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Executive summary

A Social and Demographic Trends Analysis (SDTA) aims to support purposeful social service delivery and development planning in terms of baseline information and a deep understanding of the social and population dynamics of the community. The report on this SDTA consists of a background paper followed by a series of papers dedicated to the sub-programs of the Department of Social Development (DSD) of the Western Cape Provincial Government (PGWC), including children, families, youth, older persons, disabled persons, crime, victim empowerment, and substance abuse. It is concluded by a summary of salient points, findings, conclusions and recommendations.

The background paper, presented as chapter 1 of the report, provides information on the policy and mandate of DSD and the model for integrated service delivery. This is followed by an overview of social and demographic trends pertaining to South Africa as a whole and Western Cape Province in particular, which serves as a needs audit for current society.

The background chapter suggests furthermore a procedure for outcome and impact assessment of the sub-programs based on valid indicators for program performance in improved and relevant service delivery and developmental interventions.

As far as the policy framework is concerned, the chapter provides a full list of constitutional and legislative items that mandate DSD to appropriately provide social assistance to vulnerable, disabled and marginalized individuals and groups. The chapter furthermore highlights the model according to which the DSD fulfills this mandate, namely the Integrated Social Service Delivery Model (ISDM). The goal of the ISDM is to contribute holistically to an integrated, self-sustained caring society that provides equitably for all of the members of the DSD’s target groups. Target groups are identified according to programs and sub-programs that are reviewed in the chapters following the background chapter. The ISDM works according to different levels of intervention and types of services. The model’s underlying program theory is also explicated.

A need has been expressed to develop indicators that may be applied for the standardization of future trend analyses. In the background chapter, it is argued that unless clarity is gained about the underlying program theory according to which services are delivered by the DSD, little progress in identifying of such indicators can be made. The chapter shows that a distinction should be made among input, process and output indicators on the one hand and outcome and impact indicators on the other. Due to the fact that existing indicators mainly focus on input and output indicators there is a need for developing outcome and impact indicators. The chapter presents an illustration to this
effect by showing how the development of a program theory and a logic model (or log-frame) assist in recognizing the relevant indicators and data sources on all the levels of program performance.

The illustration is presented for the sub-program for disabled persons and can be extended to other sub-programs should there be a need.

*A major implication of this approach would be that the monitoring and evaluation of sub-programs be revised to provide for this evaluation model.*

An analysis of some recent social trends at provincial level in comparison to national trends confirms that Western Cape is demographically and economically vastly different from the national profile but the social issues and challenges remain very much the same. Notably, society is racially divided and unequal, lacking strong social capital and cohesion, and burdened by diseases (particularly HIV and TB), crime and enduring poverty yet the provincial economy remains the fastest growing of all in the country. The educational and health systems are failing to provide sufficiently in the acute and chronic needs of the community, and the economy is sadly not creating sustainable job opportunities. These are to a large extent systemic weaknesses of the socio-political system that necessitate social relief that is draining resources and promoting a culture of dependency more than self-reliance.

Specific issues are highlighted with respect to the fields of the sub-programs that were reviewed in the SDTA. Reviews were conducted in chapters 2 to 9. The last chapter summarizes the main points. Here follows the highlights from these reviews:

- **Substance abuse (chapter 2)**
  Substance abuse has a very high prevalence and affects youth disproportionately. This links to adverse social and economic conditions and it is recommended that three strategies be maintained in this field – prevention, treatment and rehabilitation.

- **Older people (chapter 3)**
  The proportion of elderly people is rapidly growing and is showing a dual economic profile; on the one hand a self-sustaining well-off group and on the other hand a poor group that has the double-burden of caring their children and households members on an old age pension. The social condition of the latter group is therefore intimately linked to socio-economic trends that are affecting youth to becoming dependent on the aged. Another implication is that care and housing options have to consider both these groups among elderly.
• Crime (chapter 4)
The province is characterized by high levels of crime with a strong component of violent crime related to social conditions in the communities and another component of economic crime, again linked to trends among youth such as early dropping out from schools and the weak quality of life in the communities. The main observation is that crime is driven by adverse social and economic conditions and the inability of social institutions, such as schools, to cater for youth.

• Disability (chapter 5)
Disability is not defined in terms of its social implications but as physical and mental impairment, hence it is neglected as not being a development issue. Disability is disproportionately prevalent among black Africans in the younger age groups and among whites among the middle aged and older groups. The chief challenge in addressing disability issues is the mainstreaming of disabled persons to empower them to participate as fully as possible in society.

• Child care and protection (chapter 6)
More than a third of the population is children defined as persons below the age of 18 years. A disconcerting observation is that children’s quality of life is decreasing as indicated in mortality rates such as the infant and under-5 mortality rates. This indicates a serious challenge in health services and issues. It is also pointing to poverty conditions, child neglect and abuse. Children are victims of epidemics such HIV and fetal alcohol syndrome (FAS). Care and protection of children are major and continuous challenges in social service and welfare delivery.

• Empowerment of victims of crime (chapter 7)
There is lack of sufficient data on victims of crime and other catastrophes, which serves as an obstacle in providing proper and adequate services in this field. One particular issue raised in the review is finding an appropriate the definition for victim that will also cater for social and community consequences. Due to the fact that crime itself is intimately link to the social and economic conditions in community, victims of crime will denote similar linkages and implications that certainly have consequences for the empowerment process.

• Care and support of families (chapter 8)
The approach of care and support for needy families is the comprehensive and integrated service delivery model, which addresses issues in their systemic context. Families in need link to contextual and environmental conditions as has become clear in the different reviews. However, it was observed that the structures for providing care and support fall short to deal with the scope and volume of need. Family issues link with all other aspects raised above, such as poverty, adverse
socio-economic conditions, crime, substance abuse, violence, and neglect. Demographic trends impact directly on family issues. An example is in-migration of people to the province, which directly impacts on finding a proper place of abode and work – issues of human settlement and employment as well as social, health and educational services.

- **Youth (chapter 9)**

Youth is defined as young persons between 14 and 24 years, which contribute as 10% of the population in the province. In view of the strong link with poverty, health, economic and educational conditions youth are extremely vulnerable to and susceptible for further deprivation. They constitute the highest unemployed category in the population and are living either within an household with an unemployed head or are the head of the household without earning power. They are characterised by their high school drop-out rate, participation in criminal activities, and submission to peer group pressure in negative environments such as township gangs. The challenges are plenty including community development approaches, powerful service provision, vocational and entrepreneurial training and behaviour modification.

**Recommended direction**

Taking a critical look at the challenges within the various fields and the sub-programs as listed above, it seems clear that an ad hoc and piecemeal approach in service delivery will be totally ineffective in achieving desirable outcomes and impacts – such as a caring and self-reliant society. The need is to recognise the systemic nature of the challenges and to find strategic focus points in addressing the poverty cycle and trap that manifests itself in this province. It should also be noted that youth are affected almost everywhere in the areas of the sub-programs.

In doing so, the province needs to recognise its strengths and positive points in order to address issues from an asset-based point of view. Social development and service delivery, as an institutional initiative within government, should revisit social theoretical insights and practices in governance, amongst other developmental social welfare, holistic and integrated methodologies (such as the ISDM) and management practices such as needs assessment and monitoring and evaluation. The present SDTA has suggested a methodology towards thinking and acting systemic and logic.
Chapter 1: Background to the Social and Demographic Trends Analysis

1.1 Introduction

A Social and Demographic Trends Analysis (SDTA) of the Western Cape is compiled annually for the Annual Performance Plan (APP) of the Department of Social Development (DSD of the Provincial Government of the Western Cape (PGWC). SOREASO has been appointed to undertake this task for the SDTA of 2011/12.

The SDTA provides a baseline of social and demographic information in accordance with the structure of the DSD. The SDTA promotes evidence based planning as well as a deeper understanding of the changing and emerging trends in the Province, also in terms of the underlying factors determining such trends. A need exists with the planners of DSD to measure the impact of social development interventions and the gaps in service delivery. Therefore the SDTA aims to assist with the identification of relevant output and outcome indicators that may serve as tools for standardisation of future trend analyses.

In this chapter, we introduce key concepts for conducting this task. We first identify the policy and legal mandate for DSD’s program of service delivery and, second, the model for delivering the services. Next we introduce the notion of indicators according to the logic framework of social interventions. The chapter ends with a substantive overview of the dynamic context of DSD’s mission to undertake and enable social interventions in order to fulfil its vision of a self-reliant and caring society.

1.2 Policy and constitutional mandate for DSD

The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), contains the Bill of Rights, which provides for basic human rights including social and economic rights. The Constitution, notably section 27(1)(c), also provides for the right of access to appropriate social assistance for those unable to support themselves and their dependants.

The Social Service Professions Act, 1978 (Act No. 110 of 1978, amended), provides the framework for the development of the Council, for Social Work Professions, which is a statutory, autonomous body, tasked with the development of the social service professions, protecting the interests of beneficiaries and promoting the interests of registered social service professionals. It also sets out the code of conduct for social service and related professions and sets standards for education and training.

Amongst other, norms are proposed for the number of social workers to population with the following ratio’s as a guide:

- 1:5 000 Urban (Gauteng).
- 1:4 500 Combined Urban/Rural (KwaZulu-Natal and Western Cape).
- 1:3 000 All other provinces.

The following list identifies the Acts, Policies and Bills guiding the functions of DSD and provides a brief description of each.

<table>
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<th>Legislation</th>
<th>Impact of Department of Social Development (DSD) functionality¹</th>
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<td>Constitution of the Republic of South Africa</td>
<td>Section 28(1) sets out the rights of children with regard to appropriate care (basic nutrition, shelter, health care services and social services) and detention.</td>
</tr>
<tr>
<td>White Paper Population Policy for South Africa (1998)</td>
<td>Promotes sustainable human development and quality of life of all South Africans through integration of population issues into development planning of different spheres of government and all sectors of society. DSD is mandated by the policy to monitor the implementation of the policy and its impact on population trends and dynamics in</td>
</tr>
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</table>

the context of sustainable human development.

- **Older Persons Act**  
  **Number 13 of 2006**  
  The Act was operationalised by Presidential Proclamation on 1 April 2010. It aims at the empowerment and the protection of older persons which also includes their status, rights, well-being and their safety and security and the combating of abuse against older persons and the continuous maintenance thereof.

  Unlike the Aged Persons Act 81 of 1967 emphasis is shifted from institutional care to community-based care in order to ensure that an older person remains in the community for as long as possible.

  The Act promotes a developmental approach that acknowledges the:

  - Wisdom and skills of older persons;
  - Elder participation within community affairs;
  - Regulating the registration of older persons services;
  - The establishment and management of services and management of facilities for older persons.

- **Child Care Act**  
  **Number 74 of 1983**  
  This Act provides for the establishment of children’s courts and the appointment of the Commissioner Of Child Welfare for the:

  - Protection and welfare of certain children;
  - The adoption of children;
  - Establishment of institutions for the receiving of children;
  - The establishment of treatment centres.

- **Child Care Act – Amended 1996**  
  The amendment provides for the legal representation for children; and

  The registration of shelters.

- **Child Care Act**  
  **The amendment provides for the rights of certain natural**
• Amended 1998
  fathers’ in terms of the adoption of children born out of wedlock.

• Child Care Act -
  Amended 1999
  The amendment provides for the establishment of secure care
  facilities and prohibition of commercial sexual exploitation of
  children.

• Children’s Act 38 of
  2005 as Amended
  The Act, which was operationalised by Presidential Proclamation
  on 1 April 2010, defines:
  o The rights and responsibilities of children;
  o Parental responsibilities and rights;
  o Principles and guidelines for the protection of children;
  o The promotion of the well-being of children; and
  o The consolidation of the laws relating to the welfare and
    protection of children and provides for incidental matters.

• Child Justice Act No
  75 of 2008
  The Act establishes a criminal justice process for children
  accused of committing offences and aims to protect the rights of
  children.

• Probation Services
  Act 116 of 1991
  The Act serves as an interim measure to facilitate the
  transformation of the child and youth care system. The
  transformation of the child and youth care system relates to:
  o Early intervention;
  o Family finding;
  o Home based supervision;
  o Restorative justice;
  o Services in terms of victims of crime; and
  o Assessment of arrested children who have not been released
    from custody.

• Prevention and
  Treatment of Drug
  The Act focuses on the establishment of programs for the
  prevention and treatment of drug dependency and the
Dependency Act 1992

establishment and registration of institutions as treatment centres and hostels.

• Prevention and Treatment of Drug Dependency Act – Amended 1996

The amendment ensures the application of the Act to the entire Republic of South Africa.

• Prevention and Treatment of Drug Dependency Act – Amended 1999

Provides for the establishment of the Central Drug Authority.

• Prevention and Treatment of Substance Abuse Bill-2006

This Bill aims at promoting community based and early intervention programmes as well as the registration of all therapeutic interventions in respect of substance abuse.

• Prevention and Treatment for Substance Abuse, Act 70 of 2008

This Act provides for the implementation of comprehensive and integrated service delivery amongst all government departments. The main emphasis is the promotion of community based and early intervention programmes as well as the registration of therapeutic interventions in respect of substance abuse.


Provides for the establishment of the South African Council for Social Work Professions and professional boards for social service professions and defines its powers and functions.

• Non- Profit Organisations Act 71 of 1997

The Act cancels the Fund-raising Act, 1997, however, still promotes the relief of funds and an environment where NPOs can flourish by providing an administrative and regulatory framework in which they can operate.

• Domestic Violence

The purpose of this act is to afford the victims of domestic
1.3 Integrated Service Delivery Model

Services by DSD are delivered according to three broad programs, namely Social Security, Social Welfare Services, and Community Development. The Integrated Services Delivery Model (ISDM) serves as a guiding framework for the work of DSD. It is a multi-pronged approach aimed at addressing the social welfare and development needs of target groups in a holistic and integrated manner. It provides a basis upon which systems can be put in place to ensure that vulnerable groups are assisted to access immediate short and long-term material support, including social security when necessary.

The ultimate aim of the ISDM is to contribute to poverty reduction, protection of older persons, woman and children, persons with physical disabilities, youth development and social cohesion in a service area in an integrated and sustainable manner. Sustainability in this context refers to durability of outcome as a result of developmental inputs into healthy and self-reliant functioning of personal and social systems, such as individuals, families, communities and organizations. According to the ISDM developmental interventions ought to contribute holistically to an integrated, self-sustained caring society that provides equitably for all its members.

Clients (individuals, groups, families or communities) qualify for entering the service delivery system by making contact through one of the Department’s service points or various other agencies (e.g. NPOs associated with social service delivery and funded by DSD). After a first contact, one or more service professionals make an assessment and the nature and process of an intervention is decided and agreed upon. The client participates actively in the intervention efforts that best suit their circumstances and needs in order to ensure that they derive full benefit from available services. Movement of the client within the system is dynamic, and is not a linear process. Clients can exit the system at any point. The aim of the intervention at all levels is achievement of the desired level of social functioning. However, there are those whose functional capacity will require continued intervention, for example people with severe disabilities and chronic diseases such as AIDS. It is assumed that the approach will ensure that there is an exit strategy that will result in the enhanced sustainability of intervention efforts.

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Within the Social Welfare program various sub-programs are identified. They constitute strategic focus areas and are structured as social interventions to cater for the needs of specific target groups:

1) Substance abuse
2) Older people
3) Crime prevention and support
4) Disability services
5) Child care and protection services
6) Victim empowerment
7) HIV/AIDS
8) Care and support services to families
9) Youth development.

These are the sub-programs reviewed in the SDTA report for the Western Cape.

DSD supplies resources and services according to a policy position of developmental social welfare service delivery. It classifies services according to, first of all, four levels of intervention and, secondly, the nature of services.

The levels of intervention are:

- Awareness and prevention: The aim is to strengthen and build the capacity and self-reliance of the client. The client is regarded as functioning adequately but there is a possibility of at-risk behaviour at a later stage.

- Early intervention/prevention: Therapeutic and developmental programs are applied to ensure that those who have been identified as at risk are assisted before they require statutory services, more intensive intervention or placement in alternative care.

- Statutory intervention: When the client has become involved in court procedures or is not able to function adequately within the community, services are directed at supporting and strengthening the individual involved. The client may have to be removed from his/her normal place of abode, either by court order or on recommendation of a service provider, to alternative care (e.g. foster care), or placed in a residential facility.

- Re-integration: Through reconstruction and after-care, following on alternative care as implemented in the previous intervention level, the client is enabled to return to the family
or community as quickly as possible. Services at this level are therefore aimed at reintegration and support services to enhance self-reliance and optimal social functioning.

The client may enter the system at any of these levels and also exit at any level. The intervention method should be agreed with the client after assessment and development of an intervention program. The program serves as a contract between the service provider and client, with both committing to a developmental program that will enhance the client’s capacity to achieve their own desired level of social functioning.

The nature of services are classified by DSD into five categories, namely

- Promotion and prevention services
- Protection services
- Rehabilitation services
- Continuing care services
- Mental health and addiction services.

The target groups in these services include children, families, youth, persons in need of prevention and treatment of substance abuse, women, older persons, persons with disabilities, and persons infected with and affected by HIV and AIDS.

Another feature of the DSD is its developmental orientation. Social development is concerned with the development of society in its totality. Its efforts are directed at the development of the total potential of human beings for the maximum improvement of the material, cultural, political and social aspects of their lives.

According to the United Nations Economic Commission for Africa (UNECA), social development involves the participation of the people in bringing about qualitative and quantitative changes in the social conditions of individuals, groups and communities through planned measures such as social policy, social welfare, social security, social services, social work, community development and institution building. The developmental framework demands that service delivery be intersectoral and integrated between the various government departments and sectors. This collaboration and coordination is possible only if it is reflected in attitudes, behaviour and values that promote a developmental approach.

The ISDM therefore is a guideline for social services within the context of a developmental paradigm, and provides a value chain for social development services.
1.4 Indicators

The SDTA aims to assist with the identification of relevant output and outcome indicators that may serve as tools for the standardisation of future trend analyses. An assessment of the trends should ideally assist DSD to know how the services rendered by DSD and the funded projects of NPOs (as output) should lead to anticipated outcomes. This is referred to as project or program theory as it explains how and why a program is supposed to work. It provides a logical and reasonable description of why the things you do (program activities) should lead to the intended results or benefits.3

It should further enlighten DSD on how the different role players in the DSD and the implementing partners interpret and implement the program theory and the extent to which it can develop sustainable outcomes and impacts. This interpretation is underscored by for instance Pact4 (working with Pepfar and USAID in projects within South Africa) stressing the relevance of hypotheses and assumptions on the cause-and-effect linkage that is believed to exist in the system of delivery.

What is needed is an analysis of DSD and its implementing partners in terms of planned and perceived performance and how it is achieved. It essentially deals with the “story” (success or failure) of the program, as unpacked in the figure below suggesting the generic types of evidence needed in the assessment of the trends. The underlying logical framework traces performance (or the lack of it) at outcome and impact levels back to outputs, activities and / or inputs, or the context or situation to which the program is a response.

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### Figure 1.1: Program theory elements

<table>
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<th>Program Theory</th>
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<table>
<thead>
<tr>
<th>CONTEXT</th>
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<tbody>
<tr>
<td>The context / situation and risk factors</td>
</tr>
<tr>
<td>Needs to be addressed</td>
</tr>
<tr>
<td>What must be favourable / available externally for the implementation of the program</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>What we use to do the work</td>
<td>What we do</td>
<td>What we deliver</td>
<td>What we wish to achieve</td>
<td>What we aim to change</td>
</tr>
<tr>
<td>Evidence that you have / can get what is needed</td>
<td>Evidence that you have planned and implemented accordingly</td>
<td>Evidence that you have delivered the services.</td>
<td>Evidence that you have achieved – in beneficiaries’ lives</td>
<td>Evidence about further change that you have achieved as consequence of achieved outcomes.</td>
</tr>
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</table>

This scheme can be translated to the underlying program theory of DSD for greater clarity. The ISDM represents an implicit theory of DSD in delivering social services. As a rough approximation, one can explicate the ISDM in a program theory format as in the diagram.
Figure 1.2: The Integrated Service Delivery Model as program theory of DSD

**INPUT – PROCESS – OUTPUT**

**Awareness and Prevention** through Capacity Building and Empowerment

- **If still at risk**

**Early intervention and prevention** through Therapeutic and Developmental Programs

- **If still at risk**

**Statutory Intervention** through Removal from Home or Community

- **If still at risk**

**OUTCOME**

- **Reintegration** by returning to family and community and by being self-reliant and functioning optimally and adequately

**IMPACT**

- Integrated, self-sustained and caring society that provides equitably for all citizens in the target groups
In this figure,

IF clients enter their relationship with DSD or a partnering NPO (service provider), at the level of Awareness and Prevention,

AND they are exposed to capacity building and empowerment interventions,

THEN, they may return successfully to family and community as self-reliant, optimally and adequately functioning social actors.

HOWEVER,

IF they are assessed to be still at risk, they may enter at the level of Early Intervention and Prevention,

AND be exposed to therapeutic and developmental programs,

THEN, they may return to family and community as self-reliant, optimally and adequately functioning social actors.

HOWEVER,

IF they are assessed to be still at risk, they may be obliged according to law to enter at the level of Statutory Intervention,

AND be removed from their place of abode to alternative care and protection,

AND be exposed to therapeutic and developmental programs, and

THEN they may return to family and community as self-reliant, optimally and adequately functioning social actors.

HOWEVER,

IF they are assessed to be still at risk, they may be obliged according to law to stay under Statutory Intervention until such time that they are assessed to be successfully rehabilitated to return to family and community as self-reliant, optimally and adequately functioning social actors.

IF outcome indicators show sufficient and convincing evidence of Reintegration,

THEN an assumption of an integrated, self-sustained and caring society that provides equitably for citizens in the target groups may be made.

The SDTA functions as a needs assessment instrument in the ISDM, providing contextual information for decision-making regarding the relevance of sub-programs. The question whether a program
needs to be resourced at an equivalent, higher or lower rate demands information at the outcome level in addition to output and process (activity, program) information. Indicators therefore need to be developed at all levels of the program intervention system to be able to make meaningful decisions. Indicator development is a function of the monitoring, evaluation and reporting (MER) department of the DSD.

An illustrative example of how such a system of indicators can be constructed is presented at the end of this chapter with reference to the sub-program on people with disabilities.

### 1.5 Social trends and challenges

In the final section of this chapter we shift the attention to social and demographic trends that have a bearing on social development and service delivery. The review that follows scans trends at the national level and puts Western Cape in perspective to these trends. There are a number of benchmark analyses conducted during the last decade that highlight significant social changes in South African society. The first major study is the Ten Year Review.

#### Ten Year Review: 1994-2003

The Ten Year Review, a publication of The Presidency, reflects progress made by the South African government since 1994 in taking on the challenge of creating and establishing a new and fully-fledge functioning democracy, and highlights new emerging issues in doing so. The challenges for the following ten years arose from lessons learnt from this assessment of the first decade of freedom. The Ten Year Review revealed four social trends that constituted the social transition of the first decade of democracy. The four major social changes were:

1. A decrease in the size of households and a growth of the number of households that created more demands for household level services.
2. The growth of the economically active population was double the rate of the total population. The result was that more job seekers, including African women from rural areas were brought into the labour market.

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3. A shift in employment away from the public services, construction and mining to the service sector and the growth of the so-called second economy characterized by informal, marginalized and less skilled workers.

4. An increased movement of people from rural to urban areas that affected the social and economic fabric of both rural and urban areas.

Seen as indicators of the social transition within the country since the inauguration of democracy, the Ten Year Review provided a four-point framework (“four big ideas”)⁷ that enabled among others the Department of Social Development at national level to identify the six focus areas plus a universal principle of implementation, which functioned as guiding strategies for institutional and programmatic activities and allocation of resources in the implementation of the Population Policy for South Africa. They were:

- Sustainable local population and development
- Population, environment and development
- The social and economic integration of youth and children
- The socio-developmental impact of HIV & AIDS
- Policy development, monitoring and evaluation
- Regional population and development strategy

Gender mainstreaming was assumed to be a need in all projects emanating from the six focus areas and should therefore serve as an overarching principle in all implementation.

**Macro social trends – 1994-2006⁸**

A second review of macro social trends in South Africa comes from another report by the Presidency. The section that follows highlights features emphasized by this report.

- **Overall characterisation of society**

South Africa is seen as a society in dynamic change, both materially and spiritually. Much of the social mobility may be a reflection of immediate corrections to the history of discrimination. It

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⁷ These four ideas are: (1) defining a shared destiny and social compact to enable a framework of encompassing all long-term development objectives; (2) a better performance by the State; (3) addressing the consequences of the social transition; and (4) improving the environment in the subcontinent. (RSA, 2003. *Towards a Ten Year Review*. Pp. 103-112).

should be expected that, with the expansion of the economic base and BBBEE, such a trend should continue, even if the pace may slacken.

With regard to most of the macro-social indicators, racial profiles persist and there is little sense of an overarching identity. Racial profiles are recognised in ownership and control of wealth and income, access to social services such as health, water, housing, electricity and education; the character of civil-society structures to which individuals belong; and public opinion on various aspects of government activity.

Reconstruction and development as well as nation-building and reconciliation still feature as the core issues defining society’s endeavours and aspirations. Despite the diversity within society with respect to language, religion, and culture indications are that levels of social cohesion, in terms of unity, coherence, functionality and pride among South Africans have made some strides. However, this is drawn back by the legacy of inequality, intense migratory trends, crime related to social conditions and vestiges of racism in terms of attitudes and practical actions.

- **Main social trends**

South Africa has experienced an improvement in the quality of life of the majority of citizens, but the backlogs – defined still in terms of race – remain huge. For those on the lowest rung of the socio-economic ladder, there are manifestations of a poverty trap influenced by such factors as education, gender and geographic location and reflected in income, access to opportunities and assets – an expression of two economies in one country.

Many people have joined the middle strata and beyond as a reflection of the normalisation of society and the expansion of opportunity. Provision and use of educational opportunities proved to be crucial in the upward social mobility trend. However, inequality even within these strata seems to be increasing.

Low economic activity and a lack of a spirit of entrepreneurship seem to be present, particularly among African and coloured communities, especially in rural areas.

Massive migration to areas with higher economic potential confirms the artificiality of the apartheid economic geography, and puts high on the agenda the issue of spatial planning. The programmes of the democratic Government have put quite a high premium on equity as it applies to targeted groups, including women, children and people with disability.

The health profile of the nation, as the mortality statistics show, points to issues concerning social conditions and lifestyles. It is critically important to contain the HIV and AIDS epidemic, improve awareness of health issues generally and the health infrastructure.
While there is a myriad of causes of a variety of crimes, a critical underlying factor, especially in respect of contact and property-related crimes, is the issue of social conditions. This includes poverty, the built-environment, choice of forms of recreation and so on. Most of these crimes take place in underdeveloped areas among the poor. Combined with this, especially with regard to serious cases of robbery, drug-peddling and commercial crimes, is the element of greed in society.

- **Social networks and social capital**

There is a trend for the nuclear family to recede as a basic unit of social organisation, with an increase in single or extended households. At the one level, this reflects the dynamism of a society experiencing social change; but on the other hand, it presents serious challenges of household subsistence in poor areas and the social upbringing of the young.

Many citizens belong to social networks of various kinds outside of family circles. The poor are the ones with the least effective social capital. Data suggest that rural poor Africans seem to be the least networked. Research has shown that with the exception of churches and burial societies this group remains socially disconnected.\(^9\) In urban areas stokvels and sport may function in addition as network opportunities.

Participation in civil society activities is relatively high, and in broad terms, South African society seems to manifest a high level of socio-political consciousness. This is reflected both in electoral participation and community assertion of rights.

Religion is a critical social force among all communities. It is also seen by many as a critical instrument of social intervention, especially in relation to matters of nation building, reconciliation and poverty alleviation.

**Diagnostic Overview\(^10\)**

Many of the ideas raised in the previous section are echoed in the recent (2011) Diagnostic Overview that forms the precursor of the National Strategic Plan for development to 2030. This overview enumerates nine challenges for the socio-economic development of South Africa – many of whom are echoed in the individual provinces. The nine challenges link to two basic truths about South Africa today, despite the numerous advances and developments that can be highlighted in the post-

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apartheid period, namely (1) too few South Africans are employed, and (2) poor educational outcomes prevail. The challenges are:

- Too few South Africans are employed
- The quality of education for poor black South Africans is substandard
- Poorly located and inadequate infrastructure limits social inclusion and faster economic growth
- South Africa’s growth path is highly resource-intensive and hence unsustainable
- Spatial challenges continue to marginalise the poor
- The ailing public health system confronts a massive disease burden
- The performance of the public service is uneven
- Corruption undermines state legitimacy and service delivery
- South Africa remains a divided society.

Basic to these challenges are the need to address poverty and inequality in society. The unemployment rate (narrow definition) is illustrated below showing that it decreased over the last decade but since 2008 a slight increase is observed. Unemployment is a serious issue for young people.

**Figure 1.3: Unemployment rate by age, South Africa, 2002-2010**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2002</th>
<th>2004</th>
<th>2006</th>
<th>2008</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 24</td>
<td>55.9</td>
<td>51.8</td>
<td>50.2</td>
<td>46.6</td>
<td>51.3</td>
</tr>
<tr>
<td>25 – 34</td>
<td>34.1</td>
<td>29.8</td>
<td>28.5</td>
<td>26.2</td>
<td>29.1</td>
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<tr>
<td>35 – 44</td>
<td>21.0</td>
<td>18.2</td>
<td>18.2</td>
<td>16.6</td>
<td>17.8</td>
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<tr>
<td>45 – 54</td>
<td>16.1</td>
<td>11.9</td>
<td>12.4</td>
<td>9.3</td>
<td>12.4</td>
</tr>
<tr>
<td>55 – 65</td>
<td>10.0</td>
<td>7.2</td>
<td>6.9</td>
<td>6.5</td>
<td>7.3</td>
</tr>
</tbody>
</table>

The other side on the unemployment coin is the question of how many people in the economic age are actually working. The labour absorption rate is the proportion of the working-age population (15-64 years) that is employed. Western Cape has succeeded in employing more than half their working-age population, which is better than the percentages for South Africa over different years. Western Cape shows an improved percentage over time while South Africa’s percentage is decreasing.

Figure 1.4: Labour absorption rate for 2002 to 2010 (selection), Western Cape and South Africa.\textsuperscript{12}

<table>
<thead>
<tr>
<th>Year</th>
<th>Western Cape</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>52.9</td>
<td>43.1</td>
</tr>
<tr>
<td>2006</td>
<td>54.0</td>
<td>44.4</td>
</tr>
<tr>
<td>2010</td>
<td>54.3</td>
<td>40.8</td>
</tr>
</tbody>
</table>

Figure 1.5: Gini coefficient for income and expenditure, Western Cape and South Africa, 2009\textsuperscript{13}


\textsuperscript{13} Republic of South Africa. 2010. Development Indicators. The Presidency.
Inequality in a society is measured by the Gini coefficient. The figure shows that inequalities are less (but still high) in Western Cape in comparison to South Africa (the overall variable) for both the income and expenditure calculations. Western Cape has the second lowest inequality index of the all provinces (only Northern Cape measured lower). Changes in the Gini coefficient in South Africa over time is said not to be statistically significant.

The health trends are worth noting as they impact on many social aspects. According to the Diagnostic Overview there are four main burdens of disease. The first burden is the HIV pandemic; the second is that of injury, both accidental and non-accidental; the third epidemic consists of infectious diseases such as tuberculosis, diarrhoea and pneumonia, which interact in vicious negative feedback loops with malnutrition and HIV; and the fourth burden of disease is the growing epidemic of lifestyle diseases related to relative affluence.

South Africa’s health outcomes are poor by world standards, and the country faces several epidemics:

- South Africa has 0.6% of the world’s population, 17% of the world’s HIV infections and 11% of the world’s tuberculosis cases.
- There is a scourge of trauma cases resulting from violence and road accidents (injury death rate of 158 per 100 000 population is nearly twice the global average).
- Infant and maternal mortality rates (43 per 1000 live births and 625 per 100 000 live births respectively) are extremely high and higher than other middle income countries.
- Non-communicable diseases such as diabetes and heart disease are rising sharply (non-communicable diseases in 2004 relative to baseline value in 1997 shows a fivefold increase).

Many epidemics are not new, but the evolution of HIV has completely changed the nature of the disease burden in South Africa, especially in the past decade. Another plight that is seldom mentioned is the incidence of foetal alcohol syndrome, of which South Africa has the highest rate in the world. One of the only positive health outcomes in the past 17 years has been the reduction of smoking.

While the country’s disease burden is rising, the health system is collapsing. Improving health outcomes depends on several determinants:

- Stabilising and reducing substantially HIV and TB infections, and treating people who are already infected
- Changing lifestyles to limit HIV infections, and promoting healthier diets and exercise
• Reducing levels of violent crime, domestic violence and road accidents
• Improving nutrition levels and tackling micronutrient deficiencies, especially among children
• Improving the quality of water and increasing access to sanitation
• Improving the quality of primary health care, especially for pregnant women and very young children
• Raising the number of people trained throughout the health system (and ensuring that they are retained in the country).

South Africa remains a deeply divided society and the major dividing line in society is still race. While race is still the key dividing line, issues such as gender and locality are also important factors that explain differences in opportunity. Inequality compounds this division. While significant progress has been made in deracialising the upper end of the income spectrum, poor quality education and high youth unemployment inhibits a broadening of opportunity necessary to reduce inequality and heal the divisions of the past.

Crime finds fertile ground in countries with huge inequality and where citizens feel they need not practise good citizenship. Crime encourages the growth of gated communities. The separate living spaces generate a high degree of relational distance, so people do not see themselves as part of a common citizenry. This, compounded with the legacy of the Group Areas Act and the effects of poor public transport, means the sharing of geographical space across class and race still remain difficult.

At a micro level, the family is the principal agent for socialisation, value inculcation and creating a sense of belonging. The family represents the centre of children’s lives. According to the Macro Social report\(^{14}\), the two-parent household is on the decline, with an increase in the proportion of both single and extended households in urban and rural areas; marriage rates are falling. Households grew faster than the individual population. This therefore means additional support is needed for this institution, i.e. the family, to help inculcate values embodied in the Constitution, but also to equalise opportunity for all South African children.

For many South Africans, faith is an important element of social capital, and religious institutions are also useful for the social cohesion project because they are a repository of social values. Similarly, other social activities such as sport, recreation, education, work and community organisations are essential building blocks in uniting people by creating a common identity and understanding of their fellow citizens. They are important partners for driving nation building and social cohesion.

\(^{14}\) Republic of South Africa. N.d. (c2006). *A Nation in the Making.*
Non-sexism is enshrined in the Constitution. However, patriarchal practices still render the participation, citizenship and voice of women suboptimal. For example, women still earn less than men on average and only 18% of managers are women. Women are expected to conduct their productive and reproductive roles, (child care, caring for the sick, fetching water and fuel etc.) thus reducing the possibility of engaging adequately with the broader economy. Violence against women is rife and the rate of sexual offences is extraordinarily high by international standards with poor conviction rates for such offences.

PGWC Strategic Plan

While the overviews above address trends in the South African country context, this section turns to Western Cape. The approach is to highlight findings from the most recent strategic development planning document and to put findings where possible in comparative perspective with the total population of South Africa. The Strategic Plan lists a number of socio-economic and related problems facing the province. We follow the list as presented in the Strategic Plan.

1. Economic growth and job creation

While the GDPR increased in 2001 from R144 billion to R253 billion in 2006, with manufacturing, finance and business as the main industrial sectors, the (narrow) unemployment rate was 23.62% in 2010 (2nd quarter), including 579,683 people consisting of 272,852 coloureds and 219,777 Africans unemployed.

2. Education

There is a clear correlation between the number of years that people attend school and the level of income they earn. It is for this reason that especially illiterate people struggle to earn a decent income and this makes it difficult for them to escape poverty. For instance, 24% of the population 20 years and older has less than 9 years of schooling. Also, 40% of the labour force in the province earns no income at all.

Of the children that ought to attend school, at age 7, only 73% are enrolled. Only 44.01% of the learners that start in Grade 1 reach Grade 12 without failing, 31.7% pass matric, and 14% pass matric with exemption. The rate of school drop-outs increases strongly when learners reach 15 years of age when schooling is no more compulsory. An estimated 62,524 learners have dropped out from Grades 8 to 12.

PGWC. 2010. Delivering the Open Opportunity Society for All: The Western Cape’s Draft Strategic Plan.
The quality of education seems not to be good according to numeracy and literacy assessments of learners. Only 20% of learners in Grade 6 pass the numeracy competency assessment. The matric pass rate of 2005 drops from 84.45% to 75.8% in 2009. Pass rates for mathematical literacy at matric level drop from 91% (2008) to 89% (2009), and for physical science 71.2% to 52.9%.

In 2009, 1,163 learners fell pregnant. The majority of the pregnant learners were in Grades 9 to 12. The data for 2009 also shows that learners get involved in sexual activity from as early as Grade 4.

3. Public transport

According to the 2003 National Transport Survey, of those who used public transport, 87.4% said that the maximum walking time to the nearest transport facility was between one and 15 minutes. Just more than 56.3% of respondents said that they walk to their education institution.

4. Health

The Western Cape population suffers from a rapidly growing burden of disease. More and more people in the province are getting HIV/AIDS and tuberculosis (TB). The composition of the Western Cape population is changing because of the higher number of people with TB and HIV/AIDS. The result is that more and more adults are dying at an earlier age. This leads to a smaller number of people that children in especially the rural and informal communities can depend on to care and provide for them. The burden of disease affects the poor more because they are the hardest hit by the suffering, illness and death caused by disease. Also, the burden of disease often forces poor families into even more poverty because they normally do not have the money to care for the sick. They also lose the income of the family member who is sick or dies.

5. Crime and personal security

Crime is of increasing concern to the residents of the Western Cape and its government. The high rate of crime is recognised as one of the reasons why investors do not want to invest in a province, and this has a negative impact on the poor. Unfortunately, crime also offers poor people an opportunity to get material goods through illegal ways. For poorer people the opportunities or money that that they can get through crime far outweigh the risk of criminal prosecution.

6. Social cohesion

Social cohesion refers to the extent to which a society is coherent, united and functional, providing an environment within which its citizens can flourish. Factors that influence the cohesive capacity of the Western Cape’s population include high and violent levels of crime, gender inequality, teenage pregnancies, and substance abuse.
7. Poverty

The labour force population (defined as those between the ages of 15 and 65 years) of the Western Cape is composed of about 3.6 million people. This breaks down into 583,820 youths (those from 15 to 20 years of age), 2,854,088 adults (those aged between 21 and 59 years) and 178,023 elderly persons (60 to 65 years). Of the three groups, it is the youths who are most likely to be ultra poor (earning less than R400 per month). More than half of all adults in the Western Cape are poor (earning R401 to R1,600 per month) but many experience much lower poverty. A smaller percentage of elderly people experience ultra poor rates compared to the other age groups because they normally receive a social grant like a monthly state pension.

The inverse relationship between level of education and poverty is obvious from observations that confirm that fewer people are ultra poor if they finish matric, and the more education people have, the less poor they are.

8. Environment

Most of the carbon dioxide released from energy use within the province comes from electricity production, followed by petrol and diesel use. Industry is the largest user of electricity in the province, followed by transport, the residential sector and then commerce and government.

According to water quality testing, a high proportion of sites with poor water quality were in the Greater Cape Town area.

These observations indicate that the condition of the environment is directly linked to human activities (production, transport, residential, etc.) and may affect the quality of life of humans, and especially vulnerable groups such as the poor.

In conclusion to the Western Cape strategic planning report, one finds that it echoes strongly the social and economic issues highlighted in the Diagnostic Overview for South Africa. For instance, the same challenges are identified for both South Africa and Western Cape with respect to poverty and unemployment; quality of education; health systems and burden of disease; social cohesion and overcoming inequality; and to a limited extent infrastructure challenges (in Western Cape public transport is an issue). Western Cape highlights crime and personal security and environmental issues as challenges. South Africa sees weak public service delivery and corruption as major challenges.
1.6 Population trends

The population structure of Western Cape is very different from other provinces and from South Africa’s population. With a current population size of 5 287 863\(^\text{16}\) and representing 10.45% of the country’s population, it is the fifth most populous province out of nine. It includes the highest percentages for coloureds (50.2 \%)\(^\text{17}\) and whites (18.4 \%) in comparison to other provinces or South Africa as a whole. While Black Africans represent 79 \% in the South African population and much more in any other province they represent only 30.1 \% in the Western Cape population. In comparison with the past, Black Africans are a strong growing group in Western Cape – they increase from 20.9 \% in 1996 to their present proportion, and coloureds and whites are slightly decreasing in their proportions.

The change in the relative sizes of the racial population groups is primarily due to a net in-migration of people to the province, which is also a distinguishing feature as Western Cape is the only province other than Gauteng that shows this feature.\(^\text{18}\) The numbers of these groups are all increasing but Black Africans have grown by 7.9 \% per year over the inter-census period of 1996-2001 while coloureds grew by 2.6 \% and whites by 0.3 \%. The province as a whole increased at a rate of 2.7 \% per year. The Indian group, as a small minority of 1.3 \% of the provincial population grew significantly by 2.2 \% over the period.\(^\text{19}\)

The internal population trends over the period 1996 to 2007, based on district municipal demarcations, are given in Table 1.1. The spatial unevenness is clear: the City of Cape Town hosts about two-thirds of the population, a proportion that is steadily increasing. The population of the rural hinterland of the Western Cape is spread out over the coastal plain, mountain-valley landscapes, and the plains of the Great Karoo. The Cape Winelands provides livelihood for just less than 15 \% of the total provincial population in a decreasing proportion, followed by Eden with less than 10 \% of population. West Coast, despite the industrial concentration at Saldanha-Vredenburg, draws about 5 \% of population that seems to be decreasing. The same is true of Overberg (with 4 \%) and Central Karoo (just above 1 \%).


\(^{17}\) Northern Cape has a higher percentage for coloureds (52.3\%) but it represents a small number of people.


