

THE ROUTLEDGE INTERNATIONAL HANDBOOK OF CHILDREN'S RIGHTS AND DISABILITY

*Edited by Angharad E. Beckett
and Anne-Marie Callus*

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THE CARE DEPENDENCY GRANT IN SOUTH AFRICA

Challenges on the Road
to Inclusive Rights

Zara Trafford

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Introduction

Children living in poverty who are also disabled are one of the ‘most marginalised and underserved population groups worldwide’ (United Nations Children’s Fund 2021, p. 126). Disability does not necessarily entail vulnerability (Philpott and McKenzie 2017). However, the compounding effects of multidimensional poverty mean that disabled children living in poverty are more likely to be socially excluded and have worse access to key services for their health and well-being than non-disabled peers (Banks et al. 2017; Ullmann et al. 2021). Globally, there is evidence that government social protection interventions can help economically or socially marginalised people to provide for some of their needs (Walsham et al. 2019). State-sponsored cash transfers are generally initiated for poverty alleviation or to support disabled or elderly people (Schneider et al. 2011; Kuper et al. 2020). In low- and middle-income countries (LMICs), where public services are often under-resourced and rates of systemic poverty are high, social protection schemes targeted at disabled people along their life course are especially important (Banks et al. 2017; Kuper et al. 2020).

Various multilateral organisations and international guideline committees have embedded social protection programming into their mandates for the protection of the human rights of disabled children, in an attempt to set an inclusive and progressive global agenda (Ullmann et al. 2021). Direct (unconditional or conditional) cash transfer schemes are the most common example of state-funded social assistance in the Global South, where achieving deeper structural change is usually a long and arduous process (Hanlon et al. 2010; Leisering 2020). Cash transfers are partly based on the rationale that, if recipients are able to provide for their basic needs, their wider social, economic, and political rights are more likely to be realised. However, the evidence is mixed on whether these programmes help people provide for themselves and their families more comprehensively (Fragoso 2021).

This chapter presents a discussion of whether in one LMIC, the disabled child's right to social protection is protected by two key global human rights treaties: the United Nations (UN) Convention on the Rights of the Child (1989) (CRC) and the UN Convention on the Rights of Persons with Disabilities (2006) (CRPD). After providing some background on relevant aspects of the CRC and CRPD, I evaluate the extent to which the CRPD and CRC have been translated into local policy in South Africa (SA). I use an unconditional cash transfer, the care dependency grant (CDG), and its surrounding legislative environment as illustrative examples. As the CDG is the government's primary mechanism for the social assistance of disabled children, it is a useful case for discussing whether the country is delivering on its commitments to these children and their families. Finally, I reflect on the importance of coherent planning and thoughtful, intersectoral implementation of disability policy, concluding with applicable insights for countries with similar socioeconomic contexts.

The Right to Social Protection for the Disabled Child as Enshrined in the CRC and CRPD

The CRC and CRPD were designed to uphold the rights of children and disabled people, respectively. Historically, the human rights of these overlapping population groups were deprioritised by most societies, resulting in disempowerment and decreased autonomy for the disabled child (Ekberg et al. 2022). In an attempt to correct this pattern, both the CRC and the CRPD affirm the disabled child's right to social protection and an adequate standard of living. Both Conventions also assert that an understanding of the distinctiveness of childhood, as a specific life stage, ought to be incorporated into any provisions that are made for the disabled child's care, safety, inclusion, and legal protection.

Social Protection and Disability in the Convention on the Rights of the Child

In countries that are signatory to the CRC, disabled children are legally entitled to the services and resources that they need to live safe, healthy, and fulfilled lives. Articles 26 and 27 reassert *all* children's right to benefit from social security, especially in cases where economic disparities make some especially vulnerable. State-sponsored social protection programmes are highly recommended, and the CRC specifically notes that the social security available to children must account for their individual circumstances and the resources available for their care. The right to early childhood development and care, high-quality education, and appropriate health and rehabilitative services for all children is also declared. Article 23 instructs that the disabled child ought to 'enjoy a full and decent life' in circumstances that promote the child's dignity, self-reliance, and participation. By dedicating Article 23 exclusively to the rights of the disabled child, however, the CRC contrasts with the inclusive approach apparent in the CRPD. It *is* important to highlight challenges that might only be

faced by disabled children, but singling them out and assigning them their own, separate section may have unintended consequences. When providing for the children in their societies, policy- and decision-makers should instead be encouraged to consider disabled children an integral part of the diverse child population rather than a discrete group.

