 were living with the same people in 2008, while this was the case for only 39 per cent of people living in traditional (former homeland) rural areas.

Further analysis found that 35% of 2012 CSMs had lived in 2008 households whose members by 2012 were found in more than one household i.e. these were instances where household had split or broken up. There was very little gender difference on this measure, but Africans were again the most likely to have changes in their households and white people the least likely.

The analysis suggests substantial changes in household membership over a very short period of four to five years on all three measures used. All these measures probably under-estimate the extent of change by excluding deaths, and by focusing on CSMs covered in both the 2008 and 2012 surveys i.e. those could be located both in the first wave of NIDS and some years later. The findings suggest that any government or other development interventions that assume a stable family will not be suitable for the South African context.

A further problem is that because the family grant is given to a single individual in the household, there is no guarantee that all members benefit equitably. To circumvent this problem, the authors note that an alternative would be that each adult receives their share separately. This approach would, however, be more complex and costly administratively, and could call into question whether this still constituted a "family" grant rather than simply an extension of the CSG up to age 60.

The paper includes discussion of possible perverse incentives where recipients fear to take up work opportunities lest they lose the grant. The authors note that Brazil guarantees benefit for a fixed period regardless of changes in income over this period. Brazil also allows families to suspend payments voluntarily when they have work and to start getting them again immediately when work is no longer available. They do not discuss the details of these provisions.

The study's recommendation is for a "universally targeted" size grant, with a means-tested approach during a transition period. In essence, especially if the grant is paid to individuals rather than to a single individual in each family, the paper proposes a basic income grant.

One of the reasons that people oppose grants for working-age people is the fear that the grants create an incentive for people not to work. However, a recent paper¹⁷⁹ which re-analyses data from seven randomised controlled trials of government-run cash grant programmes in six developing countries calls into question claims that grants discourage work. The authors acknowledge that small, but statistically significant, effects supporting these claims have been founded in some developed countries. However, their analysis finds no impact for any of the seven grants on either women or men on the desire to work or the number of hours worked. When they pool the data for the seven grants, they find a small, barely significant negative effect on work in the household (such as self-employment in agriculture), but no effect on work outside the home. In all seven grant programmes, the amount of the benefit was the same for all eligible people regardless of income level. This is different from many programmes in the United States of America where the grant size varies with income of the beneficiary.

8.3.9.4 HIV and AIDS grant

There have over the years been proposals for a special HIV and AIDS grant. The motivation for this came, in part, from a concern that HIV-infected people would not take their medication because, in reducing their CD4 count and promoting their health, they would no longer qualify for a disability grant. Another motivation was that such a grant could cover the costs associated with the disease, such as transport costs to the clinic to collect medication and healthy food. In respect of the second motivation, in particular, there are questions as to why HIV should be privileged over other conditions in which those affected have similar transport, nutrition and other needs.

8.3.10 Roles and responsibilities

Table 61 summarises the current institutional arrangements in respect of different forms of social security in South Africa.

Table 61: Institutional arrangements for social security in South Africa

Social security benefits	Policy development	Implementation
Social assistance grants	Social Development	South African Social Security Agency
Unemployment insurance Illness and maternity benefits	Labour	Unemployment Insurance Fund
Compensation for occupational injuries and diseases	Labour	Compensation Fund

¹⁷⁹ Banerjee A, Hanna R, Kreindler G and Olken BA. 2015. Debunking the Stereotype of the Lazy Welfare Recipient: Evidence from Cash Transfer Programs Worldwide. Working Paper.

Retirement	Social Development National Treasury	South African Social Security Agency Private industry Financial Services Board
Health insurance	Health	Private industry ODMWA Council for Medical Schemes
Road accidents insurance	Transport	Road Accident Fund

Source: Department of Social Development

Table 62 shows the types of benefits provided by each of the different implementing agencies for social security in South Africa, namely UIF, the [Workers] Compensation Fund (CF), the Compensation Commission for Occupational Disease (CCOD), the Road Accident Fund (RAF) and SASSA.

Table 62: Social security benefits offered by different entities

Benefit type	UIF	CF	CCOD	RAF	SASSA
Pension					X
Unemployment	X				X
Family, adoption and child benefits	X				
Disability		X	X	X	X
Funeral		X		X	
Health/medical		X	X	X	
Maternity	X				
Illness	X	X		X	
Survivor	X	X	X	X	
General damages				X	

Source: Department of Social Development

The compensation funds provide medical care and income to workers who are injured at work or develop work-related diseases. The funds also provide benefits to families of victims of job-related fatalities. The funds' revenue comes from levies on employers, with the rate based on the industry risk profile and accident record. Employers register with the Compensation Fund, the Rand Mutual Association (for mining) and the Federated Employers' Mutual Assurance (for building). The mutual funds are registered with and monitored by the Department of Labour.

The Compensation Fund, which is administered by the Department of Labour, is the largest fund and covers private sector employees. The Department of Labour also assesses compensation claims of government employees, which are then, if successful, paid by the Government Pensions Administration Agency. The latter is funded through a budget vote rather than through employer payments. The Compensation Commission for Occupational Diseases in the Department of Health assesses compensation claims of current and former miners.

The benefits available under the Compensation of Occupational Injuries and Diseases Act (COIDA) (no. 130 of 1993) are higher and provide regular income unless the total amount is very small. In contrast, the Occupational Diseases in Mines and Works Act (no. 78 of 1973) pays a single lump sum. The Road Accident Fund provides compensation for loss of earnings, loss of support, general damages, medical and funeral costs, to victims of road accidents caused by negligent or wrongful driving of the driver of another vehicle.

Table 63 shows that, between them, the Road Accident fund, Department of Labour and SASSA had 577 service points around the country in 2012. The SASSA service points outnumber those of the other agencies in all provinces except Limpopo where the numbers for RAF and SASSA are the same. In all likelihood, often the service points of the different agencies are clustered close together. If the agencies collaborated with each other and shared service points, the available infrastructure could likely be used more efficiently and the reach extended.

Table 63: Service points of social security agencies, 2012

Provinces	RAF	Labour centres	SASSA	Total
Eastern Cape	12	15	43	66
Free State	7	12	22	40
Gauteng	16	23	39	78
KwaZulu-Natal	16	16	79	106
Limpopo	16	11	16	40
Mpumalanga	10	16	76	106
North West	8	11	26	42
Northern Cape	3	6	22	33
Western Cape	11	12	35	56
Total	97	122	358	577

Approximately 6.3 million of the 14 million employed in 2014 contributed – and had their employers contribute – to retirement funds. 32% of workers below the tax threshold, compared to 76% of those above the threshold have employers who contribute to retirement funds on their behalf. The percentage with contributing employers is substantially lower in construction, agriculture and domestic service than in other sectors. Workers in smaller firms are also less likely to have employers contributing.

Some social security is provided through bargaining councils. In 2011, 29 of the 40 private sector bargaining councils had one or more funds and more than a million workers were covered by these funds. Most of the retirement funds are provident rather than pension funds. Government employees belong to the Government Employees Pension Fund.

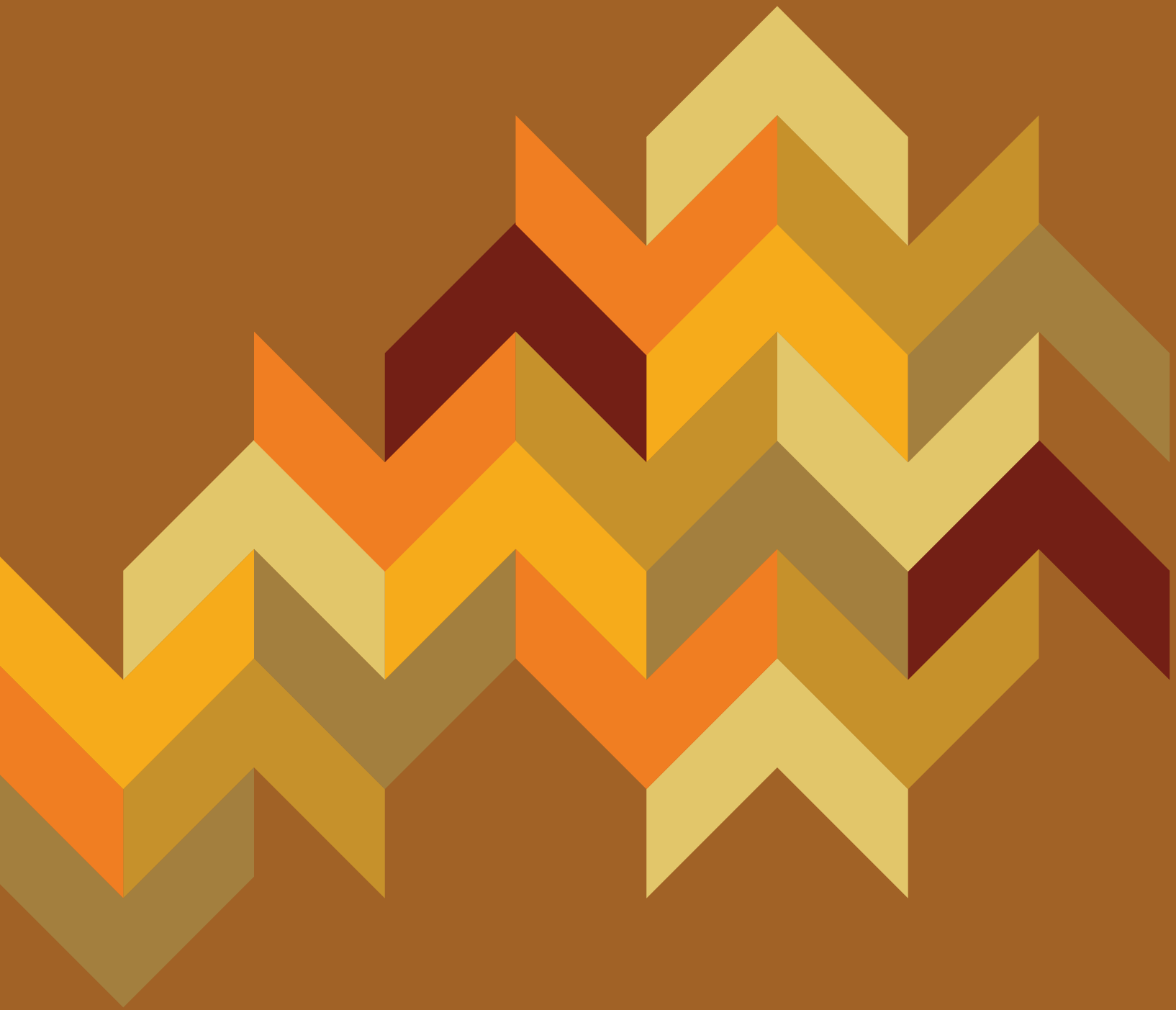
Even where people belong to a retirement fund, the value of the pension to which they are entitled may be inadequate. Research by the Department of Social Development estimated that the average replacement rate for South African retirement funds is about 24% of the worker's earnings, much less than the 40% benchmark value proposed by the International Labour Organisation.

The Committee supports the proposal that Comprehensive Social Security include mandatory pension contributions. The Committee finds that without an agreed social protection floor that sets minimum or basic entitlements, the cost of living of poor households will undermine their quality of life.

Social security:

Summary highlights

- The social grant system was the most highly rated service by beneficiaries, service providers and practitioners during the Committee's review process, and is also highly regarded internationally for its reach and impact.
- Diverse nutrition and food security initiatives are implemented by a range of different agencies, but there is little, if any, information available about effectiveness and impact.
- Proposals for comprehensive social security reforms have been developed, but there have been serious delays in adoption, and thus implementation.
- Comprehensive social security should include a social protection floor with basic social welfare services and income support measures such as social grants part of this floor.
- South Africa's social security system provides a lifeline to the poorest households and reduces poverty and inequalities.



PART VIII:

9. Review of current institutional issues

9.1 Policy framework, functions and structures

The White Paper noted that the Constitution assigned responsibility for social welfare to national and provincial, rather than local government, although some local authorities had delivered services on a small scale in both black and white areas during the apartheid era.

9.1.1 Developmental welfare services and the capable developmental state

The NDP attributes South Africa's failure to meet the targets of poverty reduction and deprivation laid out in the Reconstruction and Development Plan in part to "an overly optimistic view of the capacity of the state" and a resultant "lack of coordination between the public sector, the private sector and civil society". The last-named is especially important in the social development sector as CSOs delivers many of the relevant services. The NDP also highlights uneven and poor performance within the public sector, inappropriate staffing, and leadership instability at the administrative levels amongst other concerns. It refers to "general shortcomings in coordinating and implementing a number of government policies" as one of five gaps in the social protection and social welfare system requiring attention.¹⁸⁰

The South African government functions according to three distinctive, interdependent and interrelated spheres (i.e. national, provincial and local). The Constitution (1996) requires that the three spheres co-operate and acknowledge each other's area of jurisdiction, and act within a system of co-operative governance and intergovernmental relations. National government bears the main responsibility for making and formulating policy, the development of national standards and norms, as well as rules and regulations.¹⁸¹ The functions of provincial DSD are to implement and comply with legislation, policies and related norms and standards, and in particular to ensure that services are delivered in line with these instruments. Provinces may also prepare and initiate provincial legislation.

The local sphere does not have direct responsibility for social development. However, local government may play a role in ensuring compliance with national standards for service delivery. For example, in respect of ECD municipalities are required to ensure that the facilities used meet health and safety standards. There are some calls for local government to have more responsibility, but this might well result in greater inequity given the current situation of most local governments serving poor people.

DSD itself is structured and operates along district lines. This is meant to ensure attention to local needs and specifics. However, the district structure can cause some problems of its own, including in terms of uneven capacity, unnecessary bureaucracy and the associated delays in delivery and lessened efficiency.

¹⁸⁰ Ibid. p340

¹⁸¹ Department of Public Service and Administration. 2003. The Machinery of Government. Document prepared and co-ordinated by: Learning and Knowledge Management Unit in the Service Delivery Improvement Branch of the Department of Public Service and Administration.

10.1.2 Policy and legislative mandates

The NDP outlines the long-term growth, prosperity and socio-economic transformation plan of the country. The five-year Medium Term Strategic Framework (MTSF, 2014-2019) translates the vision and desired outcomes of the NDP into implementable, budgeted plans and targets.

Outcome 13 of the NDP is on social protection. The social protection agenda is broader than social assistance. The NDP envisages that, by 2030, South Africa will have a defined and sustainable social floor that provides a diversity of easily-accessible guarantees aimed at preventing or alleviating poverty as well as protecting citizens against vulnerability¹⁸². The notion of a social floor is not captured in the 2007 White Paper for Social Welfare or any other current legislative instruments.

The legislative and policy environment in South Africa is both comprehensive and aspirational. There are many individual pieces of legislation and policies which guide the country in its efforts to fulfil its mandate in respect of social development. However, the absence of over-arching legislation opens the door to fragmentation. National DSD's Strategic Plan 2015/2019 states that it will develop a Social Development Act by 2019¹⁸³. The danger of fragmentation is exacerbated by the limited role played by national DSD in ensuring coordination and sequencing of policy priorities as well as standardisation of structures and staffing throughout the sector.

9.1.3 Planning, monitoring and evaluation

Policy is translated into strategy through the five-year strategic plan and annual performance plans (APPs) of departments. Analysis of the plans reveals that each province has a different mix of policy and legislative mandates which are said to guide its work. The analysis suggests that there is a lack of understanding of policy and legislative alignment in some provinces as some provinces do not list any policy or legislative mandates, some list non-core or outdated policies and legislation, while others omit critical policies and legislation. Some provinces (North West is the prime example) focus primarily on provincial priorities in their strategic and APPs, while others (Eastern Cape, Gauteng, Limpopo) have plans that span all policies and legislation impacting on their work. In several provinces there is more emphasis on residential and institutional services than on potentially more developmental services and interventions.

The ISDM states that: "Effective monitoring and evaluation of the programmes and activities of the Department and sector is essential for measuring the success of developmental social service provision"¹⁸⁴. Social workers, other professionals, departmental officials and service delivery NPOs express unhappiness about the emphasis on quantitative measures in the current performance monitoring system. The concern is, in particular, that such measures do not capture qualitative aspects of service delivery, including impact. The counter-argument is that quantitative measures which focus on outputs (or deliverables) as do, for example, the quarterly performance indicators which must be reported to the Department of Performance Monitoring and Evaluation (DPME), are necessary, but not sufficient. It is only if this information on

¹⁸² National Planning Commission. 2011. The National Development Plan.

¹⁸³ DSD, Strategic Plan 2015/19: 33.

¹⁸⁴ National Department of Social Development. Integrated Service Delivery Model: 47.

deliverables is available, credible and reliable, that one can begin to ask about the qualitative (and quantitative) outcomes and impact of the services delivered.

Some of the provinces include in their plans targets which are vaguely specified, such as a numerical target of 4 000 for services “to the poor, vulnerable and special focus groups” in Limpopo, and a targeted of eight “integrated development social welfare services to the relevant targeted people infected and affected with HIV and AIDS and people with special needs” in Western Cape. Free State has an increase from 850 to 4 033 children receiving services in a single year without any explanation as to how this is to be achieved.

In the first few years of the rapid development of monitoring and evaluation in the public sector, emphasis was placed on setting up institutional structures to accommodate the function. Less attention was placed on up- or re-skilling of public service officials to perform the monitoring, reporting and evaluation functions introduced into the system. In addition, in the first years, there were regular changes to the indicators and targets. This prevented production of a series that could show development of services over time. The core indicators have now been standardised. However, some provinces report erratically and there appear to be differences in understanding of what some indicators measure, and also how annual numbers should be derived from the quarterly counts.

9.1.3 DSD functions as outlined in guidelines, models and frameworks

Various models, guidelines and frameworks have been developed for the delivery of social development services. The ISDM aims to “provide a comprehensive national framework that clearly sets out the nature, scope, extent and level of social services ... which will form the basis for the development of appropriate norms and standards for service delivery.” Further general documents include Generic Norms and Standards for Social Welfare Services (undated); Framework for Social Welfare Services (2013); the Generic Intervention Process Model for Social Work Services (undated) and the Service Delivery Value Chain (undated). In addition to these generic documents, a number of guidelines, norms and standards have been developed for specific services within the sector.

The ISDM includes an implementation plan, but it seems that this was perhaps not followed. For example, the implementation plan refers to the establishment of a Model Implementation Advisory Team at the national, provincial and local levels of government to guide implementation and the associated change management process. There was no mention during the Ministerial Committee’s review process of such teams being established (and it is questionable why they would exist at local level when local government does not have direct social development functions).

According to national DSD, funding constraints have prevented comprehensive roll-out of the Generic Norms and Standards for Social Welfare Services. In the absence of resources for roll-out and a system to monitor compliance, guidelines become suggestions rather than requirements.

Comparison of the various generic documents in terms of services, levels/focus and target beneficiaries reveals inconsistencies between them. It is also not always clear how the documents relate to each other. For example, the Generic Norms and Standards for Social Welfare Services states that this document must be read together with the 2013 Framework for Social Welfare Services and that social workers need to be trained on both documents, but does not explain further how the two documents relate to each other. The lack of clarity allows for differing interpretations and thus differences in services.

9.1.4 Organisational design

Ideally, “form follows function” and “structure follows strategy”. There are, however, challenges with adhering to this principle of organisational design and structuring throughout government. The large range of guidelines, frameworks and policies beyond the sector to which national and provincial DSD need to align adds to the complexity of organisational design.

The ISDM notes the importance of having “as much structural alignment as possible between the national and provincial departments, as this will facilitate the coordination and integration of services, and improve communication and joint planning”. There are, however, differences between the organisational structures of different provinces. There are even more differences between district structures in the nine provinces. These include differences in how sub-directorates and divisions are clustered or named. There are also differences in how functions are named, with some provinces using the word “managing” where another might use “facilitating”, “rendering” or “providing” a particular service. Decentralisation of support functions to districts results in the duplication of structures in the three levels of government, and contributes to the bloating of the organogram. For example, a corporate services division currently exists at national, provincial and district level in most provinces. Where districts have facilities falling under them, these facilities may in turn have a corporate services division.

During February 2008, the Heads of Social Development and DSD MinMec agreed upon the following organisational design principles: strategic and structural alignment; service delivery; clear lines of accountability; balanced span of control; sustainability; efficien(cy) and effective(ness); simplicity; cost effective(ness); service integration; and clear role separation between national and provincial responsibilities.¹⁸⁵

In addition, a value chain defining how all services across the sector are to be delivered, was agreed upon by top management of national DSD through a consultative process. Unfortunately, the value chain excludes non-state actors, which undermines the comprehensiveness of the model. It is also not clear to what extent the design principles and the value chain have been applied in human resources (HR) planning and organisational design.

In 2010/11, national DSD initiated collaborative development of a standardised organogram for provincial DSD.¹⁸⁶ By the deadline for the conclusion of the process (2012/13), five of the nine provinces – Eastern Cape, Free State, Gauteng, KwaZulu-

¹⁸⁵ National Department of Social Development. Undated. Position Paper: State of Human Capital Management.

¹⁸⁶ National Department of Social Development. 2012. Situational Analysis Report on the Social Service Workforce Servicing Children.

Natal, and North West – had reportedly embarked on the process of adopting the standardised organogram. However, current organograms still show a mismatch between the provincial structures and the generic functional structure even in these five provinces.

In 2014, the Minister of Public Service and Administration issued a directive spelling out the conditions within which a department may make changes to its organogram.¹⁸⁷ The directive requires consultation with the Minister of Public Service and Administration before any changes are made. Principles underlying the directive include ensuring value for money, appropriate distribution of posts across core and non-core functions, and improving the responsiveness of the structure to the mandate and strategy of departments. The directive also requires the development of norms and standards for the creation of Senior Management Services posts. This could be an important aspect for DSD, which has, for example, approximately 40 chief directors in national DSD, as against 30 or fewer in Health and Education.

National DSD's Chief Directorate: Human Capital Management has identified four phases to the process of aligning provincial structures to the generic functional structure, namely consultation, agreement on migration principles, approval by the MEC, and implementation. An undated report shows that six provinces had not progressed beyond phase 1, while two (Limpopo and Northern Cape) had approval from the MEC with implementation affected by financial constraints, while Western Cape was in the process of implementing the new structure. Protracted delays in the approval of some organograms (for example, the Eastern Cape), present a challenge to the delivery of services.¹⁸⁸

Examination of the structures of five of the nine provincial DSDs shows relatively good, although not exact, alignment with the generic structure for Mpumalanga and Northern Cape while, of the five provinces examined, Gauteng has the least alignment to the generic structure. (The other two provinces examined were Eastern Cape and Western Cape.)

Common signs of non-alignment include:

- Units (such as auxiliary services, service delivery and transformation, and infrastructure and facilities units) in the generic functional structure not included in the provincial organogram
- Location of structures and units at different levels (e.g. directorate versus sub-directorate), differences in clustering of units, and/or two units seeming to have responsibility for the same function
- Inclusion of units (e.g. war on poverty, sustainable livelihoods, probation services, talent management) not found in the generic structure.

The provincial organograms demonstrate greater alignment in respect of non-core functions, such as supply chain management, HR management, and ICT management than in respect of service delivery. However, examination of the older persons service area suggests that even in this long-established area where there is general agreement on the core set of services, the structure differs across provinces.

¹⁸⁷ Department of Public Service and Administration. 2015. Directive of Changes to the Organisational Structures by Departments.

¹⁸⁸ Eastern Cape Department of Social Development. 2013-2015. Human Resource Plan: 28.

More generally, what is noticeable about the generic structure is that job titles for social service professionals such as social workers and community development workers denote predominantly management roles rather than provision of services. This might reflect the fact that NPOs are responsible for the bulk of delivery. However, the language used to describe the functions of the professionals – with words such as “development of policy”, “coordination”, “facilitation”, and “evaluation” – does not match the more delivery-oriented functions listed in the ISDM. There are also sometimes discrepancies between job titles and job functions in approved provincial structures where, for example, the job title is “manager” but the function refers to “providing” services. Even at district level, there are more managers than one would expect. Further, while national DSD bears the primary responsibility for policy development, Gauteng has six social work policy developer posts in a single sub-directorate (older persons). The confusions are exacerbated by the serious overlaps between the job descriptions for social work policy manager and social work policy developer provided by the Department of Public Service and Administration.

9.2 Human resources

The White Paper put the total number of welfare personnel in government and the formal, subsidised welfare sector at just over 8 000. Social workers accounted for more than half (56%) of the total, and more than half of the social workers were employed by government. The total number of public sector social security personnel stood at 2 256 and public sector administrative personnel at 1 315. The White Paper highlighted the uneven distribution of human resources across and within provinces, with Eastern Cape, North West, Mpumalanga and Limpopo faring worst. It advocated for expansion of the use of other categories of social service workers so as to avoid the “over-reliance” on social workers. It commented on the “extremely low” salaries earned by welfare workers, the poor working and service conditions, lack of career path planning, and “inappropriate” management styles. It acknowledged volunteers as a “significant human resource” utilised by welfare organisations and in “development programmes” more generally and suggested that use of this form of human resources be expanded so as to extend welfare services.

The White Paper critiqued the emphasis in social work training on therapeutic and restorative services alongside neglect of a developmental approach which would respond to “the most important social development needs in South African communities.” It acknowledged the ongoing work at the time in some of the institutions to change the orientation.

9.2.1 Updating the White Paper

There has been noticeable expansion in human resources in government since the late 1990s. In April 2013, the nine provincial departments of social development combined had a total of 10 389 filled posts if social workers, social work supervisors, social work policy developer and policy managers, social work managers, and social auxiliary workers are combined. In addition, there were 1 862 filled posts for various categories of community development practitioners, and 1 694 for categories of child and youth care workers.¹⁸⁹ In terms of social security, in mid-2015 SASSA employed more than 10 000 people.¹⁹⁰

¹⁸⁹ National DSD Human Resources presentation to Ministerial Committee, November 2013.

¹⁹⁰ SASSA presentation to round table, June 2015.

The provincial budgets show the number of staff increasing from 15 417 on 31 March 2011 to an estimated 26 745 on 31 March 2017. All provinces show a steady increase over the period, but KwaZulu-Natal's numbers increase far more dramatically (quadrupling) than those of other provinces, from 2 091 in 2011 to an estimate 8 902 in 2017. KwaZulu-Natal's budget documents attribute the increase to a change in departmental structure in line with policy changes such as a district management model, an increase in the number of social work staff including bursary graduates and supervisors, transfer of community caregivers for Isibindi, and appointment of other categories of contract workers. (As discussed further below, community caregivers are not on the government payroll in other provinces. Instead, NPOs are funded to pay the caregivers)

Social work has been classified as a scarce skill within DSD. The Presidency estimated that between 2000 and 2014 the number of social workers in South Africa grew from 9 072 to 18 213¹⁹¹, with substantial further growth expected subsequent to 2014 facilitated by the social work bursary scheme. This scheme was first introduced in 2008, and by 2013 more than 6 300 bursaries had been awarded. The Presidency's estimates appear to be based on registrations with the South African Council for Social Service Professions (SACSSP). If so, it is an over-estimate because not all registered professionals are working in that profession at any point in time. For example, in March 2012, only 56% of all registered social workers were employed by either government or NPOs. In addition, any comparison with apartheid-era estimates must take into account that social workers based in homelands were not registered with the then South African Council for Social Work.

Government has committed substantial resources to addressing the human resource needs. Initiatives include substantial increases in the number of funded posts (although too many posts remain unfilled), a very substantial social work bursary programme with some follow-up employment opportunities, and funding for training and employment of other social service professional cadres, including social auxiliary workers and child and youth care workers. Nevertheless, social workers continue to perform work that could be (better) performed by other (lower-paid) categories of social service professionals.

Social workers continue to perform work that could be (better) performed by other (lower-paid) categories of social service professional. In the round tables as well as other forums concerns were expressed at the way in which most discussions of the workforce focused only on social workers, ignoring the other cadres, as well as the need for and potential of non-hierarchical multi-disciplinary teams in integrated service delivery. A submission by the SACSSP suggested that there was some "over-servicing of clients" by the different cadres.

In an effort to ensure that the skills and knowledge of those already employed is adequate, a task team made up of representatives of SACSSP, universities, unions, NPOs and national DSD was established to develop a policy on continuous professional development (CPD). Resultant policy states that all professionals must earn at least 10 CPD points per year, for which they must submit proof to the Council. Participants in the round table with higher education institutions and associations suggested that the policy was not yet firmly in place, and the Council was not yet able to monitor compliance at all adequately.

¹⁹¹ Jamieson L, Wakefield L & Briedé. XXX. "Towards effective child protection: Ensuring adequate financial and human resources" in S Mathew, L Jamieson, L Lake & C Smith (eds). 2015. South African Child Gauge 2014. University of Cape Town: 51-57.

The rural/peri-urban/urban bias cited in the White Paper persists in deployment of social welfare personnel. The imbalance is not explained only by the distribution of posts, but also by the fact that many qualified personnel do not want to work and/or live in poverty-stricken areas. DSD's national bid to National Treasury to provide for rural allowances to attract personnel to these areas did not succeed. Personnel in rural and other poorer areas also complain about poor office accommodation and the absence of necessary tools of the trade, including transport. The rollout of the Isibindi programme has focused primarily on rural and other under-served areas and thus aims to help address the imbalance. In 2015 DSD submitted a new bid to National Treasury for the 2016/17-2018/19 medium-term expenditure framework (MTEF) to provide for the necessary tools of trade, infrastructure and supervisors for the new graduates. It seems that this bid was not successful.

The conditions of work and salary of all social development personnel are now governed by a single bargaining council, the Public Service Coordinating Bargaining Council. Government must also, like other employers, comply with the Employment Equity Act.

An occupation-specific dispensation (OSD) for social workers was introduced in 2011. (The Public Sector Central Bargaining Council Resolution on OSDs was passed in 2007.) According to a presentation by national DSD, in terms of social service personnel, the OSD covers social workers, social auxiliary workers, community development practitioners, assistant community development practitioners and child and youth care workers. The OSD is meant to provide for these workers' salaries to be higher than for other government employees at an equivalent level. Nevertheless, many social workers remain dissatisfied with their salaries and conditions of work. Concerns related to various aspects of the OSD, including the requirements in terms of qualifications and experience for appointments, an organisational structure that is not always aligned to the OSD, reporting lines and supervision, gaps in job descriptions, and a range of issues related to remuneration.

9.2.2 Findings of the Ministerial Committee

The provincial dialogues convened prior to the Social Work Indaba hosted by the Minister of Social Development in March 2015 explored the views and experiences of social workers and social auxiliary workers in respect of six themes. Many issues were raised, but several emerged as concerns across provinces:

- In respect of supervision and management, there were serious concerns about social workers being supervised by non-social workers, unrealistic supervision workloads, and generally poor quality of supervision.
- With respect to working conditions, there was unhappiness about the absence of overtime and danger pay, and absence of adequate infrastructure and tools of the trade. In several provinces participants in the dialogue noted a mismatch between the entry level for social workers and the relevant National Qualifications Framework level.
- In terms of retention strategies, participants were unhappy about the lack of a rural allowance, concentration of staff in lower pay levels, and non-professional staff being paid more than social workers.
- On specialisation, the overall view seemed to be that a generalist approach was necessitated by the shortage of staff.

- On social work practice, there were concerns across provinces about the fact that their work was assessed in terms of quantitative measures rather than qualitatively.
- On promotion of integration and multi-disciplinary practices, there were concerns about duplication within DSD itself, weaknesses in the referral system, contradictory policies and legislation of different sectors, poor collaboration, and lack of clarity about roles of different agencies despite an over-abundance of forums.

The rural allowance was raised repeatedly as an issue in the Ministerial Committee's engagements. MINMEC had, in fact, approved an incentive index based on accessibility and work burden, with areas on a scale from 1 to 6, one being least remote and 6 being most remote. The bid for such an allowance to be catered for in provincial funding was, however, rejected by National Treasury.

The Sector Skills Plan for 2012/13 of the Health and Welfare Sector Education and Training Authority (HWSETA) identified the following skills needs for the sector:

- Post-graduate training in "specialist areas", e.g. probation work; adoptions; substance abuse; victim empowerment; child abuse; forensic social work; trauma counselling
- Generic skills for office-bound duties, e.g. report writing; document management; recording of work activities

Several universities reported that they had developed specialised courses for social workers but had discontinued them. Sometimes this was because they no longer had the necessary staff, or because there was not the expected demand from students who met the prescribed entrance criteria. In some cases, because of limitations of staff, the specialisations were offered only through research degrees, rather than degrees that included coursework. In yet other cases universities had not developed specialist courses in needed areas because the university subsidy system favoured research rather than development of short courses or taught masters programmes. SACCSP reported that the Social Service Policy identified ten specialist areas (adoption; clinical social work; forensic social work; social work in health care; school social work; management and supervision; educational social work; occupational social work; and probation services) but SACSSP had "adopted" only four of these to date.

Questions were raised as to whether social workers are best placed to do community work. The higher education and associations round table convened by the Ministerial Committee noted that there was often confusion about the distinction between community development workers as a separate profession and community work as a method of social work. It confirmed that community development was correctly conceived as a separate profession, with a different theoretical and philosophical orientation. This matter was, in fact, already settled in that the community development profession had been officially recognised. There were, however, some who were still not convinced of the need for a separate profession. For example, one university's submission characterised community development as "an unnecessary duplication whose only purpose is seen to steal thunder from the sterling work social workers in the communities are doing." Participants at the round table agreed on the need for the scope of practice of the different professions to be clearly delineated, ideally in the Social Service Professions Act.

9.2.3 Additional evidence

9.2.3.1 Findings from analysis of PERSAL data

PERSAL is the database system that the Department of Public Service and Administration (DPSA) uses to manage public service employment. It includes details of all employees of national and provincial governments. DPSA provided an extract from the database containing anonymised records of all employees of national and provincial DSD as at the start of December 2015. The extract contained information, among others, on which department (national or one of the nine provinces) the employee worked in, race, gender, age, year of starting work, programme and sub-programme in which employed, and several different ways of classifying the type of work done (such as rank, occupational classification, job title).

Preliminary inspection of the data revealed that provinces use different and inconsistent classifications for key items, including programme, sub-programme and the various ways of classifying work done. These inconsistencies make it more difficult to analyse the data. The inconsistencies also contribute to the multiplicity of “names”. For example, analysis in late 2014¹⁹² found that there were 77 different occupational classification descriptions across the nine provinces and 3000 different job titles in Gauteng alone.

Some cleaning of the data was done, for example where there was an obvious mismatch between the sub-programme and programme that suggested that the old budget programme names were still being used. In addition, several new categorisations were developed that attempted to standardise where different provinces used different terms for similar purposes.

As is evident from the analysis below, different nomenclature is not the only way in which the provinces differ. Even after the cleaning and standardisation, there are substantial differences in the composition of the provincial DSD workforces, despite the fact that they are governed by the same legislation and policy and meant to deliver similar services.

Figure 35 reveals that PERSAL included details on a total of 33 187 employees in late 2015. National DSD accounted for only 3% of the total. All provinces except Northern Cape had more DSD employees than national government.

KwaZulu-Natal has by far the most employees recorded on PERSAL, at 9 127. However, more than half of these were EPWP employees. This category of workers are not included on PERSAL in other provinces. If these workers are excluded, KwaZulu-Natal would have fewer employees than either Eastern Cape or Gauteng.

Eastern Cape had the most employees – at 18% of the total excluding the EPWP workers and national employees. However, this province accounted for only 13% of the total population according to the mid-year population estimates for 2015 produced by Statistics South Africa.

¹⁹² Carter J. 2014. Financing Framework and Policy for Social Welfare Services in South Africa: Validating the link codes between BAS and PERSAL and analysing the allocation of posts to sub-programmes. Cornerstone Economic Research,

Figure 35: Total DSD employees by department, 2015

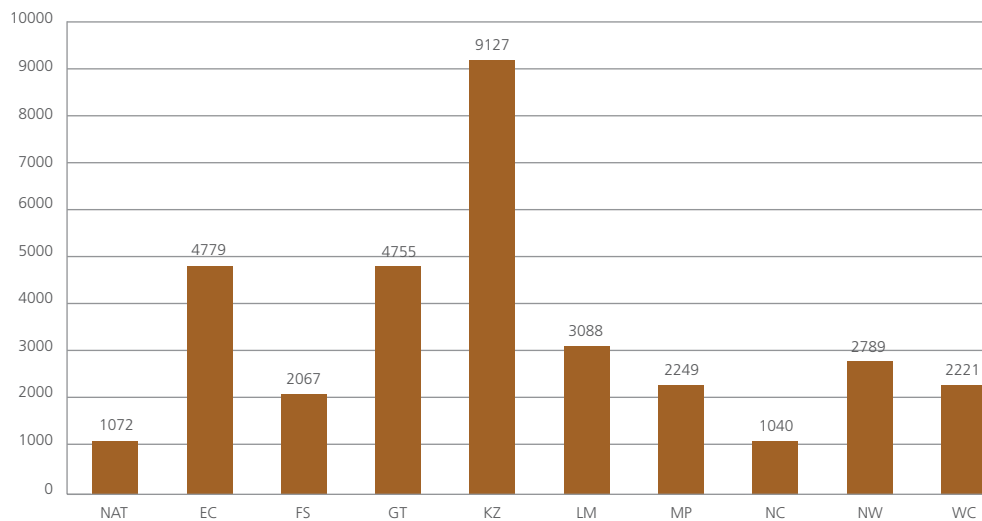
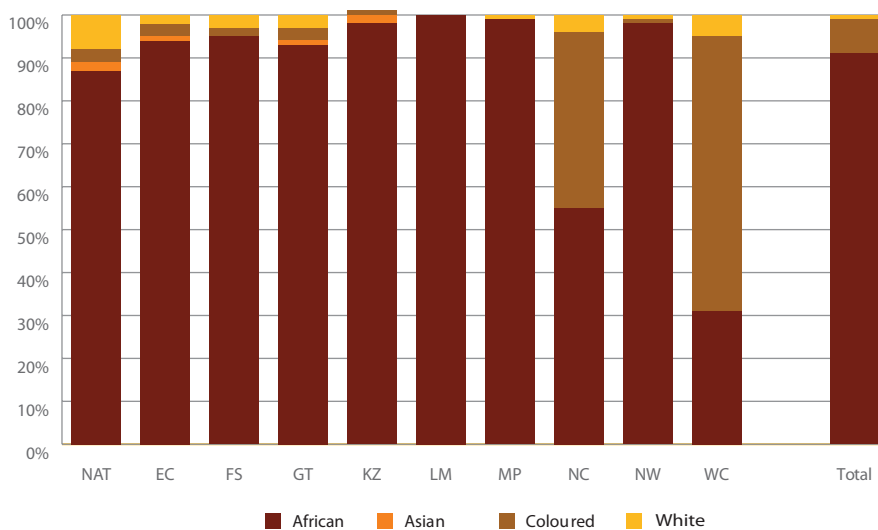


Figure 35 shows that for all DSD combined, 91% of employees are African, 7% coloured, 2% white and 1% Indian. Africans account for more than half of all employees in all provinces except Western Cape. In Western Cape Africans account for just under a third (31%) of DSD employees and coloured employees account for just over double that, at 63% of the total. In Limpopo, Mpumalanga, KwaZulu-Natal and North West, 98% or more of employees were African.

Not shown in the figure, women accounted for approximately three-quarters (74%) of all DSD employees. The female share was 82% among white employees, 75% among African, 68% for coloured and 65% for Indian. Looking beyond race and gender, less than half a percent of employees were not South African.

Figure 36: DSD employees by department and population group

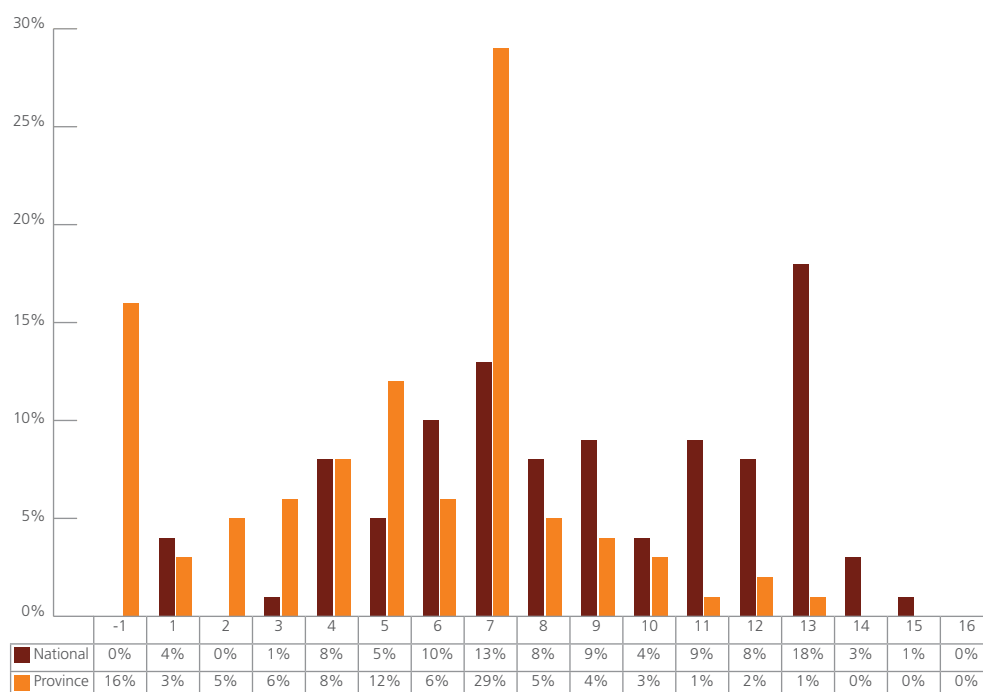


There are 16 standard salary levels, with -1 in Figure 37 used for the 5 140 EPWP workers in KwaZulu-Natal who had been put on the government payroll. Salary level information was available for 98% of employees.