The hinterland’s economy is based on agriculture, tourism and services in contrast to the metropolitan economy that has a strong industrial component among a diversified economy. Although some small towns succeed in attracting tourists and cultural events, as well as recreational and holiday opportunities, they are mostly in survival mode and are artificially maintained by government afforded and subsidized infrastructure and services. Due to a vibrant transportation industry, road infrastructure and electrification supply system, towns located on the highways of the N1, N2 and N7 and some sub-routes (e.g. R62) are showing signs of economic activity and growth.
Table 1.1: Population and household in the Western Cape and Municipal Areas over 1996, 2001 and 2007

<table>
<thead>
<tr>
<th>Variable</th>
<th>City of Cape Town</th>
<th>West Coast DM1</th>
<th>Cape Winelands DM2</th>
<th>Overberg DM3</th>
<th>Eden DM4</th>
<th>Central Karoo DM5</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area (km²)</td>
<td>2502</td>
<td>31141</td>
<td>22298</td>
<td>11395</td>
<td>23332</td>
<td>38873</td>
<td>129307</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>1996</td>
<td>2563095</td>
<td>234608</td>
<td>563176</td>
<td>159006</td>
<td>380880</td>
<td>56111</td>
<td>3956876</td>
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<td>2001</td>
<td>2892243</td>
<td>282672</td>
<td>630493</td>
<td>203519</td>
<td>454924</td>
<td>60483</td>
<td>4524335</td>
</tr>
<tr>
<td>2007</td>
<td>3497097</td>
<td>286751</td>
<td>712413</td>
<td>212787</td>
<td>513307</td>
<td>56320</td>
<td>5278585</td>
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<td>Population percentage</td>
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<tr>
<td>1996</td>
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</tr>
<tr>
<td>2001</td>
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<td>73449</td>
<td>149397</td>
<td>56658</td>
<td>119306</td>
<td>15009</td>
<td>1173304</td>
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<tr>
<td>2007</td>
<td>902278</td>
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<td>60056</td>
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<td>Household percentage</td>
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<td>2001</td>
<td>64.7</td>
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<td>7</td>
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<td>2007</td>
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<td>Household average size</td>
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<tr>
<td>2007</td>
<td>3.9</td>
<td>3.8</td>
<td>4.1</td>
<td>3.5</td>
<td>3.6</td>
<td>3.6</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Table 1.1 also shows a densification of population and households in the City of Cape Town. Households have not only increased in number and percentage in the metropolitan area but also according to the size of household while the sizes of household in the different district municipalities are getting smaller. This trend indicates that the metropolitan government is challenged to provide among other more housing units for bigger households.

Apart from fertility and mortality, internal migration is a strong driving force in the dynamics of population of Western Cape. Indications are that fertility is decreasing and comparatively low in Western Cape (TFR 2.3\textsuperscript{21}) and that the life expectation at birth for both women (65.8) and men (59.9\textsuperscript{22}) are on the increase. The population is therefore moving towards a so-called mature population. Volatility is however observed in the migratory aspect. Western Cape gained over 2006-2011 an estimated 95 556 persons as a net migration factor (on average just below 20 000 per year). This figure is down on the previous five-year period of 2001-2006 when the average figure was approximately 30 000 a year. The main migration interaction internally was with Eastern Cape, Gauteng, KZN, and Northern Cape, in this order. More than 50 % of the net gain was from Eastern Cape followed by Gauteng (24 %), KZN (8.4 %) and Northern Cape (6.3 %). Just over 36 % of the net out-migration was to Eastern Cape.\textsuperscript{23} The Western Cape is expected to remain a destination for migrants and, in terms of population dynamics, to experience continued growth of its population as a result. This seems to be becoming a diminishing trend.

There is a hint of a slightly different trend when one looks at foreign-born population in Western Cape but unfortunately recent information is scarce. Marindo (2008) informs that during 2001, the total population of foreign-born persons enumerated in Western Cape was 108 908, which comprised 2.5 % of the total population. Between 1996 and 2001, the percentages of foreign-born population declined from 5.6 % in 1996 to 2.5 % in 2001, a decline of 3.1 % over a five-year period. The Community Survey in 2007 estimated foreign-born persons in Western Cape, which was approximately 3.2 % of the total population. This represents a slight increase of 0.7 % from 2001 but still a substantial decline from the 1996 census.

Of the foreign-born persons noted in the census of 2001, over 80 % were counted in the City of Cape Town and 47 % were from European descent, 36 % from SADC and 6 % from the rest of Africa.


\textsuperscript{22} Life expectancy at birth is increasing for women from 63.9 to 65.8 and for men from 57.5 to 59.9 years, from 2001-2006 to 2006 to 2011. Statistics South Africa. 2011. \textit{Mid-year Population Estimates 2011}. Statistical Release P0302. Pretoria.

\textsuperscript{23} The net out-migration to the other provinces was Gauteng (27%), KZN (12%) and Northern Cape (9%). Statistics South Africa. 2011. \textit{Mid-year Population Estimates 2011}. Statistical Release P0302. Pretoria.
Roughly, just below 40% of the foreign-born persons were classified as non-citizens\(^{24}\) of which 52% were from European descent, 24% from SADC and 10% from the rest of Africa countries. When these groups are analysed according to age, the non-citizens from African origin clearly demonstrate a labour migration pattern and those from Europe a family or retirement migration, representing an aging population.

In summary, Western Cape is experiencing high population growth rates, particularly on the coastal plains and mountain-valley landscapes. The district municipalities of Overberg, West Coast and Eden, which are located in these areas, are showing high annual growth rates while Central Karoo shows a far lower growth rate. The rates are given in Figures 1.6 and 1.7.

**Figure 1.6: Annual population growth rates for two inter-census periods (1996-2001; 2001-2007), district and metropolitan municipalities and Western Cape\(^{25}\)**

<table>
<thead>
<tr>
<th></th>
<th>96 to 01</th>
<th>01 to 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Cape Town</td>
<td>2.45</td>
<td>3.22</td>
</tr>
<tr>
<td>West Coast DM1</td>
<td>3.8</td>
<td>0.24</td>
</tr>
<tr>
<td>Cape Wineland s DM2</td>
<td>2.28</td>
<td>2.06</td>
</tr>
<tr>
<td>Overberg DM3</td>
<td>5.06</td>
<td>0.74</td>
</tr>
<tr>
<td>Eden DM4</td>
<td>3.62</td>
<td>2.03</td>
</tr>
<tr>
<td>Central Karoo DM5</td>
<td>1.51</td>
<td>-1.2</td>
</tr>
<tr>
<td>Western Cape</td>
<td>2.72</td>
<td>2.6</td>
</tr>
</tbody>
</table>

\(^{24}\) Non-citizens could be regarded as more recent immigrants that not have registered as citizens. All information in this respect has been taken from Marindo, 2008. Marindo, Ravayi. 2008. Foreign-born and non-citizen populations in the Western Cape (1996-2006): A Demographic Overview, Chapter 7 (pp. 151-174) in: Marindo, Ravayi, Cornie Groenewald & Sam Gaisie (Editors). The State of the Population in the Western Cape Province. Cape Town: HSRC Press.

In terms of socio-economic indicators, Western Cape performs relatively favourable in comparison to other provinces and is showing the lowest poverty index in the country. There is however a small increase in the poverty index over the 1996-2001 inter-census period, perhaps due to the fact that the province invites large numbers of poor people to its population through net in-migration.27

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The comparison of LSMS for Western Cape and South Africa clearly shows that Western Cape enjoys higher living standards than the population of the country at large.

The HIV prevalence rate in Western Cape was the lowest in the country in 2008 when the rate was 16.1%. This was just below half the national figure of 29.3%. The Western Cape figure rose to 18.5% in 2010 while the national rate increased to 30.2%. The Western Cape rate not only grew faster than the national figure but no longer is the lowest provincial figure in the country (Northern Cape now rates lowest).²⁹

### 1.7 Conclusion

This is a background paper to serve the purpose of the SDTA for improved and relevant service delivery and developmental programs in the Western Cape province generally and the social sub-programs within the social welfare and development sector in particular. An SDTA supports purposeful planning in terms of baseline information and a deep understanding of the social and population dynamics of the community. It aims to facilitate informed outcome and impact assessment according to relevant and valid indicators of program performance.

²⁸ SAARF. Percentages: own calculations. The South African Advertising Research Foundation (SAARF) Living Standards Measure (LSM) divides the population into 10 LSM groups 10 (highest) to 1 (lowest) and LSMS are calculated using 29 variables taken directly from the SAARF All Media and Products Survey. It calculates an imputed average monthly income. Reported in: Republic of South Africa. 2010. Development Indicators. The Presidency. Pretoria.

According to this purpose of the current SDTA the chapter has established the policy, constitutional and legal mandate for the DSD to appropriately provide social assistance to vulnerable, disabled and marginalized individuals and groups. The chapter furthermore highlighted the model according to which the DSD fulfills this mandate, namely the ISDM. The goal of the ISDM is to contribute holistically to an integrated, self-sustained caring society that provides equitably for all of the members of the DSD’s target groups. Target groups are identified according to programs and sub-programs that are reviewed in the next number of chapters. The ISDM works according to different levels of intervention and types of services.

A need has been expressed to develop indicators that may be applied for the standardization of future trend analyses. In this chapter, it has been argued that unless clarity is gained about the underlying program theory according to which services are delivered by the DSD, little progress in identifying of such indicators can be made. It seems that a distinction should be made among input, process and output indicators on the one hand and outcome and impact indicators on the other. Work needs to be done particularly on outcome and impact indicators.

To illustrate how this may be accomplished the next section is presented as an example to serve this purpose. The sub-program for people with disabilities is used as an illustration.

Furthermore, the review of sub-programs needs to be informed by a needs assessment based on the SDTA. The chapter proceeded by perusing some recent social trends analyses at national level and comparing them to analyses at provincial level. The analysis confirms that Western Cape is demographically and economically vastly different from the national profile but the social issues and challenges remain very much the same. Notably, society is racially divided and unequal, lacking strong social capital and cohesion, and burdened by diseases (particularly HIV and TB), crime and enduring poverty. The educational and health systems are failing to provide sufficiently in the acute and chronic needs of the community, and the economy is not creating sustainable job opportunities. These are to a large extent systemic weaknesses of the socio-political system that necessitate social relief that is draining resources and promoting a culture of dependency more than self-reliance.
1.8 Illustrative Example

Sub-program on people with disabilities

Program theory

A program theory is a plausible and sensible model of how a program is supposed to work\(^{30}\) and therefore an explicit theory of how an intervention is understood to contribute to its intended and observed outcomes. Ideally it includes a theory of change and a theory of action.\(^{31}\) In explicating the program theory of the sub-program on people with disabilities the following logical elements are distinguished and described.

1. Problem statement and needs assessment

Physical and mental disability constitutes a social problem not only as a result of the magnitude of disabled people in the Western Cape province (an estimate 244 000 disabled persons, or 5% of the total population) but because of their vulnerability, disadvantage and exclusion from the mainstream society. Disability is defined as the disadvantage and exclusion which arise as an outcome of the interactions between people who have impairments and the social and environmental barriers they face due to the failure of society to take account of their rights and needs. Mainstreaming seems to be a necessary response to address the lack of recognition of disability as a developmental challenge.

Mainstreaming is the process of engaging in a structured way with an issue as an organisation, at workplace, programme and policy levels, in order to address, and avoid increasing, the negative effects of that issue.\(^ {32}\) In other words, mainstreaming is a method for addressing specific issues in areas where they wouldn’t normally be addressed. Hence it is regarded as necessary to strengthen the voice of disabled people, support them with basic as well as specialised services to enable them to participate fully as citizens in society.

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2. Program goal and aims

According to the ISDM the aim of a social intervention at all levels of service delivery is achievement of the desired level of social functioning. There are those whose functional capacity will require continued intervention as in the case of people with severe disabilities. The multilevel level approach of the ISDM ensures that there is an exit strategy that is the method towards enhancing sustainability of intervention efforts.

The sub-program for disabled persons aims to ensure that people with disabilities have access to appropriate services and networks that promote the best possible standard of living. It also aims to ensure equal access to social services, life-long learning and economic opportunities in the face of barriers that continue to exclude people with disabilities from mainstream society and its social and economic activities. It furthermore wants to ensure that people with disabilities who are poor, vulnerable and marginalised have the tools to be resilient, independent and fully integrated into society.

3. Program services

Services are rendered to people with disabilities in terms of the Integrated National Disability Strategy and the Mental Health Act, as well as international conventions. The services include prevention services, rehabilitation services and continuing care services.

Three areas of services are specifically designed for persons with disabilities:

- **Residential Care Program for** temporary or permanent care, protection, support, stimulation, skills development and rehabilitation of persons with disabilities, who due to their disability and social situation need care

- **Protective Workshops Programme for the** socio-economic empowerment of persons with disabilities

- **Social Work Services:** inclusive of counseling services, psycho-social support programs, peer group therapy, awareness and educational programs.

The DSD programme targets on the persons most in need of assistance, while other provincial state departments, like Education and Health, also cater for needs of disabled. Most of the services provided are in partnership with NGOs and other funded organisations.

4. Inputs

In supporting people with disabilities, the DSD has in the year 2010 / 2011 focused strongly on advocacy, policy education and awareness, providing direct access to services for 15 000 beneficiaries, and reaching 35 278 through awareness, prevention and early intervention programmes. The funds transferred to NPO’s delivering services for persons with disabilities are currently R46,7 million.
5. Activities

Provide and conduct -

- Residential care facilities (temporary or permanent care, protection, support, stimulation, skills development and rehabilitation of persons with disabilities in need of such care)
- Protective workshops (socio-economic empowerment of persons with disabilities)
- Social work services (counseling services, psycho-social support programs, peer group therapy, awareness and educational programs).

6. Outputs

- Residential care facilities
  - 1380 disabled persons reached through residential care services
  - Funded residential facilities for persons with disabilities – currently 33
  - Residential facilities managed by NPOs capacitated on minimum standards on residential facilities for persons with disabilities – currently 10
- Protective workshops
  - Projected target for 2011/12: 2549 through protective workshop services
  - Funded protective workshops for persons with disabilities - currently 43
- Social work services
  - Counseling services; psycho-social support programs: peer group therapy; awareness and educational programs
  - Projected target for 2011/12: 79000 through social work services inclusive of broader disability awareness and education programmes
  - Disability awareness and educational programmes – currently 35 278

7. Outcomes and Impacts

- To establish the best standard of living for disabled people through ensuring access to appropriate services and networks
- To have equal access to social services, life-long learning and economic opportunities
- To acquire tools (competencies, skills, technology and infrastructure) to be resilient, independent, and fully integrated into society.
Program theory structure according to IF-THEN statements

**IF** Government (DSD, PGWC) votes adequate resources (including a relevant policy framework, funding, infrastructure and human resources) for mainstreaming persons with disabilities

**AND** undertakes by itself and/or transfers funds to NPOs to undertake the provision of services, facilities and opportunities that would meet the special needs of disabled people and their families

**AND** these services, facilities and opportunities include advocacy, policy education and awareness, as well as direct access to special services such as residential care facilities, protective workshops, and social work services

**AND** the provided services, facilities and opportunities adhere to the minimum standards (as determined in national and provincial policy in line with international conventions and human rights) for disabled persons

**THEN** sufficient numbers of disabled persons will be served and have gained

- the best standard of living for disabled people because they were ensured access to appropriate services and networks
- equal access to social services, life-long learning and economic opportunities, and
- have acquired tools (competencies, skills, technology and infrastructure) to be resilient, independent, and fully integrated into society.
Suggested Indicators for a Program on People with disabilities and their families

**Overall program goal:** To intervene socially on behalf and in the interest of people with disabilities and their families at all levels of service delivery to achieve a desired level of social functioning

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Indicators</th>
<th>Evidence - Secondary data</th>
<th>Evidence - Primary data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To create and enhance information, education and communication through advocacy, policy education and awareness in respect of the need of people with disabilities and their families</td>
<td>Information, education and communication campaigns designed for dedicated target groups</td>
<td>Documented and designed IEC tools and campaigns ready to be used by agencies</td>
<td>IEC tools applied and used by agencies</td>
<td>1.1 Number of IEC tools applied and used</td>
<td>Number of IEC tools in stock and supplied to agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.2 Impact assessment of applications of IEC tools on target audiences</td>
<td>Impact assessment of campaigns on target groups</td>
</tr>
<tr>
<td></td>
<td>Targeting business and employers, public service providers, civil society, etc.</td>
<td>Number, places, frequency, target groups</td>
<td>Increased level of knowledge, awareness, positive attitude and action in favour of people with disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>People with disabilities and their families</td>
<td></td>
<td>Increased level of knowledge, awareness, positive attitude and action among people with disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>To provide in the residential care needs of people with disabilities in cases where their families are not adequately equipped to provide care and related services</td>
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<tr>
<td>2.1</td>
<td>Acquisition of residential care facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2.2</td>
<td>Provision of temporary and permanent care to people with disabilities in need of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Number of facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Number of people and families served over period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Number of residential care to people with disability in need of such care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Number of people and families served over period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Number of residential facilities as recorded</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Residents on register with facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents and family feedback on quality of care as provided. Feedback forms to be completed regularly (including focus groups, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>Stimulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>Skills development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7</td>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Types of services, number and frequency over period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact of service on recipient in terms of improvement of physical and mental condition, change of behaviour and social functionality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Range of services per residential recipient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Measurement of change in physical and mental condition, behaviour and social functionality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Records of service providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Records of service providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback forms by recipients / families (including focus groups, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>To provide and conduct protective workshops for training and employing people with disabilities that cannot on their own compete in the open market</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Acquisition of workshops, resources and trainers/facilitators</td>
</tr>
<tr>
<td>2.</td>
<td>Conducting workshops as related to pre-determined needs</td>
</tr>
<tr>
<td>1.</td>
<td>People with disabilities trained</td>
</tr>
<tr>
<td>2.</td>
<td>People with disabilities in protective employment</td>
</tr>
<tr>
<td>3.</td>
<td>People with disabilities employed in open market</td>
</tr>
<tr>
<td>Socio-economic empowerment in terms of skills development and earning income through protective and open employment</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Number of workshops and types of trades and training</td>
</tr>
<tr>
<td>2.</td>
<td>Number of people with disabilities successfully trained in different skills and trades</td>
</tr>
<tr>
<td>1.</td>
<td>Workshops registered</td>
</tr>
<tr>
<td>2.</td>
<td>Workshop registers of trainees</td>
</tr>
<tr>
<td>3.</td>
<td>Workshop records of employees</td>
</tr>
<tr>
<td>4.</td>
<td>Workshop records of alumni</td>
</tr>
<tr>
<td>1.</td>
<td>Feedback forms by recipients / families</td>
</tr>
<tr>
<td>2.</td>
<td>Alumni follow-up research on employment</td>
</tr>
<tr>
<td></td>
<td>To provide professional social work services that would meet the social and related needs of people with disabilities and their families</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>4</td>
<td>Peer group therapy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psycho-social support programs</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educational program</td>
</tr>
</tbody>
</table>
1.9 Bibliography


Chapter 2: Substance Abuse, Prevention and Rehabilitation (Sub programme 2.2)

2.1 Introduction

This report forms part of a bigger project that sets out to do a comprehensive social and economic trend analysis that serves inter alia to develop a deeper and more nuanced understanding of emerging social and demographic trends and the extent the DSD is in focus terms of the way it reacts to the (changing) trends.

This report focuses on an important and daunting health and social challenge faced by the Western Cape (WC), i.e. delivering an effective and sustainable response to the abuse of substances by the population of the Western Cape. The prevalence and incidence of the rampant abuse of both licit as well as illicit substances, often associated with a raft of negative and destabilizing domestic, economic and social consequences, tend to be substantially higher in chronically impoverished communities compared to more affluent human and social environments. This is mainly due to a raft of unfavourable conditions and forces characteristic of the first mentioned areas. This thus implies that the province’s substance abuse programmes should primarily be focused on these poor and vulnerable areas.

2.2 Substance Abuse in the Western Cape

Definition of Substance abuse

The phenomenon of substance abuse or—misuse is notoriously unwilling to succumb to precise definitional clarity. Firstly, there is no agreement over what actually constitutes a (mind – altering) substance, and secondly even more mistiness exists around the issue what constitutes abuse or misuse. For example, a strict medical assessment of the number of alcoholic drinks daily permissible may vary vastly within different cultures and societies. The accepted norm is often constructed and determined socially or culturally and may differ substantially from one community or society to the next. What constitutes the abuse of a substance is thus highly context specific and relative.
For the purpose of this report the definition of substance abuse as operationalized in the National Drug Master Plan (2012 – 2016) will be used:

...the term refers to the misuse and abuse of legal substances such as nicotine, alcohol, over-the-counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illicit drugs...

Substance Abuse Prevalence

In order to arrive at an informed assessment of the relative success that the DSD enjoys in meeting the needs of the population of the Western Cape through their relevant programmes and services relating to substance abuse, it is important to develop an understanding of the extent of the challenge facing the province. Simply put, we need to be able to have a sense of the size of the population that misuse or abuse substances, as well as the nature of such abuse. This will enable the DSD arrive at an informed estimate of the size of the challenge facing it, and will subsequently help to devise the appropriate response to the problem of substance abuse, i.e. the need for (in-patient or out-patient) treatment, as well as the number of people that needed to be targeted through information and educational preventative programmes. It is of critical importance to have access to (some of) this information, as only then the DSD can answer two basic but strategically important questions:

- Firstly, is the DSD doing the right thing- e.g. are the programmes and their respective foci relevant, are the most important or pressing needs addressed.
- Secondly, if the right things are being done is the DSD doing it in the correct way- this relates inter alia to programme content and – approach – e.g. the methodology, format and content of a preventative programme aimed the youth.

Determining the extent of substance abuse, however, is tricky, as earlier mentioned; apart from the diverse criteria that different researchers use to define it, substance abuse often constitutes covert behaviour. This is especially, but not exclusively in the case of so called illicit substances – i.e. those prohibited by legislation, and thus nearly impossible to determine through orthodox research methods.

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33 Government Printer, Pretoria, 2011, 147
Thus, calculating the extent of substance abuse in the Western Cape is often inferential - based on assumptions and extrapolations of data collected at different rehabilitation centres etc. However, representative household surveys do allow for more accurate calculations regarding prevalence and incidence figures. The trends relating to substance abuse used in this report come from a variety of sources, the most important taken from publications of the South African Community Epidemiology Network on Drug Use (SACENDU)\textsuperscript{34}, as well as researchers\textsuperscript{35} based at universities and specialist research institutions. The discussion will concentrate on those substances that are particularly problematic in this province, notably alcohol, marijuana (dagga), Mandrax and Methamphetamine (tik), although some discussion will be included on the abuse of less “popular” mind altering substances.

**Substance: Alcohol**

In the Western Cape, alcohol has traditionally been the most frequently abused substance. This trend appears to persist. According to a review of a number of studies into substance abuse since 2000 by Harker et al (2008), the prevalence of lifetime alcohol use\textsuperscript{36} in the Western Cape ranges from 39% to 64% and the prevalence of risky drinking or problematic use among drinkers ranges from 9% to 34%, and is dependent on a number of socio demographic factors such as age, gender, socio-economic status and degree of urbanisation and also dependent on the instruments used to assess problem drinking.

Research findings suggest that the Western Cape has higher prevalence rates for risky drinking relative to the other provinces. Shisana et al. (2005) found that compared to other provinces, the Western Cape had the highest prevalence of risky drinking (16%), compared to less than 10% in the majority of provinces in South Africa.

According to Harker et al (2008) the Demographic and Health survey (SADHS) found that

\textit{.... of the nine provinces, the Western Cape had the highest lifetime prevalence (70.3\%) and highest past 12 month (55.1\%) use of alcohol among males. Likewise, for females, the Western Cape had the highest lifetime prevalence (39.2\%) and past 12-month use (28.8\%) of alcohol (2003/2004, 8)}

\textsuperscript{34} SACENDU is based at the Medical Research Council

\textsuperscript{35} This refers to amongst other to the University of Cape Town and the Human Sciences Research Council

\textsuperscript{36} Lifetime Alcohol use refers to the drinking history and patterns of alcohol intake starting from onset of regular drinking (expressed in quantitative terms, i.e. data). It is intended primarily to assess the drinking history of heavy drinkers.
In terms of gender it is well established through various studies conducted in the Western Cape that the prevalence of the consumption of alcohol is higher amongst males than females. The South African Demographic and Health Survey (2003/4) found that prevalence rates of alcohol use amongst men to be significantly higher nearly than that of women, i.e. 70% for males and 39% for females 16 years and older. However, interestingly enough, this trend does not appear to hold regarding rates for binge drinking on weekends; substantially higher rates among females (48%) than males (23%) were reported (SADHS, 2003). Contrary to this finding though, Harker et al (2008) points to findings from Shishana’s study (2005) that found higher levels of problem drinking reported amongst males (25%) compared to females (6%). Nevertheless, these findings collectively do indicate to high levels of alcohol use and disturbingly high levels of problem drinking prevalent in the Western Cape.

Another disturbing indicator of an unhealthy drinking pattern amongst many women in the Western Cape is the high prevalence of Foetal Alcohol Spectrum Disorders (FASD). According to Shishana (2005) the Western Cape had the second highest prevalence in South Africa of hazardous or harmful drinking during pregnancy. Harker et al (ibid) quotes a number of studies that established that the Western Cape has one of the highest FASD rates in the world. Rural farming communities are most at risk in this regards, (with wine and grape farming districts particularly renown in this regard). Studies conducted in the Winelands District of the Boland (Wellington, Ceres, Piketberg), recorded alarmingly high rates of FASD, with estimates ranging between 65.2 – 89.2 per 1000 children in these communities (Marais et al., 2005; May et al., 2006).

A HSRC household survey (Shishana et al, 2005 as quoted by Harker et al, 2008) has found that the highest prevalence of problem drinking in the Western Cape, i.e. hazardous drinking with the most damaging consequences, is evident in Coloured communities, relative to Black, White and Indian communities – with Coloureds registering 18%, compared to Black (11%), White (7%) and Indian (1%) persons.

The cost of alcohol abuse in communities to society is well documented. It is related to vehicle accidents, certain categories of crime and irresponsible sexual behaviour. An analysis of 2001 statistics by Pluddemann et al (2004) found that the proportion of alcohol- positive trauma patients who sustained road and transport related injuries was higher in Cape Town (46%) than in Port Elizabeth (41%) or Durban (16%). Apart from the role of alcohol in trauma patients, according to Harker et al (2008, 10)
mortality statistics also reflect the high burden of harm associated with alcohol use in Cape Town, relative to other sites. Findings from the National Injury Mortality Surveillance System reveal that in 2004 the proportion of alcohol-positive deaths due to violence was higher in Cape Town (59%) than in Durban (47%), Johannesburg (47%), or Pretoria (51%).


Compared to other sites, arrestees in Cape Town were more likely to report being under the influence of alcohol at the time of their arrest; with 23%, 16% and 6% of arrestees in Cape Town, Durban and Johannesburg respectively, reporting being intoxicated at the time of the alleged crime for which they were arrested.

Finally, research evidence suggests that alcohol use is associated with sexual risk behaviour. Both Parry, (2008) and Shisana et al (2005) found that there exists a link between high risk sexual behaviour and substance abuse. Their findings is supported by results of studies done by Olley et al (2005) who found that condom use and other safe sex practices were lower among persons who used alcohol prior to having sex.

A disconcerting new development is the steep increase in the consumption of so called Ales - cheap and often homebrewed alcoholic concoctions of fermented sugar, have exploded, particularly in the Western Cape where they are now thought to have overtaken the volumes of “papsak” wine that was sold in foil containers until they were banned in 2007. Ales are targeted on and consumed especially by the poorest of the poor consumers (selling at around R22 per 5-litre container) – to shebeens and bottle stores situated in both the urban and rural areas. It is part of the unregulated alcohol industry of the WC, and represents essentially a cynical and opportunistic attempt by some unscrupulous wine producers in the Boland to circumvent existing liquor legislation and not paying excise duty to Government. This development is disconcerting. There is no quality control on these products and an independent investigation has linked them to deaths and illnesses among consumers.37 The emergence of Ale is reminiscent of the infamous swartvarkie phenomenon of the 1980s.38

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37 Information supplied by the Chief Executive Officer of VinPro, Paarl, 27 February, 2012.
38 The swartvarkie was a 20 litre container of an alcoholic concoctions produced by a few farmers and distributed amongst the most vulnerable communities at a very accessible price. This author conducted research amongst impoverished communities of the WC to measure its impact. On strength of the research results the swartvarkie was subsequently banned by legislation.
**Substance: Cannabis (Marijuana) and Cannabis/ Mandrax**

Historically marijuana or cannabis, (colloquially referred to as dagga) has been one of the most commonly abused substances in the Western Cape, prevalent amongst all races and socio economic groups, but particularly common in the impoverished Coloured communities.

However, in the 1980s the abuse of a new substance grew in prominence amongst marijuana users of the Western Cape in particular, i.e. Mandrax. The consequences of the widespread use of these substances together represented a serious challenge to the health and social services in this Province. Although the use of Methamphetamine, colloquially referred to as tik has reportedly overtaken marijuana as the substance of preference amongst specific age cohorts and certain communities, the use of the latter mentioned is still widespread and very popular. Although research suggests a decline in the number of people using cannabis or cannabis and mandrax as the primary substance of use reporting at treatment centres, data from a SACENDU project revealed that when cannabis and cannabis/Mandrax are considered as both primary and secondary substances of use, the proportion of patients reporting the use of these substances increased to 31.7% for cannabis and 12.6% for the cannabis/Mandrax combination for the first half of 2007 (Harker et al, 2008).

The same authors caution that with the increased emphasis on managing the mushrooming of the tik phenomenon (and especially on the treatment of tik addicts) in the Western Cape, care must be taken not to neglect the care and treatment of cannabis and cannabis/Mandrax patients that present themselves to treatment centres and facilities. They make an interesting point, i.e. that the real extent of the need for clinical and or social intervention and treatment for cannabis and Mandrax may be difficult to determine given significant social tolerance and cultural acceptance of the use of these substances as normal due to its extensive use over decades in specific communities of the Western Cape.

Although the use of cannabis is prevalent amongst all races in the Western Cape, the latest research shows that the rate of its use amongst Black or African people in the Western Cape is higher than that of Coloured users. Harker et al (2008) stated that two recent studies (Wechsberg et al, 2006 and Myers (2006) both reported substantially higher rates amongst both Black than Coloured regular.

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39 Researchers operationalize their own definitions for regular and periodic users that denotes the level of usage; however, the first term typically refers to those that use a substance, for example like marijuana or alcohol at least three times a week, whereas the latter one refer to those that might use alcohol mostly at fixed or special celebratory occasions, like typically at ten end of the month with pay day or at a wedding or birthday function.
and periodic users. The similar pattern was established by Wechsberg et al in terms of gender with significantly higher rates of lifetime, monthly and weekly cannabis use among Black/African female substance users than among Coloured women.

Recent research results shows that the same pattern as with use of cannabis was established regarding the use of Mandrax in terms of race and gender, with Myers (2007) establishing higher levels of lifetime, monthly, weekly and daily Mandrax use among Black/African substance users than amongst Coloureds. In addition, Wechsberg et al (2007, as cited in Harker et al, 2008) found that a higher proportion of Black women tested positive for Mandrax than Coloured women in an HIV and substance abuse intervention study.

The prevalence in the use and abuse of both marijuana as well as Mandrax amongst males is higher than that of females. This was established by both Pluddemann et al (2007) who found that more men attend treatment centres for cannabis and Mandrax problems, as well as by Myers (2007) who found that the use of both these substances are consistently higher amongst men compared to women. Harker et al (2008) however, stressed that a number of studies (Sawyer et al, 2006; Wechsberg et al, 2007) found that the widespread misuse of marijuana amongst females in the Western Cape constitutes a mayor challenge. This implies that although men do exhibit higher prevalence use (or abuse) rates than women, the numbers of females that do participate in the use of cannabis and /or Mandrax is substantial and presents a significant medical and sociological challenge to stakeholders in the prevention and curative ecology of this province. Women, in many instances play a pivotal role in the effective domestic and social functioning of impoverished livelihoods. If they become incapacitated and unable to perform core functions like child rearing and socialization of the youth, it can have a devastating and long term impact on society.
Substance: Methamphetamine/tik

Less than a decade ago, the majority of patients accessing the Cape Town Drug Counselling Centre for treatment was battling with cannabis and/or Mandrax abuse and addiction. This has, however, changed radically over the last number of years, with Methamphetamine (MA) addiction now the most common addiction reported by patients visiting this Centre.

A number of studies support this trend. According to findings from a study by Pluddemann et al (2007) the percentage of patients admitted to treatment with methamphetamine abuse or dependence as a primary or secondary substance of abuse has dramatically increased from less than 1% in 2002 to 49% in 2007. Although this increase is disconcerting Harker et al (2008) points to the fact that this increase does not reflect necessarily a similar increase in the prevalence of MA use in the Western Cape. This is off course, correct, although these findings do suggest a steady increase in the use of MA in the general population. However, there is a need to conduct representative household surveys in the Western Cape in order to be able to accurately calculate the prevalence of MA and to subsequently be able to react to the challenges it poses in a targeted fashion.41

A number of studies (Myers, 2007; Parry et al, 2008) have also highlighted that MA is often used in conjunction with other substances, i.e. alcohol, cannabis an Mandrax. This is done, according to Harker, to temper a MA induced high (2008).

According to Harker et al (2008) the vast majority of persons in the Western Cape accessing treatment for methamphetamine-related problems are male, with the percentage of females accessing treatment ranging between 24% and 29%. Pluddemann et al, (2007) found that Coloured South Africans were in the majority to seek help with MA addiction, with them ranging from 81% to 92%) However, Harker et al (2008) and Plüddemann et al. (2007) warn that this not necessarily suggest that methamphetamine addiction does not constitute a problem amongst Black South Africans and women, as both experience more obstacles to access treatment.

40 Information supplied by the Director of this Centre during interview on 12 January, 2012
41 Unsubstantiated estimations is that the current use of MA in the Western Cape represents more than 90% of the total consumption of South Africa.
**Substance: Cocaine**

Cocaine (including crack/cocaine) is one of the less frequently used illicit drugs in the Western Cape. Results from a study by Shisana et al. (2005) reported population prevalence rates for the use of cocaine of less than 1%. Harker et al (2008) stated that the treatment admissions for crack/cocaine abuse in Cape Town have decreased from 8% in 2000 to 3.9% for the first half of 2007. Results from a study by Myers (2007) shows to higher prevalence rates for cocaine use among men relative to women, and also suggest higher prevalence rates amongst Black/Africans compared to Coloured persons. According to Harker et al (ibid) this refers most likely to the use of a cheaper type of crack/cocaine rather than the expensive cocaine HCl\(^{42}\) powder.

The few limited urban based studies done on cocaine use suggest that it is concentrated in the Southern, Tygerberg, and Central suburbs of the Cape Metropole. Harker et al (2008) points out that a strong void exists regarding prevalence data of cocaine in the rural areas of the Western Cape.

In terms of the harm associated with cocaine use in the Western Cape, Parry et al. (2008) has established an association between cocaine use and risky sexual behaviour, while the same authors and Wechsberg et al., (2007) found cocaine use leads to sexual assault while another studies by Parry et al (2004) established a link between cocaine use and property crime.

**Substance: Heroin**

Like cocaine, heroin has a low prevalence rate in the Western Cape, with one study (Shisana, 2005) recording population prevalence rates in this province for the use of this substance of less than 0.2%. However, although insignificant compared to alcohol usage, it is estimated that in 2004 Cape Town alone had nearly 20,000 heroin users (Pluddemann, et al, 2008). Also, according to a SACENDU study, the proportion of the heroin related treatment admissions increased from 4% in 2000 to 11% in the first half of 2007. (Harker et al, 2008). This increase suggests a renewed interest in the use of this highly addictive substance. Clearly it should be of a huge concern to both the medical and social treatment services in this province, given the high risk and consequences associated with it.

The most important health risk associated with heroin use is the increased vulnerability to sexual diseases, particularly due to risky behaviour and practices, e.g. injecting drug use practices. Pluddemann (et al., 2008) study into health related risks amongst heroin users that 67% of

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\(^{42}\) Cocaine Hydrochloride
participants reported the inconsistent use of condoms and 24% reported re-using and/or sharing needles. Harker et al (2008) stressed that HIV risk reduction interventions among heroin users urgently need to be considered in the light of the established association between heroin use and HIV risk behaviour. Given the strong association between heroin use, HIV risk behaviours and hepatitis C and the implications this has for public health, HIV risk reduction interventions among heroin users urgently need to be considered.

Like cocaine, the use of (and addiction to) heroin displays a low population based prevalence rate. Nevertheless, heroin use constitutes a health and social challenge in the Western Cape. It adds additional pressure to an already precariously poised substance treatment ecology and infrastructure in this province and in Cape Town in particular.

2.3 Substance abuse and Youth

The scale of substance abuse, particularly drug use in the Western Cape has been escalating over the last decade reached. The MEC For Social Development in the WC described this increase as reaching crisis proportions over the last few years, with younger and younger people abusing substances. As illustration of this the following was mentioned:

- Children (defined as youths under the age of 19) use more tik than adults.
- According to the Medical Research Council, persons under the age of 20 in treatment for tik-related problems increased from 4% in 2003 to 57% in the first half of 2007.
- The 2008 Youth Risk Behaviour Survey reported that 41% of Western Cape secondary school learners sampled (grades 8-11) had engaged in binge-drinking in the month prior to the survey.
- Two in every five schools report the presence of drug merchants on the premises during school hours. (www.westerncape.gov.za/eng/your_gov/3576/news/2010/jun/201594)

Harker et al (2008) reported that large numbers of adolescents in the Western Cape are using alcohol, tobacco and cannabis. This became evident in the 2002 Youth Risk Behaviour Survey that reported that 34% of school-going adolescents binge-drink in the Western Cape, which is significantly greater than the national average of 23% (Reddy et al., 2003).

Other school-based studies have also reported high levels of substance use among adolescents. Among Grade 8 students, Flisher et al. (2006) reported that, in the past 30 days, the proportions of males and females respectively who had used alcohol were 25.9% and 14.8%; who had used tobacco
were 31.5% and 18.2%; and who had used cannabis were 17.2 and 5.2%. Flisher (inbid) also found evidence that the rates of use of alcohol, tobacco, and cannabis substances may be increasing, with the “tik” epidemic posing a new and significant challenge for the WC.

In the period between January and June 2010, cannabis was the primary drug of abuse for 45% of patients under the age of 20 years; however, even more disconcerting is the rapid increase in the prevalence of methamphetamine (33%) and heroin (8%) amongst these young abusers. Another study found that amongst patients under the age of 20 years, the primary drug of abuse was as follows: cannabis (42%), methamphetamine (39%), heroin (8%), alcohol (3%) and cocaine (2%). APP, 2011)

A study by Patrick et al. (2007) in Harker et al 2008) conducted amongst Mitchell’s Plain high schools found that the pattern of onset of substance abuse was similar across genders; adolescents first tried either alcohol or cigarettes, followed by both, then dagga (cannabis), and then inhalants, i.e. glue sniffing. In a comparative study of substance use amongst the youth between 1994 and 2004, Flischer et al (2006, in Harker, 2008) found that significant increases of cigarettes for males and cannabis for both males and females. There were, however, no significant differences for the use of alcohol.

Research conducted amongst youth attending schools in the Cape Metro by Pluddemann, (2007, in Harker etal 2008) into the impact of MA (tik) use of the behaviour of the youth established disturbing trends. Compared to those who had used other substances but never tried tik, learners who had used methamphetamine at least once were more likely to be in the high risk category for developing aggressive behaviour and depression. His findings also suggest learners who had used tik in the last 30 days were significantly more likely than those who had never tried it to have engaged in different types of sexual behaviour. They were also significantly more likely than those learners who had never tried tik to have either been or made a girl pregnant or contracted a STI (31%). In addition, learners engaged in methamphetamine use in the last 30 days were also significantly more likely to have had been sexually active than those who had used in the past 12 months.

A Substance abuse by the youth, especially, but certainly not exclusively amongst those living in impoverished livelihoods, often deprived of essential means and capabilities to escape the cycle of poverty, remains a deep concern and challenge to all sectors and interest groups of the Western Cape community. The DSD should be particularly cognizance of the challenge the abuse of substances amongst children and the youth poses and should through its programmes articulate an effective and
sustainable response to it. It is absolutely crucial to have in place effective intervention and awareness progress to empower and dissuade as many as possible vulnerable young people living in impoverished drug invested communities not to use substances. This is an imperative strategy towards preventing the onset of destructive pattern of substance abuse and chronic addiction amongst the youth of this province.

2.4 The Provincial Response (DSD)

The official response the DSD to the daunting challenge that abuse of substances pose is articulated through their involvement in three pivotal areas, i.e. firstly to prevent the abuse of substances, secondly, to be involved in offering quality treatment to substance addicts and lastly to facilitate the long term rehabilitation of those that have received treatment for their addiction.

The above clearly shows that is DSD follows an orthodox approach in trying to deal with substance abuse in the province; it focuses on awareness, early intervention, statutory services and aftercare support. This approach is a sound one that emphasizes the three critical pillars of a social intervention programme or regime that must manage a huge social problem – it has an initial preventative focus, and then follows the logical progress of addition through therapeutic treatment and crucially, attending to the aftercare support as part of rehabilitation of the addict, thereby minimizing the risk of relapse. The DSD documents repeatedly mentions that these services will be presented in an internal integrated fashion linking with other core DSD programmes. While this approach is off course beneficial and to be encouraged, it is a tricky exercise to make different programmes speak with one another. In this regard it is of utmost importance is that the managers and implementers of this programme be capacitated to do this; if this is not done the idea of integration of programmes to add value will not materialize. Also managers and implementers of social programmes must not allow themselves to be suffocated by beaurocratic systems and procedures- they must keep their eye on the ball – i.e. on their central mission, to prevent people to become substance abusers, to optimally assist and care for those that develop substance dependence.
2.5 Consider the strategic priorities of the Department of Social Development in light of the evidence

In a nutshell, the Substance Abuse and Rehabilitation programme aims to make the different social and auxiliary services offered by the DSD to both abusers of substances and their families, as well as to communities, as accessible and relevant as possible to their respective needs and through this aims to optimize the quality and impact of intervention services. In its quest to this the programme seeks strong links with a number of other departments of the PGWC in order to strengthen the programmes quality, delivery and ultimately its impact.

The ultimate test, however, of the relevance, appropriateness, effectiveness and impact of the Substance Abuse programme, is to determine to what extent it relates or speaks to the grassroots realities, trends and challenges as established by research studies. Simply put, it is important to know whether the DSD is in focus with the content of it programme within the context of the statistical trends.

A range of statistics regarding the youth shows that this cohort is particularly vulnerable regarding the abuse of mind altering substances. This is partially to be expected as it is during the teenager phase that young people start experimenting with adult behaviour, including participating in alcohol consumption, smoking and drug taking. Results of different research studies as reflected above have shown that the youth of this province uses a range of licit and illicit drugs. These youths are both male and female and both within the educational (school and tertiary) system and outside of it. Alcohol, marijuana and increasingly tik are the drugs of choice amongst the youth. Of great concern is the high prevalence of binge drinking amongst the youth of this province, compared to the national rate; binge drinking has inter alia serious implications on the health and safety of the young drinker, amongst other seriously impairing the sense of judgement and increasing the vulnerability of especially female drinkers. It has in addition enormous cost to the broader society, medical, economic and social.