Social Protection and Childhood in the Convention on the Rights of Persons With Disabilities

Various articles in the CRPD focus specifically on the right to social protection and an adequate standard of living for disabled children. Article 7 is a broad statement of the disabled child's entitlement to 'all human rights and fundamental freedoms on an equal basis with other children'. As part of a broad conception of social protection, Article 28 mandates that disabled children (and adults) ought to have reliable access to assistive devices, assistance from the state for disability-related costs, including counselling and respite care, and clean water, public housing, and financial support throughout the life course (Ullmann et al. 2021). And finally, Articles 16, 23, 24, 25, and 26 list additional rights intrinsically held by the disabled child: the right to protection from abuse and discrimination, to live with their own family, to all stages of education, to healthcare and rehabilitation, and to play and sporting activities.

The CRPD is a resounding call for its signatory countries to ensure that the rights of disabled children are properly understood and protected. It instructs that states parties should play a central role in securing these rights and that financial and other resources be deployed to this end, even in low-resource environments (UN Committee on the Rights of Persons with Disabilities 2018). However, the CRPD's vision is a far cry from contemporary reality. In a recent opinion piece, Jan Grue (2021), a physically disabled academic living in Norway, referred to the CRPD as 'utopian' because it describes a world in which all forms of disability-related discrimination are eliminated. Nordic countries are considered global leaders in the achievement of human rights and strong social security systems, but even from the perspective of a tenured professor living in Norway, the CRPD's goals seem unattainable. In SA and in many other Global South LMICs, where the right to basic services is not guaranteed for the vast majority of children, the CRPD's vision for disabled children (a minority population) feels, at best, unlikely and, at worst, quixotic.

A Focus on South Africa

The following case study reflects on the implementation of a social assistance programme for disabled children in SA by drawing on evidence from secondary literature and empirical data from an ongoing qualitative study (see Trafford and Swartz 2021 for full details). Although the focus is on one country, reflections from SA can provide insight into the situation of poor disabled children in other LMICs. The wider applicability of these research findings is discussed later in the chapter. At the time of writing, individual in-depth interviews had been conducted from July

2020 to November 2021. Participants included officials from a national government department and its social security agency, activists and academics, doctors who conduct disability assessments, primary caregivers of disabled children, social workers, and civil society organisation staff. There was racial and gender diversity in the group. Of 29 participants, 4 were disabled adults and 2 were mothers of disabled children.

Although prevalence and disability-disaggregated data are insufficient, literature and the existing evidence indicate that disabled children in SA have far lower access to educational and health services, play and socialisation, and societal inclusion than their non-disabled peers (Saloojee et al. 2007; Shung-King et al. 2019; Khan et al. 2020). Evidently, their rights have not yet been realised, despite the country's progressive commitments. This case study illustrates that follow through on commitments to important human rights treaties—such as the CRC and CRPD, ratified by SA in 1995 and 2007, respectively—cannot be achieved without coherent and properly resourced implementation, monitoring, and quantitative and qualitative evaluation.

The Context for Disabled Children and the Role of the Care Dependency Grant in South Africa

In SA, access to adequate educational and health services can be extremely expensive, even for the small percentage of the population that can afford services in the well-resourced private sector. Children living in poverty generally rely heavily or solely on services that are fully or partially government-funded (McKenzie and Chataika 2017; Shung-King et al. 2019; Visagie et al. 2020). Primary care services are technically available for free or at a very low cost, but structural factors can become rigid or impenetrable barriers to access (see public transport example in the following). For disabled children, this situation is further complicated by a lack of adequately trained rehabilitation professionals and access to assistive technology (AT). Some AT is state-subsidised, but waiting lists may be many years long and the devices eventually obtained are often old, broken, or inappropriate for the person's context, age, or disability (Trafford et al. 2021). Disabled children are also less likely than their non-disabled peers to access education at all stages, from early childhood development to tertiary education (Elphick et al. 2015; Khan et al. 2020). In the few educational spaces available to them, the disabled child's right to protection from violence and abuse is not secured. In an investigation of special schools in SA's North-West province, the South African Human Rights Commission reported on the death of three learners in a fire in a deaf learners' residential hostel and injury to 23 others who were hurt jumping out of windows to flee the fire (SAHRC 2018). Widespread risk of physical and sexual abuse, inaccessible toilets, inadequate security measures in high-crime areas, and unreliable access to electricity and water were also documented (SAHRC 2018, p. 48). Patterns of exclusion and insufficient access are thus particularly profoundly felt by children living in poverty who are also disabled (Philpott and Muthukrishna 2019).