Figure 37 shows that the distribution of employees in national DSD was skewed towards the higher salary levels while the distribution for provincial DSD was concentrated in the middle levels. In particular, 29% of all provincial employees were found in level 7. Social workers accounted for 78% of the level 7 employees.

While the concentration was in the middle levels for provincial DSD, even if one excludes the EPWP workers, there was more concentration in the levels below level 7 than above.

Figure 37: DSD employees by salary level



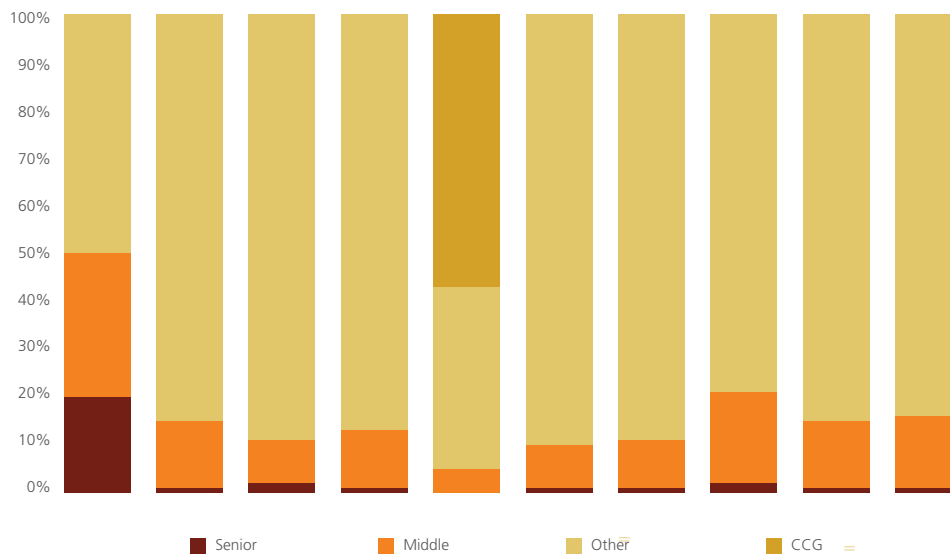
In terms of broad bands, employees in salary levels 13 to 16 can be classified as senior management, those in level 9 to 12 as middle management, and those in levels 1 to 8 as “other”. The EPWP workers are classified by KwaZulu-Natal as CCG (community caregiver) although more than 1 000 work as cleaners according to the occupational classification.

PART VIII:
Review of
current
institutional
issues

Figure 38 reveals that the EPWP employees accounted for over half (56%) of all DSD employees in KwaZulu-Natal. In all other provinces, the “other” category accounted for 79% or more of employees. If one excludes the EPWP workers, the “other” category accounted for 87% of employees in KwaZulu-Natal.

National DSD differed from the provinces, with just under half (49%) of employees in the “other” category, 30% in middle management, and 21% in senior management. Provinces had, at most, 2% of employees in senior management.

Figure 38: DSD employees by salary band and province



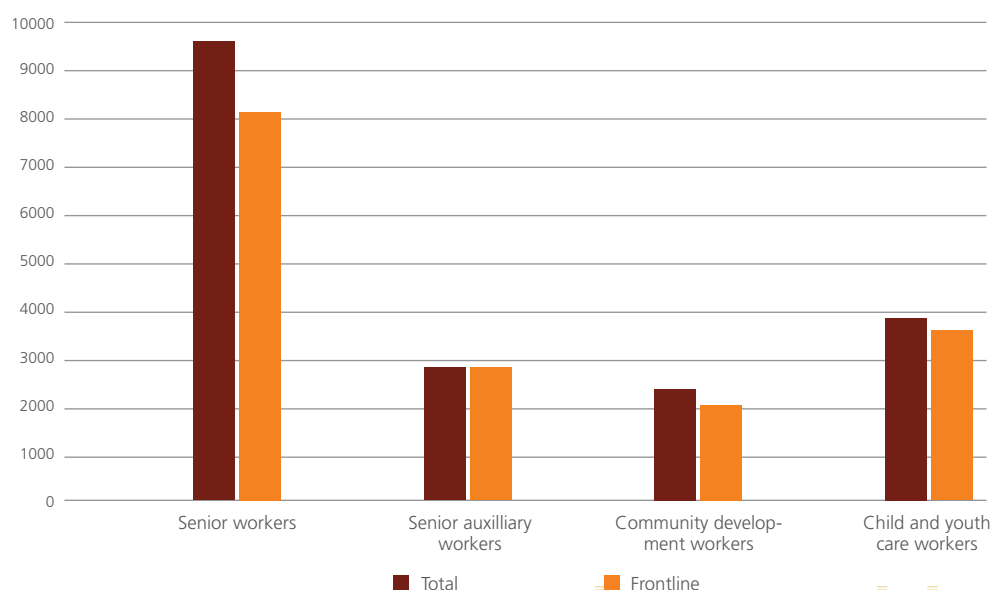
The job title can be used to identify some of the key (potential) service delivery occupations, namely social workers (SWs), community development workers (CDWs), social auxiliary workers (SAWs), and child and youth care workers (CYCWs). Together these four categories accounted for more than half (56%) of all DSD employees in late 2015. Within each of these categories, the job title can be used to distinguish “frontline” workers who are likely to be involved in direct service delivery, and “support” workers who play management, supervision, policy development, and administrative roles.

Analysis identified 9 598 social workers, who accounted for 29% of the total DSD workforce. Of the 9 598, 8 129 (85%) had job descriptions that suggested that they were frontline workers. All social workers in level 7 (see above) were frontline rather than support workers (see further discussion below). There were also 2 573 social auxiliary workers (8% of the total workforce), all of whom are assumed to be frontline workers.

A total of 2 329 community development workers were identified. These workers accounted for 7% of the total DSD workforce. A clear majority (1 993, or 85%) of the CDWs had job descriptions that suggested that they were frontline workers.

The 3 818 CYCWs accounted for 11% of the total DSD workforce. This number included those with job title “Isibindi worker” within KwaZulu-Natal’s EPWP employees. Of the total CYCWs, 3 818 (93%) had job titles that suggest that they were frontline workers.

Figure 39: Key service delivery jobs



PERSAL records when each employee was first employed in their current department. The dates go back to 1994, but it is only after 2000 that the numbers start growing. If KwaZulu-Natal's EPWP workers are excluded, 15% of all employees started working in their current DSD department only in 2015. This situation is particularly common for non-service delivery job categories (labelled "Other"). For social workers, in contrast, there were far fewer who started in 2015 than who started in either of the preceding two years.

Among CDWs, 20% were recorded as having started only in 2015. This can be compared with the 6% of social workers and SAWs in this situation, and 11% of CYCWs. Provincially, only 5% of KwaZulu-Natal employees (excluding EPWP) were recorded as having started only in 2015, and only 7% in Free State. In North West, in contrast, 26% of employees started only in 2015, and in Gauteng 23%.

Figure 40: Length of service by employee category

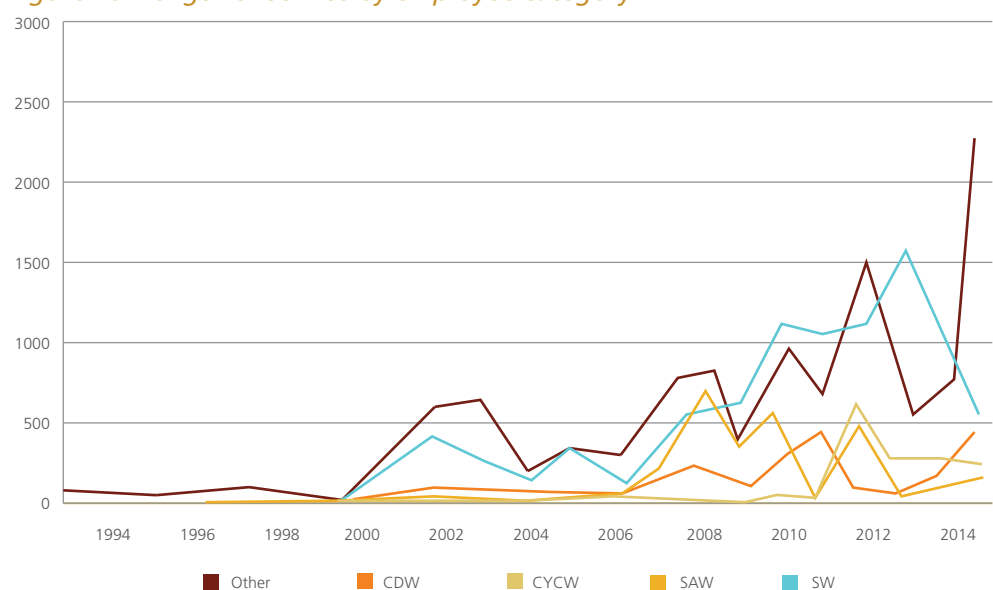


Figure 41 shows that Eastern Cape had the largest number of social workers, at 1 965, while Northern Cape had the least (279). The Restorative Justice programme accounted for the overwhelming majority of social workers in Gauteng, but for a much smaller proportion in all other provinces. Many of the Gauteng social workers were allocated to the Victim Empowerment sub-programme, and to Women Development within that. It seems likely that this categorisation, which is found for other workers, is a consistent error in Gauteng’s PERSAL records.

Children and Families accounted for a relatively large proportion of social workers in all provinces except Western Cape and Gauteng. The situation in these two provinces is perhaps partly explained by social workers in non-profit organisations carrying a substantial child protection workload. Alternatively, there may be some inaccurate recording of programmes in PERSAL. In particular, some social workers who worked in Children and Families may still have been recorded under Social Welfare Services, which previously included Child Care and Protection services.

Social Welfare accounted for the overwhelming majority of social workers in Western Cape and about half of all social workers in Northern Cape, but a much lower proportion in other provinces. Five provinces had no social workers employed in Development and Research.

Figure 41: Social workers by province and programme

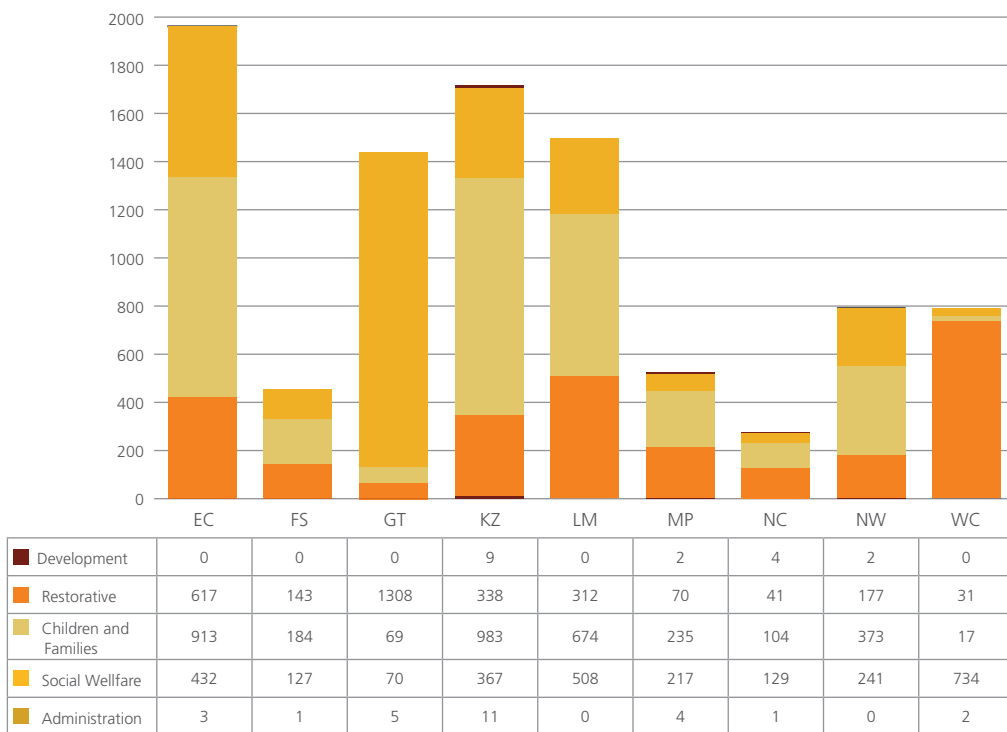


Figure 42 focuses on frontline social workers. This restriction results in relatively small changes to the picture (in the previous figure) of the distribution across programmes in each of the provinces.

Figure 42: Frontline social workers by province and programme

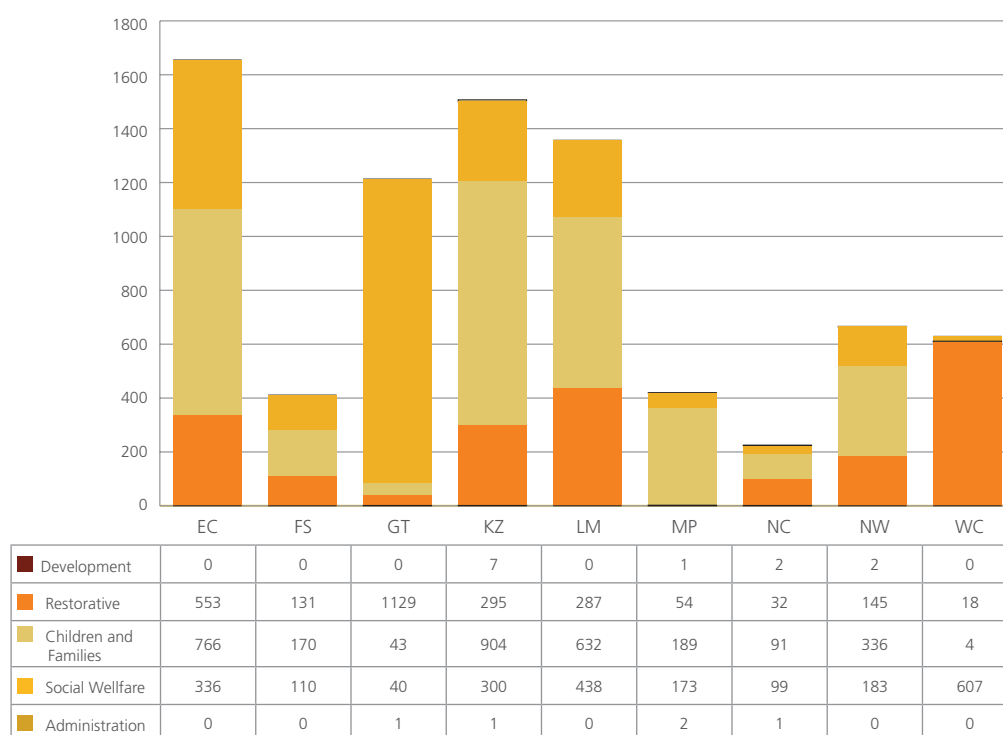


Table 64 shows frontline social workers accounting for 71% or more of all social workers in all programmes other than administration. The frontline percentage is highest in Children and Families and Restorative Services, the programmes with the largest number of social workers. In provinces such as Limpopo and Free State 90% or more social workers were frontline, as against 79% in Mpumalanga.

Table 64: Frontline social workers as percentage of all social workers by province and programme

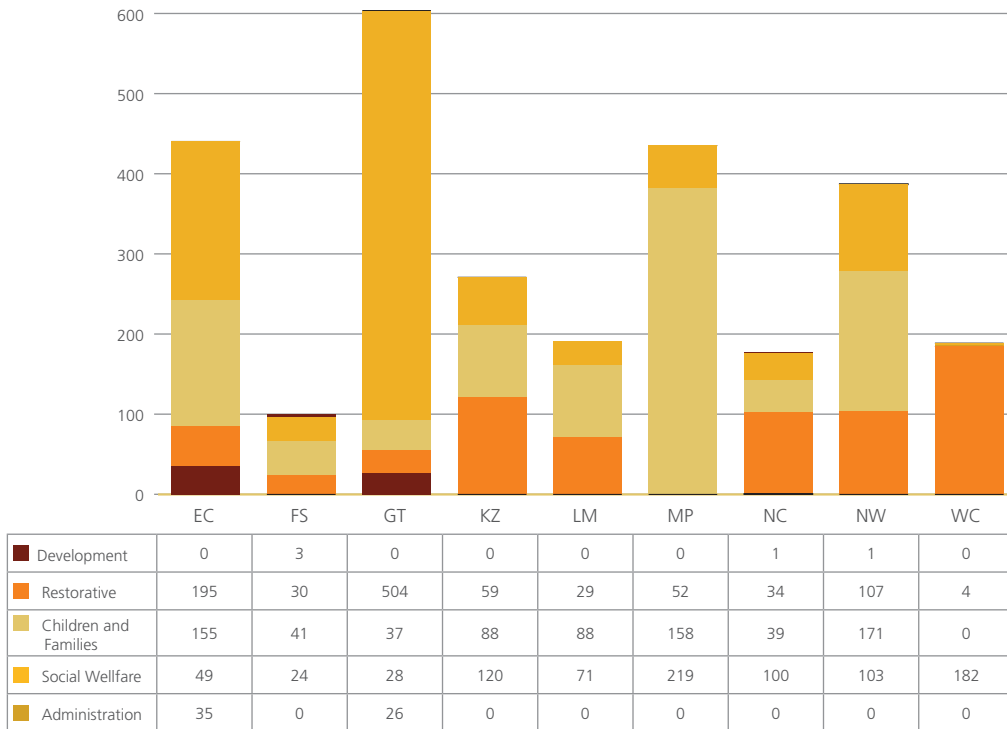
	Administration	Social Welfare	Children & Families	Restorative	Development	Total
EC	0%	78%	84%	90%		84%
FS	0%	87%	92%	92%		90%
GT	20%	57%	62%	86%		84%
KZ	9%	80%	92%	87%	78%	88%
LM		86%	94%	92%		91%
MP	50%	80%	80%	77%	50%	79%
NC	100%	77%	88%	78%	50%	81%
NW		76%	90%	82%	100%	84%
WC	0%	83%	24%	58%		80%
RSA	19%	81%	88%	87%	71%	85%

In Figure 43, Gauteng again stands out as the province with the most social auxiliary workers, while Free State had the fewest. This category in Gauteng is again concentrated in the Restorative Services programme. The Gauteng SAWs in this programme were categorised in the Women Development sub-programme. In contrast, Western Cape had

virtually all its SAWs in the Social Welfare programme. This programme also accounted for a substantial share of SAWs in Northern Cape, Mpumalanga and KwaZulu-Natal.

The Children and Families programme employed SAWs in all provinces except Western Cape, but the share of this programme was large only for Eastern Cape, North West and Mpumalanga. Eastern Cape and Gauteng were the only provinces with SAWs in the Administration programme.

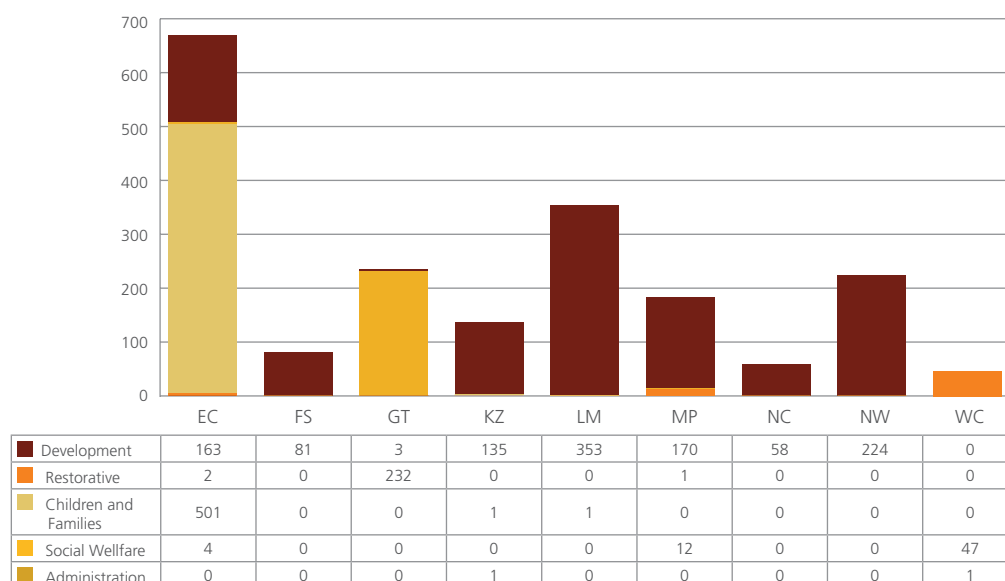
Figure 43: Social auxiliary workers by province and programme



shows that in six of the nine provinces frontline CDWs were, as expected, concentrated in the Development and Research programme. However, Western Cape had no frontline CDWs in this programme, and Gauteng had only three. Eastern Cape had more frontline CDWs in Development and Research than four other provinces, but had far more CDWs in Children and Families than in Development and Research. All other provinces had at most one frontline CDW in Development and Research.

In Gauteng, all but three of the 235 frontline CDWs were in Restorative Services. Again, these workers were in the Women Development sub-programme. Western Cape, Mpumalanga and Eastern Cape were the only provinces with frontline CDWs in Social Welfare Services. Provincially, the share of CDWs that had job titles suggesting that they were frontline workers ranges from 62% in KwaZulu-Natal and 67% in Northern Cape to 93% in Eastern Cape.

Figure 44: Frontline community development workers by province and programme



Analysis of CYCWs is complicated by the fact that KwaZulu-Natal PERSAL records include Isibindi and other EPWP workers for whom it pays salaries, while all other provinces fund salaries of Isibindi CYCWs through NPO transfers. The latter are not recorded in PERSAL. For other provinces, and also for the non-EPWP CYCWs in KwaZulu-Natal, the PERSAL information relates to CYCWs who work in other settings, such as institutions.

However, Figure 45 shows that KwaZulu-Natal had far more CYCWs than other provinces even if EPWP workers are excluded. Gauteng had the next greatest number, and had CYCWs in four of the five programmes – all except Development and Research.

The Children and Families programme had the most CYCWs in six of the nine provinces. In Eastern Cape and Mpumalanga there were more CYCWs in Restorative Services than in Children and Families, while Western Cape had no CYCWs in Children and Families. Further analysis reveals that Western Cape and Eastern Cape employed many CYCWs in the Crime Prevention sub-programme, with further CYCWs employed in the Substance Abuse sub-programme.

Figure 45: Frontline child and youth care workers by province and programme

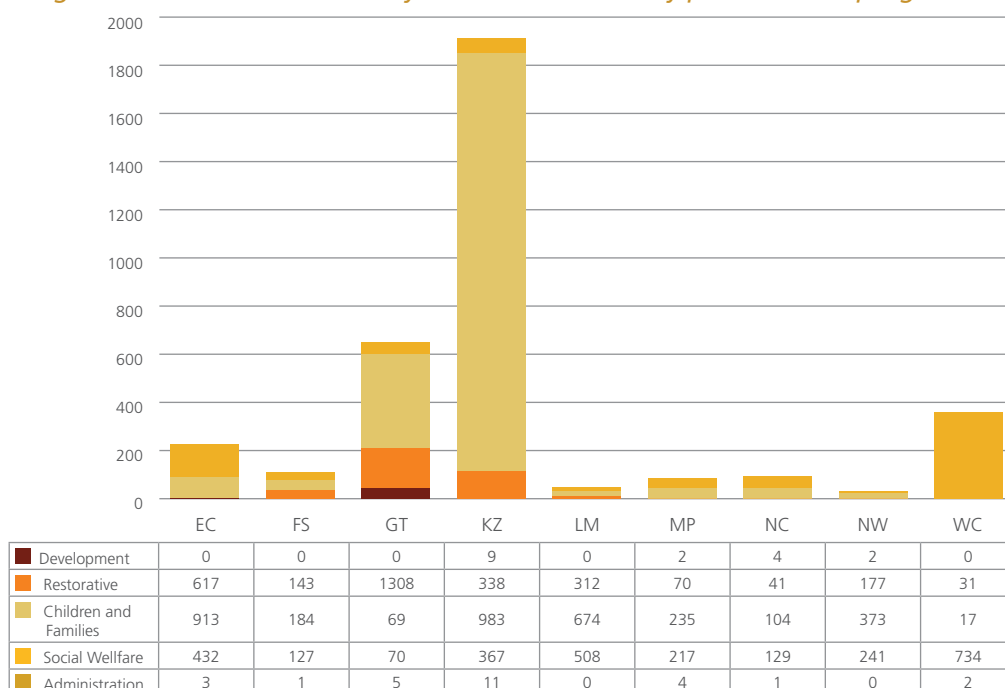


Table 65 shows the highest percentage of frontline workers among employees classified in the (non-existent) Development and Research sub-programme. (There is a programme of this name, but not a sub-programme). Other categories with a high share of frontline workers were “multiple” (where an employee was classified to more than one sub-programme, a practice that was found only in KwaZulu-Natal and Northern Cape), ECD, Families, Women Development, and Social Relief. Sub-programmes with low percentages of frontline workers were Population Policy, Institutional Capacity Building, and Sustainable Livelihoods – all within Development and Research. In HIV and AIDS and Older Persons, too, fewer than half of employees were in frontline jobs.

Table 65: Percentage of employees who are frontline workers by sub-programme (excluding EPWP)

SUBPROGRAMME	Not frontline	Frontline	Total	% frontline
SOCIAL WELFARE SERVICES				
Disability	228	262	490	53%
HIV and AIDS	374	208	582	36%
Older persons	258	234	492	48%
Social relief	14	63	77	82%
Children and families				
Child care & protection	596	869	1,465	59%
Child devt & research	258	1,005	1,263	80%
Ecd	62	323	385	84%
Families	191	988	1,179	84%
Restorative services				
Crime prevention	631	1,491	2,122	70%
Substance abuse	150	471	621	76%
Victim empowerment	66	275	341	81%
Development & research				
Development & research	37	355	392	91%
Institutional capacity bldg	122	11	133	8%
Population policy	38	1	39	3%
Sustainable livelihoods	169	48	217	22%
Youth development	523	547	1,070	51%
Unclassifiable				
Unspecified	473	834	1,307	64%
Management and support	8,487	2,751	11,238	24%
Multiple	259	1,997	2,256	89%
Office of the MEC	61	0	61	0%
Women	398	1,919	2,317	83%
Total	13,395	14,652	28,047	52%

Figure 46 and Figure 47 compare staff numbers derived from PERSAL with the number of staff in similar positions in NPOs reported as being subsidised in the provincial profile exercise commissioned by DSD and UNICEF in late 2014.¹⁹³ The fact that the PERSAL data are from 2015 and the profile data from 2014 should not introduce substantial errors. However, the picture could be misleading to the extent that some NPOs might employ social workers and SAWs using programme rather than post funding. Further national DSD subsidises

¹⁹³ Southern Hemisphere was commissioned to assist with the provincial profile exercise.

some NPOs operating in four or more provinces in respect of some posts for specified provinces. These nationally-funded positions are not reflected in the provincial profile data. Unfortunately, KwaZulu-Natal did not provide this information for its provincial profile.

Figure 46 shows that the number of social workers (including both frontline and other) employed by provinces is much larger than the number of social workers subsidised in NPOs for all provinces except Limpopo. The relative gap between government and NPO social workers is largest for North West.

Free State's NPO numbers are an undercount as they reflect posts subsidised in only one district, namely Thabo Mofutsanyane. Nevertheless, Free State subsidises more posts in this one district than Mpumalanga, Northern Cape and North West subsidise across the relevant province as a whole. Eastern Cape's NPO numbers reflect only those social workers subsidised for dedicated work related to children. The picture would change if posts subsidised in other service areas were added.

Figure 46: Social workers employed and subsidised by DSD

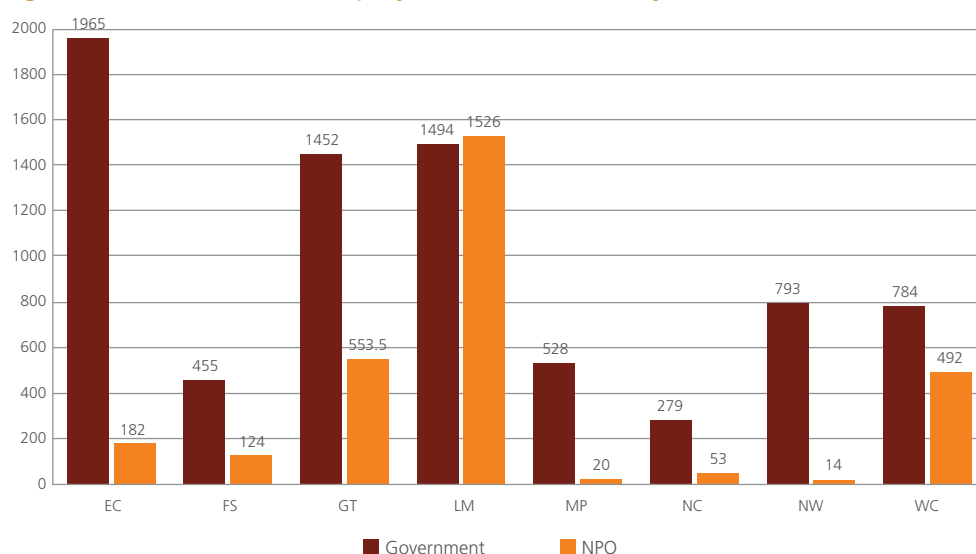
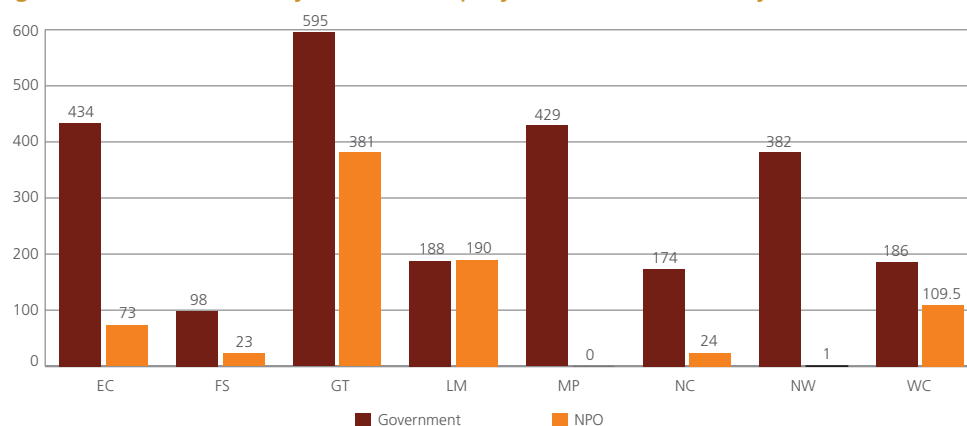


Figure 47 shows that, as for social workers, Limpopo is the only province in which there are more subsidised NPO posts than government employees for social auxiliary workers. Mpumalanga is the worst performer on this measure, with no subsidised SAWs, while North West reports only one SAW. Western Cape's ratio of NPO-subsidised to government SAWs is similar to its ratio for social workers, but Gauteng's ratio for SAWs is higher than its ratio for social workers.

Figure 47: Social auxiliary workers employed and subsidised by DSD



9.2.3.2 Findings from other government data sources

Various other government systems – Vulindlela and the annual Estimates of Expenditure (budget books) in particular – provide alternative sources of information on government employees.

Vulindlela is a government-wide system that records all expenditure transactions. The data provided for analysis covered the period April to October 2015, i.e. the first six months of the 2015/16 financial year. Although the data covered only six months, the analysis below should still be valid as it is presented primarily as percentages rather than absolute amounts when it comes to monetary amounts. When it comes to personnel data, one would not expect major changes between the six-month period and the full year as most government personnel are on permanent contracts.

The Estimates of Expenditure are the annual budget documents tabled in parliament and the legislatures at the time the budgets are tabled each year. They provide data for a seven-year period that extends two years beyond the year for which the budget is being voted. The analysis below is based on annual amounts.

The analysis of approved and filled posts focuses on permanent positions. Most of the analysis focuses on provincial Departments of Social Development (DSD). Comparison of the provinces is useful because all nine provinces are meant to deliver very similar services across the various programmes. There is, however, also some analysis of national DSD and of some other national departments.

Figure 48 shows that the percentage of total expenditure going on compensation of employees varies substantially across provinces even within a given programme. At the extremes, 81% of Free State's expenditure on Development and research went on compensation of employees, but only 3% of Western Cape's Children and families expenditure. For all provinces combined, 43% of expenditure was on compensation of employees, with the percentage varying from 28% in Gauteng to 54% in Eastern Cape.

The patterns are influenced by whether provinces include salaries of service delivery personnel in the programme budget. For example, Western Cape seems to concentrate its personnel expenditure in administration, with resultant low percentages in other programmes. However, the low percentages in Western Cape and Gauteng also reflect greater NPO service delivery than in many other provinces.

Compensation of employees tends to account for a higher percentage of expenditure in Administration than other programmes, but the percentage within Administration varies from 50% in Gauteng to 77% in Western Cape. Other programmes have even larger gaps between provinces in the percentage spent on compensation – 59 percentage points in social welfare services, 53 percentage points in children and families, and 47 percentage points in restorative services.

Figure 48: Compensation of employees as percentage of expenditure



Figure 49, derived from Vulindlela, shows the percentage of expenditure spent on the Administration programme. Overall, for all provinces combined the percentage was 15,9%. However, the percentage varied from 8,3% in Western Cape to 21,8% in Free State. One would expect the percentage allocated to administration to be lower in provinces with large populations as a result of economies of scale. However, the high percentage for KwaZulu-Natal contradicts this reasoning.

Figure 49: Administration programme as percentage of provincial DSD expenditure

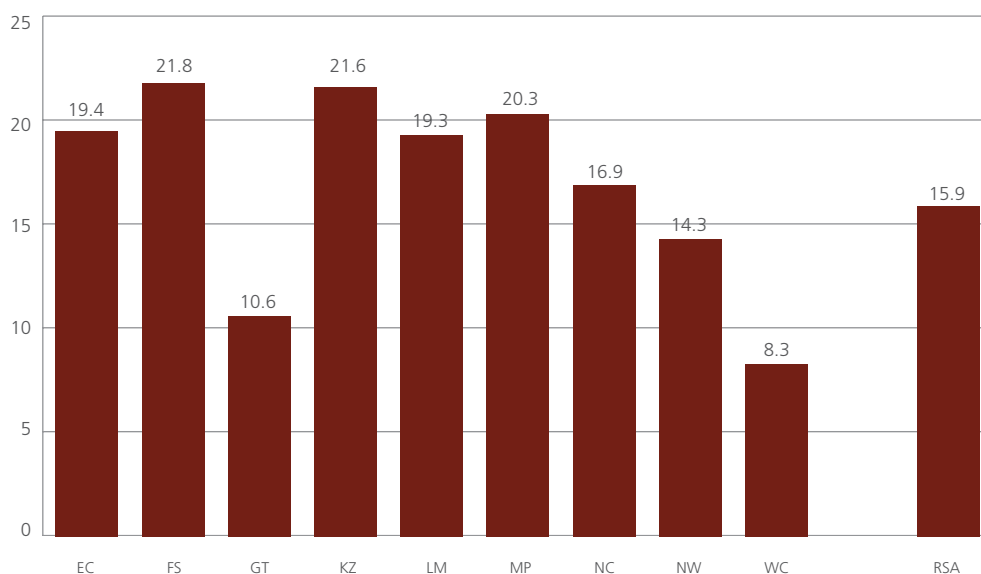


Figure 50 is derived from the provincial Estimates of Expenditure rather than six months of expenditure from Vulindlela. It adds to the information presented above by showing the trend over time for the Administration programme as a share of the provincial DSD budget. The figure shows the percentage decreasing over the period from 19% in 2011/12 to a predicted 16% in 2017/18. Free State and Mpumalanga have relatively high shares, although Mpumalanga has the sharpest decrease over the period. Gauteng and Western Cape have the lowest shares going to the Administration programme. In 2015/16 there is a gap of more than ten percentage points between the shares for Western Cape and Gauteng on the one hand and Free State on the other.

Figure 50: Administration programme as a percentage of provincial DSD budget, 2011/12-2017/18

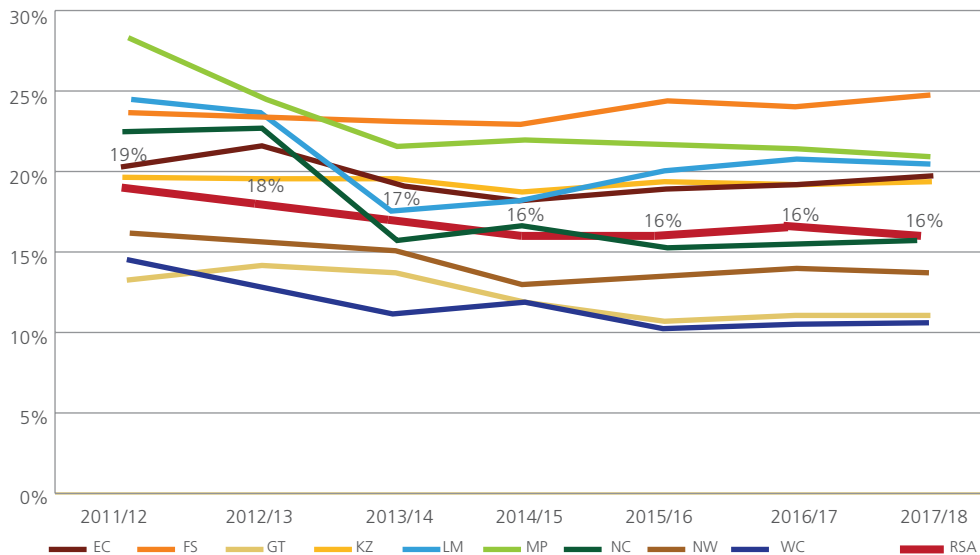


Figure 51 divides the population of the province, as reflected in the 2015 mid-year estimates, by the number of approved posts in the relevant provincial DSD, the number of posts that are filled, and the number of employed staff. The last-named – employed staff – includes both staff filling approved posts and staff employed in posts additional to the establishment. The calculations give the population: staff ratio, with a lower number indicating a province that has relatively more human resources in proportion to the population.

Eastern Cape emerges as the best resourced province in terms of approved posts, while Northern Cape is the best resourced in terms of filled posts and actual staff. Northern Cape’s position can be at least partly explained by its having the smallest population but the largest geographical area, which diminishes opportunities for economies of scale. Gauteng is the least well-resourced on all three measured followed by Western Cape and KwaZulu-Natal. The position of Gauteng and Western Cape is partly explained by the more urban nature of these provinces, and thus clustering of the population. KwaZulu-Natal’s position is not so easily explained.

Figure 51: Population per post, filled position and total staff

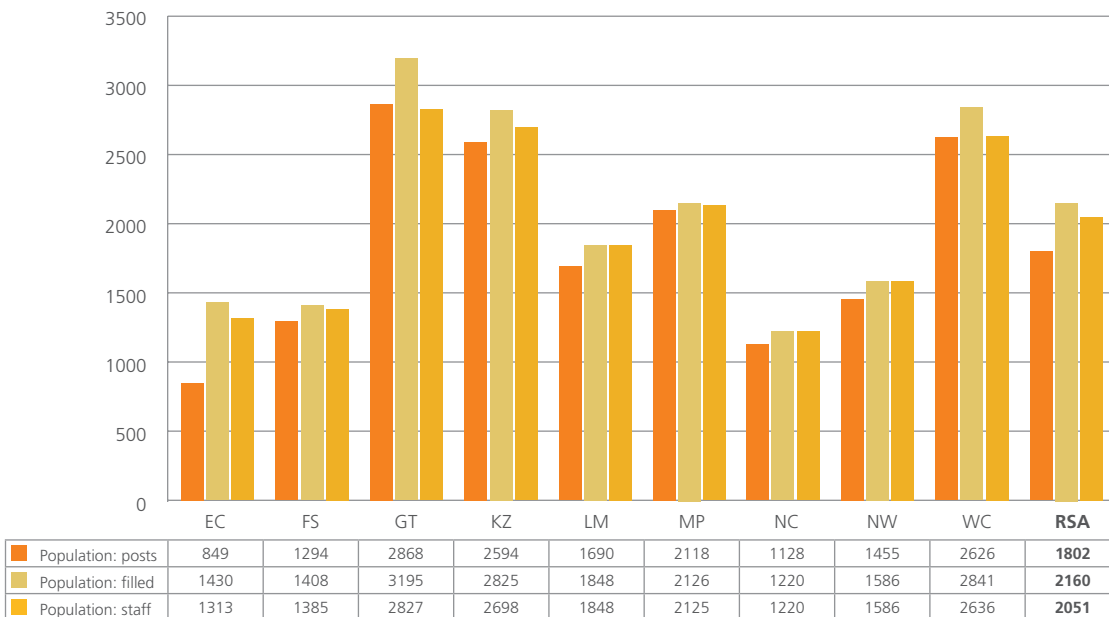


Figure 52 refines the analysis to consider only social workers, as this is the category for which norms are usually specified. Three measures are again presented, namely population per approved social worker post, population per filled approved social worker post, and population per social worker employed (whether or not in an approved post). The numbers can be compared with the norms presented in the ISDM which are 1: 5 000 for Gauteng, 1: 4 500 for KwaZulu-Natal and Western Cape, and 1: 3 000 for other provinces. However, these norms should be calculated on all social workers involved in service delivery rather than – as in the graphs – only social workers employed by government.