The DSD has developed a concerted response to act back at the issue of youth drugging and drinking through the launching of its Ke Moja Awareness prevention programme whereby the youth, a most vulnerable cohort of the Western Cape, is at an early age made aware of the potential harmful effects of substance use and/or abuse. This is a prudent approach, so much more in the case of those children that grow up and are socialized under unhealthy social conditions of high prevalence of substance abuse. It is however, important that the managers of this programme are continuously aware of changes in the profile of substances abused by the youth in this province. At the moment,
statistics suggest that both legal and illegal substances are used and abused. What is thus necessary is an awareness – prevention programme that focuses on both types of abuse, including nicotine, alcohol as well as marijuana (and Mandrax) and especially tik. Research findings suggest that concentrating on these substances will be the most effective; because of the young age of initiation into substance use/abuse it is imperative that such programmes are started rather earlier than later, both within as well as out of school context. This programme has a significant challenge facing it; it must fight a value and normative environment in many townships and impoverished communities that is highly tolerant of the public availability of drugs and partaking therein of the youth.

What is important to realize is that the DSD through this social intervention programme and agencies is called upon to act as *in loco parentis* – giving guidance and information and performing the duties that parents typically perform when they are present. Sadly, in many instances the unity of working class families is fractured, due to a range of factors including ineffectual parenting skills, absent fathers, the impact of Aids, migration and general poverty. Children thus grow up in livelihoods without consistent and/or positive role models whose behaviour they can emulate and who can offer guidance.

The focus of the Substance Abuse programme on the family is encouraging. Research suggests that substance abuse (can) seriously impact on the immediate family of the abuser or addict. Some estimates are that up to seven people are affected in total by one addiction. It is thus important that a concerted effort is made empower families that have to deal with a substance abuser; dysfunctional families can be both a cause and consequence of substance abuse. It is important, however, not to pathologize the family, but rather to see the family as the core or centre around which healthy communities can be build.

The other important focus of the Substance Abuse programme is on the treatment of substance abusers or addicts. According to the table below the province has through this programme the capacity to reach 46000 patients or clients for treatment and aftercare. This happens in 30 treatment facilities and three state institutions. These facilities must serve the entire Western Cape, both urban and rural.

From the research reviewed it appears that the most pressing need for treatment – both inpatient and outpatient - in this province is for those who are abusing and/or addicted to alcohol, marijuana and Mandrax and increasingly for the abuse of tik. An important trend and theme emanating from a raft of research studies is that the many substance abusers tend to use a number of different substances; this makes treatment demanding and requires of treatment centres to offer multi
treatment regimes. It is thus important that the DSD supports financially specifically also those treatment centres that are able to treat poly-drug users.

Table 1: Substance Abuse, Prevention and Rehabilitation Programme: Statistics and Information

<table>
<thead>
<tr>
<th>Programme</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of the programme</td>
<td>Improve fit between substance services for individuals, families and communities and the need for those services, and improve overall outcomes of treatment and interventions</td>
</tr>
<tr>
<td>Target population for this programme?</td>
<td>Individuals with substance dependency problems, as well as families and communities affected by substance abuse</td>
</tr>
<tr>
<td>State the number of projects that resonate under this specific programme</td>
<td>30 treatment organisations + 3 state facilities + 9 special projects (tertiary training – capacity building opportunities)</td>
</tr>
<tr>
<td>What areas are served by the different projects within this programme?</td>
<td>Western Province</td>
</tr>
<tr>
<td>What is the estimated number of people reached within this programme? (please specify for the different groups catered for in each programme)</td>
<td>Prevention and Awareness Level: 30,000 Early Intervention Level: 5,440 Treatment: 4,600 Aftercare: 4,600 Total: 40,040 (Note The number receiving treatment are the same clients for aftercare)</td>
</tr>
<tr>
<td>How are the above numbers determined? (please specify for the different groups as relevant)</td>
<td>The non-financial data per level and in terms of the performance indicators as specified in the Annual Performance plan are recorded monthly by regional offices and supplied quarterly to the sub programmes</td>
</tr>
<tr>
<td>What is the role of DSD in the different projects? (i.e. x=managed, x=funded, x=initiated)</td>
<td>Community-based services = funded All other levels; % managed and % funded (Awareness and Prevention, Early Intervention, In-patient treatment and Aftercare)</td>
</tr>
</tbody>
</table>

43 Information supplied by DSD January/February 2012
A central theme and strategic objective of all the different social service programmes of the DSD is that of maximizing access to facilities and services to those in need thereof. This is indeed a critical aspect and feature of any social intervention or service programme, people must be able to use it. This aspect gets additional strategic importance given firstly, the lack of (affordable) transport available to many potential clients, secondly, the deep levels of chronic poverty in livelihoods and communities in which substance abuse is rife that prohibit patients to access private institutions, and thirdly, the vast distances between some rural towns in the Western Cape and paucity of transport available in rural areas that connect farm workers with the rural towns and villages, as well as with bigger urban settlements and Cape Town in particular. It is imperative that when evaluating its respective programs, the DSD consider the ability of the people from poor communities of this province, both urban and rural to access the facilities and services offered by the provincial government.

When viewing the different facilities available in the province to those that need assistance and treatment with their abuse of substance the following observations can be made.

- Households and individuals with limited financial means living in the Western Cape dealing with substance abuse problems have limited access to free inpatient treatment of government owned institutions. A total of 120 adults and 20 youths can be accommodated for periods around 6 weeks in three centres, all situated in the Cape Metro. However, of these, only 80 beds are available for alcohol related addiction. This appears to be an anomaly with alcohol being the most abused substance in Western Cape.

- However, rural people have access to three partially subsidized in-patient treatment centres, with another two located in suburban Cape Town. This implies that poor rural patients in most instances need to pay for treatment, although at some facilities, e.g. at Heskith in Muldersvlei, Paarl, some patients do indeed enjoy free admission. This situation is once again perplexing in so far that highest rates of unemployment and subsequent chronic poverty is to be found in the rural areas of the province. This situation places serious obstacles in the way of rural people with addiction problems in accessing and being admitted for treatment. In total these centres cater for 190 adults and 40 youths.

- The province has in addition 14 privately owned treatment centres, three of which are rural based. Treatment at these centres are typically expensive and mostly only accessible to patients belonging to a medical aid scheme or that have access to private funds

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44 The information was supplied by the DSD. The author does not accept responsibility for omissions
With a few exceptions, all treatment centres in the province cater for the full spectrum of drug use. From a number of telephone interviews conducted with a sample of centres a consistent pattern emerges – amongst the youth marijuana (to a lesser extent) and increasingly tik are the drugs of choice (of abuse), with alcohol being the most frequently abused substance reported amongst adults.

The province offers four community based matrix out-patient drug treatment facilities that are attached to community health clinics – with a capacity of offering treatment to 15 adults per site. This is off course a modest number, given the enormity of the problem in the community. According to available information no such facility is operating in the rural areas of the Western Cape.

An additional, seven out-patient treatment centres are available in the Western Cape. All these centres are situated in easy accessible to potential patients or clients, with five located on the Cape Flats. However, it appears rural people do not have adequate facilities available.

2.5 Conclusion

A number of observations can be made regarding the extent of the substance abuse challenge in the Western Cape and the present response of the DSD towards it. Overall, the statistics show that the rate of abuse in the WC is in many instances above the national average; high prevalence and incidence in the rates of alcohol abuse, amongst particularly amongst coloured males, marijuana abuse, often in concert with Mandrax, especially amongst African males and tik amongst the youth (under 20 years) are cause from serious concern and pose specific challenges to DSD and its affiliated organizations. The dramatic increase in the incidence, (i.e. the increase in the rate) of tik use in the WC necessitates drastic intervention modalities.

A number of summative and concluding observations is presented:

- Given the limitation in terms of funds and capacity the PGWC faces on the one hand and the prevalence and incidence of substance addiction on the other hand, it is a given that the provincial government cannot fully meet the demand for preventative campaigns, neither for early intervention, nor for treatment modalities like lengthy institutionalization, rehabilitation and after-care programmes. Thus, the DSD can only at this stage work creatively towards the strategic objective of its substance abuse programme, i.e. improving easy access to treatment.
This makes the judicious spending of available scarce resources imperative. Programmes must be targeted and must have impact.

- The provincial programme on substance abuse and rehabilitation appears well targeted and covers a number of vulnerable groups. Its strong focus on the youth is encouraging. A recent study undertaken by Institute for Social Development at UWC in which SOREASO partook, (Louw, Bayat and Eigelaar-Meets, 2011), amongst underperforming secondary schools in the Western Cape, showed that the presence and impact of substance abuse amongst both learners and teachers constitute a serious problem. At all these schools strong pleas were made for the appointment of resident social workers and psychologists to address addiction and general behavioural problems associated with addiction. The DSD should in collaboration with WCED, consider establishing permanent social well functioning service desks at vulnerable schools.

- Regarding the out-of-school youth (never attended or dropped out), concerted efforts are needed to catch them in the net of prevention campaigns. They are often the most vulnerable youths.

- The rural areas appear to be under resourced and under capacitated in terms of treatment centres. This is disconcerting, given the rampant misuse of alcohol, in rural towns and particularly amongst those farm workers (especially over weekends) working on wine and wheat farms of the Boland, Overberg and Swartland regions of the Western Cape. It is interalia linked to the legacy of the notorious dop-system (tot system) that was outlawed in the 1960s. In terms of Jellinek’s well known typology of alcoholism, farm workers exhibit a mixture of the classical Delta and Beta profiles of alcoholism. The Delta alcoholic tends to be found mainly in the wine regions of France and some other wine growing nations. Their main characteristic is that they are seldom drunk and are seldom entirely sober, for they drink regularly throughout the day (wine with lunch, dinner) but seldom enough to be intoxicated. The Beta alcoholic again, is an opportunistic and episodic abuser of alcohol, typically over weekends when the means (e.g. weekly paid wage earner) and opportunity arise. It appears that only Worcester and Vredendal have facilities to farm worker alcoholism. The DSD should look at fortifying its presence in these regions, make it accessible in terms of costs and location and ideally it should be structured as an in- and out-patient treatment centre.
• Of special significance here is the phenomenon and high prevalence of FAS in the wine producing areas, and the subsequent need to address it in a systematic and dedicated and sustainable manner.

• An analysis of existing in- and out-patient treatment facilities, suggests a serious void in capacity for the treatment of youth presenting with addiction problems.

• The spatial distribution of treatment centres subsidized by DSD within the Cape Metropole appears fairly equitable; although an apparent gap (except for the matrix CHC in table View) in service centres seems exists along the western node towards Atlantis, arguably the fastest growing human settlement. This area has significant pockets of deep poverty, i.e. notably Atlantis and Mamre.

• The current philosophy and strategy of the DSD to channel funds to a range of specialist community based (non profit) organizations that deal with patients, whether in or out patients or both is to be applauded and encouraged to extent where appropriate. Treating substance addiction requires a high level of expertise and skill and should be left to trained and qualified professionals. In this respect the DSD can facilitate the training of professionals (therapists, psychologists and social workers) at institutions of higher learning through bursaries.

• The DSD must through its service providers take cognizance of the fast growing problems associated with the widespread use of so-called Ales, especially the medical implications and negative social and domestic consequences.

• The nature of the data available did not allow information regarding the range of substances that the different treatment centres. It appears that with view exceptions most of these centres are able and willing to treat patients with any substance addiction. This is important as a high percentage of substance abusers use a number of substances in concert and is categorized as poly-drug users.

• A raft of recent research reports is illustrated that youth in the Western Cape showed significantly higher levels of binge drinking with 41% of learners indicating to have engaged in binge drinking the month prior to the survey compared to the National average of 28.5%. In the Western Cape alcohol is the most frequently abused substance with 25% of males and 6% of females shown as consuming alcohol in a hazardous or harmful manner.

• Learners in the Western Cape also exceed the national average in several areas of substance abuse risk behaviour, when measuring usage in the past month for dagga use, lifetime (ever)
use of Mandrax and club drugs (males only). In addition, a greater proportion of young persons in the province started drinking before the age of 13 years as compared to other provinces.

In short: the Western Cape is burdened with serious challenges regarding the abuse of a range of substances. The abuse of these substances has diverse and serious consequences - for the abuser, his/her family, the community and society. The substances most used/abused in this province are alcohol, marijuana and Mandrax, as well as Methamphetamine (tik), with the latter showing a dramatic increase in prevalence and incidence over the last decade. It is estimated that more than 90% of tik use occurs in the Western Cape.

Across all substances, males tend to exhibit higher prevalence rates than females, although female abuse patterns are cause for deep concern with has shown stark increases in some instances; in addition the phenomenon of FAS amongst mostly rural (Coloured) women presents a serious health, human right and social problem to the this province.

In terms of race, Coloured people register the highest prevalence amongst the abusers of alcohol and Methamphetamine, although its prevalence amongst Black people, both amongst males and females, is substantial and disconcertingly high. As far as marijuana is concerned, Blacks, both males and females reported higher levels of use than that of Coloured people.

Of particular concern is the high prevalence and incidence of substance abuse in the Western Cape, amongst (both school going and out of school) youths. From the current programme on substance abuse and rehabilitation it is clear the DSD is aware of the challenge that addiction amongst the young population poses. This focus is to be applauded and encouraged. Of particular importance in this regard is the fortification of drug (including nicotine and alcohol) awareness - prevention programmes - at primary and secondary schools in the Western Cape in general - but especially at schools located in economically and socially marginalized and impoverished areas of the rural and urban areas of this province. In addition, special effort should be made to reach the most marginalized and potentially most vulnerable youth cohort, i.e. at the out of school youths with awareness – prevention programmes. The latter will be more demanding to undertake as far as accessibility is concerned, but it should nevertheless be ventured as this cohort of youths are the most at risk as far as substance abuse is concerned. It is not clear from the information available to what extent this is happening and the measure of success achieved with this.
2.6 Abbreviations:

AAP   Annual Achievement Plan
WC    Western Cape
FASD  Foetal Alcohol Spectrum Disorders
MA    Methamphetamine
SACENDU  South African Community Epidemiology Network on Drug Use
SADHS  Demographic and Health survey

2.7 Bibliography


National Drug Master Plan (2012 – 2016), Government Printer, Pretoria


Chapter 3: Care and Services to Older Persons (Sub programme 2.3)

3.1 Introduction

The passing of the Older Persons Act, No 13 of 2006, was a historic achievement for the elderly in South Africa, particularly the poor and disadvantaged older person. The Older Persons Act of 2006 marks a change in how support to the elderly is viewed, moving away from an approach focusing on the elderly as merely recipients of grants and thus objects of welfare, to an emphasis on the rights of older people. Furthermore the socio-economic rights of older South Africans are now grounded in law which means that all government departments and organisations serving the elderly have a duty to observe, respect and act upon these rights as stipulated in the Act. The most prominent issues set out in the Act are access to community-based care and support services within a supportive environment, the regulation of residential facilities for older people, and protection against abuse, ill treatment and neglect. The emphasis is on creating the environment and conditions under which older people can remain independent, active and contributing citizens in their communities for as long as possible.

Although the Department of Social Development (DSD) derives part of its core mandate from the Constitution of South Africa, which provides for the right of access to appropriate social assistance to those unable to support themselves and their dependents, it is further obligated by the Older Persons Act to fulfil their mandate of service delivery by ensuring the achievement of the following:

- Enabling older people to enjoy active, healthy and independent lives
- Creating an enabling and supporting environment, and
- Provide continuous care to older people in need
3.2 Population Ageing and the socio-economic history of South African elderly

Described as a key demographic feature of the 20\textsuperscript{th} century, population ageing is not just a phenomenon experienced by more developed countries, but is now a global experience for virtually all countries in the world. Population ageing or demographic ageing is the process by which the older population (those 60 years or older) become a proportionately larger component of the total population commonly as a result of a population’s demographic transition from higher to lower levels of fertility and mortality (Joubert & Bradshaw, 2006).

South Africa has one of the most rapidly ageing populations in Africa with a particular increase in the 64-70 year age category (May, 2003) and is expected to continue ageing over the next two decades. Joubert & Bradshaw (2006) show a projected increase of 48\%, that is a projected increase from 2.5 to 5.2 million, for the time period 1985-2025. This translates to more than one person in ten being 60 years or older by 2025 [Figure 3.1]. This projected growth as show in Figure 3.2 is expected to increase more rapidly over the next two decades than was the case for the past two decades. To further support these figures the 2009/2010 South African Surveys, show in their projected population numbers for 2010-2040 a general decline in population figures for the age groups 0-15 years (-21.6\%) and 15-64 years (-0.6\%). However the population size for the age group 65 years or older is projected to increase by 117.5\% for the same period.

When discussing trends related to the elderly in South Africa it is essential to mention and understand the socio-political and -economic history for the greater majority of the elderly in this country. The majority of South Africa’s older persons lived through 44 years of apartheid rule where political marginalisation and unequal access to social services was the reality and rule of the day. Although the newly elected government of 1994 has facilitated progressive transformation processes to restore these past imbalances, 55\% of persons 50 years or older still lived below the country’s poverty line at the turn of the century. Of those 60 years or older, 20\% had no piped water in their households, 19\% no toilet, 43\% no school education, and 50\% no electricity for cooking purposes (Joubert et al, 2004).

In a report for Help Age International, Julian May (2003) points to the vulnerability of the elderly regarding conditions of poverty. When using a poverty line of total household income of less than R400 a month, the report shows that one quarter of all elderly people in South Africa can be expected to be in a state of chronic poverty. The data further shows that 90\% of the elderly classified as living under
conditions of chronic poverty are Africans with a female majority for all age groups. Given that 42% of all African households are female headed (more so by the grandmother than the mother of the family), the socio economic implications of this feature is obvious.

The distribution of chronic poverty amongst the elderly largely follows the national poverty profile with the Limpopo Province, Eastern Cape, Free State and Northwest as the poorest areas, while the Western Cape and Gauteng are the least poor. Table 1 below shows the distribution of older people by using a dynamic poverty measurement.

**Figure 3.1: Population ageing in South Africa, 1985-2025 (percentage)**

![Population Ageing Graph]

Source: ASSA2002, Joubert & Bradshaw, 2006
3.3 A Profile of Elderly in the Western Cape

Demographic characteristics

The age pyramid portrayed in Figure 3.3 describes the age distribution of the South African population. When isolating individuals in the population aged 60 years or older the data show this group to contribute 7.9% to the total population size with female individuals the greater majority (South African Survey 2007/2008:9). For the Western Cape Province the older population group contributes 8.6% to the total population size of this province (Stats SA, 2007). The trend of female dominance in the population composition of the older population group is shown to be true for all 9 provinces in the country [Figure 3.4] and show a general pattern of older females than males, a common phenomenon due to women’s higher life expectancy. This is an important observation to consider given the multiple and often lifelong gender disadvantages experienced by numerous older women as a result of gender biases, widowhood and old age, all having a possible impact on the social and material well-being of older women (Joubert and Bradshaw, 2006).

When focusing on the distribution of the total elderly population across the 9 provinces the Western Cape is shown as the province with the fourth largest older population (12%) following the Eastern Cape (17%) and KwaZulu Natal and Gauteng (both at 19%) [Figure 3.5]. When comparing the proportion of
elderly to the total population for each province, the Eastern and Northern Cape is shown as having the highest proportion of elderly to its total population (9.6% and 9%) with the Western Cape laying third with nearly 8.6% of its population consisting of persons 60 years or older [Figure 3.6]. Regarding the racial distribution of the elderly for the Western Cape Province the 2007 Community Survey (Stats SA), shows the majority of older persons in the province to be within the White population group at 47%, followed by 40% within the Coloured population group and 12% in the African population group [Figure 3.7].

**Figure 3.3: Age pyramid for the South African population**

![Age pyramid for the South African population](image)

Source: Statistics SA, Community survey, 2007

**Figure 3.4: Gender distribution within the elder population group**

![Gender distribution within the elder population group](image)

<table>
<thead>
<tr>
<th>Province</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>232,987</td>
<td>393,623</td>
<td>626,610</td>
</tr>
<tr>
<td>Free State</td>
<td>86,003</td>
<td>136,241</td>
<td>222,244</td>
</tr>
<tr>
<td>Gauteng</td>
<td>304,646</td>
<td>413,588</td>
<td>718,234</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>250,233</td>
<td>472,770</td>
<td>723,003</td>
</tr>
<tr>
<td>Limpopo</td>
<td>146,653</td>
<td>297,047</td>
<td>443,700</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>93,190</td>
<td>144,909</td>
<td>238,099</td>
</tr>
<tr>
<td>North West</td>
<td>102,384</td>
<td>147,713</td>
<td>250,097</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>39,832</td>
<td>55,394</td>
<td>95,226</td>
</tr>
<tr>
<td>Western Cape</td>
<td>196,558</td>
<td>256,323</td>
<td>452,881</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa, Community Survey, 2007
Figure 3.5: Spread of older persons per province


Figure 3.6: Proportion of elderly person to total population by Province

Source: Statistics SA, Community Survey, 2007

Figure 3.7: Distribution of older persons in the Western Cape by Race

Source: Statistics SA, Community survey, 2007
When considering data on the general educational level attained by the elderly population the available data illustrate a rather dramatic difference for the Western Cape’s elderly compared to the country as a whole. Figures 3.8 and 3.9 show the greater majority of older persons in the Western Cape (48%) as having completed a secondary or some secondary educational level as compared to the national statistics (25%) [CASE, 2009 & Stats SA, 2007]. In contrast to the Western Cape elderly, national statistics show the majority of elderly (35%) to have either no formal educational training or have completed a primary or some primary educational training. The Western Cape also show varying levels of educational training for the two genders, with females in the Western Cape indicating a higher educational level than males, except in the case of tertiary education. Again this trend is not mirrored on national level, with females shown as generally worse off than males in terms of highest educational level completed. Except for the group that indicated to have no formal education, 40% were female compared to 25% male, females are slightly better off when compared to males for primary education but worse off for all further higher educational levels. The higher educational level of the older population in the Western Cape compared to the national case can most probably be related to the larger white older population in the province, who historically has shown a higher educational level than the elderly of other racial groups and thus influence the general trend.

Figure 3.8: Level of education for older persons (National)

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td>25%</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>Primary Education</td>
<td>32%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Secondary Education</td>
<td>31%</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Tertiary Education</td>
<td>11%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>ABET and other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: CASE, 2009
Living conditions and access to amenities

In a study by Vorster et.al. (2004) on the socio-economic conditions of grant beneficiaries in the Western Cape, the living conditions of OAG beneficiary households is shown in general as good. Regarding access to amenities the greatest majority of OAG beneficiary households in all magisterial districts in the Western Cape have flush toilets which are connected to a sewerage system, have electricity within the dwellings and have access to piped water either on their plots or inside their dwellings [Table 3.1 & 3.2, Figure 3.10]. From the data it would thus seem that with regards to their physical living conditions which include access to basic services and housing, the greater majority of older persons in the Western Cape are provided for.

On a national level older persons as one of the groups included in the government’s definition of vulnerable groups, are also eligible for municipal rebates as part of a subsidy scheme by the National Government where poor households have the option to register at their municipalities for subsidies on basic services. Disconcerting however is the finding in a study by CASE (2009) among the general older population group when asked whether their house-hold were registered with their local municipalities as indigent, three quarters 76% of the households said they were not registered, and therefore get no extra subsidy to cover for basic services such as electricity, water or refuse removal. In the Western Cape Province 67% of respondent households did not know about this service. It would thus seem that a lack of knowledge regarding this subsidy is the primary reason for its inaccessibility to older persons.
Table 3.1: Access to toilet facility (OAG beneficiary), Western Cape Province

<table>
<thead>
<tr>
<th>Magisterial District</th>
<th>Toilet facility</th>
<th>Row %</th>
<th>Row %</th>
<th>Row %</th>
<th>Row %</th>
<th>Row %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Flush toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(connected to sewerage system)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beaufort West</td>
<td>92.5</td>
<td>7.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Laingsburg</td>
<td>77.1</td>
<td>16.7</td>
<td>6.2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Prince Albert</td>
<td>79.5</td>
<td>18.2</td>
<td>0</td>
<td>0</td>
<td>2.3</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Murrayburg</td>
<td>66.7</td>
<td>31.6</td>
<td>0</td>
<td>1.7</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Goodwood</td>
<td>96.8</td>
<td>2.6</td>
<td>0</td>
<td>0.6</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Mitchell's Plain</td>
<td>92.4</td>
<td>6.1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.5</td>
<td>100</td>
</tr>
<tr>
<td>Vredenburg</td>
<td>89.8</td>
<td>10.2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Hopefield</td>
<td>84.5</td>
<td>13.1</td>
<td>0</td>
<td>2.4</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Ceres</td>
<td>80</td>
<td>16</td>
<td>2.7</td>
<td>1.3</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Malmesbury</td>
<td>84.1</td>
<td>14.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.6</td>
<td>100</td>
</tr>
<tr>
<td>Caledon</td>
<td>77.1</td>
<td>17.2</td>
<td>0</td>
<td>0</td>
<td>5.7</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Mossel Bay</td>
<td>88.2</td>
<td>11.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Vorster et al., 2004
Table 3.2: Access to piped water (OAG beneficiary), Western Cape Province

<table>
<thead>
<tr>
<th>Magisterial District</th>
<th>No access to piped (tap) water</th>
<th>Piped (tap) water on community stand: 200m/ further</th>
<th>Piped (tap) water on community stand: less than 200m</th>
<th>Piped (tap) water inside Yard</th>
<th>Piped (tap) water inside dwelling</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Row %</td>
<td>Row %</td>
<td>Row %</td>
<td>Row %</td>
<td>Row %</td>
<td>Count</td>
</tr>
<tr>
<td>Beaufort West</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20.8</td>
<td>79.2</td>
<td>100</td>
</tr>
<tr>
<td>Laingsburg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>37.5</td>
<td>62.5</td>
<td>100</td>
</tr>
<tr>
<td>Prince Albert</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>77.3</td>
<td>22.7</td>
<td>100</td>
</tr>
<tr>
<td>Murraysburg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>70.2</td>
<td>29.8</td>
<td>100</td>
</tr>
<tr>
<td>Goodwood</td>
<td>3.2</td>
<td>0</td>
<td>0</td>
<td>3.9</td>
<td>92.9</td>
<td>100</td>
</tr>
<tr>
<td>Mitchell's Plain</td>
<td>0</td>
<td>3</td>
<td>1.5</td>
<td>33.3</td>
<td>62.2</td>
<td>100</td>
</tr>
<tr>
<td>Vredenburg</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11.9</td>
<td>88.1</td>
<td>100</td>
</tr>
<tr>
<td>Hopefield</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13.1</td>
<td>86.9</td>
<td>100</td>
</tr>
<tr>
<td>Ceres</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9.3</td>
<td>90.7</td>
<td>100</td>
</tr>
<tr>
<td>Malmesbury</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>25.4</td>
<td>74.6</td>
<td>100</td>
</tr>
<tr>
<td>Caledon</td>
<td>0</td>
<td>0</td>
<td>1.4</td>
<td>12.9</td>
<td>85.7</td>
<td>100</td>
</tr>
<tr>
<td>Mossel Bay</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>35.3</td>
<td>64.7</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Vorster et.al., 2004
Living arrangements of the elderly

With regards to the living arrangement of the elderly the NIDS data (2009) show the majority of the elderly as either married (44%) or widowed (38%) [Table 3.3]. The same trend was found in the study by Vorster et.al. (2004) with the greater majority of the OAG beneficiaries indicating to be either married/living with a partner (45%) or widowed (42%). It is however important to note the gender difference shown by the NIDS data (2009) with men the majority within the married category (71%) and females the majority within the widowed category (52%), again showing the vulnerability of females towards social security.

When investigating data on the compilation of the households of the elderly the NIDS data (2009) show the majority of the respondents (54%) as living with a biological child(ren). Important to note however is the indication that all respondents indicating to live with a biological child in the NIDS data were female. Although possibly somewhat over stated in this study this finding does seem to support arguments showing on the great caring role of older women within households.

In an effort to develop a better understanding of the household compilation of older persons the CASE report (2009) categorised their participants according to household size. The report shows the majority (68%) of elderly households in the Western Cape to consist of 1-4 members with another 26% part of households consisting of 5-8 members. When identifying the primary care givers in the participant
elderly households, the CASE report shows the majority (79%) indicating either themselves or their partners. For the Western Cape Province 76% of the elderly respondents indicated themselves or their partners as the primary care givers [Figure 3.11].

Analysing the data to show the relationship between the older person (respondent) and the household members, approximately 41% of the household members were found to be grandchildren [Table 3.4]. This finding is supported by Vorster et.al. (2004), where a large percentage of female beneficiaries indicated to be the primary care givers of their grand children.

Demographic data show multi-generational households as common amongst Black South African families, especially for households at the bottom of the income distribution. Burns et.al. (2005) directly links this phenomenon to the economic importance of the old age pension grant within poor households thus decreasing the propensity of the elderly to live alone. Subsequently the old age grant is associated with increases in household size as well as changes in the household composition, with a larger number of children, especially those aged 0-6, migrating into pensioner households.

Table 3.3: Marital status of older persons (National)

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Gender</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>540</td>
<td>418</td>
<td>958</td>
</tr>
<tr>
<td>% within Gender</td>
<td>71.1%</td>
<td>29.7%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>47</td>
<td>27</td>
<td>74</td>
</tr>
<tr>
<td>% within Gender</td>
<td>6.2%</td>
<td>1.9%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Widow/Widower</td>
<td>96</td>
<td>734</td>
<td>830</td>
</tr>
<tr>
<td>% within Gender</td>
<td>12.6%</td>
<td>52.1%</td>
<td>38.3%</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>23</td>
<td>64</td>
<td>87</td>
</tr>
<tr>
<td>% within Gender</td>
<td>3.0%</td>
<td>4.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Never Married</td>
<td>53</td>
<td>165</td>
<td>218</td>
</tr>
<tr>
<td>% within Gender</td>
<td>7.0%</td>
<td>11.7%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Total</td>
<td>759</td>
<td>1408</td>
<td>2167</td>
</tr>
<tr>
<td>% within Gender</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: NIDS, 2009
Figure 3.11: Respondents as primary care givers in the household

![Bar chart showing the primary caregivers by relationship.]

Source: CASE, 2009

Table 3.4: Relationship to respondent

<table>
<thead>
<tr>
<th>Relationship</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent</td>
<td>1336</td>
<td>23</td>
</tr>
<tr>
<td>Partner</td>
<td>363</td>
<td>6</td>
</tr>
<tr>
<td>Biological child</td>
<td>1202</td>
<td>21</td>
</tr>
<tr>
<td>Other child</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>Relative child</td>
<td>57</td>
<td>1</td>
</tr>
<tr>
<td>Brother/sister</td>
<td>87</td>
<td>1</td>
</tr>
<tr>
<td>Parent</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>Grandchild</td>
<td>2381</td>
<td>41</td>
</tr>
<tr>
<td>Other relative</td>
<td>216</td>
<td>4</td>
</tr>
<tr>
<td>Friend</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other non-relative</td>
<td>41</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5831</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: CASE, 2009
Economic situation

Currently there are 229,142 OAG beneficiaries registered in the Western Cape (SASSA, 2011). If measured over time the data shows a clear increase in the number of OAG payouts for the province [figure 3.12]. This growth in the number of payouts is also shown on a national level with a 42% growth shown over the period of 2001-2011/2012 (South African Survey, 2009/2010) [figure 3.13]. The NIDS database (2009) indicates that, except for the white population, the majority of the elderly in the Western Cape receive an Old Age Grant [table 3.5]. Figure 3.14 shows the racial distribution of the OAG beneficiaries in the Western Cape with the greater majority of beneficiaries belonging to the Coloured population group (62%), followed by the White (19%) and then African (17%) population groups.

Figure 3.12: Old Age grant beneficiaries in the Western Cape May 2006 – April 2011

![Figure 3.12](source: SASSA, 2011)

Figure 3.13: Old Age Grant beneficiaries in South Africa

![Figure 3.13](source: Southern Africa Survey 2009/2010)
Table 3.5: Old Age Grand Beneficiaries by population group (National)

<table>
<thead>
<tr>
<th>Race</th>
<th>Actual recipients</th>
<th>Age-Eligible</th>
<th>% of eligible individuals that do receive the OAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>African</td>
<td>1,641,081</td>
<td>77.23</td>
<td>1,907,388</td>
</tr>
<tr>
<td>Coloured</td>
<td>211,945</td>
<td>9.97</td>
<td>257,171</td>
</tr>
<tr>
<td>Asian/Indian</td>
<td>85,006</td>
<td>4.0</td>
<td>104,471</td>
</tr>
<tr>
<td>White</td>
<td>186,764</td>
<td>8.79</td>
<td>751,053</td>
</tr>
<tr>
<td>Total</td>
<td>2,124,796</td>
<td>100</td>
<td>3,020,083</td>
</tr>
</tbody>
</table>

Source: NIDS, 2009

Figure 3.14: Racial and gender distribution of OAG beneficiaries in Western Cape

Source: Community Survey, 2007

With regards to the different sources of income for the elderly, the importance of the grant as an income source significantly relieving the economic vulnerability of the elderly is apparent. When exploring economic activities of the elderly, the 2001 Census data (Stats SA) show the greater majority (81%) to not take part in any formal economic activities [table 3.6] and thus dependant on other external sources of income. For the small number of individuals who do engage in self-employment activities, the majority are shown as females engaging in elementary occupations as well as crafts and other related trades (CASE, 2009). With regard to receiving private maintenance, receiving remittances
from people outside their household or membership to a community saving scheme, the greater majority of OAG beneficiaries included in the study by Vorster et.al. (2004) replied negatively. In testing the number of income sources for individual OAG beneficiaries the sole dependence of OAG beneficiaries on the grant as the primary and single source of income was shown, further accentuating the economic vulnerability of the elderly and thus the household of which they are part. The importance of the grant as single and primary source of income was also shown in the CASE study (2009) [tables 3.7 & 3.8].

Table 3.6: Employment status of older persons (Western Cape)

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>African</td>
<td>Coloured</td>
</tr>
<tr>
<td>Employed</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Unemployed</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Pensioner or retired person/too old to work</td>
<td>39</td>
<td>47</td>
</tr>
<tr>
<td>Unable to work due to illness or disability</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Home-maker or housewife</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Seasonal worker not working presently</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Does not choose to work</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Could not find work</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Stats SA, Census 2001 (persons weighted)
### Table 3.7: Means of support for respondents

<table>
<thead>
<tr>
<th>Means of support</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income generating activities</td>
<td>79</td>
<td>6</td>
</tr>
<tr>
<td>Private pension</td>
<td>92</td>
<td>7</td>
</tr>
<tr>
<td>Supported by family members</td>
<td>130</td>
<td>10</td>
</tr>
<tr>
<td>Supported by charity, church, welfare etc</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Savings or money previously earned</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Government old age grant</td>
<td>843</td>
<td>62</td>
</tr>
<tr>
<td>Other government grant</td>
<td>118</td>
<td>9</td>
</tr>
<tr>
<td>Other sources</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>N = 1,355</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CASE, 2009

### Table 3.8: Households receiving grant or other kinds of income from government

<table>
<thead>
<tr>
<th>Income Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment Insurance Fund</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Workers compensation</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Old Age Grant</td>
<td>1108</td>
<td>82</td>
</tr>
<tr>
<td>Disability Grant</td>
<td>140</td>
<td>10</td>
</tr>
<tr>
<td>Child Support Grant</td>
<td>425</td>
<td>31</td>
</tr>
<tr>
<td>Foster Care Grant</td>
<td>54</td>
<td>4</td>
</tr>
<tr>
<td>Care Dependency</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>War Veterans</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Grant in Aid</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td><strong>N = 1,354</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CASE, 2009

The importance of the OAG as a form of social security for the elderly in South Africa is also highlighted by May (2003) in referring to work done by Ferreira et. al. (2001). Ferreira notes how the old age grant goes to women more than men; that it reaches into deep rural areas; that it often secures credit for the household at the local store; and contributes to the education expenses of grandchildren; that it ensures respect for the beneficiary; and secure the right of the older person to stay in the home and be
cared for by the family (May, 2003).

In his report May notes the following on the impact of non-contributory pension programmes; “In the absence of non-contributory pension programmes, the poverty headcount and the poverty gap would be appreciably higher for households with older people. The impact on the poverty gap is much larger for the poorer households. The programmes significantly reduce the probability that individuals in households with a pension recipient will be in poverty” (May, 2003:5).

Regarding the decision making on how the elderly spent their pension money the majority indicated that they make these decisions themselves (Case, 2009).

**Older persons as care givers**

Key demographic trends, such as the large population share of school-going youth, very high unemployment rates and the devastating impact of the HIV/AIDS epidemic on younger age cohorts, have placed the social old-age pension and the elderly at the centre of the livelihood strategies of many South African households. In this context, the social pension plays a vital role as a poverty-alleviation mechanism, with the effect of pension income on the welfare of other household members being strongly conditioned on whether or not the pensioner is female (Bertrand, et al, 2003; Duflo, 2003; Posel et al, 2004; May, 2003).

Thus, while elderly women benefit significantly from the pension system, important externalities such as changes in household composition and allocation of labour time, as well as changes in child health and educational status, are also associated with pensioner receipt, especially if the pensioner is female (Burns, 2005). According to the CASE study (2009) the number of older persons who are the main caregivers in their households remain very high. Although many older persons assume the role of caregivers, there seems to still be a lack in understanding their needs and vulnerabilities.

The role of caregiver places a very heavy burden on the elderly, considering that as shown above, an old age pension is often the primary source of income for poor households. Other than covering household expenses, the old age pension is also used to pay for school fees, health services or needs, savings as well as promoting social integration through church and burial contributions. In addition to the financial burden, these elderly, most often females, also bear the burden of caring for their grandchildren who
are either left behind by their parents as they seek work in the cities or other towns, or are orphaned by HIV and Aids (UWC, 2011; Burns, 2005).

3.4 Access to Elderly Specific Services

Access to residential facilities

The Older Persons Act clearly states the government’s responsibility in ensuring that its senior citizens are in environments that maintain/improve the physical, social and psychological wellbeing of individuals who, for a variety of reasons, are not fully able to care for themselves. In the Annual performance plan of the Provincial Department of Social Services of 2009-2010 under the programme Social Welfare Services a sub-programme (2.3) is stipulated that provide services and care to older persons in the province (DSD Western Cape, Annual Performance Plan, 2009-2010).

Residential care is one of the service options for older people. The Act states that these facilities should be regulated by the Department of Social Development (DSD) and to this end has drawn up a set of Norms and Standards to be followed by residential facilities. It is important to note the emphasis of the Act in encouraging a shift away from institutional care towards community-based care, resulting in older people who need care as well as able-bodied older persons to remain in their households and community for as long as possible. To this aid the Act commits itself to offering community-based care and a supportive environment as incentive for older people living in the community.

Currently there are 140 residential facilities in the Western Cape Province that are run by different organisations and NGOs such as Badisa, ACVV, CPOA, and other religious organisations (Nursing Directory, 2010). All these facilities indicate to have long waiting lists, in most cases up to one year (DSD, 2010).

In a recent national survey of elderly household respondents, people were asked a series of questions pertaining to access to old age homes (CASE, 2009). In general only one third of the respondents indicated to be aware of such a facility in their area. The response of older people in the Western Cape Province was by far the highest with 63% indicating that they are aware of such a facility in their area. Although this does not necessarily translate to access it does show that in terms of availability of this
service the older population in the Western Cape know how to access these and that these services are operating quite well and thus do leave the older person with a choice to access these.

With regards to the state of elderly residential facilities a recent country-wide audit commissioned by the National Department of Social Development found that the majority of facilities did not comply in its current form with the National Norms and Standards regarding acceptable levels of services to older persons and service standards for residential facilities. Across the provinces only 61% (71% in the WCP) of management and 26% (23% in the WCP) of the staff knew about the new Norms and Standards (DSD, 2010). This lack of awareness again reflects negatively on the implementation of the Older Persons Act with regards to requirements stipulated towards managers and staff.

**The issue of independent residential solutions**

In a research study conducted by Eigelaar-Meets et.al. (2011), a clear need for independent residential solutions for elderly was shown. As a first effort to develop an understanding towards the need of such residential solutions, the report shows on the specific vulnerability of the elderly person, classified earlier in his or her life as part of the low- to middle working class income groups. Being part of a socio-economic group that is marked by nuclear families and economic independence be it to a varying degree, these elderly find themselves in economic difficulty at the day of their retirement. Not affording to plan sufficiently for their retirement day while working and sustaining a middle class existence, these elderly find their income significantly reduced not able to sustain their current standard of living, with accommodation the primary unaffordable item. Not wanting to live with either family or children they are left destitute if not offered alternative housing solutions. Although such housing is provided by private agencies such as NOAH, CPOA and Abbeyfield, these organisations are extremely stretched due to funding limitations together with a growing need for their service by elderly persons.

**Assessment of Service Centres and Luncheon Clubs**

In a Social Value Impact Assessment of 106 service centres and 38 clubs the authors show that the distribution of these service centres and clubs do reflect the DSD’s commitment to serving the poor and disadvantaged communities with a spread across the province including all district office areas. In data describing the target groups of these service centres and clubs it is shown that 29.3% are targeting
populations in the metro, 69.7% non-metro groups and 1.0% target groups from both areas (N=44). The racial composition of the target population shows that 39.6% of the organisations deliver services to mixed racial groups, 47.5% for predominantly Coloured, 6.9% for Blacks and 5.9% for White groups (ROADS, 2010).

Contrary to the expectation regarding the age composition, only 41.6% provide for older persons, while 49.5% focus on mixed age groups. A minority targets adults and older persons in combination. Regarding the socio-economic groups to whom services are delivered, the data show that the target groups are selected mainly from lower income groups (65.7%) and the rest from mixed levels (29.4%) and a few (4.9%) from the middle income level (N=102). The focus of these service centres is however on areas with high unemployment but equally on high and low illiteracy areas. The settlement types of the target population are recorded as mixed and formal with only 3.1% of the organisations with a focus on informal settlement areas (N=98) [ROADS, 2010].

The above information shows that although not exclusively, the older person service providers in the Western Cape do focus on disadvantaged and poor target groups. With regards to the type of services available to the target groups the services access by 80% or more individuals include spiritual care (92.7%), Meals/food provided (91.8%), Recreational activities (88.5%), Entertainment activities (84.4%), Exercise and physical activities (83.2%). 68.8% indicated to make use of health services offered at the service centres, 54.2% of social services and 23% of accommodation provided (ROADS, 2010).