The aforementioned examples depict a situation in which social protection in its broader terms (i.e. access to necessary services and an adequate standard of living,

proper care, protection, and social participation) is systematically deprioritised and under-developed for disabled children in SA. The government's most direct means for the social assistance of disabled children is the CDG, one of a range of cash transfers (known locally as 'grants') available in the public non-contributory programme that is considered 'the backbone' of the social protection system (Fall and Steenkamp 2020, p. 10). Around 18 million grants are now paid to 11.4 million beneficiaries in a population of 59 million people (SASSA 2021). To apply for the CDG, the primary caregiver of a child with disability must undergo a means test, and their child's disability must be assessed by a doctor. The nature of and arrangements associated with these assessments vary nationally but all take the form of a (medical) evaluation of the severity of the child's impairment and their capacity to perform age-appropriate daily tasks. If the grant is approved, it is distributed monthly to the applicant (caregiver), until their child turns 18. The CDG was set at 1,890 ZAR (122 USD) per month at the time of writing. In a context where a range of additional supports provided by numerous sectors in government ought to be—but often are not—available to realise these children's right to an adequate standard of living, the CDG seems to function as a 'catch-all' approach to the social protection of disabled children living in poverty (Trafford and Swartz 2021). The following discussion elaborates on the claim that, to date, SA's relatively comprehensive and progressive policies for the social assistance of disabled children have been hindered by severe pitfalls in implementation.

Legislation That Disables Instead of Enabling

Multi-nation commitments such as the Sustainable Development Goals (United Nations 2015) serve as statements of shared aims and suggested guidelines for countries across the world. In contrast, the CRC and CRPD are legally binding international human rights treaties. Signatory countries *must* thus ensure that their targets and ideals are embedded in national legislation ('domesticated') and that progress is independently monitored (Adams 2020). The CRPD instructs the full domestication of its principles as quickly as possible and mandates that attendant budgets, timelines, and monitoring processes be mobilised, even if they are costly (SALRC 2020). The *White Paper on the Rights of Persons with Disabilities* was published in 2015 to try to rationalise disability policy in SA, but by the end of 2020, the South African Law Reform Commission reported that, '(the why and the how) will need to be fleshed out . . . to ascertain how the CRPD can be domesticated' (SALRC 2020, p. 198). In other words, domestication had not yet happened. Other local legislation and international agreements align with and undergird the aims of the CRPD and CRC, including the African Charter on the Rights and Welfare of the Child, the South African Constitution, the Children's Act, and the Social Assistance Act. However, even for a professional researcher, it is difficult to identify all relevant disability policies to clarify which are currently in use and to determine the links between them.

In SA, instructions for the delivery, implementation, staffing and monitoring, and evaluation of social programmes are often too ambitious, too vague, or non-existent, and this is especially true with regard to legislation to protect and serve disabled

children. The vast majority of relevant policies have not yet been translated into formal mandates with accountability mechanisms, nor have they been enabled by proper resourcing and training (SAHRC 2018). For example, the Department of Women was expanded into the Department of Women, Youth, and Persons with Disabilities (DWYPD) in 2019, but no additional funding, human resource, or training provisions were made to facilitate their now much larger target population (South African National Assembly 2020). In its 2015/2016–2019/2020 strategic plan, the Department of Basic Education reiterated SA’s intention to improve inclusive education provisions nationally but did not facilitate this with ‘action plans, targets or budgetary allocations’ (The Right to Education for Children with Disabilities Alliance 2016, p. 4). Disability is supposed to be handled as an intersectoral, multi-department government responsibility, but this can make it difficult to institute strong accountability systems or determine which government structure holds the responsibility for ensuring policies are properly implemented. SA’s system of cooperative (devolved) governance further complicates the situation. Each of the country’s nine provinces, and even its many municipalities, may have their own hyperlocal policies. Due to historic patterns of ‘separate development’ (geographical segregation on the basis of race), different areas often have profoundly different resources and capacity for implementation. Once high-level government commitments and plans are made, they must therefore also be associated with enabling budgets, accountability arrangements, and proper monitoring (United Nations 2007).

