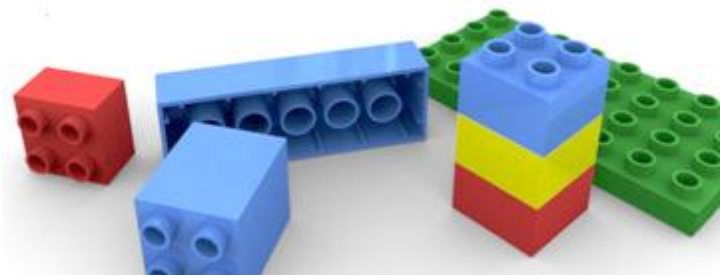
Diagnostic Review of Early Childhood Development



Format of the Report

The report consists of several sections:

- A one-page Policy Summary
- A six-page Executive Summary
- A Report
- Appendices consisting of:
    - A list of documents consulted.
    - Names of people consulted and/or invited to the four provincial panels.
    - Twelve detailed Background Papers on the following topics: 1. Scientific evidence for the importance of early child development for human capacity, health and personal and social adjustment, 2. The role of the State: Legal obligations to provide comprehensive early child development services, 3. An overview of the ECD policy framework in South Africa, 4. Maternal and child health and nutrition, 5. Parenting, 6. Safe and affordable childcare, 7. Opportunities for Learning (ECCE), 8. Human resource development for ECD programmes and services for 0-4-year-olds, 9. Grade R, 10. Government funding for ECD in South Africa, 11. Cost and impact, 12. South African data.
    - An annotation describing amendments to the Children's Act to give effect to ECD priorities.

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Diagnostic Review of the Early Childhood Development Sector

Policy summary

On the eve of the review and revision of the National Integrated Plan for Early Child Development 2005-2010, the Department of Performance Monitoring and Evaluation in the Presidency and the Inter-Departmental Steering Committee on Early Childhood Development commissioned a Diagnostic Review of the prevailing Early Childhood Development (ECD) paradigm, current services, human resources, funding and impact. The DR is based on a review of 112 relevant policy documents, evaluations and studies, as well as consultations with ECD practitioners, civil society, researchers and government officials at national, provincial and local levels. The DR was conducted by a team of people with expertise in the issues covered.

Key policy findings from the Diagnostic Review are:

- A broader definition of ECD programmes than is currently in the Children's Act is needed to cover all aspects of children's development from conception to the foundation phase of schooling.
- Using this broader definition, many elements of comprehensive ECD support and services are already in place and some are performing well. These include some aspects of basic services provision, citizenship (birth registration), social security, health care for women and children, early child care and education, and preparation for formal schooling. Improvements in access and quality must continue to be sought in all areas.
- There are important gaps, notably: support for parenting, prevention of stunting among young children, safe and affordable child care for very young children and other families needing assistance, and planned rapid expansion early child care and education and provision of services to the most at-need families, including children with disabilities.
- The key ECD strategies should be:
    i) to deliver comprehensive services to young children, using all opportunities of contact with families; to extend early child care and education ECCE through home- and community based programmes, beginning with the poorest communities not reached by current services;
    ii) to ensure food security and adequate daily nutrition for the youngest children to avert the life-long damaging effects of stunting;
    iii) to launch well-designed high-profile parent support programmes through media campaigns, community activities and services that acknowledge and reinforce the importance of positive parenting for young children.

- ECD services require strong and coordinated inter-sectoral vision, commitment and action. The current coordination structures are not working adequately. High-level authorization and legitimacy of a well-resourced central agency or mechanism is needed to drive forward key strategies for ECD.
- Achieving these goals also depends on new funding and resourcing strategies, especially for early child care and education. There is need for a decisive paradigm shift towards a rights-based ECD framework and accompanying funding model that recognises and is capable of realising the State's obligations to provide ECD services, especially those living in poor families, rural areas, informal urban areas and children with disabilities. Positive lessons from Grade R and birth registration point to the need to move towards a funding model that is government-driven and pro-equity.
- Further directed enquiry is needed to:
  a) outline the required ECD package of services, map synergies between them and develop plans for increasing integration to improve both their reach and quality;
  b) investigate optimal financing mechanisms for home- and community-based programmes to improve support for the development of young children and to increase children's opportunities to learn and grow;
  c) examine options for a government-driven funding model for ECD, also to harvest higher yields from South Africa's considerable investments in later education and health, and
  d) explore mechanisms for leadership and coordination of ECD in South Africa.

Executive summary

1 Introduction

1.1 The Department of Performance Monitoring and Evaluation in the Presidency (DPME) and the Inter-Deparmental Steering Committee on Early Childhood Development commissioned a Diagnostic Review (DR) of the Early Childhood Development (ECD) sector in October 2011. The purpose of the DR was to evaluate the current South African ECD paradigm and policy, including the role of the State, and the implementation of ECD services and programmes. The DR is based on secondary data from over 112 existing papers consultations with ECD practitioners, civil society, academia and government officials at national, provincial and local levels. The DR was conducted by a team of people with expertise in the issues covered. Apart from the main report there are 12 Background Papers (BPs) and an annotation on recommended amendments to the Children's Act required to give effect to ECD priorities.

1.2 **Early child development (ECD) services** are defined in the report as all services that promote or support the development of young children. These range from infrastructural provision such as water and sanitation, social security, birth registration and health services to safe and affordable daycare, opportunities for children to learn together in structured programmes, and preparation for formal schooling. **Early Child Care and Education (ECCE) services**, a very important aspect of ECD, are defined as services and programmes that provide care and developmentally appropriate educational stimulation for groups of young children in centres and/or in community- or home-based programmes. The definition of ECD programmes in the Children's Act is at the moment limited to learning and support (early child care and education). Moreover, it focuses on services provided in centres, which excludes much of the important work needed in the home - to support parenting and young children's nutrition, learning and protection.

2 Diagnosis

2.1 Huge strides in provisions to benefit young children have been made from the pre-1994 racially exclusive policies and programmes of *Apartheid* South Africa (see Table 1).

Table 1: Examples of good progress

Good Progress
87% of households with a young child have access to safe drinking water (BP12, p28)
82% of households with a young child are connected to mains electricity (BP12, p32)
97% of pregnant women attend at least one antenatal clinic (BP4, p17)
98% of health facilities offer the programme to prevent mother-to-child HIV transmission[1]
91% of women deliver their babies with the assistance of a professional attendant (BP4, p35)
89% of children are fully immunised at one year of age (BP4, p22)
83% of births are registered (BP2, p29)
73% of eligible young children receive the Child Support Grant (BP2, p30)
80% of children are enrolled in Grade R (BP9, p4)

2.2 The major problems with the **current paradigm** are gaps between policy and practice, disjuncture across age groups, and inequity. The White Paper 5 on Early Childhood Education and the Children's Act sketch a broad vision of comprehensive ECD services spanning early childhood, encompassing home-, community- and centre-based services across health, education, social protection and socioeconomic development. In practice, however, different sectors act largely in isolation from one another without shared vision, goals and accountability, and there are significant gaps in services – particularly with respect to nutritional support for women and children, support for parenting and families, and childcare support for very young children and children with special needs. Moreover, there is a **disjuncture across age groups** relating to the assumed roles of the family and the State in service provision. The family is presumed to be the appropriate provider of care for very young children (0-2 years), with the State giving general support. For slightly older children (3-4 years), the family is considered to be in need of considerable assistance in providing learning opportunities for young children. Services and resources needs to be better balanced across the age range, with State assistance for 0-2-year-olds, more support for 3-4-year-olds more equitably provided, and support for all parents and families across the ECD age range.

As older rather than younger children are more likely to be enrolled in centres, the **funding model** leads to greater investment in children 3-4 year old than in children 0-2 years of age. Yet the first two years of life (the first 1,000 days) are critically important to later health, achievement and wellbeing. Moreover, 3-4year old children who live in areas without registered centres, many of whom are poor and generally under-serviced, do not receive the subsidy support. Because most ECCE services are private and not-for-profit (NPO) facilities, they depend on user fees, which the poorest families cannot afford. In 2001, when the last national audit was conducted, 75 percent of services were fee-based, and in the provinces included in the 2010 ECD public expenditure study, all were fee-based despite the subsidy. This leaves many areas of the country, and many families, without learning and development services.

Equity of outcome, as opposed to equity of access, requires the allocation of resources to those most in need; in contrast, the current subsidy does little to reduce existing inequalities. Identification of the children most in need of services and focusing on those children and their families will help to erode disparities. The State must put in place laws, funding, infrastructure (including services) and programmes to bridge the access and quality gaps for the most marginalised including the 6 percent of children estimated to have special needs.

A **broad range of interventions** affect children. Health and nutrition policies, even when explicitly targeted to pregnant women and young children do not feature prominently in ECD policy documents. Parent and family support is also under-developed. Thus, whilst ECD is a clear policy priority, to date only a few ECD services have been highlighted – these are early learning and Grade R. Others, such as infrastructure, health, citizenship and social security, though the focus of other sectors, are not routinely included in what is described as ECD services.

2.3 The importance of **inter-sectoral collaboration** is recognised in the Education White Paper 5 on Early Childhood Education. Integration and collaboration are envisaged to result in expanded service delivery, cost-cutting through shared resources, and more efficient and speedy delivery of services. However we found few examples of integrated ECD programme

delivery. One with potential is *Care for Child Development*, a module of the Integrated Management of Childhood Illness (IMCI) that uses all contacts between the health system and very young children to promote feeding, play and language development among mothers and other caregivers. What is required is an overarching approach, driven from a central mechanism, which asks what ECD benefits can be gained from every contact with young children and their families. Effective inter-sectoral collaboration requires several pieces that are not yet in place. These include: a common ECD agenda and goals which are mainstreamed into relevant sectoral policies and programmes and budgets (this has not happened other than in DSD and DBE), and an integrated monitoring and evaluation process. Use must be made of existing facilities for the delivery of ECD services. These include primary health care centres, as well as mobile health services, ECCE centres and programmes, NPOs, one-stop centres, offices of traditional authorities, churches and other faith facilities, as well as municipal and provincial service points.

2.4 There are a very large number of **government services and programmes** that benefit families living in poverty and therefore contribute positively to the early development of their children, ranging from free basic water and electricity to Grade R.

Priority areas for improvement of ECD services by **Health** are maternal and child nutrition in the first 1,000 days, provision of early antenatal care, halting smoking and alcohol use during pregnancy, emergency obstetric care to prevent maternal deaths and childhood disability, preventing and treating maternal depression, deworming of children, early identification and support for children and families with special needs including disabilities, and the promotion of nutrition, health and development (especially language development and play) in all contacts with young children. Undernutrition is the single most deleterious determinant of poor child development, with a strong link also to diminished adult capacity, health and adjustment (BP4).

The priority areas for improvement of ECD services by **Social Development** are parenting support, including through public awareness and education in collaboration with civil society and mass media (BP5, p7); better use of Clause 98 of the Children's Act (Conditional Registration) to expedite access to subsidies for children in the poorest areas; the development, funding and expansion of home- and community-based care; childcare options for working parents and other families needing assistance (BP6); the inclusion of health promotion and nutrition in all programmes reaching young children (BP4); and the prioritisation of the establishment of early child care and education programmes and centres in poor and under-served communities.

The priority areas for improvement of ECD by **Education** include: consolidating expansion with improvements in infrastructure, learner support materials and equipment; standardisation of training, qualifications and remuneration of staff; and overall management and integration of Grade R in relation to earlier preschool provision, the foundation phase as a whole, and subsequent schooling. Grade R needs to be made compulsory (BP9). In addition, if Grade R is included in ECD provisions, attention must be given to the nutrition, health, safe transport and after-school care of young children in Grade R (BP9, p14).

2.5 In terms of **human resources**, all sectors have significant vacancies and unfilled posts, and there are challenges around staff qualifications, conditions of service, remuneration and retention. Capacity is needed to support implementation, monitoring and quality improvement.

There is also need for better articulation between qualifications across practitioners in different sectors and across community-based workers from all sectors who interface with young children and their families.

2.6 It is very difficult to make accurate estimates of **allocations and expenditure** on ECD as there is no identifiable ECD line item running across departmental budgets. The total DSD budget is estimated at around R1.2 billion per annum plus the CSG, of which about R1 billion per annum is paid to children under 6 years of age. The total DBE budget is roughly R3.3 billion per annum. The Department of Health does not collect data in a way which allows budgets for specific age groups to be identified.

The dependence on NPOs and **user-fees** perpetuates long-existing social and individual inequalities between regions of the country and between families. Children living in the poorest 40 percent of households are only half as likely to benefit from early child care and education services as children in the richest 20 percent of households.

There is much to learn from existing successes, including Grade R where the State assumed responsibility, grafted the service onto school education with its infrastructure and organizational systems, and subjects it to policy-based regulation. This has resulted in significant and equitable scale up of Grade R. Parenting support, educational stimulation and nutrition for very young children can similarly be grafted onto promotive health and community outreach services.

2.7 **Data** on many ECD services are routinely collected – birth registrations, CSG grant access, attendance at antenatal clinics, etc. as is national survey data. Both must be improved. An ECD scorecard, combining indicators of a basic package and updating it annually would be a powerful driver for increased performance.

2.8 Very few South African studies have examined the **impact** or **cost-effectiveness** of ECD services. Despite method and data concerns, such as lack of randomness of samples, the few studies that have been done report benefits for children, particularly with regard to nutrition and growth. There is a great deal of strong international evidence for the benefits of provisions for young children. However, it is estimated that South Africa spends almost three times less on learning in the preschool years (excluding Grade R) than on primary education and nine times less than on tertiary education, taking into account both coverage and expenditure per individual.

3 Recommendations

Recommendation 1: State responsibility

South Africa has progressively committed itself to protect and promote the development of young children, both as a human right and as a public good. To meet this responsibility requires:

- Policy and legislation to ensure that ECD services are adequately resourced and provided, including at the municipal level. This requires amendments to the Children's Act, and a review of relevant sectoral laws so that their ECD obligations can be mainstreamed.
- A Cabinet resolution or equivalent commitment to ECD as a national priority.

- A revised NIP that spells out the obligations of government role players and civil society in realising a comprehensive ECD package. Under-used space in community halls, traditional authority offices, schools, clinics, churches and homes can all be used to run home- and community-based programmes.
- An independent mechanism with the resources, expertise and authority to bring together all participating sectors in government to work towards agreed ECD goals. This could be an agency, board or commission.
- Capacitation and resourcing of provincial governments and local government, to ensure equitable provision of a comprehensive ECD programme.