Although the above data show a well represented service sector with relatively high satisfaction levels to the services offered at centres, the awareness of these services to the general older population in the province has to be investigated. In the study by CASE (2009) the majority of household respondents (82%) indicated that they were not aware of service- , luncheon or non-profit centres in their communities. The data show surprisingly low awareness levels for the Western Cape with only 18% of respondents indicating that they are aware of such centres.\(^5\)

\(^5\) It has to be noted that the Western Cape has a greater majority of White older persons who are generally less likely to make use of social assistance due to their higher economic stance. This is supported by the low number of white older persons included in the target groups at service centers (6% of total target population). Given that the CASE study used a stratified sampling technique in selecting their respondents it can be expected that a larger group of white respondents were included which would influence the data, specifically in this case regarding the knowledge of service centers.
Assessment of Health Care and Care Facilities

Since the Mothers and Fathers of the Nation Report was released in 2001 the difficulties and problems that older people experience with both access to health care facilities and with the service that is provided, has been well documented in the literature, commissions of enquiry and reports based on interviews. Since then unfortunately not much has changed. In the study by CASE it was found that 60% of the respondents indicated to have attended a public clinic and hospitals. One in 5 respondents attending a state hospital had to pay for medical services. Approximately one quarter of the respondents make use of private health care. The CASE report shows 31% of respondents had to pay a doctor or nurse in the Western Cape in order to receive medical assistance. The majority of these payments were made from peoples’ pockets with only a small percentage indicating to be members of a medical aid scheme (CASE, 2009).

In a report on the social wellbeing of older persons in the Western Cape (Marais & Eigelaar-Meets, 2007), health services and the access to these services were seen as “very, very poor….” As commented by a respondent in one of the focus groups conducted in the Cape Metro; “Hier by die daghospital, hulle treat jou soos ‘n hond” (here at the day hospital you are treated like a dog), “terrible, not senior friendly at all….”.Uncaring staff at health facilities is an issue that older people seem to often have to cope with. Difficulty in accessing transport and having to stand in long queues at health care facilities were also indicated as obstacles to the elderly in accessing health care.

With regards to home-based care and assisted living there seems to be a great lack of knowledge among the older population with the greater majority (90% and above) in all provinces indicating that they do not know anything about assisted living. With regards to knowledge on home based care the findings did show a higher awareness level with overall 29% of household respondents indicating that they do know about it. For the Western Cape however knowledge on home based care was slightly better with 34% indicating some knowledge thereof (CASE, 2009)

Safety, security and abuse

A quarter (26%) of the house-hold respondents included in the CASE study (2009) indicated to not feel safe in the areas where they live. Again the situation for the older person in the Western Cape look somewhat better with (87%) of older people interviewed indicating to feel safe. They do however
indicate that they would like the South African Police Force to be more visible in their communities. With regards to abuse it was disconcerting to learn from this research report that older people are largely unaware of what the concept mean. Asking this question to the household respondents, 43% of people did not know what it is. In the Western Cape (37%) of respondents did not know what abuse to older people mean. Those who did know named the following: Taking older persons’ belongings including stealing from them, followed closely by starvation and physical beatings. Sexual abuse was also mentioned. Twenty eight percent of house-hold respondents knew some older person that was abused, and 42% of these people did not know what to do about it (CASE, 2009).

A summary of trends and needs identified:

• Rapid ageing of population with the Western Cape showing the fourth largest elderly population across the provinces in 2008
• A majority White and Coloured elderly population (47% and 40% respectively) in the Western Cape
• The Western Cape elderly show in general a higher educational status if compared to the national average, however this seems to be a function of the larger White compilation of this group in this province. The educational profile of Coloured and African elderly reflect national statistics of relatively low educational attainment.
• In general the elderly in the Western Cape has access to basic services including access to piped water, flush toilets and electricity.
• The statistics show on a large percentage of female elderly that are living with their biological children showing on the large care giving role of the elderly. This is supported by the large percentage of grand children that are living with their grandparents.
• The economic importance of the social grant as both a source of social security for the elderly person as well as an important source of income for the poor (mixed generational) household.
• The poor complying of facilities to the National Norms and Standards regarding acceptable levels of services to older persons and service standards for residential facilities.
• The importance of service centres and luncheon clubs in providing social, emotion, spiritual and health support.
• Specific difficulties in accessing health services related to transport, long queues at the health care facilities and uncaring staff.
• Lack of knowledge with regards to home based care and assisted living.
• Vulnerability of the elderly with regards to safety and security.
• The need for alternative independent residential solutions.

3.5 The Provincial Response (DSD)

The services supported, managed and rendered by the Department and partners primarily aims at facilitating access to appropriate services and support to older persons which promote Active Ageing, the protection of older people and keeping them in families and communities as long as possible.

Services summarised in three broad categories (DSD, Strategic Plan 2010-2015):46

• Residential Facilities for the provision of 24 hour residential care
  o Benefits approximately 9 883 beneficiaries through the support of 126 Old Age Homes, across the Western Cape Province
  o Include all persons 60 years and older in need of residential care
  o DSD involvement entails funding and monitoring residential units for compliance with set Norms and Standards.

• Service Centres to provide day care such as health care, nutrition, recreation, exercise and personal hygiene
  o Benefits approximately 16 500 beneficiaries through the support of 225 service centres throughout the Western Cape Province
  o Include all healthy older persons in communities

46 Information provided by Programme Manager, DSD
o DSD involvement entails funding and monitoring the service centres for compliance to set Norms and Standards.

- Social services for Older Persons include services focusing on psycho-social support as a result of abuse, dementia, intergenerational projects and home-based care.
  - Benefit approximately 7 000 beneficiaries through the support of 12 projects spread across the Western Cape Province
  - Include all persons 60 years or older
  - DSD involvement entails funding and the implementation of services as prescribed by the Older Persons Act (2006).

### 3.6 Considering the strategic priorities of the Department of Social Development in light of the evidence

In the ten year strategy document published by the Western Cape Department of Social Development, the approach to supporting the elderly is described as supporting the concept of Active Ageing, promoting a society that is inclusive and where the elderly can fully participate on the basis of equality and no discrimination. In this strategy the Department commits itself to the empowerment and protection of older persons as well as the promotion and maintenance of their status, rights, well being and safety and security, focusing specifically on those elderly who live in the poorest communities, where socio-economic circumstances are most likely to lead to the abuse and neglect of older people (DSD, 2009).

It is given this approach together with the fact that the Western Cape population is shown as comprising one of the largest proportions of elderly to its total population that the exclusion of this group in a strategic document submitted to Parliament in August 2011, outlining the Department’s approach to address social exclusion and poverty, is rather surprising and worrying and thus worth mention in this document (DSD, Western Cape, 2011).
The Department summarises its vision for the outcome of its Older Persons Programme for 2017 as resulting in:

- All older persons having access to information about their rights, the range of services available to them and how to access them
- The transformation of services to older persons ensuring that 80% have access to community-based support services that promote self-reliance and inter-generational bonding
- All residential services being well managed, comply with minimum standards and implement programmes that promote the well-being, safety and security of older persons
- A range of interventions that are in place to speedily and effectively deal with the abuse of older persons and to systematically eliminate the prevalence of abuse

The socio-demographic trends described in this chapter to a great extent underlines and provide support for the above objectives defined however it also shows the great need for an inter-sectoral, multi-disciplinary approach in providing the support structures needed for the elderly. To live up the concept of Active Ageing, an elderly person not only need social services and support but he/she is also in need of appropriate and elderly-service-centred health services and support. This is acknowledged in the ten year strategy document where a section is included on care and services provided to older persons and where the approach is described as involving various role players in the elderly sector, civil society, other government departments, tertiary institutions and local authorities.

As indicated in the above section the provincial DSD primarily focuses its programmes toward the support of residential services, service centres and social services. The support of 24 hour care facilities is indeed of great importance with the need for these facilities marked by the long waiting lists noted by the 140 care facilities in the Western Cape. When considering housing opportunities for the elderly within the approach of active ageing, the trends analysis identifies a seemingly growing group of elderly persons that find themselves destitute and vulnerable to poverty and all related social and health consequences. This group of elderly is described as previously part of the working class who find themselves in often desperate economic situations after retirement, specifically with regards to housing in not being able to afford their previous residential units. There seems to be a strong argument for further investigation into this trend towards some form of support for institutions providing independent residential solutions to this group of elderly.
Another aspect that needs specific mention in this section is the reality described in this chapter for many elderly as, often the primary, caregiver within a multi-generational household. With the old age grand providing significant economic relief to the elderly and their households, this grand also often place the elderly in a position as having to provide for a household that often include grandchildren and biological children. Exploring the needs of these elderly and offering a support system seems relevant and important in the context of a vision for the elderly as active individuals valued and supported within their communities rather than being seen as economic resources having to support extended households.

3.7 Conclusion

In delivering services to the elderly that will enable them to enjoy active, healthy and independent lives, create an enabling and supporting environment, and provide continuous care to older persons in need the South African government has since 1994, ratified International Conventions and promulgated national legislation in an effort to promote the wellbeing of older persons in this country. In 2002 South Africa became a signatory to the International Plan of Action on Ageing (the Madrid International Plan of Action on Ageing) together with the African Union’s Policy Framework and Plan of Action on Ageing (2003) amongst others, to provide a framework for advancing the rights of older persons in South Africa. Beyond the Constitution, the socio-economic rights of older persons are also promoted and protected by other national legislation, which include:

a) The National Health Act 61 of 2003, sections 4(1) allow the Minister of Health to determine circumstances under which vulnerable groups, including older persons, may qualify for free health services at public health facilities.

b) Social Housing Act 16 of 2008 gives priority to social housing for vulnerable groups of which the elderly is one.

(Adkins, 2011)

The growing numbers of the older population within the South African context of slow economic development, place a strong onus on the South African government to ensure the actualisation of the stipulations in the Older Persons Act. With the implementation of this act described as still being in its
infancy there is a clear need to drive this process. From the needs and social trends identified in this chapter there is also a definite need for an effective coordinating mechanism on both national and provincial level that will work towards the managing of an integrated service delivery model that will ensure that all levels of government and civil society carry out their mandates providing elderly-centred services.

3.8 Abbreviations

ACVV Afrikaanse Christen Vroue Vereniging
CASE Community Agency for Social Enquiry
CPOA Cape Peninsula Organisation for the Aged
DSD Department of Social Development
NIDS National Income Dynamic Study
OAG Old Age Grant
ROADS Rural Outreach and Development Services
SASSA South African Social Security Agency
Stats SA Statistics South Africa
WCP Western Cape Province
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South African Social Security Agency (SASSA), 2011, SOCPEN data on Old Age Grant Beneficiaries as for May 2011.


Statistics South Africa, Census 2001

Statistics South Africa, Community Survey, 2007
4.1 Introduction

According to the Annual Performance Plan (APP, 2011) the Western Cape Provincial Cabinet recently approved a policy document for Provincial Strategic Objective 8 – *Promoting Social Inclusion and Reducing Poverty*. In this wide ranging policy, the reduction of poverty - whether manifested in a lack of financial and social capital, skills or access to opportunity – is conceived in broad terms and to be addressed on an extensive front. Similarly the concept of ‘social inclusion’ is viewed in broad terms and should be understood as ‘inclusion’ within families, which are viewed as the basic building blocks of society, civil society and public and private sector institutions, like participation in the educational system and economic life of society. In addition, Strategic Objective 8 firmly believes that ‘inclusion’ should also be sustainable – in other words, the province should strive to promote inclusion that is not indefinitely reliant on the state hand-outs, given the that its resources are finite.

The APP states that Strategic Objective 8 therefore subsequently asks of the DSD to take a critically look at its incumbent social policies with the following question in mind:

*‘Is this policy the best possible way to promote sustainable social inclusion and poverty reduction for its targeted beneficiaries?’ (APP, 2011)*

The purpose of this report is linked to the above question, i.e. discussing the contours of a specific sub programme of the DSD, i.e. Crime Prevention and Support within the context of the broader situation, because a programmatic intervention needs to have some sense of its relevance and efficiency. The said APP articulates it as follows

*...It is also of cardinal importance that we target our services, because we have finite resources, and we need to get maximum impact. We need to be sure that we are applying best practice in all our work.....(2011)*
4.2 Selection of Crime Statistics

The challenge facing the DSD, particularly its programme dealing with reducing crime and assisting those that have been affected by it, is daunting. According to official crime statistics, the Western Cape has emerged as the country’s most crime-ridden province at the beginning of the new Millennium. Ted Leggett (Institute for Security Studies Crime Quarterly, 2004) describes this finding as confusing to criminologist, who would typically link crime to poverty. However, the Western Cape is traditionally one of the best developed provinces in the country, with some of the highest employment levels. According to this report, the Western Cape have been registering the highest or near highest provincial per capita rates of recorded murder for a number of years, attempted murder, common assault, residential burglary, theft out of motor vehicle and general theft, and the second highest rates of rape, serious assault and commercial crime.

According to official statistics, the Western Cape has by far the worst overall crime problem in the country (Figure 1). In addition, in many crime categories, this province also boasts with the fastest growing crime problem (Table 1), although the Northern Cape has the highest rate of violent crime. Between these two provinces have the worst crime rates in the country in 17 of the 22 serious crime categories tracked by the SAPS.

Figure 1: Crime rates by province, 2002/2003

<table>
<thead>
<tr>
<th>Province</th>
<th>Other</th>
<th>Property</th>
<th>Violent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limpopo</td>
<td>138</td>
<td>1297</td>
<td>1014</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>280</td>
<td>2465</td>
<td>1509</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>294</td>
<td>2857</td>
<td>1584</td>
</tr>
<tr>
<td>North West</td>
<td>288</td>
<td>2827</td>
<td>1872</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>215</td>
<td>3181</td>
<td>1717</td>
</tr>
<tr>
<td>RSA Average</td>
<td>345</td>
<td>3611</td>
<td>2022</td>
</tr>
<tr>
<td>Free State</td>
<td>465</td>
<td>3656</td>
<td>2136</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>778</td>
<td>4640</td>
<td>3433</td>
</tr>
<tr>
<td>Gauteng</td>
<td>352</td>
<td>5727</td>
<td>3037</td>
</tr>
<tr>
<td>Western Cape</td>
<td>776</td>
<td>7013</td>
<td>3250</td>
</tr>
</tbody>
</table>

Source: SAPS Crime Information Analysis Centre, 2002/2003
Table 1: Changes in numbers of recorded crimes between 1994/5 and 2002/3

<table>
<thead>
<tr>
<th>Crime Category</th>
<th>Western Cape</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murder</td>
<td>+34%</td>
<td>-17%</td>
</tr>
<tr>
<td>Aggravated robbery</td>
<td>+121%</td>
<td>+50%</td>
</tr>
<tr>
<td>Carjacking</td>
<td>+254%</td>
<td>+14%</td>
</tr>
<tr>
<td>Theft of motor vehicle</td>
<td>+56%</td>
<td>-12%</td>
</tr>
</tbody>
</table>

Source: SAPS Crime Information Analysis Centre, 2002/2003

Violent crimes

According to Leggett (2004) the Western Cape had the highest rate of murder at the beginning of 2000s: 85 murders per 100,000 citizens in 2002/3. This was significantly higher (nearly double) than the national average of 47 per 100,000. Criminologists agree that murder is the most accurate barometer of violent crime in an area; because of its nature the changes are better that it will become known to and recorded by the police than other violent crimes. Fewer murders thus remain unrecorded. As is illustrated in the table below, the Western Cape is the only province that registered an increase in the murder rate over this period.

Figure 2: Change in recorded murder rates between 1994/5 and 2002/3 by province

Source: SAPS Crime Information Centre
The high prevalence of crime in the Western Cape was not limited to murder; the province had registered at the same time the country’s highest levels of common and indecent assault, as well as common (but not aggravated) robbery. And aside from the violence, the province also suffers from the highest overall rates of property crime (ibid, 2004).

**A more recent picture: The crime situation in 2010/2011 in the Western Cape**

The following tables reflect a more recent picture of crime statistics and trends in the Western Cape. The prevalence of a selection of different crimes is compared with those of the other eight provinces in South Africa.

**Table 2: Attempted murder ratios sorted from highest decreases to highest increase between 1 April 2010 and 31 March 2011**

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>% increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>35.3</td>
<td>31.0</td>
<td>-12.2%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>45.6</td>
<td>36.7</td>
<td>-19.5%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>34.0</td>
<td>22.7</td>
<td>-33.2%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>13.9</td>
<td>12.0</td>
<td>-13.7%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>29.2</td>
<td>25.5</td>
<td>-12.7%</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>44.2</td>
<td>36.8</td>
<td>-16.7%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>62.0</td>
<td>58.8</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Free State</td>
<td>29.1</td>
<td>27.3</td>
<td>-6.2%</td>
</tr>
<tr>
<td>North West</td>
<td>24.3</td>
<td>22.0</td>
<td>-9.5%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>31.9</td>
<td>41.4</td>
<td>29.8%</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012

According to the latest South African Police Statistics (2010/2011), the Western Cape still has the highest murder rate, i.e. 42 per 1000, compared to the national average of 34. Only the Eastern Cape has a higher rate of murder than the Western Cape. In addition, the Western Cape shows a massive increase in attempted murders, i.e. 30% compared to the national average registering a decrease of 12%. This is a disconcerting trend that reflects an underlying malaise in the communities of this province.

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Table 3: Assault with the intent to inflict grievous bodily harm ratios sorted from highest decreases to highest increases between 1 April 2010 and 31 March 2011

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>% increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>416.2</td>
<td>397.3</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>466.1</td>
<td>416.4</td>
<td>-10.7%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>439.8</td>
<td>399.0</td>
<td>-9.3%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>254.8</td>
<td>237.8</td>
<td>-6.7%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>485.0</td>
<td>456.8</td>
<td>-5.8%</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>295.6</td>
<td>287.3</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>830.7</td>
<td>815.5</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Free State</td>
<td>542.5</td>
<td>546.6</td>
<td>0.8%</td>
</tr>
<tr>
<td>North West</td>
<td>421.9</td>
<td>439.9</td>
<td>4.3%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>449.2</td>
<td>473.3</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012

Table 4: Common assault ratios sorted from highest to lowest decreases between 1 April 2010 and 31 March 2011

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>% increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>400</td>
<td>371.8</td>
<td>-7.10%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>559.8</td>
<td>486.8</td>
<td>-13.00%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>171</td>
<td>149.3</td>
<td>-12.70%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>310.6</td>
<td>285.8</td>
<td>-8.00%</td>
</tr>
<tr>
<td>North West</td>
<td>257.7</td>
<td>243.2</td>
<td>-5.60%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>260.4</td>
<td>246</td>
<td>-5.50%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>485.7</td>
<td>461.9</td>
<td>-4.90%</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>315.6</td>
<td>303.1</td>
<td>-4.00%</td>
</tr>
<tr>
<td>Free State</td>
<td>655.2</td>
<td>634.9</td>
<td>-3.10%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>642.3</td>
<td>637</td>
<td>-0.80%</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012
Table 5: Robbery with aggravating circumstances ratios sorted from highest decreases to highest increases between 1 April 2010 and 31 March 2011

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>% increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>230.6</td>
<td>203</td>
<td>-12.00%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>449</td>
<td>357.9</td>
<td>-20.30%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>222.4</td>
<td>183.9</td>
<td>-17.30%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>183.3</td>
<td>153.4</td>
<td>-16.30%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>90.4</td>
<td>80.7</td>
<td>-10.70%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>56.8</td>
<td>50.8</td>
<td>-10.60%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>234.1</td>
<td>234.5</td>
<td>0.20%</td>
</tr>
<tr>
<td>Free State</td>
<td>171.2</td>
<td>171.8</td>
<td>0.40%</td>
</tr>
<tr>
<td>North West</td>
<td>157.1</td>
<td>158.7</td>
<td>1.00%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>145.5</td>
<td>154.9</td>
<td>6.50%</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012

Table 6: Robbery at residential premises sorted from the highest decreases to the highest increases between 1 April 2010 and 31 March 2011*

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>case difference</th>
<th>% increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>18 786</td>
<td>16 889</td>
<td>-1 897</td>
<td>-10,1%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1 300</td>
<td>1 045</td>
<td>-255</td>
<td>-19,6%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>4 580</td>
<td>3 998</td>
<td>-582</td>
<td>-12,7%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>8 051</td>
<td>7 039</td>
<td>-1 012</td>
<td>-12,6%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>584</td>
<td>530</td>
<td>-54</td>
<td>-9,2%</td>
</tr>
<tr>
<td>North West</td>
<td>894</td>
<td>828</td>
<td>-71</td>
<td>-7,9%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>1 606</td>
<td>1 556</td>
<td>-50</td>
<td>-3,1%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1 167</td>
<td>1 215</td>
<td>48</td>
<td>4,1%</td>
</tr>
<tr>
<td>Free State</td>
<td>535</td>
<td>637</td>
<td>102</td>
<td>19,1%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>64</td>
<td>41</td>
<td>-23</td>
<td>-.**</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012
Table 8: Robbery at non-residential premises ranked from the highest decreases to the highest increases between 1 April 2010 and 31 March 2011*

<table>
<thead>
<tr>
<th>Province</th>
<th>2009/2010</th>
<th>2010/2011</th>
<th>case difference</th>
<th>% increase or decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSA</td>
<td>14 534</td>
<td>14 667</td>
<td>133</td>
<td>0,9%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>6 379</td>
<td>5 553</td>
<td>-826</td>
<td>-12,9%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>2 066</td>
<td>1 943</td>
<td>-123</td>
<td>-6,0%</td>
</tr>
<tr>
<td>North West</td>
<td>1 130</td>
<td>1 162</td>
<td>32</td>
<td>2,8%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>147</td>
<td>157</td>
<td>10</td>
<td>6,8%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>978</td>
<td>1 105</td>
<td>127</td>
<td>13,0%</td>
</tr>
<tr>
<td>Free State</td>
<td>873</td>
<td>1 024</td>
<td>151</td>
<td>17,3%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>630</td>
<td>756</td>
<td>126</td>
<td>20,0%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1 058</td>
<td>1 309</td>
<td>251</td>
<td>23,7%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>1 273</td>
<td>1 658</td>
<td>385</td>
<td>30,2%</td>
</tr>
</tbody>
</table>

Source: SAPS, 2012

The Western Cape has also recorded the highest increase in ratio of assault with the intent to inflict grievous bodily harm, i.e. 5,4% compared to a national decline of 4,5%. As far as common assault is concerned the Western Cape did show a decrease in the prevalence, albeit very modest, 0,8% compared to a substantive decline of 13% recorded in Gauteng and a national decline of 7%.

Robbery

Nationally a decrease of 12% in prevalence of robbery with aggravating circumstances was registered over 2010- 2011, with Gauteng boasting an impressive decrease of 20%; the Western Cape, on the contrary, however, showed a increase of 0,2% , in line with the Eastern Cape that showed an increase of 6,5%. Similarly did the Western Cape showed a small increase in robbery of residential property of 4% while the national trend reflected a decrease of 1%; regarding robbery of non residential property the trend was equally disturbing, with the Western cape showing a huge increase of 24% compared to the national average of only 1%

The overall trend of prevalence of crimes in the Western Cape registering higher than the norm national applies to sexual offences as well with the highest prevalence of reported sexual offences recorded in
the Western Cape, followed by the Free State and Northern Cape. Nationally, the movement in the trend of reported sexual offences since last year shows a decrease of 4.4%, with the Western Cape registering a (substantially smaller) decrease of 1.5% in line with for other provinces.

4.3 Crime and the Youth in the Western Cape

The vulnerability of the ‘at risk’ youth of the Western Cape to become either involved or a victim of crime is acknowledged by the PGWC in general and the DSD in particular. For example, in 2009, 73 youths under the age of 18 were in custody, with 94% of these male. In addition, the province has a high burden of mortality amongst young men. Fatal violence among men is 60% higher than the international average of 3.2 male deaths for every female death.

Twenty percent of children in the Western Cape between the ages of 12 and 17 years have been exposed to various forms of domestic violence; 23% of children in this age group have been threatened with harm, have been fearful of being harmed, or have actually been hurt in a violent incident while they were at school, while 68% of children in this age cohort reported having seen someone being intentionally hurt outside of their home, mostly in the local neighbourhood; 75% of them knew the attacker (APP, 2011).

Gangsterism is endemic in the Western Cape and increasingly affects young people, both youths that have completed or dropped out of school, as well as those attending school. A recent study on the causes of underperformance at secondary schools in the Western Cape (Louw, Bayat and Eigelaar-Meets, 2011) established that crime plays an important role in the underperformance of both schools and learners, with high percentages of learners mentioning the presence and impact of crime in their household, their community and in their classroom, or on the school property, on their ability to concentrate on their school work. In a nutshell, the omnipresence of crime impacts negatively on their ability to perform at maximum scholastically. This is especially the case at schools situated on the Cape Flats, like Khayelitsha. The report by Louw et al (2011) found that the Safe School Project is effective to some extent; however, findings from this study suggest this initiative has little impact on protecting learners against acts of violent crime and intimidation in the classrooms, corridors and open spaces within the school precinct.
4.4 Possible explanations for the high crime rate in the Western Cape

The high prevalence of different expressions of crime in the Western Cape compared to other provinces in South Africa is perplexing, specifically considering some key indicators to general wellbeing. The Western Cape Province has the highest human development index, i.e. the highest level of wellbeing; it also boasts with a comparatively low unemployment levels compared to the national case. This province is better resourced in just about every aspect than any other province, its school system produces better results and it has a more equitably distribution of facilities and resources, probably a result of a better performing local economy compared to the other eight provinces. However, it is also true that the Western Cape has a very high drop out rate of learners from the school system. Youth that have left the school system prematurely are particularly vulnerable to engage in deviant behaviour as they are ill prepared to succeed in entering the labour market and are thus economically marginalized.

Why then, is one of the best-developed and performing provinces in South Africa so crime-ridden? Answering this question is not easy. Although there are, according to Leggett (2004) two strategic variables that has been identified as possible explanations for this apparent contradiction, i.e. the higher prevalence of substance abuse in the province and the high urbanisation and in-migration rate to the Western Cape with resultant increase in overcrowding, and a resultant battle for basic services and overall demographic-social instability in the province, it is also necessary to look at the important factors that explain the high prevalence of crime and violence in South Africa in general.

The Western Cape is very much part of South Africa and are thus also affected by a range of factors and forces typically associated with causing or associated with crime and violence. Below is a synopsis of what are commonly regarded as the most important ‘risk factors’ that contribute to the high levels of crime and violence. These factors can be grouped into the following categories (Louw, 2007):

- **Adverse socio-economic circumstances:**
  Here the issues are around income inequality and poverty, high rates of urbanization are critical, poor housing provision, problems in core institutions for societal stability such as the family and schools, low levels of education and weak provision of childcare, recreational and after care facilities at schools.
• **Attitudes to crime and violence:**
  This refers interalia to a range of covert and often referred to as intangible variables. This includes a ‘culture of violence’ and, is what Louw (2007) link to repeated experiences of violence in childhood, poor socialisation, questions around identity and a sense of inclusion in the society, poor anger and conflict management skills, and a ready rationalisation of crime and violence. Alternatively, of great importance in understanding high prevalence of crime and violence is the lack of social constraints that might inhibit violent behaviour. In addition, the diminished status of women and children in a society is a key factor associated with higher levels of violence against these groups.

• **The presence of facilitating factors:**
  These factors typically include alcohol and drug abuse, gangs and firearms, all of these are prevalent in the Western Cape. Another important facilitating factor refers to poor urban design (which makes it easier to commit crime or more difficult to react to it). This is what the Chicago School of Sociology referred to as the criminogenic architecture of a human settlement.

• **Weak regulatory systems:**
  This primarily includes weaknesses in the criminal justice system (which as a result fails to deter criminals), as well as a weak local government that fails to strictly enforce adherence to municipal by-laws and regulations and fails to control and manage of urban spaces.

According to Louw (2007) these risk factors are not unique to South Africa and are present to explain crime globally. Why South Africa exhibits such high crime levels though, is because nearly all the risk factors prevail here, whereas other countries tend to be affected by only a few. The author points out that of all these factors, the category which is perhaps most critical and subsequently most challenging for South Africans, in terms of analysis and intervention policy content and direction, is that of attitudes to crime and violence. The best way to understand this is by using a term coined by then-President Mandela that referred to a condition or attitude of “spiritual malaise”. He used this to explain the high crime and violence in South Africa – this refers to a lack of spirit, hope and faith, that

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48 The Sociology Department at the University of Chicago did groundbreaking work in undertaking systematic descriptive and analytical empirical studies of rapid increase in inner city crime and violence during the early part of 19th century due to immigration and urbanization. Afterwards it was common to refer to their work and theoretical postulations as the Chicago School of (deviant behaviour)
leads inter alia to greed and cruelty, of laziness and egotism, of personal and family failure – a state of affairs in society that helps to fuel the problems of crime and corruption and hinders efforts to deal with them. What is needed is a strong recommitment to morality. According to Louw (2007) the challenge is now one of how to rebuild the social fabric of South African society and change prevailing attitudes to crime and violence. This remains a key and according to her a largely unanswered question for policy makers.

It can be safely assumed, given what crime statistics tell us, that most, if not all of the causative factors of crime and violence discussed above are present in the Western Cape. Also, it can be accepted that the spiritual malaise mentioned, a specific attitude towards crime and violence that allows for a tacit acceptance and tolerance towards it, which is prevailing in contemporary South Africa, is also prevalent in communities in the Western Cape.

4.5 The Provincial Response (DSD)

The programme on Crime Prevention and Support of the DSD articulates the policy and systematic approach of the provincial government to the daunting challenge of firstly, creating a socio economic ecology that is contra – crime, i.e. a less criminogenic environment, and secondly to develop supportive systems and institutions to assist and help those - individuals, livelihoods and communities - that have either perpetrated acts of crime and violence or have been affected, hurt or brutalized by acts of crime and / or violence.

The umbrella vision of the Crime Prevention and Support programme, according to the APP (November, 2011) is to:

...develop and implement social crime prevention programmes and provide probation services targeting children, youth and adult offenders and victims in the criminal justice process.

Two core objectives of the Crime Prevention and Support Programme relevant here are to
• Reduce the extent of contributing factors of social crime to reduce recidivism through an effective probation service to all vulnerable children and adults by 2015
• Substantially reduce the extent of recidivism and vulnerability to crime by providing psycho-social and statutory services to children and adults

The focus of the Crime Prevention and Support Programme is the:

• Development and implementation of social crime prevention programmes through the assistance of NGOs
• Provision of probation services that target children, youth and adult offenders and victims in the criminal justice process
• Development of and accreditation of diversion programmes for children and adults that will lead to behavioural change and that promote restorative justice

Clearly the focus of this programme is on people, both on adults and children, minimizing their vulnerability to become involved in crime and violence, and if have been involved to assist them to deal with it successfully, by recovering from the consequences, from avoiding falling back into a career of crime through the offering of diversion programmes and provision of probation services.

4.6 Considering the strategic priorities of the Department of Social Development in light of the evidence

The sub-programme on Crime Prevention and Support aims, as mentioned above, is to reduce the criminogenic environment that characterizes many communities in which thousands of young people and adults grow up and socialized in, in the Western Cape. By creating a healthier human ecology, the programme aims to reduce recidivism, i.e. the habitual relapse into criminal activity by establishing a viable probation programme (an alternative system to the penal system and specifically to incarceration).

Available official crime statistics clearly shows that the Western Cape has an extraordinary high prevalence (and in many instances also high incidence) of different crimes. Of deep concern are the high rates in so called social crimes in this province, i.e. crimes that are directed at people. Examples of
this include and attempted murder, serious and common assault and assault, robbery and sexual offences involving predominantly, but not exclusively children and women. The nature of social crime is that it involves both a perpetrator and victim, somebody attacks and somebody suffers. Both parties are in need of psychological and social work intervention; the perpetrator needs to be involved in crime diversion and probation programs, while the victim needs to be cared for and supported in victim empowerment and healing programmes. The strategic framework developed by DSD evidently has made allowances for this. While the scope of this report does not allow the consideration of the content of intervention and empowerment programmes, it is of import to stress that strong emphasis need to be placed on conflict and anger management value as well as normative behaviour modification programmes, especially those that are focussed on the perpetrators of violence and crime.

Statistics strongly suggest that males are the vulnerable gender in terms of being more likely to be involved in so called social crimes committed in the Western Cape, both as perpetrator and victim. This applies to all age groups, but is especially pronounced in the age cohort of 16 – 34. It is not clear from the information available whether crime diversion programmes offered by the DSD have taken cognizance of this crucial aspect. The exception to this is of course crimes of a sexual nature, e.g. rape, where the overwhelming majority of victims are female. There are thus distinct gender contours in the manifestation of social crimes and in order for programmes to have maximum impact on behaviour modification and support and rehabilitation this reality must be taken into account.

The DSD needs to continue with the strong emphasis on recidivism avoidance amongst perpetrators of crime; this is a strategic priority of its programme and of critical importance; perpetrators should be closely shadowed by those professionals (e.g. social workers) and institutions (e.g. NICRO) involved in post – punishment rehabilitation and support programmes as the changes of a person relapsing in crime are great, especially in a sociological – criminogenic environment that continues to fuel opportunities and pressure to break the law.

The DSD has as decided to identify the family (whether nuclear or extended) as the core institution in the communities of the Western Cape that should embody virtue, good and solid values; the family is essentially the engine room and prime socialization agent for the youth to develop into law abiding citizens with acceptable normative behaviour with the requisite mental tools to deal with societal challenges; ultimately a well functioning family can act as citadel to protect its members against a
social ecology that could spawn anti social and criminal behaviour. Although rehabilitation institutions are of strategic importance to assist both perpetrators and victims of crime and violence, it is the family as institutions that form the bedrock to build both successful and sustainable recidivism – avoidance and probation programmes on.

This strategic approach or philosophy embedded in the approach of the DSD cannot be faulted - healthy families will translate into healthy communities, from this a healthy society will flow. However, in order for families to develop and maintain good health they need a good diet in the sense of supporting the family in disparate ways. The DSD needs through its diverse programmes (e.g. Sustainable Livelihood support and Children and Family programmes) to make sure that livelihood and family security, capacity and resilience is ensured in the face of enormous odds like chronic poverty, lack of adequate housing and overcrowding and inadequate parental and communication skills.

4.7 Conclusion

The overview of statistics of a selection of crimes that were recorded in the Western Cape over the last decade paints a disconcerting picture; it clearly shows that this province has registered and still registering some of the highest prevalence and incidence, i.e. the number of actual crimes recorder and the increase (or decrease in the number of crimes recorded over a fixed period). Official statistics showed that this province had at the beginning of the new millennium by far the worst overall crime problem in the country and in addition, in the case of a substantial number of many crime categories, the Western Cape boasted with the fastest growing crime problem.

The persistence of the extraordinarily high prevalence and incidence of crime in the Western Cape is extremely disturbing. It shows a disconcerting trend that reflects social fracturing, lack of social cohesion and indicative of an underlying malaise in certain vulnerable communities of this province.

Obviously the PGWC needs to react through its different departments to this reality and challenge the Western Cape. The DSD specifically through its manifold social programmes is the most significant actor and stakeholder in the onslaught to turn the indices of crime and violence around.
The overall programme on Crime Prevention and Support of the DSD appears good. The strategic framework of the programme is sound; it focuses on the correct areas of intervention as well as the disparate target groups. Two interest groups that are not explicitly mentioned in the available documentation are the elderly and people living with disability. Both groups are particularly vulnerable to become victims of crime and violence. Another area of concern is the impact that the prevalence and incidence of crime and violence within schools located in vulnerable areas has on the learners and their ability to perform. Special attention should be given to the role of gangsterism in the phenomenon of school-based violence and crime. The DSD should attend to this challenge. The strong emphasis on the fortification of the family as pivotal institution cannot be faulted; it is the best suited to drive a moral regeneration of this province—something that is evidently lacking in many communities is evident in the high prevalence of social crimes like murder, assault, and rape where the victim is often known to the perpetrator. However, the family based in impoverished areas is under enormous socio-economic pressure and often precariously poised; in addition, the high prevalence of HIV and Aids in certain geographical pockets of the Cape Metro has decimated the family as institution in some townships.

The DSD is faced with unenviable task to try and address the huge problem of crime and violence in this province. The latest crime statistics and trends are disconcerting and will require innovative and strategic thinking to address the most pressing areas for intervention in order to minimize the harmful impact of crime and start to turn the trend around. The balance struck in the programme between awareness—prevention on the one hand and support-curate programmes on the other hand is the correct one.
4.8 Abbreviations

APP    Annual Performance Plan
DSD    Department of Social Development
NICRO  National Institute for Crime Prevention and the Reintegration of Offenders
PGWC   Provincial Government of the Western Cape
SAPS   South African Police Services

4.9 Bibliography


5.1 Terminology and conceptual clarification

Disability can be defined (Webster, 2006) as the disadvantage and exclusion which arise as an outcome of the interactions between people who have impairments and the social and environmental barriers they face due to the failure of society to take account of their rights and needs.

The source developed by VSO cited stresses the very important distinction in this definition between impairment and disability (Webster, 2006:6).

An impairment is “a physical, intellectual, mental or sensory characteristic or condition, which places limitations on an individual’s personal or social functioning in comparison with someone who does not have that characteristic or condition”.

Impairment is seen as individual. “There are as many different impairments as there are impaired individuals. An impairment can be the result of illness, injury, or a congenital condition. For example, different impairments can affect someone’s physical mobility or dexterity, her ability to learn, to communicate or interact with other people or to hear or see.” This view is associated with the medical model based on an individualistic perspective on disability.

In contrast, disability is social. “It is the exclusion of people with impairments, due to social and environmental discrimination that acts as a barrier to their full and equal participation in mainstream society. Disability is fundamentally an issue of rights”.

A recent analysis of disability in South Africa highlights the need of defining disability from both an individual and social perspective (Watermeyer et al (2006) – “Disability thus includes external environmental factors and internal personal factors. ... This change from focusing on the individual to focusing on the individual plus the environment has important implications for measuring and researching disability, as well as developing policies on disability.”
At an international level the trend in dealing with disabilities is through **mainstreaming** that is described as “The process of engaging in a structured way with an issue as an organisation, at workplace, programme and policy levels, in order to address, and avoid increasing, the negative effects of that issue. In other words, we see mainstreaming as a method for addressing specific issues in areas where they wouldn’t normally be addressed.”

Mainstreaming goes hand in hand with strengthening disabled people’s own initiatives and organisations as advocates for inclusion and supporting the provision of enabling services (such as mobility assistance, early childhood development or sign language teaching) so that disabled people have the basic assistance they need to participate in society in an unfettered fashion.

Mainstreaming is one of the four key components of what VSO describes as a comprehensive response to disability. The other being:

- **Voice**: strengthening the voice of disabled people at every level, particularly through building the capacity of disabled people’s organisations (DPOs).
- **Inclusive services**: supporting basic services to include disabled people
- **Enabling services**: strengthening disability services to meet the specific needs of individuals with impairments that prevent them from participating.

Disability as a societal issue and challenge is still largely invisible in the wider development agenda, in particular in discourse on the international Millennium Development Goals (MDGs) and country-level Poverty Reduction Strategy Papers (PRSPs). Disabled people are not mentioned explicitly in the MDGs (United Nations, 2008). This approach is reflected by national governments and NGOs. Although disabled persons may be catered for as far as they are included in the other goals, disabilities as impairment as well as its social consequences are not specifically catered for. As a result, most multilateral and bilateral donors, who tend to focus on the MDGs, do not consider disability as a development priority (Webster, 2006).

However, there are signs that disability is gaining recognition as a development issue at international level, particularly by the World Bank. The current UN process to develop a Convention on the Rights of Persons with Disabilities (United Nations, 2006) offers an enormous opportunity to raise the visibility of disability around the world.
It should be noted that a recent publication by Statistics South Africa\textsuperscript{a} (2011) excluded data on disabled persons from their review of vulnerable groups in South Africa. Although people with disabilities are acknowledged as “perhaps the most vulnerable group”, a proposed chapter on disability was not included in this publication because inconsistent findings were noticed when comparing the GHS 2009 and 2010 data.

5.2 Prevalence and trends of disability

The General Household Survey of 2010 as released August 2011 (Stats SA\textsuperscript{b}, 2011) provides the latest available estimate of disabled people with a breakdown for the provinces. Figure 5.1 below, compiled from information in this report provides the numbers (x1000) and percentage disabled for the Western Cape and the total for RSA.

Figure 5.1: Percentage of persons aged 5 years and older with disability by gender, Western Cape and total RSA, 2010

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total Western Cape</th>
<th>Total RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>4.7%</td>
<td>5.2%</td>
<td>5.0%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa, 2011
The estimates for 2010 indicate 244,000 disabled persons in the Western Cape, 132,000 (54%) being female and 112,000 (46%) male.

The 2001 Census counted 96,549 male, 90,301 female and a total of 186,850 disabled persons in the Western Cape. Although not completely comparable\(^49\) the numbers show an increase of around 30% in the Western Cape from 2001 to 2010. It should be noted that Stats SA in the 2010 household survey only include 5 years and older. With the under 5 years group included the increase would have been larger.

The General Household Survey of 2010 only offers limited breakdowns profiling the disabled population. The questions used on disability in the questionnaire required each person in the household to rate their ability level for a range of activities such as seeing, hearing, walking a kilometer or climbing a flight of steps, remembering and concentrating, self-care and communicating in his/her most commonly used language, including sign language. During the analysis individuals who stated that they had some difficulty with two or more of the activities or had a significant difficulty/were unable to perform any one activity, are then ranked as disabled. The category ‘disabled’ developed for the sake of the consequently exclude the possibility of using some of the specific breakdowns as reported on in the survey. Since the definition of “disabled” is also very different from the one used in previous surveys and the 2001 Census, comparisons should take this into account.

Using the classification system explained above, 6.3% of South Africans and 5% in the Western Cape are defined as disabled.

A dedicated Census Report published in 2005 using the 2001 census data (Stats SA, 2005), although a bit outdated, provides a breakdown and offer comments for the country in terms of variables such as type of disability, age, level of education and employment. The comments or profile may not fit or describe the situation in the Western Cape entirely, but at least provide some significant pointers, and is briefly summarised below.

\(^{49}\) Since this question on disability for the 2010 survey is very different from the question asked in previous surveys, the results can only be compared to the findings from 2009 when the question was first introduced.
Types of disability

It should be noted that each type of disability has a unique impact on an individual's ability to perform certain activities. The implications for programmes servicing the needs should thus take note of the disability and the associated needs.

The distribution of the different types of disability as reflected in the 2010 survey (Stats SA, 2011) grade the types of disability into 3 categories, complicating breakdowns and interpreting it for the purposes of this report [Figure 5.2]. The 2001 Census report on disabilities do provide breakdowns and analysis. Countrywide, it reported sight as the most common disability (32%), followed by physical (29%) and hearing disabilities (20%) in third position. The 2010 survey confirms sight as most common disability in the Western Cape.