The CDG Assessment—A Long Way to Go to CRPD Compliance

In recent interviews, respondents within and outside of government both identified the Department of Social Development (DSD) as the default department for disability-related service delivery and support from the state. The DSD is responsible for designing and updating the Social Assistance Act (Act 13 of 2004, South African Parliament), the legislation that governs state-funded social protection. The South African Social Security Agency (SASSA) is the DSD’s implementation agent. SASSA administers and manages all grant applications in the country, including disability-related grants. SASSA officials interface with clients (i.e. the general public), doctors, social workers, hospital management, government officials from multiple departments, and others in the process of grant administration. SASSA designs its own processes and forms internally, and specific arrangements vary somewhat across provinces. These guidelines are formulated by managers and administrators and tend to focus on daily procedures and injunctions against fraud. In contrast, there is a noticeable lack of any guidance regarding disability.

According to the Social Assistance Act, the CDG assessment is supposed to evaluate the child’s need for ‘permanent care and/or support services’ on the basis of their impairment(s) (South African Parliament 2004, p. 10). Despite some variation, the assessment process adopts a medical model of disability across the country. There is a focus on grading the impairment level of the applicant with little or no emphasis on

consideration of the child's day-to-day life or access to necessary resources. Children, especially, tend to be assessed for the *severity* of their impairment rather than the child's particular context and the specific manifestation of their disability. Currently, only medical doctors are permitted to conduct assessments, although local researchers, activists, and clinicians suggest that allied health workers are usually better trained to identify and assess disability in context.

Attempts to standardise and bring disability grants assessments in line with the broader conception of disability represented in the CRPD have so far stalled or failed (Kelly 2016). According to interview respondents who had been personally involved in these processes, these failures were because of a lack of resources, insufficient infrastructure for service delivery, and interdepartmental tensions. Using a social relational model of disability, the CRPD describes disabling barriers as the outcome of the interactions between an individual with impairment(s) and their (social, economic, attitudinal, and political) environment, rather than disability being the result of decontextualised individual pathology (United Nations 2007). The medicalised CDG assessment process currently contravenes the CRPD. Assessments are also inconsistent with the CRC recommendation that each child be considered individually and that social security provisions be tailored to the resources available to the child for their care (United Nations 1989).

As the CDG represents such a significant proportion of the state support available to disabled children in SA, it is especially important that the grant's assessment process is well-aligned with the CRC and CRPD. Choices about changes to the public non-contributory system must be made wisely and cautiously, as this enormous programme is funded by the tiny segment of the population that pays tax. Grants are under constant public scrutiny. However, these are not optional provisions—they are a matter of human rights. Additional resource allocation will also be crucial for progress, and as the government has noted, the CDG ought to sit within a 'basket of [complementary] services' (DPME 2021, p. 82). These improvements will require more and better collaboration between various government departments taking the lead on interventions (such as the DSD and the Department of Health), but these departments must be appropriately supported by all spheres of government in order to enhance impact (Philpott and Muthukrishna 2019).

Social Assistance for Disabled Children and Their Families—Not Enough and Too Hard to Get To

At the end of September 2021, there were 148,295 beneficiaries in receipt of the CDG, which accounts for 0.8% of the grants distributed nationally (SASSA 2021). In SA, the two most commonly used childhood disability prevalence estimates are considered under- and over-estimates in turn. There is also a poor understanding of the diverse spectrum of childhood disability, and the 2011 census, the most commonly referenced estimate, did not gather data for the under-5 population (Philpott and McKenzie 2017). This lack of comprehensive prevalence data makes it difficult to assess the scale of exclusion errors or unmet need. However, there is sufficient

evidence and consensus among local researchers and civil society representatives that the rate of access to the CDG is too low (Kidd et al. 2018). The presidency's *Medium-Term Strategic Framework 2019–2024* echoes this concern, noting that '[c]hildren with disabilities are . . . struggling to access the care dependency grant, largely due to the highly stringent application and medical assessment processes' (DPME 2020, p. 120). By the time an updated 2021 version of this report was published, disabled children were no longer highlighted as a specific interest group (DPME 2021). Although Covid-19 has interrupted and delayed strategic planning, this is emblematic of the aforementioned deprioritisation of disabled children in SA, who, if anything, are likely to need *more* support following the pandemic.