Recommendation 2: Focus on equity

An equity-based approach ensures that the state and its partners prioritise the provision of services and support to those children and families who most need them. Work should begin immediately in the poorest and most disadvantaged wards. The most urgent next step is to develop a basic 'ECD package of services' to be rapidly expanded to reach vulnerable children. This must be done in collaboration with both civil society and the private sector, using all opportunities of contact with young children by community-based cadres. Implementation strategies must include every possible mode of delivery and progress should be tracked against coverage targets.

Recommendation 3: ECD services should be comprehensive

The elements should include:

- Family planning, healthy pregnancies and postnatal care to give children an optimal start in life from conception.
- Nutrition support for pregnant and breastfeeding women and young children through home-, community and facility-based programmes.
- Birth registration, social security through the CSG and other instruments, subsidised housing and other state provisions for the poorest families.
- Supporting parenting through public education campaigns, as well as using the faith sector and traditional leadership, and care groups and companionship support through outreach programmes.
- Quality learning by young children encouraged at home and in groups, programmes and centres that focus on building enjoyment of learning, the confidence to learn from others especially adults, and self-control and social respect so that children can participate in and contribute positively to social life.
- Preparation for formal schooling by enrolment and regular attendance in Grade R, with support for learning from parents and other adults in the home.

Recommendation 4: New funding provided in a new way

ECD services, as a whole, are currently un- or under-funded. A basic 'package' of services to reach universal coverage must be costed for different modes of delivery. Many services are already in place, such as those provided by the Departments of Health and Home Affairs, but funds are needed to reach the families not yet enrolled. In under-serviced areas, ECD capacity and infrastructure, especially for early learning services, need to be established from scratch. A costing for the sector must be made from a population-wide perspective, rather than merely increasing funding for existing services, many of which are in already relatively well-provisioned geographical areas. There is need for a decisive paradigm shift towards a rights-based ECD framework and accompanying funding model that recognises and is capable of realising the State's obligations to provide ECD services, especially those living in poor families, rural areas, informal urban areas and children with disabilities. Positive lessons from Grade R point to the need to move towards a funding model that is government-driven and pro-equity. An investigation should be commissioned to look at funding models for comprehensive ECD services that do not inadvertently subsidise better-off families at cost to the most needy - despite the means test - or incentivise centre-based early learning programmes or out-of-home care over home- and community-based programmes for working parents and other families needing assistance.

Recommendation 5: Workforce development

The following workforce developments are needed:

- A human resource development strategy to pay staff in early learning centres, improve staff qualifications and retain ECD workers. This should include an audit of existing staff qualifications and resourcing for initial training and upgrading for all workers in the sector including those in support and monitoring positions, as well as centre-based and outreach ECD practitioners.
- Expand and subsidise training opportunities for all categories of ECD practitioners, including those working with families and communities. By creating the demand, the training supply will increase.
- Professionalise ECD by enabling practitioners at all levels to register through appropriate occupational bodies which will assist with the development of job hierarchies and career progression. This needs to be linked to incentives.
- Develop a core package of ECD messages for inclusion in training of home- and community-based workers employed in different sectors who reach young children in the course of their work. These include a very large number of trained people, most of who interface with children and families, especially young children, in the home and community. If there was an overall framework under which such groups work in communities, and some common conditions, training, qualifications and remuneration, it would be possible to advocate for training in and delivery of basic early child development principles and practice.

The NIP review and re-planning must be used to envision and give substance to the recommendations outlined above.

CONTENTS

List of Tables & Figures

Abbreviations

ABET	Adult Basic Education and Training
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ATL	Approaches to learning
AZT	Zidovudine
BP	Background Papers
C2005	Curriculum 2005
CAPS	Curriculum Assessment and Policy Statement
CBA	Cost Benefit Analysis
CBO	Community-based organization
CBR	Community-based rehabilitation
CCGs	Community Caregivers
CCW	Community Care worker
CD4	Cluster of differentiation 4
CDG	Care Dependency Grant
CDWs	Community Development Workers
CEA	Cost Effectiveness Analysis
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CHC	Community Health Centre
Child PIP	Child Healthcare Problem Identification Programme
CHW	Community Health Worker
CS	Community Survey
CSG	Child Support Grant
CWD	Children with disability
DALY	Disability Adjusted Life Gain
DBST	District-Based Support Team
DC	District Council
DHET	Department of Higher Education and Training
DBE	Department of Education
DoH	Department of Health

DPME	Department of Performance Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DR	Diagnostic Review
DSD	Department of Social Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
EFA	Education for All
EHW	Employee Health and Wellness
ELRU	Early Learning Resource Unit
EMIS	Education Management Information System
EPI	Expanded Programme on Immunization
EPWP	Expanded Public Works Programme
ETDP SETA	Education, Training & Development Practices Sector Education & Training Authority
FAS	Foetal Alcohol Syndrome
FCG	Foster Care Grant
FET	Further Education and Training
FETC	Further Education and Training Certificate
GDP	Gross Domestic Product
GETC	General Education and Training Certificate
GHS	General Household Survey
GNP	Gross National Product
HAZ	Height-for-age z-scores
HCBC	Home And Community Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICU	Intensive Care Unit
ID	Iron deficiency
IDA	Iron deficiency anaemia
IDP	Integrated Development Plan
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
INP	Integrated Nutrition Programme
KIDS	KwaZulu-Natal Income Dynamics Study

LFS	Labour Force Survey
LTSM	Learning and Training Support Material
MCH	Maternal and Child Health
MEC	Member of Executive Council
MTEF	Medium Term Expenditure Framework
NAFCI	National Adolescent Friendly Clinic Initiative
NCCEMD	National Committee into the Confidential Enquiries into Maternal Deaths
NCV	National Certificate Vocational
NELDS	National Early Learning and Development Standards
NFCS-FB	National Food Consumption Survey-Fortification Baseline
NGO	Non-governmental organization
NHI	National Health Insurance
NIDS	National Income Dynamics Survey
NIP for ECD	National Integrated Plan for Early Childhood Development
NLRD	National Learning Records Database
NPC	National Planning Commission
NPO	Non-profit organization
NQF	National Qualifications Framework
NSP	National Strategic Plan
OBE	Outcomes Based Education
OECD	Organisation for Economic Co-Operation and Development
PCR	Polymerase Chain Reaction
PEM	Protein Energy Malnutrition
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PSU	Primary sampling unit
RCT	Randomised control trials
RNCS	Revised National Curriculum Statement
RPL	Recognition of Prior Learning
RTO	Resource Training Organization
SABC	South African Broadcasting Corporation
SACE	South African Council of Educators
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SAPS	South African Police Service

SAQA	South African Qualifications Authority
SASSA	South African Social Security Agency
SAW	Social Auxiliary Worker
SES	Socioeconomic status
SEWA	Self Employed Women's Association
SIAS	Screening, Identification, Assessment and Support
TB	Tuberculosis
TEEP	Turkish Early Enrichment Programme
UIF	Unemployment Insurance Fund
UN MDGs	United Nations Millennium Development Goals
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with disabilities

1. Introduction

1.1 Background

The Department of Performance Monitoring and Evaluation (DPME) in the Presidency and the Inter-Departmental Steering Committee for Early Childhood Development (ECD) commissioned a Diagnostic Review (DR) of the current status of ECD, in parallel with a review of the National Integrated Plan (NIP) for ECD. The DR and the NIP review are to be combined into an ECD Sector Review[2].

The purpose of the DR is to evaluate the current South African ECD paradigm and policy, including the role of the State, and the implementation of ECD services and programmes. Topics to be covered include human resource development, inter-sectoral collaboration, funding, impact and cost-effectiveness.

1.2 Importance of early child development

Scientific evidence accumulated over the last two decades confirms the importance of the early years of life, not only in determining capacity (education and earnings)[3], but also health and longevity (especially related to chronic disease)[4], and personal (stress, anxiety) and social (withdrawal, aggression) adjustment[5]. This compelling evidence, especially the important roles played by nutrition[6], parenting[7], and early stimulation[8], makes ECD services a priority for national socio-economic development[9].

From conception, the development of a child occurs progressively - in sequence - driven by genetic potential in response to pre- and post-natal conditions. Children are uniquely sensitive to their environment during the first 1,000 days of life (the 270 days of pregnancy plus 365 days in each of the first two years). In this period very rapid development, adaptation and consolidation occur, particularly in brain structure and function, metabolic reactions, interpersonal engagement and self-regulation[10]. Beneficial or protective experiences during this time determine the degree to which a child is equipped to take advantage of further opportunities and to face challenges. Children exposed to risks and adversity in the early years need additional support to help them compensate for missed learning and adaptation. This support is most effectively provided within this unique early 'window of opportunity'[11].

Once this opportunity is missed, remedy seldom occurs naturally in the typical environment of children living in low-resource settings[12], and intentional efforts to make up for deficits are less effective at later ages and much more costly[13]. Disadvantaged children who receive little or no support to catch up are less likely to be able to realise their individual developmental potential. They tend to fall further behind their peers, slipping towards the margins, unable to bridge the widening gap between themselves and those who are forging ahead. Inequalities expand and become more intractable and harder to address. The personal tragedy of the unfulfilled promise of one child, combined with that of many other children in similar circumstances, constitutes a serious challenge of dependency, exclusion and ill-health in society. For this reason, ECD services have been called 'a powerful equaliser"[14], because they provide assistance during a time when children are most able to make up for disadvantages carried over to them from

previous generations, such as limited education, or challenges that arise in their own development, such as low birth weight or faltering growth.

We know what children need in the early years, we know how they grow and learn, and we know which exposures and experiences in the early years are most beneficial for children and which are most injurious[15]. We also know which interventions are, in principle, effective and feasibly taken to scale in low-resource contexts[16]. Concerted efforts to improve the early development of all children - especially those who continue to be denied opportunities to grow, develop and achieve - through effective interventions at the environmental, social and personal levels - could boost education, productivity, health and social adjustment over the next two to three decades.

The scientific evidence supports a developmental approach to early childhood interventions, beginning in pregnancy and continuing into formal schooling. This includes the promotion of planned and safe pregnancies, assisted delivery and postnatal care; nutritional support for pregnant women and young children; social protection to enable families to care for a young child; preparation for and support for parenting; childcare for working parents and other families needing assistance; opportunities for young children to learn at home and with other children in the company of supportive adults, and preparation for formal schooling.

In addition to the explicit benefits for children, the expansion of services for young children provides opportunities to create work and potential career opportunities, as envisioned in the Social Sector Expanded Public Works Programme[17]. Good quality childcare also enables parents, especially women, to continue with full-time education, to take up employment and to advance in their work and professional lives. In turn, parental participation in work benefits household economic status and improves financial security for children.

1.3 Diagnostic process

Members of the team were invited to participate in the review based on their expertise in the areas to which they contributed. The team met in person and by telephone, and exchanged emails and documents to: 1) discuss the assignment and apportion tasks, 2) resolve queries, and 3) come to broad consensus on the main points of the analyses and the recommendations. We do not necessarily agree on finer points, but we are of one mind on the overall diagnosis and way forward.

Given the limited time and the need for a set of high level observations and recommendations, we worked as follows: 1) we assembled and read the very large number of documents on ECD in South Africa, especially those commissioned during the last few years (see Appendix A for the list of more than 110 documents consulted[a]), 2) brought our expertise in the various areas to bear on the subject, also by conducting overviews of relevant literature, 3) consulted web-sites and colleagues, including government officials, for specific information, 4) hosted four panels with provincial stakeholders in Gauteng, Western Cape, KwaZulu-Natal and Free State to discuss the topics listed in the scope of work and our emerging perspective (see Appendix B for

[a] These documents are available on the DVD submitted with the Diagnostic Review and through the Dropbox hosted at the HSRC.

a list of people invited to panels and/or who were consulted), and 5) met regularly with the Inter-Departmental Steering Committee to discuss progress and respond to queries and comments.

In addition to this report, twelve detailed Background Papers (BPs) are included in the Appendices. The topics covered in the Background Papers are: 1. Scientific evidence for the importance of early child development for human capacity, health and personal and social adjustment, 2. The role of the State: Legal obligations to provide comprehensive early child development services, 3. An overview of the ECD policy framework in South Africa, 4. Maternal and child health and nutrition, 5. Parenting, 6. Safe and affordable childcare, 7. Opportunities for Learning (ECCE), 8. Human resource development for ECD programmes and services for 0-4-year-olds, 9. Grade R, 10. Government funding for ECD in South Africa, 11. Cost and impact, 12. South African data. An annotation is also appended with recommendations for amendments to the Children's Act required to give effect to ECD priorities.

1.4 Definitions

To facilitate understanding, we define here what we mean when we use the following terms:

Early child development (ECD) services are all services that promote or support the development of young children. These range from infrastructural provision such as water and sanitation, social security, birth registration and health services to safe and affordable daycare, opportunities for children to learn together in structured programmes, and preparation for formal schooling.

Early Child Care and Education (ECCE) services, a very important aspect of ECD, are services and programmes that provide care and developmentally appropriate educational stimulation for groups of young children in centres and/or in community- or home-based programmes[b].

Comprehensive services refer to a range of services for pregnant women, mothers and young children across infrastructure, health, education and social services.

Integration refers to how services are provided. Integration takes advantage of synergies and efficiencies associated with inter-sectoral collaboration, by linking several services together. For example, centre-based learning and development services may also offer parenting programmes, feeding for young children in the surrounding community, and be a venue for outreach primary health care services targeting young children. Services can be integrated but not comprehensive. Services are integrated and comprehensive when all or most elements of ECD are provided and there is cross-sectoral collaboration to ensure the best outcomes, efficiently achieved at the lowest cost.