On this measure Eastern Cape again emerges as the best resourced province, followed by Limpopo. In Eastern Cape the population per approved post stands at less than 3 000, the approved norm, even before considering social workers employed by NPOs. At the other end of the scale, in Gauteng and Mpumalanga the population per approved social worker post stands at more than 7 000. Yet Mpumalanga is a predominantly rural province.

Figure 52: Population per social worker posts, filled and staff

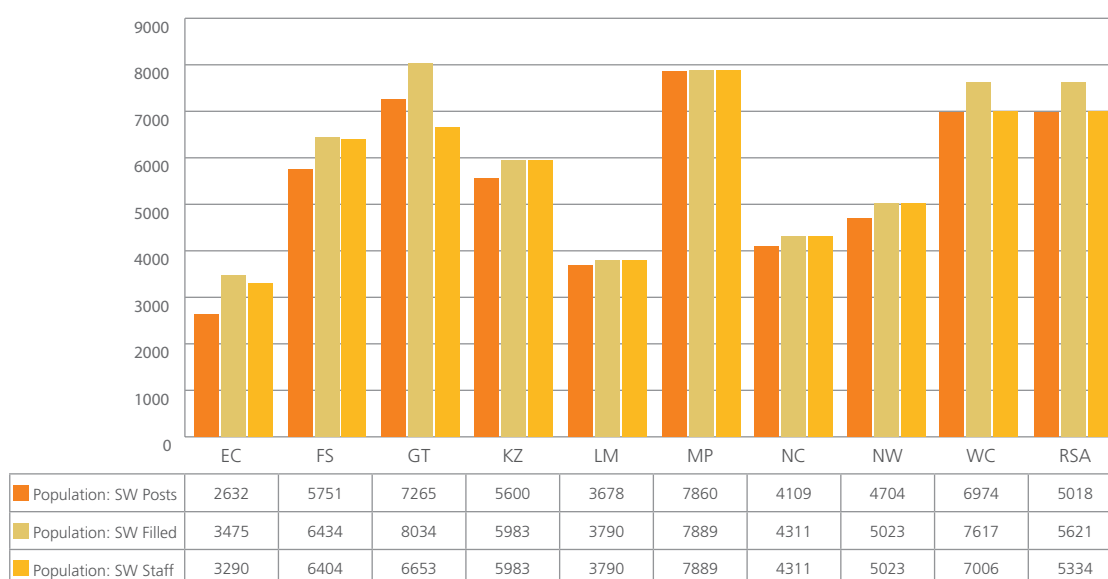


Figure 53 shows the percentage that staff filling both approved and additional posts constitute of total approved posts. The graph shows the position for each of the five programmes in each province as well as for the province as a whole.

For the measure for the province as a whole (shown on the figure), the percentage is 88% for all programmes combined. The range is from 65% in Eastern Cape to 101% in Gauteng. Mpumalanga and Western Cape follow close behind Gauteng, both at 100%. In Mpumalanga all programmes have the number of staff more or less matching the number of posts. In other provinces there is more variation between programmes. Eastern Cape has the largest range between programmes in the extent to which the number of staff equates with the number of posts. In restorative services in Eastern Cape the number of staff is only slightly more than half the number of posts.

Figure 53: Filled and additional staff as percentage of approved posts

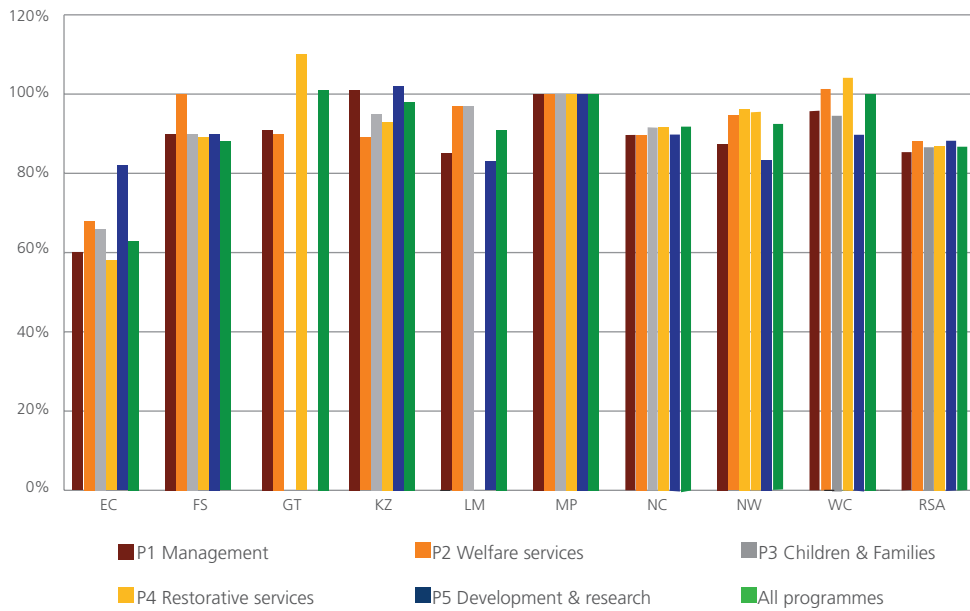


Table 66 shows the number of approved posts recorded for what can be regarded as service delivery occupations. Comparison of the numbers for these occupations with those for other occupations gives some idea of the ratio of service delivery: support and administration. The ratio is, however, likely to be over-optimistic as many social workers – and probably other service workers – are employed in management and support roles rather than in direct service delivery.

There are large differences in the number of posts for particular occupations that are not easily explained. For example, Eastern Cape provides for 210 probation workers while five provinces provide for none. Eastern Cape also has more than double the number of social work posts in all other provinces except KwaZulu-Natal, and more than eight times the number of community development workers in all other provinces except Limpopo.

The blank cells in the table indicate where a particular province does not provide at all for a particular occupation. For example, Northern Cape’s organogram makes no provision for youth workers and Mpumalanga makes no provision for auxiliary and related workers. Mpumalanga and Northern Cape have no staff nurse, pupil nurse or nursing assistant posts. Gauteng and Western Cape are the only provinces with psychologist and counsellor posts.

Table 66: Number of posts for service occupations by province, 2015

Service occupation	EC	FS	GT	KZ	LM	MP	NC	NW	WC	RSA
Auxiliary and related workers	271	141	639	221	369		105	370	440	2556
Community development workers	993	112	49	243	373	210	91	289	34	2394
Handcraft instructors	4							2		6
Health sciences related	8		5	1	1					15
Home-based personal care workers				1						1
Judges	1		1							2
Nursing assistants	7	29	63	9				47	1	156
Occupational therapy	1	2	8	1	1				4	17
Physiotherapy					1					1
Probation workers	210	3		23	19					255
Professional nurse	6	16	33	9	20	4	4	13	11	116
Psychologists and vocational counsellors			5						1	6
Social work and related professionals	2628	490	1817	1950	1557	545	289	788	889	10953
Staff nurses and pupil nurses	5		22	2	3				5	37
Youth workers	7	11	260	55	32	63		44	1	473
Total	4141	804	2902	2515	2376	822	489	1553	1386	16988

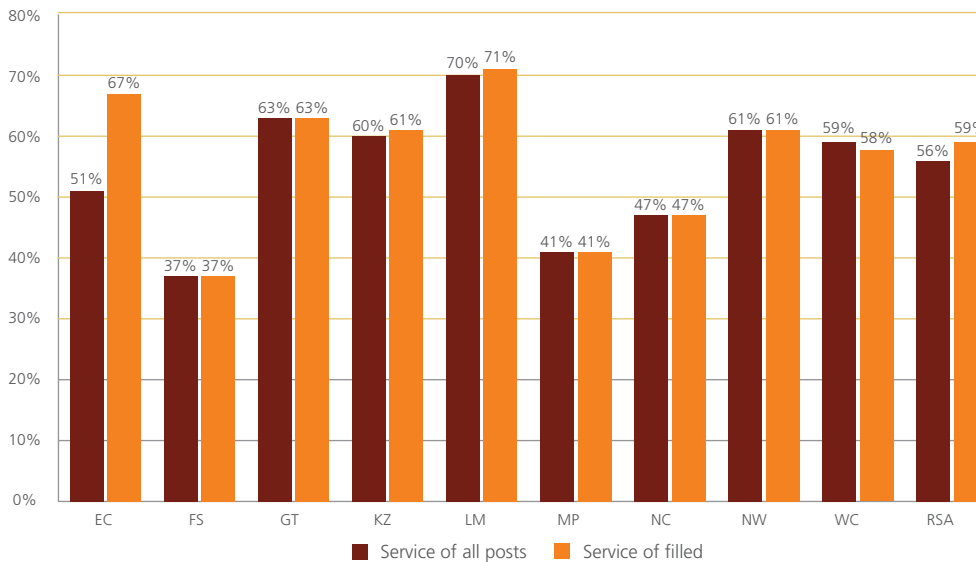
Figure 54 shows approved service posts as a percentage of all approved posts as well as filled (approved) service posts as a percentage of all filled (approved) posts. This presents a rough measure of the extent to which a province is prioritising service delivery in its organogram and recruitment.

The service share for both measures is lowest for Free State (37%) and highest for Limpopo (70-71%). The share in Limpopo is almost double that for Free State.

For most provinces the shares are similar for approved and filled posts. The exception is Eastern Cape where service posts accounts for 51% of all approved posts, but 67%

of all filled approved posts. While Eastern Cape has only 1 990 of 2 628 approved posts for social work and related professionals filled, it has even larger shortfalls in non-service posts. For example, for the category “Other administrative and related clerks and organisers”, only 413 of 1 078 approved posts are filled.

Figure 54: Service workers as percentage of all and filled posts



The previous graphs focused on provincial DSD. The DSD budgets for the nine provinces combined amount to R16 714,7 million for 2015/16. The national DSD budget for the same year is R138,17 billion, but R130,09 billion of this is for grants and a further R6,66 billion for SASSA, leaving much less than in provinces for other services and functions.

Figure 55 shows two measures of the relative importance of the Administration programme in the national DSD budget. The first measure is as a share of the full national DSD budget, and the second excludes the large amounts allocated for grants and for SASSA. On the first measure, the Administration share remains at around 0,2% throughout the period 2011/12 to 2017/18. On the second measure, Administration’s share decreases from 24% to 21% in 2015/16, with a small predicted increase by 2017/18. The share for the second measure is higher than the average share of Administration across all provinces combined.

Within national DSD, 53,5% of expenditure within the Administration programme is on compensation of employees, as against 21,3% for the programme (Welfare services policy development and implementation support) with the next highest percentage. The Administration programme accounts for 41% of approved posts within national DSD.

Figure 55: Administration as percentage of national DSD budget

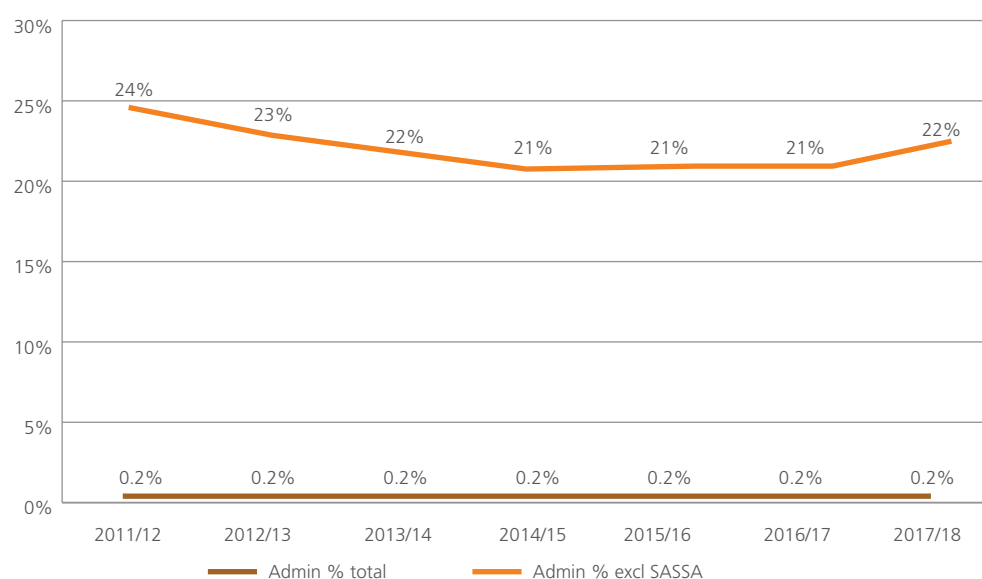


Table 67 shows the number of approved posts, filled posts, and appointments additional to the establishment for the three occupations that relate to direct service delivery. However, even more than at provincial level, the people employed in these positions in national DSD may not be delivering services. The numbers are very small when compared to the numbers employed in provincial DSD shown in Table 66 above.

Table 67: Service delivery occupations in national DSD

	Approved	Filled	Additional
Social work and related professionals	134	132	54
Community development workers	19	17	0
Psychologists and vocational counsellors	1	1	0

Table 68 shows the number of social work and related professionals employed in other national departments in which one would expect social workers to be employed. None of these departments have any of the other service delivery occupations identified in provincial DSD. Three of the departments have more social work posts than national DSD, although Justice has fewer social work posts filled than national DSD. The Department of Health has very few social work posts. It is, however, likely that more social workers are employed by provincial Departments of Health.

Table 68: Social work and related professionals

	Approved	Filled	Additional
Department of Health	4	4	0
South African Police Service (SAPS)	316	290	0
Department of Justice and Constitutional Development	151	128	0
Department of Correctional Services	640	555	6

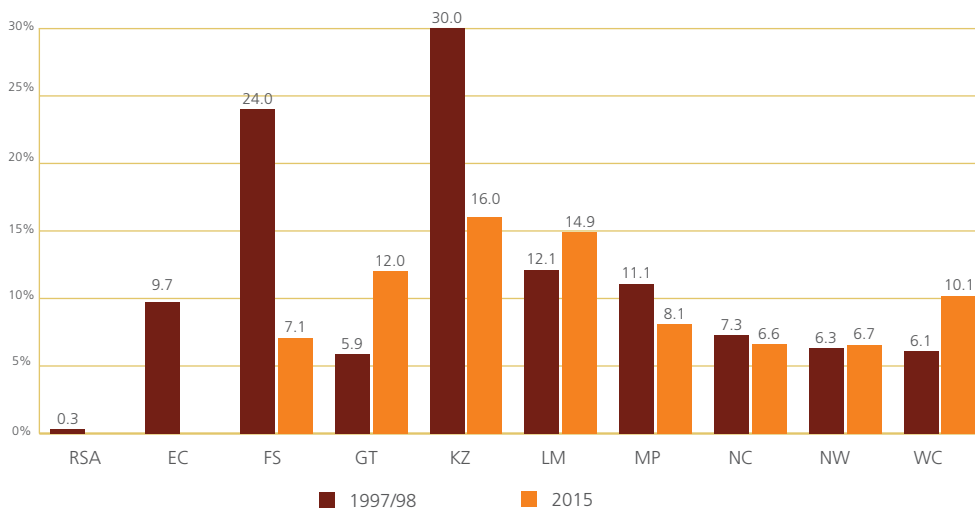
9.2.3.3 Comparisons with 1996/97

A statistical compilation of national and provincial DSD data for the period April 1996 to March 1997¹⁹⁴ allows comparison of the human resource situation at the time the White Paper was released with the situation in late 2015 as depicted by PERSAL. One challenge with the earlier data is that for Free State it includes employees of NPOs subsidised by government. Comparisons for Free State must thus be treated with caution. A further caution is that the staff recorded for 1996/7 relate primarily to those doing work relevant to welfare services and community development. That said, the administrative “overhead” component is likely to have been relatively small in 1996/7, among others because social welfare was generally combined with health.

Figure 56 shows the number of service delivery staff for each director/manager. For 1996/97 director/managers are defined as deputy director generals, chief directors, directors, and deputy and assistant directors. Service delivery staff includes chief, senior and ordinary social workers, social auxiliary workers, and community liaison officers (CLOs). (Free State’s chapter notes that CLOs may be social workers or “other qualified people”. There are no CDWs recorded for 1996/97. For 2015, all individuals with “manager” in their job title are included in the director/manager category and all types of social worker, social auxiliary worker and community development managers are included as service delivery. The director/manager category for 2015 thus includes some administrative-type managerial positions that do not seem to be recorded in the 1997 publication and perhaps did not exist, as the publication notes a total of only 485 personnel providing administrative support services across all nine provinces combined. In contrast, in 2015, 3 251 DSD employees have the term “administration” or “administrative” in their job title.

Figure 56 shows a smaller bar (thus a greater bias towards management) for Free State, KwaZulu-Natal, Mpumalanga and Northern Cape in 2014 than in 1996/7, but the opposite pattern for Gauteng, Limpopo and Western Cape. Eastern Cape does not have useable 1996/7 data for 1996/7 and North West shows very little difference over the period. Despite the substantial fall in KwaZulu-Natal, this province records the largest service delivery: manager ratio in both years, while Northern Cape and North West have among the lowest ratios for both years.

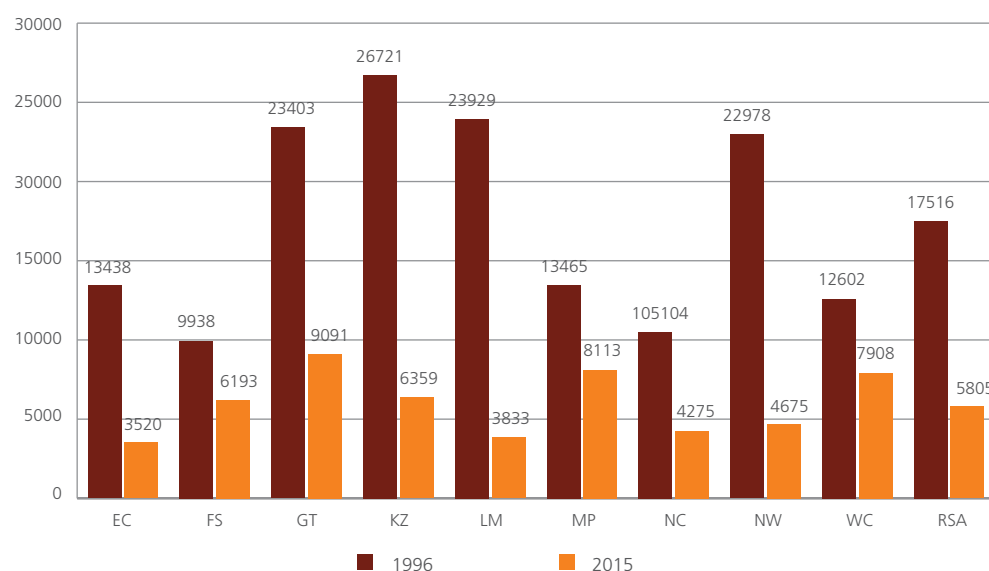
Figure 56: Service delivery staff per director/manager



¹⁹⁴ Department of Welfare. 1997. Social Welfare Services in South Africa: Annual Statistical Report 1996/97. Pretoria.

Figure 57 shows the population per government social worker, using the 1996 census and 2015 mid-year population estimates for the calculation. All social workers – chief, senior and ordinary – are included. All provinces show a marked decrease in the population per social worker over the period. The decrease is especially marked for Limpopo, which ends the period in the second best position after Eastern Cape. The decrease is smallest in relative terms for Free State, Western Cape and Mpumalanga. The Free State pattern is misleading because the 1996/97 number includes social workers employed by NPOs. The relatively high 2015 ratios for Gauteng and Western Cape (and perhaps KwaZulu-Natal) can mislead because these two provinces are better endowed with non-government social workers than most other provinces and thus need fewer government social workers. These two provinces are also the most urbanised, and the norm for the ratio is therefore higher.

Figure 57: Population per government social worker, 1996/7 and 2015



9.2.4 Human resource planning

In 2008 a detailed Change Readiness Assessment was done within the national and all provincial DSD.¹⁹⁵ The report revealed widespread “perceptions of bureaucracy, rank-consciousness and a ‘silo’ operating approach” across all departments. Poor communication was singled out as a particular concern, as the bureaucratic nature of the department prevented messages from filtering down through the layers of the organisation. Some participants indicated that high staff turnover in the departments was a result of the dysfunctional organisational culture.

In 2010, DSD embarked on a Norms and Standards project, which was to inform standardisation of business processes and development of operational norms and standards. It is not clear whether the recommendations of the review were implemented. Interviews with social workers highlighted ongoing problems with business processes and workflow management within the department, especially at district/regional level. There is also weak integration of processes between districts, provinces and national DSD. North West has conducted its own business process mapping exercise, and produced a manual in this respect. However, the manual does not show any links with national processes.

¹⁹⁵ KPMG/Department of Social Development. 2008. Consolidated Change Management Readiness Assessment. Unpublished report.

HR planning is regulated by the Department of Public Service and Administration (DPSA). The regulations require that all departments undertake an intensive HR planning process alongside development of the MTEF. In addition, in 2010 DPME introduced the Management Performance Assessment Tool,¹⁹⁶ which provides for self-assessment, moderated assessment, and development of an improvement plan that is monitored on a quarterly basis. Within the HR performance area, the department is rated on the extent to which the HR plan addresses both the current and future workforce needs of the organisation.¹⁹⁷ In 2014, in Gauteng the moderation team did not find any evidence of a medium-term HR Plan, or an Annual HR Planning Implementation Report and therefore allocated the lowest score, 1. National DSD, Mpumalanga and North West provinces achieved a level 2 score, indicating partial compliance.

In 2013, DSD developed an HR model for the sector. The model aims for alignment with the legislative mandate, paying attention to specialisation, addressing the skills shortages and providing a broad framework for managing social service professionals.¹⁹⁸ DSD is also currently leading a process of developing a sector human resources plan, in an attempt to align HR plans of national DSD and all nine provinces.¹⁹⁹ The plan covers professionals in NPOs offering statutory services who are funded by government, but not those offering non-statutory services. The focus on statutory services implies a bias away from ensuring a full continuum of services, starting with primary prevention and intervention. In so doing, it loses the opportunity of reducing the need for statutory intervention.

The ISDM indicates that “span of control” is one of many factors to be taken into consideration in the development of norms and standards. It recommends norms for both community-based and institutional care in this respect. The HR Model for the Social Welfare Services (2013) does not provide norms and standards in respect of lines of accountability and span of control although it does provide guidelines in respect of lines of accountability. In contrast, while the Generic Norms and Standards for Social Welfare Services (undated) and the Framework for Social Welfare Services (2013) do not indicate lines of accountability, they provide guidance in respect of span of control for social work supervisors. There are, however, no norms and standards for span of control for management functions. It seems that this gap could have contributed to the bloated management structure within DSD.

Presentations made by provinces during the Ministerial Committee’s provincial review sessions highlighted concerns expressed in other sources about shortfalls in supervision. Examination of organograms suggests unrealistic supervision workloads. For example, Eastern Cape’s proposed structure provides, in the Social Welfare division in the Mbizana Local Service Office, for a span of control for a Social Work Supervisor of 1: 29²⁰⁰ as against a maximum norm of 1: 13. In Gauteng, in contrast, at the Ekurhuleni Regional Office there are three community development supervisors for only one community development practitioner while the norm is 1: 6.

¹⁹⁶ The Presidency: Department of Planning, Monitoring and Evaluation. MPAT 2014 National Launch.

¹⁹⁷ Department of Planning, Monitoring and Evaluation. MPAT Standards.

¹⁹⁸ National Department of Social Development. 2013. HR Model of the DSD: 4.

¹⁹⁹ Position Paper: State of Human Capital Management. Undated. Document submitted to the Ministerial Committee on the Review of White Paper on Welfare Services.

²⁰⁰ The organogram states that there are 8 Social Work Supervisors, 47 Social Workers and 188 Social Auxiliary Workers. The assumption is that the Supervisors provide supervision services to all SWs as well as SAWs.

Interviewees suggested that, with a shortage of supervisors, consistent supervision is reserved for newer social workers and social auxiliary workers. This approach is in line with the Supervision Framework for the Social Work Profession in South Africa.²⁰¹ A wide span of control is acceptable if workers are capable and able to work on their own, and if jobs are routine. However, with this approach supervisors will tend to focus primarily on performance management, rather than training and development, while the latter seems to be the intention of the Supervision Framework.

National DSD's Human Capital Management Chief Directorate was established to address workforce planning for national DSD only.²⁰² However, there are concerns about high vacancy rates, poorly capacitated staff, incorrect placement of staff in jobs (i.e. incorrect "fit"), poor personal development and career-pathing, inappropriate span of control and other HR issues throughout the sector.

In his audit of 2013/14, the Auditor-General found "stagnant or little progress" in human resource management across the sector (national and provincial departments).²⁰³ The main conclusion reached was that there was a shortage of social service professionals to ensure that the necessary services are available to all communities. The root causes were identified as: a) the lack of monitoring to ensure that adequate and sufficiently skilled social service professionals are in place; and b) insufficient budgets available for provinces for the appointment of social service professionals. Unfortunately, the Auditor-General's comments and recommendations did not seem to take into account the role that NPOs can and could play in addressing the service delivery gaps if adequately funded to do so.

9.2.5 Staff shortages

The 2006 Recruitment and Retention Strategy for Social Workers resulted, among others, in the development of benchmark job descriptions for social auxiliary workers, implementation of the social work scholarship programme, and research on the physical working conditions of social workers. An evaluation of the effectiveness of the strategy in 2010/11 exposed lack of awareness of the strategy among interviewees and misplacement of managerial responsibility. It also described the poor working conditions of many social workers.

The 2013 HR Model is silent on the extent of the demand or need for developmental social welfare services in the country. The absence of a clear mapping of demand/need frustrates meaningful HR planning. A costing of the Children's Bill at the time it was being developed projected that for this piece of legislation alone 16 504 social workers, 14 648 social auxiliary workers, and 12 955 child and youth care workers would be needed by the sixth year of implementation, calculated at the lowest possible cost²⁰⁴. At full cost, the numbers would be 66 329, 48 660 and 216 913 respectively.

²⁰¹ National Department of Social Development. 2012. Supervision Framework for the Social Work Profession in South Africa.

²⁰² National Department of Social Development. Undated. Position Paper: State of Human Capital Management. Status Report compiled for the Ministerial Committee on Review of White Paper on Welfare Services. Compiled by the Chief Directorate: Human Capital Management (national DSD): 42.

²⁰³ Auditor General. 2014. Social Development Sector Report. A consolidated Social Development sector report containing a summary of the audit outcomes as well as audit focus area findings raised for the provincial departments of Social Development and the national Department of Social Development for the financial year ended 31 March 2014.

²⁰⁴ Cited in National Department of Social Development. 2012. Situational Analysis Report on the Social Service Workforce Servicing Children.

More recently, KPMG has been commissioned to develop a demand and supply model for the department but has struggled to find appropriate data sources for many services. Delays in the filling of vacancies across all areas of DSD's core functions remain a challenge. High turnover is also a problem, with Eastern Cape reporting a rate of 3.2% for social work services (compared to the expected standard of 2%)²⁰⁵. Staff shortages are reported to be especially challenging in rural areas. That said, however, the most rural province – Eastern Cape – has a lower (and thus better) population to social worker ratio than any other province, with very rural Limpopo also performing relatively well on this measure.

For social workers and community development workers, the vacancy rate ranges from 0% in Limpopo and Mpumalanga to 24% in Eastern Cape. If one excludes Eastern Cape, with its relatively generous and unapproved organogram and thus moratorium on filling posts, the highest vacancy rate is in North West, at 11%. The Generic Norms and Standards for Social Welfare Services (2013: 40) state that the vacancy rate for critical posts should not exceed 5%. Four provinces fail on this measure. Strategic plans highlight the shortages of social and related workers, yet departmental HR Plans are not convincing as to how departments intend to address the matter.

Many qualified personnel do not want to work and/or live in poverty-stricken areas. A national bid by DSD to National Treasury to provide for rural allowances to attract personnel to these areas did not succeed. Personnel in rural and other poorer areas also complain about poor office accommodation and the absence of necessary tools of the trade, including transport.

The conditions of work and salary of all government-employed social development personnel are governed by a single bargaining council, the Public Service Coordinating Bargaining Council. Government must also, like other employers, comply with the Employment Equity Act.

An occupation-specific dispensation (OSD) for social workers was introduced in 2011. It covers social workers, social auxiliary workers, community development practitioners, assistant community development practitioners and child and youth care workers. The OSD is meant to provide for these workers' salaries to be higher than for other government employees at an equivalent level.

Although the OSD was intended to ensure that social workers would not leave the profession, there are claims that it has had the opposite effect²⁰⁶. It seems that many are unhappy with the way that OSD has been implemented, and that it has led to low morale across all nine provinces. Importantly, there has been a noticeable exit of social work supervisors, which has affected the quality of social work services in general. However, to the extent that exit has occurred in the NPO sector, this cannot be blamed on poor implementation of the OSD as the OSD does not apply to NPO salaries. It is, however, conceivable that introduction of the OSD for government personnel has exacerbated unhappiness among NPO workers by increasing the relative gap.

²⁰⁵ Eastern Cape HR Plan, 2013-2015.

²⁰⁶ National Department of Social Development. 2012. Social Service Workforce Servicing Children.

The rural/peri-urban/urban inequities which have persisted since the time of the White Paper are explained not only by the distribution of posts, but also by the fact that many qualified personnel do not want to work and/or live in poverty-stricken areas. Allocated posts thus remain unfilled or have high turnover. Personnel in rural and other poorer areas also complain about poor office accommodation and the absence of necessary tools of the trade, including transport. The rollout of the Isibindi programme has focused primarily on rural and other under-served areas and thus aims to help address the imbalance, but does so only in respect of child, youth and family work.

In the round tables organised by the Ministerial Committee as well as other forums concerns were expressed at the way in which most discussions of the workforce focused only on social workers, ignoring the other cadres, as well as the need for and potential of non-hierarchical multi-disciplinary teams in integrated service delivery. A submission by the SACSSP suggested that there was some “over-servicing of clients” by the different cadres.

9.2.6 Workload management

The Ministerial Committee was informed that some social workers have to deal with caseloads of up to 300, well beyond the norms and standards set by the sector. DSD has revised its Guidelines for the Management of Workload of Social Service Practitioners, which covers social workers, child and youth care workers and care givers. DSD informed the Ministerial Committee that it had plans to train staff on implementation of the guidelines.²⁰⁷

Foster care has presented particular problems in relation to workload management. In 2006, provincial DSD reallocated social workers from other work to foster care to deal with the large backlogs of pending cases. Some provinces also employed additional social workers and social auxiliary workers to assist with investigations, compiling reports and finalising children’s court enquiries. By late 2014, the terms of reference of the foster care committee estimated that the work of more than 5 300 social workers and more than 1 600 social work supervisors was focused on foster care.

Social workers who were interviewed²⁰⁸ as part of the review reported overwhelming workloads, and an inability to focus on work specified in their job descriptions. This resulted in feelings of despair and hopelessness about the impact of their work in a situation where they were involved in ongoing crisis management. High vacancy rates, inappropriate “job fit”, poor comprehension of organisational goals and objectives, high workloads, scant (or no) supervision, inappropriate span of control and poor personal development planning contribute to high levels of burn-out and wellness-related problems reported by some interviewees. This, in turn, has a negative impact on DSD’s ability to achieve its developmental social welfare mandate.

²⁰⁷ National Department of Social Development. Undated. Status Report Welfare Services Transformation. Report produced by the Chief Directorate: Welfare Services Transformation for the Ministerial Committee on the Review of the White Paper on Social Welfare (1997).

²⁰⁸ Focus Group with HR personnel and social workers, 29 January 2016.

9.3 Non-profit organisations

The White Paper observed that there was a large institutional infrastructure for welfare in civil society, with a “rich tradition” and organisational resource base. While accurate statistics were not available, as many as 10 000 civil society organisations (CSOs) were thought to focus on welfare and development. This number included government-subsidised formal welfare organisations, both subsidised and unsubsidised religious organisations, and an unsubsidised “informal” welfare sector. The informal sector was characterised as being rooted in the anti-apartheid movement, and reliant primarily on foreign funding.

The formal sector was made up of approximately 4 800 organisations registered in terms of the Fundraising Act of 1978, of which about half were registered as welfare organisations in terms of the National Welfare Act of the same year. While receiving government subsidies, these organisations also raised “substantial” proportions of their budgets from elsewhere. Most were affiliated to 26 national councils which were, in turn, also subsidised by government. The informal sector was characterised by the White Paper as rooted in the anti-apartheid movement, and reliant primarily on foreign funding. These organisations “pioneered people-centred development strategies”, attempted to fill gaps in formal service delivery, and engaged in advocacy.

The White Paper noted that social workers in private practice provided services to those who could afford to pay for services, and were also contracted by organisations, institutions and companies to provide services.

The Department of Welfare published a draft new NPO financing policy for consultation even before the White Paper was published.²⁰⁹ The plan was that an agreed policy would be included in the White Paper by the time it was published in late 1997. This did not happen.

The draft policy proposed a move to primarily programme funding, so as to move away from the bias towards “single-purpose residential facilities” as well as away from subsidising posts and unit costs. The document confirmed the department’s commitment to supporting organisations financially, but was clear that government would not “take sole responsibility for the financing of services, thereby creating a culture of dependence”. Further, the level of financing would be “subject to the availability of funds within the Department’s budget”. However, NPOs would be given priority (over for-profit providers) “in line with the principle of democracy”.

The draft NPO financing policy developed before the White Paper included a component termed Capital Investment Financing but noted “lack of clarity” in respect of providing funds for civil society organisations in respect of building and land for facilities. The document noted that no funds had been “earmarked” for this function, and inclusion of the issue in the document did not mean that Welfare departments would take responsibility for funding it. Nevertheless, it was “noted as a priority and needs to be resolved”.

²⁰⁹ Department of Welfare. May 1998. Policy for the Financing of Developmental Social Welfare Services. Draft policy document for consultation with all stakeholders. Pretoria.

9.3.1 Updating the White Paper

Today there are still no accurate numbers for welfare organisations. While DSD manages a database of registered NPOs, and registration is required before an organisation can receive funding from government as well as many donors, the database currently has several shortcomings. These include delays and other challenges in the registration process, not being up-to-date (and thus including organisations that no longer function), not distinguishing clearly between NPOs involved in service delivery and those engaged in other activities, and not having a categorisation that neatly matches the social development service areas.

The national councils no longer exist in their previous form. However, many of the previously existing organisations of the welfare sector continue to exist. The organisations also continue to come together into federations and other associations. Some are so large, and have so many branches, that they are effectively federations or associations in themselves. All or most of the older organisations have expanded their services to new groups, geographical areas and communities. They have also introduced new, more “developmental” services.

The extent of government subsidies, and in particular in the number of organisations funded, has expanded substantially, although many organisations are not funded, or are funded erratically, by government. Foreign funding has, however, declined sharply over the period since 1997. The largest single funded NPO category, and the one that has grown fastest, consists of ECD centres. In 2014/15, the budget for transfers to ECD centres across the nine provinces amounted to 30% of total NPO transfers within provincial DSD. For 2016/17 there is a conditional grant for ECD that is likely to see ECD’s share of NPO transfers increase even further.

In addition to NPOs that are registered, the Committee’s attention was drawn repeatedly to “mushrooming” of unregistered organisations and facilities in areas such as ECD, older persons, disability and substance abuse. This mushrooming can be attributed in part to inadequacy of existing services, as well as – in some cases – inability or unwillingness to comply with norms and standards which sometimes may be unrealistic, especially for poor rural areas. Informal societal networks, of course, continue to exist but can be placed under strain in a context of poverty, unemployment, migration, HIV and AIDS, and the like.

The range and nature of services provided by NPOs has expanded since 1997, especially in relation to non-institutional services, and in line with legislation and policy. There is no longer the same distinction between formal established and informal “anti-apartheid”. Instead, the most commonly mentioned divide is between “emergent” and “established”. There is no agreed definition for these categories, but the terms are generally understood to link to distinctions such as between black and white control, small and large size, and local and broader reach. During the provincial and district review processes, several of the larger NPOs reported that they were conducting courses and providing other organisational development support for small organisations, although they were generally not funded by government to do so.

There appear to be varying understandings as to what transformation of the non-governmental social welfare sector would entail. These understandings span changes in the race of staff, “owners” of NPOs, and beneficiaries, as well as shifts in funding of larger to smaller NPOs, from funding of urban- to rural-based NPOs, and/or from funding of non-governmental organisations to community-based organisations. The discussion is often framed in terms of “established” and “emerging” organisations, sometimes with insufficient acknowledgement of the extent to which the older organisations have changed over the years in terms of approach, services, staffing, beneficiaries and geographical reach. Government has recognised the weaknesses of many of the “emerging” organisations and attempted to provide capacity building support for “emerging” organisations, in particular through the NDA. However, the support seems to focus primarily on generic elements, such as finances and governance, rather than on the skills and knowledge necessary to manage and deliver quality support. Some of the more established NPOs might be willing and able to provide this support, but would need to be resourced to do this.

Beyond NPOs, private practice social work continues to exist, but serves primarily better-off people. Some areas – such as adoption, and treatment for substance abuse (whether falling under DOH or DSD) – remain dominated by private provision. Private provision poses a problem in terms of access for the poor.

9.3.2 Findings of the Ministerial Committee

Views of NPOs were among the various voices heard by the Ministerial Committee during a day of presentations in each of the nine provinces, as well as during focus groups conducted with service providers and practitioners in two districts in each province. There was also a round table event devoted to NPOs and the disability sector.

The presenters at the provincial sessions consisted mostly of larger, more established organisations, some of which presented in more than one province. Their voices represented other NPOs to the extent that many of them consisted of associations of organisations, and/or provided support to a larger number of other organisations in the same field. However, the voices would not have been representative of unaffiliated smaller and community-based organisations. A letter from a welfare organisation that was scheduled to present in Mpumalanga asked that the organisation be excused on the basis that they had not received a request from the Minister, were a “very small company” and “cannot comment on the White Paper at an extent most of the other organizations can.” This organisation, with 16 offices spread across four provinces, was nevertheless much bigger than most organisations in the country.

In the focus groups, both the service provider and practitioner groups included both government and non-government representatives, and it was therefore not usually possible to separate out the views of NPOs. Comments from the groups are nevertheless recorded here where relevant NPO-related issues were raised. In some provinces the beneficiary focus groups also made comments relevant for our purposes. The discussion below also include relevant observations made by government presenters at the provincial and national presentations.

When discussing achievements since 1997 in their reports and presentations some NPOs noted achievements of the country more generally, including new and improved legislation, and an expansion in the delivery of services of different types. NPOs also described how they had contributed. Many of these descriptions refer to what can be broadly defined as transformation. For example, while many of the NPOs that presented had been in existence for many years, they provided evidence of how they had transformed in terms of their beneficiaries (race, urban/rural, and socio-economic status) as well as types of services offered (outreach, preventive, etc). This was also acknowledged by some provincial governments, such as Gauteng.

Despite the reported achievements, there were also challenges with transformation. A Western Cape NPO noted that their “client profile” matched the profile of the province, but the poor remuneration that they offered had hampered efforts to change the staff profile. More generally, an NPO in Mpumalanga noted the “lack of clarity and agreement on the definition of transformation implied by the [White Paper] e.g. is it in the form of urban versus rural shift; transformation in the form of staff composition of NPOs (social workers, social auxiliary workers, community development workers, etc); transformation in the form of beneficiaries being targeted?” The NPO noted that all of these changed affected funding systems. This observation was echoed in the comments by many NPOs, noted above, that the funding approaches did not cover the extra costs associated with delivery in rural areas. In Mpumalanga an NPO reported that after DSD stopped providing services in an area “plagued under social unrest”, the NPO was expected to step in and provide services without any payment for doing so. One NPO said that the “expensive” Basic Conditions of Employment Act hampered extension of services.

In several provinces participants noted language difficulties related to transformation. These included the difficulty that social workers experienced in serving Afrikaans-speaking beneficiaries in Free State, although in this case the reference might have been to government social workers. North West reported that “[d]ue to language and cultural barriers, NGOs who are mostly representative of white Christian people will be utilized to serve those communities where the social workers can speak the language and understand the underlying values and principles of the communities they serve. This however, does not suggest that NGOs can only render services in the mentioned communities, but negotiations are of the utmost importance to determine deployment of NGOs in any area where the services are desperately needed.”

In Free State, in particular, there were complaints from government about the lack of transformation, and the imbalances between the traditional organisation and “emerging” (black) organisations, including community-based organisations. A North West NPO observed that the increasing number of emerging organisations had led to competition for funding – a situation that is no doubt also present in other provinces. The Free State government complained that community-based organisations (CBOs) had “not been capacitated to render professional services, thus NPOs monopolise and take ownership of this space.” One suggestion emerging from such observations was that legal provisions and requirements should distinguish between emerging and established organisations rather than having a “one-size-fits-all” approach. The comments from Free State must be balanced by the reports of some of the NPOs across the provinces about the mentoring, training and other support that they provided to smaller organisations.

Participants in the NPO round table acknowledged that substantial progress had been made in capacitating CBOs, but the progress was not sufficient. They called for recognition that CBOs were not all the same and proposed differential responsibilities and privileges. They argued further that the processes related to registering as an NPO, submitting proposals, reporting and the like needed to be simplified. Subsequently, the Ministerial Committee learned about similar proposals in terms of differentiating between categories of organisations and streamlining processes emanating from the joint National Treasury-DSD initiative to develop and financing framework and policy for social welfare services in South Africa.