Qualitative evidence from my primary research highlighted various difficulties in gaining access to the grant, some of which were detailed in a prior article (Trafford and Swartz 2021). Government officials and civil society representatives pointed to high rates of unregistered births locally as a significant barrier to access, a problem also reported elsewhere as a barrier to various forms of government and other support (Hoag 2010). Respondents with clinical expertise reported that due to delays in establishing and strengthening systems for identification and linkage to health and rehabilitative care, children are not initiated onto the CDG at an early-enough age to facilitate optimal impact and development. This pattern of late access was reflected in statistics from November 2021 (see Table 9.1), which show that far fewer children in the 0-to-4-year-old age group receive grants than those in the 5-to-17-year-old age group (SASSA 2021, p. 35). Many factors may influence this pattern, including more lenience in the past and the noted difficulties in connecting with the very young disabled population due to weak data collection (Philpott and McKenzie 2017).

The cost and difficulty of obtaining transport for multiple visits back and forth between grant offices and health facilities also serve as a potent barrier to access (Schneider et al. 2011; Fourie 2017; Pretorius and Steadman 2018). For caregivers of disabled children, travel costs are likely to be much higher than average because they are required to make more trips back and forth and may have to take their mobility-limited children with them. In our interview, a mother of a child with cerebral palsy explained how difficult it is to persuade the driver of one of SA's (ubiquitous but notoriously hurried) minibus taxis to wait while a child is moved out of or into their mobility device or onto or off their mother's back. Caregivers are often forced to use expensive private transport instead, which can rapidly deplete the little funds they may have available or significant amounts of the CDG itself, if they have managed to gain access (Letsie 2016).

Even once caregivers do manage to gain access to the CDG, there is a strong sense from primary research in this study and secondary sources (Dimhairo 2013; Letsie 2016) that the amount provided falls far short of covering the direct and indirect costs entailed by caregivers of disabled children. The CDG amount is four times higher than the poverty-alleviation child support grant (CSG) available to caregivers of non-disabled poor children, but in the context of insufficient public service provision, individuals are often forced to pay out-of-pocket for private services. Such 'catastrophic' (Liu et al. 2019) expenditure places extreme pressure on the household

Table 9.1 The number of children in receipt of the CDG according to age group (adapted from the 2021 statistical report of the South African Social Security Agency)

| Age of children | CDG |
|-----------------|----------------|
| 0 | 457 |
| 1 | 1 868 |
| 2 | 2 896 |
| 3 | 4 006 |
| 4 | 4 491 |
| 5 | 5 488 |
| 6 | 6 890 |
| 7 | 7 719 |
| 8 | 8 293 |
| 9 | 9 005 |
| 10 | 9 915 |
| 11 | 10 410 |
| 12 | 11 589 |
| 13 | 12 571 |
| 14 | 13 020 |
| 15 | 13 451 |
| 16 | 13 972 |
| 17 | 12 262 |
| Total | 148 303 |

Reference: SASSA 2021. Sixth Statistical Report (payment system period September 2021). Statistical Reports—Strategy and Business Development. [Online] [Accessed on 19 November 2021]. Available from: www.sassa.gov.za/Pages/Statistical-Reports.aspx.

and may displace fundamental needs like food, clothing, and education. In addition, as respite and disability-appropriate care services are not usually available to parents in poorer communities or rural areas, respondents in my study and in other qualitative research (Letsie 2016) indicated that the grant commonly serves as income replacement so that a parent, usually a mother, can stay at home and care for their disabled child. In families with minimal or no other income (the majority of CDG recipients), the grant is reportedly often distributed throughout the household. This is a common pattern for cash transfers in SA, where unemployment rates are so high that finding work is a daunting task, and there may be many people in the household who

need support (Francis 2020). The country's social assistance programme does not yet seem to be adequately reaching or supporting this profoundly underserved group and their families enough to have a positive and sustained impact.

Battling Stigma and Changing Attitudes

Attitude change is important, but it requires considerable political will and can be slow and challenging. Even in the relatively well-resourced United Kingdom, around 45% of schools in one study reported that they did not feel that they had enough time to encourage positive attitudes towards disabled people in their curriculum. These schools worried that making space for such adjustments would mean removing another teaching area (Beckett and Buckner 2012). This attitude is reminiscent of the peculiar implicit resistance described by a national government official during interviews for my CDG study. This research respondent, who had worked in a government social development department for many years, felt that disabled laypeople were excluded from policy planning because officials feared that if they conducted the public consultations mandated by the Constitution, they would be forced to roll out costly programmes or interventions. In various spheres of society, both in SA and internationally, there seems to be a widely held perception that there is no space or sufficient time or money for the inclusion of disabled children.