Figure 5.2: Percentage of disabled persons affected by specific disabilities, 2001 Census

![Bar chart showing the percentage of disabled persons affected by specific disabilities, 2001 Census](image)

Source: Statistics South Africa, 2011

Prevalence by population group

Figure 5.3 shows variations when comparing the incidence of types of disability when comparing the population groups. African sight the highest followed by physical, in the coloured and Indian groups physical followed by sight and in the white group physical followed by hearing. All the other disabilities are below 20% in the other groups than the white group. Although the 2001 Census report does not
provide disability breakdowns per province for population group it serves as an indicator of the probable trends in the Western Cape.

**Figure 5.3: Percentage of disabled persons affected by specific disabilities by population group, 2001 Census**

![Chart showing percentage of disabled persons by age group and disability type]

<table>
<thead>
<tr>
<th>Disability Type</th>
<th>Population Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sight</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>33.8%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>24.2%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>27.4%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>23.6%</td>
</tr>
<tr>
<td>Hearing</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>19.7%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>18.2%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>16.2%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>26.1%</td>
</tr>
<tr>
<td>Communication</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>6.0%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>8.4%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>7.6%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>8.7%</td>
</tr>
<tr>
<td>Physical</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>28.0%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>37.9%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>36.1%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>37.0%</td>
</tr>
<tr>
<td>Intellectual</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>11.5%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>15.3%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>13.9%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>17.6%</td>
</tr>
<tr>
<td>Emotional</td>
<td>African</td>
</tr>
<tr>
<td></td>
<td>15.7%</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
</tr>
<tr>
<td></td>
<td>18.2%</td>
</tr>
<tr>
<td></td>
<td>Indian / Asian</td>
</tr>
<tr>
<td></td>
<td>15.4%</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>14.1%</td>
</tr>
</tbody>
</table>

Source: Stats SA, 2005

**Prevalence by age**

The age profile of the disabled population per population group is shown in Figure 5.4 below and indicates that only 2% of persons aged 0-9 years were reported as disabled. This percentage increased steadily among those aged less than 40 years and increased rapidly thereafter. There were no significant differences between females and males. The age profile of the disabled (2001) is compared in the table below, followed by a graph showing the differences between the age groups.
Table 5.4: Disabled numbers by gender and as % of age groups, SA, 2001

<table>
<thead>
<tr>
<th>Age Group</th>
<th>N Male</th>
<th>N Female</th>
<th>N Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>2.2%</td>
<td>1.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>10-19</td>
<td>3.2%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>20-29</td>
<td>3.7%</td>
<td>3.5%</td>
<td>3.6%</td>
</tr>
<tr>
<td>30-39</td>
<td>5.4%</td>
<td>4.3%</td>
<td>4.9%</td>
</tr>
<tr>
<td>40-49</td>
<td>7.5%</td>
<td>6.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>50-59</td>
<td>10.8%</td>
<td>10.3%</td>
<td>10.5%</td>
</tr>
<tr>
<td>60-69</td>
<td>13.7%</td>
<td>12.5%</td>
<td>13.0%</td>
</tr>
<tr>
<td>70-79</td>
<td>16.9%</td>
<td>17.7%</td>
<td>17.4%</td>
</tr>
<tr>
<td>80+</td>
<td>25.6%</td>
<td>27.9%</td>
<td>27.2%</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa, 2005

The figure below (Figure 5.5) shows a proportionally larger concentration of disabilities in the Black African group overall, with low percentages (all below 1%) for the other population groups across all the age cohorts. In the age groups from 40 and up.

Figure 5.5: Percentage distribution of disabled persons in each population group by age (Source: Stats SA, 2005)

Source: Stats SA, Census 2001
Prevalence by level of education

Figure 5.6 below gives the percentage of disabled persons aged 20 years and above who had never been to school by population group. Predictably, the figures indicate that Africans were the most affected, while white people had the lowest proportion (7%). However, interestingly, females were more affected than males regardless of population group.

Figure 5.6: Percentage of disabled persons aged 20 years and above who had no schooling in 2001

The contrasts between population groups in terms of educational status could be a reflection of the fact that black disabled persons were often in the past excluded from educational opportunities, as the environment in normal schools did not facilitate integration. Another possible explanation is that low levels of education are generally associated with prevalence of poverty, which in turn renders people more vulnerable to become impaired because of factors such as lack of access to healthcare and rehabilitation. Hence the higher prevalence of disabilities in the group with no education could be as a result of both lack of access to educational opportunities and poverty.
Prevalence by employment levels

In the Western Cape 28.4% disabled males and 22.7% disabled females were employed, against 57% males and 42.4% females in the non-disabled group. When comparing the Western Cape seemed to be in a more favourable situation than most of the provinces. Only Western Cape comparisons between disabled and non-disabled are reflected below (Figure 5.7).

Figure 5.7: Percentage of disabled and non-disabled persons aged 15-65 years who were employed in the Western Cape, 2001

![Figure 5.7](image)

The profile of the disabled population – A Summary

Conclusions on the profile should be qualified due to the lack of recent research in the Western Cape. Nevertheless, likely patterns and trends are noted as follows:

- The 2010 Stats SA Household Survey indicated 244,000 disabled persons (0 to 9 years olds excluded) in the Western Cape; 132,000 (54%) being female and 112,000 (46%) male representing 5% of the province’s total population.

- Countrywide, the 2010 Stats SA Household Survey indicate sight as the most common disability (32%), followed by physical (29%) and hearing (20%) in third position. This survey also confirmed sight as the most common recorded disability in the Western Cape. Compared by population group the prevalence of sight-disability is the highest in the Black African group (33.8%) and physical disability in the case of all other groups. The two most prevalent disabilities across all
groups are sight and physical with hearing, emotional and intellectual between 10% and 20% in all groups, with communication below 10%.

- The age profile of the disabled population indicates that 2% of persons aged 0-9 years are disabled. This percentage increased steadily among those aged less than 40 years and increased rapidly thereafter. There were no significant differences between females and males. In terms of population group, a proportionally larger concentration of disabilities manifest in the Black African group in the under 20 age groups and larger concentration of Whites in the age groups from 40 and up.

- The percentage of disabled persons aged 20 years and above who had never been to school indicate that Black Africans were the most affected, while white people had the lowest proportion. Females were more affected than males regardless of population group. The contrasts between population groups could be a reflection of the fact that Black disabled persons were often in the past excluded from educational opportunities, as the environment in regular schools does not facilitate integration or may not be experienced as a viable option. Another possible explanation is that low levels of education are generally associated with prevalence of poverty, which in turn renders people more vulnerable to become impaired because of factors such as lack of access to healthcare and rehabilitation. Hence the higher prevalence of disabilities in the group with no education could be as a result of both lack of access to educational opportunities and poverty.

- The 2001 Census showed that in the Western Cape 28.4% disabled males and 22.7% disabled females were employed, compared to 57% able bodied males and 42.4% able bodied females in the non-disabled group. The Western Cape seemed to be in a more favourable situation than most of the provinces with only Gauteng better off in 2001. It clearly shows the disadvantage disabled persons experience in this regard and the need to create dedicated or sheltered work opportunities for the disabled who cannot or are not allowed to compete in the open labour market.
5.3 The spectrum of needs of persons with disability

The range of daily human needs of disabled persons is generally the same as non-disabled persons. However, disabled people do have specific needs, depending on the nature of their disability. These can be of a medical, social and/or environmental nature (Watermeyer et al, 2006). These diverse needs again define the policies required and the range of interventions needed.

Watermeyer et al (2006) provides an extensive treatment of the theme and cover the following as an indication of the spectrum of aspects covered and needs specific to the disabled person:

- Disability and human rights,
- Integrating disability within government – services needed
- HIV / AIDS and disability
- Managing disability in courts
- Sign language and Braille
- Disability in the schools and higher education
- Developing literacy with deaf adults
- Disability, poverty, gender and race
- Disability and health care
- Disability and human spaces: access, housing, public buildings
- Disability and entrepreneurship, employment and skills
- Media and disability
- Attitudes and perceptions

5.4 The Provincial Response (DSD)

It should be noted that according to programme information (DSD, 2011) the beneficiaries targeted by the DSD are a much smaller percentage of the disabled population as indicated above. Of the more than 244,000 persons in the Western Cape indicating some form of disability (2010), 35,000 persons with
disabilities are projected for inclusion in the DSD programme for the strategic planning period (2014/15), while 15,000 persons with disabilities have presently access to social development services\textsuperscript{50}. The DSD programme targets on the persons most in need of assistance, while other provincial government departments, like Education and Health, also cater for the needs of the disabled.

To optimally serve the disabled, and in view of the wide spectrum of needs, the programme envisages collaboration with other government departments as follows (DSD, Western Cape, 2010):

<table>
<thead>
<tr>
<th>Programmes (Internal DSD)</th>
<th>Integration and mainstreaming of disability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Housing</td>
<td>Collaborate with Department of Housing to provide accommodation to people with disabilities</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Rehabilitation of newly disabled and existing people with disabilities.</td>
</tr>
<tr>
<td>Department of Transport and Public Works</td>
<td>Accessible buildings and public transport for people with disabilities.</td>
</tr>
<tr>
<td>Department of Labour</td>
<td>Access to open labour market and skills development programme for people with disabilities.</td>
</tr>
<tr>
<td>Department of Education</td>
<td>Mainstreaming and inclusive education for children with disabilities</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>Integration of disability issues in the local authority IDPs.</td>
</tr>
<tr>
<td>Department of the Premier</td>
<td>Commemoration of international and national disability events or days.</td>
</tr>
</tbody>
</table>

Services are rendered to people with disabilities in terms of a number of statutory prescriptions and regulations – including the Integrated National Disability Strategy and the Mental Health Act, as well as international conventions such as the –

\textsuperscript{50} Different target numbers in DSD reports cited in this document
- UN Rules on the Equalisation of Opportunities for Persons with Disabilities (UN, 1993)
- Disability Rights Charter of South Africa
- UN Declaration on the Rights of Disabled Persons (1975)

- **Prevention services**

These include promoting the inclusion and mainstreaming of people with disabilities, the rights of people with disabilities, awareness of disability issues, and the accessibility of services, community and public resources; the prevention of discrimination against people with disabilities; programmes for the early identification of genetic disorders and awareness regarding the prevention of the transmission of genetic disorders; life-skills and capacity-building programmes; and skills development services.

- **Rehabilitation services**

Services to people with chronic illnesses like HIV and AIDS, community-based services like stimulation centres and protective workshops, and counselling services fall in this category.

- **Continuing care services**

These include residential care for people with disabilities, respite care and supported/assisted living. The services rendered, funded and managed by NGOs aim at facilitating and providing developmental social welfare services to persons with disabilities and their families/caregivers, aimed at promoting their well-being and socio-economic empowerment.

The services rendered in terms of the stated policies and criteria will therefore not necessarily be spread in accordance and in proportion to the profile of disability summarised above but rather follow the policy guidelines and the priorities to include the most vulnerable and those who cannot cope without help of the public sector. It includes (DSD, Western Cape, 2009)\(^51\):

- **Residential Care Programme for** the temporary or permanent care, protection, support, stimulation, skills development and rehabilitation of persons with disabilities, who due to their disability and social situation need care, (when the need cannot be met at home and in the community) within a safe, secure and stimulating environment of a Home for Persons with Disabilities or in a Residential Care Facilities. At the moment the following such services are provided;

\(^{51}\) Information provided from Programme Manager, DSD
o 1,380 through residential care services
o 33 through funded residential facilities for persons with disabilities
o 10 through residential facilities managed by NPOs capacitated on minimum standards on residential facilities for persons with disabilities

• **Protective Workshops Programme for the** socio-economic empowerment of persons with disabilities.
  o Projected target for 2011/12: 2,549 through protective workshop services;
  o Funded protective workshops for persons with disabilities - currently 43

• **Social Work Services:** inclusive of: counseling services; psycho-social support programmes: peer/group therapy; awareness and educational programmes
  o Projected target for 2011/12: 79,000 through social work services inclusive of broader disability awareness and education programmes
  o Disability awareness and educational programmes – currently 35,278

Most of the services are provided in partnership with NGOs and other funded organisations. At the moment the amount transferred to NGOs delivering services for persons with disabilities is R46.7 million.

During the 2010 / 2011 period, the DSD has focused strongly on advocacy, education and awareness, early intervention programmes and campaigns (reaching 35,278 people), as well as providing direct access to dedicated services for 15,000 beneficiaries (DSD, Western Cape, 2010).

The available information, however, indicate that around 15% from a disabled population of more than 244,000 in the Western Cape are reached by the programmes being offered. The position of the remaining 85% with some form of disability is not sufficiently clear.

Despite initiatives of individual disabled people and access to services offered by other state departments and NGOs, as indicated above, and by the private sector, the question remains unanswered about the possible gaps and inadequacies in provision to this most vulnerable group as highlighted in the profile above. The aspects that will need further research include both the dimensions of impairment and the extent to which social and environmental discrimination and the issue of rights acts as a barrier to the full and equal participation of disabled in mainstream society. The limitations and challenges of mainstreaming in the workplace also need attention.
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Chapter 6:  Child Care and Protection Services (Sub programme 2.6)

6.1  Introduction

This section focuses on care and protection services to children, i.e. persons under the age of 18 years. Although services to children are discussed separately, it should be noted that the department’s Child Care and Protection Services are integrated and implemented in conjunction with the Care and Support Services to Families, with the result that the two programmes overlap in many respects.

This chapter gives an overview of the socio-demographic profile of children in the Western Cape, the legal framework for services to children, programmes and projects to address issues related to children as well as statistical data and projections up to 2015.

6.2  Children in the Western Cape: Socio-Demographic Profile

- According to the Community Survey in 2007, the Western Cape is home to 1,770,859 children under the age of 18 years. In terms of population groups, 54, 42% of these children are Coloured; 33, 07% are Black; 11, 41% White and 1, 11% Indian/Asian (Proudlock et al, 2008).

- 1, 2% of children in the province are orphans who have lost both parents. 57, 7% lives with both their parents and 31, 7% with their mothers only (Pendlebury, et al, 2009).

- The results of a quantitative audit of ECDs conducted by the Department indicated that there are 154,670 children enrolled in the audited ECDs and 10,163 ECD practitioners (September, 2009). This provides a child to ECD Practitioner ratio of about 1:15.

- In the Western Cape, both the infant mortality (IM) and under-five mortality (USM) rate has been increasing (DSD: Annual Performance Plan 2012/2013, 2011). The under-five mortality rate over the period 1997 to 2004 increased from 52, 64 to 58, 09 per 1,000 live births. This means that in 2004, 59 deaths occurred per 1,000 live births. The following children have a higher risk of dying: children from
informal settlements, children whose mothers are uneducated, very young and malnourished or with health problems such as being HIV positive.

- Over half of the deaths in young children in the province in 2000 were due to diseases of underdevelopment and poverty and therefore preventable (DSD: Annual Performance Plan 2012/2013, 2011).

- Children in the Western Cape face a high risk of child maltreatment. Recent research identified child neglect as the main reason for the statutory removal of children in five Magisterial Districts of the province (Makoae, et al, 2008).

- Three in every 1 000 children in the province were subject to a Children’s Court Inquiry in 2005 (Dawes, 2006).

- Most physically abused children requiring hospital treatment are under the age of five years, and more than half are boys.

- The perpetrators of child abuse are typically male and someone known to the child – often the child’s father or the mother’s partner. Most assaults occur in the child’s home.

- There appears to be an upward trend in reports of sexual assaults on children under 13 years as reported to health facilities.

- Data from Childline indicated that the Western Cape had the highest proportion of all calls in the country relating to sexual abuse.

- Many children are subject to corporal punishment in homes. In a 2003 survey, 40% of women admitted using a strap, belt or stick to beat children under the age of three years (HSRC, 2003).

- Issues such as child abandonment, missing children and child sexual exploitation continue to raise concern. However, it is not possible to obtain a clear understanding of the extent of these issues due to a lack of reliable data.

- Child poverty in South Africa is widespread. In the Western Cape, 38, 9% of children were found to be living in households regarded as ‘income poor’ in 2007 – these are households with an income of less than R350 per month (Pendlebury, 2009).
• The quality of life of children is further affected by poor living conditions. In 2007, 23% of children in the Western Cape were living in informal housing. Of concern is an increase in the percentage of children living in overcrowded households in the province namely from 25, 4% in 2002 to 31, 9% in 2007.

• Projections indicate that the number of HIV infected children in the province will increase to 17,499 by 2011 while the number of children orphaned by AIDS will increase to 68,043 in 2011 (DoH, Western Cape, 2007).

• According to the 2007 General Household Survey, 1, 2% of children in the province had lost both their parents.

Family Situation
In 2009, about a third of all children in South Africa were living with both parents while just fewer than 40% were living with their mothers only. About a quarter were living with neither biological parent, while less than four percent lived with their father only. In the case of the Western Cape, more than half were living with both parents and a third with their mother only. Fifteen percent were living with neither of their parents, and four percent with their father only. The relatively large percentage of children living with neither parent is probably accounted for by skip-generation and other types of extended families common among Black South Africans. As indicated in the table below, the tendency for children to live with people other than their biological parents is far more common among Blacks than other population groups [table 6.1].

Table 6.1: Children Living with Biological Parents by Population Group, 2009

<table>
<thead>
<tr>
<th>National case/population group</th>
<th>Living with Biological Parent (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>Black</td>
<td>41.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Coloured</td>
<td>31.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Asian</td>
<td>10.7</td>
<td>3.3</td>
</tr>
<tr>
<td>White</td>
<td>12.4</td>
<td>3.3</td>
</tr>
<tr>
<td>RSA Total</td>
<td>38.2</td>
<td>3.6</td>
</tr>
<tr>
<td>WC Total</td>
<td>28.7</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Data presented by Zulu and Sibanda (in Zhiel, 2011) showed that the likelihood of living with one’s biological mother is age dependent and varies substantially from one population group to the next. In the case of Asians and Whites, between about 85% and 90% of children live with their biological mothers until the age of 17 (which corresponds roughly with leaving school). On the other hand, only about 65% of Black children live with their biological mothers in the year of their birth. This proportion falls significantly (by about 10%) until the age of four (corresponding roughly to going to school), then declines very slowly until the age of 13 (when it is about 55%). Thereafter, it declines sharply, so that at 17 years of age, only about half of Black children are living with their biological mothers.

The tendency for children in the Western Cape to live with both biological parents is higher (52%) than is the case for South Africa as a whole (32%), and the percentage living with neither parent, is much lower (15% vs. 26%) [table 6.2].

### Table 6.2: Children’s Co-residence with Biological Parents, 2009

<table>
<thead>
<tr>
<th>Co-residence with Biological Parents (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Father</td>
</tr>
<tr>
<td>RSA</td>
<td>38.2</td>
</tr>
<tr>
<td>WC</td>
<td>28.7</td>
</tr>
</tbody>
</table>


**Child-headed Households**

Much has been made of the idea that since HIV/Aids causes deaths to young adults, an increasing proportion and number of children are being left parentless and destitute and are living in ‘child-headed households’. There are a number of logical problems with this view, the most important being an illegitimate leap from statements on death to statements on household structure. The crucial intermediary variable here is the question of how individuals, within the context of families, deal with misfortune generally and death in particular. In this regard, the idea that the death of a parent leads to children being left to fend for themselves in child-headed households are not borne out by research. In 2010, Statistics South Africa investigated the prevalence of child-headed households in South Africa using data from the General Household Surveys from 2002 to 2009. Child-headed households were defined as “households that comprise only individuals younger than 18 years of age” (Stats SA, 2010 in
Zhiel, 2011:21) [Tables 6.3 & 6.4]. They concluded the following:

“Between 2002 and 2009 the proportion of children living in child-headed households has consistently remained below 1% of all children . . . (and) the proportion of child-headed households have similarly lingered between 0.5% and 0.7% of all households” (SSA, 2010 in Zhiel, 2011:21)

Table 6.3: Proportion of Children Living in Child-headed Households, 2002-2009

<table>
<thead>
<tr>
<th></th>
<th>2002-2009 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>RSA</td>
<td>0.7</td>
</tr>
<tr>
<td>WC</td>
<td>0.0</td>
</tr>
</tbody>
</table>


Table 6.4: Child-Headed Households as Proportion of all Households, 2002-2009.

<table>
<thead>
<tr>
<th></th>
<th>2002-2009 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>RSA</td>
<td>0.7</td>
</tr>
<tr>
<td>WC</td>
<td>0.0</td>
</tr>
</tbody>
</table>


The report further investigates the connection between child-headed households and death through an analysis of the orphan-status of members of child-headed households. Table 6.5 presents data using three definitions of an orphan: Maternal (a child whose mother is dead), Paternal (a child whose father is dead) and Double (a child who has lost both parents). It shows that in 2009, just under 5% of South African children and just over 1% of children in the Western Cape had lost both parents.

Table 6.5: Orphans as a Proportion of All Children, 2009.

<table>
<thead>
<tr>
<th>Orphan typology</th>
<th>RSA</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Orphans</td>
<td>3.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Paternal Orphans</td>
<td>11.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Double Orphans</td>
<td>4.7</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Putting this data in relation to the data on child-headed households, the report concludes:

“Although a larger proportion of children in child-headed households are orphaned than in the general population, it is interesting to note . . . that less than a tenth of these children are double orphans while for half of them the parents are still alive. The majority of children who live in child-headed households are therefore not orphans at all and the vast majority have at least one living parent” (Stats SA, 2010 in Zhiel, 2011:22) [Table 6.6].

### Table 6.6: Distribution of Children in Households by Orphan Status, 2009.

<table>
<thead>
<tr>
<th>Children by Orphan Status</th>
<th>Children in Child Headed Households</th>
<th>All Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not orphans</td>
<td>54.0</td>
<td>80.5</td>
</tr>
<tr>
<td>Double Orphans</td>
<td>9.8</td>
<td>4.7</td>
</tr>
<tr>
<td>Paternal Orphans</td>
<td>21.5</td>
<td>11.4</td>
</tr>
<tr>
<td>Maternal Orphans</td>
<td>14.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>


An analysis of the age of members of child-headed households further shows that the majority (57%) is over the age of 14 years and the vast majority consists of two members or less (Statistics South Africa, 2010 in Zhiel, 2011:22).

The researchers therefore found that child-headed households do not represent a significant social phenomenon (0.5% of households in South Africa and none in the Western Cape), have not increased and in most cases are not linked to the death of parents (or a parent). As indicated in the table 6.7, the vast majority (97%) of children in South Africa either live with their parents and siblings or in family units that contain relatives over and above this nucleus (extended families).
Table 6.7: Distribution of Individuals in Households by age and population group, 2001.

<table>
<thead>
<tr>
<th>Household type</th>
<th>All children</th>
<th>Only children 0-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>Coloured</td>
</tr>
<tr>
<td>Single Person</td>
<td>3.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Nuclear</td>
<td>38.1</td>
<td>32.7</td>
</tr>
<tr>
<td>Extended</td>
<td>53.0</td>
<td>65.1</td>
</tr>
<tr>
<td>Complex*</td>
<td>5.5</td>
<td>0.1</td>
</tr>
</tbody>
</table>


**Education**

In both South Africa and the Western Cape, almost all children of primary school going age (99%), were attending school in 2009. These figures have increased from 96.6% and 98.5% in 2002 respectively (an increase of 2.3% for South Africa and 0.6% for Western Cape) [Table 6.8].

Table 6.8: Proportion of 7-13 Year Olds in Educational Institution, 2002-2009

<table>
<thead>
<tr>
<th></th>
<th>Attendance over time (2002-2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>RSA</td>
<td>96.6</td>
</tr>
<tr>
<td>WC</td>
<td>98.5</td>
</tr>
</tbody>
</table>

Source: Zhiel, 2011

The figures for secondary school age are slightly lower (93% and 90%) but still substantial and the improvement since 2002 has been about 1.5% in both cases. Where the Western Cape fared better than South Africa as a whole in primary school attendance in 2002 and 2009, it was doing worse in secondary school attendance in both years [Table 6.9].

Table 6.9: Proportion of 14-17 Year Olds in Educational Institution, 2002-2009.

<table>
<thead>
<tr>
<th></th>
<th>Attendance over time (2002-2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>RSA</td>
<td>91.6</td>
</tr>
<tr>
<td>WC</td>
<td>88.6</td>
</tr>
</tbody>
</table>

Source: Zhiel, 2011
The following tables give some indication of pre-school children attending ECD Centres, the whereabouts of those not attending these centres as well as children of school going age attending educational institutions and the main reasons for not attending school.

Approximately 40% of children in the Western Cape are indicated as attending an ECD centre, evidently the highest percentage in the country if compared to other provinces (figure 6.1). Of those who are not attending an ECD centre, the greater majority consistently for all the provinces, indicate to be at home with a parent or primary care giver [Table 6.10]. For those children five years or older that were indicated to attend an educational institution, the majority, again for all provinces, indicated to be at school. It is important to note however that this percentage is the second lowest for the Western Cape at 84% compared to the 89% for the National average. However, the Western Cape shows the second highest percentage of five year olds that are in pre-primary classes [Table 6.11].

For those 7-24 year olds who indicated not to attend any educational institution, the primary reason cited was a lack of money to pay for fees (36% Nationally). For the Western Cape, slightly more indicated working at home at 26.3%, with 25.5% indicating lack of money to pay for fees [figure 6.2].

**Figure 6.1: Percentage of children attending learning centres and being exposed to early childhood development per province, 2010**

<table>
<thead>
<tr>
<th>Province</th>
<th>Attend ECD</th>
<th>ECD at Centre</th>
<th>ECD at Home</th>
<th>ECD Anywhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>WC</td>
<td>39.4%</td>
<td>35.8%</td>
<td>70.7%</td>
<td>83.3%</td>
</tr>
<tr>
<td>EC</td>
<td>32.6%</td>
<td>28.6%</td>
<td>43.4%</td>
<td>56.6%</td>
</tr>
<tr>
<td>NC</td>
<td>21.1%</td>
<td>19.7%</td>
<td>58.8%</td>
<td>65.0%</td>
</tr>
<tr>
<td>FS</td>
<td>33.4%</td>
<td>27.5%</td>
<td>41.4%</td>
<td>58.0%</td>
</tr>
<tr>
<td>KZN</td>
<td>25.1%</td>
<td>20.2%</td>
<td>50.3%</td>
<td>58.3%</td>
</tr>
<tr>
<td>NW</td>
<td>26.7%</td>
<td>24.0%</td>
<td>56.1%</td>
<td>68.3%</td>
</tr>
<tr>
<td>GP</td>
<td>42.6%</td>
<td>36.7%</td>
<td>42.3%</td>
<td>59.1%</td>
</tr>
<tr>
<td>MP</td>
<td>28.5%</td>
<td>26.3%</td>
<td>79.5%</td>
<td>88.6%</td>
</tr>
<tr>
<td>LP</td>
<td>29.6%</td>
<td>26.4%</td>
<td>39.4%</td>
<td>53.9%</td>
</tr>
<tr>
<td>RSA</td>
<td>32.3%</td>
<td>28.1%</td>
<td>51.0%</td>
<td>63.5%</td>
</tr>
</tbody>
</table>

Source: Zhiel, 2011
Table 6.10: Whereabouts of the children aged 0-4 years who were not attending child care centres, 2010 (%)

<table>
<thead>
<tr>
<th>Whereabouts of children not attending a centre during the day</th>
<th>Province</th>
<th>RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>% at home with a parent, foster parent/guardian</td>
<td>WC</td>
<td>EC</td>
</tr>
<tr>
<td>87.1</td>
<td>93.3</td>
<td>94.5</td>
</tr>
<tr>
<td>% home with other adult</td>
<td>WC</td>
<td>EC</td>
</tr>
<tr>
<td>9</td>
<td>4.6</td>
<td>3.7</td>
</tr>
<tr>
<td>% home with someone younger than 18 yrs</td>
<td>WC</td>
<td>EC</td>
</tr>
<tr>
<td>0</td>
<td>0.1</td>
<td>0</td>
</tr>
<tr>
<td>% another dwelling</td>
<td>WC</td>
<td>EC</td>
</tr>
<tr>
<td>3.9</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>% other</td>
<td>WC</td>
<td>EC</td>
</tr>
<tr>
<td>0</td>
<td>0.1</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Zhiel, 2010

Table 6.11: Percentage of persons aged 5 years and older attending educational institutions (numbers in thousands), 2010

<table>
<thead>
<tr>
<th>Type of institution</th>
<th>Statistic</th>
<th>WC</th>
<th>EC</th>
<th>NC</th>
<th>FS</th>
<th>KZN</th>
<th>NW</th>
<th>GP</th>
<th>MP</th>
<th>LP</th>
<th>RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school</td>
<td>Number</td>
<td>59</td>
<td>68</td>
<td>18</td>
<td>46</td>
<td>105</td>
<td>32</td>
<td>131</td>
<td>38</td>
<td>30</td>
<td>526</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>4.3</td>
<td>2.9</td>
<td>5.3</td>
<td>4.8</td>
<td>2.9</td>
<td>3.1</td>
<td>4.7</td>
<td>3.0</td>
<td>1.4</td>
<td>3.3</td>
</tr>
<tr>
<td>School</td>
<td>Number</td>
<td>1161</td>
<td>2156</td>
<td>305</td>
<td>811</td>
<td>3279</td>
<td>922</td>
<td>2250</td>
<td>1150</td>
<td>2000</td>
<td>14034</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>83.5</td>
<td>92.6</td>
<td>90.6</td>
<td>85.2</td>
<td>91.3</td>
<td>90.6</td>
<td>81.5</td>
<td>89.6</td>
<td>93.7</td>
<td>88.8</td>
</tr>
<tr>
<td>ABET</td>
<td>Number</td>
<td>7</td>
<td>14</td>
<td>2</td>
<td>8</td>
<td>15</td>
<td>14</td>
<td>21</td>
<td>13</td>
<td>20</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>0.5</td>
<td>0.6</td>
<td>0.7</td>
<td>0.8</td>
<td>0.4</td>
<td>1.4</td>
<td>0.8</td>
<td>1.0</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Literacy classes</td>
<td>Number</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Higher educational inst(^\text{52})</td>
<td>Number</td>
<td>100</td>
<td>56</td>
<td>5</td>
<td>54</td>
<td>124</td>
<td>24</td>
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<td>0.1</td>
<td>0.4</td>
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<td>0.7</td>
<td>0.3</td>
<td>0.2</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: Zhiel, 2011

\(^{52}\) Unspecified was excluded from the denominator when calculating percentages
6.3 Policy and legislative framework

Services to children are rendered in terms of the Child Care Act of 1983. The Children’s Bill is currently being debated in Parliament and this piece of legislation has far reaching service delivery implications. The Policy on the Transformation of the Youth and Child Care System also informs service provision to children, and there are various international conventions that inform policies relating to services to children.

These include the:

- UN Convention on the Rights of the Child
- African Charter on the Rights and Welfare of the Child
- Hague Convention on International Child Abductions

Source: Zhiel, 2011
• Hague Convention on Inter-country Adoptions
• UN Protocol to Prevent Trafficking in Persons.

Legislation that provides the legal framework for services to children is set out in the table below.

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Functions of Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care Act Number 74 of 1983</td>
<td>This Act provides for the establishment of children’s courts and the appointment of the Commissioner of Child Welfare for the:</td>
</tr>
<tr>
<td></td>
<td>• Protection and welfare of certain children;</td>
</tr>
<tr>
<td></td>
<td>• The adoption of children;</td>
</tr>
<tr>
<td></td>
<td>• Establishment of institutions for the reception of children;</td>
</tr>
<tr>
<td></td>
<td>• The establishment of treatment centres.</td>
</tr>
<tr>
<td>Probation Services Act, 1991</td>
<td>The Act serves as an interim measure to facilitate the transformation of the child and youth care system.</td>
</tr>
<tr>
<td></td>
<td>The transformation of the child and youth care system relates to</td>
</tr>
<tr>
<td></td>
<td>• Early intervention</td>
</tr>
<tr>
<td></td>
<td>• Family finding</td>
</tr>
<tr>
<td></td>
<td>• Home based supervision and</td>
</tr>
<tr>
<td></td>
<td>• Restorative Justice</td>
</tr>
<tr>
<td></td>
<td>• Services in terms of victims of crime</td>
</tr>
<tr>
<td></td>
<td>• Assessment of arrested children who have not been released from custody.</td>
</tr>
<tr>
<td>Child Care Act – Amended 1996</td>
<td>The Act provides for</td>
</tr>
<tr>
<td></td>
<td>• the legal representation for children,</td>
</tr>
<tr>
<td></td>
<td>• the registration of shelters.</td>
</tr>
<tr>
<td><strong>Child Care Act- Amended 1998</strong></td>
<td>The amendment provides for the rights of certain natural fathers in terms of the adoption of children born out of wedlock.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **Child Care Act- Amended 1999** | The amendment provides for  
- The establishment of secure care facilities,  
- The prohibition against the commercial sexual exploitation of Children |
| **Child Justice Act** | The purpose of the Act is to establish a criminal justice process for children accused of committing offences and aims to protect the rights of children. |
| **Children’s Act 38 of 2005 as Amended** | The Act defines  
- The rights and responsibility of children,  
- Parental responsibilities and rights,  
- Determines principles and guidelines for the protection of children,  
- The promotion of the well-being of children,  
- The consolidation of the laws relating to the welfare and protection of children and provides for incidental matters. |

### 6.4 The Provincial Response (DSD)

Given the above issues and realities, the DSD has designed and implemented a range of programmes to prevent or remedy the situation. The department’s Child Care Programmes are described as an integrated programme and services that provide for the wellbeing, development, care and protection of the rights of children.

The programmes of the department are centred upon three focus areas; prevention, treatment and curative services and long term and sustainable social functioning of children and families. Prevention
services include programmes such as family preservation, marriage and family enrichment and early childhood development. Treatment and curative services constitute the bulk of services by the department and its partnering organizations, and focus on services such as home based care, group work programmes for children, youth and parents, education and therapeutic services to abused individuals, foster care and alternative placement services, residential care, adoption services, reunification services to child and family, family therapy and divorce and mediation services. Long term prevention services and capacity building include programmes such as ABET services, holiday and after school care, life skills development, prevention against violence, gender based education, moral regeneration, sports and cultural activities. The three-pronged approach of the department is implemented in co-operation with other state departments with whom established links exist. These departments and programmes include the Expanded Public Works Programme, the Department of Justice and the Department of Correctional Services. Furthermore, the above services are rendered in partnership with CBOs and NGOs in the different communities of the Western Cape. The latter organizations are funded in terms a service level agreement and annual subsidies.

These services are rendered within the strategic objectives of the department that intends to promote the wellbeing of children and build the resilience of families and communities to care for and protect their children. The objective is to invest in and ensure quality services to children including those in need of care and protection through facilitating the provision of a continuum of services that promote the well-being of 97 000 children and families by March 2015. Currently, the number of children and families in the Province who access care and protection services, is projected at 52 500.

6.5 Considering the strategic priorities of the Department of Social Development in light of the evidence

In dealing with child care and protection services, the department had seen some significant successes in some areas, but also some glaring challenges in others for example, foster care where backlogs are experienced. A dedicated foster care backlog project has commenced and is monitored fortnightly by the DSD Executive. In other instances, children accessing registered ECD facilities increased from 85,000 to 86,107 due to the expansion of home and community based programmes. In general, these services exceed projected targets as a core business activity of the department. In support of families, a range of
services are offered. Of special note are the family preservation services with its focus on adolescent pregnant mothers, as well as the targeting of 792 men in fatherhood workshops and programmes. All targets for the departments Family Programme were exceeded and the work broadened through creative partnering.

The programme focus of the department will concentrate on the following key areas for intervention:

- Awareness and prevention programmes targeting a total of 57,000 beneficiaries, inclusive of children, parents, families and communities so that they are aware of their rights and responsibilities as well as government services and where to access them. Public awareness will particularly focus on the identified trend of child abandonment in the Province.
- Provision of supportive developmental programmes and services to children and families at risk (reported cases of child abandonment, child neglect and abused children) inclusive of assessment of children and families; counselling services; and temporary safe care.
- Early childhood development opportunities as a departmental priority for children 0 – 4, focusing on services for babies and toddlers. The budget over the MTEF period does not allow for an expansion of the targets as indicated, nor the funding levels to be in line with National requirements.

Given the statistics and issues faced by children in the Western Cape, the following projects are envisaged:

- 90,000 children having access to Early Childhood Development (ECD) programmes. This includes children in centres as well as home and community based services to children that do not have access to formal centres.
- A drive to register all unregistered centres to ensure compliance with norms and standards as per the Children’s Act. This will imply that at least 2,179 unregistered facilities will have to be supported and assessed and potentially increased numbers of children qualifying for subsidy.
- The registration of ECD programmes in registered Partial Care facilities (ECD centres) with training and capacity building on implementation of programmes as per the Children’s Act becomes critical.
- The ECD Assistant project in partnership with EPWP.
- Protection services to children found to be in need of care targeting.
- 1,400 children found to be in need of care and protection by the Children’s Courts will be placed in new foster care placements.
• 400 children are placed in lifelong family relationships through the provision of adoption services.
• Strengthen Residential Care services to 2,309 children in Child and Youth Care Centres by increasing funding levels.
• Transformation of Shelters into Child and Youth Care Centres.

The realization of these objectives is of course subject to the availability of the human resources and budgetary constraints.

### 6.6 Conclusion

The socio-demographic profile of children in the Western Cape indicates that the Province is home to 1,770,859 children under the age of 18 years. There are indications that both the infant mortality rate and under-five mortality rate has been increasing. Over half of deaths in young children in 2000 were due to underdevelopment and poverty and therefore preventable. Child poverty was found to be 38.9% in 2007 indicating a household income of less than R350 p.m.

Children in the Western Cape face a high risk of maltreatment, physical abuse as well as sexual abuse. Projections also indicate that the number of HIV infected children in the Province will increase to 17,499 in 2011. The family situation in the Western Cape reveals that a large percentage of children (15%) were living with neither parent, a third with their mother only and 4% with their father only. There are also indications that child-headed households are increasing as a result of HIV/Aids.

Currently, 154,670 children are exposed to pre-school or ECD services with 10,163 practitioners one of the highest in the country. Almost all children of primary school going age (99%) are attending school. The figures for secondary school age in the Western Cape, is lower than the rest of the country.

In dealing with child care and protection, the department had seen some significant successes in a number of areas, but also some glaring challenges in others, for example foster care where backlogs are experienced. A dedicated foster care backlog project has commenced and is monitored fortnightly by the DSD Executive. In other instances, children accessing registered ECD facilities increased from 85 000 to 86 107 due to the expansion of home and community based programmes. In general, these services exceed projected targets as a core business activity of the department. In support of families, a range of services are offered. Of special note are the family preservation services with its focus on adolescent
pregnant mothers as well as the targeting of 792 men in fatherhood workshops and programmes. All targets for the departments Family Programme were exceeded and the work broadened through creative partnering.

The baseline data on children and families who access care and protection in the Province is projected at 52,500. The objective is to provide a continuum of services to promote the wellbeing of 97,000 children by 2015.

6.7 Abbreviations

CBO: Community Based Organization
DSD: Department of Social Development
ECD: Early Childhood Development
EPWP: Extended Public Works Programme
HSRC: Human Sciences Research Council
NGO: Non-Governmental Organization
UN: United Nations

6.8 Bibliography


Department of Social Development, *Western Cape, Annual Report, 2010/2011*


Chapter 7: Victim Empowerment (Sub programme 2.7)

7.1 Introduction

The National Crime Prevention Strategy (NCPS) which was developed in 1996 presented a comprehensive approach to crime control and crime prevention, and the promotion of victim support (National Prosecuting Authority, 2005). This resulted in the Victim Empowerment Programme (VEP) being established in the late 1990s. The aim of the VEP is to lessen the long term impact of crime by proactively tending to the needs of all victims.53

The National Policy Guidelines for Victim Empowerment which aims to provide direction for the empowerment of all victims of crime and violence define victim empowerment as an approach to facilitate access to a range of services for all people who have individually or collectively suffered harm, trauma and/or material loss through violence, crime, natural disaster, human action and/or through socio economic conditions (National Policy Guidelines for Victim .Empowerment, p.3) The Department of Social Development’s VEP define a victim as "any person who has suffered harm, including physical or mental injury; emotional suffering; economic loss or substantial impairment of his or her fundamental rights, through acts or omissions that are in violation of the criminal law. Victim includes, where appropriate, indirect victims such as the immediate family or dependents or even neighbours or colleagues of a direct victim."54

7.2 Profiling victims of crime – A dilemma

Statistics on victims of crime and more specifically violent crime victims, including sexual assault victims, are sorely lacking in South Africa. Sources of statistics commonly refer to the nature, type and circumstances surrounding crime, rather than on profiling the victims of crime. This has been further complicated by the change in the definition of sexual assault in late 2007. Previously the definition of rape was understood as referring exclusively to vaginal penetration by a male sexual organ. In the latter part of 2007 it was extended (SAPS, 2011:10) to also include vaginal, oral and anal penetration of a

54 The definition of a victim according to the National Policy Guidelines for Victim Empowerment (page 2)
sexual nature by whatever means (and thus also including male rape) which previously resorted under the category indecent assault. The concept of sexual offence then also goes further to add a whole range of transgressions which never previously formed part of rape or indecent assault – such as sex work, pornography, public indecency and human trafficking (SAPS, 2011:10).

Sigsworth (2009) in her notes that the research studies on sexual violence conducted in South Africa over the last 10 years are surprisingly few and tend to be localised. Presumably due to the difficulties of conducting research on sexual violence – which includes the relative inaccessibility of victims and perpetrators who are willing to talk, the social stigma surrounding sexual violence and the complexity of the ethics involved in conducting such sensitive research – local studies on sexual violence tend to focus on small groups of the population in restricted geographical locale. Sigsworth only makes mention of one study done in the Western Cape, Cape Town specifically, that reported more than 40% of women in the sample had experienced at least one sexual assault experience, and more than one in five men openly admitted to having perpetrated sexual assault against women.

In another study on the perpetration of sexual violence towards intimate partners, the findings showed that 7.1% of the men reported forcing sex on an intimate partner during the preceding 10 years. A further 8.2% of the men reported attempting to force sex on an intimate partner during the preceding 10 years. Of those who reported perpetrating sexual abuse, 80.9% also reported perpetrating physical and emotional abuse.

### 7.3 Profile of crime and perception on crime

The South African Police Services Crime report 2010/2011 (SAPS, 2011) broadly categorises crime into two categories. The first category is what they call ‘contact crimes’. The other encompasses all other crimes and is categorised as other crimes. Contact crimes are defined as crime which involves physical contact between the perpetrators and victims. Such contact may last anything from a second or two (e.g. where a perpetrator grabs the handbag from a victim’s hand and runs off with it) to an ordeal of several days (e.g. where a perpetrator kidnaps a victim during a carjacking, rapes her repeatedly and eventually kills her). Contact crime basically consists of violence against the person, irrespective of the nature of such violence.
Categories of crimes classified as contact crimes include:

- Murder
- Attempted murder
- Assault GBH (Assault with the intent to cause grievous bodily harm)
- Common assault
- Sexual offences
- Aggravated robbery
- Common robbery

Murder, attempted murder, rape, and all other assaults are referred to as ‘social’ crimes, mainly because these crimes are generally committed by perpetrators known to the victims but also because of the role which alcohol and drug abuse (to a lesser extent) play in these crimes.