[b] Acronyms for early childhood education and care vary, though the terms have a lot in common. ECCE is used by UNESCO, as well as the Education for All (EFA) initiative and the Global Monitoring Report (GMR) to refer to care and education/development provided to children in the preschool years (2006, p.1). The OECD uses ECEC (early childhood education and care) and UNICEF prefers ECCD (early childhood care and development. See Kamerman, S. (2006). A global history of early childhood education and care: Background paper prepared for the Education for All Global Monitoring Report 2007 Strong Foundations: Early Childhood Care and Education. Paris: UNESCO

Human rights are inalienable entitlements of human beings. Children have, amongst others, rights to protection from abuse, neglect and discrimination and rights to provision (food, shelter, education and health care). However, there are several models by which children's rights are realised and protected by governments and parents, as illustrated, for example, by birth registration, schooling and immunisation (the right to health care). Only the State offers birth registration; there is no choice of provider. Parents are legally obliged, and assisted by the State, to take up the service and register their children. The State and others offer education, but there is a choice of providers. Parents are legally obliged to educate their children, even if by home schooling. They are not obliged to take up State services although the State is obliged to offer the service to all. The State regulates education provision by non-State providers. The State and others offer immunisation. Parents are not obliged to take up the service, whether offered by the State or others. The State does not regulate provision in general, but does regulate specific aspects of provision, such as the qualifications of people who may immunise children, the brand and date of the inoculant, etc. In all three cases, the State makes a special effort to bring its offerings closer to poor and marginalised communities in recognition of the fact that they may experience challenges in accessing services provided by the State and that they cannot afford the services of non-State (private) providers.

Children have a right to ECD services – and the State is obliged to offer the range of ECD services to all children. Many of these services are already provided in South Africa. Early care and learning, as one of the range of ECD services, is most in need of expansion. It is more like immunization than schooling or birth registration. The service must be developed to a certain quality and be offered free of charge to those families who are unable to pay. The State must finance such services, regulate training and some aspects of practice. However, like immunisation, the service is not compulsory and families have a wide choice of providers.

Progressive realisation recognises that the high costs involved may mean rights have to be realised progressively. However, governments have an obligation to take steps to realise these rights through a time-bound plan with benchmarks, targets and indicators of progress. Many of the rights-based provisions for young children are also public goods, meaning the State has an obligation to provide them to children and families, and also has an interest in ensuring that the rights of all children are realised.

The age range of early child development is defined differently across a number of important policy documents. The United Nations General Recommendation No. 7: Implementing Child Rights in Early Childhood, adopted in 2005, refers to all young children including at birth and throughout infancy, during the pre-school years, as well as the transition to school up to the age of 8 years. Like White Paper 5 on Early Childhood Education, the NIP defines young children as those up to the age of 9 years, but the NIP prioritises services for children 0-4 years. The Children's Act (No 38 of 2005, as amended) defines early child development from birth to school-going age (Section 91(1), which is normally 5-6 years of age. Health services are provided free to children under 6 years of age. The focus of the Expanded Public Works Programme with respect to ECD is on the training of practitioners to work with children aged 0-4 years. The National Planning Commission's Diagnostic Overview refers to early stimulation for children 0-4 years, and Grade R. The Minister of Social Development in 2011 committed to expanding ECD access and quality for children 0-5 years of age.

In the Diagnostic Review, ECD refers to children from conception to Grade R when children are 5-6 years of age, mainly because of time limitations on the review. However, it is important that the age parameters of ECD in South Africa are made consistent and we recommend the range from pregnancy to age 8 years as outlined in the UN General Recommendation No 7.

2. Diagnosis

2.1 Overview

Huge strides in provisions to benefit young children have been made from the pre-1994 racially exclusive policies and programmes of *Apartheid* South Africa[18]. Past policies severely discriminated against Black people and damaged children through malnutrition, family disruption and instability, exposure to injurious environments and limited opportunities. White children had greater access to ECD services of higher quality and what services there were for other groups had a distinctly urban bias. But, by 2001, beginning with the transformation to a democratic State in 1994, there were more than 30 policy, laws and programmes demonstrating government's commitment to help improve the conditions in which children live and their prospects into the future[19].

The State has obligated itself to provide many ECD services by virtue of being a signatory to international and regional agreements such as the African Charter on the Rights and Welfare of the Child, the Convention on the Rights of the Child, Education for All, and the Millennium Development Goals, as well as by the South African Constitution and a number of Acts and policies. Government has also expressed positive intentions to support ECD and, in particular, to redress inequity, through the Children's Act, the NIP for ECD, and various White Papers. Importantly, Vision 2030, articulated by the National Planning Commission, acknowledges the significant role that ECD can play in achieving the country's shared goals for socioeconomic advancement[20] (see also BP2 and 3).

There is, though, still much to be done to achieve the broad vision of ECD outlined in national policies. ECD services in South Africa have yet to become comprehensive, coordinated, provided in an equitable manner, and funded at a level to achieve their objectives. There is an absence of both a strong leadership structure and a funding model to fill gaps and attain equity. Sectorally-based services (infrastructure, health care, birth registration, social security, etc.) are extremely valuable, and they could be better used to provide additional supports for parenting and early child development. This could help to compensate for some of the disadvantages experienced by young children living in the poorest families.

Much of this has been said before. White Paper 5 on Early Childhood Education (2001) recorded that:

> "The Department of Education's departure point for all ECD policy development is that the primary responsibility for the care and upbringing of young children belongs to parents and families. However, because of the inequality in income distribution, and because ECD is a public good whose benefits spill over from individual parents to society as a whole, the Department sees it as the State's responsibility to subsidise and assure the quality of ECD services" (section 3.1.4).

This vision and these challenges remain.

In some areas, a great deal of progress has been made. Much more needs to be done in other areas, as illustrated in Table 2.

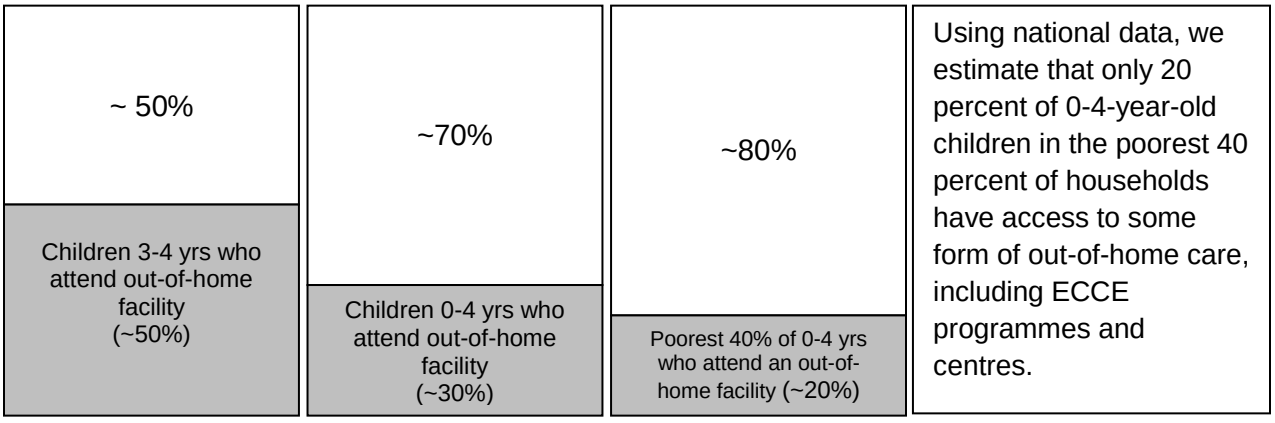
Table 2: Examples of good progress and remaining challenges

Good Progress	Remaining Challenges
87% of households with a young child have access to safe drinking water (BP12, p28) 82% of households with a young child are connected to mains electricity (BP12, p32) 97% of pregnant women attend at least one antenatal clinic (BP4, p17) 98% of health facilities offer the programme to prevent mother-to-child HIV transmission[21] 91% deliver their babies with the assistance of a professional (BP4, p35) 89% of children are fully immunised at one year of age (BP4, p22) 83% of births are registered (BP2, p29) 73% of eligible young children receive the Child Support Grant (BP2, p30) 78% of children are enrolled in Grade R (BP9, p4)	Prevent early unwanted pregnancies and improve maternal nutrition and care Ensure the nutrition of young children and prevent stunting (low height-for-age) Promote and support positive parenting to enable families to give their young children the best start in life Devise funding and services for safe, affordable and stimulating care for 0-2-year-old children in families that need assistance, Expand home- and community-based programmes to provide support for parenting and improve opportunities for young children to learn, especially for children from the poorest families with least access to services and young children with disabilities. Ensure early child care and education services in rural and poor urban areas through State provision and financing, in collaboration with non-profits and the private sector Provide comprehensive and integrated services to young children and their families. This enables children to gain from the mutually reinforcing benefits of responsive parenting, good nutrition, protection from harm and opportunities for learning, and for services to achieve efficiencies from streamlined delivery systems. Use all available infrastructure and cadres of community workers to reach poor and distant families to promote parenting and early child health and development. Use fixed and mobile clinics and promotive child health services to promote parenting and early child health, nutrition and development.

Without strong coordination, important gaps remain. This can be illustrated with respect to ECCE services.

- Very little is in place to support parents and families despite the fact that they are the strongest and most enduring influences on children, especially in the early years[22]. The 2011 Green Paper on Families[23] does not explicitly address parenting nor the care and protection of young children, and there is limited implementation of the 2008 Parental/Primary Caregiver Capacity Building Training Package which, in any case is not enough[24].
- Very small numbers of the youngest children (0-2 years old) are in formal early child development centres, a proportion of which are registered and receive a per-child subsidy. Far more children in this youngest age group are in the care of home-based childminders. This form of care has no training, registration or funding framework (BPs 5, 6 and 8). Data from the 2010 General Household Survey (GHS), indicates that 33 percent of mothers who are co-resident with their children 0-6 years of age (28 percent of children under 2 years) are engaged in some economic activity (BP12, p15), and 15 percent of parents with children under 6 years (13 percent with children 0-2 years) may need assistance with childcare because the parent/s are chronically ill or disabled (BP12, p64). Parents in full-time education may also need assistance with childcare. Realising the extent and seriousness of childcare needs in the formal sector and the barriers created for the advancement of women's careers, the Department of Public Service and Administration (DPSA) has produced a Discussion Document on plans to address the childcare needs of the civil service[25].
- Children 3-5 years old from poor families are eligible for subsidised attendance at early learning and care centres, across a range of quality, but only if they are fortunate enough to live in an area that is served by a registered, subsidised centre run by a not-for-profit organisation (NPO) and, in almost all cases, if their parents can afford to pay fees. More than a million children under four years of age are estimated to be in some form of out-of-home care or programme (BP7, p10). Of these, 467,000 children receive means-tested subsidies in 18,826 registered centres[26]. However, the registration requirements of the current funding model often inadvertently excludes the most disadvantaged children from services[27], as shown in Figure 1 (BP7, p10).

Figure 1: Declining access to out-of-home services by age and socioeconomic status



- Early learning and support for child development should not be restricted to services provided by centres; it must expand to include home- and community-based programmes. There is currently no government support for the establishment of either centre-based or expanded services in underserved areas, nor are there policies to ensure that children from families who cannot afford fees, can still access services, either in centres or in home- and community-based programmes (BPs 2 & 3). Expansion of the current funding model - a per-child subsidy for children in registered centres - without a deliberate strategy to develop services through centres and home- and community programmes in disadvantaged areas, will maintain (and could possibly exacerbate) inequalities between better- and worse-off families. As a result of disadvantage, about a third of poor South African children reach school age stunted or underweight (BP4, p12, 25), many with health and learning disadvantages which they are unlikely to overcome[28].

The overview given above is based on detailed assessments of the current paradigm, existing policies, current inter-sectoral collaboration, available services and programmes, human resources, and funding. A summary of each of these assessments is provided below. Full analyses are provided in the twelve detailed Background Papers attached as Appendix C.

2.2 The current paradigm

Assessment

The major problems with the current paradigm are gaps between policy and practice, disjuncture across age groups and inequity.

Existing policy - White Paper 5 on Early Childhood Education, the Children's Act, and the NIP - sketches a broad vision of comprehensive ECD services spanning early childhood, encompassing home-, community- and centre-based services across health, education, social protection and socioeconomic development (BP3). Comprehensive ECD requires the promotion of planned and safe pregnancy, delivery and postnatal care; nutritional support for pregnant women and young children; social protection to enable families to care for a young child; preparation for and assistance with parenting; childcare for working parents and other families needing help; opportunities for young children to learn at home and with other children in the company of supportive adults, and preparation for formal schooling. In addition, ECD services and programmes provide ideal opportunities for the prevention, early identification and timely provision of assistance for children with disabilities and children requiring additional support for health, development and social problems (BP4, p48).

In practice, however, different sectors act largely in isolation from one another without shared vision, goals and accountability, and there are significant gaps in services – particularly with respect to nutritional support for women and children, support for parenting and families, and childcare support for very young children and children with special needs. Moreover, there is a disjuncture across age groups relating to the assumed role and capacity of the family. The family is assumed to be the appropriate provider of care for very young children (0-2 years), with the State giving general support to the poorest families. For slightly older children (3-5 years),

the family is considered to be in need of considerable assistance in providing learning opportunities for young children. Services and resources need to be better balanced, with State assistance for 0-2-year-olds, more support for 3-4-year olds more equitably provided, and support for all parents and families with young children.

Some of the disjuncture between policy and practice appears to have arisen because of challenges in designing and implementing an appropriate funding and delivery model for home- and community-based ECD programmes; and with respect to the promotion of parenting as the foundation of all ECD provision, through awareness-raising, education and support.

South Africa has made very considerable contributions to the wellbeing of children through infrastructural development (housing, water, electrification), health services, citizenship, and social security. However, the current ECD paradigm favours services for children 3-5 years of age in ECD centres. As a result, children and families who require services other than those currently provided in centres - often the case for 0-2 year olds; children in areas where centres have not been established; and children with disabilities - are not yet supported by the State.

As older children are more likely to be enrolled in centres, the funding model leads to relatively larger investments in children 3-5 than in children 0-2 years of age. Moreover, as the subsidy model does not support infrastructure development, other start-up costs and services (water and sanitation), it leads to inequitable provision of services among 3-5-year-olds. Children who live in areas without registered centres, many of which are poor and generally under-serviced, do not receive the subsidy support.

The per-child subsidy model does not provide for infrastructure development or maintenance, but prescribed infrastructure is required to meet specified standards for registration. Because most early learning and care services are private and not-for-profit (NPO) facilities, they depend on user fees to help to fund infrastructure, amongst other things. In 2001, when the last national audit was conducted, 75 percent of services were fee-based and in the provinces included in the 2010 ECD public expenditure study, all were fee-based despite the subsidy[29]. This leaves many areas of the country, and many families, without early learning and care services.