Ignorance and negative beliefs about disability contribute to disabled children's lack of access to their human rights in SA (Philpott and McKenzie 2017; Shung-King et al. 2019). Disabled children are often seen as passive, incapable, and even pitiful, rather than as autonomous rights-holders. These conceptions must be actively and urgently challenged, partly because they limit the ways that non-disabled decision-makers think about disabled people and make provision for their needs. Useful precedents were set during SA's extensive HIV/AIDS de-stigmatisation programmes, some of which were state-funded (Stangl et al. 2013; Howell et al. 2017). These efforts have not eliminated discrimination, but they have been remarkably helpful in improving acceptance and social inclusion in the country with the world's highest HIV prevalence. De-stigmatisation campaigns make a clear statement about the importance of protecting the rights of all people regardless of illness, impairment, or identity.

For negative perceptions to change, disabled children must be made more visible. The profound invisibility of disabled children was a consistent theme throughout reviews of the local secondary evidence and during in-depth interviews in SA. Even in wealthier communities, but especially in poorer ones, this invisibility can mean a literal absence from shared spaces due to inaccessible built environments or homes (Trafford et al. 2021). This invisibility may be compounded by parents keeping their disabled children home to try and protect them from ridicule or prejudice (Khan et al. 2020). Disabled children are also 'invisible' in much of the social protection literature. There is a huge body of research on both the child support grant (CSG) for the nutritional support of children living in poverty and on the adult disability grant (DG) for income support for unemployed disabled adults. Despite clear

synchronicities with both the CSG and the DG, the CDG and its beneficiaries are generally excluded from in-depth analyses of the grants programme. Only 2 masters studies take the CDG as their primary focus (Dimhairo 2013; Letsie 2016). The continued invisibility of these children in society, academic research, and policy is an impediment to the disabled child's social participation and proper integration in an expressly non-discriminatory country.

South Africa in Context—Considerations for Similar Economies

It is useful for SA and similar economies, such as India and countries in the Latin America and the Caribbean (LAC) region, to learn from one another in trying to design and implement strong social protection programmes. Like SA, these countries have high rates of poverty and unemployment, reasonably democratic but under-resourced public sectors, a deeply unequal distribution of wealth, ethnically and culturally diverse populations, and long, violent histories of colonial oppression. Many of these countries have rolled out social protection schemes (Leisering 2020), but policy and implementation flaws can restrict efficacy, efficiency, and most importantly, access and appropriateness for their beneficiaries. Recent reviews indicate, for example, that India's social protection programming for disabled children has limited coverage, widespread inclusion and exclusion errors, and insufficient transfer amounts aimed at the lowest poverty line, against best practice recommendations (Wapling et al. 2021). In the LAC region, efforts to extend social protection to disabled children and adolescents have begun, but limitations include data weaknesses, onerous conditionalities, and poor linkage to other opportunities for support and care (Ullmann et al. 2021). In addition, many of the transfer amounts are not adjusted for the higher costs associated with disability, coverage is much too low, and there is a dearth of applicable research and evidence (Ullmann et al. 2021).

SA shares some of the difficulties cited previously but has a comparatively strong system in place. Transfers are targeted, unconditional, and adjusted (although not sufficiently) for the additional costs of disability. However, as this chapter shows, implementation is a serious challenge. Following are a range of reflections generated from this study example that may be applicable in similar economies. In light of the ever-increasing 'austerity' cuts to public budgets in wealthier countries over the last two decades, these insights may also be useful for counterparts in the global north.

Signatory countries must adopt models for the assessment of childhood disability for social assistance that are compatible with the CRPD. Ensuring assessment models and high-level commitments are aligned is admittedly difficult everywhere, even in better-resourced countries (cf. Porter, Pearson and Watson 2021). But it is nonetheless critical. It is also important that people who work in the administrative or bureaucratic aspects of service provision for disabled children and their families are given some disability-related training and a firm reorientation so that they understand the rights of these children. At a societal level, work ought to be done to upgrade systems for inclusion and to 'retrain' society in general, particularly non-disabled people

(Wapling et al. 2020; Wapling et al. 2021; Ullmann et al. 2021). This work can happen throughout the life course, but the schooling period is a particularly powerful moment for interventions to shift norms and expectations, as long as this is done with care (Beckett 2009; Beckett and Buckner 2012).