According to all research conducted by the Crime Research and Statistics component of Crime Intelligence, (SAPS, 2011) over the past decade approximately 80.0% of murders, 60.0% of attempted murders, 75.0% of rapes and 90.0% of all assaults (whether GBH, common or indecent assault) involve victims and perpetrators who know one another (whether as family members, friends, acquaintances or colleagues). This point is reiterated by the Victims of Crime survey of 2011, which states that 29.9% of the victims of assault, who formed part of the survey, were attacked by a known community member from the area. 20.9% of the respondents were attacked by their spouse or partner, while 9.4% was assaulted by a relative. Only 10.5% of the respondents stated that they were attacked by an unknown community member (Stats SA, 2011:39). The sexual assault statistics for the same survey simulate the same trend. 38.4% of victims were sexually assaulted by known members of their communities, 15.8% was assaulted sexually by relatives and 12% was sexually assaulted by known people from outside their community. Twenty two percent respondents who fell victim to sexual assault reported the perpetrator as an unknown community member (Stats SA. 2011:39).

The latest research also indicates that roughly 65% of murders are associated with social behaviour (SAPS, 2011:6) Figure 7.1 illustrates that 78.4% of murders were committed by someone known to the victim.
Taking the social nature of contact crimes and the role of stimulants into account it is daunting to note that the Western Cape display the highest incidents of Drug related crimes. 60,409 incidents out of 134,840 incidents recorded nationally; occurred in the province. This represents an increase of 14.5 percent over last year’s figures for the region. The province also has the third-highest rate of sexual crimes in the country (9,678), an 11.5 percent increase from last year. The Western Cape also has the second highest incidence of common assault in the country (33,278 incidents) (SAPS, 2011).

When looking at the murder rate in South Africa it is alarming to notice that the Western Cape has the 4\textsuperscript{th} highest number of murder cases (n=2311)\textsuperscript{55} in the country. Leggett (2004) draws an interesting correlation between the high murder rate and the high drug related crime rate in the Western Cape. According to Leggett: “it is likely that alcohol and drugs also play a role in the violence in the Cape.”\textsuperscript{56} Leggett also makes mention that in 1998 for 55% of all non-natural deaths in Cape Town the deceased

\textsuperscript{55} SAPS crime statistics for April 2010 to March 2011


had blood alcohol concentrations exceeding the legal limits. In a 2002 the National Injury Mortality Surveillance System (NIMSS) found that 59% of murder victims had alcohol in their bloodstream.

**Public knowledge on victim support**

According to the Victim of Crime Survey (VOCS) of 2011 the greatest majority (91%) of households in the Western Cape (WC) knew where to take someone to access medical services if they fell victim to a violent crime. However 50% of Western Cape households did not know where to take someone to access counselling services and only 19.9% knew where to take someone for shelter or a place of safety if they became victims of violent crime (Stats SA, 2011:17). There is no significant variation between the situation in the Western Cape and the national statistics as is evident in the Figure 7.2 below.

**Figure 7.2: Percentage of households who knew where to take someone to access selected services if he/she was a victim of crime by institution and province, 2010**

![Figure 7.2: Percentage of households who knew where to take someone to access selected services if he/she was a victim of crime by institution and province, 2010](image)

<table>
<thead>
<tr>
<th>Institution</th>
<th>WC</th>
<th>EC</th>
<th>NC</th>
<th>FS</th>
<th>KZN</th>
<th>NW</th>
<th>GP</th>
<th>MP</th>
<th>LP</th>
<th>RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical services</td>
<td>91.1%</td>
<td>91.2%</td>
<td>92.9%</td>
<td>93.8%</td>
<td>80.8%</td>
<td>97.6%</td>
<td>90.6%</td>
<td>95.5%</td>
<td>96.3%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Counselling services</td>
<td>50.0%</td>
<td>44.1%</td>
<td>47.0%</td>
<td>61.6%</td>
<td>45.7%</td>
<td>56.8%</td>
<td>53.5%</td>
<td>64.3%</td>
<td>65.8%</td>
<td>53.0%</td>
</tr>
<tr>
<td>Shelter or a place of safety</td>
<td>19.9%</td>
<td>14.3%</td>
<td>17.1%</td>
<td>22.9%</td>
<td>12.0%</td>
<td>12.3%</td>
<td>19.8%</td>
<td>15.2%</td>
<td>17.3%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

Source: Stats SA, 2011

Figure 7.3 show that most WC households (87.2%) would take someone who was a victim of crime to access medical services to a hospital or trauma unit. Almost half (46.3%) of Western Cape households as opposed to 71.2% nationally said they would go to a local clinic to access medical services. Just over a quarter (26.6%) said they would take the victims of crime to a police station for medical services. Approximately 30% said they would go to a private doctor, if they had to take a victim of crime to a
place where the victim could access medical services; 1.5% saying that they would go to a victim empowerment centre. Only 0.3% would take a victim of crime to a traditional leader or traditional authority.

Figure 7.3: Percentage of households who knew where to take someone to access medical services if he/she was a victim of crime by institution and province, 2010

Figure 7.4 shows the percentage of households who knew where to take a victim of crime to access medical services by institution type and population group of the household head. More than three-quarters of black African households would take someone who was a victim of crime to the local clinic (78,2%), hospital or trauma unit (74,4%), or police (33,2%), while 27,3% would take them to a private doctor. Most of the coloured households (83,8%) would take someone who was a victim of crime to a hospital or trauma unit and 50,5% would take them to the local clinic. Most Indian/Asian households (82,9%), would take someone who was a victim of crime to a hospital or trauma unit, followed by the local clinic (59,4%), private doctor (47,4%) and police (33,2%). The vast majority (89,9%) of white households would take someone who was a victim of crime to a hospital or trauma unit, 46,5% would take him/her to a local clinic and 44,8% would take such a person to a private doctor.

Source: Victim of crime survey 2011

57 Note: It was possible to provide more than one response per respondent.
Figure 7.4: Percentage of households who knew where to take someone to access medical services if he/she was a victim of crime by institution and population group of the household head, 2010

Source: Victim of crime survey 2011

Figure 7.5 depicts the percentage of households who knew where to take someone to access counseling services, by province 60.3% of Western Cape households would take someone to access counseling services to a hospital or trauma unit and local clinic if he or she was a victim of crime. Nationally nearly two thirds (64%) of the households would take someone who needed to access counseling services to a hospital or trauma unit and local clinic if he or she was a victim of crime.

The Western Cape was the least represented with 38.6 of respondents indicating that they would take victims of crime to a local clinic to access counseling services. A further 54.8% of Western Cape respondents indicated that Hospitals were also a place of choice where households would access counseling services.

Few households were aware of Victim Empowerment Centres and Thuthuzela Care Centres as places to take victims to access counseling services. Nine percent of Western Cape respondents were aware of such centres compared to 10.4% nationally, as illustrated in the figure below.
Amongst the black African households, 71,0% indicated that they would take someone who was a victim of crime to a local clinic for access to counseling, followed by 64,0% who said that they would take the victim to a hospital or trauma unit (Figure 7.6).

Amongst all the other population groups, the majority would take the victim to a hospital or trauma unit, followed by those that would go to a local clinic. Specifically in the coloured households, more than half (55,1%) would go to a hospital if they became crime victims, 47,8% would go to a local clinic to access counseling services, 22,3% would go to a private doctor, and 14,2% would go to non-governmental organisations or other volunteer groups.

Of the white households, 68,7% indicated that they would take victims of crime to a hospital or trauma unit to access counseling services, but only 11,5% would go to Victim Empowerment Centres.
Figure 6: Percentage of households who knew where to take someone to access counseling services if he/she was a victim of crime by institution and population group of the household head, 2010

<table>
<thead>
<tr>
<th>Institution</th>
<th>Black African</th>
<th>Coloured</th>
<th>Indian/Asian</th>
<th>White</th>
<th>RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>35.1%</td>
<td>48.1%</td>
<td>29.0%</td>
<td>36.6%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Hospital or trauma unit</td>
<td>64.0%</td>
<td>55.1%</td>
<td>65.0%</td>
<td>68.7%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Local Clinic</td>
<td>71.0%</td>
<td>47.8%</td>
<td>55.5%</td>
<td>40.6%</td>
<td>64.0%</td>
</tr>
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<td>Private doctor</td>
<td>24.0%</td>
<td>22.3%</td>
<td>49.7%</td>
<td>43.7%</td>
<td>27.6%</td>
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<td>NGO/Volunteer group</td>
<td>12.6%</td>
<td>14.2%</td>
<td>22.6%</td>
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<td>13.1%</td>
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<tr>
<td>Victim Empowerment centres/Thuthuzela</td>
<td>10.4%</td>
<td>8.3%</td>
<td>12.9%</td>
<td>11.5%</td>
<td>10.4%</td>
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<td>1.7%</td>
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<td>4.0%</td>
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<td>6.8%</td>
<td>5.1%</td>
<td>3.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Other</td>
<td>3.9%</td>
<td>3.7%</td>
<td>2.0%</td>
<td>5.3%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

Source: Victim of crime survey 2011

Figure 7.6 shows that 51.1% of households would take victims of domestic violence to a state-run institution to get assistance. The Western Cape had the lowest percentages of households who would take the victims of domestic violence to a state-run organisation (31.2%).

Of those respondents in the VOCS of 2011, 63.0% would take the victim of domestic violence to an NGO, the percentage being the highest with the nationally percentage being 34.8%.
In the coloured headed households, 45.2% knew of state-run organisations and more than half (50.8%) of coloured headed households knew of non-governmental organisations as a place that offered shelter to victims of domestic violence. An almost similar proportions of Indian/Asian headed-households indicated that they would take the victims to state-run organisations or non-governmental organisations (47.5% and 47.0% respectively). More than half (52.3%) of white headed-households indicated that they knew state-run organisations as a place that offered shelter for victims of domestic violence, followed by non-governmental organisations at 37.3% (Stats, SA, 2011).
Figure 7.7: Percentage of households who knew of a place of safety/shelter where they can take someone who was a victim of domestic violence by institution and population group of the household head, 2010

Source: Victim of crime survey 2011

7.4 The Provincial Response (DSD)

According to the Western Cape Department of Social Development (DSD) their primary mandate; as set out in the Blue Print for the Province under mandate from the Premier of the Western Cape; is policy making. Implementation of these policies lays at the regional level. This said, the Department of Social Development in the Western Cape do provide funding to several victim empowerment projects in the province. These services are mainly located within the Metropolitan area. However there are some services to victims of crime available in the Eden Karoo area.

The Western Cape DSD currently supports\(^58\) 2 types of victim empowerment programmes and one special project. The first type of programme is called Social Service Organisations (10 organisations in total) which renders counseling services to support victims of rape, domestic violence and family

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\(^58\) Only financial support is provided. According to the provincial DSD their head office, located in Cape Town, is primarily mandated with policy making. Implementation occurs only at regional level. Implementation include amongst others, imbizos, awareness campaigns, participation in events such as the 16 days of activist against violence against women and children, etc.
mediation to create support to victims of rape and domestic violence. The second service is to Shelters for Victims of Violence (12 organisations in total) which provides an array of service ranging from:

- Providing shelter / accommodation to abused women and children
- Providing therapeutic and practical support to abused women and children
- Providing support to abused women and children through reintegration process.

Seven of the 12 Shelters for victims of violence are located in the Metro, while 3 are in the Eden Karoo district and 2 in the Winelands region.

Five of the 10 Social Service organisations are located in the Metro North region, whilst 4 are located in the Metro South region and 1 in the Metro East region.

The special project called ‘Mosaic’ is a Training, Service and Healing centre for women offering the following service:

- Court support
- Social services
- Social enterprise, training and development
- Sexual and reproductive health
- HIV Voluntary counselling and Testing

7.5 Considering the strategic priorities of the Department of Social Development in light of the evidence

The policies of the VEP is very explicit and stresses the importance of a holistic approach to the issue of victim support, however the aim of actual interventions in some measure miss the mark. In the Western Cape the focus is primarily on women and children as the victims of crime and more specifically if these are victims of domestic violence and sexual abuse. However the policies include all victims of crime. The policy states that “all victims of violence and crime including their families have a right to access services.” The policy also makes room for interventions focused toward youth, amongst others, the diversion of youth offenders and perpetrators of less serious offences.

59 Department of Social Development, Western Cape, Annual Performance Plan 2010/2011
60 Department of Social Development, Western Cape, Annual Performance Plan 2010/2011
Implementation of the policies are however not straight forward. When looking at the foci of the VEP it is apparent that there is no allowance for any other victims except women and children and in some cases youth. There are no known programmes which focus on secondary victims of crime, such as programmes for the families of murder victims, etc. Programmes focusing on male victims of crime are also not forthcoming. In the Annual performance plan of 2010/2011 the Department of Social Development did make provision for the inclusion of forums for engaging men and boys in the prevention of specifically gender based violence, however evidence of this provision being realised is lacking.

7.6 Conclusion

The aim of the Victim Empowerment Program coupled with the definition of what a victim is, covers a huge scope. When looking at the purpose of the VEP, taking into account its description of what a victim is, it is recommended that the DSD reconsider the focus of the VEP or alternatively reconsider the definition of the term ‘crime’. A possible suggestion would be to consider the distinction with regards to types of crime as defined in the South African Police Services report of 2010/11 (SAPS, 2011). The aforementioned report broadly categorises crime into two categories. The first category is what they call ‘contact crimes’. The other encompasses all other crimes and is categorised as ‘other crimes’. Contact crimes are defined as crime which involves any physical contact between the perpetrators and victims.

The primary focus of the VEP in the Western Cape on women and children is another aspect that needs some reflection. The crime statistics in the Western Cape clearly show the most dominant crimes (murder and assault with the intent to cause grievous bodily harm) to be primarily committed against males (SAPS, 2011). This is not suggesting that women and children should not be the focus of the programme, it is merely suggested that the definition of what a victim is as well as who the focus of the Victim empowerment programmes should be, probably deserves some reconsideration.
The social issues surrounding crimes, especially in the Western Cape deserves closer inspection. The Department of Community Safety’s Report on Identification of Policing needs and priorities in the Western Cape (2010/11) note that the following are all contributing to crime in this province:

- Poverty
- Unemployment
- Proliferation of shebeens
- High school dropouts
- The high influx of people into the province
- Shortage of community cohesion
- Environmental circumstances; as well as
- Densely populated settlements

These factors are mainly concentrated in the more disadvantaged communities and the combination of these factors makes residents more susceptible to crime\(^6^1\). It is thus recommended that the DSD consider a holistic approach when dealing with the various types of victims of crime, especially in its programmes on diversion and reintegration of specifically youth.

A last recommendation would be that the average Western Cape family should be made more aware of the VEP and the support provided through this programme. As stated earlier in this chapter only 50% of households in the Victims of Crime Survey for 2011 was aware of how to access counseling service whilst more than 80% of households did not know where to take someone to find shelter or a place of safety, should they fall victim to violent crime (Stats SA, 2011:17).

7.8 Abbreviations

DSD – Department of Social Development

GBH – Grievous bodily Harm

NIMSS - National Injury Mortality Surveillance System

SAPS – South African Police Service

VEP – Victim Empowerment Programme

7.9 Bibliography

Department of Social Development, Western Cape, Annual Performance Plan 2010/2011

Department of Social Development, Western Cape, Strategic Plan 2010/2015


Statistics South Africa: Victim of Crime Survey 2011: Embargoed until 24 November 2011: (page 39) -


Report On The Identification Of Policing Needs And Priorities In The Western Cape Province (2010/11) -

Northern Cape provinces. (Published in Crime Quarterly No 7 2004) -
http://www.iss.co.za/pubs/CrimeQ/No.7/Leggett1.htm

Third Annual Report of the National Injury Mortality Surveillance System, Crime, Violence And The

Modernisation Blueprint document for the Western Cape Premier’s office -
8.1 Introduction

In this Section on care and support services to families, the focus will be on the department’s theoretical frame of reference and approach to render support and services to families in the Western Cape Province. The Section also highlights needs and challenges manifesting amongst families and programmes put in place by the department to prevent and remedy the situation. It is also important to identify services rendered by the department through its own structures and services contracted out or subsidized to Non-governmental Organizations (NGOs). Finally the section focuses on population trends manifesting in the Western Cape and projections and outcomes of interventions.

8.2 Theoretical approach

The Integrated Service Delivery Model is applied by the Department of Social Development (Department of Social Development; Concept Paper on Children and Families Programme, 2009). This is regarded as a developmental framework which demands interrelated, inter-sectoral and integrated services by the different sectors and government departments involved. The aim is also to secure the integration of the different programmes by the department. “The programme will further intensify its efforts towards integrated service delivery through mobilizing, partnering and collaborating with a range of service providers across the province, working closely with other government departments, other spheres of government and community structures”.(Department of Social Development; Concept Paper on Children and Families Programme; 2009).

In pursuance of the above approach, the development and empowerment of families is paramount for DSD and includes prevention, early intervention, statutory intervention, residential and alternative care, reconstruction and aftercare services. This strategy intends a shift in emphasis from statutory intervention to the strengthening of families and communities through awareness and prevention, early intervention and accessible, integrated services delivery at the ground level. The point of departure is
the socio-economic development of families as a foundation for their independence, resilience, a sense of dignity and continued growth and social integration.

Care and support services to families are rendered in conjunction with services to children. The view is that the socio-economic development of the family should cover the entire lifespan of family members from early childhood to old age. The vision of the Department is to have self-reliant and resilient families by 2017. To achieve this goal, they have embarked on a ten year strategy called: *Social Development 2017: Self Repliant Communities* (Social Development 2017: Self-Reliant Communities: A Ten Year Strategy, 2009). This strategy includes *A Children and Families Programme* aimed at assisting in the wellbeing of families with emphasis on their ability to nurture and develop their children. In pursuance of this objective, the Department supports children and families so that they can function well, support, protect and develop children. By doing this, the Department projected itself as the lead Department in the Western Cape in the provision of social services that help to reduce poverty and the development of communities. The Department specifically targets those families who live in the poorest communities where social and economic conditions place pressures on families. These families are given the opportunities and support to be self-reliant and able to care for, and develop their children.

The potential of the Integrated Service Delivery Model can be found in its focus on the whole person and the total context. The model aims to deliver inter-sectoral and integrated services by the different sectors and government departments involved. In practice, there is no evidence on how this approach is pursued and achieved. There seems to be no structures in place to facilitate this approach.

### 8.3 Socio-demographic profile of Families in the Western Cape

A situation analysis of families and households in the Western Cape reveals the following:

- More than 96% of people in the Western Cape live in family groups. The dominant family types in the Western Cape are nuclear and extended families (Amoateng & Makiwane, 2005).
- The number of female-headed households in the province has increased from 27, 8% in 1996 to 33, 5% in 2007, especially in urban areas.
- The number of households headed by older persons has increased from 11, 9% in 2001 to 12, 7% in 2007.
• Many households in the province lack the resources to provide adequately for their family members. In 2005, 10% of the population of the Western Cape had a per capita income of less than R250 per month. This is an increase from 1995, when only 9% of the population fell below this line (Presidency, 2008).

• From 1996 to 2007, the percentage of households with no income increased from 5, 9% in 1996 to 12% in 2001 and 17, 1% in 2007.

• The ability of households to provide for their dependants is also affected by unemployment. In 2007, the province’s unemployment rate was 17% (Stats SA, 2007). This increased to 19, 1% in June 2008 and 20, 5% in June 2009 (Stats SA, 2009).

• Female-headed households appear to be particularly disadvantaged. The percentage of female-headed households with no income increased from 41% in 1996 to 44, 9% in 2007. At the same time, the percentage of female heads that are employed, has decreased from 43, 3% in 1996 to 26, 3% in 2007. In addition; the percentage of female-headed households living in shacks has increased from 30, 9% in 1996 to 36% in 2001 and 33% in 2007.

• Families have a huge burden of care as illustrated by its age specific dependency ratios for children. The dependency ratios for children in the age group 0 to 14 years per population group is 43, 5% for Blacks; 42, 4% for Coloureds; 27, 5% for Indians and 21, 9% for Whites. The implication of this is that every 100 working Coloured persons (between the ages of 15 to 64) potentially support 42 children under the age of 15. (Annual Performance Plan 2012/2013 Second Draft, 29th November 2011).

The abovementioned factors are serious issues for the department’s services and strategies to address it. A situational analysis of children and families indicates that many families are in crisis and are faced with a number of challenges that impact negatively on their ability to sustain themselves. These issues are unemployment, poverty, lack of basic services and poor infrastructure especially in rural areas and informal settlements. These are areas where mainly rural migrants settle without basic services required for their human needs.

The spread and prevalence of HIV and Aids, teenage pregnancy/parenting, the abuse of alcohol and other substances (in particular tik) are serious issues impacting negatively on the functioning of the family. Abuse within the family as well as current changes in the form and structure of the family such as single parenthood, as well as child-headed and granny-headed households, are serious issues to
consider in dealing with families and households. The inability of the family to provide care increases the vulnerability of its members, especially children, the disabled and the elderly.

For the identification of a family, the department works with the UN definition that says: “A family is a group of persons united by the ties of marriage, blood, adoption or cohabitation, characterized by a common residence or not, interacting and communicating with one another in the respective family roles, maintaining a common culture and governed by family rules”. (Department of Social Development; Concept Paper on Children and Families Programme, 2009). This definition corresponds with the African Union Plan of Action for Families in Africa which says that the family is:

- A psycho-biological unit where members are linked together by blood ties, kinship relationships, personal feelings and emotional bonds of its members.
- A social unit where members live together in the same household and share tasks and social functions.
- A basic economic production unit. (Ibid).

Working with these definitions, the focus is mainly on families at risk. These are families that are socially isolated, subjected to the least empowering circumstances, without support systems and or adult supervision, not linked to resources, do not function due to various challenges that expose family members to circumstances that are detrimental to their development and may have an imminent risk of removal) and families in crisis. These are families that function well enough to cope with daily challenges, but which experience a crisis as a result of sudden trauma or setback, such as death, disability, unemployment, rape, and violence among others. Urgent intervention may be required to assist families to manage the crisis.

Statistics on families and households

According to statistics, there is a constant increase in the population of the Western Cape. The only other provinces where similar trends are noticed are Gauteng and KwaZulu-Natal. This trend is clearly related to employment opportunities in the big cities. These migration trends have serious implications for the scope and extent of the department’s service programmes. A similar trend is observed in terms of families and households, as can be seen in the following tables below.
Table 8.1: Number of individuals (in thousands) per province, 2002 - 2010

<table>
<thead>
<tr>
<th>Province</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>4.646</td>
<td>4.755</td>
<td>4.659</td>
<td>4.964</td>
<td>5.071</td>
<td>5.162</td>
<td>5.258</td>
<td>5.369</td>
<td>5.469</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>1.088</td>
<td>1.098</td>
<td>1.106</td>
<td>1.115</td>
<td>1.123</td>
<td>1.131</td>
<td>1.140</td>
<td>1.148</td>
<td>1.154</td>
</tr>
<tr>
<td>Free State</td>
<td>2.777</td>
<td>2.705</td>
<td>2.811</td>
<td>2.826</td>
<td>2.842</td>
<td>2.863</td>
<td>2.884</td>
<td>2.905</td>
<td>2.919</td>
</tr>
<tr>
<td>Limpopo</td>
<td>5.011</td>
<td>5.049</td>
<td>5.081</td>
<td>5.111</td>
<td>5.138</td>
<td>5.171</td>
<td>5.201</td>
<td>5.230</td>
<td>5.250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45.533</strong></td>
<td><strong>46.116</strong></td>
<td><strong>46.665</strong></td>
<td><strong>47.198</strong></td>
<td><strong>47.731</strong></td>
<td><strong>48.257</strong></td>
<td><strong>48.793</strong></td>
<td><strong>49.382</strong></td>
<td><strong>49.869</strong></td>
</tr>
</tbody>
</table>

Source: Stats SA, 2010

Table 8.2: Number of households (in thousands) per province, 2002 - 2020

<table>
<thead>
<tr>
<th>Province</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>1,166</td>
<td>1,204</td>
<td>1,244</td>
<td>1,266</td>
<td>1,333</td>
<td>1,379</td>
<td>1,428</td>
<td>1,478</td>
<td>1,532</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>1,484</td>
<td>1,517</td>
<td>1,549</td>
<td>1,580</td>
<td>1,614</td>
<td>1,654</td>
<td>1,696</td>
<td>1,738</td>
<td>1,781</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>256</td>
<td>263</td>
<td>270</td>
<td>277</td>
<td>284</td>
<td>293</td>
<td>302</td>
<td>311</td>
<td>320</td>
</tr>
<tr>
<td>Free State</td>
<td>713</td>
<td>731</td>
<td>749</td>
<td>768</td>
<td>788</td>
<td>812</td>
<td>837</td>
<td>861</td>
<td>885</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>2,073</td>
<td>2,140</td>
<td>2,266</td>
<td>2,278</td>
<td>2,356</td>
<td>2,438</td>
<td>2,525</td>
<td>2,615</td>
<td>2,712</td>
</tr>
<tr>
<td>North West</td>
<td>791</td>
<td>811</td>
<td>831</td>
<td>852</td>
<td>876</td>
<td>901</td>
<td>928</td>
<td>954</td>
<td>982</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>768</td>
<td>795</td>
<td>821</td>
<td>848</td>
<td>877</td>
<td>909</td>
<td>943</td>
<td>978</td>
<td>1,015</td>
</tr>
<tr>
<td>Limpopo</td>
<td>1,081</td>
<td>1,115</td>
<td>1,148</td>
<td>1,181</td>
<td>1,216</td>
<td>1,258</td>
<td>1,302</td>
<td>1,346</td>
<td>1,394</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,013</strong></td>
<td><strong>11,362</strong></td>
<td><strong>11,712</strong></td>
<td><strong>12,075</strong></td>
<td><strong>12,476</strong></td>
<td><strong>12,901</strong></td>
<td><strong>13,351</strong></td>
<td><strong>13,812</strong></td>
<td><strong>14,304</strong></td>
</tr>
</tbody>
</table>

Source: Stats SA, 2010

8.4 Policy and legislative framework

Laws that provide the framework for services to families and children can be divided into International Obligations and South African Legislation. International Obligations include the:

- UN Convention on the Rights of the Child.
- Malta Statement.
- Copenhagen Declaration on Social Development, 1995
The South African Legislation includes a range of laws from the Constitution to the Children’s Act. This list includes the following:

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Functions of Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care Act, Act 74 of 1983.</td>
<td>The Act provides for the establishment of Children’s Courts, the protection and welfare of children, for adoption of children and the establishment of facilities of care and treatment of children.</td>
</tr>
<tr>
<td>Children’s Act, Act 38 of 2005.</td>
<td>Gives effect to certain rights of children as contained in the Constitution, sets out principles relating to the care and protection of children and define parental responsibilities and rights.</td>
</tr>
<tr>
<td>The Children’s Amendment Act, Act 41 of 2007.</td>
<td>Provision for prevention and early intervention services to families</td>
</tr>
<tr>
<td>Adoption Matters Amendment Act, Act 56 of 1988.</td>
<td>Provides for legal representation for children in Children’s Courts, the rights of natural fathers where adoption of their children born out of wedlock is concerned</td>
</tr>
<tr>
<td>Act</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Children’s Status Act, Act 82 of 1987.</td>
<td>This Act deals with paternity, guardianship and the status of certain children, such as extramarital children of avoidable marriages.</td>
</tr>
<tr>
<td>Divorce Act No 70 of 1979.</td>
<td>This Act deals with the law relating to divorce.</td>
</tr>
<tr>
<td>Natural Father’s of Children Born out of Wedlock Act No 86 of 1997.</td>
<td>Act provides for the possibility of access to and custody and guardianship of children born out of wedlock by their natural fathers.</td>
</tr>
<tr>
<td>Birth and Death Registration Act No 51 of 1992.</td>
<td>This Act regulates the registration of births and deaths.</td>
</tr>
<tr>
<td>Choice on Termination on Pregnancy Act No 92 of 1996.</td>
<td>The Act determines the circumstances and conditions under which the pregnancy of a woman may be terminated</td>
</tr>
</tbody>
</table>
Domestic Violence Act No 116 of 1998. This Act makes provision for the maximum protection from domestic abuse for the victims of domestic violence.

8.5 The Provincial Response (DSD)

The department’s Children and Families Programme makes provision for a range of support services to families. Of special note are the family preservation services with its focus on pregnant adolescent mothers, as well as the targeting of 792 men in fatherhood workshops and programmes. This programme addresses special issues that affect fathers and stressors or behaviours that can affect their abilities to support their children emotionally and financially. The programme has the intention to improve parenting skills, increase father’s involvement with their children and improve attitudes or feelings toward children including the improvement of social and family interactions. The Family Preservation Programme has the purpose of working with families to prevent the removal of family members. The programme implies that families should be strengthened and supported to keep them together as far as possible. In this way, the removal of family members is prevented. A further aim with this programme is to achieve permanency in the lives of family members for them to be together and to work with the family to prevent out-of-home placement. Family preservation has the purpose of working together with families to enhance qualities such as communication, respect, togetherness, joy and strength. This programme, with its focus on families, couples, fathers, mothers and parents, targets about 15 517 families.

A similar programme focusing on the family, promotes parenting skills. The DSD believes that parents who play a positive role in their children’s lives and are able to raise well adjusted children, contributes to a stable and well functioning society. This programme therefore seeks to empower parents with positive parenting skills; understanding of a child’s developmental process and the importance of the parent’s role in the child’s life. It further seeks to assist in improving of the communication patterns between parents and children, to improve and strengthen family functioning by increasing capabilities of family members. Positive Parenting Practices also improve and strengthen family functioning and
increases the capabilities of family members. It is estimated that this programme reaches approximately 2 375 parents through workshops.

The men and boys programme was started due to a lack of service delivery to men and boys as social service clients and a lack of role models for young boys. The purpose is to contribute to gender equality and the establishment of inclusive service delivery to address particular needs of men and boys within a family context. The focus is on older men and young boys and reaches 695 men and boys.

The awareness or “family expo” programme is to provide integrated and targeted awareness activities that link families to available support services, to improve access to information and create understanding of the centrality of families in service delivery and improve collaboration with other governments departments and civil society organisations that render services to families. The estimated population reached by this programme is 16 670 people.

The programme for homeless adults reaches about 12 534 people and caters for a vulnerable group as a result of family disintegration.

These programmes are implemented all over the Province through various projects by the department itself and in partnership with NGOs.

The abovementioned programmes intend to achieve the following objectives:

- Wellbeing of the family, believing this to be critical for the overall functioning of society.
- To help build families that function well, and communities that care for, protect and develop children appropriately.
- To prevent any breakdown in a family’s functioning and its ability to provide care as this increases the vulnerability of its members.

To promote access to the services, the department also disseminates information on laws and policies related to children and families.

According to the department’s concept paper on children and families issued in January 2009, the Children and Families Programme is at the heart of the Department of Social Development’s ten year Integrated Service Delivery Strategy. The strategy includes five key functions:

- Early Childhood Development (ECD),
- Victim Empowerment Programme,
These key functions are pursued through programmes of the department that focus on prevention services, treatment and curative services and long term continuous and sustainable social functioning of children and families.

These services are rendered within the strategic objectives of the department that intends to promote the wellbeing of children and build the resilience of families and communities to care for and protect their children. The objective is to invest in and ensure quality services to families and children through facilitating the provision of a continuum of services that promote the well-being of families.

8.6 Considering the strategic priorities of the Department of Social Development in light of the evidence

The strategic priorities of the department are spelled out in various internal documents such as the Strategic Plan 2010 -2015; Social Development 2017: Self-Reliant Communities: A 10 year Strategy, as well as the department’s Annual Performance Plan 2012/2013 and Annual Reports. Accordingly, the vision of the Department of Social Development is to ensure that by 2017:

- 80% of children know their rights and responsibilities.
- All parents and families have access to programmes that increase their parenting abilities and skills and develop their resilience so that they can care for and protect themselves and their children.
- The Department of Social Development has an Early Childhood Development (ECD) provisioning plan that promotes access to quality ECD provision for 80% of children between the ages of 0 – 4 years.
- A comprehensive community-based safety net - (child protection committees, trained, accredited safety parents at ward level, support groups) – is in place for children, families and victims of violence.
• All children and family organisations adopt and effectively implement the agreed-upon early risk identification tools and referral systems and procedures.

• A child protection register is fully implemented; functions optimally and provides reliable information about child abuse and neglect in the province.

• All statutory services comply with minimum norms and standards.

• All victims of violence have access to information and services that will rebuild their lives and help them integrate into communities. (Social Development 2017; Self-reliant Communities, A 10 Year Strategy, May 2009).

As in the other sub-programmes, what is needed here is an analysis of DSD and its implementing partners in terms of planned and perceived performance and how it is achieved. It essentially deals with the “story” (success or failure) of the programme. The underlying logical framework needed should trace performance (or the lack of it) at outcome and impact levels back to outputs, activities and / or inputs, or the context or situation to which the programme is a response.

This requires analysis of the trends of change in family life (and other programme fields) as well as the wider context (as normally provided for in the trend analysis), information on the inputs, activities, outputs, outcomes and impacts and the development of indicators. The current indicators developed by DSD stop at output level (numbers reached), with very little attention to outcomes and impacts.

The only DSD based information currently available are in the Annual Reports, the Annual Performance Plans and other DSD documents, none really attending to the monitoring and evaluation needs to link trends in the profiles of problem areas dealt with to the services delivered beyond output levels.

Input indicators of the department focus mainly on the Rand value of funds transferred to NPOs delivering services to families. This indicator reports the amount of funds spend on family services. The output indicators represent the number of families accessing developmental social welfare services as well as the number of government funded NPOs providing care and support services to the various programmes referred to above.

In terms of these output indicators, the department aims to double most of its services to families on the different programmes.
8.7 Conclusion

The strategy of the Children and Families Programme is to create awareness, prevention, early intervention and integration. Therefore, a family centered approach is followed to promote dignity and self-worth and build on the strength of individuals, families and communities. Adopting this approach, the department tries to move away from a statutory intervention model. The Integrated Service Delivery Model attempts to follow a developmental and empowerment approach and makes provision for prevention, early intervention, statutory intervention, residential and alternative care, reconstruction and after care services. With this approach the department envisions to have self-reliant and resilient families by 2017.

The Western Cape Province is currently home to 5.4 million individuals and 1.532 million households. More than 96% of people in the Western Cape live in family groups with an increasing number of female-headed households as well as households headed by older persons. Many of the families in the Western Cape lack the resources to provide adequately for their family members.

The department implements several programmes to achieve its objectives. These programmes are implemented by the department’s own initiatives and in partnership with partnering organizations in the community. The relevant legislation provides the framework for the family support programmes. Currently the different programmes reach the following persons and families:

- Awareness Programme: “Family Expo”: 16 670
- Parenting skills : 2 375
- Family Preservation :15 517
- Fatherhood Programme : 792 fathers
- Men and Boys : 695
- Programme for Homeless Adults : 12 534

The outcomes of the department’s involvement with these families and individuals are not clear. However, the vision of the department is that a much higher number of families and households should be reached by 2017 to achieve the objectives set out above.
8.8 Abbreviations

NPO: Non Profit Organization

NGO: Non-Governmental Organization

8.9 Bibliography


Department of Social Development, Western Cape: Strategic Plan 2010-2015.


Department of Social Development, Western Cape, Annual Performance Plan 2012/2013 Second draft, 29th November 2011

Department of Social Development, Western Cape: Annual Report 2010/11.


Statistics South Africa (2010), Household Survey
Chapter 9: Youth Development (Sub programme 3.2)

9.1 Introduction

The definition of youth globally as well as in South Africa varies considerably and is mostly dependant on the context it is used in, as well as socio-economic and political factors. In this report the definition of youth will include those young individuals between the ages of 14 and 24 years following the definition of the target population for the Western Cape Youth Development Plan\(^62\).

According to the United Nations people between the ages of 15–24 years is estimated to constitute 18% of the world’s population. This is the largest ‘youth generation’ ever recorded in history. With an estimated 1.2 billion young people living in the world today this figure is projected to increase by 72 million by 2025\(^63\). In South Africa the number of youth (those between the ages 14-24 years) was estimated at approximately 10 million in 2011 constituting approximately 20% of the total population (Stats SA\(^6\), 2011).

Within the South African context, as in most parts of the world, being young is, however, not a general and homogenous experience. Where the time of transition to adulthood is often associated with advancement, prospects and opportunities, the reality for a large portion of young people today is rather characterised by great challenges and difficulties. This is probably best illustrated by the large number of young people that live in poverty within the South African context, with an estimated one third of all youth living in poverty of which approximately half live in extreme poverty (Youth Development Network, 2010).

\(^62\) www.westerncape.gov.za/eng/directories/services/152796/209520

9.2 Demographic profile of youth in the Western Cape Province

When compiling a demographic profile of a specific population it is imperative to construct a precise definition of that population or group of persons. As indicated above, in this report youth will be defined as those male and female individuals within the age cohort 14-24 years. Young people within this age cohort constitute approximately 18% of the total population in the Western Cape which is consistent with the global figure (Stats SA, 2007). Figure 9.1 contains a distribution of youths across South Africa as well as the gender distribution of these young persons within each province. The data clearly show that KwaZulu-Natal, Gauteng and the Eastern Cape have the greatest proportion of young people in terms of their total provincial population. The Western Cape ranks fifth with (as is the case for the other provinces) an equal distribution of male and female youth.

When analysing the distribution of youth across the different racial population groups, Table 9.1 shows the Western Cape with the Northern Cape as the only two provinces that do not have a Black African majority. Figure 9.2 shows the Western Cape youth as primarily comprised of young person’s identifying themselves as part of the Coloured population group (51%), followed by Black African youth (34%) and White youth (14%).

Figure 9.1: Provincial distribution of youth (15-24 years) by gender

Source: Statistics South Africa, Community Survey 2007
Table 9.1: Provincial distribution of youth (15-24yrs) by race

<table>
<thead>
<tr>
<th>Province</th>
<th>Black African</th>
<th>Coloured</th>
<th>Indian</th>
<th>White</th>
<th>N (000)</th>
<th>Provincial Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>3.4</td>
<td>5.1</td>
<td>0.2</td>
<td>1.4</td>
<td>993</td>
<td>10.0</td>
</tr>
<tr>
<td>Eastern Cape</td>
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<td>1.0</td>
<td>0.0</td>
<td>0.4</td>
<td>1 394</td>
<td>14.1</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>0.9</td>
<td>1.1</td>
<td>0.0</td>
<td>0.1</td>
<td>207</td>
<td>2.1</td>
</tr>
<tr>
<td>Free State</td>
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<td>0.0</td>
<td>0.4</td>
<td>574</td>
<td>5.8</td>
</tr>
<tr>
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<td>0.3</td>
<td>1.6</td>
<td>0.6</td>
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</tr>
<tr>
<td>North West</td>
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<td>0.0</td>
<td>0.4</td>
<td>632</td>
<td>6.4</td>
</tr>
<tr>
<td>Gauteng</td>
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<td>1 876</td>
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<td>782</td>
<td>7.9</td>
</tr>
<tr>
<td>Limpopo</td>
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<td>0.0</td>
<td>0.2</td>
<td>1 156</td>
<td>11.7</td>
</tr>
<tr>
<td>South Africa</td>
<td>82.1</td>
<td>8.6</td>
<td>2.4</td>
<td>6.9</td>
<td>9 885</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa, Community Survey 2007

Figure 9.2: Distribution of youth (15-24yrs) by race within the Western Cape

Source: Statistics South Africa, Community Survey 2007

Youth headed households

According to Meintjies et. al. (2009) more than half (55%) of children living in child-headed households are 14 years or older, thus within the definition used in this paper, 55% of child headed households within South Africa are indeed youth headed households. The authors further state that the vast majority (88%) of child headed households has at least one child present who is 15 years or older. Youth thus make up a significant number of those children affected by the reality of households where an adult is not present.
The 2007 Community Survey (Stats SA, 2007) indicated the estimated number of youth headed households within the Western Cape Province at 57,895. At the time the survey was conducted this was the third lowest number in the country. Figure 9.3 shows the majority of these household heads as males within the age cohort 20-24yrs. In measuring the occurrence of such households over time, Table 9.2 show a general decline in numbers for the Western Cape for the period 2002-2009, however with some spikes within this period.

When analysing data on some characteristics of child/youth headed households, research show these young people to generally live in conditions that are worse compared to the living conditions of children living in mixed generational households. These households are less likely to live in formal dwellings, or to have access to adequate sanitation and water on site, partly because they are disproportionately located outside of cities where better services are available. Child/youth headed households also portray significant economic vulnerability with very few children/youth within these households that are working to earn an income (Meintjies et.al, 2009). Although the official definition used here for child headed households is a household consisting of members younger than 18 years, the economic vulnerability of youth headed households as comprising of members between the ages of 14-24 years is supported by the high unemployment rate of persons between the ages of 20-24 years. According to the 2007 Community Survey (Stats SA, 2007), 17% of youth headed households aged between 20-24 years are unemployed with another 15% indicated as not economically active.

Meintjies et.al. (2009) show these children/youth headed households to fall outside the safety net created by the social grant system for millions of so many poor South Africans, with the majority falling outside of the eligible age threshold for child support grants (younger than 18 years or born after 31 December 1993\(^6\)). These households also do not have the advantage of benefiting from the government pension grant that support so many mixed generational households in this country. Although the majority of child/youth headed households (77%) receive remittances – money send by family members or other adults – suggesting that they do have some support, the reliance on remittance in the absence of earnings and grants income may be unreliable.