Early learning and care services also tend to be area-based and small-scale. There are, as yet, no exemplary models of integrated ECD planning or service delivery at scale. In a country with more than 5 million children 0-4 years of age - 2.3 million of whom are poor - there are 18,826 registered ECD facilities, which receive State subsidies for some 467,000 children from income means-tested families (BP7). By our calculations, about 2 in 5 children (0-4 years old) in any crèche or preschool receive a subsidy[c]. Although the subsidy is means tested, inequality is created because the State does not ensure infrastructure development and start-up costs, including in areas where the need is greatest. Current provision privileges children who can access centre-based services and whose families can afford fees. These are not the poorest parents with the most at-need children, the majority of whom are currently being cared for at home.

About 6 percent of children have special needs, with a higher proportion among very young children[30]. Little progress has been made in the way of concrete plans, budgets and

[c] Based on NIDS 2008 and registration figures from DBE 2011 (D. Harrison).

programmes for the provision of ECD services for children with disabilities since White Paper 5 on Early Childhood Education noted that they are, for the most part, not provided for either in the mainstream or within specialised services.

Moving forward

Since 1994, the goal has been full State provision and implementation at scale of programmes to support young children, including the youngest age group (0-2 years), those with special needs, and children in the poorest families in urban and rural areas. As envisioned in South Africa's exemplary policies with respect to ECD, we also need to provide support for parents and families in home- and community-based programmes. This can be done through comprehensive approaches that include health, nutrition, protection and socioeconomic development, with the aim of promoting children's developmental capacity and providing them with opportunities to grow and learn.

To reach these goals, the gap between policy and practice must be closed, and the disjuncture in approach across age groups must be addressed. But this alone, is not enough. Current policies are based on a broad vision of comprehensive and integrated ECD services, especially for those children and families who most need them. Some families are in the fortunate position of being able to assist their children to reach their potential without much support from the State. Therefore government does not have to provide comprehensive services for every child. However, judging by the socioeconomic distribution, close to two thirds of families may require State assistance in one or other way. This can only be achieved with a shift towards an equity-driven ECD framework.

Equity of outcome, as opposed to equity of access, requires the allocation of resources to those most in need. The State could aim for all children to receive some service by opportunistically expanding access as NPOs establish more centres. This describes the current model. The alternative, which we strongly recommend, is that government focus on ensuring that those in greatest need of services receive them. Access based on the current method entrenches existing inequalities, while focusing State effort on areas of greatest need, will help to erode them. Progressively realising equity of outcome requires the identification of the children most in need of services and ensuring that those children and their families receive them.

The State must put in place laws, funding, infrastructure and programmes to bridge the access gap for the most marginalised. At present, the State is taking the measures necessary to ensure access by the most marginalised communities to birth registration, health care, social security, access to water and electricity, and Grade R. The same approach needs to be taken to other aspects of ECD services. These include food and nutrition to prevent (not only to treat) malnutrition, early childhood care and education services for poor children aged 0-4 and children with disabilities, and support for parents and families including with childcare for very young children.

A paradigm premised on equity will require a number of policy changes. Firstly, adequate funds must be allocated to ensure ECD services for the most vulnerable children. This must be backed-up with a leadership structure which is accountable for the implementation and monitoring of services. This requires attention to: a) infrastructure, basic services, personnel and other resources needed for the provision of ECD services; b) a costed and State-funded

ECD policy and plan of action for children with disabilities; c) programmes to ensure vulnerable young children receive adequate nutrition, and early detection and remediation of stunting; d) eligible pregnant women receive material and nutritional support, including pre-birth registration for the Child Support Grant; e) all employers (starting with the State) providing paid maternity leave to employed mothers and offering breastfeeding support for mothers returning to work, and f) the introduction of laws governing sectoral responsibilities not covered by the Children's Act (such as water and sanitation, and food and nutrition) to fill gaps.

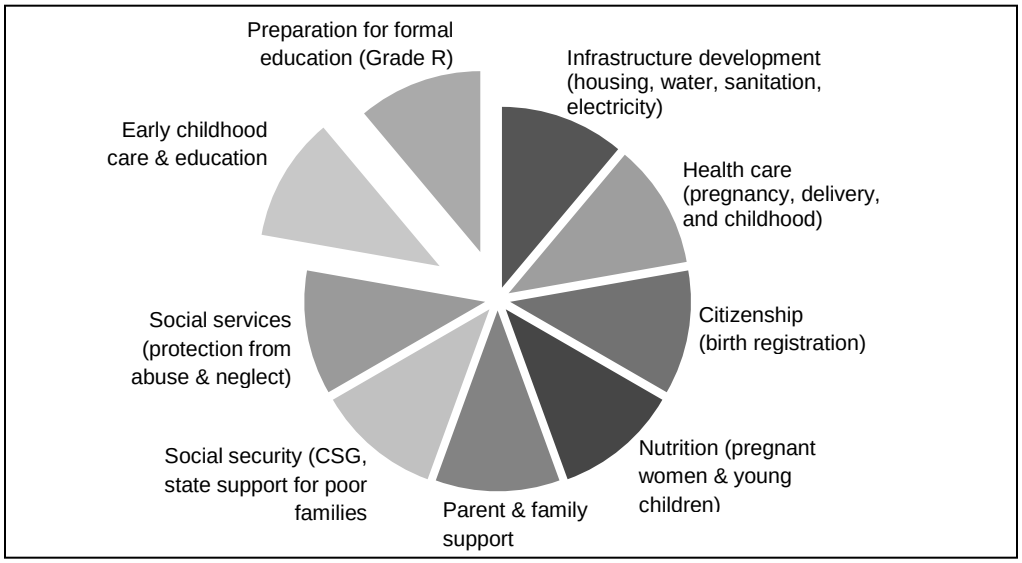
2.2 Current policies

Assessment

The government has demonstrated its support for ECD by signing the African Charter on the Rights and Welfare of the Child, the Convention on the Rights of the Child, Education for All and the Millennium Development Goals. Moreover, children's rights are protected by the South African Constitution and various Acts and policies (BP2). The Children's Act, the National Integrated Plan for ECD, and various White Papers further demonstrate government commitment to ECD (BP3). These policies, papers and plans reflect vision of a comprehensive approach to ECD.

However, a holistic and comprehensive approach to early child development is yet to be achieved. Figure 2 illustrates the package of services that promote and protect the development of young children. Many of these are already provided in South Africa and active steps have been taken to expand their coverage to the poorest families in need.

Figure 2: Services that promote and protect the development of young children



Health and nutrition policies, even when explicitly targeted to pregnant women and young children, tend not to identify with ECD as currently formulated, and they do not feature prominently in ECD policy documents. Parent and family support is also under-developed. Thus, whilst ECD is a clear policy priority, to date only a few ECD services have been highlighted – these are early childhood care and learning and Grade R. Others, such as infrastructure, health

and citizenship are not routinely included in what is described as ECD services. While early childhood learning and Grade R are critically important aspects of ECD, this approach fails to mobilize support across a broad front, and to benefit from the budgets, workforce, and delivery mechanisms of several sectors and departments. It also limits opportunities to maximise cross-sectoral collaboration, reach more families and achieve complementarities between the benefits of different ECD services.

The Children's Act, as the overarching legislative framework, does not obligate national, provincial or local government to fund or ensure provision of ECD services, including early learning and care programmes. The Act obliges only the Minister of Social Development to develop a comprehensive national strategy aimed at securing a properly resourced, coordinated and managed early childhood development system, giving due consideration to children with disabilities and chronic illnesses (BP2, p49).

Provincially, the Act obliges the MEC for Social Development to register and to maintain a record of all registered early childhood development programmes and, within the national strategy, to develop a provincial strategy aimed at a properly resourced, coordinated and managed early childhood development system. The Act does not oblige, but affords the MEC for social development the discretionary (unenforceable) power to provide and fund ECD services (Section 93(1)). This minimal direction to fund refers only to early learning and care services, not ECD more broadly. In the same vein, the Children's Act defines ECD widely, but it regulates only early learning and care facilities, leaving aside regulation of other ECD services (BP2, p37).

As indicated under **Definitions**, there is lack of agreement as to the age of children falling within the ECD framework in South Africa. This needs to be made consistent and we recommend the range from pregnancy to age 8 years as outlined in the UN General Recommendation No 7.

Moving forward

Most components of the 'ECD package' - health, nutrition, education, social services, protection, and a name and identity - enjoy an elevated constitutional status. According to S28 and S29 of the Constitution, realisation of these rights is not subject to progressive realisation. This means that they should be immediately available and accessible to all children in South Africa. In contrast, the current approach to the provision of ECD, as articulated in the Children's Act, is premised on the notion of progressive realisation. Section 2(2) provides that government must take reasonable measures to the maximum extent of their available resources to achieve the realisation of the Act.

Constitutionally then, ECD services should not be subject to progressive realisation. If they are, the State must take clear legislative and supporting steps to ensure realisation of the right to ECD services. Such steps must be reasonable. Rights cannot only be recognised in law. The State must also put forward a plan that is capable of realising the right to ECD services and it must implement that plan.

Critically, the State must make provision for securing the rights of the most vulnerable members of society. As pointed out in the Grootboom judgement[31], it is not enough to show statistical advancement of the right. The plan must ensure that those whose needs are most urgent and

whose abilities to enjoy the right are most at peril are not excluded or ignored. Special and additional measures by the State are necessary to secure their rights.

At present, the ECD plan is at risk of not meeting the "reasonableness" requirement because of the implicit exclusion of the most vulnerable children in poverty and those with disabilities. In order to remedy this omission, it is necessary for the revised NIP to articulate a clear and enforceable obligation on the State – national, provincial and local government – that will secure ECD services for the most vulnerable children. This means that, in addition to subsidising and regulating ECCE services for child in registered centres, the State must provide and fund ECD.

2.3 Inter-sectoral collaboration

Assessment

The importance of inter-sectoral collaboration is recognised in White Paper 5 on Early Childhood Education[32] and is key to realising the goals of the NIP. In the NIP, integration and collaboration are envisaged to result in expanded service delivery, cost-cutting through shared resources, and more efficient and speedy delivery of services.

The Plan recognises that: a) different departments and stakeholders are responsible for different components of ECD, but that they should work collaboratively to achieve a common development goal; b) at a structural and systems level, the plan "requires an inter-sectoral and interdepartmental system and mechanisms for it to be realised", and c) "that the inter-sectoral coordination mechanism of the integrated plan is the most critical aspect to the success of the implementation of the plan".

The advantages of coordination are clear. The vast majority of pregnant women and very young children are in contact with health services, creating opportunities to support nutrition, parenting, access to social security and other ECD interventions. Birth registration and applications for Child Support and other grants provide opportunities to raise awareness and provide key messages to promote parenting and early child health and development. Early learning and care centres and programmes, as well as schools and centres offering Grade R, are potential sites for primary health care and parenting programmes, and could be used as distribution points for supplementary feeding for young children. The mechanisms envisaged, however, have either not been established or have failed to generate the desired results. We found few examples of integrated ECD programme delivery. One with potential is *Care for Child Development*, a module of the Integrated Management of Childhood Illness (IMCI) that uses all contacts between the health system and very young children to promote feeding, play and language development among mothers and other caregivers[33]. The various one-stop service delivery and multi-purpose community (Thusong) centres could also be used to disseminate key ECD messages and link families to services[34].

What is required is an overarching approach, driven from a central mechanism, which asks what ECD benefits can be gained from every contact with young children. This is critical to ensure the delivery of ECD services to poor children and their families, and to benefit from complementarities between ECD services.

The mechanisms envisaged in the NIP for attaining an integrated approach to ECD services include: a) inter-sectoral collaborative planning and service delivery for ECD and agreement on targets for services; b) ensuring that each department makes a budgetary commitment, and c) co-ordination and monitoring of a comprehensive programme.

The NIP establishes various coordinating political and administrative structures at the national, provincial and local level. These are: a) MEC Committees of the Social Cluster through which political leadership and support will be provided for implementation; b) ECD Inter-Sectoral Committees (government and non-government members) as a component of the Presidency's National Advisory Council on Children's Rights. This locates all matters at a national level in the Presidency and at a provincial level in the Premier's office, and c) A National Inter-departmental Committee for ECD, established and led by the DSD on which sits the Departments of Health, Basic Education, Home Affairs, the Presidency and others to facilitate the planning and implementation of integrated services in terms of the Plan (BP2, p8).

An Inter-Departmental Committee and ECD Inter-Sectoral Committees (known as ECD forums) have been established at national and provincial levels. But several serious challenges to integration and inter-sectoral collaboration persist. Amongst these is the marginalization of key departments such as the Department of Health. Whilst Health has numerous programmes that target and benefit young children and their families, its services are not identified with ECD policies and programmes and are not, in their design, implementation or evaluation, linked to the NIP (BP2, p11)[35].

Moving forward

Effective inter-sectoral collaboration requires several pieces that are not yet in place. These include: a) ECD objectives being mainstreamed into relevant sectoral policies and programmes. A review of policies and programmes across different departments indicates that the NIP does not appear to have been translated into departmental ECD plans, programmes and budgets, other than in DSD and DBE (BP2); b) There must be a common ECD agenda and goals across the relevant departments to align with the NIP objectives beyond DSD and DBE. As an example, the provision of water and sanitation to ECD centres and programmes, including ECD centres, and prioritising households with infants and young children in terms of indigent policies or infrastructure development plans; c) There must be an integrated monitoring and evaluation process or framework as envisaged in the NIP against which the various departments and stakeholders plan and report on progress to the NIP's coordinating structures; and lastly d) There must be costing and budgeting for the roles and responsibilities of the different departments assigned by the NIP (BP2)[36].

There is very little inter-sectoral collaboration across ECD services. This raises questions about the effectiveness of the design and location of the current structure responsible for oversight of the Plan and its objectives, budget and outputs. Concerns have been raised before about the perceived inappropriateness of locating a multi-sectoral coordinating structure within a specific lead department, as opposed to a truly representative structure independent of any specific department[37].

Mechanisms for integration and stronger inter-sectoral collaboration have to be investigated. The importance of ECD to outcomes of national importance for health, education and

productivity, the wide scope of ECD services across several sectors, and the size of budgets allocated to ECD services (such as the CSG, primary health care, Grade R, etc.) necessitates that the mechanism have the authority and autonomy to act effectively. The mechanism also needs to be serviced by a knowledge hub to ensure that stakeholders across many departments are kept informed about the latest developments in ECD research, programming and evaluation, as well as dedicated staff to perform coordinating and accountability functions. Options include an agency, board, commission or programme with Cabinet-level authority, tasked to achieve ECD objectives across various sectors. This has been done in other low- and middle-income countries[38]. The exact nature of such a mechanism is a matter for further discussion, but it is clear that the current institutional arrangements are not sufficient to drive ECD forward in a coordinated way.