9.3.3 DSD transfers to NPOs

9.3.3.1 Information from non-profit organisations

Funding was the most common issue raised by and about NPOs during the Ministerial Committee's provincial and district review processes. The concerns raised included:

- The disparity in salaries and benefits between social workers (and other categories of funded workers) in government and NPO employ, and the fact that posts are subsidised in respect of the entry level salary were raised across all nine provinces, including by some government representatives. The disparity was said to result in NPOs serving as a training ground for young, newly qualified social workers who leave as soon as they secure a job in government or perhaps the private sector. This in turn results in lack of institutional memory within NPOs and lowers the quality of service provision.
- Inadequate funding of NPO services was also raised across all provinces. Particular NPOs reported that the DSD funding amounted to around half of the cost of provision. An Eastern Cape NPO reported that they received funding for 130 beneficiaries but provided services to 192. Several NPOs noted that only particular types of services were funded. For example, in at least some provinces residential services are subsidised only for the frail. (This practice started in 1998 in Free State, perhaps as a direct response to the White Paper.) Further, preventive and early intervention services are less likely to be funded than statutory services or, expressed differently, the bias is towards clinical and therapeutic casework rather than preventative and developmental work.
- A Mpumalanga NPO noted that the fact that paraprofessionals were not yet able to register with SACSSP meant that they could not claim subsidies for these staff members as DSD only funded posts for registered professionals. This should now be less of a problem with registration of CYCWs now available. An Eastern Cape disability NPO noted that the post funding approach used did not cover all the types of professionals needed to provide a full rehabilitation service.
- There were many concerns raised about disparities in funding, and therefore stipends paid, for HIV and AIDS and other caregivers. This resulted in some cases in caregivers being paid below the prescribed minimum wage for the EPWP. In several provinces participants commented that R1 600, which was the approximate level of the EPWP minimum at the time, was itself unfair and failed to retain caregivers. The situation in respect of

funding of caregivers' pay is complicated by similar services being funded by DSD in some cases and DOH in others, and the approach of the two departments to such funding being different. A similar complication can exist in respect of mental health services.

- Several representatives noted that the additional costs associated with delivery in rural and under-served areas were not covered. A KwaZulu-Natal organisation echoed others in saying it had been forced to cut back on provision in "extreme rural areas". Subsidies also did not keep pace with inflation. For example, in Eastern Cape some, if not all, of the per-post and per-beneficiary subsidies had reportedly not been increased since 2007. A North West NPO said that their subsidy had remained constant over the past five years.
- In some provinces it seems that funding had been reduced rather than simply not increased. Thus a North West NPO said that their budget from DSD decreased each year. Given financial cutbacks, an Eastern Cape NPO observed in their annual report of 2012 that their "greatest achievement to date will be to have kept the doors of the [service] open." Well-established organisations in other provinces recorded that they had to cut back on services in different ways because of financial constraints. Often the cutbacks affected less urban areas for which the cost of delivery was higher. Northern Cape NPOs reported that the cutbacks since 1994 in that province had been more severe than elsewhere. In the North West, the DSD-dominated practitioner focus groups suggested that an exit strategy from funding should be developed for NPOs, but did not indicate what form such a strategy could take.
- Problems with timing were noted across many provinces. The Western Cape government noted that transfer budgets (which provide for NPO payments) were only finalised in March, which made it extremely difficult for NPOs to plan and budget for delivery for a year which started in April. A KwaZulu-Natal NPO reported that delays in approval for requisitions (where NPOs must request approval for particular expenditures even where they are already in approved budgets) hindered service delivery. The same NPO observed that they heard reports that DSD returned unspent funds to the Provincial Treasury while they struggled to deliver because of limited funds. Across several provinces – and in North West in particular – organisations raised concerns about late or non-payment of subsidies. In Eastern Cape there was unhappiness about monthly claim forms for subsidies having to be physically delivered to DSD offices, rather than being able to submit claims electronically. The Free State government itself suggested that online submissions should be possible.
- Across several provinces concerns were raised about disparities in subsidies across provinces in respect of the same service, as well as disparities between NPOs and government. For example, the funding per bed for NPO residential care was said to range from R600 to R3 400 per month, depending on the province, while the allocation for government provision of the same service was R6 000. In Gauteng CYCCs reported that government funding per child per month for NPO CYCCs was R2 983 as against the R30 416 per child spent by DSD on its own CYCCs.

- A Free State NPO reported that in one case they had struggled to keep an office open because DSD had not increased the subsidy. DSD had then reopened the office as a government facility and appointed six social workers to handle the caseload previously handled by one NPO worker. The change would have substantially increased the cost to government. Similarly, in Northern Cape an NPO reported that DSD had terminated funding and taken over services when NPOs struggled to recruit staff. The NPO claimed that this was sometimes done for party political reasons. At the overall budget level, there were comments on the increasing share of the DSD budget allocated to compensation of (government) employees alongside a decreasing share allocated to transfers to NPOs.
- A Free State NPO said that the introduction of minimum norms and standards for services was welcomed, but these could be expensive and sometimes placed a difficult burden on financially-strapped NPOs. In North West, DSD's report on finance noted that the subsidies provided were insufficient for compliance with the prescribed norms and standard. Similarly, Northern Cape DSD noted that legislation and policies such as the NPO Act, Public Finance Management Act, the policy on Financial Awards to Service Providers and norms and standards contradicted each other.
- A Limpopo NPO noted that because they delivered services to the "poorest of the poor", they could not generate income by charging for services. A Free State substance abuse NPO reported that because it was no longer funded for preventive services, it had been forced to charge a fee for such services.

There were several references to the need for a costing model for each programme that could be used as the basis for funding. However, a Free State government official observed that while they had now determined a unit cost for the various services (in the process of the NAWONGO case), the limited funds available meant that they would have to choose between increasing payments per unit and expanding services as they could not do both.

Already in 1998 the then Department of Welfare issued a consultation document on financing of DSW services that proposed a shift from post funding to programme funding, especially for the more established organisations.²¹⁰ The consultation document is discussed in more detail below. Nearly two decades later most commentators seemed to feel that there was very limited use of programme funding. There were differing views on programme funding, and it seems that there are also differing practices across provinces and different understandings of what programme funding entails. In this respect, it is noteworthy that the concept was not fully explained in the 1998 draft policy other than to suggest that it would mean each NPO submitted a single funding proposal that covered all its planned activities. A Free State participant felt that programme funding would assist emerging organisations in rural and informal settlement areas. This directly contradicts the 1998 document which envisaged grant funding for smaller, less-established organisations. A Limpopo NPO similarly favoured programme funding. However, there was concern around the lack of transparency in programme funding. Gauteng DSD proposed a mix of programme and per capita funding.

²¹⁰ Department of Welfare. 198. Policy for the financing of developmental social welfare services. Draft policy document. Pretoria.

Virtually all NPOs have sources of funding other than DSD. Many noted that the funding environment had become more difficult over recent years, among others because of the global financial and economic crisis that started around 2007-08. Several noted that some areas, such as children, were more difficult than others to get funded. North West reported that the difficulties facing the mining industry had affected this funding source. Across virtually all provinces NPOs observed that the National Lottery was not very helpful in addressing funding needs. In general, it seemed that Lottery funding had become more unreliable over time, and the Fund had become more restrictive in what it would fund. Thus organisations that had relied on annual funds from this source no longer could do so.

Strongly related to funding, there were concerns relating to the agreements signed between provincial DSD and funded NPOs. A Western Cape NPO noted the inflexible nature of the transfer payment agreements (equivalent to service level agreements (SLAs) in some other provinces. The NPO said that this made it difficult to use the funds to respond to communities' needs. Mpumalanga NPO said that they were not given enough time to study the SLAs drawn up by DSD before signing, but were instead bullied into signing immediately without queries being addressed.

A discussion on financing and funding at the NPO round table, produced the following proposals:

- Recognition that NPOs are valuable and play a role in delivering government's constitutional mandates;
- Funding to address needs rather than funding driven by the "flavour of the month";
- Equalisation and standardisation across provinces;
- Funding that provides for government-aligned salaries in NPOs;
- Availability of information about available funding, allocation and expenditure of various government-related sources;
- NPO involvement at the annual planning stage for service delivery and associated funding;
- Inclusion of a social welfare component in the equitable share formula; and
- Development and public availability of a costing model that includes provision for extra costs associated with rural delivery and delivery to people with disabilities.

9.3.3.2 Information from DSD

DSD's report on the 2012 NPO summit includes the following table, which shows the number of NPOs registered at that point, the number funded (and the percentage this constitutes of the number registered), and the total funding per province.

The percentage of registered NPOs funded ranges from 7% in Gauteng to 45% in Northern Cape. However, while Gauteng's percentage is lowest, it has the second highest number of NPOs funded. Conversely, while Northern Cape has the highest percentage, it has the lowest number of funded NPOs in absolute terms if one excludes national DSD. National DSD funds the smallest number of NPOs, but the mean amount (R2,2 million) is much higher than the mean amount for provinces. For provinces the

mean ranges from R0,9 million in Eastern Cape and Northern Cape to R0,63 million in Gauteng. The mean amount will to some extent be biased by the type of NPOs funded. In particular, where a large proportion of the funded NPOs are ECD centres, the mean is likely to be lower. In contrast, national DSD funds larger organisations that operate across more than one province.

Table 69: Funded NPOs per province, 2012

Province	No of funded NPOs	Amount (Rm)	Funded as % of registered	Registered NPOs
EC	2023	383	28	7194
FS	1423	342	35	4106
GT	2025	1274	7	27223
KZ	2573	692	14	16810
LM	1814	334	19	9392
MP	1214	298	23	5248
NW	604	204	13	4485
NC	772	144	45	1826
WC	1890	700	22	8755
National	33	72	0.04	85039
Total	14357	4443		

DSD in several provinces responded to the Ministerial Commission's request, when asking for information during the provincial reviews, that they provide information on funding of NPOs. Unfortunately, not all provinces did so. Further, of the provinces that did provide information, each did so using a different format and approach. The analysis presented below illustrates the type of analysis that can be done but unfortunately the findings for one province cannot be extrapolated to others that did not provide similar information.

Free State provided information in disaggregated service area categories and also provided the actual allocations. Table 72 shows the total allocation for each service area, the number of NPOs funded in the service area, and the mean amount per NPO. ECD accounts for close on half of the total allocations for NPOs, and for more than half of the NPOs. The per-NPO allocation for children's homes is far larger than for any other service area, while the amount is lowest for EPWP. The very large mean amount for children's homes is explained by one of the five homes being allocated over R21 million.

Table 70: NPO allocations by service area, Free State

Service Description	Total	Total	Per NPO
Children In Conflict With Law	188,419	2	94,210
Children's Homes	23,386,822	3	7,795,607
Comm Based Care & Support (Old)	19,337,780	178	108,639
Community Based Care & Sup (Disability)	2,032,733	16	127,046
Community Victim Support	8,697,048	50	173,941
Crime Prevention & Support	3,920,581	14	280,042
Daycare Children & Disabilities	5,980,184	41	145,858
Educare Regional Training & Dev	240,900	2	120,450
EPWP	15,500	1	15,500
EPWP IG: Sustainable Livelihood	3,694,000	11	335,818
Girl Child Programmes	938,000	12	78,167
HIV and Aids	18,398,814	124	148,378
Homes For Disabled	7,056,000	9	784,000
Isibindi Project	12,473,382	14	890,956
Justice Agency	2,335,750	7	333,679
Out Patient Clinics	436,477	3	145,492
Places Of Care (ECD)	172,070,935	917	187,646
Protected Workshops	2,080,260	23	90,446
Prov Manage & Co-Ordinator	3,336,790	5	667,358
Residential Care	20,822,400	35	594,926
Shelters For Abused Women	1,491,250	9	165,694
Social Service Organisation (Older)	1,214,609	4	303,652
Social Service Organisation (Children)	23,570,654	47	501,503
Social Service Organisation (Disability)	3,271,072	12	272,589
Social Service Organisation (Prev)	7,159,112	45	159,091
Street Children & Shelters	3,226,260	17	189,780
Sustainable Livelihood	10,723,600	47	228,162
Training Programme	286,102	5	57,220
Treatment	797,916	1	797,916
Women Development Programmes	1,036,000	11	94,182
Youth Development	4,724,899	22	214,768
Total	364,944,247	1687	216,327

Table 71 shows Gauteng funding close to 2 000 NPOs, with more than half of these in the children and families service area. No doubt a larger proportion of the latter are ECD centres. Older persons is the next most common area and substance abuse the least common.

Table 71: Funded NPOs by service area, 2014/15, Gauteng

Service Area	Funded NPOs
Children & Families	1136
Crime	77
Disability	98
Elderly	260
HIV	216
Poverty alleviation	177
Substance abuse	31
Total	1995

Table 72 shows the number of NPOs funded by service area and district in Limpopo, with an overall total of 1 407 NPOs funded. District-wise, Sekukhune has the largest number of funded NPOs, while Mopani has the least, with less than half the number of either Sekukhune or Capricorn. As expected, ECD accounts for the largest number of NPOs, at 931 of the 1 407 total i.e. about two-thirds. The next largest category is drop-in centres and combined drop-in centres and home- and community-based care (HCBC). Limpopo is known to be unusual in the extent to which it favours drop-in centres. The drop-in centres are very unevenly distributed across the five districts.

The Limpopo categorisation suggests that there might be some conflation or non-standard usage of terms. For example, either the terms drop-in centre and HCBC are being conflated (perhaps because “community care” is provided in the centres), or some organisations are explicitly funded for both services. The term stimulation centre, which is usually used for care for young children with disabilities, seems to be used by Limpopo also for older people with disabilities and a care service and service centre for the elderly.

Table 72: Funded NPOs by service area and district, 2014/15, Limpopo

Type	Capricorn	Mopani	Sekukhune	Vhembe	Waterberg	Total
Child Shelter	1				1	2
Child & Family					6	6
ComDev	1					1
CYCC	2				4	6
DIC	101	54			30	185
DIC/HCBC			77			77
Disability				6		6
Disabled Home	1		1			2
ECD	199	84	261	213	174	931
Elderly	1	6	1	11	7	26
Elderly SC	6		17		4	27
HIV	12	1		47	3	63
Protective	5	1	11		3	20
Stimulation			7		4	11
Substance		2	1	4		7
SW Post	4		1			5
VEP	2	1	9	14	6	32
Total	335	149	386	295	242	1407

Further analysis using beneficiary information shows the number of beneficiaries per NPO and service area ranging from two for community development to 183 for drop-in centre/HCBC combination. The low number for community development suggests that the beneficiary data are not reliable.

Table 73 shows the funding patterns for Western Cape by service category within service area. ECD is again the largest single category, accounting for more than half of NPOs funded, but "only" 27% of total NPO funding. The mean amount of funding is largest for the substance abuse treatment centre and lowest for aftercare services for children.

Table 73: Funded NPOs by service area and category, 2014/15, Western Cape

Service area and category	Total allocation	NPOs	Mean allocation
2.4 Crime Prevention and Support	10265434	6	1710906
Adult Diversions	2158238	1	2158238
Community Courts	1965810	1	1965810
Diversions	2106368	1	2106368
Reintegration	1553175	1	1553175
Social Service Organisation	2481844	2	1240922
Care and Support to Families	43676767	68	642305
Shelter For Adults	12528983	25	501159

Service area and category	Total allocation	NPOs	Mean allocation
Social Service Organisation	31147784	43	724367
Child Care & Protection	210053874	246	853878
Children's Homes	80224492	41	1956695
Drop-in Centre	5192460	13	399420
HIV	10132096	35	289488
Organisation	106792154	150	711948
Shelter For Children	7712671	7	1101810
Disability	85865747	183	469212
Day Care Centre	7929806	24	330409
Homes for Disabled	28906176	31	932457
Protective Workshops	10154484	49	207234
Social Service Organisation	34578731	48	720390
Special Care Centres	4296549	31	138598
Early Childhood Development	241924848	1132	213715
Aftercare Services	9417408	82	114846
ECD Childcare	232507440	1050	221436
Institutional Capacity Building	1365000	3	455000
SSO	1365000	3	455000
Older Persons	175123108	344	509079
Assisted Living	831379	4	207845
Independent Living	988683	2	494342
Old Age Homes	134165063	124	1081976
Service Centre	28810851	201	143338
Social Service Organisations	10327133	13	794395
Substance Abuse	50309761	81	621108
Aftercare	3285660	18	182537
Awareness Prevention	2057635	4	514409
Community Based Treatment Centre	19187565	20	959378
Early Intervention	1514929	9	168325
In-Patient Treatment Centre	14132755	6	2355459
SSO	3608242	19	189907
Universities	6522975	5	1304595
Sustainable Livelihood	34657872	85	407740
Mod Centre	28728000	49	586286
Targeted Feeding	5929872	36	164719
Victim empowerment	22471366	36	624205
Shelter For Victims	11766886	14	840492
Social Service Organisation	10704480	22	486567
Youth	5170176	11	470016
EPWP	5170176	11	470016
Total	880883952	2195	401314

PART VIII:
Review of
current
institutional
issues

9.3.3.3 Legislation and policy

Current welfare service legislation deals unevenly, if at all, with the issue of funding NPOs for delivery of services, as illustrated by the following:²¹¹

- The National Welfare Act of 1978 provides for the establishment and funding of national council.
- The Children’s Act of 2005 (as amended) provides that the provincial MEC “must” fund prevention and early intervention programmes, child and youth care centres, and drop-in centres, and “may” fund partial care facilities and ECD programmes.
- The Older Persons Act of 2006 provides that the Minister, or MECs through delegated authority, may make financial awards to providers of services to older persons and regulations elaborate on how this should be done
- The Child Justice Act of 2008 provides for accreditation of diversion programmes and service providers but does not deal directly with funding.
- The Prevention of and Treatment for Substance Abuse Act of 2008 provides for financial awards to service providers, and regulations in this respect. The regulations include a full chapter on contracts with service providers.

As noted above, the Department of Welfare started working on a new NPO financing policy even before the White Paper was published. A draft policy document on the topic was published for consultation in May 1998.²¹² The plan was that consultation would be finalised and an agreed policy included in the White Paper by the time it was published in late 1997.

The policy proposed a move to primarily programme funding, so as to move away from the bias towards “single-purpose residential facilities.” The move to programme funding would at the same time be a move away from subsidising posts and unit costs. Instead of the standard existing categories of service, the document proposed the following four main categories:

- Empowerment
- Community intervention
- Residential intervention
- Resource development, planning and management.

The term “programme” was not fully defined in the document other than in discussion of applications for financing, where the document noted that “for the purposes of financing and clarity, an organisation’s total service is defined as its ‘programme’”, while the different components of the organisation’s programme would be termed “projects”. Projects were to be defined in relatively broad terms to avoid a large number of business plans.

²¹¹ Sourced from Cornerstone Economic Research. 2015. Proposed Framework for Managing Transfers to NPOs. Draft for discussion.

²¹² Department of Welfare. May 1998. Policy for the Financing of Developmental Social Welfare Services. Draft policy document for consultation with all stakeholders. Pretoria.

While favouring programme funding, the document warned that “one should also be mindful not to be so vague that social welfare services have no boundaries.” In particular, Welfare should not be responsible for financing responsibilities of other sectors. The document noted, in particular, several areas where lack of funding by other sectors affected Welfare, namely the lack of provision for welfare housing; services to profoundly mentally handicapped children and adults; sheltered and protective employment; health services in welfare facilities; and payment of school fees for children in the welfare system.

The paper proposed four financing “components”, as follows:

- Component I: Foundation Financing [e.g. needs assessment, developing models, etc]
- Component II: Furniture and Equipment Financing
- Component III: Programme Implementation Financing [corresponding more or less to what is currently covered by subsidies]
- Component IV: Capital Investment Financing

However, it noted “lack of clarity” in respect of providing funds for civil society organisations in respect of building and land for facilities. While one might expect this to be covered by the fourth component, the document noted that no funds had been “earmarked” for this function, and inclusion of the issue in the document did not mean that Welfare departments would take responsibility for funding it. Nevertheless, it was “noted as a priority and needs to be resolved”.

In order to obtain programme funding, the applicant organisation/body would need to have the capacity to provide the service. This requirement was not specified for grant funding, which was intended for developing organisations that did not yet meet all requirements for programme financing. Grant funding would be limited to R50 000 “per project” per year, and the capacity of the organisation was to be built during this period. The policy also proposed that developing organisations that were not yet formally registered could affiliate with and apply for programme financing through registered organisations. The draft stated that such a registered organisation “may” receive funding for its responsibilities in supporting the capacity building of the developing organisation.

The draft document was clear that government would not “take sole responsibility for the financing of services, thereby creating a culture of dependence”. Further, the level of financing would be “subject to the availability of funds within the Department’s budget”. However, NPOs would be given priority (over for-profit providers) “in line with the principle of democracy”. The draft document was clear that where users were able to contribute, they should be required to make some payment for services except for services such as child protection. This would need to be done through funded organisations applying means tests and sliding scales.

Despite the warning about dependency, the draft document confirmed the department’s commitment to supporting organisations financially. It cited as evidence the fact that in most provinces the amount allocated for transfers was far larger than the amount allocated for the department’s own service delivery. However, the more detailed description of the proposed financing model stipulated that the “base” amount of

funding would normally be equivalent to only 50-60% of an organisation's net operational expenditure i.e. the operational expenditure after deducting any fees or other operational income, including donor funding for operations. To this base amount, further smaller amounts might be added in the form of "credits" in respect of a good business plan, and a "bonus" for achievement of outcomes in previous periods.

DSD's status report on social welfare transformation prepared for the Ministerial Committee notes that its work on developing a financial policy was intended as a tool to transform the traditional welfare sector. Development of the policy was put on hold in 2000 because of slow implementation. DSD also felt that the policy should be developed as part of a broader review of welfare legislation, costing of services, and transformation of the profession.

A new Policy on Financial Awards to Service Providers (PFA) was approved in October 2004, with implementation phased in from April 2005 onwards. DSD sees this policy as having contributed to extension of services to rural, under-served areas, and also having resulted in significantly increased budgets for transfer payments to NPOs. National "baseline costing models" and a national funding model were reportedly also developed. However, in 2009 DSD recognised that a further review of the policy was needed. DSD's status report also openly acknowledges that the available budget for financing NPOs is "far less" than actual costs and requests, and that disparities remain in funding of the same services across provinces, as well as in management, administration, and monitoring and evaluation of funding.

DSD's 2013 status report on social welfare transformation to the Ministerial Committee notes as follows:

Government needs to make optimal use of the for-profit, non-profit and voluntary sectors given its own limited capacity... In many areas the non-profit and voluntary sectors are the primary providers of social welfare services especially to children. Despite this, government does not provide adequate subsidies or have proper funded service level agreements in place.

DSD's Framework for Social Welfare Services of 2013 notes as follows in respect of funding of NPOs delivering services:

Funding and subsidisation should be based on principles of fairness in relation to the costing of the required services. However, within a developmental paradigm, non-government organisations should also embark on economic development and fund-raising initiatives to augment what government provides.

The portfolio committee's BRRR for 2014/15 notes that DSD developed a draft Review Policy on Financial Awards to Service Providers. National DSD's annual report for 2014/15 states that the department "facilitated an internal review" on the policy, which included consultative sessions with the "DSD/NPO Forum" as well as other stakeholders in the sector. PACT has awarded a tender to a consulting company to finalise the PFA. The terms of reference include development of an implementation plan, costing of the roll-out plan and ongoing implementation, development of guidelines for NPOs, development of guidelines and templates for DSD, and development of a comprehensive M&E framework.

Meanwhile, a separate joint National Treasury-DSD project in respect of a framework for funding of social welfare services developed proposals for discussion in mid-2015.²¹³ The framework encompasses a differentiated approach in respect of financial management, reporting requirements, funding renewal procedures, and monitoring of NPOs based on the size of the NPO, their past DSD funding history, and risk profile. The framework was proposed as a way of facilitating transformation by helping provincial DSD to use the request for proposals process to direct funds to extend services to under-served areas and to emerging NPOs; by reducing administrative obstacles to accessing government funding; by allowing NPOs to plan through the use of payment schedules and longer-term funding agreements; and by highlighting the importance of DSD providing support when problems arise.

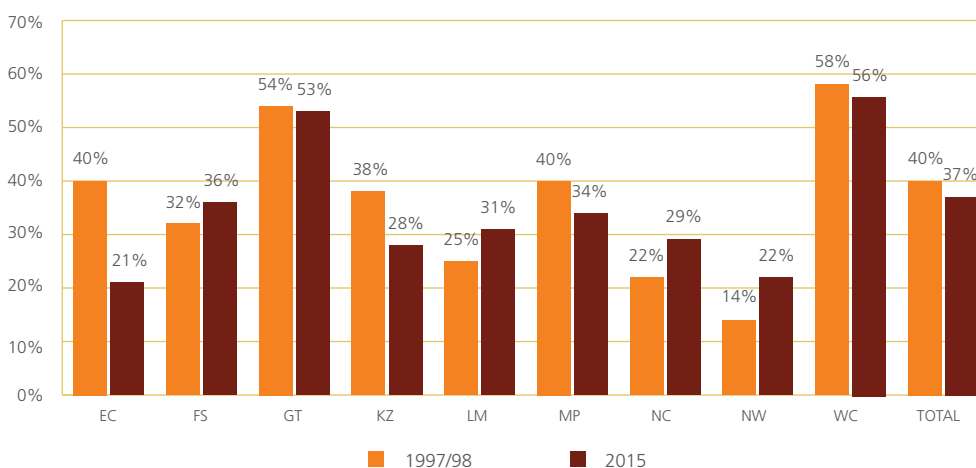
9.3.3.4 Transfer budgets and amounts

Transfers to NPOs for service delivery account for 37,1% of the combined DSD budgets of the nine provinces in 2015/16 (and for less than 0,1% of the national DSD budget in the same year). The allocations, while substantial, are less than the 44,5% of the budget allocated for compensation of DSD employees, and the gap between the two components has been growing over time. This pattern does not reflect the relative contribution to service delivery of NPOs.

Analysis of the budgets of the nine provincial departments shows the share of combined budgets allocated to compensation of (government) employees increasing over time, from 39,3% in 2011/12 to 45,2% in 2017/18. Conversely, the share allocated to transfers (subsidies) to the NPOs that are responsible for the bulk of delivery decreases from 38,0% to 36,6% over the same period.

Figure 58 shows that if one goes back further to 2005/06, the percentage of the DSD budget across the nine provinces allocated to NPOs has decreased from 40% to 37%. (Comparisons with earlier years would not be reliable because provincial budgets in the earlier period included funding for social grants.) The percentage of the budget going to NPOs fell in five of the nine provinces – almost halving in Eastern Cape. The four provinces where the percentage increased were the ones with the smallest allocations to NPOs in 2005/06.

Figure 58: NPO transfers as a percentage of provincial DSD budgets



²¹³ Cornerstone Economic Research. 2015. Proposed Framework for Managing Transfers to NPOs. Draft for discussion.

NPOs delivering welfare services typically obtain further funds from other sources, including international and local donors, corporate social responsibility programmes, the NDA and National Lottery Distribution Fund, and fund-raising and income generation. However, government remains an important – and often the largest – source of funding for many of the NPOs. Further, other sources of funding have become less available with the ongoing global and local economic downturn, and a perception among international donors that South Africa should at this point be funding its own development.

Figure 59 shows the variation across provinces in NPO per capita transfers for various residential services – for older people and persons with disability, as well as child and youth care centres (CYCCs) for children in need of care. The transfer amounts are those reported to a meeting organised by National Treasury that brought together national DSD and all provincial DSDs in the preparation phase of the 2015/16 budgets. The figure shows the actual (monthly) amounts for both the Afrec costing and the various provinces. Figure 60 shows the per capita monthly amounts for other services. In the case of residential care for older person, the Afrec amount is more than four times the amount paid by the lowest-paying province. In the case of other services, the disparities are even greater.

Figure 59: Provincial subsidies for 2014/15 and Afrec 2011/12 costs for residential services

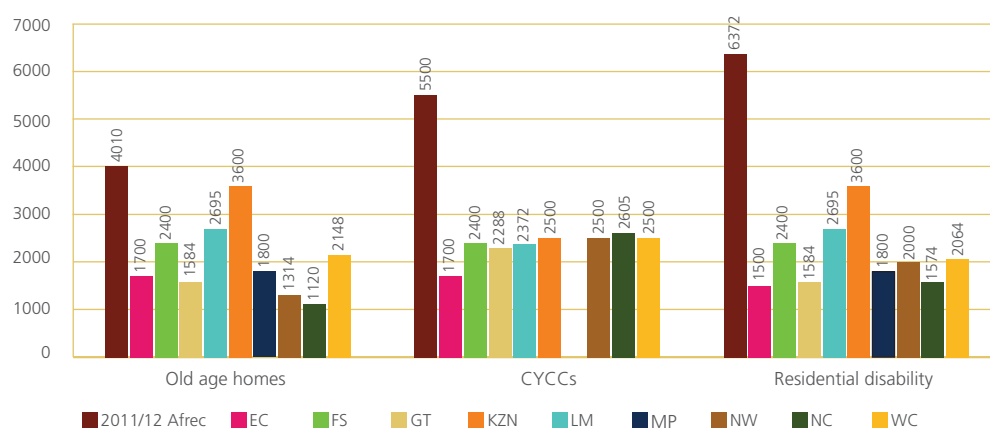
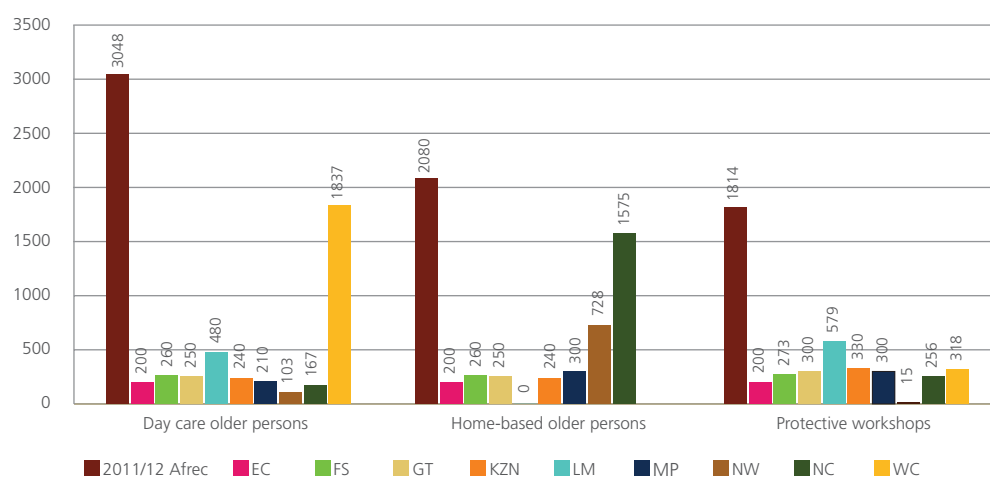


Figure 60: Provincial subsidies for 2014/15 and Afrec 2011/12 costs for other services



Unfortunately, national DSD does not have a record of, and was not able to source, information about the subsidies paid by the nine provinces for different services. Information was therefore sourced for the Committee by the National Coalition of Social Services (NACOSS).

Coalition members requested their provincial offices to complete simple questionnaires recording information about subsidies received over the past three years. In at least some cases, the information had to be obtained at district level as an organisation had different agreements for different districts within a province. Information was collected on both subsidies provided for particular services, and subsidies provided for posts.

Unfortunately, information was not provided for all provinces in respect of all services. Nevertheless, the available information gives some sense of the disparities, as well as the extent to which subsidies are increased each year. The NACOSS-supplied information is supplemented by information provided by Limpopo in the consolidated document that province produced for 2015/16 showing all subsidies.

The tables below implicitly suggest that there is a single subsidy amount in each province for a particular service. It seems that this is not the case in Gauteng (where a NACOSS member was aware of a facility in a disadvantaged area receiving a noticeably higher subsidy than they did), and perhaps also in some other provinces. The information presented here shows the subsidies reported by NACOSS members.

Table 74 shows information for four provinces in respect of child and youth care centres (CYCCs). The amounts shown are the allocations per month per resident child. For children's homes the amounts range from R1 700 per month in Northern Cape to R2 650 in Western Cape. Western Cape's subsidy is thus 35% higher than that for Northern Cape. Northern Cape has no increase over the three-year period, KwaZulu-Natal has an increase in 2014/15 but not in 2015/16, while Western Cape has annual increases. In Western Cape shelters receive the same amount per child as children's homes, but in KwaZulu-Natal the amount differs for different types of CYCC.

Table 74: Monthly per-child subsidy for child and youth care centres (CYCCs)

Province	Service	2013/14	2014/15	2015/16
KZN	CYCC: Children's home	2230	2372	2372
LM	CYCC: Children's home			2500
NC	CYCC: Children's home	1700	1700	1700
WC	CYCC: Children's home	2120	2650	2650
WC	CYCC: Street children's shelter	2120	2650	2650
KZN	CYCC: Other	59	63	63

In its support in respect of the NAWONGO case, KPMG estimated the core monthly per-child cost to be funded by DSD in respect of a children's home as R5 653 in 2013.²¹⁴ This estimate does not represent the full costs of running the services. In particular, the KPMG amount excludes a range of costs which NAWONGO argued were necessary to run the service, including vehicle maintenance and replacement, bank charges, accounting and audit fees, equipment insurance, and medical equipment. In respect of staff, government salary rates were used by KPMG but the subsidy costs exclude a 13th cheque, pension fund and medical aid contributions, and housing allowance. The subsidy costs also do not make allowance for a share of the overall management of the NPO.

²¹⁴ KPMG August 2013 final report 20130827

Table 75 provides the information for ECD centres. In 2015/16, four of the five provinces with information paid R15 per child per day, but KwaZulu-Natal paid R16. Four of the provinces covered 264 days in the year, but Free State covered 261 and Limpopo 226 (or 204 if centres close during school holidays). Eastern Cape paid R15 for all three years, while Northern Cape increased from R12,50 in 2013/14 and 2014/15 to meet the national standard of R15 in 2015/16. Limpopo gives R20 per day for children in stimulation centres rather than the R15 per day provided for ECD, suggesting that it may be taking the extra cost of serving people with disabilities into account. Organisations did not give information about stimulation centres in other provinces.

Table 75: Daily per-child subsidy for ECD centres

Province	Days p.a.	2013/14	2014/15	2015/16
EC	264 days	15.00	15.00	15.00
FS	261 days	13.50	13.50	15.00
KZN	264 days	15.00	16.00	16.00
LM	226 days			15.00
NC	264 days	12.50	12.50	15.00
WC	264 days	15.00	15.00	15.00

Table 76 shows sparse information for three provinces in respect of drop-in centres for children. The sparseness suggests that funding of this service might be erratic. Western Cape again has the largest subsidy; for 2015/16 its subsidy is nearly four times that for Northern Cape. The differences might to some extent reflect the number of children served. For this service there is no increase in Western Cape for 2015/16. Limpopo pays R9 per child for smaller drop-in centres, and a quarterly amount of R45 900 (R15 300 per month) for centres servicing 100 or more children.

Table 76: Monthly subsidy for drop-in centres for children

Province	Service	2013/14	2014/15	2015/16
NC	Drop-in centre			200.00
WC	Drop-in centre	530.00	795.00	795.00
FS	Drop-in centre (per programme)	131.00	123.36	

Table 77 shows information on residential homes for people with disabilities for three provinces. The amounts reflect the monthly allocation per resident. There are two amounts for Western Cape, with Group 3 reflecting frail care and Group 2 reflecting somewhat lower need. Western Cape varies these and some other subsidies based on a means test in respect of the residents. The table shows the maximum amounts payable i.e. for the poorest group. Western Cape's maximum amount for Group 3 is lower than the amounts for KwaZulu-Natal in each of the three years despite KwaZulu-Natal having a very small increase in 2014/15 and no increase in 2015/16. Limpopo's amount is the highest – 52% higher than the highest amount for Western Cape. In 2013, KPMG estimated the monthly per-resident cost of running a residential facility for people with disabilities at R6 500.

Table 77: Monthly per-resident subsidy for homes for people with disabilities

Province	Service	2013/14	2014/15	2015/16
KZN	Residential care	2542	2695	2695
LM	Residential care			3600
WC	Residential care Group 2	954	1011	1072
WC	Residential care Group 3	2064	2188	2375

Table 78 shows monthly subsidies for old age homes in seven provinces. As before, the amounts reflect the allocation per resident per month. In most cases the subsidy is shown as relating to Group 3, i.e. frail care. Western Cape is the only province where other groups are specified, but the Group 1 subsidy is not available even in this province for 2015/16. Focusing on Group 3, Limpopo has the highest subsidy for 2015/16 and Northern Cape the lowest. Limpopo's subsidy is more than three times that of Northern Cape. Eastern Cape and Free State show no increases in subsidy over the three-year period. In 2010 KPMG estimated the core monthly cost to be funded per frail resident (group 3) as R5 000.

Table 78: Monthly per-resident subsidy for old age homes

Province	Service	2013/14	2014/15	2015/16
EC	Old age home Group 3	1700.00	1700.00	1700.00
FS	Old age home Group 3	2400.00	2400.00	2400.00
GT	Old age home Group 3			1584.00
KZN	Old age home Group 3	2533.00	2695.00	2695.00
LM	Old age home			3600.00
NC	Old age home Group 3	1050.00	1102.50	1157.63
WC	Old age home Group 1	300.00	300.00	
WC	Old age home Group 2	761.00	807.00	855.00
WC	Old age home Group 3	2148.00	2277.00	2414.00

Table 79 suggests that day care and service centres for older persons may be funded differently across provinces. Alternatively, the organisations were all reporting, in different ways, an approach based on about 20 days per month. Northern Cape's and Western Cape's amounts translate into about R9 per person for a 20-day month, noticeably less than the Free State and KwaZulu-Natal amounts. The Limpopo amount is higher still. With Eastern Cape it is not clear if the R50 is per person per month or per day. Not shown in the table, Western Cape again has different subsidy levels depending on the means of persons serviced.

Table 79: Subsidy for day care/service centre for older persons

Prov	Period	2013/14	2014/15	2015/16
EC	Month	50.00	50.00	60.00
FS	20 days	13.00	13.00	13.00
KZN	Month	15.00	16.00	16.00
LM	Day			20.00
NC	Month	167.01	R170.00	178.42
WC	Annum	1837.00	1947.00	2064.00

For substance abuse and victim empowerment there were too few organisations that provided information to allow any comparisons.

The above tables show funds based on the level of service delivery. As noted above, there has been talk since the 1990s about shifting from funding of posts to funding of programmes. In some cases the funding approach has changed, and the extent to which this has happened differs across provinces as well as across different service areas. However, in many cases post funding continues. It could be argued that this is appropriate where, for example, the service level agreement is primarily in terms of statutory or other services that must be delivered by designated staff.

In most cases the funding for posts consists of two parts, namely an amount for the salary of the person, and a further amount to cover (or contribute towards) administrative support for the person. However, some provinces no longer specify separate amounts.

In some cases the organisations did not know how the amounts were calculated. Thus one organisation in particular said that while in North West each of their offices had one social worker, the subsidy amounts differed across the three districts; in Mpumalanga they received lump sums without any specification as to how the money should be allocated; and in Limpopo percentages were specified indicating how the allocation should be divided but the percentages were “confusing” and “unrealistic”.

Table 80 shows the subsidies reported for social workers across provinces. Mpumalanga is excluded because it seems to fund combinations of social workers and auxiliary workers rather than funding per social worker. Western Cape has two entries because different organisations provided different amounts for some of the items. Limpopo and one organisation in North West are excluded as the relevant organisations seem to have provided the total amount for social workers rather than the amount per social worker. Of the seven provinces included, the post amount in 2015/16 ranges from R112 761 in Gauteng to R196 331 (74% higher) in Free State. The admin amount ranges from R22 066 in Free State to R56 952 in KwaZulu-Natal. If the two amounts for 2015/16 are added, the range is from R133 416 in KwaZulu-Natal to R218 397 in Free State. The combined Free State amount is thus 63% higher than the KwaZulu-Natal amount.

For chief social workers, Table 81 shows the amount ranging from R151 110 in Gauteng to R253 082 (67% higher) in Western Cape. Western Cape also gives a much larger administrative amount than Gauteng. Mpumalanga does not have an administrative amount, but has the second highest post amount in 2015/16. Eastern Cape shows no increases of the three-year period, and KwaZulu-Natal has no increase for 2015/16.

Table 82 provides information for six provinces in respect of social auxiliary workers. For both Gauteng and Western Cape two organisations provided information where some of the amounts were the same while other amounts differed. However, in both cases the post amounts for 2015/16 were the same and for Western Cape both the post and admin amounts were the same for this year. In 2015/16 the post amount ranged from R35 775 in Eastern Cape to R91 242 (about 150% higher) in Gauteng, with the admin amount also larger in Gauteng than Eastern Cape. For Eastern Cape there are again no increases over the three year period and KwaZulu-Natal again has no increases in 2015/16.