---

Figure 9.3: Youth headed households in the Western Cape

Table 9.2: Proportion of households headed by youth aged 15-24 years by province

<table>
<thead>
<tr>
<th>Province</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>3.9</td>
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<td>5.1</td>
<td>5.1</td>
<td>4.2</td>
<td>4.1</td>
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<td>Eastern Cape</td>
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<td>8.3</td>
<td>6.9</td>
<td>7.6</td>
<td>8.9</td>
<td>8.0</td>
<td>7.4</td>
<td>5.7</td>
<td>7.3</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>4.1</td>
<td>5.0</td>
<td>4.7</td>
<td>6.0</td>
<td>5.0</td>
<td>4.8</td>
<td>4.3</td>
<td>5.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Free State</td>
<td>7.6</td>
<td>6.9</td>
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<td>8.8</td>
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<td>7.2</td>
</tr>
<tr>
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<td>6.4</td>
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<td>7.4</td>
<td>6.3</td>
<td>5.5</td>
<td>6.8</td>
</tr>
<tr>
<td>North West</td>
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<td>6.1</td>
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<td>3.9</td>
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<td>Gauteng</td>
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<td>5.7</td>
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<tr>
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<td>South Africa</td>
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<td>5.9</td>
<td>6.6</td>
</tr>
</tbody>
</table>


Household characteristics of youth headed households

Household characteristics are often indicators of how household members react to socio-economic conditions by means of various strategies. It is important to realise that the living arrangements of households are influenced by aspects such as social policy formulated by politicians, access to housing, health, education and socio-economic amenities. It is there for expected that the organisation within a household structure will respond to changes within the mentioned conditions. Amoateng et.al. (2007)
developed a household typology with the following categories for types of households consisting of a) a single persons, b) a nuclear household, c) an extended household and d) a complex household. Nuclear households are defined as households consisting of heads of households, their spouses and offspring, while the extended household would typically include other relatives in addition to the nucleus unit. Complex households are all households with members who are not related to the head of the household.

From figure 9.4 it would seem that youth headed households are most likely to be single person households (47%) or extended households (31%). When analysing the data further in terms of population group and gender [figure 9.5] the data show that both African and non-African youth headed households are more likely to be characterised as single households (47% and 44% respectively), African youth headed households are much more likely to live as part of an extended household units (34%) compared to non-African youth household heads who are more likely to live as part of a complex household unit. The data also show some variance for the two gender groups with male youth household heads more likely to live in single person households (56%) where as female youth household heads are mostly (46%) heading an extended household unit (Stats SA\textsuperscript{b}, 2011).

For the general youth population in South Africa the majority of young people live in extended household types with African youth most likely to live in such households. The majority of Coloured youth lives either as part of nuclear households (45%) or extended households (46%). Indian and white youth are more likely to live as part of nuclear families (58% and 68% respectively) with white youth the least likely to live as part of extended households (20%) see figure 9.6 (Stats SA\textsuperscript{b}, 2011)
Figure 9.4: Household characteristics of youth headed households: Household type

[Bar chart showing household types by age groups and overall.]

Source: Statistics South Africa, 2011, Social Profile of South Africa 2002-2010

Figure 9.5: Household characteristics of youth headed households: Household type by population group

[Bar chart showing household types by population groups.]

Source: Statistics South Africa, 2011, Social Profile of South Africa 2002-2010
9.4 Social profile of youth with specific reference to youth in the Western Cape

Youth and education

The educational system in South Africa has shown considerable change since 1994, with the right to basic education up to the age of 15 set in the Constitution. Access to primary education has increased and South Africa is currently close to meeting the Millennium Goal of universal primary education (Western Cape Youth Commission, 2008:83). When measuring the educational participation across the different population groups, the data show that until age 16, participation is broadly similar and high for the different groups. Of great concern, however, is the substantial failure of young persons to complete secondary school, specifically in the case of African and Coloured youth (Sheppard, 2009).

In terms of the South African Schools Act 84 (1996), school attendance is compulsory for learners from Grade 1 to Grade 9. Disconcerting, however, is the high number of students who drop out of the education system after Grade 9. Of the 1 million students who enrolled in Grade 10 in 2007 only 51% entered Grade 12 in 2009 with only 31% that achieved a matric pass. Data on out-of-school youth
show an increase in their number over the period 2002 to 2007 confirming the increased drop-out rates of learners at the higher grades in secondary education. Of particular concern is the apparent increase in the number of drop-out rates at Grade 11 with each successive wave of learners progressing through the school system (Sheppard, 2009; Holborn & Eddy, 2011). Figure 9.7 gives an illustration of the attendance of Western Cape youth at educational institutions. The rather sharp drop in the number of youth attending school for the age group 15-18 years is a clear indication of the great number that leave the educational system before completing Grade 12.

At this point it seems important to consider the link between educational attainment and employment as this has a direct impact on the future economic dependence or independence of current youth. Although education does not guarantee employment it definitely impacts on the likelihood for a person to find employment. According to Bhorat (2006), an individual in the age group 15 to 24 with incomplete secondary school education has a 75% change of being unemployed. This figure drops to 66% if they have completed Grade 12. For those young people who attained a tertiary qualification but no degree, the likelihood decreases to 50%, while for those who attained a degree the likelihood of not getting a job decreases to 17%. It is thus the early school leavers that make up the bulk of the unemployed group (Bhorat & Papier 2006).

Figure 9.7: Educational status of youth in the Western Cape Province, 2007

Source: Statistics South Africa, Community Survey, 2007
Youth and poverty

Although poverty is a far reaching social aspect affecting a wide range of people living under diverse circumstances and of different ages, youth is shown as one of the most vulnerable groups to poverty with an estimated one third of all young persons in this country live in extreme poverty (Youth Development Network, 2010). Given the large proportion of young persons in the South African population, as well as the importance of this group for the future economic growth and social well-being of the country, this aspect needs specific mention and consideration.

In the General Household Surveys conducted by Statistics South Africa, data is collected on income earned from employment, government transfers through social grants and remittances (Stats SA^b, 2011). The percentage of youth living in low per capita income households is established by using a poverty threshold proposed by Statistics South Africa at R570 for 2010^c. Per capita income is then calculated by adding all reported income for the household, including remittances, social grants and income from private pensions, and then dividing the total income by the number of household members. This developed threshold is then used to determine the position of youth in terms of their general welfare, how they access education, employment, health care and nutrition.

Figure 9.8 shows the percentage youth living in low-income households by gender and population for the extended definition of youth (15-34 years). It is clear from the data that the younger cohort is much more likely to live in low-income households than the older cohort. This is possibly due to a higher employment figure for the older youth as more individuals from this group would be employed compared to the younger group where the majority is still of school going age resulting in a higher dependency ratio. The data further shows a higher likelihood for female youth to live in low-income youth than male youth. When presenting the data on low-income households per province, figure 9.9 shows the Western Cape and Gauteng youth as better positioned economically, when compared to youth from other provinces, with these two provinces showing the lowest number of low-income households of which youth is a part.

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^b In developing the poverty threshold an ‘upper-bound’ threshold providing for essential food and non-food consumption was set at R322 per capita per month as for 2000 prices. When increased with inflation the threshold equivalent for 2010 was set at R570. This amount is merely used to identify low income household and should not be considered an official poverty line.
The group of youth that can probably be described as the most vulnerable to poverty and the group that should be of specific priority for intervention is the approximately 3.3 million young people (33%) between the ages of 15-24 years that are neither employed, nor attending any education or training institution [see figure 9.10]. The social impact of such large numbers of youth sitting by idly daily with nothing constructive to occupy them with, be it in the field of education, training or employment, is...
likely to be significant. Such youth are more at risk to develop depression; feelings of hopelessness and fatalism, as well as getting involved in high risk behaviour and become tangled up in social problems such as teenage pregnancy, HIV/AIDS, drug and alcohol abuse and criminal activity, all indicators of social marginalization and exclusion (Holborn & Eddy, 2011; Stats SA^b^, 2011).

**Figure 9.10: Percentage of youth aged 15–24 who are not attending any educational institution and who are not employed, 2010**

![Graph showing percentage of youth not attending educational institution and unemployed, 2010.](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Not attending and not working</th>
<th>Attending educational institution</th>
<th>Employed</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>24</td>
<td>53.5</td>
<td>7.2</td>
<td>39.3</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa^b^, 2011

**Youth and employment**

Currently there are 4.1 million unemployed workers in South Africa, that is, one in four persons who are available to work who are not employed. Approximately 2.8 million of these are long-term unemployed with a further 2.2 million that have grown discouraged^66^. Despite making up just 0.5% of the global work force, South Africa accounts for 2% of global unemployment (National Treasury, 2011). Considering these already disconcerting figures, statistics show the challenge of unemployment to be even greater for the youth with South Africa having one of the highest youth unemployment rates in

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^66^ Discouraged work seekers are those who would like to work but did not make an effort to find work or start a business because they believed that there were no jobs available in the area. Were unable to find jobs requiring their skills, or had lost hope of finding any kind of work. Persons in long-term unemployment are defined as those who are without work and have been trying to find a job or start a business for one year or more.
the world, standing at 51% in 2010 compared to 12% for Sub-Saharan youth and 13% for youth worldwide (Holborn & Eddy, 2011).

Currently there is more than 1.2 million unemployed youth between the ages 15-24 years (that is 30% of overall unemployment in the country) with an unemployment rate of 49%. This means that one in every 2 people younger than 25 years that are looking for employment is unemployed (National Treasury, 2011). A study by Usombovu Youth Fund in 2003, found that 68% of persons between the ages of 15-35 years never had a job at that time. Of those that did indicate to be employed approximately 32% started their working career in the informal sector (In Holborn & Eddy, 2011).

Although the Western Cape Province has the lowest unemployment rate in the country, at 22,2% compared to the national rate of 23,2%, youth in this province is also particularly vulnerable to unemployment as is the case for youth in the rest of South Africa. According the 2007 Community Survey, 41% of youth (15-24yrs) in the Western Cape, who were looking for employment were unemployed at the time the survey was conducted [see figure 9.11] (Stats SA, 2007).

**Figure 9.11: Western Cape youth (15-24yrs) employment status**

<table>
<thead>
<tr>
<th></th>
<th>Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>32%</td>
<td>19%</td>
</tr>
<tr>
<td>Female</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td>59%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Source: Statistics South Africa, Community Survey, 2007,

---

Although educational status and the availability of employment opportunities are self evident factors impacting on the likelihood of gaining employment, another aspect identified as complicating young person’s access to the labour market concerns poor information systems available on employment and career opportunities in both educational institutions and the labour market\textsuperscript{68}.

**Youth and health**

The health status of youth acts as a clear indicator of the future health status of a country's future adult citizens. Such an indicator is of great importance as it gives some indication of the future economic ability of a country by showing the economically active aged citizens’ ability to either actively take part in the economy or as dependents on the economy in aid of support to sustain their daily livelihood as a result of poor health.

In a report by the United Nations Economic Commission for Africa (UNECA, 2005) a strong positive correlation is established between education and health. In the report a high probability for improvement in reproductive decisions, HIV prevention, and infant mortality is shown as result of education of the youth in Africa and other developing regions. The World Development Report (2007) shows the building of human capacity at a young age as an important intervention not only for future opportunities available to young people but also to mitigate the intergenerational transmission of poverty. The report also emphasizes that more educated youth are more willing to control family size and invest in the health and well-being of their children, the impact of which is particularly strong for women (UNECA, 2005).

**Youth and sexual behaviour**

A large portion of research conducted on the health of youth has focused on the sexual behaviour among youth and HIV awareness and incidence within this group. In a study conducted by the Medical

\textsuperscript{68} This point was highlighted by both Bhorat (2006) and Holbron & Eddy (2011) where Bhorat specifically referred to poor communication systems on the part of the labour sector and Holborn & Eddy referred to the lack of information on the labour market presented to learners by the educational sector – specifically schools.
Research Council [MRC] (2008) on youth risk behaviour of school going youth it is shown that a significant proportion of young people are involved in risky behaviour that will adversely affect their health. According to the research findings 37.5% of learners reported having had sex with approximately 13% having had their first sexual encounter before the age of 14 years; 52% of learners indicated to have had one or more sexual partners in the three months leading up to the study.

While nationally 16.2% used alcohol before having sex, the Western Cape province showed a significantly higher prevalence at 36.5%; 14.3% used drugs before having sex and nearly 18% indicated using no method of contraception. While 45% of learners mostly used condoms for contraception, 31% used condoms consistently. 19% of learners indicated that they had been pregnant or made someone pregnant with 18% reported having had a child/children.

Youth and HIV/AIDS

The figures stated above with regards to first sexual encounter, correspond closely with the HIV prevalence studies conducted by the Human Science Research Council (Sishana et al, 2009) where it is reported that approximately 10% of youth aged 15-24 years stated having had their first sexual experience before the age of 15 years. Although the figure did not change significantly between 2002 and 2008 there were substantial gender differences with approximately 5% of female youth compared to roughly 12% of male youth reporting early sexual debut. Youth in the Western Cape had slightly higher levels of early sexual debut (9.3%) than the national average (8.5%) although not statistical significant.

Sexual debut is a crucial factor in the vulnerability of youth to HIV infection with early sexual debut linked to a lower likelihood of contraceptive use and resulting unplanned pregnancies. Another factor linked to early sexual debut is the sexual abuse of girls with evidence suggesting that girls experiencing sexual abuse are more likely to engage in riskier sexual behaviour compared to their peers. It is thus even more important to protect children from sexual abuse and encourage youth to delay their sexual debut for as long as possible (Gary et al, 2008 in Shishana et al, 2009).

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69 This study was conducted by the Medical Research Council and involve 10,800 learners within the nine provinces in the country (1200 learners per province). The study population comprised of grades 8, 9, 10 and 11 learners in the nine provinces. Data was collected in August 2008.
Although the HIV epidemic in the Western Cape has been described as a less mature epidemic in comparison with other provinces (figure 9.12) Shaikh (2008) shows the difference in the HIV prevalence rate within different areas within the province where some areas show rather high prevalence rates even compared to the National incidence levels. Although the HIV prevalence rate for the Western Cape was 15,1% in 2007, according to data from the Western Cape Department of Health (in Shaikh 2008) the area surveys showed HIV prevalence ranging from 4% in the Klein Karoo to 33% in Khayelitsha. “These findings demonstrate that the diversity of the epidemic at local levels is an important consideration for resource allocation and programme delivery at district level” (Shaikh, 2008:178)

With regards to the HIV prevalence amongst Western Cape youth aged 15-24 years, figure 9.13 shows rapid increase for the period 2001-2004 with a slow down from 2005 to 2006. Important to note the gender difference in incidence rates with females shown as accounting for 90% of recent infections among youth aged 15-24 years with a six fold higher risk of infection compared with males of the same age cohort (Shaikh, 2008:181)

**Figure 9.12: HIV Prevalence among antenatal clinic attendees in the Western Cape compared with South Africa (1994-2006)**

![HIV Prevalence Chart](chart.png)
Youth and fertility

Literature on the fertility rate in South Africa, show researchers in general agreement to its general decline among all the major population groups in the country (HSRC, 2003). The 1996 and 2001 census data as well as the 1998 Demographic and Health Survey show a declining fertility rate for South Africa since the 1960s (Moultrie and Timæus, 2003). The latter authors as well as the HSRC report on Fertility (2003) place this marked fertility transition as among the most advanced in Sub-Saharan Africa. More recent data confirm this slowdown in fertility with a total number of 1,199,712 births registered for the year 2006-2007 by the Department of Home Affairs. This represents a decline of 10% in registered births (1 346 119) for the same period in 2005-2006. Although part of this figure could be attributed to late registrations, it is accepted that the data do confirm a continuing slowdown in fertility rates (Statistics South Africa, 2007:8).

However, in spite of this general decline in fertility, teenage pregnancies are still a major concern for Government, communities and researchers. According to Ehlers (2003:17) approximately 17,000 babies are born to mothers younger than 16 years of age in South Africa annually. Statistics provided by the South African Human Rights Commission show that teenage pregnancies account for approximately one third of all births in South Africa (2007:7). Earlier statistics provided by the South African Demographic

\[70\] A teenage/adolescent mother is any mother age 19 or younger at the time of the birth of her baby, irrespective of the pregnancy outcome or her marital status (Ehlers, 2003:15)
Health Survey (1998) found that 35% of all teenagers had been pregnant or had a child by the age of 19 (HSRC, 2003; Jewkes et al, 2001).

For the Western Cape data for 2008 show that approximately 2,000 schoolgirls fell pregnant within that academic year (Cape Argus, 26 June 2009:14). In 2006/7, 9% of births in the Western Cape were to mothers under the age of 18, compared to 7% in 2009/10. The figures are generally similar for the various districts though in 2009/10 the Cape Metro had the lowest rate (7%) and the Cape Winelands the highest (9%) (Zhiel, 2001). According to the Youth Risk Survey (2008) nearly 10% of interviewees in the Western Cape had a child of his/her own.

<table>
<thead>
<tr>
<th>District Municipality</th>
<th>2006/07 %</th>
<th>2007/08 %</th>
<th>2008/09 %</th>
<th>2009/10 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Winelands</td>
<td>10.2</td>
<td>9.6</td>
<td>9.8</td>
<td>9.2</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>9.6</td>
<td>9.8</td>
<td>9.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Cape Metro</td>
<td>8.2</td>
<td>7.8</td>
<td>7.2</td>
<td>6.6</td>
</tr>
<tr>
<td>Eden</td>
<td>9.3</td>
<td>9.2</td>
<td>8.9</td>
<td>8.4</td>
</tr>
<tr>
<td>Overberg</td>
<td>8.4</td>
<td>9.2</td>
<td>7.7</td>
<td>8.3</td>
</tr>
<tr>
<td>West Coast</td>
<td>12.2</td>
<td>9.2</td>
<td>10.3</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Total: Western Cape</strong></td>
<td><strong>8.8</strong></td>
<td><strong>8.3</strong></td>
<td><strong>7.9</strong></td>
<td><strong>7.3</strong></td>
</tr>
</tbody>
</table>

Source: Department Social Development Western Cape, 2010 in Ziehl, 2011

**Youth and substance abuse**

“Alcohol and drug abuse has reached crisis proportions in the Cape metropole with devastating effects on the lives of thousands of Capetonians.” These are the opening words of the Executive Deputy Major or Cllr. Grant Haskin on the City of Cape Town’s alcohol and drug webpage71. According to the Youth at Risk Survey (2008) youth in the Western Cape showed significantly higher levels of binge drinking with 41% of learners indicating to have engaged in binge drinking the month prior to the survey compared to the National average of 28.5%. In the Western Cape alcohol is the most frequently abused substance

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with 25% of males and 6% of females shown as consuming alcohol in a hazardous or harmful manner (Shishana et al, 2005 in Haker et al, 2008).

Although not specifically referring to youth problem drinking, destructive drinking among women in the Western Cape is very high. A household survey by Shishana et al (2005) found the Western Cape registering the second highest prevalence of hazardous or harmful drinking during pregnancy. This is evident in the high rates of Foetal Alcohol Spectrum Disorder (FASD) in the province, reportedly as one of the highest in the world (in Haker et al, 2008).

In addition to alcohol use learners in the Western Cape also exceed the national average in several areas of substance abuse risk behaviour, when measuring usage in the past month for dagga use, lifetime (ever) use of Mandrax and club drugs (males only). In addition, a greater proportion of young persons in the province started drinking before the age of 13 years as compared to other provinces. In a review of treatment demand data collected via the SACENDU project from over 20 treatment centres in Cape Town since 1996 the data indicates the following (Haker et al, 2008):

- A dramatic increase in treatment demand for drugs such as dagga, Mandrax, cocaine and heroin a primary drugs of abuse over time (each increasing by 8 percentage points)
- A sudden increase in the number of patients having methamphetamine (Tik) as a primary or secondary drug of abuse since the second half of 2003 (from 121 patients to 376 in the first half of 2004), with over half of the methamphetamine patients being under 20 years of age.
- Drug use also show major demographic shifts in pattern of use, including:
  - An increase in the proportion of patients under 20 years of age, from 5% in 1996 to 25% in the 1st half of 2004,
  - An increase in the proportion of heroin and Ecstasy patients who are Coloured.
- In increase in poly-drug use, with 10% of patients in treatment in Cape Town in the 2nd half of 2003 reporting four or more substances abuse.

More statistics on drug abuse within the province adds in the dismal picture already presented:

- 98% of persons in South Africa seeking help for tik addiction come from the Western Cape.

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72 These statistics were quoted by the Western Cape Premiers’ Department in a document released during the introduction of a comprehensive plan to beat substance abuse (13 May 2010).
• According to police statistics almost half of all South Africa’s drug related crime in 2008/09 occurred in the Western Cape (52 000 out of 117 000)
• According to a 2004 survey, more people from the Western Cape reporting using drugs than any other province

Other for the cataclysmic effects of drug and alcohol abuse on the individual and his/her family associated risks to substance abuse include an increase in TB, HIV and AIDS, Hepatitis B (HBV) and Hepatitis C (HCV) risk and infection. It is also well known that the associated affects of substance abuse include higher incidence of risky sexual behaviour, criminality and violent behaviour73.

Youth in conflict with the law
In a presentation to a forum titled South African Youth: Reducing vulnerability and supporting youth development in June 2009, Andy Dawes presented the following statistics relevant at that time related to youth in conflict with the law.

• 36% of all non-natural deaths occur in the 15-29 year old group
• 20% of people in relationships experience partner violence – a significant proportion of them are young and poor
• 36% of the prison population is under 26 years of age
• 53% of those awaiting trial is under 26 years of age
• 69% of those detained by the police are between 18 and 35 years of age.

In her report to the Department of Social Development Zhiel (2011) shows the proportion of sentenced and unsentenced juveniles (18-21 years) in the Western Cape for the period 2007-2010 [table 9.4]. According to these statistics there were 26,222 juveniles detained by the Western Cape correctional service compared to 33,961 for 2009. Young people get entangled in a web of crime and prisons hardly provide an environment conducive to rehabilitation in learning behaviour that is marked by responsible citizenship. On the contrary prisons have been shown as the ideal environment for falling deeper into the criminal world specifically via the routes of gangs.

Table 9.4: Juveniles (18-21) in Custody in Western Cape, 2007-2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>Unsentenced</th>
<th>Sentenced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>18,729</td>
<td>16,880</td>
<td>35,609</td>
</tr>
<tr>
<td>2008</td>
<td>19,084</td>
<td>16,458</td>
<td>35,542</td>
</tr>
<tr>
<td>2009</td>
<td>17,429</td>
<td>16,532</td>
<td>33,961</td>
</tr>
<tr>
<td>2010</td>
<td>13,178</td>
<td>13,044</td>
<td>26,62</td>
</tr>
</tbody>
</table>

Source: Department Correctional Services, 2010 in Department Social Development Western Cape, 2011:35

Youth and the gang culture in the Western Cape

Gangs in South Africa are no new phenomenon with its genesis in the late 1880’s on the Witwatersrand with the discovery of gold. Initially gangs were established inside prisons but eventually grew beyond these boundaries. The forced removals orchestrated by the South African Government in the mid 1960’s created a context within which street gangs rapidly grew in townships such as Sophiatown and District Six (Kinnes, date unknown). According to a report by IRIN Global it is estimated that there are tens of thousands of gang members in Cape Town, where the rites of passage often include ritual killings and rape (27 February, 2007)74

According to Kinnes the rising of gangs is a reaction to unequal social relations of power that restrict legitimate opportunities to marginalised groups. They emerge as interest groups in a community that are formed around very specific goals. These gangs flourish in areas where the collective expression of society is dependent on exclusion of poorer groups of people from the dominant social relations of production. The author goes further attributing the rise of gang membership among youth to the democratization of the state in 1994 explaining that the political transformation came with an unconscious restriction of economic opportunities including the growth of the illegitimate opportunity structure that rewards deviant behaviour and encourages young people to drift into a life of crime. Although gangs are found in all urban centres in South African it is in the cities of Cape Town and Johannesburg were the problem is most acute (Kinnes, date unknown).

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74 IRIN Global provides humanitarian news and analysis and is a service of the UN office for the coordination of Humanitarian affairs (www.irinnews.org)
Important to note on the gang culture in Cape Town (or anywhere in the country) for the sake of this report is probably not the structure nor intrinsic inner workings of a gang, but rather to consider why young people in masses join these “institutions”, and thus enter the world of criminal activity. According to Prof Brian Robertson, former head of Cape Town University’s Department of Psychiatry and Mental Health, the path to gang life is not preordained by for many adolescents rather stem for a variety of mental issues, coupled with an impoverished upbringing and dysfunctional families (IRIN, 2007).

"What seemed to be happening was that these youngsters committed murder or rape in response to wanting to join a gang, or because they came from a background of abuse or neglect. Almost all of these people came from families where violence was an everyday phenomenon. The conclusion I came to was: the youngsters were not committing serious crimes because of some sort of abnormal criminal streak, but because of the circumstances they were brought up in" (IRIN, 2007)

While conducting research in juvenile detention centres, Robertson and his team also conducted psychological tests and found the majority of those evaluated to have some degree of cognitive impairment due to childhood abuse and neglect. This manifested itself in an inability to think and reason properly. His research further recorded psychiatric disorders ranging from depression and post-traumatic stress, to attention-deficit disorders and hyperactivity (IRIN, 2007).

"This has huge implications for their criminality, as the kids would often misinterpret people's intentions. Their family experiences dictated that they were mentally wired to react in a certain way: they always expected trouble and never stopped to consider the consequences of their actions," (IRIN, 2007)

A summary of trends and needs identified

- The data clearly shows the great risk of being poor and vulnerability to an impoverished lifestyle for youth in the Western Cape. This vulnerability lies on two levels, i.e. 1) as a member of the household dependant on an adult household head that is unemployed or has low income and 2) as the household head that is unemployed and thus not able to support the rest of the household members.
• A stronger and more concerted drive is required to support and motivate youth to first complete their educational careers. Thereafter there is a great demand for financial, educational and personal support in enabling out of school youth to engage in some form of post-school skills/ educational training.

• Given the large unemployment rate in the country there seems to be a great need in providing strategic support to youth by means of information sharing with regards to employment opportunities and specifically entrepreneurial possibilities and skills.

• With regards to youth and health the data strongly suggests strategic approaches that are preventative in nature. A strong focus is necessary on information sharing with the ultimate objective being behaviour modification, specifically with regards to sexual activity and substance abuse.

• Given the staggering statistics with regards to substance abuse among the youth in the Western Cape it would seem that a renewed focus on rehabilitation and support of individuals with addictions is warranted.

• The vulnerability of youth to criminal activity and gang culture emanating from a variety of mental issues, coupled with an impoverished upbringing and dysfunctional families.

9.5 The Provincial Response (DSD)

In the ten year strategy document published by the Western Cape Department of Social Development the strategy to support youth is described as a multi-dimensional approach focussing on different aspects of the individual, including skills development, emotional and behavioural growth, interpersonal relationships and relationship with the community. The aim of the programme is described as empowering youth in poor communities to become resilient and self-reliant. This is to be achieved by means of programmes that focus on skills development and community service, volunteerism and accountability equipping youth to become responsible citizens. The Department summarises its vision for the outcome of its Youth Development programme for 2017 as enabling youth through skills development, behaviour modification and recreation (DSD, Western Cape, 2009).
The services rendered by the Department can be broadly categorised in three categories:

- Skills Development and facilitating access to employment/employment opportunities by means of initiatives such as the following:
  - Training sessions
  - Skills development
  - Youth day skills Expo with the purpose to expose young people to entrepreneurial opportunities as well as career opportunities within the provincial government
  - Assisting youth to enter employment opportunities by means of private and parastatal partnerships

- Personal development by means of programs such as:
  - Life skills training
  - President’s Award for Youth Empowerment Programme
  - The alignment of the Ke-Moja substance abuse programme with the provincial substance abuse strategy

- Recreation
  - An example here is the management of an after school support programme for learners with a focus on sport and the performing of arts.

9.6 Considering the strategic priorities of the Department of Social Development in light of the evidence

In its vision for 2017 the Department for Social Development, Western Cape states the aim of its Youth Development Programme as “to enable youth to take responsibility for positive lifestyles and to contribute through skills development, behaviour modification, recreation and to participate in family and community activities, as well as their own mental health and emotional well-being”.

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75 Information provided by Programme Manager, DSD
76 This is a bi-annual Gold Award Ceremony at which young people in the Western Cape are recognised for their community service and leadership.
The data presented in this chapter would definitely support such an aim with both the social and demographic data showing trends that are taking the youth of specifically African and Coloured communities on a downward spiral toward destruction and social disarray. In considering the presented data it is important to note the different factors or variables that play into the life of a young person, forming and shaping that youth into the type of adult citizen he/she will be within their respective communities. Poverty, unemployment, dysfunctional families, poor education and abuse are all factors that are shown to be a stark reality for a great proportion of the youth of this province.

The vision formulised by the provincial DSD for the youth quoted above does show a recognition of the many challenges faced by this group as well as the different levels at which the impact of these factors has to be addressed. It would however seem when considering the different programmes supported and service rendered by the department that much still has to be done in developing a strategy to the implementation of this vision. It would seem that stronger focus on preventative initiatives are needed as well as services providing mental health services and support. Another group also shown as particularly vulnerable are youth caught within the criminal justice system with one of the obvious places for intervention into a troubled young person’s life is the prison system. This system not only provides a captive audience but also a structural framework in which interventions can take place.

9.7 Conclusion

Considering youth as the building blocks of a society, ensuring its continuous existence as well as being the force that determines the character of that society, the importance of investing in this group can never be overstated. Building into the lives of young people, specifically those vulnerable to poverty, dysfunctional families and communities, aspects shown as often related, is essential to ensure a healthy society that has the potential to advance economically and structurally. This seems to be the responsibility of the Department of Social Development in adhering to their vision of providing support to young people in poor communities in order to become resilient and self-reliant, thus becoming an attribute to society rather than a social welfare responsibility.
9.8 Abbreviations

AIDS    Acquired Immune Deficiency Syndrome
FASD    Foetal Alcohol Spectrum Disorder
HIV     Human Immunodeficiency Virus
HSRC    Human Sciences Research Council
IRIN    Humanitarian news and analysis service
MRC     Medical Research Council
Stats SA Statistics South Africa
TB      Tuberculosis
UNECA   United Nations Economic Commission

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Chapter 10: HIV/AIDS (Sub programme 2.8)

10.1 Introduction

Assessment of the programs related to HIV/AIDS should be informed by global, national, provincial and local trends in the prevalence and incidence of HIV/AIDS. While statistics for global, national and provincial regions are readily available and regularly published, local level statistics are difficult to come by and are often unstable. Health clinics providing antenatal services located within local areas are responsible for reporting all relevant information regarding HIV infections and people living with AIDS to their higher level authorities. Through a process of collating all statistics received from the clinics, local authority statistics are published but ward and neighbourhood statistics are not readily published.

On the assumption that local level trends follow broad provincial, national and global trends the analysis will start with the global trends working down to the local level as far as possible. Thereafter the social impacts of HIV and AIDS are highlighted. The responses to the epidemic are then outlined, first as broad strategies, and second according to strategic points following from South African case studies. An analysis follows of how the Provincial Government of the Western Cape responded through her social development programs to the disease. The paper ends with a conclusion.

10.2 Review of HIV and AIDS Trends

HIV/AIDS: the life cycle of an epidemic

The Human Immunodeficiency Virus (HIV) epidemic in South Africa is traced back to the early 1980s, when the first person was reported to have Acquired Immune Deficiency Syndrome (AIDS). At that stage the epidemic was limited largely to men who have sex with men (MSM). In 1985, following the implementation of universal blood screening, it became apparent that the epidemic had spread to haemophiliacs and recipients of blood transfusions. At this stage the HIV epidemic was of the Clade

B subtype. The 1990s saw the emergence of the Clade C virus subtype, characteristic of the most rapid increase in HIV prevalence amongst the heterosexual population in South Africa.

The first decade of the country’s new democracy, starting 1994, was a period of political redress and emphasis on addressing diseases related to poverty, which manifested with high levels of malnutrition, infant mortality rates, maternal deaths and pre-natal mortality rates, diabetes and hypertension. During this period, the country was also experiencing the dual epidemic of HIV and Tuberculosis (TB). South Africa soon became the country that had the highest number of people living with HIV/AIDS.

In South Africa, the epidemic may be described as a ‘generalized type’, which affects mainly young heterosexual adults, and disproportionately younger women. UNAIDS defines a ‘generalized HIV epidemic’ as a situation where HIV prevalence exceeds more than 1% in pregnant women, who are considered to be representative of the general population. The epidemic in South Africa qualifies as a generalized epidemic due to the high prevalence figures among the population. At the country level the epidemic is regarded as a ‘mature’ epidemic when the incidence figures are reported to be levelling out.

People become infected with HIV through one or more of five direct ways:

- Sexual intercourse – in South Africa heterosexual sexual intercourse is responsible for approximately 85% of all infections
- Mother to child transmission (MTCT) could be responsible for as high as one-third of all infections if no medical intervention is applied
- Blood transfusion is a relatively small medium of infection, estimated to happen in 1:400 000 cases
- Blood exposure is another but relatively insignificant way of becoming infected
- Intravenous drug use (IDU) can be a cause of infection especially when using equipment of previously infected persons.

Contextual factors that may promote the chances (susceptibility) to become infected include conditions of poverty; gender and gender based violence (GBV); cultural attitudes and practices; stigma, denial, exclusion and discrimination; mobility and labour migration and informal settlements.

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78 WHO sometimes uses 5% as the indicator for a generalised epidemic.
HIV infections rates have become a barometer of urbanization (more infections under urban conditions), sexual risky behaviour and networks, unemployment, social deprivation, migration, high population density, human settlement, unstable communities, and weak health and social service delivery.

In as far as race is still a proxy for poverty and poverty related characteristics, labour migration and human settlement in informal structures, cultural attitudes and practices, statistics show that in South Africa black Africans are infected at a rate of 6-7 times more than other groups. Females in the age group of 15 to 29 years are infected up to 3-4 times more than in other age cohorts. In the age group 20 to 24 the ratio of infection between women and men is 23.9%:6% (4:1), and in age group 25 to 29 it is 33.3%:12.1% (3:1).

When a person becomes infected by the HI-virus four stages of developing full blown AIDS are awaiting this person. During Stage 1, the person looks and feels well, carries on with normal daily activities and has an immune system that functions effectively. In Stage 2, minor illnesses start to develop as the first sign that the immune system is being attacked and not able to respond to defend itself sufficiently. In Stage 3 opportunistic diseases become more manifested and continuous discomfort is experienced. The person starts to take medicine such as co-trimoxazole. Stage 4 is the final stage when the immune system is not able to defend the body anymore. This is measured by a count of the CD4 cells. The person will be qualifying for antiretroviral treatment (ART) when his/her CD4 count is less than 200 cells/mm³ blood. This person is now a full blown AIDS sufferer.

A child born with HIV infection requires ART from the outset. It is estimated that 3% of children between 2 and 14 years are infected.

In terms of the *HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011* (RSA, 2007) provision is made for ART at various clinic and hospital outlets or people qualifying for such treatment and who need assistance due to financial inability. The availability ARV treatment has made it possible to approach AIDS as a chronic disease and manage it accordingly to enable an infected person to live a long and relatively healthy life.

The primary aims of the Strategic Plan (RSA, 2007) are to reduce:

- the number of new HIV infections by 50%, with a focus on young people in the age group of 15 to 24 years, as a target for 2011, and
- the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV.
The Strategic Plan (RSA, 2007) provides for four strategies in dealing with the epidemic:

1. Prevention and awareness
2. Treatment, care and support
3. Protecting human and legal rights of PLWHA
4. Research, monitoring and surveillance.

Trends in the prevalence and incidence of HIV and AIDS

Global, regional and national trends

The overall growth of the global AIDS epidemic appears to have stabilized. The annual number of new HIV infections has been steadily declining since the late 1990s and there are fewer AIDS-related deaths due to the significant scale up of ART over the past number of years. Although the number of new infections has been falling, levels of new infections are still high, and with significant reductions in mortality the number of people living with HIV worldwide has subsequently increased (UNAIDS, 2010).

The implication of these changes in the trend of HIV incidence and the longevity of AIDS sufferers is that the need for health and social care, in the form of ART and home based care (HBC), has become even bigger and more pro-longed. More people need care and over a longer period of time.

According to the UNAIDS report (2010) on the global AIDS epidemic, in 2009 alone, an estimated 2.6 million people became newly infected with HIV. This is nearly one fifth (19%) less than the 3.1 million people newly infected in 1999, and more than one fifth (21%) less than the estimated 3.2 million in 1997, the year annual new infections peaked.

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79 The prevalence rate is the percentage of a group who are infected at a particular point in time. The incidence rate is the percentage of people who are uninfected at the beginning of a 12 month period who will become infected over the following 12 months. It is a better measure of where we are in the epidemic than prevalence, in that prevalence is an index of past cumulative incidence less past mortality.

80 Figures and observations in this section are collected from UNAIDS (2010; Chapter 2).
In 33 countries, the incidence of HIV has fallen by more than 25% between 2001 and 2009; 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million people became infected in 2009; considerably lower than the estimated 2.2 million people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics.

UNAIDS estimates that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999—a 27% increase. Although the annual number of new HIV infections has been steadily declining since the late 1990s, this decrease is offset by the reduction in AIDS-related deaths due to the significant scale up of antiretroviral therapy over the past few years.

The estimated number of children globally living with HIV increased to 2.5 million in 2009. The proportion of women living with HIV has remained stable, at slightly less than 52% of the global total.

With an estimated 5.6 million people living with HIV in 2009, South Africa’s epidemic remains the largest in the world. New indications suggest a slowing down of the HIV incidence rate amid some signs of a shift towards safer sex practices among young people. The annual HIV incidence among 18-year olds declined sharply from 1.8% in 2005 to 0.8% in 2008, and among women between 15 and 24 years old it dropped from 5.5% in 2003–2005 to 2.2% in 2005–2008.

Important observations noted by the UNAIDS report (2010) emphasize the following strategic points:

- Young people are increasingly practicing safer sex and sexual behaviour changed in most countries, including South Africa.
- As access to services for preventing the MTC of HIV has increased, the total number of children being born with HIV has decreased.
- The number of annual AIDS-related deaths worldwide is steadily decreasing. The decline reflects the increased availability of ART, as well as care and support to people living with HIV, particularly in middle- and low-income countries.
- The impact of ART is especially evident in sub-Saharan Africa, where an estimated 320,000 (or 20%) fewer people died of AIDS-related causes in 2009 than in 2004, when ART began to be dramatically expanded.
• Sub-Saharan Africa still bears an inordinate share of the global HIV burden. Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009, that number reached 22.5 million, 68% of the global total. Sub-Saharan Africa has more women than men living with HIV.

• The largest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe—have either stabilized or are showing signs of declining. The estimated 1.3 million people who died of HIV related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million deaths attributable to the epidemic.

• South Africa is one of the few countries in the world where child and maternal mortality has risen since the 1990s. AIDS is the largest cause of maternal mortality in South Africa and also accounts for 35% of deaths in children younger than five years.

• For ART to be effective it needs to be started timely. Most people receiving ART in sub-Saharan Africa start treatment late that limits the overall impact of HIV treatment programs.

• The infrastructure, systems, and staff required to properly monitor treatment retention and loss are becoming increasingly inadequate as programmes are scaled up.

• The vast majority of people newly infected with HIV in sub-Saharan Africa are infected during unprotected heterosexual intercourse (including paid sex) and onward transmission of HIV to newborns and breastfed babies.

• Increasing evidence indicates that unprotected paid sex, sex between men, and the use of contaminated drug-injecting equipment by two or more people on the same occasion are significant causative factors in the HIV epidemics of several (including African) countries with generalized epidemics.

**Trends in South Africa and Western Cape**

Statistics that describe HIV trends for South Africa and her provinces have been collated from official sources in the latest *South African Survey, 2010/2011* compiled by the South African Institute of Race Relations (SAIRR, 2011). A selection of relevant statistics is summarized below for the Western Cape compared to South African data.

From Figure 1 the following may be noted:

• Incidence rates for Western Cape are substantially lower than for the country.
• Both series of incidence rates are increasing over the period.

• In relative terms the Western Cape’s incidence rate grew much faster than the country’s rate over the period (1992-2009) as well as over the last ten years (1999-2009). For the total period HIV incidence grew in Western Cape 56 times while it grew in the country 13 times; over the last ten years Western Cape’s incidence multiplied by 2.4 times and the country’s by 1.3 times.

Many factors can explain these trends (such as more efficient service delivery in the Western Cape at clinic level causing more women to pass through the health care system) but it also points to the fact that the HIV epidemic still has scope to grow. The epidemic may also be fed by the high rate of in-migration of vulnerable members of population creating higher susceptibility to become infected as statistics on race and gender will show.

**Figure 1: HIV infection rates of women attending public antenatal clinics, 1992 to 2009**

<table>
<thead>
<tr>
<th>Year</th>
<th>WC</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>0.3</td>
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</tr>
<tr>
<td>1993</td>
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<tr>
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</tr>
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</tr>
<tr>
<td>2008</td>
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<td>29.3</td>
</tr>
<tr>
<td>2009</td>
<td>16.1</td>
<td>29.4</td>
</tr>
</tbody>
</table>

**Sources**: SAIRR, 2011:561. Data were extracted from Department of Health, 2008; 2010. South African Medical Journal, 200881&82.

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81 Note a: The antenatal survey may not be fully representative as only 80% of pregnant women attend public antenatal clinics, 85% of them African.

82 Note b: The figure dated 2007b above is sourced from the report entitled *Re-estimated provincial HIV antenatal survey prevalence for 2007 and a reinterpretation of the national trend* (South African Medical Journal, 2008). The report’s authors argue that the reductions in HIV prevalence shown by the Department of Health’s official report are due to methodological changes in the 2008 report. The authors have re-estimated the prevalence rates in the report, which when corrected for changes in methodology show a slight increase in HIV prevalence overall, as opposed to the decrease shown by the official figures.
Prevalence rates (Figure 2) of both entities (SA and WC) show the same trend although the magnitude of the two lines differs significantly with Western Cape the lower of the two. There is a hint that the rate for Western Cape will stabilize over the next fifteen years. Again, note that the prevalence rate in the case of Western Cape multiplied over the period 2000 to 2011 by 2.4 times while the country’s figure increased 1.7 times.

Table 1 shows statistics of HIV prevalence that indicate the vulnerable groups for becoming infected and living with HIV. These are national figures valid for 2008.

Table 1: HIV prevalence rates in South Africa according to different variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
<th>Prevalence rate (%) (2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
<td>7.9</td>
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<td>Age</td>
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</tr>
<tr>
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<td>25+</td>
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<td></td>
</tr>
<tr>
<td>Race</td>
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<td></td>
</tr>
<tr>
<td>Black African</td>
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</tr>
<tr>
<td>Coloured</td>
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<tr>
<td>Indian</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Province</td>
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<td></td>
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<td>KwaZulu-Natal</td>
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<td></td>
</tr>
<tr>
<td>Free State</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>9.0</td>
<td></td>
</tr>
<tr>
<td>Limpopo</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Western Cape</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>10.9</td>
<td></td>
</tr>
</tbody>
</table>

Vulnerable groups are females, young adults, Black Africans, and citizens from the provinces of KwaZulu-Natal (KZN), Mpumalanga and Free State; these provinces have historically been the most affected by HIV and AIDS. Of the three (known as the highest infected provinces) KZN shows decreases in the HIV rates, but Mpumalanga and Free State are still increasing. Among the middle group, North West is still increasing but Gauteng and Eastern Cape are decreasing. Of the three provinces with lowest rates, Western Cape is occupying the lowest prevalence among all the provinces. However, all three in this group – Limpopo, North Cape and Western Cape - are still showing an increase in their respective HIV infection rates.