2.4 Services and programmes

Assessment

There are a very large number of government services and programmes that benefit families living in poverty and therefore contribute positively to the development of their young children[39]. These include, for example, free basic water and electricity provided by the Department of Water Affairs and Energy, respectively, and a housing subsidy provided by the Department of Human Settlements. In addition to these indirect services, there are a range of services and programmes which directly benefit young children's development. A number of these programs are reaching a large proportion of poor children and have likely already generated considerable benefits for South African children.

Services and programmes are funded and provided by the Department of Health to promote the health and wellbeing of pregnant women and young children; social security, social services and early learning and care centres are funded by the Department of Social Development, and Grade R is funded by the Department of Basic Education. Indications are that there has been good progress to date in certain ECD services including in antenatal care, birth registration, access to safe drinking water and electricity connection, among others (Table 2). The per capita subsidy for children in ECD facilities has increased and has been expanded to cover more than 460,000 children; 80 percent of children are enrolled in Grade R.

Through the policy of free health care for women and preschool children, satisfactory although not always high, coverage has been achieved for contraception use, antenatal visits, HIV screening, skilled attendance at delivery, initiation of breastfeeding and immunisation.

As previously indicated, more than a million children younger than 4 are estimated to be in some form of out-of-home care or early learning or care facility or programme (BP7, p10). National information on the quality and distribution of ECD facilities is dated and a follow up audit to the one conducted in 2001[40] is being planned. Except in one or two provinces which make a small contribution, early learning and care services and programmes have to fund their own infrastructure, maintenance and improvements from subsidy income (if they receive it), user-fees and donations. In only 25 percent of facilities is the equipment and learning materials rated as adequate[41]. Only a small number of children (11,470) have been registered as part of the home-based ECD programme[42]. Very few children with special needs are catered for in

ECD programmes, and little has been done to actively prevent childhood disability through better pregnancy and birth care, to increase parent and family awareness of home dangers causing childhood injury or to develop, expand or fund home- or community-based programmes for children with special needs (BP4, p33, p40).

The Reception Year, as the first year of foundation phase schooling for 5-year-olds was envisaged in 1995 and phased in from 2001. With accelerated expansion, 80 percent of children in 2011 were attending Grade R programmes, with most in public school classes and about 20 percent in private or community centres (BP9, p8).

Moving forward

As indicated before, additional benefits for the development of young children would arise from improved coordination between departments. In addition, it is important to address gaps in current services provided by Health, Social Development and Education.

A focus on nutrition is especially important given that about 16 percent of children in South Africa are born of low birth weight (<2500gms)[43] and 18 percent of children are stunted (below 2 SDs of expected height-for-age)[44]. Low birth weight is the single best predictor of child health and wellbeing and is caused by poor maternal nutrition, stress and/or ill-health[45]. Stunting results from long-term undernutrition due to inadequate frequency of feeding, poor quality food and recurrent infections. It affects children's strength, stamina and cognitive ability, both in the short- and the long-term[46]. The trajectory of linear growth is laid down in the first two years of life, and children who are stunted in early childhood do not make up for their lag at a later age. Data from several low- and middle-income countries, including South Africa, show that stunted children achieve, on average, one school grade less than their better grown peers[47]. Long-term follow up in Guatemala has found that stunted children who received no intervention earn roughly 46 percent less as adults than stunted children who received supplementary feeding in their first two to three years of life[48].

Priority areas for improvement of ECD services by Health are maternal and child nutrition in the first 1,000 days, provision of early antenatal care[49], reducing smoking and alcohol use during pregnancy[50], emergency obstetric care to prevent maternal deaths and childhood disability[51], preventing and treating maternal depression[52], deworming[53], early identification and support for children and families with special needs including disabilities[54], and the promotion of nutrition, health and development (especially language development and play) in all contacts with young children[55]. South Africa has one of the highest rates of foetal alcohol syndrome in the world and this is a significant contributor towards disability among young children[46]; and more than 30 percent of women with a young child report being depressed[48].

The priority areas for improvement of ECD services by Social Development are parenting support, including through public awareness and education in collaboration with civil society and mass media (BP5, p7); the development, funding and expansion of home- and community-based care; childcare options for working parents and other families needing assistance (BP6); the inclusion of health promotion and nutrition in all programmes reaching young children (BP4); and the prioritisation of the establishment of learning and care programmes and centres in poor and under-served communities. Current registration procedures are cumbersome, resulting in delays and centres and programmes being excluded (BP7). Further, municipal engagement is

limited to inspection with little, if any assistance and support for ECD services and programmes to reach the standards required for registration (BP2).

The priority areas for improvement of ECD by Education include: consolidating expansion with improvements in infrastructure, learner support materials and equipment; standardisation of training, qualifications and remuneration of staff; and overall management and integration of Grade R in relation to prior preschool learning and care, the foundation phase as a whole, and subsequent schooling. Grade R needs to be made compulsory (BP9). In addition, if Grade R is included in ECD provisions, attention also needs to be given to the nutrition, health, safe transport and after-school care of young children in Grade R (BP9, p14).

2.5 Assessment of human resources

Assessment

ECD services depend on human resources from a number of sectors, and each sector has its own structures. Health and Education fund posts for the delivery of services. DSD funds posts for the delivery of social welfare services, but it does not fund posts for the delivery early learning and care programmes and centres. All sectors have significant vacancies and unfilled posts. However, in early learning centres and programmes, as well as in Grade R, it is especially important also to improve the average level of training and possibilities for career advancement. Particular effort is required to create training opportunities for practitioners employed in outreach or centre activities by community groups and smaller service providers (BP8).

The health sector has an established formal staffing structure with both differentiated professional levels and trained non-professional cadres (such as HIV counsellors, community health workers and clinic assistants). There are, however, a number of serious human resource problems, including critical staff shortages, mal-distribution of staff, gaps in key skills, problems with staff motivation and performance, fraud and corruption, and inadequate supervision and management (BP4, p39).

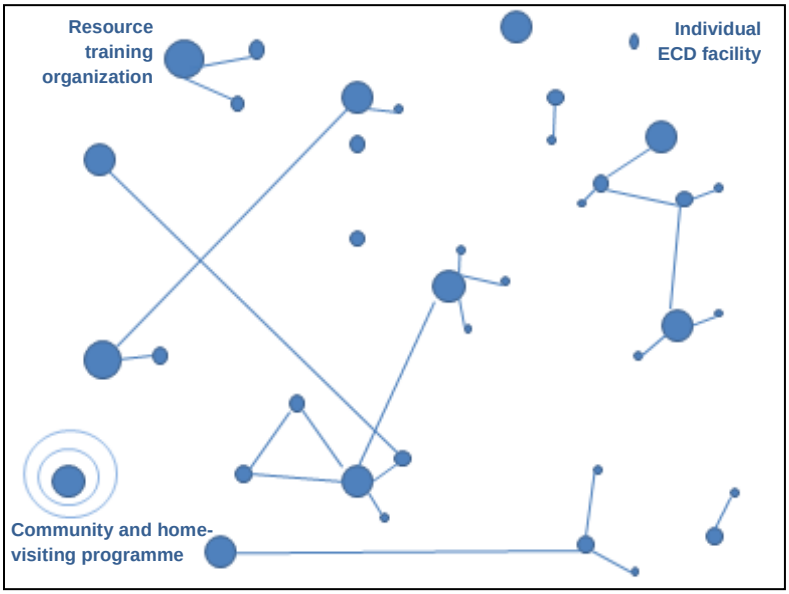
The education sector also has an established formal staffing structure, with many of the same problems as health. Grade R training, qualifications and remuneration have still to be fully integrated into the education post structure. It will take some time to fulfil the new policy on minimum requirements for teacher educations which propose a Level 6 (360 credit) Diploma in Grade R (BP9). The Department of Basic Education is also responsible for human resource development for services for 0-4-year-olds. There are accredited courses for ECD practitioners at Levels 1, 4 and 5. However, up to two thirds of practitioners are not qualified, under-qualified or need skills upgrading (BP8).

Since 2004, the Expanded Public Works Programme (EPWP) ECD Programme is a major a source of funding for the training of practitioners in early learning and care. DSD identifies practitioners in registered ECD sites and the DBE selects candidates, offers training and pays a stipend during the training (BP8). The current target for 2014 is to train 80,000 practitioners and Grade R teachers at Levels 4 and 5. By 2011, 26,032 had been made available[56]. However, it is not clear how many practitioners have been trained, how many practitioners have been placed in Grade R or in ECD, and how permanent the work opportunities are. Grade R, which offers a

better salary package tends to draw practitioners away from ECD, once they have been trained (BP8).

An illustration of early learning and care programmes and services are distributed in relation to Resource Training Organizations is shown in Figure 3. Some centres and programmes are stand-alone, some are linked together in informal or more formalised networks, and some are linked to RTOs, but there is no overall national structure for supporting services across the country.

Figure 3: Graphic representation of the current organisation of ECD provision in SA



About 65 Resource Training Organisations (RTOs) provide training and in-service support to smaller community-based organisations (CBOs) and individual crèches that provide early learning and care services. There is also donor-supported accredited training through NGOs registered as private FET institutions but this kind of support has declined due to public sector involvement in training (BPs7&8). Opportunities exist for those practitioners and aspiring practitioners who can afford to pay fees.

A number of skills courses that can improve performance and work efficiency are offered by different providers e.g. Financial Management, Governance and Leadership Training, HIV AIDS Awareness, Legalities and Childcare, and basic classroom enrichment. The extent of this is not known and these courses are currently not accredited for early learning and care work in ECD centres (BP7, p27).

There are several categories of community-based workers across a number of sectors, including about 3,440 Community Development Workers (DPSA) who are being specifically tasked to direct children to ECD services and centres to DSD registration and assist in the establishment of ECD services)[57], more than 40,000 Community Health Workers as at 2004 (DOH)[58], about 20,000 Community Caregivers (CCGs) have been trained by the DSD[59], and there are unknown numbers of Community Care Workers, Child Care Workers[60] and other categories of home and community-based workers. While there may be potential overlap in the numbers, these people comprise a significant human resource and all interface with children, especially young children, in their homes and in the community. White Paper 5 on ECE noted that “Community-based services meet the needs of infants and young children are vital to ECD”[61]. If there was an overall framework under which such groups work in communities, and some common conditions, training, qualifications and remuneration, it would be possible to advocate for training in and delivery of basic early child development principles and practice.

Moving forward

A number of steps can be taken to improve the human resource situation, especially for the delivery of early learning and care services. These include: a) the development and implementation of a strategy to fund staff, improve staff qualifications and retain staff in early learning and care. This includes provision for continued training and upgrading for practitioners, subsidised training opportunities for community outreach workers, development of job hierarchies and career opportunities, and incentives to improve skills and qualifications; b) better articulation between qualifications across practitioners in different sectors and across community-based workers, and c) the development of a core package of ECD messages for inclusion in the training of home- and community-based workers, from all sectors who interface with young children and their families.

2.6 Assessment of current funding levels and mechanisms

Assessment

It is very difficult to make accurate estimates of allocations and expenditure on ECD. This is because ECD cuts across several sectors and departments do not budget according to a common ECD framework. There is thus no identifiable ECD line item running across departmental budgets. Similarly, local government budgets do not identify ECD spending and, in the main, do not fund ECD services (BP10).

It is possible, though, to discern the funding streams within DSD and DBE. Most of these budgets are allocated at the provincial level. The total DSD budget for per-child subsidies, transfers to NPOs, the EPWP, and other programme support, with the possibility of double-counting, is estimated at around R1.2 billion per annum (BP10, p7)[62]. Moreover, there is a large and increasing budget for the CSG, of which about R1 billion per annum is paid in respect of children under 6 years of age[63]. The total DBE budget is roughly R3.3 billion per annum for the provision of Grade R in public schools, subsidies for community-based Grade R services, training of practitioners for pre-Grade R, and materials (BP10, p8). Funding levels for ECD in both of these departments have risen substantially in recent years, far outpacing inflation. The other major funder of ECD services, the Department of Health, unfortunately does not collect data in a way which allows budgets for specific age groups to be identified. However, it is unlikely that the allocation of the health budget is proportional to the 40 percent share of the population that children comprise (BP4, p41).

Although it is clear that additional funding is needed, it is difficult to determine the extent of the shortfall. There has been no costing of an ECD package of services, nor has there been population-based mapping of the need for ECD services, highlighting the areas of deprivation that must be prioritised.

The dependence on NPOs and user-fees perpetuates long-existing social and individual inequalities between regions of the country and between families. There is much to learn from Grade R expansion. Whilst there are concerns about quality that must be addressed, the State assumed responsibility for meeting its commitment to establish Grade R, grafted the service onto school education with its infrastructure and organizational systems, and subjects it to policy-based regulation. This has resulted in significant and equitable scale up of service

access. Children in the poorest provinces have flocked into Grade R (BP9, p8) because it meets their needs and those of their families for free childcare, food (even if it is minimal), and activities that may contribute to children's development. Parenting support, educational stimulation and nutrition for very young children can similarly be grafted onto promotive health and community outreach services.

The good news is that funding levels for ECD are increasing. However, the funding increases do not always support pro-equity service provision. Social security, health care and Grade R funding and provision probably contribute substantially to the reduction of inequality. There is, though, genuine concern that funding early learning and care through per-child subsidies to registered centres does not adequately respond to need (BP7). Instead, it leaves children's chances of receiving services to where they happen to live, where NPOs establish services, and the ability of their family to pay user fees. If a NPO is not present in their area, there is likely no centre, or likely no centre that reaches the standard required for registration. The State subsidy can therefore not be accessed on the child's behalf. If an NPO-based centre has been established, and is registered, but the child's family cannot afford user fees, the child also receives no State support. There is little, if any State support for infrastructure investments and other start-up costs, and no commitment by the State to ensure services are available. As a result, in places where there are currently no services, there are unlikely to be services anytime soon.

The per-child subsidy is targeted by a means test to reach poor children, but it does not ensure equal access to services for all children. At the margins are poor children, including those in unregistered facilities, children living in rural and informal urban areas without access to centres, and children with disabilities who have less access to registered centres. Almost all facilities charge user fees. Fees range from 27 to 72 percent of centre income, depending on quintile area[64]. User-fees range widely from R50 to well over a R1,000 a month. As a result, children living in the poorest 40 percent of households are only half as likely to benefit from early learning and care as children in the richest 20 percent of households).