Table 80: Annual subsidy for social workers

	2013/14		2014/15		2015/16	
	Post	Admin	Post	Admin	Post	Admin
EC	128140	39996	128140	39996	128140	39996
FS	171482	46840	183486	34938	196331	22066
GT	102287	25058	106378	26060	112761	27624
KZN	125868	53724	133416	56952	133416	56952
NC	114542	35131	120264	44268	126277	46481
NW	148013	13987	146907	23193	188760	27907
WC	119431	23886	119515	29879	167321	41830
WC	112750	28187	112750	28187	167321	41830

Table 81: Annual subsidy for chief social worker / social work supervisor

Prov	Post	2013/14		2014/15		2015/16	
		Post	Admin	Post	Admin	Post	Admin
EC	Chief social worker (Social work supervisor)	192942	39996	192942	39996	192942	39996
GT	Chief social worker	137074	25058	142557	26060	151110	27624
KZN	Chief social worker	161100	53724	170760	56952	170760	56952
MP	Chief social worker	231876	0	244404	0	244404	0
NC	Chief social worker (Social work supervisor)	142687	52496	149820	55116	157311	57870
WC	Chief social worker	170540	34108	180773	45193	253082	63271

Table 82: Annual subsidy for social auxiliary worker

	2013/14		2014/15		2015/16	
	Post	Admin	Post	Admin	Post	Admin
EC	35775	20000	35775	20000	35775	20000
FS	50813	13970	54370	10310	58176	6530
GT	82766	25058	86077	26060	91242	27624
GT	82766	24163	82766	24163	91242	24163
KZN	62940	53724	66720	56952	66720	56952
NC	59051	21730	62004	22812	65104	23953
WC	70095	14019	70095	17524	72243	18061
WC	64296	16080	64296	16080	72243	18061

Information on timing of payment was received for 15 different agreements across the nine provinces.

KwaZulu-Natal contracts to pay organisations retrospectively i.e. after services have been delivered and reports submitted. Most other provinces contract to pay in advance. Some organisations in other provinces (Eastern Cape, North West, and Western Cape) indicated that payment was retrospective, but this may have indicated that the payment was, in reality, paid late even though it was meant to be paid in advance. This confusion is likely because in all provinces there are delays in payments as well as in contracting with organisations. These delays are found across all three financial years, namely 2013/14, 2014/15 and 2015/16.

One organisation noted that in KwaZulu-Natal the delays in payments had worsened since they had been required to submit documents to the local office rather than provincial office. The new arrangement also resulted in documents being lost more often. In at least one case an organisation experienced a delay of 2-3 months in payment because, they were told, DSD did not have funds.

In some cases organisations were not able to give the date on which the service level agreement was signed because DSD did not provide them with a copy of the agreement after DSD had signed it. Among those that provided information, for 2015/16 there was only one organisation that signed – in March – before the financial year began. At least two organisations still did not have contracts in October 2015. For 2013/14 and 2014/15, there were one or two cases where contracts were signed in March at the beginning of the financial year, but at least one case in each year where the contract was signed only in the March at the end of the financial year.

The first payment generally will not happen until after the contract is signed. For 2015, four organisations (Eastern Cape, Gauteng and Western Cape) reported receiving a first payment in April. However, at least two (Free State and North West) had still not received a first payment by October 2015 when the survey was conducted. Several organisations with contracts in several provinces noted that Western Cape usually paid on time. An organisation that dealt with eight different offices in Gauteng said that the dates of payment differed across offices, but overall this was the province with which they had least payment problems. Nevertheless, they experienced difficulties because when payments were made it was not specified for which office this was done.

Frequency of payments varies across provinces. North West pays (or is meant to pay) six-monthly; Free State, Gauteng, Limpopo, Mpumalanga and Western Cape pay quarterly, and Eastern Cape, KwaZulu-Natal and Northern Cape pay monthly (although one organisation said that KwaZulu-Natal paid twice a month). These frequencies relate to what is stated in the service level agreements. When payments are delayed, several payments may be made at one time.

The discussion above relates to NPO transfers from provincial DSD. Six organisations provided information about subsidies from national DSD over the last three financial years. All said that the subsidies are meant to be paid in advance, and on a six-monthly basis. All said that their service level agreement for 2015/16 had not yet been signed by October 2015, when they provided the information for this survey, although applications for funding had been submitted in November 2014. None had received any payment in respect of 2015/16 although October is the first month of the second six-month period. Late payments can result in delays in progress reports being submitted. More seriously, late payments mean that organisations must either find bridging finance or try to meet agreed levels of delivery within a severely compressed time period.

For 2013/14, the earliest first payment was received in September and the latest in March. For 2014/15, all except one organisation said the first payment was received in November, while the sixth said it was received in September.

Five of the six organisations received the same amount – without adjustment for inflation – in 2013/14 and 2014/15. The sixth received less in 2014/15 than in 2013/14.

National DSD's annual reports represent another source of information about transfers and subsidies. Since the 2013/14 report there is a table in the annual report that indicates the purpose for which the funds are allocated, as well as how much is spent. The information presented here is compiled from the reports for 2012/13, 2013/14 and 2014/15.

Table 83 shows the transfers by broad category. Overall, the table shows a marked increase in the total amount allocated over the three years – from R71,3 million in 2012/13 to R112,7 million in 2014/15. The annual increases in the total are far higher than inflation. However, by 2014/15 the total of R112,3 million remains a tiny fraction (less than 1%) of the combined total of R15 390,9 million of NPO transfers for the nine provinces combined.

Table 83: Transfers by broad category, 2012/13-2014/15 (R000s)

	2012/13	2013/14	2014/15
Programmes & projects	49394	49677	53578
% of total	69%	56%	48%
Welfare Services Support & Monitoring	20890	20804	18072
% of total	29%	23%	16%
Food distribution	1000	19000	41001
% of total	1%	21%	36%
Total	71284	89481	112651

The first category (programmes and projects) of national transfers refers to four or five transfers in each of the three years that are for specific activities. The largest of these in each of the years is the transfer to loveLife for advocacy in respect of social and behaviour change. This transfer accounts for 95% or more of this category in each of the three years. The share of all national transfers going to this category decreases substantially over the period, but is still 45% - close on half of the total – by the end of the period.

The second category relates to development, delivery and monitoring and evaluation of welfare services. This category includes the national associations and organisations operating in the general welfare field as well as in specific service areas. The number of organisations in this category is 23 in 2012/13, 24 in 2013/14 and 22 in 2014/15. The share of total transfers for the category falls from 29% to 16% over the period. In terms of absolute amounts, the allocation to welfare services support and monitoring fell over the period.

The final category, food distribution, accounts for an amount more than 40 times bigger in 2014/15 than in 2012/13. The share of the total budget increases from 1% to 36% - more than a third of the total. The number of organisations funded increases from 1 to 3 and then to 57. In 2014/15, there are nine relatively large allocations for provincial food distribution, together with a much larger number of allocations each with R187 000 in respect of establishment of a community development and nutrition centre. The expenditure column in the 2014/15 annual report shows no expenditure at all in respect of the centres. The reason given is challenges in selection and screening of the organisations to host the centres. National DSD's annual report for 2014/15 notes that funding of the additional 57 organisations "had a negative impact on performance in other areas of work."

In the second category, a total of 17 organisations received funding in each of the three years. This leaves 13 organisations that received funding for only one or two years. Of the 17 that received funding in all three years, six (ACVV, Apostolic Faith Mission, Child Welfare South Africa, Childline, Ondersteuningsraad, Suid Afrikaanse Vroue Federasie) have not received any increase over this period. Of the remaining organisations, three had increases over the period, two (Deaf Federation of South Africa, Disabled Children Action Group) had decreases, and six organisations had both an increase and a decrease.

In 2013/14 three organisations that were budgeted were not made because of outstanding progress reports or prior non-compliance. The three organisations affected were National Association of People Living with HIV and AIDS, National Association of Burial Society of South Africa, and SA Older Persons Forum. The first two of the three did not receive an allocation in 2014/15.

9.3.4 Funding of NPO infrastructure

Prior to 1994 the Department of Local Government, Housing and Works used the development and housing fund to grant loans to welfare organisations at an interest rate of 1% repayable on a biannual basis over 30 years. The organisations used these loans to finance capital costs of centres and other facilities.²¹⁵

²¹⁵ South African Human Rights Commission. 2015. Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons.

There is no dedicated conditional grant for social development infrastructure other than the recent substance abuse treatment centre grant. The latter is restricted to a few years and four provinces. The absence of a dedicated grant places DSD in a different position from Education, where there is a dedicated grant, and Health, where there is a health facilities grant. There is the EPWP Integrated Condition Grant for Provinces is meant to be used “other economic and social infrastructure”, among other purposes. DSD can compete for these funds with other provincial departments. However, the funds are not intended for use for NPO infrastructure.

DSD and the Department of Human Settlements have together developed a National Special Housing Needs Policy and Programme. Government has consulted with NPOs on the policy, which the NPOs welcomed. However, six months after the policy was presented to stakeholders in mid-March 2015, it seemed that the Minister of Human Settlements had not yet taken the policy to the Human Settlements MINMEC as requested by both the Parliamentary Portfolio Committee for Human Settlements in April 2012 and the MINMEC in 2013.

The policy recognises that NPOs are the main providers of accommodation and related services to people with special needs and that they therefore need assistance with capital funding. It therefore provides for capital grants to be available to established NPOs with proven institutional and financial capacity for this purpose, and capital grants combined with support to be provided to emerging NPOs.

9.3.5 National costing models²¹⁶

In 2011/12 the United Nations Office on Drugs and Crime (UNODC) provided funding for the development of tools for social development to use in respect of “financial awards” to NPOs. The estimates derived are those referred to as “Afrec” costs elsewhere in this report. The team developed six tools, namely eligibility criteria, business plans, evaluation grid, quarterly report format, a memorandum of understanding/contract, and costing models. The costing models were developed in respect of seven welfare services, namely victim empowerment, disability, older persons, families, social crime, children, and substance abuse. In each of these services a number of identified programmes or programme areas were costed. During workshopping of the models, several further “new” programme areas were identified as needing costing. These were not included in the costing models for this project. For children, the “new” areas were partial care, drop-in centres for orphans and vulnerable children, cluster foster care, child protection, and adoption.

The costing exercise focused on operational costs. It took existing norms and standards into account but found that they were “inconsistent, too generic and lacked detailed programme specific norms.” The manual for the module thus recommended that norms and standards be reviewed and made “meaningful for application within a service delivery context.” The manual also noted that the cost models would need to be updated at least annually, ideally at before the start of the new financial year.

The costing also drew on a survey of NPOs conducted in 2004/05, and a review of implementation of financial awards in five provinces. Of the five, four used the national

²¹⁶ Dawood Ghalieb & Maphiri Donald. 2012. National Costing Models: Consolidated Report. Prepared for Department of Social Development.

financial awards policy, of which one (Western Cape) was close to finalising their own policy. The fifth province, Free State, already had its own policy. The manual noted that the silo approach of DSD meant that a single NPO might work with one section on governance issues, another section on funding, and a third section on monitoring and evaluation.

The consultants recommended that the then three-tier system of eligibility criteria be changed to two tiers – emerging and established – and that these two tiers also be used for other purposes, such as reporting requirements. The suggested criteria do not seem to take into account the capacity to deliver services.

The manual argued against prioritisation of statutory services. It noted that “[i]n some cases, non-statutory services are more important for improving societal outcomes, but may be under prioritized because of a legalistic interpretation of service delivery.” The manual notes further that a costing model is not the same as a funding model. Instead, the technical estimates generated by the costing tools would inform the policy decisions in respect of funding.

The salary scales developed by the Department of Public Service and Administration for government employees specify three different levels. The costing models generally used the “community” level scale for staff, rather than the higher “intermediate” and “senior” levels. However, where “actual” data from other sources differed from (i.e. were lower than) the community level, the “actual” data were used.

9.4 Other government funding sources

9.4.1 National Lottery

The National Lotteries Act of 1997 makes provision for the operation of a countrywide lottery. The Lotto and scratch cards were launched in 2000. The money raised through the sale of Lotto tickets and scratch cards is to be distributed according to a formula: 50% to prizes, 20% as profits to the operating agency, and 30% to good causes. Five categories were established to further define “good causes” and these are the Reconstruction and Development Programme; Charities; Arts, Culture and National Heritage; Sports and Recreation, and; Miscellaneous Purposes. The Lottery falls under the auspices of the Department of Trade and Industry.

9.4.2 National Development Agency

The National Development Agency Act was passed in 1998, in the year after the White Paper was published. The NDA was established only in 2001. It served as the successor of the Independent Development Trust (IDT) and then the Transitional National Development Trust. The decision to establish the NDA rather than continue to rely on the IDT was informed by the fact that the IDT was seen as an apartheid-era institution. However, today, the IDT continues to receive far greater funding from a range of government agencies than the NDA receives. The NDA’s budget is funded by national DSD.

The primary mandate of the National Development Agency (NDA) is to fund CSOs in respect of development projects in poor communities that contribute to the eradication of poverty. The secondary mandate is to promote dialogue between CSOs and government and undertake research to inform development policy.

NDA provincial offices made presentations in most provinces during the provincial reviews of the Ministerial Committee. The NDA also made a presentation to the Ministerial Committee at the national level. These presentations as well as comments by NPOs revealed that the agency has restricted its funding to ECD, food security, income-generating projects, and capacity building. Even within these areas, the scope of funding is restricted. Income-generating projects have for the most part been in traditional areas that do not require substantial capital investment, such as sewing, agriculture (crop and livestock), brick-making, arts and craft, tourism, bakery and hydroponics.

Overall, the NDA increasingly sees itself as needing to focus on capacity building before, and perhaps more than, funding CSOs to implement development projects. In its presentation, the agency also reported that the DSD grant which funds its operation had increased at an average of 4% per annum over the previous ten years, and had thus not kept pace with inflation. Those outside the NDA – and NPOs in particular – were critical of the NDA, including its growing role as implementer rather than supporter and funder of NPOs, alongside lack of recognition of, and funding for, the coordination and capacity-building roles played by NPO networks and structures;

A civil society research project on the NDA and National Lottery²¹⁷ commented on the “huge” mandate of the NDA, and the agency’s inability to meet it, especially given limited financial allocations. The report questioned the lack of independence from government – and DSD in particular – of the NDA, citing the fact that the agency understands its mandate as being to fund CSOs in line with government’s development agenda, with the focus, for example, on food security and ECD. This critique can be questioned on the grounds that the NDA is a government agency, and the development agenda is meant to be that of the country. However, the critique that the NDA has not met its mandate of consulting with CSOs is more valid, as may be the critique that the NDA has (like many other funders) developed its own programmes in terms which it funds some CSOs to implement, rather than seeing itself as a funder of CSOs’ own programmes. If the agency does not do the latter, it is difficult to distinguish its role from that of DSD itself.

The civil society report notes that the NDA sources applications for funding in two ways. In the “request for proposals” approach the agency advertises in the media asking for submission of proposals meeting prescribed criteria. This “competitive” approach targets established NPOs. In the “programme formulation” approach the NDA provincial office assess the needs in the poorest areas and then approach NPOs working in the area and request them to develop proposals for economic development and/or food security. In this second approach, the NDA may require that different organisations work together. Information for 2005/06-2007/08 shows 102 projects funded according to the proposals approach as against 151 funded according to the programme formulation approach. This trend may suggest a focus on smaller, less-established organisations. However, the survey conducted as part of the civil society research found that smaller, less resourced community-based organisations had experienced the most difficulties in the process of accessing NDA funds and support.

The 2015 Estimates of National Expenditure note that DSD is reviewing the NDA’s mandate as it “is not sufficiently focused.” The document suggests that the NDA’s focus

²¹⁷ Funding Practice Alliance. 2011. Meeting their Mandates? The research report on the National Lottery Distribution Trust Fund (NLDTF) and the National Development Agency (NDA)

will shift from funding of NPOs to building capacity of NPOs and CBOs, and the budget will be reprioritised accordingly. In the period 2011/12-2013/14 the NDA spent R308 million in grants as against R48 million in capacity building. The capacity building was for the most part done on behalf of various provincial DSDs. In this same period, the NDA spent R234 million on administration. The 2016 Estimates of National Expenditure signal that going forward NDA will shift further away from grant making to capacity building.

9.5 Corporate funding²¹⁸

Dialogue identifies the following as among the key developments relating to CSI funding since 1994:

- In August 1994, the South African Grantmakers' Association was launched, with support from about 60 companies and a few other funders. However, the association closed in early 2006.
- In 2000, the Taxation Laws Amendment Act introduced the concept of a public benefit organisation.
- In March 2000 the South African National Lottery was launched and the first disbursements by the National Lottery Distribution Trust Fund were made in 2001.
- The New Companies Act (No. 78 of 2008) came into effect from 1 May 2011. It introduced the non-profit company, "a company incorporated for public benefit", which replaced the Section 21 company.

Dialogue notes that South Africa is unusual – perhaps unique – in that black economic empowerment legislation requires that companies spend 1% of profits after tax as CSI. However, the new codes introduced in 2015 reduce the number of BEE points to be earned through traditional CSI, instead emphasising development of suppliers and small business.

Dialogue has conducted annual research into corporate social investment (CSI) every year since 1998. The report on the 17th round of research in 2014 brings together findings from a survey of 99 companies, and an online survey of 171 NPOs. Among the surveyed firms, financial services account for 22% of respondents, followed by retail and wholesale (13%) and other manufacturing (12%). More than half of responding companies (58%) employed fewer than 5 000 staff. Nearly two-thirds (65%) earned more than R1 billion in revenue during the year.

Among the surveyed NPOs, 32% employed more than 50 people while 34% employed less than ten people. The proportion receiving more than R20 million was 14%.

By extrapolating from available data on CSI expenditure of large South African companies and state-owned enterprises, Dialogue estimated that total CSI expenditure in South Africa amounted to R8,2 billion in 2013/14. In its first handbook in 1998, Dialogue estimated annual CSI expenditure at about R1.5 billion.

The 2014 estimate includes both cash and non-cash contributions as well as expenditure on social causes as a result of operating conditions, and expenditure by non-CSI

²¹⁸ Matthews M. 2014. The Dialogue CSI Handbook 2014, 17th edition. Dialogue: Cape Town.

departments. Non-cash CSI includes the value of donated products and services and the time spent by employees in volunteering. Only 31 companies account for half of total CSI expenditure, and the 100 largest CSI spender accounts for 70% of the total. Companies falling under industry sector charters tended to give more than other companies.

After adjusting for inflation, estimated CSI expenditure in 2014 had stagnated when compared to 2013. In 2015, Trialogue again reported a decrease in CSI spending – this time in both nominal and real terms.²¹⁹ This was the first time that this had happened in Trialogue’s 18 years of monitoring CSI spend. The decrease amounted to 6% in real terms, i.e. after controlling for inflation.

However, among the surveyed companies for 2014, mean CSI grew from R10,2 million in 2013 to R14,4 million in 2014. This suggests that the sample might be biased towards the “better” and more loyal givers. (Triologue does not report non-response rates.) Increases or decreases in profits were the most common reasons for increases or decreases in CSI expenditure. However, this reason accounted for 35% of increased CSI but 52% of decreased CSI.

More than two-thirds (69%) of corporates supported projects in Gauteng. Each of the other eight provinces received support from at least a quarter of the corporates, but none received more than 13% of total expenditure. Projects spanning more than one province accounted for 29% of funding.

About three-quarters (73%) of corporates gave to more than ten organisations and 24% made more than 100 individual grants during the year. On average, companies invested in between four and five development sectors. The overwhelming majority (94%) gave to education and 49% of CSI expenditure went to education initiatives. In 1998, Trialogue reported that 54% of CSI spend went to education.

On the NPO side, 50% of respondent organisations work in Gauteng. Overall, the mean number of provinces worked in was three, and 18% of the NPOs also worked outside South Africa. Trialogue warns that the profile statistics change substantially from year to year suggesting that they may be skewed by a particular year’s sample.

CSI does not always involve funding for NPOs as money can be channelled elsewhere. However, for the first time since Trialogue started doing these surveys, all the corporate respondents channelled some CSI funding through NPOs, while 70% funded government institutions such as schools, universities and hospitals. On the NPO side, CSI funding accounted for 22% of income, followed by 16% from private individuals and 11% from the South African government, with only 4% from foreign governments. (The picture might be different if restricted to social service NPOs.) However, 63% of NPOs generated some of their own revenue by selling training and 44% by providing other services. The National Lotteries Board was the most common source of decreased funding (42% of respondents), followed by foreign governments (34%).

Well over a third (39%) of NPOs reported that they received corporate support for only one year at a time. Similarly, corporates reported that nearly two-thirds of their

²¹⁹ Vicente A. 2015. “Spend down, impact up” in CSI Year in Review. Supplement to the Mail & Guardian, 23 December 2015-7 January 2016.

non-flagship projects are supported for less than three years. Only 28% of corporates funded costs such as monitoring and evaluation, and only 10% funded research.

Among the NPOs, 79% were registered with DSD and 65% reported that they had Section 18A (public benefit organisation) status.

The Trialogue survey identified social and community development as the second biggest CSI sector, after education. Social and community development was supported by 77% of corporate respondents and received 16% of budgets. In 1998, in the first Trialogue survey, social development also received the second-largest share of CSI funding, with 12% of CSI budgets.

In 2014, for the 71 respondents reporting detail of social and community development funding, the foci were as follows:

- 51% Support for welfare organisations
- 19% Infrastructure, facilities and equipment
- 15% Job creation programmes
- 8% Awareness programmes
- 7% Other interventions

The breakdown in terms of target groups was as follows:

- 33% Orphans and vulnerable children
- 12% People living with HIV/Aids
- 11% Non-specific beneficiaries
- 8% Unemployed
- 8% People with disabilities
- 6% Victims of violence and abuse
- 4% The aged
- 3% Homeless people
- 2% Animals
- <1% Prisoners and former prisoners
- 13% Other beneficiaries

In 1998, the top four priorities were (a) education and skills development of personnel from welfare organisations; (b) self-sustainability and economic empowerment in communities; (c) care of the aged; and (d) HIV & Aids counselling.

In 2014, food security and agriculture was the fourth most common sector, with support from 42% of companies, amounting to 7% of CSI spend. More than a third (34%) of the funding went to subsistence farming initiatives, including food gardens, and 29% went to food relief and feeding schemes.

Safety and security initiatives received only 1% of CSI expenditure.

9.5.1 Pay and conditions of work

Until 1997, employees in welfare organisations – alongside domestic workers – were not covered by standard labour law instruments. In particular, clause 2 of the Basic Conditions of Employment Act (no 3 of 1983) excluded from the definition of employees, among others, “any person employed by an institution as defined section 1 of the Children’s Act, 1960” as well as “any person employed by any organization registered or deemed to be registered as a welfare organization in terms of section 13 of the National Welfare Act, 1978 (Act No. 100 of 1978), which receives financial aid from the State, in respect of his employment as such.” In contrast, clause 1 of the Basic Conditions of Employment Act (no 75 of 1997) (BCEA) defined the term “employee” to include “any person, excluding an independent contractor, who works for another person or for the State and who receives, or is entitled to receive any remuneration.”

The 1997 BCEA meant that NPOs were now expected to comply with a range of stipulations in respect of working conditions, including limits on hours of work, leave and the like. Many welfare organisations reported difficulties in complying with these conditions. In 1999 the Minister of Labour issued an interim ministerial determination which exempted employers in the sector from paying overtime. The Minister of Labour then asked the Department and Employment Conditions Commission to advise him on a possible ministerial determination that would “vary” (amend) the required conditions for the sector. A series of public hearings were duly held in mid-2000, and a total of 36 written submissions made. Of the latter, 28 were from employers (organisations) or employer forums or representative organisations and three from trade unions.²²⁰

From the employer side, the concerns related mainly to hours of work and work on Sundays. In particular, many organisations providing care for children said that their care workers played a role similar to that of parents and thus needed to be on duty, or at least on the premises and on call, 24 hours a day. Some said that they gave these workers extra leave days to compensate for this (but did not explain who played the parental role during the leave periods). Organisations providing care for older, and particularly frail, people noted that these beneficiaries, too, needed 24-hour care and that complying with a 45-hour week would require introduction of new shift systems and additional workers and would substantially increase costs. Instead some submissions proposed an alternative maximum number of ordinary hours per week.

Some of the organisations noted that workers lived on the premises, and that the work could thus not be regarded as a standard job with the usual clear distinction between work and non-work. Many of the organisations noted that personnel costs accounted for a substantial proportion – often as much as 80% - of their expenditure even before complying with the new legislation. Payment for overtime or additional workers was thus not deemed possible.

Some of the employers making submissions were from private for-profit institutions. These would not have been covered by the BCEA 1983 exemption unless government was subsidising them. The majority of employer submissions were from NPOs. The latter noted that they were heavily dependent on government subsidies, but that the subsidies

²²⁰ There were a few submissions from organisations representing people with disabilities, but these seemed to focus on the need for workers with disabilities to have full protection at work rather than on the core issue,

covered only a portion of their expenditure even before incurring the additional costs that the new legislation would entail. Some noted that the subsidies did not keep pace with inflation – and might not increase at all from year to year. Those which charged fees noted the impossibility of increasing fees so as to be able to cover the additional costs given that most of their beneficiaries were poor.

The submissions from the unions argued against any variation of the BCEA. The National Education Health and Welfare Union (NEHAWU) acknowledged that many organisations were dependent on the government subsidy but noted that because “funding decisions are based on compatibility of policies and plans with identified needs and the provisions of an effective service that meets minimum standards ... we believe that because overtime work is necessary to provide the required care to the e.g. the aged, the subsidy has been allocated with this in mind.”

The union submissions tended to focus on old age homes. This probably reflects where the bulk of their members were found, and would include private for-profit institutions. The National Union of Public Service and Allied Workers explained at some length why they felt that these institutions could well afford better conditions:

It is common knowledge that the so-called Welfare Institutions, particularly the retirement homes were established solely to cater for the aged and retired people who after having raised their children found themselves alone and lonely, more often than not in palatial homes who no longer needed big houses for one thing. Apart from that, Old Age homes do not admit each and every elderly person who would want to stay there, one needs to be able to afford the fees charged for their up-keep. In other words, prospective inmates need to have money in order to make for the institution that accommodates them over and above the subsidies they receive from the government.

The Old Age Homes found it easy to accommodate Lilly-white inmates in that they could afford due to the retirement benefits they got from the decent-paying jobs they occupied as a result of the apartheid era job reservation programme, especially in the Public Service while the overwhelming majority of frail and destitute black elderly could barely afford a roof over their heads. This clearly illustrates that these so-called Welfare Institutions are in fact Luxury Holiday Institutions for the rich elderly privileged Whites and not the other way round.

Workers in most of these Institutions are expected to work inhumanly long hours as they operate twenty-four hours a day seven days a week for wages that would normally be taken for a joke or a stipend while the Institutions are making a killing in terms of turnover which in itself is supplemented by government subsidies and donors.

The effect of these long hours on the workers is oftenly evidenced by broken down families with spouses divorcing on the grounds on work pressure on the one and children turning into street kids and more likely prostitutes and criminals on the other as a result of lack of properly supervised upbringing at home.

In March 2001 the Minister of Labour issued a new ministerial determination for the welfare sector.²²¹ The determination is applicable to “employers who render non-profit social

²²¹ Government of South Africa. 3 March 2001. Ministerial Determination Welfare Sector. Government gazette Vol 429, no 22096. Regulation 7014.

services”, and is therefore not restricted to those receiving government subsidies. It does not cover for-profit operations. The determination provides for the following variations:

- Overtime is limited to 15 (rather than 10) hours per week;
- The employer and worker can agree to ordinary pay for overtime in exchange for one extra week of paid leave per annum;
- The employer and workers can agree, for a period of 12 months, to average hours over a four- month period, but must not have more than 45 ordinary hours and 10 overtime hours per week on average over that period. After two such 12-month agreements, there is no time limit on agreement;
- Ordinary pay can be paid for work on Sundays, but three extra days paid leave must be given per annum if the worker works one Sunday per month, and six extra days leave per annum if she work two Sundays per month;
- Employees can waive their right to a night allowance; and
- Workers on regular standby get one extra week’s leave per year.

The discussions around the ministerial determination related to conditions of work, not to minimum wages. But – as seen above – even without considering wages the issue of the government subsidy and the cost of providing a service – and particularly a residential service – was core to the discussion. The arguments advanced by Free State DSD in the NAWONGO case as to why NPOs could operate at lesser expense than government facilities providing the same services are interesting in this respect in terms of what they imply for NPO employees’ pay and conditions of work, as well as the expectations of family members of employees and even beneficiaries. Paragraph 41 of the DSD representative’s affidavit read as follows²²² :

The discrepancy which exists between the level at which the Department funds the residential care facilities which it operates, and that at which it subsidises such facilities operated by NPO’s is necessitated by the differences in their composition and functioning, the most significant of these being that whilst:

41.1 children’s homes run by NPO’s are invariably located in a satellite house, where 10 - 12 children live under the care and supervision of a married couple of which one of the spouses is employed by the NPO, government facilities are larger in order to allow them to accommodate a far greater number of children (up to 170 children in certain facilities);

41.2 government facilities must of necessity employ sufficient numbers of child and youth care workers to enable four shifts to be worked daily in order to render a 24 hour service to the children in these facilities, children’s homes run by NPO’s do not;

41.3 government facilities must of necessity employ sufficient numbers of laundry and cleaning staff, children’s homes run by NPO’s utilise the services of the spouse it employs to render these services, who may have one person assisting her;

²²² Linström, Johannes. June 2010. Affidavit. National Association of Welfare Organisations and Non-governmental Organisations & Other vs Member of the Executive Council for Social Development, Free State & Others. Case No 1719/2010. Free State High Court

- 41.4 *government facilities must of necessity either employ sufficient numbers of catering staff or outsource its catering services to private companies, children's homes run by NPO's utilise the services of the spouse it employs to render these services, who may enlist the assistance of the older children in the house for this purpose;*
- 41.5 *government facilities are obligated to provide their employees with remuneration and benefits negotiated at the Public Service Bargaining Council, such as medical aid, housing allowances, Sunday allowances, night duty allowances and security allowances, children's homes run by NPO's do not have expenses that are so determined or include such benefits;*
- 41.6 *government facilities are obligated to provide around the clock security and access control services for the buildings and their surrounds, children's homes run by NPO's do not have these expenses;*
- 41.7 *government facilities are obligated to employ private contractors to provide garden services in respect of their facilities, the children often perform this function in children's homes run by NPO's;*
- 41.8 *government facilities do not receive donations of any kind, children's homes run by NPO's invariably receive a wealth of donations in the form of money, clothing, furniture, services and the like.*
- 41.9 *government facilities are not permitted to solicit donations of any kind, NPO's are not precluded from so doing;*
- 41.10 *government facilities are not permitted to utilise volunteers, NPO's are not precluded from so doing;*
- 41.11 *government facilities are obligated to utilise the Department of Public Works for the repairs and maintenance of their equipment and facilities, whom they must remunerate at fixed tariffs, similar repairs and maintenance in respect of NPO facilities are frequently performed free of charge by volunteers;*
- 41.12 *government facilities are obligated to utilise vehicles which it must rent at fixed tariffs from the Government Garage, whilst transport for inhabitants of NPO facilities is often provided either by the house mother or volunteers;*
- 41.13 *government facilities must of necessity employ large numbers of administrative personnel, due to the labour intensity of the various prescribed systems which government institutions must implement. Whilst government's systems mandate the segregation of duties, many, if not all of these duties are performed by the same person in respect of NPO facilities;*

41.14 government facilities are obligated to employ staff additional to the staff establishment, in order to facilitate the absorption into the system of officials previously employed in the TBVC countries, as the cost attendant upon their retrenchment would be prohibitive.

Some welfare work has been declared an essential service.²²³ Such a declaration restricts the right of employees to strike. The services which have been declared essential are those provided by registered old age homes, children's homes and places of care, and work related to SOCPEN and payment of grants.

Minimum wages for "volunteers"

The Employment Conditions Commission (ECC), which advises the Minister of Labour on minimum wages and conditions for vulnerable workers, received representations from unions for a sectoral determination for the welfare sector in the early 2000s. From the start, it was clear that there was a serious tension caused by the fact that many of the non-profit welfare organisations which employed the majority of workers in the sector were dependent on funding from government, in particular, DSD. The fact that DSD payments to these organisations did not fund the full amount of even the existing low wages added to the complication.

After research (including a survey) and public hearings around 2007, a draft report was tabled at the ECC in 2012.²²⁴ The Department of Labour (DOL) had engaged Treasury on the impacts of a sectoral minimum wage and Treasury expressed a concern about the possible fiscal impacts, given that much of the sector is funded by government. DOL therefore recommended to the ECC that there should not be a sectoral determination and that instead the sector should continue to be governed by the Basic Conditions of Employment Act, with some sections of the sector being covered by the EPWP Ministerial Determination. The ECC did not accept the DOL's recommendations and said there should be further engagement between Treasury, DSD, and the DOL. This did not happen.

In the meantime, DOL became concerned about regulation of volunteers and attempted to source information through the ILO. When this yielded little information, in 2014 TORs were drawn up for research into the issue by or through the DOL's Research Department. The Acting Director-General did not want to pursue the matter. After the ECC insisted, they were told that the national minimum wage discussions meant that the issue, as well as revision of existing sectoral determinations, should be put on hold.

There was a parallel process led by DOH in collaboration with DSD of drawing up a policy on community caregivers. The policy was targeted at workers employed by NPOs who were not registered with professional bodies and was seen as an alternative to a "labour determination". The process included consultations and went through a large number of drafts. The draft policy would have prohibited people working as volunteers on a long-term basis. In terms of remuneration, it envisaged standard stipend rates for learner community care workers (CCWs), CCWs and supervisor CCWs that would be fully covered by DOH and DSD transfers to NPOs, and that would be adjusted on an annual basis in line with inflation. The proposed CCW rate for 2010 was R1 500 per month for a full-time worker. However, the policy process appears to have got stuck or been abandoned.

²²³ <http://www.ccma.org.za/FAQView.asp?ID=87>, accessed 6 January 2016.

²²⁴ Information from Jane Barrett, member of Employment Conditions Commission.

Among countries which have a national minimum wage, Syria is the only one known to exempt welfare workers. The Syrian exemption applies to employees of charitable organisations among 100 categories that are excluded from coverage.²²⁶

Australia sets minimum wages and conditions of work through awards. The awards are in some ways similar to South Africa's sectoral determinations, but tend to be far more detailed. In particular, they set wages for different levels of worker while sectoral determinations tend to focus only on the minimum wage for the lowest paid workers in a sector.

Australia's Social, Community, Home Care and Disability Services Industry Award 2010 covers a sector defined as:

the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services

It covers employers in the social and community services sector alongside the crisis assistance and supported housing, home care and family day care scheme sectors. It would therefore cover NPOs delivering welfare and social development services. It explicitly covers workers hired through labour brokers ("on-hire"), as well as part-time and casual workers.

The award provides for minimum wages for levels and "pay points" for each of a range of different types of workers – social and community service employees, crisis accommodation employees, family day care employees, and home care employees. The levels relate to skills and experience, while the pay points provide for progression within levels. Level 1 for a social and community services sector employee is described as someone who "works under close direction and undertakes routine activities which require the practical application of basic skills and techniques. They may include the initial recruit who may have limited relevant experience." A level 8 employee "will operate under limited direction and exercise managerial responsibility for various functions within a section and/or organisation or operate as a specialist, a member of a specialised professional team or independently". Such an employee will usually have completed a degree and have "extensive" relevant experience.

As from July 2015, the minimum weekly pay for level 1 pay point 1 social and community service employees is AUD\$ 714.40 (R7 881 at exchange rate of 11.032). The only lower level specified is for home care level 1 employees, at AUD\$ 707,00 per week (R7 780). The weekly minimum for pay point 1 for a level 8 social and community service employee is AUD\$ 1 226.70 (R13 533).

Australian commentators²²⁷ discuss reasons why wages for female-dominated occupations, including the social and community service workers, tend to be low. They suggest that standard approaches to economic analysis are based on invalid assumptions

²²⁶ Kirsten Sobeck, International Labour Office Geneva, personal communication, January 2016.

²²⁷ Austen S and Jefferson T. 2015. "Economic analysis, ideology and the public sphere: insights from Australia's equal remuneration hearings" in Cambridge Journal of Economics 39: 405-419.

that result in under-valuation of, and thus unfairly low wages for, such work. They note, among others, that the usual forces assumed to be at play in economic exchange are missing when the beneficiaries (“consumers” in economic terms) are not those who pay for the service. This undermines theories as to what determines market value. Meanwhile the nature of care poses difficulty for determination of “productivity”, which is often assumed to be what determines the wage

EPWP has funded a relatively substantial number of work opportunities within different types of welfare services, including ECD, child and youth care (including Isibindi), victim empowerment, and youth development. Apart from KwaZulu-Natal, the EPWP workers are generally employed by NPOs who receive subsidies for the wages. The working conditions and payments for EPWP have become more carefully regulated over the years, with the introduction of a ministerial determination in 2009. However, there are reports that government funding of NPOs is not always aligned with the minimum EPWP wage level. Even where there is alignment, these work opportunities remain precarious, and are funded only on an annual basis. Opportunities funded by donors are similarly subject to unreliable funding, as well as changes in donor priorities, which have affected the HIV and AIDS sector in particular.

9.6 NPO regulation²²⁸

The most recent annual report under the NPO Act suggests that South Africa’s legislative framework on NPOs “is the most progressive internationally.” Nevertheless, there are sufficient challenges related to NPO registration that the Department of Performance Monitoring and Evaluation has commissioned an evaluation of the NPO regulatory system.

The NPO Act (no 71 of 1997), which was passed in the same year as the White Paper was published, provides for voluntary registration of NPOs. Its origins date back to discussions starting in 1992, or even earlier, with the process led after 1994 by the then Department of Welfare.

In the second half of 2004, at a point where more than 38 000 NPOs had been registered, Umhlaba Development Services was commissioned by DSD to conduct an NPO impact assessment.²²⁹ Currently, DNA Economics is undertaking a similar NPO regulatory impact assessment commissioned by the DPME. Many of the findings of the current assessment are likely to be similar to those of ten years ago as the regulatory environment has not seen substantial changes.

The 2004/05 assessment report records the following four principles for an enabling environment agreed at a workshop that brought together representatives of NGO coalitions from Africa and beyond:

- The legislative framework should promote the independence of civil society, not control it;
- The regulatory framework should allow state intervention only when absolutely necessary
- The law should promote accountability of NGOs without placing on them undue burdens, and
- The law should be simple and user-friendly.

²²⁸ Department of Social Development. 2015. 2014/15 State of South African Registered Nonprofit Organisations. Pretoria

²²⁹ Umhlaba Development Services. 2005. NPO Impact Assessment. Department of Social Development: Pretoria.

The 2004/05 assessment concluded that there had been a high impact in the administrative and regulatory environment, less impact on standards in the NPO sector, and little impact on government-donor-NPO relationships. It noted a lack of clear definition of the benefits of registration. It noted repeatedly that larger NPOs benefited more than small ones from the legislative provisions of both the NPO Act and provisions of other legislative and regulatory instruments (including taxation), and that the “one-size-fits-all” approach of the NPO Act was inappropriate. However it noted, also, that small organisations interviewed generally felt that the environment for civil society participation in the general development arena had improved. In contrast, another study of NPOs that had previously been registered under the Fundraising Act found that these more established NPOs felt that the NPO Act had not brought about a change in the environment. Corporate social investment representatives interviewed for the 2004/05 study focused on the benefits, such as taxation, to corporates rather than for NPOs.

The 2004/05 assessment commented on a “general lack of capacity within NPOs to manage their affairs, and to deliver quality services” and, in particular, poor standards in financial reporting. Among NPOs in the health and welfare (social development) sector it found concerns around lack of transparency in awarding of subsidies for services delivered. Further, welfare organisations that had received government support prior to 1994 now received less funds than previously, threatening their sustainability.

NPO registration is not the only type of registration open to, and sometimes required of, NPOs. Those NPOs that deliver services are often required also to register for that particular service (such as early childhood development). NPOs may also choose to register as a company, trust or cooperative. The 2004/05 assessment suggested that the “fragmented” regulatory environment was, counter-intuitively, enabling as organisations could choose which registrations were in their best interests.

Twelve out of the sixteen funding organisations interviewed for the 2004/05 assessment did not require NPOs to be registered before they funded them. NDA and Umsobomvu did require this, but the National Lottery did not.

As part of the review process, Ministerial Committee members conducted site visits in two districts in each province to assess the legal, financial, human resource, programme, partnership, monitoring and evaluation (M&E), and transformation at selected NPOs as well as some government service delivery sites. Of the 146 sites visited, 71 were registered NPOs of some kind. An extract of the findings emerging from the site visits is provided in the text box below.

Findings from site visits

Many of the governing bodies or management met on a regular basis. There were, however, at least six NPO sites where there was no governing body, or the board did not meet regularly or was not representative of the community or of beneficiaries. This was a relatively small number of the total NPOs. There were also four sites – primarily development projects – which were noted as defunct (once again a relatively small number).

At least 102 of the sites were given a clean bill of health on financial governance and management issues. At the other end of the scale, four sites (in addition to the four dysfunctional ones) were recorded as not performing at all in this area. A range of sites acknowledged that funding was inadequate, and there were at least four non-government sites where government was said to be the only source of funds.

There were no human resource inadequacies in at least 109 of the sites, but definite problems in 17 sites. On collaboration and integration, 121 of the 128 sites for which there was a response recorded that there was collaboration of some sort with other stakeholders. However, one of these noted that the partnership was only with DSD, while another noted that their partnership with the Department of Education was "slow". Among those for whom partnerships with government were specified, Department of Health was named nine times, Department of Education three times, and South African Police Service twice. The Departments of Justice and Constitutional Development, Correctional Services, Home Affairs and [provincial?] Safety were each named once. SASSA was named twice. The fact that the Lotto was named as a partner for one site suggests that the term was interpreted broadly in some cases to include funders.

At least 79 of the sites were reported to have adequate and/or appropriate infrastructure, with 44 having inadequate or inappropriate infrastructure. Performance on this aspect was thus weaker than on some of the other aspects. At least 36 sites were said to perform well on all aspects of transformation (i.e. racial integration, service delivery "to other communities", "integration" of services, and employment equity).