Other vulnerable groups include people with disabilities, people incarcerated, MSM, commercial sex workers (CSW), mobile and casual workers, refugees, and people practicing injection of drugs. From Figure 3 it can be noted that in Western Cape the proportion of deaths classified as AIDS deaths is expected to stabilize over the next fifteen years. For the country this is expected to increase. Figure 4 emphasizes a stark difference between Western Cape and the rest of the country. The country’s accumulated death number is growing steeply while Western Cape’s growth is moderate. This may be a function of more effective treatment and care for AIDS sufferers in the Western Cape specifically and a higher human development status in this province generally.

**Figure 3: AIDS deaths as proportion of total deaths, 2000 to 2025**

<table>
<thead>
<tr>
<th>Year</th>
<th>SA</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>23.8</td>
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</tr>
<tr>
<td>2005</td>
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<td>2010</td>
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<td>2011</td>
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<tr>
<td>2015</td>
<td>32.8</td>
<td>17.0</td>
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<tr>
<td>2020</td>
<td>34.3</td>
<td>18.0</td>
</tr>
<tr>
<td>2025</td>
<td>35.5</td>
<td>17.7</td>
</tr>
</tbody>
</table>

**Sources:** SAIRR, 2011:58 &62. ASSA, 2011.
Increase in life expectancy (see Figure 5) is, however, to be expected earlier for the country and somewhat later for Western Cape, perhaps due to the expectation that the epidemic still has to mature in Western Cape. This may point to the urgent need to sustain interventionist programs regarding HIV infections over the next decade and more.
Local and district level trends

Western Cape apparently is the only province publishing district level figures on prevalence of HIV infection among the population through executing HIV antenatal surveys. However, this information is not published in full on the internet and has become difficult to access. The following figure (6) was published by the National Strategic Plan (RSA, 2007, 29) showing HIV infections according to the HIV antenatal survey of 2005 in the Western Cape.

Figure 6: HIV infection by area in City of Cape Town, Western Cape and South Africa 2005

![Graph showing HIV infection rates by area.](attachment:image)

The yellow bars represent metropolitan (health) districts of the City of Cape Town (CCT) compared with Western Cape and South Africa. It shows clearly high infection rates in Khayelitsha – higher than the national average – and relatively high rates for other districts such as Klipfontein, Northern, Southern, and Tygerberg districts, all being districts hosting poor and black African populations. The low rate in Mitchell’s Plain is interesting as this is a poor district yet dominated by coloured people, manifesting a lower infection rate than the more wealthy and white dominated areas of the Eastern and Western districts. This figure suggests that contextual factors such as mentioned above are indeed playing a determining role in the HIV infection rates.

The data in Table 2 are 10+ years old (valid for 2000 to 2002) and illustrate the same point. It also provides a baseline for comparison and shows the volatility of the forces behind HIV infection.
Determining changes over two (and in some cases three) years are also possible, which enables one to see the dynamics of the situation.

Looking at the figures presented in Table 2 three types of trends may be distinguished based on the rates for 2001 and 2002:

1. Districts that manifest high increase in the average level of prevalence plus high increase in the diversity of the district population composition (as indicated by the confidence interval (CI)).

   Blaauwberg, Cape Town Central, Mitchell’s Plain, Gugulethu / Nyanga, Oostenberg, Tygerberg Eastern, Tygerberg Western, Vredendal, Klein Karoo,

2. Districts that manifest moderate changes and relative stable diversity situations. Two sub types can be distinguished:
   a. Changes that occur from a high base level in the average of prevalence
      Khayelitsha, Paarl, Knysna / Plettenberg Bay,
   b. Changes that occur from a relatively low base level in the average of prevalence
      Greater Athlone, Bredasdorp / Swellendam, Ceres / Tulbagh, Malmesbury, Stellenbosch, Central Karoo

3. Districts that manifest a stable (or even decrease in the) rate in both the average and diversity percentages
   Helderberg, South Peninsula, Caledon / Hermanus, Worcester / Robertson, Vredenburg, Mossel Bay / Langeberg, George
### Table 2: HIV prevalence by districts of Western Cape, 2000 to 2002

<table>
<thead>
<tr>
<th>Region</th>
<th>District</th>
<th>HIV Prevalence Rate</th>
<th>Pilot 95% CI</th>
<th>Survey 95% CI</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
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<td>CCT</td>
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<td></td>
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<tr>
<td></td>
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<td>8.2</td>
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<td>Cape Town Central</td>
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<td>12.2</td>
<td>1.0</td>
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</tbody>
</table>

Source: PGWC, 2003

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83 CCT: City of Cape Town  
84 CI: Confidence Interval  
85 Pilot and Survey figures are percentages, calculated as averages. The CI shows the average deviance on a 95% interval of confidence and should be interpreted as the upper and lower limits of the range above and below the average of where the majority of the cases fall. Add to and subtract from average the CI value to find this range of confidence. While the average (mean) is a indicator of concentration, the CI indicates dispersion (and therefore diversity in the sample).
The figures for 2000 are based on the pilot study for the antenatal survey that followed and are generally fairly low. In all cases except Mitchell’s Plain they represent the lowest averages in the series of three figures (for 2000, 2001 and 2002) where the subsequent figures are indicating increases in the level of infection rate. Mitchell’s Plain is an anomaly as the 2000 figure starts out as 5.4%, then drops to 0.7% in 2001 and increases to 4.0% in 2002. Note how the CI changes also.

It is suggested that high increases in the CI are caused by a dramatic change in the composition of the district’s population due to in-migration, and in certain cases a re-demarcation of the district boundaries to administratively include different population sections.

The municipal districts for the CCT changed recently and it is difficult to compare figures over time and between health and municipal districts.

The situation regarding HIV/AIDS in the Western Cape has not stabilized as yet particularly when looking at the district level where volatility in the figures is observed. The need for particular services and interventions is indicated by projections by the Western Cape Department of Health (2007) and reported in various documents, such as the Annual Report for 2009. For instance,

- The HIV prevalence\(^{85}\) in the 15-24 year age group was 11.9% in 2006 and 21.1% in the 25 to 29 age group.
- Women in the age group 25 to 29 years have the highest HIV prevalence with an increase from 12.4% in 2002 to 18.3% in 2006.
- In 2006, the HIV prevalence rate of pregnant women attending public health antenatal clinics in the Western Cape was 15.1%. However, prevalence rates at a sub-provincial level show significant variation.

With respect to numbers,

- An estimated 267 289 persons in the Western Cape are infected with HIV.
- 36 000 youth aged 15 to 24 are HIV positive.
- The majority of people infected with HIV in the province (153,792) are women between the ages of 25 to 29 years.

• Projections\(^{86}\) indicate that the number of HIV infected children in the province will increase from 11,453 in 2006 to 17,499 by 2011 while the number of children orphaned by AIDS will increase from 29,830 in 2006 to 68,043 in 2011.

### 10.3 Social Impact of HIV/AIDS

Due to demographic changes that follow the HIV epidemic “family life cannot be taken for granted in a time of HIV/AIDS” (DSD, 2003: 14). The decline in the middle-aged adult population is directly due to AIDS deaths while the decline in the child population is due to rising infant mortality rates and to fewer births, the latter as a result of adult deaths and declining fertility caused by HIV infection. The rising number of orphans is a direct consequence of these trends. The (National) Department of Social Development (DSD, 2003) observes:

> Millions of children are rendered parentless, often homeless, disinherited of social, economic and political rights and possibilities (p. 14); and

> The burden of care is pushed upwards, particularly onto grandmothers; outwards, particularly onto female kin; and downwards, to children themselves (p. 14).

Countries that have been hit hard by HIV/AIDS have seen mortality surge and life expectancy drop in the last two or more decades (Ashford, 2006). These countries, many from sub-Saharan Africa, were previous characterized by high population growth rates that are now slowing down. This is a disconcerting trend: people are living shorter and are experiencing a far worse quality of life while alive\(^{87}\). The demographic and social effects of AIDS include increased mortality rates and lower life expectancies, dramatic changes in age and sex structures, loss of main care-givers in the household with resultant child - headed households and finally, enormous accelerated demands on the health care systems. Business and agriculture are affected and economic stability is compromised. These and other effects urgently call for comprehensive multi layered responses, globally, state, community, corporate and company as well as personal and family levels.


\(^{87}\) South Africa experienced these consequences but it is expected that recovery will (and indeed is) taking place as figures above are showing.
Among the demographic and health effects the following are most pertinent:

- Population growth in countries hit hardest by the epidemic, such as countries in the southern African region and with South Africa having the largest number of infected people, has slowed down or even stopped. This is due to the increase in mortality, both in child mortality and pre-mature adult mortality, particularly in the age group 12 to 49. Because women are more vulnerable than men in becoming infected with HIV, mortality is higher among females and fertility is dropping as a result. An overall effect is that life expectancy is dropping dramatically.

- AIDS ranks high as a cause of death.

- People living with HIV and AIDS are prone to develop other illnesses and infections because of their suppressed immune systems. AIDS fuelled an upsurge of pneumonia and tuberculosis in highly affected populations.

- AIDS-related deaths are altering the age structure of populations. Because HIV infections happen mostly in adolescent and young adult age groups, AIDS deaths occur frequently in the prime working-age of adults (25 to 45 years). This is a new mortality pattern, deviating from developing countries with low HIV and AIDS levels where most deaths occur among the very young and the very old.

Effects on family, society and the economy include:

- The disproportionate loss of women robs families and households of their primary care-givers and often leaves young children without a mother-parent. They are frequently send to live with relatives, or to be cared for by grandparents, or, even worse, left to fend for themselves. Some households may dissolve as a result.

- Care-giving has become as a result a priority for government and non-government institutions.

- Loss of the breadwinner of the household cause financial hardships. The loss of income and the cost of caring for a dying member can and do impoverish households.

- Health care systems experience an enormous demand and can cripple weak systems. Due to the high cost of treatment of AIDS and AIDS-related opportunistic infections, allocation of scarce resources to HIV/AIDS sometimes divert attention from other health concerns. Costs are borne by government and tax payers as well as the private sector including private households and individuals.
• Employers are hard hit by a loss of workers, often highly trained specialists, absenteeism, the rising costs of providing health-care benefits, and the payment of death benefits.

• The economic viability of small farms and commercial farms is compromised by a loss of farm workers. Growing food insecurity may follow as a result.

• Economic stability is compromised as business and agriculture suffer. A loss of gross domestic product (GDP) is already shown in severely infected regions.

• In the long-term loss of human capital and lower investment in young people could affect economic performance for some decades.

These observations point to the recognition that HIV/AIDS is not merely a health issue but equally a social challenge.

10.4 Responding to HIV/AIDS

Two broad strategies
There are two broad strategies for addressing challenges related to HIV and AIDS, namely prevention and care. As HIV continues to spread, prevention remains the key strategy for curbing the epidemic. Because sexual contact is the most common mode of HIV transmission, HIV prevention is closely linked to men’s and women’s sexual behaviour and reproductive health. Effective prevention programmes include interventions that promote abstaining from sex, delaying the onset of sexual activity, staying with one mutual faithful partner, limiting the number of sexual partners, consistently and correctly using condoms, and counselling and testing for HIV. Interventions are strengthened when they are combined. Social, economic, and cultural factors that influence people’s behaviour should also be considered.

HIV transmission from mother to child is also a key area for prevention, and involves the need to provide HIV positive women with the capacity to make contraceptive choices and to avoid unintended pregnancies. In addition, anti-retroviral drug therapy needs to be applied during delivery and to newborns of HIV infected mothers.

A second strategy flows from the fact that people living with AIDS are now living longer due to ART. The implication is that more AIDS sufferers are now in need of care over a protracted period and that the health care systems are not fully capacitated to provide such care institutionally. Therefore home and
community based care, in conjunction with the health system, has become an option for many. Care is therefore an important challenge for government and communities and often requires effective community mobilization of resources, civil society and individuals to become partners with government in providing effective responses to AIDS.

In the final analysis, effective responses to the challenges of HIV and AIDS require improvement of health infrastructure and capacity to deliver services, the reduction of severe poverty, illiteracy and other social, economic, and political factors that increase people’s vulnerability to HIV infection, and reduction of the stigma and discrimination against those living with HIV. All these responses are best located at local level environments and would improve sustainable human development.

South African case studies and lessons learnt

During 2002 to 2007 the National DSD invited case studies on local responses to HIV and AIDS and produced a number truisms, lessons learnt and recommendations. These are listed below for consideration (DSD, 2002-2007).

1. Evaluation research on HIV and AIDS programs needs to be conducted to determine what constitutes best practice models and sustainability.

2. Experience has shown that an accelerated focus on specific target at risk groups such as youth, the military, prisoners, immigrants and refugees seems to deliver best results.

3. Participation in projects can be strengthened by involving more community structures, such as the church, sport, youth and women’s groups. Religious structures, i.e. churches, synagogues and mosques in particular should be involved more strongly as they can reach more people among poor communities.

4. Capacity building programs should target communities that have a high HIV prevalence rate.

5. Strengthen primary health care. PHC clinics generally need more staff and infrastructure, and should be expanded to offer the widest range of maintenance, management and support services possible. PHC clinics should take responsibility for long-term ART-management. The range of other services that can be offered by clinics should be supported with capacity, including VCT, PMTCT, ART and TB management. Social workers in clinics are a tested and highly satisfactory arrangement, and should be widely replicated.
6. Strengthen civil society organizations. CSOs offering home and community based care need more official recognition and support, (including financial), as well as organisational capacity building, career paths and qualification routes for carers, equipment and material support as a basic condition of service, and stipends that are commensurate with responsibility. Technical training in support of a career path development should be incorporated into the widest possible expansion of the services offered by the CSOs.

7. The efficiency of care visits should be optimized, relieving pressure on these services from both clients and the facilities providing them. Options may include collecting and dispensing medication from pharmacies, monitoring blood pressure, drawing blood and administering injections. A great many other services for chronic conditions are also possible in a home environment.

8. Strengthen integration. Research has pointed to a need for Inter-sectoral HIV and AIDS Committees at municipal level comprising the departments of Health, Social Development and Education and all local municipalities, within a District Municipal context. This should be instituted as a portfolio of the municipal representatives carrying the necessary authority of the Mayor’s Office. In addition, the establishment of Local and District AIDS Councils and the appointment of HIV and AIDS Coordinators in the district have become an urgent need to provide an integrated and coordinated service and campaign for the prevention of HIV and care of HIV and AIDS people.

9. To avoid confusion and duplication of energy and resources, a single strategic HIV and AIDS planning model is proposed that is managed by District AIDS Councils and is accountable to SANAC. Furthermore, support the HIV and AIDS component of the IDP, the sector plans as well as joint funding plans from the strategy and ensure alignment. Provide succinct documentary evidence to CSOs wishing to use the HIV and AIDS strategy to motivate for external funding aligned to their role.

**HIV/AIDS program of Western Cape**

The Provincial Government of Western Cape (PGWC) has identified programs for responding to the challenges of HIV/AIDS and may be regarded as a leader within the South African context. The Department of Health of PGWC is known for taking the lead with ART at a time when the national program did not provide such treatment at a broad scale. The Department of Social Development (DSD) undertakes a sub-program for HIV/AIDS within in its Social Welfare program.
Tracing the DSD’s program back to 2007 (PGWC, 2007), its aim was to develop and implement a comprehensive HIV/AIDS strategy with three objectives, namely to promote awareness among youth and instil among them positive living and a healthy teenage sexuality orientation; to support home and community based care (HCBC) programs; and to increase service delivery for orphans and vulnerable children (OVC). Eighty-two (82) HIV/AIDS organisations within the Western Cape were supported financially of which 56 were said to be emerging organisations.

Moulded within the framework of the Integrated Service Delivery Model (ISDM) (RSA, n.d.) the aim of the HIV/AIDS sub-program was reformulated as follows: to design and implement integrated community based care programs and services aimed at mitigating the social and economic impact of HIV and AIDS (PGWC, 2009).

At this stage the goal of the sub-program had been formulated as follows: To have promoted an optimal quality of life for those infected and affected by HIV / AIDS through the provision of appropriate services. These services were planned to be organized and delivered according to the ISDM framework:

- **Awareness and prevention** - Society has access to reliable, up to date information on HIV / AIDS as well as awareness on social development policies, programs and services available for people infected and affected by HIV / AIDS.
- **Early intervention** - Children and families at risk of HIV / AIDS are identified early and provided with a range of developmental and therapeutic programs and services.
- **Statutory** - All AIDS infected individuals below prescribed CD4 count levels and OVC receive adequate social assistance or statutory services.
- **Reintegration** - Aftercare and support services provided for children infected and affected with HIV / AIDS allows them to remain in their families and community whenever possible.

This framework guided the program in 2009 and 2010 but due to financial constraints the sub-program reduced its scope under a new and more restricted aim, which was formulated as follows: Facilitate psycho-social support programmes and services to infected and affected children and families (PGWC, 2011). The scope of service delivery was limited and at present only 47 NPOs (in contrast to the 82 organisation in 2007) are supported.
Despite the Concept Paper for the HIV/AIDS program (DSD, 2008) that lays out the “comprehensive HIV/AIDS strategy” (PGWC, 2007) to strive for the vision of a “society free from HIV/AIDS” the Annual Performance Plan (APP) for 2011/2012 calls for the **design** and implementation of integrated community based care programs and services aimed at mitigating the social impact of HIV and AIDS while the 2012/2013 APP states that this **sub-program responsibility by DSD has been shifted to the Department of Health** (PGWC, 2011). It seems that 2011/2012 is the last year that DSD will be hosting a sub-program for HIV/AIDS.

The changes in the extent of financial support allocated to this sub-program over the past four years reflect the rise and fall of the program.

<table>
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<td>15 306 000</td>
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<tr>
<td>2008/9</td>
<td>19 319 000</td>
<td>19 319 000</td>
<td>13 779 000</td>
<td>For HCBC in EPWP</td>
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<tr>
<td>2010/2011</td>
<td>11 296 000</td>
<td>9 116 000</td>
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**How is the program applied in the Western Cape?**

Very little information is available beyond the Annual Report on the sub-program. The current application, 2011/12, is described by the program management as follows:

The purpose of the program is said to facilitate psycho-social support programmes and services to infected and affected children and families. The target group is defined as infected and affected children and adults (adults including caregivers who are not biological parents of the children). The types of projects run under the auspices of the program are five-fold:

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88 Information in this section was provided by the program management from Social Welfare, DSD, PGWC.
• Psycho-social support to orphaned and vulnerable children in the form of therapeutic support groups and provision of school uniform. The support groups help the children to cope better with issues of loss and grief

• Adult support groups for infected and affected individuals

• Provision of food support to: (1) families whose caregivers are awaiting social grants as a result of being unable to work due to being tested positive and having very low CD4 counts; (2) caregivers who are awaiting either child support or foster care grants for children whose dependents have been affected by HIV and AIDS

• Provision of succession planning workshops aimed at educating the parents realise the importance of drawing up wills in order to protect their children’s inheritance

• Behaviour modification through prevention and awareness.

No information is available regarding the number of projects and the spatial distribution of these projects in the province. The estimated number of people reached within this program according to projects is as follows:

• Psychosocial Support Group (PSSG): 1 640 OVC

• Adult Support Groups: 1 788 persons

• Food support: 455 families

Factors that are taken into account to determine the output include the need (measured by prevalence of HIV and AIDS), availability of service as provided by service providers, availability of funds, and service providing ratio’s (e.g. 10 children per group, 15 adults per support group).

DSD funds 42 organisations and supports them in the form of capacity building. One of the 42 organisations is a training provider that empowers organisations to conduct support groups to deal with loss and grief as well as coaching and mentoring. It
10.5 Conclusion

HIV/AIDS is a multi-dimensional challenge to the quality of life of individuals, families, communities and the nation. It represents one of the most serious threats to sustainable human development. Its impacts are wide and devastating. To address HIV/AIDS challenges a multi-disciplinary and sectoral approach is needed. It may seem to be a health issue only; however, this is patently clear to be false - it has profound demographic, economic and social – cultural ramifications that demands responses from social, cultural, educational and economic sectors. The apparent closing down of the sub-program HIV/AIDS within DSD will therefore be a short-sighted decision and a move that can only be justified under conditions of shortage of funds.

The analysis in this overview and review has shown that HIV prevalence is quite low on average in Western Cape but that it is far from a stabilized epidemic and that increases in incidence of new infections and the prevalence figure should be expected in the next decade. The high influx of new migrants, although declining, is partly fuelling the epidemic.

In view of these observations continued attention to HIV/AIDS from the non-health perspective remains imperative and urgent. Programs that proof to be effective in HIV/AIDS prevention and care are typically multi-disciplinary and sectoral. It would be prudent of the PGWC to continue in providing the necessary resources to persist with this manifold approach to arrest and attack the impacts of this scourge.
10.6 Abbreviations / Acronyms

AIDS Acquired Immune Deficiency Syndrome
ART Anti-retroviral treatment
ARV Anti-retroviral
CCT City Of Cape Town
CI Confidence interval
CSO Civil society organization
CSW Commercial sex worker
DSD Department of Social Development (National or Western Cape)
GBV Gender based violence
HBC Home based care(r)
HCBC Home and community based care
HIV Human Immunodeficiency Virus
HSRC Human Sciences Research Council
IDU Intravenous drug use
ISDM Integrated service delivery model
KZN KwaZulu-Natal
MSM Men having sex with men
MTCT Mother to child transmission
OVC Orphaned and vulnerable children
10.7 Bibliography


Chapter 11 Summary

In concluding the report this chapter provides first a summary presented as per chapter. Secondly, and finally the chapter concludes with a final prognosis given the specific socio-economic face of the province as it emanated from the statistics presented in the respective chapters.

Chapter 1 provides a brief account of the socio-economic trends of the Western Cape Province placed within the broader South African context. Coming from an era of oppression and deliberate adverse treatment of citizens based on the perceived colour of their skin the country has shown some remarkable advances and achievements. The legacy of racist policies and practices still remains especially for those from the lowest rung of the socio-economic ladder among whom poverty manifests as a trap reinforced by inadequate education, gender discrimination and geographic marginalisation that reflect in lack of sufficient income, access to opportunities and assets. This ambivalence in historical emergence expresses itself in the phenomenon of two economies in one country – one formal and the other informal where the latter often does not succeed to provide in the bare essentials of life.

Although it is true that many people have joined the middle strata and beyond inequality seems to be increasing. Low economic activity and a lack of a spirit of entrepreneurship seem to be present, particularly among African and coloured communities, especially in rural areas. Massive migration to areas with higher economic potential confirms the artificiality of the apartheid economic geography, and puts high on the agenda the issue of spatial planning.

Mortality statistics is shown as pointing to issues concerning social conditions and lifestyles and the critical need for the improvement of awareness of health issues generally and of the health infrastructure. Knowing that most crime takes place in underdeveloped areas among the poor, there is a clear need to develop an in-depth understanding of the role of social conditions in causing crime. These include poverty, the built-environment, and choice to forms of recreation and so on.

Changes in the social networks of individuals down to the family level are also shown as a national trend with an increase in single or extended households. This may be an expected result of a dynamic society but it also presents serious challenges of household subsistence in poor areas and the social upbringing of the young.
In giving a diagnostic overview of the country and despite the numerous advances and developments that can be highlighted in the post-apartheid period, nine primary challenges remain that are linked to two basic truths about South Africa today, namely (1) too few South Africans are employed, and (2) poor educational outcomes prevail. The challenges are:

- Too few South Africans are employed
- The quality of education for poor black South Africans is substandard
- Poorly located and inadequate infrastructure limits social inclusion and faster economic growth
- South Africa’s growth path is highly resource-intensive and hence unsustainable
- Spatial challenges continue to marginalise the poor
- The ailing public health system confronts a massive disease burden
- The performance of the public service is uneven
- Corruption undermines state legitimacy and service delivery
- South Africa remains a divided society.

These challenges have been found to be challenges for Western Cape as well.

Chapter 2 gives an account of the social trends related to substance abuse in the Western Cape. Drawing from a number of research studies Western Cape is shown to face a great challenge in the prevention of substance abuse, as well as treatment and rehabilitation of those that have developed a substance abuse problem. Statistics on substance abuse show the prevalence and incidence figures for the use and misuse of alcohol, marijuana (dagga), Mandrax and Methamphetamine\(^8^9\) as extraordinarily high in the Western Cape. The use and abuse of these substances are shown as particularly high in vulnerable areas characterised by dense and overcrowded housing conditions, low educational levels, high unemployment and subsequent chronic poverty.

Chapter 3 speak to socio-economic characteristics of the elderly within the province, including all persons older than 60 years of age. South Africa is one of the most rapidly ageing populations in Africa with particular increase in the 64-70 year category. Data picture Western Cape as the province with the third largest proportion of elderly in its population (8.6%) trailed by Eastern and Northern Cape (9.6% and 9% respectively). Although the elderly in Western Cape is relatively well off with regards to service

\(^8^9\) Popularly known as tik.
delivery and the provision of basic services, as is the case across the country, the data clearly show a
large part of this group as having to carry a heavy burden in social and economic responsibilities most
often in caring for their children and extended household members.

The chapter shows the effect of key demographic trends, such as the large population share of school-
going youth, very high unemployment rates among young people and the devastating impact of the
HIV/AIDS epidemic on younger age cohorts, as placing the elderly and the social old-age pension at the
centre of the livelihood strategies of many poor households. The old age grant is shown to play a vital
role in the poverty alleviation of other household members than the recipient, a fact strongly
conditioned by whether or not the pensioner is female.

The chapter also shows the need for the expansion of residential solutions to the elderly. Two groups of
elderly are highlighted: 1) elderly that are in need of institutionalised and specialised care as they can no
longer care for themselves physically and mentally, and 2) elderly that were part of the lower and
middle income group during their economic active years but since retirement no longer economically
independent and self-sufficient due to their inability to provide financially to maintain their previous
standard of living. Their social and economic profile is marked by them used to be living as a nuclear
family and their inability to provide for sustaining a middle class residential life pattern.

In presenting data specifically aimed at the sub-programme for Crime Prevention and Support, Chapter
4 provides a description of the crime rates in the Western Cape Province together with a discussion on
the social aspects believed to result in or add to criminal behaviour or tendencies of communities
and/or individuals. Labeled as the country’s most crime ridden province at the beginning of the
millennium, the Western Cape have been registering the highest or near highest provincial per capita
rates of recorded murder for a number of years, attempted murder, common assault, residential
burglary, theft out of motor vehicle and general theft, and the second highest rates of rape, serious
assault and commercial crime. The province is also shown as persistently registering above average rates
of so-called social crimes associated with violence, that is crimes that can have (a lasting) impact on the
physical and /or mental health of the victims and perpetrators.

Recent figures released by the South African Police Forces for the period 2010/2011 for the Western
Cape show the province to have the highest murder rate in the country, 42 per 1000, compared to the
national average of 34. In addition, the Western Cape shows a massive increase in attempted murders,
i.e. 30% compared to the national average registering a decrease of 12%. This is a disconcerting trend that reflects an underlying malaise in the communities of this province.

This chapter specifically refers to the involvement of the Western Cape youth in crime – both as perpetrator and as victim. This group is particularly vulnerable to the gang activities with gangsterism reaching and endemic state in this province involving all youth – school dropouts, those in school as well as those that have completed school. Crime plays an important role in the underperformance of both schools and learners, with high percentages of learners mentioning the presence and impact of crime in their household, their community and in their classroom, or on the school property, on their ability to concentrate on their school work. This is especially the case at schools situated in the most impoverished human settlements on the Cape Flats.

**Chapter 5** presents a profile of disabled persons in the province. Disability is defined as the disadvantage and exclusion which arise as an outcome of the interactions between people who have impairments and the social and environmental barriers they face due to the failure of society to take account of their rights and needs.

There seems to be an agreement among commentators that the mainstreaming of disability is one of the four key components of what can be described as a comprehensive response to disability. The other is described as the strengthening of the voice of disabled people, supporting basic services to include disabled people, and strengthening disability services to meet the specific needs of individuals with impairments that prevent them from participating.

This chapter shows the still largely invisible nature of disability as a societal issue with it being mostly ignored in the wider development agenda as defined in the international Millennium Development Goals (MDGs). The big challenge is to get disability recognised as a development goal. Disability is not sufficiently catered for whether or not defined as impairment or as a social issue. As a result, most multilateral and bilateral donors, who tend to focus on the MDGs, do not consider disability as a development priority.

Conclusions on the profile of the disabled population of the Western Cape should be qualified due to the lack of recent research in the Western Cape. Available information confirms at least 244 000 disabled persons in the Western Cape, representing 5% of the total population for the province. The two most prevalent disabilities across all groups are challenges with respect to sight and hearing. Only 2% of the
disabled population is between 0-9 years old while there is a steady increase among those aged less than 40 years and a rapid increase thereafter. In comparison to other population groups a proportionally larger concentration of disabilities manifests in the Black African group in the under-20 age groups while a larger concentration is found among Whites in the age groups from 40 years and older.

In considering the services that are rendered to people with disabilities the chapter shows the delivery of services as primarily guided by the Integrated National Disability Strategy and the Mental Health Act, as well as international conventions. The services include prevention, rehabilitation and continuing care services. It would seem that because of the mechanisms used to inform service types, the services rendered are found to be not necessarily spread in accordance with the profile of disability but rather to follow policy guidelines and the priorities to include the most vulnerable and those who cannot cope without help from the public sector.

The chapter concludes pointing out that despite initiatives of individual disabled people and access to services offered by other state departments and NGOs, and by the private sector, the question remains unanswered about the possible gaps and inadequacies in provision. The aspects that need further research include both the dimensions of impairment and the extent to which social and environmental discrimination and the issue of rights acts as a barrier to the full and equal participation of disabled persons in mainstream society. The limitations and challenges of mainstreaming in the workplace also need attention.

Chapter 6 provides a brief account of the state of child care and protection services in the Western Cape Province. According to the 2007 Community Survey, the Western Cape is home to 1,77,841 children under the age of 18 years. This translates to approximately 34% of the total Western Cape population as being younger than 18 years. The majority (54%) of the province’s children is classified as part of the Coloured population group, 33% as Black, 11% White and 1% as Indian/Asian. The greater majority (58%) of children is indicated to live with both their biological parents, although a rather large proportion (32%) is indicated to live with their biological mothers only.

Aspects specifically relevant when discussing child care and protection include child mortality and child maltreatment which include neglect and abuse. With regards to all these aspects the statistics presented for the Western Cape Province are rather worrying. For example, an increase is shown in both infant and under-five mortality. The impact of poverty on the well-being of children is also very clear...
when one considers that more than half of deaths of young children in the province are attributed to diseases resulting from underdevelopment and poverty.

The picture is not less daunting when considering data on child maltreatment and abuse. Child neglect is stated as the main reason for the statutory removal of children in five magisterial districts in the province. The sexual abuse of children also seems to be in an upward trend, with data from Childline indicating the Western Cape Province as having the highest proportion in the country of all calls relating to sexual abuse.

An overview of services indicates that a variety of services and programmes are available to secure the wellbeing of children in the Western Cape. Service programmes follow a three-pronged approach including Prevention services, Treatment intervention programmes and Continuous treatment.

In Chapter 7 an overview of victims of crime is presented within the context of the Victim Empowerment Programme (VEP) managed by DSD. The aim of the VEP is defined as to lessen the long term impact of crime by proactively tending to the needs of all victims. The empowerment of victims is approached by facilitating access to a range of services for all people who have individually or collectively suffered harm, trauma and/or material loss through violence, crime, natural disaster, human action and/or through socio economic conditions.

The great dilemma for the VEP discussed in this chapter is the lack in statistics on victims of crime, more specifically violent crime victims, including sexual assault victims. This is a result of not only the manner and/or format in which data is captured, but also of changing definitions of crime and criminal acts.

Here again as in chapter 4 (on crime) the Western Cape is pictured as a province with exceptionally high rates of crimes related to drugs and violence. Western Cape had the fourth highest number of murders in the country in 2010. The relationship between violent crime, specifically murder, and high drug related crime is noted, particularly with the use of alcohol involved.

The chapter notes some general concerns and aspects for further consideration including:

- Reassessment of the definition of a victim according to the mandate of DSD
- Broadening the services to victims of crime support to include male and youth victims and possibly also youth perpetrators
- The factors that play into crime such as substance abuse and the social nature of many crimes need further investigation.
The central point in this chapter is probably the need for the re-assessment of who/what a victim is. Realising that the social repercussions of crime reaches further than the immediate individual or even family of the victim, there seems to be an urgent need for a re-evaluation of the programme and its defined target group. In the case of murder, gang wars and drug related crimes whole communities are victims.

**Chapter 8** speak to aspects related to the care and support of families within the Western Cape Province. Within the department of Social Development, this sub-programme aims to promote self-reliant and resilient families in which respect the Integrated Service Delivery Model is applied to achieve the anticipated objectives. This approach makes provision for inter-sectoral collaboration and inter-departmental co-operation with other spheres of government and community structures. There seems however to be a lack of structures in place to execute/implement this comprehensive approach envisaged by the department.

A situation analysis of families in the Western Cape reveals a disturbing picture of issues such as unemployment, substance abuse, housing shortages and changing family patterns. Statistics on families and households in the Western Cape also reveals a constant in-migration of families to the province with the hope to find suitable employment. This trend continues despite high levels of unemployment manifesting in the province. This trend is not adequately catered for in terms of human resources and budgetary provision.

The chapter closes with the observation that despite the development philosophy professed by the department, service programmes to families pursue mainly a traditional social work approach. In addition, the service programmes to families show a lot of overlapping with care and support services provided to children, an aspect that needs re-consideration and strategising.

In **chapter 9** the case of youth within the province is presented. The chapter describes youth as individuals that are between the ages of 14 to 24 years. Comprising approximately 10% of the total population in the Western Cape, the majority (51%) consists of Coloureds, followed by Black Africans (34%) and Whites (14%) according to the 2007 Community Survey.

The data presented to give an account of the socio-economic context of the youth in this province clearly show the great vulnerability of this group to poverty and an impoverished lifestyle. This vulnerability is said to result from two types of household conditions, i.e. 1) *a youth being a member of a household where he/she is dependent on an adult household head that is unemployed or has low...*
income, and 2) a youth being a household head that is unemployed and thus not able to support the rest of the household members.

Given the high school drop-out rate of young people, specifically after the age of 15 years, the chapter strongly argues for a concerted drive to support and motivate youth to complete their educational careers. The great demand for financial, educational and personal support that will enable out-of-school youth to engage in some form of post-school skills/educational training is also shown. Adding to this, and taking note of the high unemployment rate of young persons in the country and this province, a need is expressed to provide these youths with some form of strategic support by means of information sharing with regards to employment opportunities and specifically entrepreneurial possibilities and skills.

With regards to youth and health the data strongly suggests strategic approaches that are preventative in nature. A strong focus is necessary on information sharing with the ultimate objective being behaviour modification, specifically with regards to sexual activity and substance abuse.

Finally, the chapter discusses the vulnerability and susceptibility of youth to criminal activity and gang culture emanating from a variety of mental issues. This together with the high incidence of drug and substance abuse and risky behaviour are clear indications that concerted, strategic and multi-faceted efforts are needed to address the plight of youth and thus to invest in the social and economic welfare of this province.

**In Closing: A Diagnostic Prognosis of the Province**

The aim of this Social and Demographic Trends Analysis was to provide a baseline of social and demographic information for the Western Cape Province with the primary objective of providing the department with data that will aid in the future development of programme objectives and directives. Data was organised in accordance with the programme structure of the DSD and trends as relevant for the different sub-programmes presented in individual chapters.

When trying to typify the Western Cape the best description would probably be a province characterised by great ambiguities with regards to its socio-demographic qualities. According to Stats SA (2010) the Western Cape has been – consistently for the past 15 years - the third largest contributor to
South Africa’s total GDP and has shown the highest economic growth rate of all provinces\textsuperscript{90}. In his budget speech 1 March, 2012, Alan Winde, the minister of finance for the Western Cape, stated that the province’s economy has continuously outperforming the national economy which is forecasted to grow at 3.5\% in 2012 and 4\% in 2013 \citep{Minister_of_Finance_Budget_speech_2012}. Together with the lowest unemployment rate in the country this province also prides itself in its achievements on educational level with the provinces secondary schools achieving the highest matric pass rates in 2011 at 82.9\%\textsuperscript{91}. The province is shown as the most highly educated province in the country, with a very skilled workforce in comparison to any other African region and a large proportion of adults with a degree or higher. In addition the province also boasts five internationally acclaimed universities, namely the University of Cape Town, Stellenbosch University, the University of the Western Cape, Cape Peninsula University of Technology and a campus of Nelson Mandela Metropolitan University (NMMU).

In the context of all this performance and praise it seems ironic that this province also seems to pride itself outperforming other provinces in incidence rates of alcohol and drug abuse, violent crime, crimes against women and children and school dropout rates to name a few. In chapter 2 the Western Cape is shown as the province with the highest prevalence rate of risky drinking (16\%) compared to less than 10\% for the majority of provinces in South Africa. It is also shown as having the highest reported rate for Foetal Alcohol Syndrome in the world with the rural farming communities specifically at risk \citep{2011_Bulletin_of_the_World_Health_Organization}.

The abuse of drugs in the Western Cape has reached crisis proportions over the last few years, with the statistics showing that the age of young people abusing substances to become younger and younger. Persons under the age of 20 in treatment for methamphetamine\textsuperscript{92}-related problems increased from 4\% in 2003 to 57\% in the first half of 2007 with more youths under the age of 19 using methamphetamine than adults.

With regards to crime, official statistics describe the Western Cape as the country’s most crime-ridden province at the beginning of the new millennium, exhibiting the highest or near highest provincial per

\textsuperscript{90} In 2009 the GDP of the Western Cape was 14.0\% compared to that the 33.9\% of Gauteng and 16.1\% for KZN. The average growth rate (at 2005 prices) was 4.3\% in 2009 compared to the 4\% of Gauteng. \citep{Stat_SA_Gross_Domestic_Product_Regional_Estimates_2000-2009_Statistical_Release_P0441}.

\textsuperscript{91} \url{http://www.news24.com/SouthAfrica/News/Western-Cape-has-best-matric-pass-rate-20120104}

\textsuperscript{92} Popularly known as tik.
capita rates of recorded murder, attempted murder, common assault, residential burglary, theft out of motor vehicle and general theft, and the second highest rates of rape, serious assault and commercial crime. In addition, in many crime categories, crime is growing fastest in this province. It is disconcerting that province persists to register above average rates of so-called social crimes associated with violence, i.e. crimes that can have (a lasting) impact on the physical and/or mental health of the victims and perpetrators.

Another paradox is found in the province’s educational attainment where the great achievement in secondary school graduation must be viewed together with the large school drop-out figure for the province’s secondary school learners. In 2008, 62 524 learners from Western Cape public ordinary schools between Grades 8 and 12 dropped out. School dropout rates show a dramatic increase once learners reach the age of 15, when schooling is no longer compulsory. According to a report by AfriMAP and the Open Society Foundation (2007) 48% of learners in the Western Cape leave school before the completion of grade 12. These statistics add a whole new perspective to the educational performance and achievement of mostly young people in this province.

A last aspect that is discussed in this report within different chapters and that needs specific mention here is statistics presented on HIV/AIDS in the province. Although the HIV epidemic has been described as a less mature epidemic in comparison to other provinces it is growing fast and has high levels of prevalence in specific local areas. The regional diversity in the pattern of prevalence clearly has an important consideration for resource allocation and programme delivery at district level.

The Western Cape is vastly different from other provinces in South Africa. It shows contrasts not only reflecting internal duality but also sharp differences with the rest of the country. It is important to consider what factors contribute to this situation and specifically to the so-called negative face of the province. Amidst the sound and positive growth of the province’s economy one observes social pathology and economic deprivation and marginalisation. Recognising that social issues do not present themselves in isolation the first and most important realisation should arguably be the overlapping nature of the negative issues discussed in this report evident from the often equally overlapping themes presented in the respective chapters. Viewed in this way, the social ails emanate as a systemic reaction or response to a reality experienced by that community, often pictured as social and economic exclusion and deprivation. Under such conditions poverty becomes a symptom of the social relations and

93 Western Cape Draft Strategic Plan, 2010.
structural conditions of society that obstruct economic development and growth to reverse destructive and negative social behaviour driven by fatalistic and conspicuous consumption values. Due to its exceptional demography, racial generalistion and stereotyping reinforce perceptions of inequality to a level of self-fulfilling prophesy. This situation creates immense challenges for policy and programme formulation and implementation for public institutions such as government.

Structural arguments as above are hollow unless social reality is fed by personal choice and action. The personal element finds substance in the individual’s definition of self and how the self is played out in everyday life and in choices that are made for survival and coping or in reactive behaviour that displays risk and short-term indulgence. Measuring interventions that seek to address these learned coping mechanisms and reactive behaviour is not that simple although not at all impossible as is also shown in the first chapter of this report.

It is clear from the strategic approach accepted by the DSD that the department realises this multi-faceted nature of poverty and it seeks to address the ensuing issues in a integrated manner and as strategic as possible as paraphrased in the Integrated Service Delivery Model (ISDM)\textsuperscript{94}. This model is a multi-pronged approach aimed at addressing the social welfare and development needs of target groups in a holistic and integrated manner. Working towards sustainable solutions the primary aim of the ISDM is to contribute to poverty reduction, protection of older persons, woman and children, persons with physical disabilities, youth development and social cohesion. Sustainability in this context refers to durability of outcome as a result of developmental inputs into healthy and self-reliant functioning of personal and social systems, such as individuals, families, communities and organizations. It would seem that it is in the measuring of the durability of the outcomes of programmes that a gap exists. This gap is two-fold; first, a need exists for the actual assessment of intervention and delivery programmes, and second, for developing indicators that go beyond the measuring of input and output variables to include outcome and impact variables. These challenges touch upon the need for looking anew at the department’s approach of monitoring and evaluation of its sub-programmes.

In chapter 1 the report discusses in much detail an approach known as project or programme theory, as a method to identify relevant output and outcome indicators that has the strength to assist the department in measuring the durability of the outcomes of its programmes, identify gaps and adapt

\textsuperscript{94} Republic of South Africa. N.d. (c2006). Integrated Service Delivery Model. Department of Social Development.
accordingly. The standardisation of future trend analysis will require that the primary aim for the assessment of trends should be assisting DSD to know, anticipate and measure the outcomes of the services rendered by the department and its partners such as the NPOs it funds. While this report may be regarded as a first step towards such an outcome, a second phase would be the development of such indicators for each sub-programme considering the respective objectives, target populations and daily operatives of the different stakeholders. The report suggests a procedure for this second phase.

11.1 Bibliography


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