Moving forward

What is needed is a new funding model which prioritises resources for the most vulnerable children. This means providing services where there are none, not only in centres but also in home- and community-based programmes, based on a per-capita allocation. Funding must also be allocated for programme development and maintenance, such as training, resource materials, monitoring and quality assurance.

The model must be capable of realising the State's commitments and legal obligations to provide ECD services, including opportunities for early learning and care, especially to young children living in poor families, rural areas, informal urban areas and to children with disabilities. This requires the State to take responsibility and be accountable for supporting and funding a range of ECD services – including home- and community-based programmes - and ensuring that services are prioritised for the most marginalised children. A funding model restricted to a means-tested per-child subsidy to registered centres will not, on its own, achieve this end.

There is a need to move towards a funding model that is government-driven – properly costed in terms of needs, numbers and quality – and which is pro-equity. It must start with and prioritise

provisioning of services for the hardest-to-reach children. The cost of services must include infrastructure and facilities, staffing, and maintenance needed to deliver a basic package of services. This package must include at least the following:

1. Early antenatal care for pregnant women, including nutrition and counselling against alcohol and tobacco use.
2. Birth registration and CSG registration.
3. Breastfeeding support, food and micronutrient supplementation for young children at risk and enhanced food fortification.
4. Child promotive health care visits for growth monitoring and promotion, immunisation and developmental screening.
5. Home visitation, community groups and other support mechanisms for mothers and families who show indications of vulnerability (for example, women are who socially isolated, who skip postnatal visits, screen positive for depression or domestic violence, and whose children show growth faltering or early signs of disability).
6. Parent guidance on growth monitoring and promotion, the importance of language and play for educational stimulation, and the adverse effects on development of harsh punishment of young children.
7. Participation in centre or home- and community-based early learning and care programmes that provide safe care and feeding, basic health and hygiene promotion, opportunities to interact and play with other children, language exposure through storytelling, songs, and reading, and learning of basic concepts in preparation for school.

A government-driven model does not mean the State must provide all services, but it does mean that it should ensure adequate funds to provide services for families who cannot afford to pay for them. A government-driven funding model does not mean that the State cannot raise funds from partners or facilitate provision by the private sector and non-governmental partners, as it does in health and education. But government is accountable for finding and directing the necessary funds to meet its expressed commitments and legally created responsibilities. Partners must commit to a common national ECD plan and contribute their funds to the delivery of national ECD policies and standards in a coordinated manner to ensure an equitable spread of essential good quality ECD services.

The new funding model must be designed to ensure resources are directed to the most needy children to start with. In many areas this will involve the establishment of or payment for infrastructure or the use of available facilities. Areas of multiple deprivation in each province are already mapped, including through the school quintile ranking system[65]. The poorest areas must be prioritised and ECD support in these areas accelerated. From this base, a system of universal provision, along the analogy of immunization given earlier, can be developed.

The new funding model must ensure services for children 0-2 years of age as the evidence is clear that interventions for this age group are greatly needed and highly effective (BP1). However, care must be taken to avoid the creation of inappropriate incentives. For example, giving preference to centres (because they are easier to fund and monitor) over home- and

community-based programmes may encourage caregivers to send very young children to centres to access resources such as feeding, when children in this age range are best cared for at home or in very small groups in a home environment (BP5). The private sector and the State as an employer must be encouraged to provide childcare for parents in formal employment. However, safe childcare is also needed by poor women working in the informal sector and in subsistence livelihoods. We recommend that this issue be brought into discussions on the way forward.

The new model must have a simple approach to funding and monitoring programmes. Providing subsidies directly to families for ECD services depends on parents' appreciation of investments in early childhood. Subsidies to centres may entail perverse incentives to put very young children in centres to obtain benefits. For programmes to receive subsidies, they will have to ensure a specified package of quality ECD services to eligible families. As specified, delivery of the suggested basic package can be monitored through existing data collection systems (service statistics, national surveys), as well as regular community audits.

Consistent with a comprehensive approach, use must be made of existing facilities for the delivery of ECD services. These include primary health care centres, as well as mobile health services, centres and programmes providing early learning and care, NPOs, one-stop centres, offices of traditional authorities, churches and other faith facilities, as well as municipal and provincial service points.

2.7 South African evidence and data

Assessment

The Diagnostic Review emphasises the need for large-scale coordinated intervention. Given tight resource constraints it is critical to ensure that any increased spending is appropriately directed. This requires a good understanding of the current level of service provision and the impact of ECD on young children, as well as up-stream impacts on their subsequent growth, cognitive development, school performance, health and productivity.

South Africa is fortunate to have several repeated nationally representative surveys from which data can be drawn. These include the Census, the General Household Survey, the Labour Force Survey, and the National Income Dynamics Study. In general, though, age is seldom disaggregated within the early childhood period (0-2, 3-4 and 5-6 years), in relation to historical and contemporary indicators of access such as race, gender and socioeconomic status.

There are an estimated 5.1 million children 0-4 years of age, of whom about 2.3 million children (±50 percent) are poor. Although fewer than half of households in which very young children live cite salaries and wages at their main source of income, there are encouraging developments in other measures of their socioeconomic circumstances (BP12). Areas in which decisive action needs to be taken – because the youngest children are the most adversely affected by such conditions – are food insecurity (reported by 17 percent of households with a child 0-6 years); unsafe water (13 percent); absence of hygienic sanitation (30 percent), and no mains electricity connection (18 percent). Also worrying is the fact that only 34 percent of children 0-6 years of age live with both their parents, a figure that varies from 28 percent in households with monthly expenditure below R1,200, to 78 percent in households with monthly expenditure above

R10,000; 20 percent of young children in the poorest households live with neither parent (BP12).

The data in the GHS surveys is ambiguous with respect to participation in ECD programmes, and this also affects comparisons across time. In fact, the only indicator that can actually be tracked is *the proportion of children in some form of out-of-home environment for an unknown proportion of the day*. This is because: a) the questions includes a variety of environments, not all of which can be assumed to provide quality learning and care, including preschools, crèches, play groups and childcare, and b) the classification of the environment or whether a child is exposed to an ECD programme is done according to the respondent's interpretation. A respondent in the GHS is any available competent household member aged 15 years or older, and might thus be someone who is not well informed about either the child's activities or the characteristics of the child's participation or placement in a centre or programme. Within these constraints, the ratio of children 0-4 years who are in out-of-home environments for some proportion of the day, has increased from 17 percent in 2005 to 35 percent in 2010. Attendance has remained stable, at roughly 50 percent, of children in the highest SES group, and doubled from about 14 percent in 2005 to 29 percent in 2010 among the poorest group (BP12, p50). This certainly indicates a demand for out-of-home care among poor families.

The needs for safe and affordable childcare of working and other parents for assistance with childcare receives little, if any attention, in current ECD provisioning (BP6). However, about 32 percent of women with children 0-4 years of age indicate that they do some form of work. Some 1.4 million 0-4-year-old children have parents who may need assistance with child care because either the parents work, are engaged in full-time study, or are chronically ill or disabled (BP12, p60).

The definition of disability in the 2009 and 2010 GHS is completely unsuitable for children 0-4 years, leaving the ECD sector with little information on disabilities among young children. The definition relies on difficulties, amongst others, in walking a kilometre or climbing a flight of steps, remembering and concentrating, and self-care such as washing or dressing. All young children would have difficulties in these areas by virtue of their developmental stage.

Moving forward

Decisive steps need to be taken to improve the quality of data collected in repeated national surveys. The NIDS includes questions that enable better differentiation of the exposure of young children to early learning and care programmes. Improved measurement applies also to the assessment of disability amongst young children, and specialist follow-up consultations may be needed to achieve this.

In addition, data on many ECD services are routinely collected – birth registrations, CSG grant access, attendance at antenatal clinics etc. An ECD scorecard, combining indicators of a basic package and updating it annually would be a powerful driver for increased performance. Information on other services, such as learning and care programmes, are only collected when a facility is registered, or not at all – as is the case with child minders looking after fewer than 6 children. In order to extend financial support to home- and community-based programmes in a systematic way, all children in programmes need to be registered with their ID document or other form of unique identifier (BP7).

A lot of effort has and is being expended on tracking, monitoring and evaluation information on children in South Africa. Examples include the Child Indictors project run by the Human Sciences Research Council[66], the South African Child Gauge compiled annually by the Children's Institute at the University of Cape Town[67], the Children's HIV and AIDS Scorecard 2011: Monitoring South Africa's Response to Children and HIV and AIDS compiled by the Children's Rights Centre[68], the ELRU/ACCES Score Card for Monitoring Obligations to Young Children[69], the District Health Information System[70], and so on.

We have proposed strong leadership for ECD. This must include also an information hub and the technical capacity to extract, understand, summarise and make data available as needed by the sector.

2.8 Impact and cost-effectiveness

Assessment

Very few South Africa studies have examined the impact of ECD services on one or other child outcome. Despite method and data concerns, the studies that have been done, report benefits for children, particularly with regard to nutrition and growth[71].

Two studies, one using data from 2008 National Income Dynamics Survey (NIDS)[72] found participation in some form of out-of-home care at 3-4 years of age to be beneficial for children in rural informal areas; another using data from the 2007 SACMEQ III found that exposure to out-of-home care improved test scores at Grade 6 level in reading, math and health knowledge.The greatest impact came from the first year of participation and somewhat less from subsequent years of participation[73]. However, both analyses are problematic because they are based on non-random participation. Without adequate controls – some of which were adopted in the SACMEQ analysis - the family characteristics associated with sending a child to an early learning centre are similar to those associated with encouraging school performance, regardless of ECCE attendance. This means that the differences in performance at school cannot unambiguously be attributed to early learning and care.

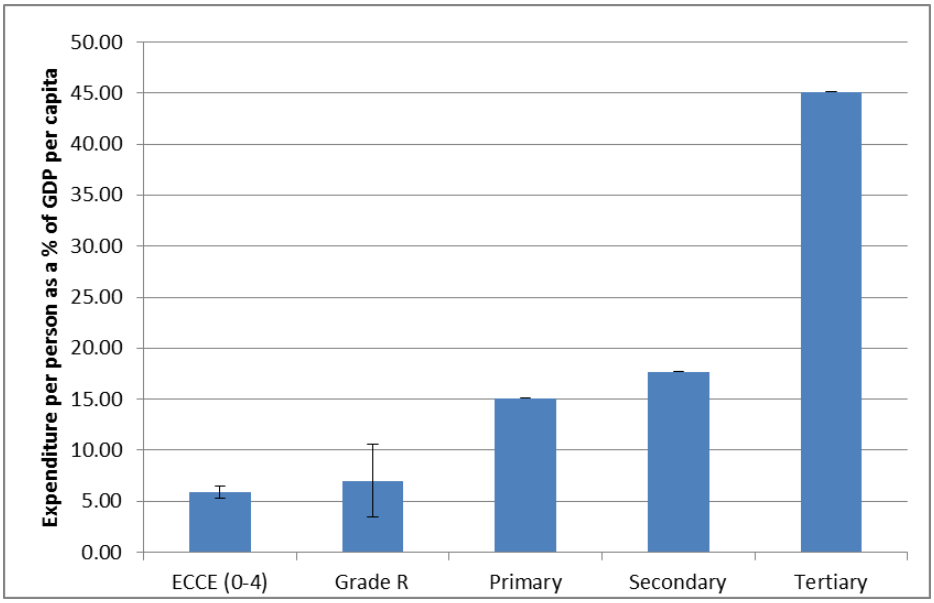
However there is very strong international evidence of the benefits of interventions for young children, including for nutrition supplementation[74], parent and family support[75], and early learning and care programmes[76]. The known benefits of quality ECD services for children's growth, health, cognitive performance and personal and social wellbeing justify its provision by the State from a human rights perspective. Additional individual and social benefits that accrue over the longer term, making ECD a public good, further justify State intervention. If public goods are not subsidised, they tend to be under-provided. Failure to appropriately subsidise ECD services, moreover, will lead to skewed coverage and skewed uptake, which will increase rather than reduce inequalities.

The benefits of ECD are amplified by complementary services, for example, good nutrition and engaged parenting at a young age are more beneficial when they occur together[77], and even more so when followed by a smooth transition to formal schooling. But ECD services also help to compensate or substitute for both past, current and future disadvantages accruing from household poverty and/or low quality schooling. Quality ECD prepares children to deal better

with future challenges. The role of ECD in determining children's ability to benefit from or endure future environments is one of the reasons why returns to ECD investments are so high[78].

Although ECD services have the potential to generate high returns, investments in this sector remain disproportionately low in comparison to later investments in education. This is partially due to the low coverage of early learning and care services, but also to low levels of investment per child who is covered. As indicated in Figure 4, it is estimated that almost three times less is spent on early learning and care (excluding Grade R) than on primary education and nine times less than tertiary education[d].

Figure 4: Expenditure per child/student enrolled in education as a percentage of GDP per capita



The estimates are not intended to argue for funding to be reduced at the tertiary level. Rather, it is to demonstrate that despite the known high returns, investment in early education is low – even for children who are covered by the subsidy.

It is easier to make the argument for investment in ECD than it is to determine which ECD outcomes to prioritise - between, for example, health, psychological wellbeing, educational readiness and civic mindedness. Unless ECD is defined by a single outcome measure, interventions cannot be ranked according to their efficiency at producing that outcome (which is what cost-effectiveness analysis does). Children's development benefits from many types of

[d] See the Annex of Background Paper 11 for a detailed explanation of the data. ECD (0-4) is based on the average of the total subsidy payable in the Free State and the Western Cape plus a 20% overhead. Grade R is based on average of reported expenditure divided by the number of children reported to be enrolled in Grade R and 70% of the cost per child in primary school. Primary and secondary school data are taken from World Development Indicators 2011. Tertiary expenditure is based on the Ministry of Higher Education budget for university subsidies plus a 10% overhead.

interventions - such as clean water, access to reading materials, support for parents, etc. and their complementarity is important; this makes cost-benefit analyses challenging.

The cost-effectiveness and efficiency of early intervention is grounds for a focus on very young children (0-2 years), but it does not negate the need for later intervention. It is imperative that every child has the best possible 'first chance'. However, every child deserves a second chance, especially if they were deprived of the most optimal conditions to begin with.