9.7 NPO registration

By the end of March 2015, the number of organisations registered since the inception of the NPO Act was 136 453. This is 16,5% (from 117 093) more than one year earlier (117 093). Gauteng province had the most registered NPOs at 32,2% followed by KwaZulu-Natal with 19,2%, Limpopo 10,4% and Western Cape with 10,2%. The Northern Cape had only 2.1%.

Of the total number of applications for registration received in 2014/15, 21 092 (72%) were eventually registered and 8 338 (28%) did not meet the requirements of sections 12-13 of the NPO Act. There were 42 voluntary and 9 non-voluntary deregistrations in 2014/15 – a tiny fraction of the total number of registered NPOs. These numbers are not confined to NPOs in the social development area.

Sections 18 and 19 of the Act state that registered organisations must submit, within nine months of the financial year end, annual reports (a narrative report, annual financial statement and an accounting officer's report) including any changes to the organisation's constitution, physical address and office bearers. The report records a total of 75 919 non-compliant as against 60 534 compliant NPOs. Unfortunately, it does not indicate whether non-compliance primarily takes the form of non- or late submission of reports or something more serious. (It is also possible that in some cases NPOs submitted reports that were mislaid.) The fact that a moratorium was placed on deregistrations in 2012 makes it difficult to interpret compliance rates as many of the organisations on the register may no longer be operational. The non-reported compliance rate was much higher among voluntary associations (which account for 93% of all registered NPOs), which are likely to be smaller and/or less formal, than among not-for-profit companies. Unfortunately, there are not separate statistics on compliance among social development NPOs and, in particular, among those funded by DSD.

During the Ministerial Committee's engagements, across many provinces a range of issues was raised relating to compliance. Northern Cape DSD said that NPOs did not always submit the required reports, but also noted that the compliance requirements might require a higher capacity than was common for NPO personnel. In Limpopo and Mpumalanga government representatives commented on poor compliance by NPOs with various requirements for funding, resulting in deregistration. The Mpumalanga representative said that the NPOs had responded by blaming government for lack of support, and it had therefore allocated an official to each organisation. The Gauteng government reported that management boards of NPOs were sometimes inactive.

In addition to concerns around compliance, Government officials across several provinces noted problems related to the logistics of NPO registration, including the suggestion that this should be handled at district rather than provincial or national level. In North West practitioners (mainly DSD officials) reported the establishment of local and district NPO forums had provided support for registration and compliance and enabled more organisations to access funding from donors. Also in North West, practitioners in one district noted slow turnaround times at province level for registration for specific services, such as ECD and service clubs. Northern Cape DSD reported that NPO registration was done on-line and "does not take too long".

Registered NPOs are grouped, accordingly to the International Classification of Nonprofit Organisations. Social Services is the leading sector with 39,9% of the total, followed by development and housing (20,9 %). The sub-categories of social services are shown in Table 84.

Table 84: Social service categories of ICNPO

Objective	Theme	Description
Emergency and Relief	Refugee assistance	Organisations providing food, clothing, shelter and services to refugees and immigrants
	Temporary shelters	Organisations providing temporary shelters to the homeless, includes travellers aid, and temporary housing
	Disaster/emergency prevention and control	Organisations that work to prevent, predict control and alleviate the effects of disasters, to educate or otherwise prepare individuals to cope with the effects of disasters, or provide relief to disaster victims, includes volunteer fire departments, life
Income Support and Maintenance	Material assistance	Organisations providing food, clothing, transport and other forms of assistance, includes food banks and clothing distribution centres
Income support and maintenance	Temporary shelters	Organisations providing cash assistance and other forms of direct services to persons unable to maintain a livelihood
Services to Children	Disaster/emergency prevention and control	Services to children, adoption services, child development centres, foster care, includes infant care centres and nurseries
	Child protection	An organisation involved with identifying, reporting and supporting abused and neglected children. Also provides for placement of children in foster care.
	ECD and Partial Care Centres	A place that cares for more than 6 pre-school children for part of the day. It is non-residential. ECD services include crèches, pre-schools & day-care centres & also; <ul style="list-style-type: none"> • After-school supervision & partial care for children of all ages • ECD outreach program
	Temporary Safe Care/ Place of Safety	A facility where vulnerable or orphaned children are placed by court orders in cases of emergency. These are usually short term until permanent alternative arrangements are made.
	Secure Care	A facility for children who are awaiting trial or sentence or have been sentenced.

Objective	Theme	Description
	Children's Homes	A facility for the provision of residential care to more than six children outside their family's environment. Also known as an orphanage or child and youth care centre (CYCC). They accommodate:
	Homes for Children with Special Needs	A facility for children with psychological and emotional difficulties, disabilities, chronic illnesses, alcohol or drug addictions, psychiatric conditions or who need assistance with the transition when leaving the centre at the age of 18.
	Schools of Industry/ Reform Schools	A residential facility where children with behavioural difficulties are sentenced to by the Children's or Criminal Court.
	Community-Based Care Services for Children	Drop-in-centre/ISIBINDI. A drop-in centre is a community-based, non-residential facility providing basic services aimed at meeting the emotional, physical and social development needs of vulnerable children.
	Adoption Services	A facility which helps in the process of adoption. Adoption is defined as a child being placed in the permanent care of a person other than a biological parent, by a court order.
Social Services	Services for the handicapped	Services for the handicapped; includes homes, other nursing homes; transport facilities, recreation and other specialized services.
	Services for the elderly	Organisations providing geriatric care, includes in-home services, homemaker services, transport facilities, recreation, meal programs and other services geared towards senior citizens. (Does not include residential nursing homes)
	Youth services and youth welfare	Services to youth, includes delinquency prevention services, teen pregnancy prevention, drop-out prevention, youth centers and clubs, job programs for youth, includes YMCA, YWCA, Boy Scouts, Girl Scouts, Big Brothers/Big Sisters
	Self-help and other personal social services	Programs and services for self-help and development, includes support groups, personal counseling, credit counseling/ money management services

Objective	Theme	Description
	Family services	Services to families, includes family life/parent education, single parent agencies and services, family violence shelters and services

The NPO summit of 2012 proposed that DSD monitor the number of NPOs registering to deliver the same service to avoid duplication in a particular geographical area. This proposal presumably relates to registration for a particular service rather than simply registering as an NPO. The summit also proposed that DSD improve its document management system to avoid application forms and submitted reports being mislaid.

9.8 Public Benefit Organisations²³⁰

The Income Tax Act (no 58 of 1962) provides for registration of non-profit organisations as public benefit organisations (PBOs) which provides various tax benefits. In particular, it provides that PBOs are not subject to income tax and are also exempt from donations and dividends tax, estate duty, transfer duty, securities transfer tax, skills development levy, and (in part) from capital gains tax. Exemptions from VAT and customs and excise are more limited.

The tax exemption provision is intended to mirror the exemption from income and other taxes enjoyed by religious, charitable and public educational institutions during the apartheid years. Eligibility for PBO status is not confined to organisations registered under the NPO Act, but is also not automatically available for all registered NPOs. Eligibility is determined based on a set of public benefit “activities” listed in the Ninth Schedule to the Act.

PBO status is available to non-profit companies, trusts, association of persons, and branches of foreign organisations that are exempt from income tax in that other country. The sole or principal objective of the organisation must be to undertake public benefit activities and the organisation’s funds must be used only for this objective.

The PBO provisions were introduced in 2001 and have undergone several amendments since that date. Initially organisations lost their PBO status if they engaged in trading or business activities beyond narrowly defined boundaries. An amendment in 2006 provides that a PBO can be partially exempt from taxation for the non-trading/business activities while the latter are subject to tax. Nevertheless, the restrictions continue to call into question recommendations that NPOs should all become self-sustaining through income generation activities.

In addition to exempting PBOs from tax, the Income Tax Act also provides for organisations to apply for section 18A status. This status entitles their donors to a tax deduction in respect of the donations. Previously these deductions were only available for donations to secondary and tertiary educational institutions. There is now a much longer list of eligible activities, and the maximum deductible amount has also been increased.

²³⁰ South African Revenue Service. 2014. Tax Exemption Guide for Public Benefit Organisations in South Africa (Issue 4). Pretoria.

A PBO that is a non-profit company must comply with the requirements of the Companies Act, but trusts and associations with PBO status are not automatically required by SARS to have their financial statements completed by a qualified accountant.

The broad categories of public benefit activities listed in the Ninth Schedule are as follows, with those shown in *italics* also eligible in respect of Section 18A status:

- Welfare and Humanitarian
- Health Care
- Land and Housing [not all in Part II]
- Education and Development
- Religion, Belief or Philosophy [not in Part II]
- Cultural [not in Part II]
- Conservation, Environment and Animal Welfare
- Research and Consumer Rights [not in Part II]
- Sport [not in Part II]
- Providing of Funds, Assets and Other Resources [not in Part II]
- General [not in Part II]

The more detailed sub-categories for the activities most relevant for social development are as follows:

Welfare and humanitarian

1. (a) The care or counselling of, or the provision of education programmes relating to, abandoned, abused, neglected, orphaned or homeless children.
- (b) The care or counselling of poor and needy persons where more than 90 per cent of those persons to whom the care or counselling are provided are over the age of 60.
- (c) The care or counselling of, or the provision of education programmes relating to, physically or mentally abused and traumatized persons.
- (d) The provision of disaster relief.
- (e) The rescue or care of persons in distress.
- (f) The provision of poverty relief.
- (g) Rehabilitative care or counselling or education of prisoners, former prisoners and convicted offenders and persons awaiting trial.
- (h) The rehabilitation, care or counselling of persons addicted to a dependence-forming substance or the provision of preventative and education programmes regarding addiction to dependence-forming substances.
- (i) Conflict resolution, the promotion of reconciliation, mutual respect and tolerance between the various peoples of South Africa.
- (j) The promotion or advocacy of human rights and democracy.
- (k) The protection of the safety of the general public.
- (l) The promotion or protection of family stability.
- (m) The provision of legal services for poor and needy persons.
- (n) The provision of facilities for the protection and care of children under school-going age of poor and needy parents.
- (o) The promotion or protection of the rights and interests of, and the care of, asylum seekers and refugees.
- (p) Community development for poor and needy persons and anti-poverty initiatives, including—

- (i) the promotion of community-based projects relating to self-help, empowerment, capacity building, skills development or anti-poverty;
 - (ii) the provision of training, support or assistance to community-based projects contemplated in item (i); or
 - (iii) the provision of training, support or assistance to emerging micro enterprises to improve capacity to start and manage businesses, which may include the granting of loans on such conditions as may be prescribed by the Minister by way of regulation.
- (q) The promotion of access to media and a free press.

Health care

2. (a) The provision of health care services to poor and needy persons.
- (b) The care or counselling of terminally ill persons or persons with a severe physical or mental disability, and the counselling of their families in this regard.
- (c) The prevention of HIV infection, the provision of preventative and education programmes relating to HIV/AIDS.
- (d) The care, counselling or treatment of persons afflicted with HIV/AIDS, including the care or counselling of their families and dependants in this regard.
- (e) The provision of blood transfusion, organ donor or similar services.
- (f) The provision of primary health care education, sex education or family planning.

Education and development

- (h) The provision of educare or early childhood development services for pre-school children.

Cultural

- (c) The provision of youth leadership or development programmes.

9.9 Education, training and skills development

The White Paper proposed that “effective training programmes [and] accreditation systems” be developed, as well as clear definitions of the roles and responsibilities of social workers and other categories of workers. It envisaged scope for specialist workers alongside generic and development-oriented workers. It proposed a five-year strategic plan be developed to reorient existing workers towards developmental approaches.

9.9.1 Updating the White Paper

Education, training and skills development remain critical for the provision of social development services across government, NPOs and the private sector. Meeting the scarce skills demand in the social development sector requires urgent attention. The need for a wide range of generic and specialised social service workers to meet current and future demands in the social development sector was highlighted in the NDP. Existing social conditions alongside new risks and vulnerabilities arising from changes in the social and economic context create an environment for the care and treatment interventions

to be relevant, responsive and based on contextually different approaches. Universities and other tertiary programmes experience difficulties in designing curricula content and providing education to meet the changing social and economic conditions given the limited pool of academics in social development and the scarce skill environment in South Africa.

9.9.2 Findings of the Ministerial Committee

Today, all universities except the very newly established universities in Northern Cape and Mpumalanga provide social work qualifications. All universities have moved from teaching traditional social work methods to a more DSW approach. All have introduced curricula changes to be more responsive to the South African higher education context and the South African Council for Social Service Professions (SACSSP).

9.9.3 Social work and social development qualifications

A national review of all social work education providers conducted by the Council for Higher Education in 2013 found that although most higher education institutions have aligned with the Bachelor of Social Work requirements of the South African Qualifications Authority, there are differences in the quality of the degrees, in the throughput rates, in the resources that are available and in the course outcomes and graduate attributes. These differences, especially at universities with high numbers of students and fewer resources, have a direct effect on the quality of social work graduates and their capabilities to deliver professional social development services in practice. While the quality of social development professional education varies across South Africa, the CHE has developed standards for the Bachelor of Social Work and these standards are being used to ensure that educational providers are able to set their qualifications within specified minimum criteria that will ensure graduates acquire knowledge, skills and attributes that equip them to function professionally.

Some universities have introduced both social work degrees and social development curricula at undergraduate and postgraduate levels to ensure a wider mix of social service professionals who are capable of responding to the need for therapeutic interventions as well as interventions designed to address structural conditions. For example, the University of Cape Town has a Bachelor of Social Work degree and a Social Development major towards a BSoc Sc degree. These undergraduate programmes articulate with postgraduate specialist degrees in social work and in social development (refer to box).

The Committee finds that the quality of education provided differs across all 20 universities, and many struggle to find placements where students can gain practice-based experience to implement a developmental rather than purely statutory approach. There is also a serious shortage of competent supervisors. The increase in the number of students resulting from the bursary programme has exacerbated challenges in finding placements for the practical component of the learning programme.

Lessons of experience: Some highlights in transforming curricula content

The Department of Social Development of the University of Cape Town took into account the changes that had taken place in the broader South African socio-economic and political context in the transformation of its degrees. Thus the curriculum content reflects theories and practices that could address the social and economic needs of individuals, families and communities who are trapped in widespread poverty and growing inequalities.

The overall design balances the need for an Afro-centric focus as well as relevance for professional social development practice in a globally competitive environment. Students who graduate with a social development undergraduate degree as well as social work graduates have the option of enrolling for a specialist Honours degree in Social Development. This acts as an entry into a Master's in Social Development and a PhD in Social Development. Included in the development-oriented curricula are courses in community/youth development, social inclusion, comparative social policy in Africa, social and economic development and development planning amongst others.

The university has also introduced specialist professional degrees in Social Policy & Management at both Honours and Master's degree levels to address key concerns in the social services sector such as transformative leadership and financial management. The need to provide probation and correctional officers with further theory and practice skills in youth justice and forensic practice is addressed in the Probation & Correctional Services Honours and Master's degree. Challenges related to youth exclusion, poverty, inequality in major sectors such as health, welfare, education and employment are the foci of concern in the Social Development Honours Master's degrees. The Clinical Social Work Honours degree focuses on substance abuse prevention and treatment. The Master's degree in Clinical Social Work focuses on responses to psycho-social trauma in the context of individual, family and community functioning, mental health care and the care of survivors of violence.

Other university-based programmes are also promoting more responsive social development curricula and are introducing indigenous knowledge systems relevant to the South African context.

9.9.4 Inadequate funding of social work and social development

University-based educators expressed concerns about the funding formula for universities and urged that it be amended so as to provide a higher level of funding for professional degrees such as social work and related degrees in the social service professions because of the critical role of such professionals who provide essential services. Changes in the funding formula should allow for better staff: student ratios that will allow for teaching- and supervision-intensive arrangements. Additional funding is urgently required to support growth of specialised postgraduate programmes in critical areas such as social development with an emphasis on youth and community development, substance abuse, probation and corrections and social policy and management. Such

additional funding will be used to promote better articulation from undergraduate through to specialist degrees as a response to new and deepening social challenges. It will also increase the pool of professionals in the social development sector as well as the research and teaching pool of academics from which the university sector can draw. In the sections that follow an overview is provided of the issues raised both by educational providers within the university sector as well as the sector education and training authorities that engaged with the Committee during the review process.

The university funding formula consists of several different components.²³¹ The formula allocates additional money if there are increased numbers of enrolments (volume/teaching input) and/or graduates (teaching outputs), as one would expect if bursaries were provided. Both these increases can be expected as a result of the social work bursary scheme.²³² The size of the increase depends on the overall amount allocated for tertiary education funding, the relative increases in other institutions, and the funding band in which a particular course of study falls. Social work currently falls in the lowest funding band as it is part of Classification of Educational Subject Matter 19. The Minister's declaration that a particular profession is a "scarce skill" does not affect the university funding formula.

9.9.5 The sector education and training authorities and social development

The skills development system, and in particular the sector education and training authorities (SETAs), constitute a funding source for education and training. In 2014/15 DSD received R2,93 million from the Health and Welfare Sector Education and Training Authority (HWSETA) in respect of various study courses for its employees.²³³ Its contribution to the SETA for the same year was R1 128 million. Government departments do not pay levies, but are required to contribute to SETA funding. A Cabinet circular of 2013 increased the requirement from 10% to 30% of their training budget. In turn, the training budget is set at 1% of the total personnel budget.

During the round table with the education and training sector, the Ministerial Committee heard that the bulk of the HWSETA's funding came from the health sector as most employers on the welfare side were levy-exempt. The SETA was, nevertheless, willing to fund training but struggled to do so at any scale, in part because the welfare sector lacked the skills, knowledge and/or inclination to submit proposals.

Meanwhile, many provinces report inadequate training budgets. In addition to the workplace skills plan, provinces are required to produce an annual training report showing training provided to employees. Training challenges should also be discussed in the HR plans.

Eastern Cape's HR plan for 2013-16 notes that it targeted few employees for training because it had not conducted a skills audit on which to base its training interventions.²³⁴ Free State's plan raised concerns about an inadequate training budget, but the province

²³¹ Information provided by Hardy Maritz and Jane Hendry

²³² The portfolio committee's Budgetary Review and Recommendation Report on the 2014/15 DSD budget notes that they were informed in their visit to the Eastern Cape that 661 social work bursary graduates had not been absorbed, despite policy that states that they must be absorbed within three months of graduation.

²³³ Department of Social Development. 2015. Annual Report 2014/15. Pretoria.

²³⁴ Eastern Cape Department of Social Development. HR Plan for the period 2013-2015.

also incurred fruitless expenditure when some of the nominated trainees did not attend training. The province also mentioned the need for a training needs analysis.²³⁵ Northern Cape had conducted training needs analysis based on the performance of employees and units and asking managers and supervisors to identify gaps.²³⁶ North West highlighted the lack of credit-bearing courses available in the province. Western Cape had youth and staff with long service in the department as priorities for training. None of the provinces mentioned the continuous professional development (CPD) policy in their HR or workplace skills plans.

The HWSETA Sector Skills Plan for 2013/14 sees supervision training for social workers as the “most pressing skills development need”. This would allow social workers to supervise less experienced colleagues as well as social auxiliary workers. The SETA’s plan also acknowledges the importance of the other professional cadres.

9.9.6 Social development and social work professional education and the NDP

The Committee concurs with the NDP that in the immediate and medium term increasing the supply in four categories of social service professionals is required to respond to the demand for appropriate basic social welfare services. The four categories are social workers, auxiliary or assistant social workers, community development workers, and child and youth care workers. In addition specialist education in social development is urgently required. The categories of professionals who should receive specialised education include those in the field of treatment and care of substance addictions, those in probation and correctional practice, those in social policy and management, those in financial management of the social development sector, those who are involved in social development (including development planning, social inclusion and community development and peace-building).

As noted above, the Presidency’s estimate of 18 213 social workers for South Africa in 2014 appears to be based on registrations with the SACSSP and, if so, is an over-estimate because not all registered professionals are working in that profession at any point in time. To meet the demand for welfare provision by 2030, universities need to increase the numbers of students admitted to study social work each year and provide support measures to ensure efficient through-put rates of social work graduates.

Social auxiliary workers require adequate levels of education and training to enable them to work under the guidance of qualified social workers. Tertiary institutions providing such training must comply with the minimum standards and requirements set by the SACSSP and the Council on Higher Education. The accepted ratio for social auxiliary workers to social workers is 5:1. This means that a social worker should not have more than five social auxiliary workers assisting them as more than this compromises the quality of supervision provided to social auxiliary workers and also compromises the quality of care at the service delivery point. It has been estimated that increasing welfare service provision to meet current needs and demands requires that approximately 75 000 social auxiliary workers be brought into the system through a gradual process so that absorption into the employment system does not create additional problems.

²³⁵ Free State Department of Social Development. HR Plan for the period 2015-2017.

²³⁶ Northern Cape Department of Social Development. HR Plan for the period 2015/17.

The recruitment pool from which social auxiliary workers could be brought into tertiary level training includes unemployed youth who have passed grade 12 but who do not qualify for entry to university. A system needs to be designed for auxiliary training and practice to build credits towards a social work degree after a minimum of five years practice as an auxiliary. This would provide the country with a response to the shortages in social work service in the medium term and also become a taproot for growing social work professional numbers in the longer term.

Education and provision of community development professionals is required to ensure efficient service delivery at local community levels with regard to building community structures, responding to crime prevention, youth and adult continuous learning, the promotion of sport, recreation and the facilitation of community cohesion. It is estimated that approximately 10 000 community development workers are employed in provincial and local government settings across South Africa. The quality of their education and training needs to be assessed and aligned with the minimum requirements for professional service delivery. Curriculum development for professional community development practitioners, adherence to minimum standards and assessment criteria are needed within all tertiary education sectors.

Research is required to determine the future demand and supply side issues related to community development practice. The role of community development professionals and their functions need to be clarified. The links between community development and other programme activities also need to be identified and assessed to avoid duplication and misallocation of resources.

Child and youth care professionals who meet the minimum requirements to provide statutory and non- statutory services are required. The current situation of children and youth in South Africa highlights the gaps in service provision for children and youth. Education and training for CYCWs requires a formal educational route beyond the level 4 qualification within the higher education sector with minimum standards for curriculum content and assessments. Formal recognition and accreditation of this category of workers have been achieved but conditions of employment and wages remain a concern.

Human resource development, human resource planning and conditions of work in the government and non-government sectors for the many social service professionals working in the social development sector are an ongoing challenge.

9.10 Partnerships

The White Paper recognised the wealth of knowledge, skills and resources available in government and its partners, and that these needed to be harnessed by the Government and its partners in a restructured welfare system. However, it bemoaned the inequity, fragmentation, duplication of services, deficiencies in capacity and infrastructure, and inadequate collaboration and communication which hampered full utilisation of the available wealth. It noted uneven distribution of skills (and resources) across fields and geographical areas, as well as differences in approach, philosophy, working styles, methods and traditions. Competition over, and unequal access to, financial and other

resources were also a concern, as was the failure of government to accord equal status to the different categories of organisations delivering services.

The White Paper noted that during the apartheid era advisory structures were established at national, regional and local levels in terms of the National Welfare Act of 1978 and other legislation. The structures were, however, neither inclusive nor truly participatory.

The National Development Plan places much emphasis on partnerships. As can be expected given the nature of its focus, DSD works with and encounters a large range of partners in the course of its work. The range of partners presents both opportunities and challenges.

In the mid-2000s, DSD developed the Integrated Service Delivery Model (ISDM). The “integration” in the title refers to the integration of DSD’s three programmes, namely Social Security, Social Welfare and Community Development, as well as the integration of “social intervention with economic development”. The model aims is therefore to provide a national framework that “sets out the nature, scope, extent and level of social services” and that can be used to develop norms and standards for service delivery.

The model identifies four overlapping “levels” of welfare services, namely prevention; early intervention; statutory, residential and alternative care; and reconstruction and aftercare. Welfare services are then further classified into four categories, namely promotion and prevention; rehabilitation; protection; continuing care; and mental health and addiction services. Community development includes women and youth development, poverty reduction programmes, and registration and facilitation of NPOs.

The ISDM document acknowledges, as the start, that “[partnership with organs of civil society remains a key element in the Department’s efforts to ensure optimal functioning and the fulfilment of its mandate.” It sees “developmental services” as the joint responsibility of government, NPOs and the private sector.

9.10.1 Partnership with NPOs

While many different partners exist, perhaps the most central partnership underlying delivery of social welfare services is that between government and NPOs. During the review process, there was widespread acknowledgement of the crucial role played by NPOs in service delivery. The only apparent explicit questioning of their continued role came from the National Association of Social Workers which argued that DSD take full responsibility for delivering social development services and “not rely on NPOs as a pseudo service delivery arm for government. These must be a cherry on top not the backbone for government service delivery.”

The report on the NPO summit organised by DSD in August 2012²³⁷ starts with a strong message of the importance of the NPO contribution, as follows:

Government emphasised the realisation that NPOs are key in the delivery of social services and therefore the need to harness this sector in tackling poverty, unemployment and inequality. The President Mr. JG Zuma addressed the summit emphasizing the importance

²³⁷ Department of Social Development. 2012. National NPO Summit Report.

of partnerships between government and the NPO sector in the pursuit of the common goal of building a better life for all our people.

However, the report also expresses government's concern about:

- "the lack of transformation in the NPO sector especially at community centres"
- The "unacceptable situation" noted by the Minister "where a few large organisations are able to access huge resources whereas many community-based organisations struggle from day to day for survival. Too many well-resourced non-governmental organisations are concentrating their services in urban and well-developed areas of our country while there is a critical shortage of services in poor and rural deserving areas".
- A perception that funds provided by government are used for administration rather than the delivery of services.

Seeming to contradict the third point, the summit recommended that DSD move to funding NPOs rather than programmes so as to "allow the Directors to take decisions about the administrative needs of NPOs."

The summit proposed the establishment of an independent NPO Council "with the view to achieve some level of self-determination from government", but/and also recommended that DSD "lead" the establishment of an NPO sector federation at national, provincial and local level by end 2012.

National DSD's annual report for 2014/15 reports that the Department held consultations on a Partnership Model with relevant stakeholders during the year.

During the Committee's review process, there were many comments on the relationship between DSD and NPOs. A small number of the comments were positive. For example, an Eastern Cape NPO acknowledged assistance from DSD in compiling their business plan and also reported a marked improvement in the relationship over time: "There has been a profound change in the way we interact with one another. It used to be one of trepidation and frustration, but it has evolved into a warm and open relationship." However, the majority of comments on the relationship were negative. Comments were most negative in Free State, but negative comments were offered across all provinces, including by some organisations that elsewhere said that they had a good relationship with DSD.

Some government presentations noted their reliance on NPOs. Limpopo noted that NPOs provide "most of the services in communities". Free State noted that "DSD continues to work closely with NPOs in delivering services." It noted further that NPOs are "looked upon as equal partners within the developmental social welfare services."

These positive comments were counter-balanced by negative ones from frustrated NPOS, with the following as examples of many others: "The NPO sector and DSD relationship is unworkable" (Free State); "While the White Paper recognized and valued the role played by traditional NGOs, the current relationship between the DSD and the NGO sector has sadly deteriorated almost to the point of no communication." (KwaZulu-Natal); "DSD staff's attitude is very unacceptable. DSD staff always assumes the role of 'the most powerful' vs. partnering the sector stakeholders" (Western Cape);

and “Despite raising substantial proportions of their budgets, NPOs are treated as government property by DSD” (Free State). A Northern Cape NPO said that NPO staffs are “branded as ‘second hand servants’ to the nation.” It stated further that NPOs felt that the “precious partnership” with DSD was starting to “fade”. Overall, NPOs experienced the relationship as a top-down one in which government imposed its views. NPOs said that the relationship had deteriorated over time.

In Eastern Cape, there were complaints from the disability sector that government social workers sent people to disabilities to disabled people’s organisations without attending to their needs or providing adequate referral letters. Government social workers were also reported to conduct only one visit per beneficiary, leaving NPO social workers to do all the follow-up tasks, including statutory work.

In the NPO round table convened by the Ministerial Committee participants called for an equal partnership, formalised in a way that allowed NPOs to speak with one voice rather than engaging individually. They noted that such forums existed in some sectors, such as victim empowerment. On its visit to the Eastern Cape, the Committee heard positive feedback on the improvement in the relationship that came about when the province appointed a liaison person with this specific mandate and NPOs, from their side, came together to engage with the person. However, the Committee heard subsequently that this had been a temporary measure and the person was no longer in place.

Round table participants expressed concern about the apparent stalling in 2010 of the development of legislation on the position, role and relationships of NPOs. They complained about the unrealistic workload faced by NPO staff, including a substantial administrative workload associated with the department’s requirements which kept social workers away from delivery. They asked for acknowledgement on the part of government and donors that NPOs cannot be expected to be self-sustainable when delivering services to vulnerable people.

In terms of reporting and accountability, there were some concerns expressed by government and in some beneficiary focus groups around non-accountability of NPOs and the need for better monitoring. These comments presumably related primarily to NPOs funded by DSD. A KwaZulu-Natal government representative observed that NPOs viewed the submission of performance data to DSD “as a form of interference in their financial matters.” Equally, if not more, common were concerns expressed by NPO representatives about the substantial administrative burden placed on them by DSD in terms of reporting. Anger resulted when DSD officials lost NPOs’ reports and supporting documents, forcing them to resubmit. A Free State NPO noted that the challenge for NPOs was increased by different districts having different requirements. A KwaZulu-Natal NPO said that they fully agreed that they should account for use of public money but the “manner in which it is undertaken is most unsatisfactory.” In Mpumalanga, an NPO observed that DSD required confidential information such as ID numbers of beneficiaries. Several people across different provinces noted that the lack of an electronic system for reporting aggravated the problems. There were also complaints about lack of feedback when reports were submitted as requested.

There were many references to forums of various kinds, but less discussion as to the purpose and achievements of the forums. A Free State participant suggested that a

Provincial Social Welfare Council with representatives of NPOs, government departments and experts be established in terms of the National Welfare Act to coordinate services, advise the MEC for Social Development with regard to the services and activities, evaluate and monitor services, and plan and promote new services. In contrast, a KwaZulu-Natal NPO observed that the large number of government and municipal forums which they were expected to attend left less time for service delivery. Elsewhere there were complaints about lack of funding for forums required by legislation, such as provincial substance abuse forums. There was also a comment on lack of decision-making power of VEP forums. More generally, across different provinces NPOs observed that they were not involved in DSD's planning processes, thus undermining coordinated service delivery. One established NPO in Mpumalanga complained that they had not been invited to any of the meetings organised by provincial DSD over the past two years.

9.10.2 Partnerships with donors

Each year national DSD receives both financial and in-kind donations from various bilateral and multilateral donors. Relatively limited funds come in the form of direct financial contributions, where funds are channelled into the government financial system. Far more come in-kind, where donors pay consultants and other service providers or buy goods on behalf of the department. Unfortunately, DSD and National Treasury do not have a record of donations that the bilateral, multilateral and other donors contribute directly to other actors, and to NPOs in particular.

In recent years DSD's annual reports and budget documents include information on donor contributions. Unfortunately, the tables are not comprehensive. Firstly, there is some missing information, including in respect of amounts. Secondly, the International Development Cooperation Unit of National Treasury is not informed by donors (and/or recipient departments) of all commitments and transaction. Further, there are likely to be donor contributions to other government agencies, such as the National Prosecuting Agency in respect of Thuthuzela Centres, which indirectly contribute to DSD. Donors beyond bilaterals and multilaterals may also contribute. For example, DG Murray Trust is funding research and analysis to support National Treasury and DSD in developing a sustainable way of funding social development services, as well as in respect of funding of ECD services.

The available information suggests a strong bias towards activities relating to children – and OVC in particular, and also a strong emphasis on monitoring (as evidenced, for example, by information systems and audits) and capacity building (as evidenced, for example, by tools and training). The largest single amount is the more than R33 million provided in respect of the 2014/15 financial year for the Government Capacity Building Systems (GCBS), which is funded by USAID but managed by PACT SA. It is a multi-year support programme. DSD's annual report for 2014/15 has an amount of R21,9 million for this programme.

While some of the funding can be seen as one-off in that it relates to establishment of systems and policies and training on new systems, other programmes involve recurrent expenditure that will need to be taken over by government when donor funding comes to a halt. Examples of such programmes include the provincial data capturers for the

Community-based Intervention Monitoring System (CBIMS) funded by the Global Fund, and the operational costs of the Gender-Based Violence Command Centre.

A further danger is that funding of the UN agencies is often driven by the interests of those agencies' donors as the UN is often a conduit for other funds. For example, UNICEF has served as the conduit for funds from the United Kingdom's Department for International Development in respect of violence against women and children, and such funds are unlikely to be available going forward as the UK moves away from funding South Africa. The current USAID grant to the National Prosecuting Authority in respect of Thuthuzela centres provides funding for services only for four new centres, with nothing for services at the 42 existing centres.²³⁸ DSD meanwhile subsidised stipends of care workers at only 13 of the 27 NPOs providing post-rape services at these centres.

9.10.3 Partnerships with other government agencies

Some reference is made to intergovernmental and inter-sectoral partnerships and collaboration by all provincial DSD in their strategic plans. However, these issues are not discussed in the APPs.²³⁹

The Framework for Social Welfare Services outlines responsibilities of national departments that provide complementary services to facilitate the holistic delivery of developmental social welfare services.²⁴⁰ However, managers lack the authority to ensure that agreed-upon sectoral work is followed through. DSD initiated an interdepartmental forum for social welfare services, but the forum has not been successful due to lack of a clear mandate.

The Ministerial Committee found that, across the nine provinces, there was confusion about the roles of different departments. As a result those who were at risk and vulnerable might not receive critical social services because it was assumed that another department was responsible. Previous sections of this report highlight the roles and responsibilities assigned to different agencies in particular service areas. Near the end of its term, the Committee also convened a consultation with officials of other national departments to explore the primary, secondary and/or overlapping roles and responsibilities of DSD and the other departments. This consultation highlighted social development-related activities of the various departments as well as some of the issues of concern.

South African Police Service (SAPS) officials noted a concern about the lack of availability of social workers after hours, particularly in rural and remote areas. Such lack of availability, as well as lack of availability of facilities, meant that children such as unaccompanied minors and those in conflict with the law were sometimes held in police station cells. In terms of child justice, SAPS attributed the decrease in the number of child offenders to the effectiveness of the Inter-ministerial Committee which was led by the Department of Justice and Constitutional Development (DOJCD).

²³⁸ Shukumisa. 2015. 15DaysOfDiscontent: Day 7: Undervaluing care work.

²³⁹ National Department of Social Development. Undated. Status Report Welfare Services Transformation. Report produced by the Chief Directorate: Welfare Services Transformation for the Ministerial Committee on the Review of the White Paper on Social Welfare (1997)

²⁴⁰ National Department of Social Development. Undated. Status Report Welfare Services Transformation. Report produced by the Chief Directorate: Welfare Services Transformation for the Ministerial Committee on the Review of the White Paper on Social Welfare (1997)

The Department of Defence (DOD) reported that they employed about 150 social workers who were responsible for providing services to 360 000 people if both members and their families were included. The relevant directorate had a range of programmes, including some on substance abuse, but these reached only a limited number of officials.

In the area of youth, DOD ran a twice-yearly programme in the area of youth development in Kimberley. About 1 000 youth were involved, and the programme included life skills. DOD also had a military skills development programme that targeted youth aged 18 to 22 years and which was used for recruitment. Unfortunately, budget constraints meant that there was no further provision for youth who were not recruited at the end of the two-year programme.

DOD had a few ECD centres under its ambit and ensured that both the practitioners and centres were registered with DSD. The directorate also offered life skills training in respect of HIV and AIDS. A constraint in this respect is that the United States Presidential Emergency Programme for AIDS Relief (PEPFAR) and government budget focused on roll-out of anti-retrovirals rather than the first objective of the National Strategic Plan drawn up under the auspices of the South African National AIDS Council, which related to addressing social and structural barriers that increase vulnerability.

In relation to poverty and livelihoods, DOD noted the importance of grants for military veterans so that they could, among others, cover the costs of access to health care. In the area of family strengthening, DOD had a family resilience programme that targeted members and their families before members were deployed. Research was underway in this area of work on reintegration of members after their return.

DOJCD officials confirmed the problem of shortage of probation officers from DSD. In the area of gender-based violence, DOJCD had recognised the need to address victims' court-based needs. They had been housing NPOs in the courts to provide such services but the exit of some of these NPOs on account of budget constraints had been a "wake-up call" for the department. DOJCD was thus in the process of identifying the necessary services and costing them so as to be able to draft a court-based victim support model. DSD meanwhile assisted with counselling of some victims.

DOJCD was rolling out sexual offences courts, with particular emphasis on reducing turnaround time in finalisation of cases. The model for sexual offences courts required at least one social worker in each such court. With UNICEF support the Department had commissioned a survey to find out the needs of adult and child victims from counselling through to post-trial debriefing.

In the area of maintenance, DOJCD provided some support services for traumatised victims, such as in camera proceedings. More generally, DOJCD had introduced a direct maintenance system which provided for quicker receipt of payments. DOJCD had also during the 2015/16 financial year advertised for more than 100 intermediaries, some of whom were registered social workers with two years' experience.

In the area of children, DOJCD reported complaints about delays in the finalisation of foster care orders and adoptions due to the Form 30 issued by the Registrar of the National Child Protection Register not being sent to the courts. These forms serve as

certification that the applicants for foster care and adoptions are not registered on the register and cases cannot be finalised without these forms.

The DOJCD officials who attended the consultation were not able to talk about Thuthuzela care centres or diversion because these issues fall under the NPA which is regarded as a different department.

DOJCD gave further information in respect of inter-sectoral collaboration around implementation of the Child Justice Act, for which they are the lead agency. They explained that there was a national technical committee that supported the directors-general (DGs) in respect of operational issues. At provincial level there were further inter-sectoral structures that were responsible for monitoring implementation of the legislation. The chairpersons of the provincial structures served on the national operational committee where they shared success stories and challenges. Where the national operational committee could not address challenges, the issues were escalated to the DG committee. The DG committee, in turn, reported directly to the Minister of Justice who could raise the issues with other ministers in the cluster. While the system worked well overall, it was not without challenges. At national operational level NPOs were involved, and provincial structures were encouraged to include NPOs. Ideally, NPOs should also participate in the DG-level committee but this was not yet happening. Other challenges related to departments sending different representatives to meetings, and lack of analysis of the data and information collected and reported.

DBE noted that learner wellbeing was one of the goals of the education sector and was critical in terms of improvement of learner performance. On nutrition, in response to a Cabinet request to all departments to come up with an integrated plan, DBE had held a “mini-Phakisa” during 2015 that had done this.

In the area of ECD, DBE acknowledged that there was a gap in respect of financial and other support for Grade R delivery in community sites rather than in schools. In the area of disability, there was an inclusive education unit that provided a range of services including assistive devices and that also bore responsibility for reform schools and schools of industry. There was also a psychosocial section of DBE that dealt with mental health. For substance abuse, DBE had health promotion, which also addressed other learner “behaviour disorders” such as teenage pregnancy and HIV and AIDS. HIV and AIDS activities were funded through a conditional grant. While DBE’s structure provided for the area of social cohesion, a big gap in this area related to involvement of parents. Further, while DBE had a range of programmes such as those mentioned, educators were over-burdened and there was a need for social workers in schools. Some provincial Departments of Education had employed social workers and educational psychologists, but there were fewer than 200 of each of these cadres for more than 24 000 schools.

DBE noted that schools could be used as vehicles for community members – and not only children – to access a range of services. However, this had happened on a very limited scale to date.

DBE had a protocol agreement with DSD and other government departments. The protocol was, however, not well understood at provincial level. There were integrated school health programmes that brought together officials of the Department of Health,

DSD and DBE into health teams. However, DBE reported that there were fewer than 100 such teams to service the 24 000 schools in the country. DBE had approached higher education institutions to place students in schools to do their protocol, but there was no protocol on this as yet.

COGTA supported the idea that there should be sharing of infrastructure and facilities and, more generally, enhanced coordination. They suggested that the social sector cluster had worked well in the past but was no longer ensuring that departments cooperated and collaborated. The example of indigence policies was used to illustrate the lack of coordination and standardisation, in this case across municipalities.

DCS has a directorate of social work services that deals with women, children, youth, people with disabilities as well as the elderly as different categories of offenders. The Department has policies for all these categories. Programmes for offenders cover areas such as parenting, youth resilience, anger management, sexual offences, substance abuse, and life skills. There is a total of 12 programmes, with a further programme for female offenders currently being finalised. A quality assurance committee oversees delivery of these programmes by external service providers. Where those who are awaiting trial have withdrawal symptoms from substance abuse, they are referred to hospitals.

Two categories of children are found in DCS facilities. Firstly, there are children aged 0-2 years who stay with their offender mothers in the mother and child unit. DCS has a registered ECD centre in Durban Westville to serve this category and similar centres in Johannesburg and Western Cape are in the process of being registered. Secondly, there are children aged 14-17 years who have committed serious crimes and are housed in youth centres separate from other offenders.

To address high vacancy rates for social workers and other specialised categories, DCS officials visited all regions during 2015 to try to recruit people to fill the posts. Social workers were the majority of those who applied, and it seemed there were many qualified but unemployed social workers. This should address the problem of vacant posts, but raised a question as to whether this was, in reality, a scarce skill. In addition to social workers, DCS employs correctional intervention officials (CIOs) who implement didactic programmes among other functions. DCS is planning to create permanent posts for CIOs.

DCS acknowledged the problems that offenders faced in finding jobs after serving their sentences.

DOH noted that, in talking about nutrition, one needed to look beyond whether people were eating sufficient food in addition to looking at the type of food they were eating. If this was not done, it would contribute to an increase in non-communicable disease in later life. In the areas of older persons, disability, mental health, DOH interacted with DSD but the interaction was not optimal. In addition, there was not always agreement on how particular issues should be dealt with. For example, DSD might tend to a more institutional approach whereas DOH felt that the approach should be more community-based.