Finally, the child's right to play, to spend time with their family, and to interact extensively with their wider community is also enshrined in the CRC. These rights are just as important but are often excluded from discussions about rights and access, especially in underserved contexts, where issues of basic survival generally feel more urgent. I acknowledge that, by focusing on a cash transfer in this chapter, I have also taken a narrow view of the diversity of disabled children's needs and have thus omitted other important aspects of their lives, some of which are valuably explored in other chapters in this handbook. There is an argument to be made that children with improved social protection will be more likely to access these rights, which may be perceived as less urgent, but it is crucial that those of us writing about childhood disability continue to assert and emphasise the disabled child's right to opportunities for disability- and age-appropriate play, recreation, and socialisation. These aspects of life are the right of every child, and they must not fall off the agenda.

Conclusion

Although SA has a relatively strong social assistance (grants) programme 'on paper', close consideration of the programme's real-world implementation has highlighted numerous weaknesses. In its most recent strategic plan, the South African presidency agreed, noting that there was an urgent need to 'resolve [the] fragmentation, inefficiencies and misalignments' that decrease the 'effectiveness of existing social protection systems and [hamper] government efforts to provide services to those who need them most' (DPME 2021, p. 82). To date, however, services and interventions for the social protection of disabled children remain deeply uncoordinated. Progress towards compliance with the CRC and CRPD in SA has been lumbering and insufficient, despite the country's being an early signatory to both treaties. As in many other countries, especially those with limited resources and systemic dysfunction, the ratification of a global rights treaty is clearly only the first (and likely the smallest) step towards achievement of its goals. Implementation is always a critical aspect of the translation of high-level international rights treaties into the realisation of rights in specific country contexts. These high-level commitments also need 'teeth' in order to generate real change and impact. In order to get closer to the vision enshrined in the CRC and CRPD, regular and honest investigations ought to be conducted into the *implementation* of human rights interventions for disabled children. Ideally, mechanisms should also be established to incorporate the findings of these investigations into practice and to improve accountability.

State-funded social protection programmes may assist in addressing some of the extreme rights violations faced by disabled children living in poverty worldwide, provided that such programmes are 'accessible, . . . sufficient to meet needs and . . . comprehensive and coordinated with other social services' (Ullmann et al. 2021).

Cash transfers on their own seem to be insufficient for accelerating access and participation at the rates required to obtain equity for disabled individuals in most LMICs (Trafford and Swartz 2021). The efficacy of these transfers may be greatly increased if they are embedded within a system of intersectoral service delivery and informed by a broader conception of disability. These sorts of changes will require strong political will, coherent and decisive governance, proper budgetary allowances, and strong monitoring and accountability mechanisms. This case study also shows that while it is important to study policies, it may be just as or even more important to consider who is implementing the policy, the relationship between different workers at different agencies or departments, and the nature of interdepartmental links or tensions.

Devolved democratic government systems have been lauded for their capacity to increase citizen participation, improve the speed and efficacy of service delivery, and decrease costs and administrative duties to the national (central) government (Conyers 2007). However, since most policy is designed by the national government and then devolved to provincial or municipal governments for implementation, access and participation on this model can vary considerably according to context and local power structures (Mbatea 2017). In South Africa, where devolved governance has been in place since the mid-1990s, wide differences exist between provinces in terms of population size, economic and administrative capacity, and levels of rurality or urbanity. The ongoing effects of apartheid, contemporary proliferation of labour migration to urban centres and recent corruption and misuse of public funds have deepened the unfair distribution of resources across the country. The devolved model may also be limiting progress toward the achievement of equal rights for disabled children. The South African Constitution stipulates that socioeconomic rights be delivered based on ‘adequate resources’ and according to the principle of ‘progressive realisation’. This declaration has sometimes been (mis)used to rationalise government’s inadequate service delivery to vulnerable populations. In fact, section 28 of the same Constitution notes that children are an exceptional population group and that systems for their protection and upliftment ought to be immediately implemented (Chenwi 2013). A more forceful approach, which is financially *and* administratively supported by central government, may be necessary for rapid progress needed toward equal rights for the disabled child.

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