Moving forward

The quality of evidence on the impact of ECD services must be improved. This can be done by: a) improving the quality of questions in existing national surveys; b) conducting randomised control trials which provide the gold standard for evidence on impact, and c) longitudinal cohort studies[79]. Future impact studies need to address: a) selection effects, attributed to more motivated and engaged parents enrolling their children in services; b) assessment of the quality of services which is important in itself, but also to prevent averaging out the effects of services which differ widely in quality, from good to bad; c) direct measurement of outcomes to prevent distortions arising from the use of routinely collected administrative data which is often incomplete or inaccurate, and d) evaluation of more than one outcome for interventions. For example, nutrition interventions not only affect growth, but attention and activity levels; sociability, play and peer relations; exploration and school performance, and health.

3. Recommendations

A number of programme-specific recommendations have been mentioned in the assessments, and they are not repeated here. The aim of this section is to highlight recommendations which will prompt the shift necessary to improve institutionally the nature and scale of services provided. We highlight five recommendations pertaining to State responsibility, an equity driven framework, the necessity of adopting a comprehensive approach, funding and workforce development. We also make suggestions for some specific recommendations to fill gaps in the current paradigm and approach.

3.1 Recommendation 1: State responsibility

In 1994 South Africa embarked on a path along which it has progressively committed itself to protect and promote the development of young children, both as a human right and as a public good. To meet this responsibility requires:

- Policy and legislation that obligates all levels of government to ensure that ECD services are adequately resourced and provided. This requires amendments to the Children's Act, and a review of all relevant sectoral laws so that their ECD obligations can be mainstreamed.
- A Cabinet resolution or equivalent commitment is needed to give legitimacy to pursue ECD provision as a national priority.
- Authority and organisation to bring all participating sectors in government together to work towards agreed ECD goals. This requires an independent mechanism - an agency, board or commission - with high-level influence, an explicit mandate, and the necessary resources including expertise, to drive the ECD agenda forward and deliver results.
- Capacitation and resourcing of provincial and local government to ensure provision of a comprehensive ECD programme, including funding, infrastructure and quality assurance.
- A National Integrated Plan for ECD for all children in a defined age range, with buy-in and accountability from all relevant government departments, civil society, donors and the private sector. The Plan must spell out the obligations of the different government role players and civil society in realising a comprehensive ECD package.

3.2 Recommendation 2: Focus on equity

An equity-based approach ensures that the State, and its partners, prioritise the provision of services and support to those children and families who most need them.

Not all families need State support, and the State should prioritise those families in the greatest need. Most provinces have mapped the poorest and most disadvantaged wards. Work should begin in these areas immediately. Poor children in other areas, young children with disabilities, and children living in situations where parenting is compromised also need to be given precedence.

The most urgent next step is to develop a basic 'ECD package of services' to be rapidly expanded to reach vulnerable children. This must be done in collaboration with both civil society and the private sector, using all opportunities of contact with young children by community-based cadres. Implementation strategies must include every possible mode of delivery and progress should be tracked against coverage targets. A possible package of ECD services was outlined earlier.

3.3 Recommendation 3: ECD services should be comprehensive

The NIP review must be used to envision and give substance to a comprehensive approach to promoting early child development that rests on support for parenting, nutrition and health, and opportunities to learn. The elements of a comprehensive programme must include support across the developmental spectrum, including:

- Family planning, healthy pregnancies and postnatal care in order to give children an optimal start in life from conception.
- Nutritional support for pregnant and breastfeeding women and young children through a defined package of nutrition support in home-, community and facility-based programmes. It is especially important to prevent stunting and to address it timeously because it is the single most deleterious determinant of poor child development, with a strong link also to diminished adult capacity, health and adjustment.
- Families accessing social security through the CSG and other grants, subsidised housing and other State provisions for the poorest families so that parents and other caregivers are able to give children the care they want to provide them with.
- Parenting is supported through a wide range of mechanisms, including a) well-designed, high profile and frequent public education campaigns and series on radio, television and in print, b) through the faith sector and traditional leadership, and c) care groups and companionship support provided through home- and community-based programmes. Innovative communication technology, including cell phones and product marketing and distribution networks, should be used to reach deep rural communities. Growth monitoring, hygiene, nutrition and feeding, the importance of talking to children, the critical role of kind and caring protection by adults for children's development etc., all lend themselves to public education messages. In addition, traditional practices, such as responsive feeding, co-sleeping and carrying babies, need to be valued to prevent them from being discarded in favour of less child-friendly approaches and products. Exemplary public education programmes are currently being conducted in the United Kingdom[80] and the United States[81]; South Africa also has some programmes that could be used for this purpose[82].
- Quality learning by young children is encouraged at home and in groups, programmes and centres that focuses on building enjoyment of learning, the confidence to learn from others especially adults, and self-control and social respect so that children can participate in and contribute positively to social life.

- Preparation for formal schooling by enrolment and regular attendance in Grade R, with support for learning from parents and other adults in the home.

3.4 Recommendation 4: New funding provided in a new way

ECD services, as a whole, are currently un- or under-funded to achieve desired results. A basic 'package' of services to reach universal coverage must be costed for different modes of delivery. Many services, such as those provided by the Departments of Health and Home Affairs, are already in place but funds are needed to reach the families not yet enrolled. In under-serviced areas, ECD capacity and infrastructure, especially for early learning and care services, need to be established from scratch. A costing for the sector must be made from a population-wide perspective, rather than merely increasing funding for existing services, many of which are in already relatively well-provisioned geographical areas.

The youngest children (0-2 years) do well at home with parents and caregivers or in small group child-minding environments. Children 3-5 years of age benefit from some group experience and some structured learning activities, though this does not necessarily have to take place in a formal centre. Under-used space in homes, community halls, traditional authority offices, schools, clinics, and churches can all be used to run home- and community-based programmes for this age group. A targeted investigation should be commissioned to look at funding models for comprehensive ECD services that doesn't inadvertently incentivise centre-based early learning and care over home- and community-based programmes, or out-of-home childcare over family-based home care for working parents and other families needing assistance. While the argument has been made that fees may increase parental commitment and increase demand for better quality services, the very high enrolment in Grade R in the poorest provinces demonstrate that free services are much appreciated and meet the needs of poor families.

There has been no in-depth assessment of current philanthropic or private sector allocations to ECD, or future willingness by the private sector to support ECD. A third of the companies listed in the Corporate Social Investment Handbook indicate that they provide funds for children's programmes[83]. In many countries, early child development programmes are an attractive investment for the private sector. However, any non-State contributions must be aligned to government priorities for equity and universal coverage. Like Health and Education, ECD as a system needs to be regulated and overseen by the State.

3.5 Recommendation 5: Workforce development

The only ECD workforce assessments that have been made to date is with respect to practitioners working in early learning and care programmes and centres. In the main, they have been found to be in short supply, un- or under-qualified.

Children, especially young children, are at home or with a childminder, and they are best reached by community-based personnel. There are many such cadres in South Africa. A common framework that includes ECD amongst its priorities would create many opportunities to raise awareness, promote basic ECD services and provide referrals for children and families in great need.

The following workforce developments are needed to realise the scale and quality of ECD services to which we all aspire:

- A human resource development strategy to pay staff working in early learning and care centres and programmes, improve staff qualifications and retain ECD workers. This should include an audit of existing staff qualifications and resourcing for initial training and upgrading for all workers in the sector including those in support and monitoring positions, as well as centre-based and outreach ECD practitioners.
- Expand provision of subsidised training opportunities to all categories of ECD practitioners, including home and community workers.
- Professionalise ECD by enabling practitioners at all levels to register through appropriate occupational bodies which will assist with the development of job hierarchies and career progression. This needs to be linked to salaries and other incentives.
- Develop a core package of ECD messages for inclusion in training of home- and community-based workers employed in different sectors who reach young children. These include the very large number of trained people, most of who interface with children and families, especially young children, in the home and community. If there was an overall framework under which such groups work in communities, and some common conditions, training, qualifications and remuneration, it would be possible to advocate for training in and large-scale delivery of basic early child development principles and practice.

4. Next steps

The recommendations made in Section 3 depend on further expert or technical work in a number of areas. Detailed consideration of these issues was beyond the mandate of the Diagnostic Review.

1. Inter-sectoral coordination

The DR recommends that a coordinating mechanism be established - an agency, board or commission - with high-level influence, an explicit mandate, and the necessary resources including expertise, to drive the ECD agenda forward and deliver results. An examination needs to be conducted of the options, pros and cons of the best mechanism for inter-sectoral coordination, how it could be established and what its terms of reference would be.

2. Emerging policy developments

Discussions are underway regarding the possibility of two years of preschool education for all children. While a downwards extension of Grade R could provide 4-year-old children with a safe space to play and learn and a facility from which to provide poor young children with a meal during the day, information needs to be collected to determine if the implementation of this may constrain, displace or delay interventions for children 0-3 years. If it is a choice between expanding Grade R by an additional year or rapid scale up of services for 0-3 year olds, interventions for the youngest children must be prioritised because the scientific evidence is clear on the fact that the earliest years lay the foundation for all subsequent child development.

3. Funding

The DR recommends the expansion of current early learning and care services beyond centres into home- and community-based programmes and to explicitly target children 0 to 3 years of age. In addition, the DR points to the inequitable nature of the current subsidy. A funding model needs to be devised and tested. This model must take account of population-level need and distribution and potential perverse incentives, promote the development and funding of services for children 0 to 3 years of age, and target services to the most disadvantaged children. It must serve to achieve the principle goals of ECD, which are to support the development of disadvantaged children in order to level the playing fields for them and maximise the yield from the considerable investments South Africa makes in the subsequent education of children and youth.

4. A basic package of ECD services

Recommendations in the DR are made for a basic package of ECD services including the following: family planning, healthy pregnancies and postnatal care to give children an optimal start in life from conception; nutrition support for pregnant and breastfeeding women and young children through home-, community and facility-based programmes; birth registration, social security through the CSG and other instruments, subsidised housing and other State provisions

for the poorest; parenting support through public education campaigns, as well as using the faith sector and traditional leadership, and care groups and companionship support through home- and community-based programmes; quality learning by young children encouraged at home and in groups, programmes and centres that focuses on building enjoyment of learning, the confidence to learn from others especially adults, and self-control and social respect so that children can participate in and contribute positively to social life; and preparation for formal schooling by enrolment and regular attendance in Grade R, with support for learning from parents and other adults in the home. However, considerable more detail needs to be added to these recommendations, including goals, standards, implementation strategies, training requirements, support structures, monitoring and evaluation.

5. Disability

It is imperative to try and prevent disabilities in children brought about by adverse exposures in pregnancy, during delivery and the first few years of life. When they do occur, they must be recognised timeously and children and families referred for assistance. The greatest prospect for reducing and remediating their effects results from support and interventions provided as early as possible. For this reason, ECD services are critical for identifying and supporting children with disabilities and their families. Further work needs to be done to scope the challenges for integrating children with disabilities into ECD services and how they might be met.

6. Working parents and other families needing assistance with child care

The DR recommends that consideration be given to the provision and funding of safe and affordable child care for working parents in both the formal and informal sectors. The DPSA has acknowledged this need in the public service and discussions on models are underway. Further technical work needs to be done with DPSA, the private sector, trade unions, corporate social responsibility programmes and other interested parties in how such provision could feasibly be approached and what costs should be borne by employers and the potential role of the State in framing standards, accreditation and the like. . Providing services only within the formal sector will, however, not be enough. Given the size of the informal economy and the disproportionate number of women in informal and unprotected employment, serious attention must also be given to care provisions for potentially vulnerable young children of these working parents.

7. Measurement

The DR has drawn attention to problems with information about young children collected in the General Household Survey. The questions on preschool participation are too general to provide information for policy development and amendment. Similarly, the questions on disabilities among preschool children are inappropriate. A technical group must be tasked to work on measurement of these two important aspects of ECD and work with Statistics South Africa and others to improve the measurement of child care, preschool experience and disabilities.

Endnotes

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Appendix C: Background Papers

1. Scientific evidence for the importance of early child development for human capacity, health and personal and social adjustment
   Professor Linda Richter
2. The role of the state: Legal obligations to provide comprehensive early child development service
   Patricia Martin
3. An overview of the ECD policy framework in South Africa
   Patricia Martin
4. Maternal and child health and nutrition
   Professor Haroon Saloojee & Wiedaad Slemming
5. Parenting
   Linda Biersteker & Professor Linda Richter
6. Safe and affordable childcare
   Linda Biersteker
7. Opportunities for Learning (ECCE)
   Dr. David Harrison
8. Human resource development for ECD programmes and services for 0-4-year-olds
   Linda Biersteker
9. Grade R
   Dr. Nosisi Feza
10. Government funding for ECD in South Africa
    Patricia Martin
11. Cost and impact
    Dr. Chris Desmond
12. South African data
    Professor Justine Burns

Background Paper 1

Scientific evidence for the importance of early childhood development for human capacity, health and personal and social adjustment

Linda Richter

Contents

Key Points

- Poor growth and exposure to adverse environmental events during foetal development and early infancy are associated with chronic diseases in adulthood
- Stunted growth and low levels of home stimulation are associated with poor cognitive development, low levels of schooling and reduced adult income
- Poor growth and exposure to toxic stress during foetal development and early infancy are associated with mental illness, and social and psychological adjustment in adulthood.
- Poverty has pervasive adverse effects on children's health development, but their impact can be attenuated by countervailing supportive factors.
- Resilience protects many children and helps them to recover from disadvantaged conditions. These include warm and supportive families, secure homes, and opportunities and encouragement to participate and succeed in some area of their lives.
- There is heightened susceptibility to insult in the early years, but remarkable recovery is possible with interventions and the earlier the intervention the greater the benefit.
- The recommendations made in the Diagnostic Review are aligned with other major reviews of research and programmatic evidence for early child development in low- and middle-income countries.

Scientific evidence for the importance of early child development for human capacity, health and personal and social adjustment

Introduction

The scientific pendulum on early child development has swung several times from a predominately deterministic to a predominately dynamic standpoint. Sigmund Freud, John Watson, John Bowlby and others posited that very early experiences determine later personality and behaviour. However, this was challenged by scientists who argued that invariance in environments, particularly the fact that adverse environments seldom improved, made early experiences appear to be more influential than they actually were.