DOH noted that, just as DOH itself hired social workers, DSD could hire health practitioners in its institutions. Where users needed more specialised care, they could be referred to DOH's institutions. DSD's institution would meanwhile need to be open to inspections by health authorities to ensure that standards were maintained.

DOH noted plans to establish a National Health Commission which would look at the social determinants of health and would probably be chaired by the Deputy Minister. The Commission would be inter-ministerial with a technical committee reporting to ministers. The Committee would provide an ideal space for social development issues to be considered.

On the nutrition side, DOH promotes exclusive breastfeeding for the first six months of a baby's life, but encounters resistance to this idea, especially in urban areas. In terms of school health, there are 407 school health teams distributed across the nine provinces, but 837 are needed. Some provinces have appointed retired nurses to provide school-based services. The focus in this respect is on Grades R, 1 and 8, with children in other grades referred by educators when deemed necessary. On mental health, DOH felt that there was good collaboration with DSD. There was also a working system of referring malnourished and other children to DSD where necessary, although this did not currently include any monitoring as to whether the referred child received the needed services. In the area of post-exposure prophylaxis in cases of rape, DOH also needed stronger coordination with DSD so that victims could receive the necessary counselling.

For youth, DOH had established youth-friendly services. The foci of the youth services included adherence to anti-retroviral therapy, prevention of pregnancy through multiple contraceptive methods, and a mobi site where young people could register and receive information on health-related issues such as mental health and pregnancies.

The Department of Rural Development and Land Reform (DRDLR) noted that there was no legislation that governed the scope of the department. Instead its functions were determined by the Constitution. The rural development branch was responsible for the comprehensive rural development programme which, in turn, was based on the rural transformation strategy approved by the Minister in 2013.

DRDLR plays a coordination rather than implementation role, although it does have a few interventions. Previously it did some work on food gardens and livelihoods, but the current focus is on rural enterprise and development and rural infrastructure development. This focus encompasses promotion of skills development and job creation. While there is some overlap with other departments, such as Small Business and Arts and Culture, the need is so great that "double-dipping" is not seen as a serious concern. The focus going forward will be on the areas surrounding the Agri-parks which will be established in 44 municipalities.

DRDLR is also responsible for the National Rural Youth Service Corps (NARYSEC). This is a three-year programme which includes basic training and instilling discipline, where there is good collaboration with DOD. The youth receive life skills and vocational training, and then return to their communities where they work for a stipend. The work includes household profiling which is similar to that done by DSD but asks some different questions. DRDLR has a unit that does spatial planning and hopes to establish rural desks.

9.10.4 Partner structures

The White Paper noted that during the apartheid era advisory structures were established at national, regional and local levels in terms of the National Welfare Act of 1978 and other legislation. The structures were, however, neither inclusive nor truly participatory.

Historically, DSD coordinated the establishment of the National Interim Consultative Committee on Developmental Social Services (NICC). The NICC's 15 members represented national and provincial DSD, the South African NGO Coalition, the National Welfare Services and Development Forum, training institutions, statutory bodies, and service beneficiaries, the business sector, professional bodies and the religious sector. The NICC participated in the development of the Developmental Welfare Governance Bill of 2000. The Bill was approved by Cabinet, but rejected by the NICC on account of amendments to the original draft introduced by DSD. Among the changes was that the role of the proposed structure had been changed from policy to advisory, and the number of members reduced from 21 to nine. NICC representatives claimed that the amended bill no longer reflected the White Paper of 1997.²⁴¹

The bill was not passed, and its place was taken by the Advisory Board on Social Development Act of 2001. The 9-11 member board is intended both to advise the Minister of Social Development and act as a consultative forum. It is meant to include both government officials and people with knowledge and skills and who are actively involved in the sector. Members are to be appointed by the Minister on the advice of parliament, based on a call for nominations. A call for nominations for the advisory board was issued in 2001, but by 2015 the board has not yet been established.

The DSD meanwhile engaged with national councils established in terms of the National Welfare Act and some NGOs through the Joint Strategic Committee. This committee was not a fully representative structure, but rather a forum in which DSD could discuss and share information with some national NPOs. Other structures such as NACOSS, Welfare Forum, NAWONGO and SANGOCO meanwhile engaged with provincial DSDs.

In 2012, DSD convened a national summit of NPOs, following a series of provincial summits. Prior to the summit, the (ANC-aligned) South African Congress on Non-Profit Organisations (SACONO) was launched as a means for DSD to engage with its NPO partners. SACONO was also involved in post-summit follow-up activities.

While the establishment of SACONO was welcomed by the Minister of Social Development, there is some tension and confusion as to the respective role of the South African Non-Governmental Coalition (SANGOCO) and that of SACONO. SANGOCO was established in 1994 but at the time of the launch of SACONO was in a weakened state compared to earlier years. There were also concerns that SANGOCO represented the voice of more established organisations and did not sufficiently reflect the voice of more community-based ones.

The Committee's engagements confirmed some confusion around the roles and responsibilities of the various structures related to human resources, most of which have been established since 1997.

²⁴¹ Welfare and Population Development Portfolio Committee. 20 September 2000. Developmental Welfare Governance Bill: Discussion. <https://pmg.org.za/committee-meeting/210/>, accessed 4 November 2015.

The Welfare Laws Amendment Act (no 106 of 1997) saw the Social Work Council replaced by the **South African Council for Social Service Professions (SACSSP)**, which would cover all social service practitioners required by the developmental social welfare system. The Social Service Professions Act (no 110 of 1978) was subsequently amended accordingly. SACSSP is a statutory body with which all professionals are required to register. SACSSP's mandate covers three areas – registration and professional services; education, training and development; and professional conduct and ethical standards. The Council encompasses professional boards – one for social workers, as well as a board for child and youth care work which was officially inaugurated by the Minister during 2013– which looks into areas such as registration, education and training, professional conduct and ethics, and continuing professional development. The Committee heard that while the number of professionals registered with SACSSP now stood at 36 000, the staff complement had not grown since 1998. Registrations managed by SACSSP include more than 7 000 in respect of child and youth care workers.

The **National Association of Social Workers (South Africa) (NASW SA)** is a non-statutory and voluntary membership-based organisation affiliated to the International Federation of Social Work. The body was established in 2008 when the then Minister of Social Development wanted a body which could speak on behalf of social workers. In the early years it was dominated by government social workers. It has fairly recently made steps to establish some independence from government, and hope to establish provincial structures alongside the head office. The NASW submission to the Committee identified the role of NASW as being to “safeguard the social worker in a professional and personal capacity.” It distinguished this from the role of a trade union in managing employer-employee relations “in the best interests of a social worker.”

The **National Association of Child Care Workers**, another non-statutory membership-based body, was established in the 1970s as a progressive (anti-apartheid) organisation. In 2015 the association has 44 000 active members. The members elect provincial and national leaders who, in turn, employ a relatively large staff. Among other functions, NACCW serves as the main accredited provider of child and youth care training and is in a partnership with government for the national roll-out of the Isibindi programmes.

The **Community Development Professional Committee** is a non-statutory structure was established in 2011 to regulate the sector for quality assurance and standardisation of service. The committee would like to become a professional board and council, but would be prepared to affiliate to another council if assured that it would be inclusive and thus provide for the multi-disciplinarity and multi-sectoral nature of community development work.

The **Association of South African Social Work Education Institutions (ASASWEI)** is a voluntary body which brings together universities that teach social work.

The **National Social Work Veteran's Forum** has its roots in 2010, when Minister Bathabile Dlamini initiated the establishment of the Social Work Veteran's Programme. The programme was established in response to the need for retired and veteran social workers to remain connected to the social development sector, and for the department to be able to draw on their experience and knowledge to address challenges such as the shortage of social workers, the need for coaching, mentoring and supervision of the newly qualified social workers, and support to already practising social workers.

The National Social Work Veteran’s Forum was launched in October 2012, and consists of the chairpersons and an additional member from each of the provincial forums. The forum is tasked with:

- ensuring that national and provincial forums are operational
- identifying veterans over the age of 55 and developing and maintaining a national database
- ensuring that the majority of veterans participate in the activities of the forum
- networking and partnering with other professional structures and relevant stakeholders

Some provincial departments have appointed veterans to assist with the foster care backlog, supervision, mentoring and coaching of newly qualified social workers and new supervisors. Veterans have also participated in other activities, such as trauma counselling for victims of GBV, and quality assurance panels for diversion programmes. Veterans enter into formal contracts to do the work and recorded on the PERSAL system.

The **South African Association of Social Workers in Private Practice** (SAASWIP)²⁴² is a voluntary professional association of social workers in private practice. Because it is voluntary, not all social workers who are in private practice to belong to SAASWIPP.

As of 1 September 2015, membership numbers were as shown in Table 85.

Table 85: SAASWIP membership numbers, September 2015

Province	Members
Eastern Cape	37
Free State	33
Gauteng	317
KwaZulu-Natal	85
Limpopo	23
Mpumalanga	23
North West	17
Northern Cape	7
Western Cape	122
Total	664

SAASWIPP does not have a statistical breakdown of whether members are in full-time or part-time practice, but anecdotal evidence suggests that those in full time private practice are in a minority. Many members rely on contracts with welfare organisations, employee wellness groups, training institutions alongside fee-for-service clients. Some members in full-time employment offer fee-for-service counselling after hours.

SAASWIP sees new recruits to SAASWIPP falling into two main categories:

- Senior social workers employed by DOSD who want to enter private practice because they feel overburdened and under-stimulated by their jobs, and want an opportunity to deepen and practise their professional skills.
- Younger, less experienced social workers who are unable to find employment in the government or NPOs.

²⁴² Information provided by Dana Labe.

In terms of services, an on-line survey in 2013 attracted 160 responses, among whom 91% reported that they offered some form of counselling or psychotherapy service as the mainstay of their practices. More than 60% of these provided short term counselling (between one and ten sessions). The fees charged varied, but anecdotal evidence suggests that the Discovery Health rate of approximately R400 for 60 minutes is the benchmark rate. Rates vary by area, but most members charge on average between R300 and R550 per session, and most members have some form of sliding scale.

Some members specialise in particular areas of service. Areas include, but are not limited to, geriatric social work, play therapy, couple therapy, oncology services, transplant social work, addictions, eating disorders, perinatal loss and postnatal depression, trauma, forensic services, adoption services, employee wellness, supervision and consultation.

SAASWIPP is financed solely by membership fees, which amount to R800 to join. Twenty percent of members' fees in provinces in which there are constituted branches (namely Eastern Cape, Gauteng, KwaZulu-Natal and Western Cape) are given to the branch to finance workshops and CPD activities for members. SAASWIP is investigating ways to encourage networking, support groups and mentorship/supervision/consultation opportunities for all our members. SAASWIP does not have any paid staff.

9.11 Planning and information systems

9.11.1 National Information System for Social Welfare

In 1997 the then Department of Welfare published what was envisaged as the first of an annual series of statistical reports.²⁴³ This first report covered the period April 1996 to March 1997 and included information on finances, human resources, services and community projects among others. The information was collated by provincial DSD using the draft manual National Information System for Social Welfare (NISWEL) and a standardised questionnaire. Each province also took responsibility for compiling a chapter of the national report. The exercise was coordinated by the Welfare Information Coordinating Forum established under the Departmental Committee for Developmental Social Services, made up of heads of provincial departments with national DG as chair. Further development and maintenance of NISWEL, as a system that would include information on welfare-specific needs, inequalities and development backlogs, poverty and related social indicators was noted as a top priority.

The publication notes that while both national and provincial officials verified the data, they should be regarded as "soft figures" and treated with caution, including because of a high non-response rate. The latter might include the rate of response from NPOs as the publication aimed to report on activities undertaken by both government and subsidised NPOs. Newly created provinces which brought together several different apartheid administrations faced particular difficulties. However, despite the caveats, the publication provides a wealth of information and more detail than provided in standard publications produced nearly 20 years later.

The report clearly showed the disparities between provinces in terms of facilities. Figure 61 shows the capacity of children's homes per 100 000 of the population under 20 years of age, and capacity of homes for persons with disabilities per 100 000 of population

²⁴³ Department of Welfare. 1997. Social Welfare Services in South Africa: Annual Statistical Report 1996/97. Pretoria.

estimated as disabled (assumed to be 5% in the 1997 report).²⁴⁴ In each case, a higher bar suggests better provision. For both types of institution, Northern Cape has far better provision than any other province while Limpopo is worst off – tying with Mpumalanga for this place in respect of children’s homes. Limpopo has only 11 spaces in children’s homes for every 100 000 young people in its population, and only 65 spaces for every 100 000 people with disabilities. After Northern Cape, Western Cape and Gauteng are the best performers. The report notes further disparities within provinces. For example, in Eastern Cape the Western region (around Port Elizabeth) accounted for 47% of facilities and Central region (around East London) for 34%, leaving 3% in the Eastern Region and none in the North Eastern region.

Figure 61: Capacity per 100 000 target population: Children’s homes and residential facilities for people with disabilities, 1996/97

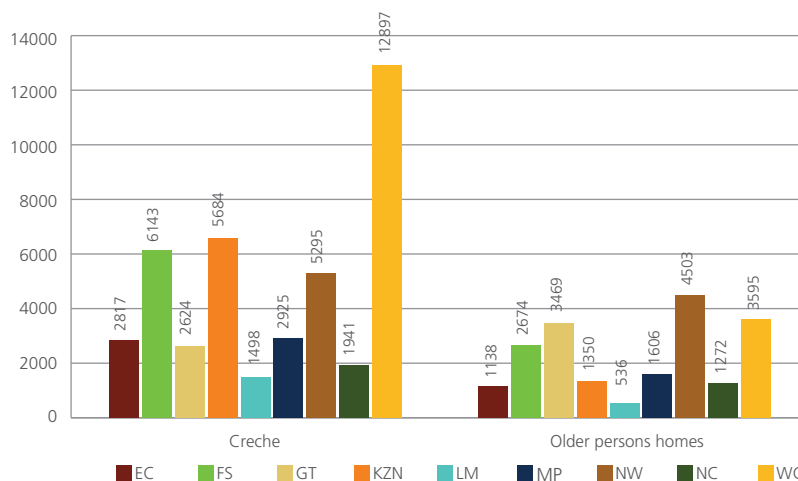
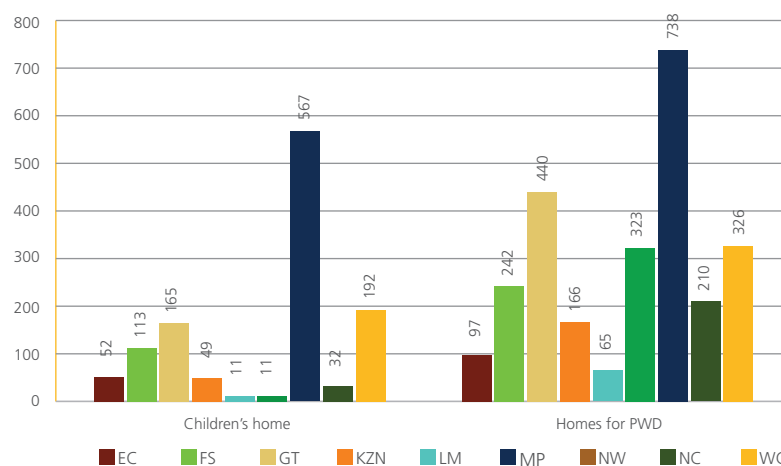


Figure 62 reveals Western Cape as by far the best performer in respect of ECD centres, and second best performer for homes for older persons. Northern Cape is the best performer on homes for older persons. Limpopo maintains its position as the worst provider for both these types of facility. Limpopo has only 1 498 spaces in ECD centres for every 100 000 children under five, and only 536 spaces in old age homes for every 100 000 people aged 65 years and above.

Figure 62: Capacity per 100 000 target population: Early childhood development centres and homes for older persons, 1996/97

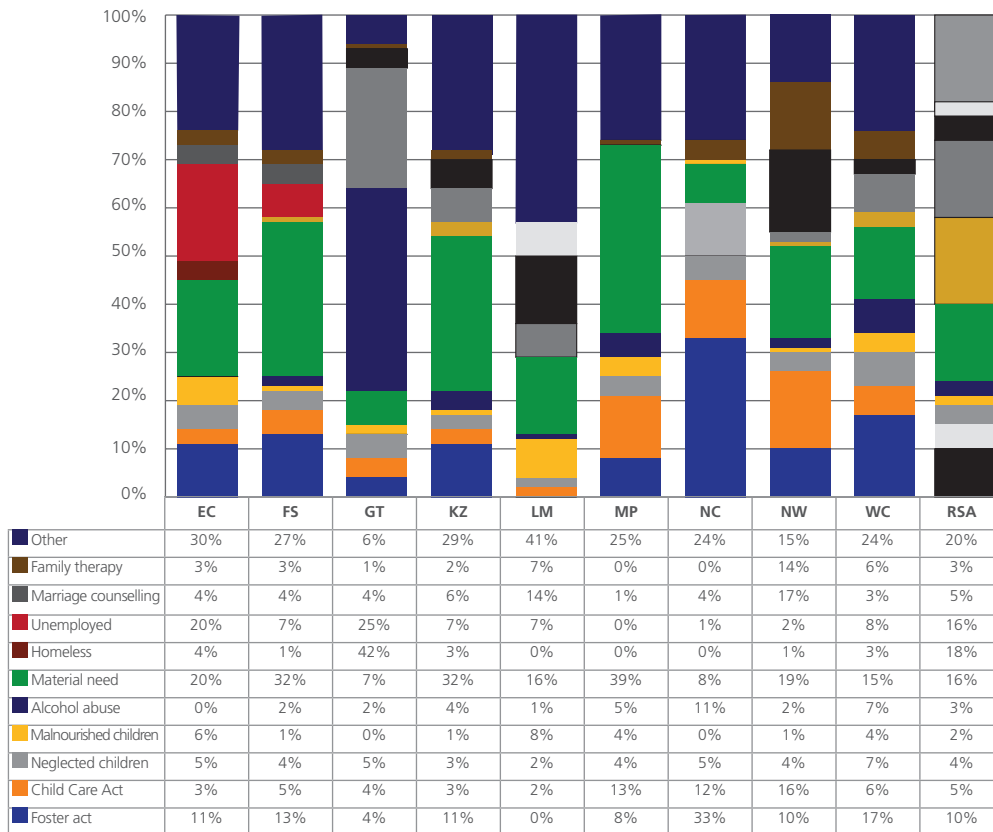


²⁴⁴ Apart from disability, the population estimates are as recorded in the 1997 report, but the ratios are recalculated as the publication appears to have some calculation errors. For disability, the estimates seem to be incorrect (perhaps 10% rather than 5%), and are therefore replaced by calculations based on Census 1996.

All provinces were asked to record the number of cases dealt with by government and subsidised NPOs over the 12-month period using 34 “codes” relating to different types of problems or needs.

Figure 63 shows separately all codes for which there were 10 000 or more cases nationally, with the remaining codes grouped together as “other”. For the country as a whole, homeless people (18% of the total), those in material need (16%), and the unemployed (16%) were the largest single categories, followed by foster care. This pattern provides a strong indication of the reason why the concept of developmental social welfare – with its emphasis on economics – was so appealing. The graph does show differences across provinces. For example, homeless people accounted for 42% of all Gauteng’s cases, and material need for 39% of Mpumalanga’s and 32% of KwaZulu-Natal’s. In Gauteng, the top three codes together – all related directly to poverty – account for 74% of cases. However, these same three codes account for only 23% of cases in Limpopo, one of the poorest provinces, and an even lower 9% in Northern Cape. Limpopo has a higher share of malnourished children than any other province.

Figure 63: Welfare case services, 1996/97



In addition to the just under 513 000 welfare cases recorded for 1996/97, slightly more than 266 500 people were reached through community work projects, 2,95 million by social security and 378 232 by welfare facilities.

9.11.1 Matching need for and supply of services in Western Cape

Western Cape has developed a geography-based system which maps need for different services and supply.²⁴⁵ The system works in terms of service delivery areas, with 24 areas outside and 21 within the metro area. The service delivery areas were designed to have more or less equal weighted population (where weightings relate to the specially constructed four-dimension index) and take account of ease of transport, and do not match other administrative boundaries. Some of the data in the model is available down to the subplace level, and the socio-economic index which forms one of the layers (see below) is calculated at the ward level – from Statistics South Africa’s Supercross program. The system uses an existing tool that the province already had as part of its corporate license, so there is no extra cost for the software.

The Western Cape’s geographic information system has three layers.

- The first layer is the population target, at the level of municipality, and by the eight health districts within the city. The population target is, where possible, refined for a particular service. This is relatively simple where the target is age-based, but very difficult for some other areas, particularly given the absence of norms as to the percentage of the population to be targeted.
- The second layer is the composite socio-economic index. City of Cape Town uses the same index which has been used since 1998, and Mpumalanga has begun using the index more recently. That underlying data are from the population census. Spectrum is being used for population projections until Thembisa estimates become available. There are also youth and NEETS indices, with the NEETS index a sub-component of the youth index.
- The third layer is services, which uses polygons (for areas served by a service provider) and points (e.g. where an ECD centre is). There are serious challenges in determining the polygons e.g. a NPO might serve a given area but not cover the farming areas within that. The system includes private facilities. While these will not usually serve the DSD target population, it will often make more sense to expand services through the private facilities than establish new ones.

There has been most progress with ECD in developing and using the system. For VEP it is difficult as the facility must not be too close to where the victim lives but also must not be too far so as to allow the victim and her children to continue with other aspects of their lives. For older persons the population 85 years and above is used as a proxy for frail care because the province currently subsidises residential facilities mainly in respect of frail care.

The system is not currently used for budgeting purposes as budgeting is done by programme rather than by geographical area. Ideally budgeting it should be done by district within programmes, but that is not the case as yet. The plan is that programmes will use the system for budgeting for the 2017/8 financial year, with older persons starting for the 2016/17 financial year.

Over time, the idea is that the basics would be available to the public, so that one would be able to see where the nearest facility/service is.

²⁴⁵ Information provided by Gavin Miller, DSD Western Cape.

The province is building an NPO management system. The hope is that this will be in place by the end of the year. It was partly funded by DPSA on the basis that it would subsequently be used by other provinces.

The plans for Western Cape's system to be publicly accessible is in line with the provision in the Generic Norms and Standards for Social Welfare Services that a database of all registered and unregistered social welfare facilities be developed and accessible to "stakeholders", service providers and beneficiaries. The provision notes that the information should be available at province, district and municipality level – as is the case with the Western Cape tool – and that the database should be updated and published by DSD on an annual basis. The electronic tool used in the Western Cape might obviate – or be more useful than – a hard copy publication.

The service standards document also proposes the establishment of a national 24/7 toll-free social welfare service call centre that would be linked to the national database as well as to provincial call centres. This call centre could be used to queries, lodging complaints and "disciplinary requirements" and would have at least one qualified social worker on duty at all times.

In addition, the document proposes that DSD should each year compile and publish a report on research findings with recommendations.

9.11.2 Information systems

In late 2015 Entsika Consulting completed the first phase of a project to develop an information management systems technology (IMST) strategy, under the USAID-funded GCBS programme.²⁴⁶ The output of first phase was an "as-is" report describing the current situation in the national and provincial departments. DSD will be responsible for phase 2. Although the investigation was termed "sector-wide", the focus was on technology within national government and did not include NPOs in the sector.

The detailed report on national and provincial DSD highlights the uncoordinated and fragmented nature of information technology and systems within DSD. This is ascribed, in part, to the "highly federated structure of DSD in the provinces". The lack of coordination is seen both in a variety of different packages and applications being used for a single purpose, and simultaneous development of strategies. Lack of coordination existed even within a single department. In Mpumalanga, for example, three strategy projects related to information technology were in process at one time – a national DSD one, a provincial DSD one, and one falling under the Office of the Premier.

On the application side, the fact that the same information is captured in different systems that do not link to each other, opens the way for conflicts in information. While the report refers to the desire to integrate information across departments beyond DSD, such integration is not happening well even within DSD. Where systems are developed and rolled out, "lack of uptake" by government officials results in their not being used properly, if at all. Poorly maintained and inaccurate systems result, in turn, in problems in service delivery. In this respect, the report notes among others delays in payments to NPOs.

²⁴⁶ Entsika Consulting. 2015. Assessment and development of a sector-wide IMST strategy (phase 1). Prepared for Department of Social Development.

The report is primarily concerned with technology and systems rather than the particular services and functions of DSD. However, it includes useful tables that document the extent to which service delivery indicators as well as objectives differ across provinces. These inconsistencies will hinder development and implementation of standardised systems. A table that shows provincial use of 40 different applications suggests that only six of the 40 are used by all nine provinces, namely BAS (financial management), LOGIS (for supply chain management), PERSAL, case management intake, the adoptions register, and the child protection register. Two others were being tested by all provinces, namely victim empowerment case management and child and youth care case management.

Review of current institutional issues:

Summary highlights

- DSD had developed a range of guidelines, models and frameworks related to development social welfare and delivery of social development services.
- Implementation has often been limited, with lack of resources cited as one of the reasons, but not the only one.
- Organisational structures differ across provinces and are not neatly aligned with mandates and functions.
- There are serious shortages of all of the core categories of social development professionals, despite initiatives such as the social work bursary programme and occupation-specific dispensation.
- The available data – which have clear weaknesses – suggest that the profile of staff differs markedly across provinces.
- Most of the various initiatives in respect of human resources have focused on DSD employees, yet NPOs deliver a substantial proportion of social development services.
- Urgent action is required to address the serious problems that have persisted for many years in respect of NPO funding and, in particular, transfers from DSD for service delivery. These problems, which include but go beyond the quantum of funding, have resulted in NPO cutbacks or even closure. This results in reductions in service delivery for the poor, vulnerable and at risk.
- The level of corporate social investment appears to have remained static, or even declined, over recent years.



PART IX:

10. Policy and Legislative
Options for Change

Proposal 1: Establish a social protection floor that includes social welfare

1. The issue, condition or problem addressed by the proposal

The Social Assistance Act (no 13 of 2004), as implemented through the social grant system, gives effect to the right to social assistance established in the Constitution (although it does not provide adequately for those of working age unable to support themselves and their families). There is no similar legislation or provision that establishes a social protection floor. Such legislation would need to delineate specific welfare and community development services to which everyone in South Africa is entitled in the same way as the National Health Act lays down an entitlement to emergency services for everybody, and an entitlement to free primary health care services for specified groups such as children and pregnant and lactating women. In the absence of such a floor, whether someone in need gets the necessary basic welfare and community development services depends on where they are geographically, their race, gender, income, whom they know and other factors. This results in inequity and reproduces social isolation and alienation rather than social cohesion and individual and collective wellbeing.

2. The proposed action/s

- Determine the set of services to which all South Africans, or all South Africans in particular categories, should be entitled, allowing for expansion of the set of services over time.
- Once the floor is officially established, all provincial DSD must assess current service provision and develop a plan to ensure that the floor is achieved within a three-year timeframe.

3. Alignment with the NDP

The NDP refers explicitly to a social protection floor “which, through social solidarity, we deem that no person should live below”. The NDP states: “An acceptable minimum standard of living must be defined as the social floor, including what is needed to enable people to develop their capabilities.”

4. The delivery agents / partners

The national DSD officials responsible for delivering the set of services must ensure full consultation with provincial DSD and with civil society stakeholders, in particular NPOs who deliver social development services.

5. Resource implications

The establishment of a floor will require additional resources as services are currently inadequate and unevenly available across provinces and within provinces. The floor may be partly achieved by some reprioritisation of resources away from less crucial service areas but such reprioritisation will need to be done in a way that does not conflict with the principle of progressive realisation.

6. Timing and sequencing of the recommended actions

The initial set of services to be included in the social floor should be agreed on within twelve months. All provincial departments must then determine how they will achieve at least the basic minimum within a three year period as part of the MTEF.

Proposal 2: Develop a national social development act

1. The issue, condition or problem addressed by the proposal

South Africa has developed and amended a range of different pieces of legislation since 1994. However, the country still does not have an over-arching social development act similar to the overarching acts in health and in higher education. In the absence of such an act, each province determines the services it will deliver. This results in a serious lack of uniformity, with substantial differences in the availability of services across and within provinces. For example, the preamble to the National Health Act (no 61 of 2003) sees it as providing “a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith.” Clause 2 states that the objects of the Act are “to regulate national health and to provide uniformity in respect of health services across the nation.”

A national social development act should also provide a framework for a uniform social development system that takes into account the obligations imposed by the Constitution and other laws with regard to social development services that are protective, developmental and preventive. Such an act will also require objectives designed to regulate social development and provide uniformity in respect of the type, scope, reach and quality of social development services across the country.

2. The proposed action/s

- Conduct a scan of overarching social development/welfare legislation in other countries.
- Consult relevant stakeholders on the scope of such an act.
- Develop a draft bill and take it through the parliamentary process.

The proposed bill should, at the least, specify the roles, powers and obligations of different actors. It should also make provision for a social protection floor which would be expanded in terms of the types of measures, levels of coverage and quality of service, to as many people as possible as soon as possible in line with principles of equity and need.

3. Alignment with the National Development Plan

This proposal aligns with the importance accorded social protection within the NDP.

4. The delivery agents / partners

The Minister and Director-General must guide the development of the Act.

The national DSD officials responsible for developing the bill must ensure full consultation with provincial DSD and with civil society stakeholders.

Parliament must debate and pass the Act.

5. Resource implications

The Act will need to take available resources into account, and should not introduce requirements that are beyond what is feasible in terms of financial, human and other resources and capacity. At the same time, the Act will need to take account of Constitutional and other legislative mandates and rights, but it can provide for progressive realisation of rights which are not specified as needing to be realised immediately.

6. Timing and sequencing of the recommended actions

The scan of social development legislation in other jurisdictions, consultation on the scope of a South African act, and development of a draft South African bill should be completed within eighteen months.

The bill should then be tabled in Parliament.

Proposal 3: Include a social development component in the provincial equitable share formula or increase the poverty component to fund welfare services

1. The issue, condition or problem addressed by the proposal

The provincial equitable share formula, which determines the block funds allocated to each of the nine provinces, currently consists of six components. While there are explicit components for education and health, there is no explicit component for social development. Some policy makers and analysts have argued that the poverty component, which accounts for only 3% of the equitable share, caters for social development because social development needs are closely correlated with poverty. However, the poverty share – which is relevant for many other aspects in addition to social development – has been 3% since the equitable share was first introduced. Keeping the share at 3% does not take into account important new legislative and policy mandates within DSD. It also does not take into consideration the extent to which provinces are currently (not) meeting their social development mandates. Changing the equitable share will not compel provincial treasuries to allocate the additional funds to DSD, but it will send a strong message about the importance of social development.

2. The proposed action/s

Two alternatives are possible.

- Increase the poverty component of the equitable share. This is the simpler option, but will not send a strong message unless the share is renamed, for example to “poverty and social development”.
- Introduce a new social development component to the equitable share. This would allow for other factors, such as rurality, to be built into the formula for the new component.

The second option is the preferred one.

3. Alignment with the National Development Plan

This move aligns with the importance accorded to social protection within the NDP.

4. The delivery agents / partners

National Treasury is the overall “owner” of the equitable share.

The Financial and Fiscal Commission provides annual advice to National Treasury, including on the equitable share.

The Technical Committee on Finance and the Budget Council are included in discussions around changes to key elements of the budget process such as the equitable share.

Parliament debates the Division of Revenue Bill which specifies the equitable share formula.

Provincial Treasuries will need to be alerted to the motivation for, and purpose of, the new component.

After the equitable share formula is revised, provincial DSD will need to submit well-motivated budgets to ensure that they receive an increased share of the provincial block grant.

5. Resource implications

This proposal will not change the overall resource envelope, but should result in a larger share of provincial funds coming to DSD.

6. Timing and sequencing of the recommended actions

Annexure W1 to the 2016 Division of Revenue Bill states that the National Treasury will in 2016 embark on a detailed review of the equitable share formula, and that it will consult the Technical Committee on Finance and the Budget Council as part of this work.

Ideally, this work should be completed in time for the new formula to be used for the 2017/18 budget.

Proposal 4: Increase DSD welfare budgets incrementally

1. The issue, condition or problem addressed by the proposal

Currently welfare services are seriously underfunded, resulting in far fewer services being delivered than are needed, as well as inadequate payments to NPOs that deliver services on DSD's behalf. There are also stark inequalities in the size of provincial DSD budgets relative to need.

Calculations based on the 2015/16 budget suggest that an annual increase of 1,9% per year in social development spending for five years would more than double welfare service spending (i.e. the total DSD amount less social security and administration) if expenditures on administration and social assistance/security remained constant. This increase would also more than allow for all provinces to achieve the level of DSD spending of Northern Cape per poor person, as it requires an increase, over the five year period of 95% rather than the 100% implied by doubling.

2. The proposed action/s

- At national level, provide for an annual 1,9% increase in the real value (i.e. after inflation) of provincial DSD budgets excluding the amount allocated for inflation.
- Allocate the additional funds proportionately to the degree of under-expenditure relative to current Northern Cape expenditure per poor person.
- If the additional funds are allocated through the equitable share, all provincial treasuries must undertake to allocate the additional funds to DSD, and provincial DSDs must undertake to utilise the additional funds on service delivery.
- Provincial DSD must ensure that the additional funds are not used for early childhood development (ECD) (given that 14% of current provincial budgets go to this single service area and a special conditional grant for ECD is already planned for 2017/18), and should also not be used for compensation of government employees.

3. Alignment with the National Development Plan

The NDP states explicitly that “[s]ocial welfare services must be expanded”. The specification that additional funds be utilised for service delivery rather than administration is in line with the thrust introduced in the 2016/17 budget.

4. The delivery agents / partners

National Treasury, National DSD, provincial treasuries and provincial DSD will need to agree on the best way to effect this increase to ensure it achieves the objective of expanding service delivery and enhancing equity.

5. Resource implications

By the fifth year the additional funds needed amount to R15 billion in 2015 rands. The phasing in of the additional funds will avoid a sudden demand on national finances and will also allow time for provinces to build the capacity to utilise the additional funds.

6. Timing and sequencing of the recommended actions

The increase is to be phased in over a five-year period, with the first increase in the 2017/18 budget.

Proposal 5: Strengthen national planning and standardise service offerings across provinces

1. The issue, condition or problem addressed by the proposal

The nine provinces have similar organisational and budget structures for DSD, and many similar services. Nevertheless, the priority given to different services differs widely across provinces. There is further variation across districts within a province, and even possibly between service points within a district. In a few cases – such as in respect of substance abuse in Northern Cape – some variation is understandable given the situation in needs of a particular province. In some cases the differences reflect historical legacies that have not yet been overcome. In other cases, there is no compelling rationale for the differences. The result is inequity for people in similar circumstances of need but living in different provinces and areas within provinces.

The variation across provinces, or even across districts, is facilitated by the absence of strong guidance from national DSD. While norms and standards have been developed for many services, these are often over-ambitious and unachievable in the near future. They also sometimes focus on the standards for a particular facility or the like, rather than norms related to the population in need (apart from the general ratio of social workers to population). They also do not specify the relative priority of different services. In the absence of strong direction from national, officials designated as having policy responsibilities at provincial and even district level develop their own approaches and priorities, with limited harmonisation with other provinces and districts.

A further factor that results in differences in quality of services is the wide variation in subsidies paid to NPO service providers in respect of the same service.

2. The proposed action/s

- Put in place realistic and achievable standardised norms, standards, priorities and transfer payment amounts.
- Utilise existing work, such as the KPMG and Afrec costings after updating, for determining transfer payment amounts so as to avoid unnecessary waste of time and resources.
- Ensure that the new provisions are implemented across all nine provinces.

3. Alignment with the National Development Plan

The NDP takes a strong stance on the need to address ongoing inequity and the negative consequences of inequality. It states: "Inequality and inequity continues. Opportunity continues to be defined by race, gender, geographic location, class and linguistic background. 'Inequality hardens society into a class system, imprisoning people in the circumstances of their birth. Inequality corrodes trust among fellow citizens, making it seem as if the game is rigged.' [citing Packet]"

4. The delivery agents / partners

National DSD, in consultation with provincial DSD and civil society partners, must develop and/or revise norms, standards and priorities.

National DSD, provincial DSD, civil society partners, and national and provincial treasuries must develop reasonable and standardised transfer payment amounts for standard services. (The amounts would then be adjusted on an annual basis.)

Provinces must reassign staff who have been given inappropriate responsibility for policy development at provincial and district level.

5. Resource implications

There will be an initial limited cost associated with the (re-)development of norms, standards and priorities.

Determination of NPO transfer amounts will be covered by the broader financing reform work. (See other proposal)

In terms of recurrent expenditure, there will be relative savings to the extent that provincial and district staff currently assigned responsibility for planning will be freed up for other tasks.

6. Timing and sequencing of the recommended actions

The norms, standards, priorities and transfer amounts can be developed incrementally over a period of two years. Standardisation of transfer amounts should be prioritised so that the standard amounts can be built into the 2017/18 budgets.

Proposal 6: Establish and enforce simple, effective and standardised data collection

1. The issue, condition or problem addressed by the proposal

National DSD is not currently able to produce basic statistics, for example relating to the number of all the different types of facilities, services and/or service providers registered in each province in accordance with the various pieces of legislation, the number of facilities, services and service providers funded by the provincial DSDs, and the number of beneficiaries the facilities, services and providers can/do service. All provinces should have

this information, but are not necessarily able to produce it. In some cases their inability to do this may be because data collection is decentralised to district level and not aggregated. In some cases officials in NDS responsible for a particular service area have (some of) the information, but there are usually gaps, and the information is not centralised within DSD. Different units also use different formats and collect different items of information.

The absence of comprehensive and reliable information hampers – or even prevents – effective planning and budgeting, and also undermines other responsibilities of DSD. In some service areas provincial and national DSD have tried to put in place complicated information systems related to particular service areas that attempt to capture detailed data – including information on individual beneficiaries. None of these systems appear to be operating effectively and the effort and logistics involved in ensuring that they are up-to-date and useful seems unachievable if the simpler data collection is not yet possible.

2. The proposed action/s

- Put in place standardised and simple (e.g. Excel) methods of capturing basic information on the different key facilities, services and service providers and make use of these methods compulsory for all provinces.
- The system should not attempt to capture information on individual beneficiaries. It should be restricted to basic information such as name, type, location (municipality), whether registered, whether funded, and number of beneficiaries.
- Provinces must be required to update the information on a regular basis and submit it to a centralised point (M&E or the relevant programme) in national DSD at least once per year.

3. Alignment with the National Development Plan

The NDP proposes the establishment of a national register of welfare and social service recipients. Such a register already exists in respect of social grants. However, at this point it does not seem sensible to try to develop such a database in respect of welfare and social service recipients (among whom there is likely to be much more volatility over time than for social grants) given that DSD is not yet able to collect and collate data efficiently even on services, facilities and service providers.

4. The delivery agents / partners

National DSD must design the system in consultation with provinces. Provincial DSD must ensure that all units utilise the system.

5. Resource implications

The resource implications are minimal if an already available package such as Excel is used. Human resource implications are also minimal as staff are probably already allocating time to the current largely unstandardised and sometimes dysfunctional data systems.

6. Timing and sequencing of the recommended actions

The increase is to be phased in over a five-year period, with the first increase in the 2017/18 budget.

Proposal 7: Integrate youth development and women development into other programmes

1. The issue, condition or problem addressed by the proposal

The youth development and women development programmes are relatively new DSD programmes introduced since 1997. The women development programme, in particular, has only been introduced as a separate area of engagement very recently in some provinces, and in others not at all. With women development, there is serious overlap with other programme areas, including both sustainable livelihoods and victim empowerment. With youth development, where the emphasis is primarily on unemployment, there is also overlap with sustainable livelihoods, while the Masupatsela cadre overlaps with community development work. With both areas provincial DSD sometimes appears to be doing work that is the mandate of other agencies.

2. The proposed action/s

- Abolish these two areas of work as separate areas of work in favour of a mainstreaming approach.
- Allocate current work being done in these areas, as appropriate, to the other programmes within DSD where it fits within mandates and functions.
- Discuss current work that duplicates that of other agencies with those agencies to reach agreement on appropriate location and responsibilities.

3. Alignment with the National Development Plan

The NDP notes the challenges that arise when agencies have overlapping mandates, and advocates for a “streamlined” approach. The NDP calls for “proper gender mainstreaming in departments.”

4. The delivery agents / partners:

Within DSD, national DSD should lead a process with the provincial youth and women development programmes to identify the best home for current activities in these programmes. Staff responsible for the identified “homes” would then need to be brought into the discussions.

National DSD should initiate the discussion with other national agencies with which there are overlapping functions. Provincial DSD – and provincial counterparts of the other national agencies where applicable – will subsequently need to be included in the discussions.

5. Resource implications

This proposal could result in savings due to removing duplication of management, coordination, and duplicate implementation costs.

6. Timing and sequencing of the recommended actions

Planning for a new streamlined structure should start immediately. The process should not need extended time as many of the issues have been previously discussed and problems highlighted, including in the Ministerial Committee’s report. The relevant organisational and human resource changes should be in place within a 12-month period.

Proposal 8: Focus the responsibility of the Department of Social Development in respect of disability

1. The issue, condition or problem addressed by the proposal

Between 2009 and 2014, DSD was responsible for social security and social development services in respect of people with disabilities. The overall coordination and policy role for people with disabilities was assigned to the Department of Women, Children and People with Disabilities. From 2014 DSD was assigned the overall coordination and policy role.

The disability sector made it clear in their interactions with the Ministerial Committee that disability should not be seen as a welfare issue. While DSD must take responsibility for ensuring that the needs of people with disability are catered for in terms of social security and social development services, all other government agencies must similarly ensure that this group's needs are catered for, in order that people with disabilities may be economically, socially, and environmentally empowered and integrated.

2. The proposed action/s

- Discuss within Cabinet the appropriate location of responsibility for coordination and policy in respect of people with disabilities.
- Focus DSD's responsibility in respect of people with disabilities on social security and social development services.

3. Alignment with the National Development Plan

The NDP notes in its vision for social protection that people with disabilities should enjoy the full protection provided under the Constitution when they experience vulnerabilities and are at risk. This vision is to be attained through a combination of public and private provision of services that cut across a range of government and other sectors.

4. The delivery agents / partners

The Minister of Social Development will be responsible for taking forward the necessary discussions within Cabinet.

National DSD and SASSA (in respect of social security) and provincial DSD (in respect of services for people with disabilities) will be responsible for mainstreaming of disability as well as special provisions for people with disability in their ongoing work.

5. Resource implications

This proposal could reduce the resource requirements of DSD to the extent that resources are currently allocated for overall policy and coordination in respect of people with disabilities.

6. Timing and sequencing of the recommended actions

The Minister should raise the issue of location of responsibility for coordination and policy in respect of people with disability as soon as feasible to avoid ongoing confusion and unhappiness among people with disability and their organisations.

Proposal 9: Coordinate with other departments and agree on roles and responsibilities

1. The issue, condition or problem addressed by the proposal:

Concerns were repeatedly raised during the Ministerial Committee's review process about lack of clarity on the respective roles and responsibilities of the Department of Health and DSD in several services areas. Residential homes (for the elderly, people with disabilities and children) were named in particular, as were substance abuse and mental. Questions of roles and responsibilities also arose in respect of the long-delayed Harmonised Assessment Tool for disability. The confusion about the roles of these two particular departments arises, in part, because they were previously generally combined in a single department. When the departments split, functions were allocated, but all the necessary resources did not necessarily follow.

The confusion is particularly severe in respect of the Department of Health. Nevertheless, similar concerns were raised in respect of a range of other departments, including Education, SAPS and DOJCD. Concerns were also raised about duplication of activities and lack of clarity of roles and responsibilities in the area of sustainable livelihoods. While the NDP places the primary responsibility for such services in the economic sector, DSD and NPOs need to know where they can refer people who might benefit from the services.

Currently DSD has just over 800 offices of various sorts country-wide, of which 182 relate to institutions. Approximately half of the offices – including the institutions – act as service points, while the rest are primarily administrative. The Thusong Service Centre concept introduced in 1999 envisaged at least one such multi-purpose centre being established in each district. However, by 2016 there are only 178 centres, plus a further 165 clusters where the anchor services – SASSA, Departments of Labour and Home Affairs, and SAPS – are in close proximity to each other. Many of the centres and clusters do not have services beyond the anchor services. Meanwhile virtually all areas have government premises such as schools which may not be utilised to the extent possible to provide access to other services. In the area of gender-based violence, there has been limited rollout of Khuseleka centres.

2. The proposed action/s

- Organise meetings between senior officials in DSD and Health to discuss and agree on the appropriate allocation of roles. Include National Treasury in the DSD-DOH discussions to allow exploration of whether the agreed role allocation necessitates any shifts in resources. Include counterpart officials in provincial DSD, Health and Treasury in discussions so that the approach can be harmonised across provinces.
- Organise regular meetings between officials responsible for relevant functions in DSD and other departments to discuss and agree on roles and responsibilities and ensure ongoing collaboration that ensures that services are delivered efficiently and effectively and in a way that does not disadvantage users.
- Ensure that relevant frontline social development officials and staff of NPOs are aware of the services on offer in respect of work opportunities, entrepreneurship, skills development and sustainable livelihoods more

generally, so that they are able to refer those who could benefit from these services to the appropriate agencies.

- Collaborate with the anchor service agencies for Thusong centres as well as other key agencies with, or with responsibility for, multiple facilities to explore sharing of facilities so as to make services more easily accessible. Consider, in particular, how such shared facilities can be made disability-friendly in physical terms as well as through sign language, braille and the like.

3. Alignment with the National Development Plan

The NDP notes, in respect of departments with responsibility for micro-economic issues that “more could be done to improve clarity about their respective roles and how they relate to one another”. The observation is equally valid in respect of Health and DSD. The NDP also emphasises the importance of partnership. It notes that services that enable easy access to basic needs and government support should be prioritised in areas – predominantly rural – with little productive economic activity.

4. The delivery agents / partners

National and provincial DSD, Health, Treasury in respect of clarification of roles and responsibility and possible funding shifts.

National and provincial DSD and Education, as well as SAPS and DOJCD, in respect of clarification of roles and responsibilities.

National and provincial DSD and Education, SAPS, DOJCD, Home Affairs, Department of Public Service and Administration, Department of Public Works and SASSA in respect of sharing of facilities.

National DSD in respect of rollout of Khuseleka centres.

5. Resource implications

The proposal may highlight need for additional resources if some necessary activities are found which are not currently budgeted for by either Health or DSD.

6. Timing and sequencing of the recommended actions

The discussions should be initiated as a matter of urgency as this problem is longstanding and denies individuals the services that they need. The partners should aim to reach agreement and implement the agreed roles and responsibilities within a period of 18 months.

The meetings with other departments should be initiated within a three-month period and then be held on a regular basis.

Proposal 10: Policy on orphans living with relatives

1. The issue, condition or problem addressed by the proposal

The foster care system was designed for 55 000 children, but is now dealing with approximately 500 000 children. The majority of these children are living with relatives, and are not in need of care and protection services, although they do need social assistance. The strain on the foster care system results in children who are abandoned, abused or neglected not receiving the level of service they require, as a great deal of social workers’ time is spent on dealing with the administrative and court processes related to foster care.

2. The proposed action/s

- Support the extended CSG for orphans in the care of relatives and children in child-headed household that was approved by Cabinet on Wednesday 9 December 2015.
- Amend the Social Assistance Act and regulations to enable the extended CSG to be operationalised.
- Ensure that the budget is approved to enable the above.
- Fast-track amendments to section 150 of the Children's Act and related sections to align with the extended CSG. The effect of the amendments will be to ensure orphans and abandoned children living with relatives are screened at community level by a social service practitioner, who will refer them to apply for the extended CSG and who may refer them to a social worker only if it appears that the child has care and protection needs.
- Retain those relatives already receiving the foster child grant for orphans in their care in that system, but make increased use of section 186 of the Children's Act which extends the orders until the child turns 18 and requires home visits at two year intervals by a social service professional.

3. Alignment with the National Development Plan:

The NDP records that 3,6 million children are single or double orphans and that this number is expected to peak at 5 million in 2020. The NDP points out that most orphans live with relatives, and highlights the importance of extended kinship networks in providing family care. Almost all of these children are black and living in poverty.

Although the NDP does not include a specific proposal on this issue, this proposal of an extended CSG coupled with more community-based support for orphans living with relatives aligns with using the available workforce more efficiently, because social work time will be freed up for care and protection services, while other social service professionals can provide the community based services.

4. The delivery agents / partners

Department of Social Development will have to drive this policy change.

Parliament will need to pass the required legislative changes.

SASSA will need to implement the extended CSG.

Community-based organisations and social service practitioners will play a key role in initial assessments and referrals.

Designated child protection organisations will play a role.

Treasury will be a key role player in the sourcing and allocation of funds.

The children's courts will be approached by social workers with applications for increased use of the longer-term foster care.

5. Resource implications

The action will have considerable resource implications as there are large numbers of orphans living with relatives who will be eligible for the extended CSG amount. However, this will cost less than taking all those who are eligible into the foster care system, both in terms of social assistance costs and in terms of human resource time. The proposal is that the extended CSG will be an additional 50% of the current CSG added to the CSG amount. Treasury is already working on the budgetary implications.

6. Timing and sequencing of the recommended actions

The legislative amendments should be fast-tracked and passed within the next twelve months.

The new extended CSG should be introduced in the 2017/18 budget year.

Proposal 11: Accelerate NPO funding reform process

1. The issue, condition or problem addressed by the proposal

Non-profit organisations (NPOs) deliver a substantial proportion of social development services across most service areas. Their service delivery assists government in fulfilling its commitments. There is, however, widespread acknowledgement that the current funding arrangements for NPOs are inadequate in many respects, including the amount of funding, disparities across and within provinces, and inefficient processes. Many of the challenges were highlighted in the NAWONGO case in the Free State which ran from 2010 to 2014, but the challenges are not confined to the Free State province. National Treasury and DSD have been collaborating on a project to address the problems, and have already done substantial diagnostic work. There are, however, as yet no fixed plans or dates for addressing the problems. In the meantime many NPOs are struggling to continue delivering services, some are closing, some retrenching staff, some cutting back on service areas. All of these actions reduce the already inadequate services available in terms of need. There is a serious danger that with all government agencies required to cut back on their budgets from 2016/17 going forward, NPO transfers will bear the brunt of the cutbacks.

2. The proposed action/s

- Put in place immediate measures to address inefficiencies such as late payment. Require that all provincial DSD and their sub-units comply with approved and efficient measures and monitor that they do so.
- Accelerate the project and allow for phased introduction of reforms, with a first substantial phase to be implemented in 2017/18 financial year at the latest.

3. Alignment with the National Development Plan

The NDP calls explicitly for “a review of funding for non-profit organisations.”

4. The delivery agents / partners

National Treasury and DSD play the lead role in the project

Provincial Treasuries and provincial DSD must be engaged in respect of solutions, and will be required to implement agreed actions and approaches

NPOs must be consulted and informed about progress and proposals. Consultation must not be allowed to delay reforms unnecessarily.

5. Resource implications

Introduction of efficiencies into the NPO funding system should result in better use of available resources as NPOs will receive funding on time and be able to plan and spend in a more organised way.

Addressing current under-funding of NPOs will require non-negligible additional resources. (see earlier proposals on expanding allocations for DSD).

6. Timing and sequencing of the recommended actions

Measures to address inefficiencies should be put in place within the next six months at the latest.

The broader reforms should be introduced in phases, with a first substantial phase to be implemented in 2017/18 financial year at the latest.

Proposal 12: Institutional reforms

1. The issue, condition or problem addressed by the proposal

The Constitution assigned responsibility for welfare to national and provincial government. In the apartheid era, some local authorities delivered services in both black and white areas. Government partners in service delivery are Correctional Services, Health, Justice, Education, Labour, Public Works, Housing and Sport and Recreation. This results in duplication, fragmentation and confusion about roles and responsibilities. Provinces bear the primary responsibility for service delivery, while national government is responsible for policy and coordination. Provincial DSD works according to a district structure which aims to ensure attention to local needs and specifics. Problems include poor distribution of social welfare programmes and staff at district levels with uneven capacity and unnecessary bureaucracy.

There is currently confusion about what is core to national DSD functions, provincial functions and local government. This results in staff at operational levels being tasked to perform many different functions and being unable to focus on core responsibilities.

There are no accurate numbers for NPOs delivering social development services as the NPO database includes other categories. Close to 40% of registered NPOs work in the social services sector. Of these, only a portion would fall under the social development umbrella. The extent of government subsidies – in particular the number of organisations funded – has expanded since 1997, but other sources of funds have declined. About 30% of NPO transfers go to ECD centres.

2. The proposed action/s

- Specify the core basket of social protection provisions (including basic welfare services) that are to form part of the social protection floor.
- Provide clarity on the core functions of DSD in relation to the basket of social protection services – including social welfare – and on any overlaps across other government departments.
- Ensure that there is a fit between the organisational structure and the mandate and functional structure of National and Provincial DSD.
- Design streamlined and simple process maps to guide planning, decision-making, coordination, monitoring and accountability processes within and across the social development sector.
- Align the Integrated Service Delivery Model and existing service delivery frameworks, norms and standards at an operational level, ensuring that the role of NPOs is fully incorporated.
- Expand the types and reach of developmental social welfare services and improve the quality of care.
- Clarify the role of NPOs and related sectors in the provision of

developmental social welfare and improve the partnership model so that it extends beyond a focus only on funding and monitoring.

- Ensure that services provided for in existing and future legislation for social welfare services is properly managed, funded and audited so that the responsibilities of the state and of the service providers are understood and carried out.
- Review and improve funding and other support measures to NPOs providing social welfare services.

3. Alignment with the National Development Plan

In chapter 11 of the NDP planning and policy priorities include addressing the neglect of developmental welfare services, expanding social welfare services and improving access to social welfare services in generic and specialised fields.

4. The delivery agents / partners

These will include national and provincial Government departments of social development working with the NPO sector and other appropriate service providers.

5. Resource implications

An incremental and phased approach should be adopted to expansion of welfare services so that the financial and other costs can be managed without compromising the services needed by those who are most vulnerable and at risk.

6. Timing and sequencing of the recommended proposal

Changes to the system need to begin immediately so that the changes improve the possibility of meeting the MTSF objectives and the NDP priorities set in chapter 11 and government outcome 13.

Proposal 13: Human resource reforms

1. The issue, condition or problem addressed by the proposal

PERSAL recorded a total of 33 187 employees of national and provincial DSD in December 2015. Of this total, 8 129 social workers, 2 573 social auxiliary workers, 1 933 community development workers, and 3 818 CYCWs appeared to be frontline workers. The distribution of the various categories of staff across programmes and sub-programmes varies substantially across provinces.

DSD's ISDM proposed social worker: population ratios of 1: 5 000 in Gauteng, 1: 4 500 in KwaZulu-Natal and Western Cape; and 1: 4 000 in other provinces. In Eastern Cape the population per approved post stands at less than 3 000, the approved norm, even before considering social workers employed by NPOs. At the other end of the scale, in Gauteng and Mpumalanga the population per approved social worker post stands at more than 7 000. Yet Mpumalanga is a predominantly rural province. Provincial analysis does not show the full extent of geographical disparities as there are further disparities within each province.

Government has committed substantial resources to addressing the human resource needs in the sector. Initiatives include substantial increases in the number of funded

posts (although too many posts remain unfilled), a very substantial social work bursary programme with some follow-up employment opportunities, and funding for training and employment of other social service professional cadres, including community development practitioners, social auxiliary workers and child and youth care workers. Nevertheless, social workers within the government and NPO sector perform work that could be (better) performed by other categories of social service professionals.

Government salaries and conditions determined in Public Service Coordinating Bargaining Council. Occupation-specific dispensation (OSD) for social workers was introduced in 2011 and also reportedly covers other categories. Many social workers remain dissatisfied with their salaries and conditions of work and with aspects of OSD.

The situation is worse in the NPO sector, where salaries are substantially lower and there are more limited, if any, benefits. This was the issue raised most often in the Ministerial Committee's reviews. Many of the complaints focused on social workers, in particular, being paid less when employed by NPOs than when employed in government, with various perverse results. An important part of the problem is that there is no agreed minimum wage for social workers and others (generally lower-paid) workers in NPOs. There have over the years been some attempts to develop a sectoral determination for the welfare sector, but these attempts have stalled. The reason for the most recent interruption in the process is that there is currently a national process ongoing towards national minimum wage that would cover all workers in the economy, including social service professionals such as social workers, community development practitioners, child and youth care and associated workers.

National DSD is currently developing a comprehensive five year HR Sector Plan in collaboration with provinces. Meanwhile DSD, like all other government agencies, is required – in consultation with National Treasury and the Department of Public Service and Administration – to develop and implement a plan to manage its personnel expenditure within a reduced budget for 2016/17 going forward. The necessary reductions are required to focus on reducing unnecessary managerial and administrative staff.

2. The proposed action/s

- Take forward DSD's current ongoing work on a comprehensive five-year human resources sector plan with full consideration of actual and potential human resources in the NPO sector.
- Develop an appropriate organisational design for the sector as part of the development of the HR Sector Plan.
 - o The design must take into consideration the partnerships which must be formed with the NPO sector in particular, and other partners in general to adequately address the service need/demand.
 - o Organisational structures must be aligned from the national to district level. The "line of sight" must be clear in terms of the specific contribution of each sphere, programme, division or unit to the developmental social welfare mandate.
 - o Redundant hierarchies must be eliminated and problematic hierarchies must be addressed (e.g. employees reporting to a manager on the same level)

- o Job descriptions and skills profiles should be customised in relation to functions, not occupational categories.
- Use the demand/supply study, when concluded, as the basis for a longer-term plan to produce appropriate quantity and quality of the core cadres of social workers, social auxiliary workers, child and youth care workers and community development workers.
- Collaborate with institutions of higher learning, SACSSP as well as government partners such as the National School of Government to ensure continuous professional development.
- On a minimum wage, two options are proposed, depending on the progress of the national minimum wage process:
 - o If the national minimum wage process is delayed, reinstitute the process for a sectoral determination for all categories of professionals in social development (eg. social workers, community development professionals, child and youth care workers) including a minimum wage, and pursue it with energy.
 - o If the national minimum wage process proceeds smoothly, ensure that the social welfare sector is not excluded, and that NPO transfer amounts are adjusted to align with the prescribed minimum.

3. Alignment with the National Development Plan

The NDP notes the need for equity to be considered in the determination, and enforcement, of a minimum wage. It notes that earned wages constitute an important component of the social wage which, in turn, is a core component of the social protection floor.

4. The delivery agents / partners

- DSD management must lead the HR reform processes.
- Department of Public Service and Administration will advise DSD in respect of HR aspects within the department.
- Department of Labour and Employment Conditions Commission will have the responsibility of developing the determination if the sectoral determination route is pursued.
- Relevant unions in welfare services as well as NPO employers will need to be consulted in the process if the sectoral determination route is pursued.
- DSD will need to adjust NPO transfer amounts whatever route is chosen.

5. Resource implications

A minimum wage would require an increase in the size of NPO transfers.

6. Timing and sequencing of the recommended proposal

Reforms need to be introduced as soon as possible as sufficient and motivated human resources are key to delivery of social development services.

Proposal 14: Education, training and skills development

1. The issue, condition or problem addressed by the proposal

Education, training and skills development remain critical for the provision of social development services across government, NPOs and the private sector. According to the NDP the numbers of social service professionals are too few to cope with the extent and the wide range of chronic social conditions.

All universities except the very newly established universities in Northern Cape and Mpumalanga provide social work qualifications, and they indicated that they have moved from teaching social work through a traditional clinical model of social work to a DSW approach. There is, however, a serious shortage of competent supervisors. This is exacerbated by the increase in inexperienced social workers resulting from the rolling out of the bursary programme.

Several universities that previously developed specialised courses for social workers had discontinued them. Accredited qualifications and training exist, although there are very few opportunities for higher-level qualifications in categories such as community development and child and youth care work.

For example, the current situation of children and youth in South Africa highlights the gaps in service provision for children and youth. The ministerial rollout of the Isibindi programme, with its target of 10 000 new qualified auxiliary child and youth care workers at the end of the five-year period is contributing to addressing the gap. However, the need is for more than this number of workers. Further, funding for the full rollout is under threat.

The categories of professionals who are in demand and require specialised education include those in the field of treatment and care of substance addictions, those in probation and correctional practice, those in social policy and management, those in financial management of the social development sector, and those who are involved in social development (with courses that include development planning for the sector, social inclusion and community development and peace-building).

2. The proposed action/s

- Increase the numbers of students admitted to study social work each year and provide support measures to ensure efficient through-put rates of social work graduates.
- Ensure that education and training for all four categories of social development professionals complies with the minimum standards and requirements set by the SACSSP and the Council on Higher Education.
- Ensure that the ratio of social auxiliary workers to social workers does not exceed 5:1.
- Recruit social auxiliary workers from among unemployed youth who have passed grade 12 but who do not qualify for entry to university.
- Design and implement a system for social auxiliary education and practice which builds credits towards a social work or community development degree after a minimum of five years practice as an auxiliary.

- Align the quality of education and training for community development workers with the minimum requirements for professional service delivery and develop the associated curricula, minimum standards and assessment criteria for the degree qualification.
- Build on the achievements of the ministerial rollout of child and youth care worker training and employment under the Isibindi programme to expand this workforce.
- Develop a formal educational route beyond the level 4 qualification for child and youth care workers.

3. Alignment with the National Development Plan

The NDP notes the need in the immediate and medium term to increase the supply in four categories of social service professionals to respond to the demand for appropriate basic social welfare services. The four categories are social workers, auxiliary or assistant social workers, community development workers, and child and youth care workers.

4. The delivery agents / partners

- National DSD should continue provision of social work bursaries.
- SACSSP, the Council on Higher Education, the South African Qualifications Authority, and the Health and Welfare SETA all have responsibilities for establishing minimum standards and/or ensuring they are met.
- Higher education institutions and other government and non-government training providers are responsible for developing and offering education and training programmes.
- National and provincial DSD is responsible for funding and management of the Isibindi rollout and similar initiatives.

5. Resource implications

Initiatives such as bursaries and development and implementation of new teaching programmes require resourcing. These can take the form of subsidies or transfers to learners as well as subsidies or transfers to providers. Resources are also required to provide salaries to the newly qualified and to employ sufficient supervisors to ensure that their learning continues and that potential service users receive quality services.

6. Timing and sequencing of the recommended proposal

Activities that involve continuation of existing activities, such as the Isibindi rollout and provision of social work bursaries, should continue with delay.

Development of plans and proposals for other activities should be formulated within a twelve-month period. Well-formulated plans can then be put forward to the relevant authorities in funding proposals.

Proposal 15: Community development and sustainable livelihoods

1. The issue, condition or problem addressed by the proposal

Community development is one of the strategies identified in the White Paper “to inform the orientation of social welfare programmes towards comprehensive, integrated and developmental strategies”. However, the inadequate integration of community development strategies and programmes in the implementation of developmental social welfare services is a concern. Issues are being raised about how to ensure community members can come together through programmes to be active citizens and take more control of their communities, engage in collective action/s and generate solutions to community and social problems.

Both the development of sustainable livelihoods and community development strategies and programmes are sine qua non towards comprehensive social development for the improvement of the quality of life, especially of the poorest people and households. This reinforces the view of social development understood as “economic and social progress [that] should be anchored in people’s lives through processes of ‘capacity building’ and empowerment.”²⁴⁷

However in all spheres of government, as well as in the community sector itself, there is a lack of clarity about the place, functions, processes and programme activities that constitute community development and social enterprise development. This lack of clarity and understanding creates a disabling environment for community development practitioners.

The challenges are exacerbated by the lack of recognition of community development practitioners as a professional category, the lack of appropriate education and training for community development practitioners, and the absence of appropriate provision of workplace supervision by supervisors with appropriate knowledge and skills.

2. The proposed action/s

- Clarify the concept of community development, and identify its links with poverty and sustainable livelihoods and the series of activities that lead to building community resilience.
- Recognise community development as a distinct profession.
- Ensure that education and training programmes exist to produce competent community development practitioners.
- Ensure that community development practitioners are supervised by individuals with appropriate qualifications and experience.
- Provide links with sustainable development strategies that generate livelihoods for those between 18 and 59 years.

3. Alignment with the National Development Plan

The NDP recognises community development workers as one of four categories of social service professionals which are critical to respond to the demand for appropriate basic social welfare services. Chapter 11 of the National Development Plan focuses on the importance of economic and social inclusion through social protection and community

²⁴⁷ Reutlinger, in Social Work and Society- International Online Journal; Vol 6, No 2 [2008].

development measures. Social protection measures go beyond social assistance, social welfare services and social insurance to include developmental strategies that focus on building sustainable communities and livelihoods.

4. The delivery agents / partners

- DSD's role includes clarifying the activities and functions of community development practitioners, and ensuring that the organisational structure and operations provide for adequate supervision of workers.
- COGTA, the South African Local Government Association and any government agencies that employ more than a small number of community development practitioners must be part of discussions as to how the first element of this proposal can be implemented.
- SACSSP's role includes recognition of community development as a distinct profession and establishment of a separate board.
- Higher education institution's role relates to providing quality qualifications for this cadre of workers.
- The above actors should engage with the Community Development Professional Committee, so as to ensure buy-in and that the needs and interests of these workers are addressed.

5. Resource implications

This proposal need not have significant resource implications as government already employs many community development practitioners. The proposal should ensure that the resources associated with this employment are effectively utilised for the benefit of poor and vulnerable communities.

6. Timing and sequencing of the recommended proposal

DSD should initiate discussions with the other key roleplayers within a six month period.

More concrete plans for taking the proposal forward should be in place, and implementation should start, within a further twelve month period.

In the medium term – until economic growth takes off and employment opportunities increase – strategies for community development could include social enterprise development, employment through community work programmes and other income-generating activities within communities. Such measures can enhance community and social development by focusing on those who are living in poverty, who are between 18 and 59 years and who fall through the system because they do not have access to paid work or vocational training.

Proposal 16: Comprehensive social security

1. The issue, condition or problem addressed by the proposal

In 2007 Cabinet appointed an Inter-Ministerial Committee (IMC) on social security reform. The reform agenda includes extension of the social assistance net; introduction of a compulsory pension system; improved unemployment insurance and better linkage to labour market policies; reform of the Road Accident Fund; National Health Insurance; alignment of social insurance benefits provided by the Road Accident Fund,

Compensation for Occupational Injuries and Diseases, and the UIF; social security governance and institutional restructuring; and fiscal and financial aspects. Progress to date has been slow, but in April 2015 DSD reported to parliament that the Consolidated Comprehensive Social Security Reform proposals had been completed.

The proposals of 2015 differ in some respects from earlier proposals developed in 2012. Instead of a firm single proposal, the 2015 paper presents two options. The 2015 paper also no longer provides for the same degree of coordination by a single agency. A further element that fell away was income support for people aged 18-59 years. Other differences between the two papers reflect the fact that some proposals in the first version have already been taken forward.

2. The proposed action/s

- Adopt and implement the proposals on comprehensive social security
- Adopt the options with strongest alignment to the proposals in the 2012 paper, for establishment of a single National Social Security Fund.

3. Alignment with the National Development Plan

The NDP states as its vision that South Africa would, by 2030, “have a comprehensive system of social protection that includes social security grants, mandatory retirement savings, risk benefits such as unemployment, death and disability benefits and voluntary retirement savings.

4. The delivery agents / partners

National Treasury, Social Development, Labour, Transport, Health, Public Service and Administration and the Presidency all have roles to play, as evidenced by their membership of the IMC.

Other government agencies such as SARS will also have roles to play as the reforms are rolled out, as will non-government actors such as employers, trade unions and existing private sector funds.

5. Resource implications

The reforms could bring savings alongside the need for additional expenditure. Establishment of new structures and systems will involve both one-off and recurrent expenditures. Elements such as subsidies for poorer workers will require expenditure. On the savings side, a more streamlined system will reduce costs associated with duplication and coordination of multiple different actors. Further, an improved and comprehensive social security system could reduce expenditures related to dealing with the negative impacts on poor individuals and their families.

6. Timing and sequencing of the recommended proposal

Cabinet should adopt the proposals within the next six months. Adoption of the reforms as a comprehensive package should reduce the possibilities of resistance as happened when the measures related to withdrawal of provident fund contributions was introduced without the full reform package having been adopted.



PART X:
11. Conclusion

11.1 Conclusion

The review of the implementation of the White Paper for Social Welfare of 1997 encapsulates a substantive and rigorous assessment of social development provision in the country. It provides both a historical analysis of what was proposed in the White Paper as well as an analysis of contemporary social and economic trends and the changes in social conditions, problems and demography that influence social development.

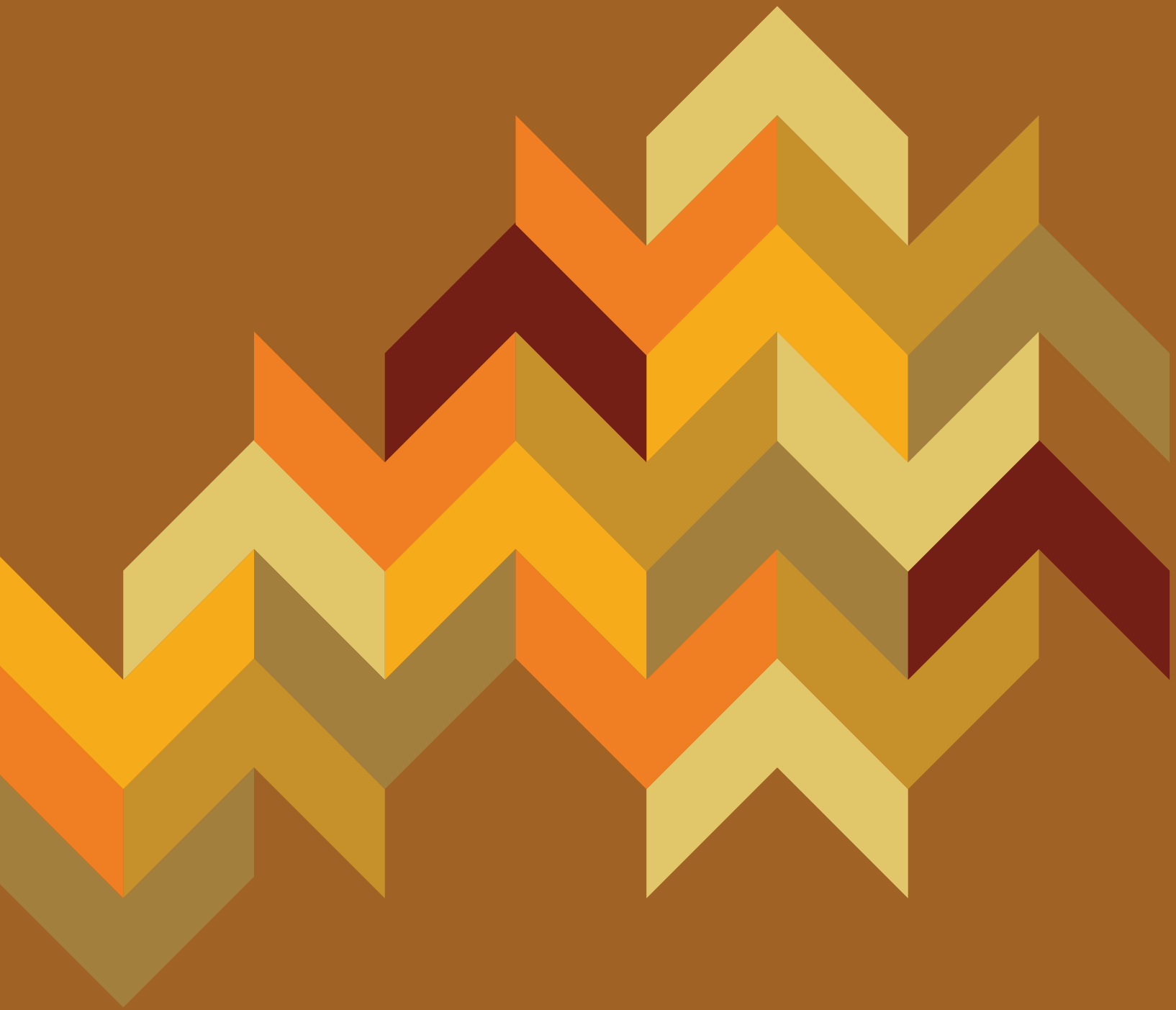
The methods used to conduct the review included both primary and secondary research of both qualitative and quantitative trends. This is the first time that such a comprehensive policy assessment process has taken place in social development after almost two decades of implementation of the White Paper. The timing for a review of policy implementation and the impacts on the lives of people receiving services is appropriate. The findings and recommendations framed as proposals are linked directly to the changes in the South African context. This context takes note of the need for alignment with the Constitution of the Republic of South Africa, the National Development Plan and the commitments made by the government to achieving 17 Sustainable Development Goals agreed at the United Nations in 2015.

All nine parts of the Comprehensive Report present evidence-based findings and identify critical issues and gaps in social development service provision. While a myriad of issues and problems were raised during the Review the Committee found that many of these issues and concerns were focused on routine operational and procedural matters and do not require policy or institutional changes. Because of the urgency with which these issues and problems were raised the Committee referred them to the relevant department section or division to address in the immediate or short term.

Part IX of the report provides 16 major policy proposals that require specific action, that have resource implications and that require careful timing and sequencing so that implementation can take place without disruption to ongoing social development activities.

11.2 Next steps

The Comprehensive Report and the Summary Report will be submitted to the Minister of Social Development, the Deputy Minister, all MECs, the Chair of the Portfolio Committee as well as national and provincial Departments of Social Development for their engagement and deliberations. It will follow the usual process for submission to the appropriate Cabinet Committee for approval and adoption of the proposals after due consideration. Thereafter the Comprehensive Report will be launched publicly by the Minister of Social Development and will be distributed to all those who participated in the review process.



APPENDIX 1:

Terms of reference

MINISTERIAL COMMITTEE ON THE REVIEW OF THE IMPLEMENTATION OF THE WHITE PAPER FOR SOCIAL WELFARE

As revised in the meeting held in October 2013

PURPOSE

To set out the scope of work of members of the Ministerial Committee for the review of the implementation of the White Paper for Social Welfare and the review of the White Paper itself.

BACKGROUND

The White Paper for Social Welfare (1997) provided a framework for the transformation and restructuring of social welfare services to realise the goals of the developmental approach. This include amongst others, building a consensus on a national social welfare policy framework, developing representative governance structures to build up partnership between government and civil society organisations, implementation of legislative reforms at all levels of government and developing a financially sustainable social welfare system.

Sixteen years after the adoption of the White Paper as a social welfare policy reform guiding social welfare service delivery, the Department of Social Development acknowledges the need to assess the appropriateness and relevance of the White Paper and to review it in order to respond to the needs of the beneficiaries within the sector.

In the Budget Vote Speech for the current financial year the Minister announced that Departmental polices are geared towards responding to the life cycle needs of communities through services to children, youth, adults and older persons. These services are realised through programmes that strengthen and empower communities and find expression through family focused and community based interventions. The delivery of integrated quality social welfare services is central towards the care and protection of children, women, older persons and people with disabilities, alleviation of poverty, prevention and mitigation of the impact of HIV and Aids, prevention of and support for substance abuse, child justice and probation services and promotion of social integration for the marginalised groups accessing social welfare services.

The review seeks to establish whether the implementation of the White Paper has translated to effective, efficient and adequately accessible and appropriate services to communities.

PURPOSE OF THE MINISTERIAL REVIEW COMMITTEE

The purpose of the Ministerial Committee is twofold:-

- Review the implementation of the White Paper for Social Welfare (1997) in all provinces.
- To review the White Paper for Social Welfare and make recommendations and proposals arising from the review.

APPENDIX 1:
Terms of
reference

TERMS OF REFERENCE OF THE COMMITTEE

To review the White Paper for Social Welfare (1997) in relation to the following:

- Assessment of the changes in the current context in South Africa
- Determination of the relevance of the White Paper for Social Welfare in the current context of South Africa.
- To review the theoretical framework underpinning the White Paper.
- To determine the extent to which the provisions of the White Paper are being implemented.
- Ascertaining the achievements, challenges experienced in the implementation of the White Paper and lessons learnt.
- To identify the gaps within the White Paper and service delivery interventions.
- To consolidate the findings, recommendations and proposals for the review of the White Paper.

SCOPE OF THE REVIEW

The review will be undertaken in three phases:-

Phase 1: Desk top study and preparation for the review

- 1.1. Analysis of the current South African Social Welfare Context.
- 1.2. Analysis of the findings of relevant research on the approach and implementation of the White Paper for Social Welfare for the period 2005-2012.
- 1.3. Commission papers and presentations by experts and informants representing services to children, youth, women, older persons, people with disabilities, prevention, treatment and rehabilitation of substance abuse, prevention, care and support for people infected and affected by HIV & AIDS, prevention, care and support for mental health and wellness, poverty alleviation, social integration, family strengthening, identify gaps, new needs and challenges
- 1.4. Analysis of key social development policies, legislation and strategies, to establish the degree to which the country has restructured and transformed social welfare services in line with the Constitution.
- 1.5. Identify areas for further research and commission relevant studies.
- 1.6. Develop appropriate research methodological framework in line with the identified themes.
- 1.7. Analysis of the existing human resource pool for Social Development(supply and demand)
- 1.8. Assessment of the current budget allocation and future projection for the delivery of social welfare and Development services, including allocations in other spheres of government.
- 1.9. Conducting comparative analysis of Institutional arrangements and models for social development services.

Phase 2: Conduct the review on the implementation of the White Paper

- 1.10. Assess the nature and extent of social welfare services in all provinces focusing on services offered at service offices and facilities for children, youth, adults, People with disabilities and older persons in relation to development, care and protection, rehabilitation and treatment of substance abuse.
- 1.11. Assess the degree of integration with multi -disciplinary services for the delivery of holistic social development services
- 1.12. Establish the nature and scope of stakeholder relations and partnerships for social development
- 1.13. Assess the accessibility of welfare services with specific reference to rural areas and farming communities.
- 1.14. Conduct a comparative analysis of service delivery systems focusing on governance structures across the three spheres of government.
- 1.15. Assess and determine the nature and extent to which social welfare services have been devolved to municipalities in all provinces.
- 1.16. Assess the sustainability of financial resources allocated to the NGO sector and viability of funding by other government departments having core responsibility over social welfare services.
- 1.17. Assess infrastructure and communication applicable for the delivery of social development services.
- 1.18. Assess information management and information technology capabilities as critical service enablers for integrated social welfare service delivery.
- 1.19. To assess the human resource capacity in terms of skills, competencies, supervision, workload management, restructuring and transformation of personnel to support delivery of social welfare services.
- 1.20. Assess quality assurance, monitoring and evaluation systems, applicable for social development services.
- 1.21. Conduct site visits to selected facilities, each representing care and protection of children, women, older persons and people with disabilities, rehabilitation of people with disabilities, treatment and rehabilitation of persons abusing substance in all provinces. This should be inclusive of government, privately and NGO owned and managed facilities to establish the nature of services, overall infrastructure, management and governance systems as well as progress made regarding transformation and restructuring of services.
- 1.22. Conduct public hearings and presentations by private social welfare service providers, NGOs and government departments in all provinces to establish the nature and extent of accessibility of social welfare to line with the objectives of the White Paper for Welfare.
- 1.23. Assess the extent to which changes that have been implemented are developmental (e.g. link social and economic development, community development) in nature
- 1.24. Assess the extent to which there is an equitable (issues of race, spatial location, peri-urban, gender, disability, etc.) distribution and allocation of social development services
- 1.25. Assess the extent to which services promote social integration.

Phase 3: Deliverables, Reporting and recommendations

Upon completion of the review process the Committee shall deliver to the Minister the following:

- 1.26. A composite report on the research findings and recommendations undertaken in line with the review of the implementation of the White Paper since its inception in 1997.
- 1.27. Reports on site visits conducted in identified facilities highlighting infrastructure, governance, service enablers, services and service beneficiaries.
- 1.28. Reports on public hearings and presentation by private service providers, government and NGOs highlighting the nature and extent of this sector's service delivery in relation to the DSD mandate.
- 1.29. A report on the review of the White Paper including all of the above.

Make recommendations to the Minister on

- 1.30. The review of the implementation of the White Paper.
- 1.31. Proposed strategies to be undertaken to strengthen the transformative and restructuring processes within the welfare services sector.
- 1.32. Critical elements to be considered in addressing the gaps within the White Paper.

Phase 4: Review of the White Paper for social welfare

- 1.1. Develop a framework for the review process.
- 1.2. Develop a discussion paper and policy proposals on the review of the White paper.
- 1.3. Conduct a round table discussion with experts on the state of implementation of the White Paper provincially and nationally.
- 1.4. Conduct consultative session/workshop on the review of the White Paper for social welfare.
- 1.5. Consolidate and submit a draft reviewed White paper for social welfare services.
- 1.6. Develop an implementation plan for adoption by the Minister.

2. TIME FRAMES

The Committee will commence its work upon appointment by the Minister and undertake the review over a period of twenty four (24) months.

3. DECLARATION OF INTEREST

Relevant interest which may give rise to potential conflict of interest should be declared upon appointment by the Minister.

4. INSTITUTIONAL ARRANGEMENTS

The following institutional arrangements will be observed for the duration of the Ministerial Review process.

Chairperson of the committee

The Chairperson of the Ministerial Review Committee shall report to the Minister of Social Development on matters at appropriate times.

Establishment of working groups

Working groups will be established to undertake detailed work as prescribed by the terms of reference. These working groups will be led by committee members and experts may be co-opted as and when necessary. These working groups will include the following:

- Social development context
- Chapters 2 – 4: Social welfare strategy, Human resources, institutional arrangements
- Policy and legislation
- Finance and budgeting
- Research
- Stakeholder engagement

Administrative support

The Department will appoint a Project Management Support Unit to offer technical support as per the prescribed terms of reference. This Unit will operate under the Directorate: Service Standards and will report administrative activities to the committee as required.

5. COMPLIANCE

Public Finance Management Act

The appointment of the Committee is subject to the provisions of regulations 20, Part 8, of the Treasury Regulations for Departments, Trading Entities, Constitutional Institutions and Public Entities, issued in terms of the PFMA.

Code of conduct governing committee members:

Quorum: If 50% of the members plus one is available for the meeting, this will constitute a quorum.

Attendance: If a member fails to attend three consecutive meetings without reasonable apology, this will be brought to the attention of the Minister by the chairperson.

6. REMUNERATION

The remuneration of members of the Ministerial Review Committee shall be calculated based on the Treasury Regulations 20.2.2 which gives effect to the approved remuneration payable to non-official members of Commissions and Committees.

7. INAUGURATION

The inaugural meeting of committee members shall take place soon after appointment by the Minister. At this meeting the Minister shall announce the chair and the deputy chair.