Under normal circumstances, it is unusual for children born into supportive or adverse environments, such as middle-class comfort or poverty, to experience dramatic changes in their life circumstances. Because of the overall consistency of environments across the lifespan, chain effects are often set in motion early, whereby 'good' and 'bad' experiences recur and their impact is increased (Rutter, 1989). This means that early determinants, together with relatively unchanging environmental conditions over the course of childhood and early adolescence, tend to reinforce each other.

Regardless of which way the pendulum swings, no scholar of child development has ever suggested that early experiences are not important. Nor that improvements in early experiences, as occurs with interventions to create more favourable conditions could not set off a sequence of enduring beneficial effects (Clarke & Clarke, 1984).

However, recent scientific advances in neuroscience and genetics, as well as the results of lifespan studies, have tipped the balance decisively towards asserting with confidence that early life developments have a strongly determining effect on a broad range of adolescent and adult outcomes. This is most dramatically illustrated by the work in epigenetics. Environmental influences affect the way genes are expressed, causing them to up- or down-regulate or turn on or off (Meaney, 2010). Some of these epigenetic modifications endure, causing changes in children's brain and behavioural development. The period of early development (pregnancy and infancy) is particularly susceptible to epigenetic changes that can occur in response to nutrition, exposure to toxins and disease, stress and other environmental conditions. For example, exposure to repetitive highly stressful experiences can cause epigenetic changes that weaken one's ability to deal with stress and adversity later in life, as can resilience be strengthened by exposures to positive experiences. "Put simply, the brain adapts to the experiences it has" (National Scientific Council on the Developing Child, 2010, p.2). Some early epigenetic changes

have also been found to pass on intergenerationally, affecting the health of future offspring (Champagne, 2010).

Long term outcomes and early life experiences

Long-term outcomes attributable to early life experience can be examined under three broad headings: health, education and productivity, and psycho-social adjustment.

A. Health

Poor growth and exposure to adverse environmental events during foetal development and early infancy are associated with chronic diseases in adulthood

The idea that conditions early in life could influence health in later life firmly took hold with the publication of very high correlations between low birth weight and later risk of diabetes and cardiovascular disease (Barker & Clark, 1997). However, birth weight is not alone in the causal chain, but includes growth and nutritional processes operating across foetal and early post-natal development.

Early experience affects long term health outcomes because the foetus and the very young child derive information from the environment and adjust to it, resulting in changes to the phenotype or the way that genetic potential is expressed, as explained above (Bateson et al., 2004). This type of plasticity is limited to the earliest phases of development (Gluckman et al., 2007), but these adaptations persist regardless of changes in the environment for the better. Foetal growth retardation is one such adaptation in the face of limited nutrition, with a trade-off against long-term consequences.

Known as the DOHaD hypothesis – the developmental origins of health and disease – early experiences and exposures have been found to be related to a wide range of chronic diseases, including mental illness (Victora et al., 2008).

Birth weight and birth length are positively correlated with adult height, such that a 1cm increase in birth length is associated with close to a 1cm increase in adult height (Adair, 2006). Intergenerational effects occur because short maternal stature is associated with intrauterine growth retardation (Black et al., 2008) and maternal size is correlated with the size of her newborn children (Kramer, 1987).

Offspring body composition (fat and lean mass) is also affected, which is brought about by deficits in foetal lean body mass (Yajnik, 2003), as well as alterations in the sensitivity of hypothalamic-pituitary-adrenal metabolism which, in turn, affects appetite and physical activity (Vickers et al., 2000). Effects have also been found on lipid concentrations and cholesterol (Barker, 2003) but are hypothesised to be associated with rapid postnatal weight gain rather than birthweight (Lucas et al., 1999).

Insulin resistance and Type 2 diabetes are thought to be set in motion by epigenetic changes through what is called the “thrifty gene hypothesis”. Maternal dietary deprivation is associated with reduced lean tissue growth and insulin sensitivity, resulting in impaired pancreatic

development. This leads to diabetes and insulin resistance in later life (Ozanne & Hales, 1999). In animal studies, maternal diet restriction is related to elevated blood pressure in offspring, thought to result from restrictions on nephron proliferation which restricts adult renal functional capacity. Many human studies confirm the relationship between low birthweight and high blood pressure (Huxley et al., 2002). People at highest risk are those with intrauterine growth restriction but a high body mass index in adulthood. Similarly, there are established associations between undernutrition and cardiovascular disease and stroke (Barker, 2002). Patterns of early growth are also implicated in lung and immune function, bone mass and some cancers (Victora et al., 2008).

Early social and psychological experiences have also been found to affect adult physical health. In addition to others, the Adverse Childhood Experiences (ACE) Study, a retrospective analysis of the histories of more than 17,000 people, has found consistent relationships between early childhood neglect and abuse, and exposure to violence, parental mental illness and substance abuse to be associated with a very wide range of chronic health conditions (Felitti et al., 1998), including heart (Dong et al., 2004) and liver disease (Dong et al., 2003).

B. Human capital

Stunted growth and low levels of home stimulation are associated with poor cognitive development, low levels of schooling and reduced adult income

Early physical, mental and social development is related to short- and long-term educational outcomes and to occupational achievement and earnings. It is estimated that more than 200 million children worldwide fail to reach their full human potential as a result of unremitting poverty and undernutrition experienced during their early years. Poor linear growth in infancy and early childhood (low height-for-age, HFA) and lack of stimulation is related to delayed school entry, fewer years of schooling achieved and lower school performance, as well as lower earnings assessed in prospective longitudinal studies, including in South Africa (data from Birth to Twenty) (Grantham-McGregor et al., 2007; Martorell et al., 2010).

The human brain is experience-expectant and experience-dependent. When the environment is of poor quality, some potential neurocognitive functions either don't develop completely or their capacity weakens (Rodier, 2004). Foetal and infant growth predicts early cognitive development and schooling (Daniels & Adair, 2004), and early cognitive development predicts schooling (Liddell & Rae, 2001). In turn, schooling predicts adult productivity and income (Psacharopoulos & Patrinos, 2004).

Stunting, indexed by low height-for-age (more than 2SD below the standard) is associated with lower cognitive test scores and attained grades in longitudinal analysis in low- and middle-income countries (including South Africa); as is socioeconomic status (Grantham-McGregor et al., 2007). In combined data analyses, it is estimated that stunting is associated with the loss of one grade of schooling. Stunting combined with poverty (below the third quintile for income) is associated with the loss of 2.15 grades of schooling. Schooling affects productivity via two pathways: fewer years of schooling and less learning per year of school. Studies from 51 countries show that, on average, each year of schooling increases wages by almost 10 percent (Psacharopoulos & Patrinos, 2004).

In the longest follow-up study in a low-income country, a nutritional intervention delivered in early childhood produced highly significant differences in education and earnings, compared to controls. All children in two villages were randomly assigned to receive a nutritious supplement and children in two matched villages a less nutritious one. Follow up when the participants were between 25 and 42 years of age found that women in the intervention group had completed on average 1.2 more grades of school than those in the control group, and both men and women in the intervention group scored a quarter of a standard deviation higher on tests of standardised reading and nonverbal cognitive ability (Maluccio et al., 2009). Similarly, adults who were exposed to the nutrition supplement as children earned on average 46 percent more than adults who were in the control villages, and tended to work fewer hours (Hoddinott et al., 2008). Importantly, the educational and earnings differences were only found for children who received the supplement before 3 years of age, and not for children who received the supplement between 4 and 7 years of age.

These studies demonstrate clearly the benefits of early nutritional interventions for children at risk for stunting and the critical importance of intervening when children are very young. The results also demonstrate that investments in childhood nutrition can be long-term drivers of economic growth.

Early stimulation has also been shown to have long-term effects on schooling. Generally, early stimulation programmes are targeted at three groups of children: children whose cognitive development is at risk as a result of poverty and limited stimulation in the home; children with disorders associated with developmental delay, such as protein-energy malnutrition or Down's Syndrome; and children at risk as a result of preterm birth or low birth weight. Stimulation programmes produce benefits for all three groups. For example, a meta-analysis of Head Start programmes started in 1965 show decreases in school drop-out rates, crime rates and welfare service rates, although long-term support is needed to maintain the effects (Bonnier, 2008).

Importantly, a recent analysis of Early Head Start found that the greatest benefits of participation accrued to children who came from households where the level of warmth and stimulation were the lowest (Bradley at al., 2011). These results challenge findings that the greatest benefits of preschool are for children from better functioning homes. However, as demonstrated in another study, net of socioeconomic status, the children who benefit the most from stimulation are children who receive stimulation at home, in preschool and in the first year of formal schooling, demonstrating the importance of consistent stimulation throughout early childhood in support of cognitive performance (Crosnoe et al., 2010).

C. Psycho-social adjustment

Poor growth and exposure to toxic stress during foetal development and early infancy are associated with mental illness, and social and psychological adjustment in adulthood.

There are several postulated pathways between early childhood experiences and mental wellbeing in adulthood (Lanius et al., 2010; Rutter, 1989), but only three will be described here to illustrate the link between early childhood development and adult outcomes.

Poor growth, especially during foetal development, is associated with mental illness, thought to result from alterations in a child's brain function associated with maternal undernutrition. The evidence for this comes from long-term follow up of the children whose mothers experienced extreme hunger during pregnancy, as occurred during the 1944-1945 Dutch famine and the 1958-1961 famine in China. Other cohort studies have shown similar associations with depression, leading Bennet and Gunn (2006) to conclude that "nutritional inadequacy in one form or another is one of the largest single non-genetic contributors to mental retardation and aberrant mental development".

Exposure to adverse experiences as a young child, described in the ACE study earlier, are consistently associated with a wide range of psychological and social problems of adjustment. These include work absenteeism (Anda et al., 2004), obesity (Williamson et al., 2002), cigarette smoking (Anda et al., 1999) as well as alcohol and drug abuse in adolescence and adulthood (Dube et al., 2002), teen pregnancy (Hillis et al., 2004), sexual risk behaviour among women (Hillis et al., 2001), depression (Chapman et al., 2004) and suicide risk (Dube, 2001).

Early childhood experiences exert their influence on childhood health and wellbeing by modifying physiological and psychological responses to stress. Maternal stress, experienced by the foetus, as well as early childhood stress can produce epigenetic changes that chemically alter the intensity and duration of the brain's hormonal responses (McGowan et al., 2009). Cortisol levels in children who experience toxic stress remain persistently high, likened to an engine being revved for a long period of time (National Scientific Council on the Developing Child, 2011). Toxic stress is stress that goes beyond levels that are manageable, or is experienced in the absence of support (Shonkoff et al., 2012). Cortisol and other stress responses become hyper-sensitive, reacting like a hair trigger to signs of danger and threat. High baseline cortisol levels are also associated with erratic attentional and emotional responses, affecting self-regulation and behavioural control (Ellis et al., 2006). In the absence of protective factors in childhood, such as nurturant care (Champagne & Curley, 2009), toxic stress over the lifespan can lead to both physical and mental illness.

Reviews of the current state of knowledge in this field have led to wide-ranging policy recommendations in the United States to prevent or avoid children being exposed to life-changing stress in their early years. These include child welfare, especially with respect to avoiding non-family placements for young children; investments in high quality childcare for working women; improved perinatal and newborn health care and support for new parents (Committee on Psychosocial Aspects of Family Health et al., 2012; National Scientific Council on the Developing Child, 2011).

A third mechanism through which early childhood experience affects lifelong personal and social adjustment is attachment relationships (Bowlby, 1979) and the construction of a mental template (an internal working model) of what the individual expects subsequent relationships to be like (Bretherton & Mulholland, 1999). Over the course of the first few months of life children develop a sense of the permanence of people, show preferences for their intimate caregivers, make efforts to remain in contact with them through gaze, vocalization, gesture and movement, and are very distressed when separated from them (Ainsworth et al., 1978). The warmth, stability, sensitivity and responsivity of attachment figures create expectations in the infant of similar characteristics in relationships with new people they encounter, contributing to their

sense of self and of others. If primary attachments are insecure or disorganised, a child is likely to be timid, apprehensive and suspicious in subsequent interactions with people, making it difficult to create confident supportive relationships that are protective against stress (Rutter, 1995). Separation from primary caregivers, and changing caregivers in the first two years of life (as occurs, for example, with hospitalisation or institutional care) is especially damaging if special efforts are not made to protect young children's developing emotional and social control systems (Zeanah, 2000)

Poverty and early development

Poverty has pervasive effects on children's health development, being associated with inadequate food, poor sanitation and hygiene which, combined, lead to increased infectious illnesses and stunted growth. Poverty is also associated with poor maternal education, increased maternal and family stress, maternal depression and lack of stimulation in the home (Bradley & Corwyn, 2002; Cooper et al., 1999; Villegas et al., 2011). All these factors detrimentally affect children's development.

Compromised child development at school entry leads to lower school achievement, which is further exacerbated by low quality schooling. Poor parents are often not able to support their children's schooling because of their own inadequate education and economic stresses (Grantham-McGregor et al., 2007).

Poor parents are also at higher risk of being emotionally unavailable because of long working hours, uncertainty and stress, and low morale (Richter, 1994; 1999). These conditions similarly make it more likely that parents will spend less time with and talk less to their children, be less engaged in their children's activities and try to control young children's behaviour with physical punishment rather than by explanation and guidance (Kaiser & Delaney, 1996).

Most differences between young children are attributable to differences in socioeconomic status, which forms a socioeconomic gradient that gets entrenched by continued exposure to differential living conditions and opportunities (Herzman & Boyce, 2010). This embedding or canalization of experiences occurs through epigenetic regulation in response to the environment, weathering by the continued erosion of positive capacities in the face of adversity, and the absence of protective or remedial influences and supports.

The risks of living in poverty to children's emotional, cognitive and social development increase with an increase in the number of risk factors to which they are exposed (Rutter, 1989). However, the number of stressful experiences to which a child is exposed can be contained and their impact attenuated by countervailing supportive factors. For example, a warm, responsive and engaged caregiver can protect a young child from many of the material and social adversities associated with poor living conditions (Richter, 2004).

Resilience

Only a minority of young children exposed to poverty and other forms of adversity develop discernible physical, mental and social problems. This is because many are protected or helped to recover by compensating supportive experiences and people in their everyday lives. Resilience refers to the supportive factors that enable children exposed to disadvantage to remain developmentally on track and to achieve at or exceed the level of achievement of their more advantaged peers (Maston, 1994; Rutter, 1987).

Long-term follow-up studies of disadvantaged children have identified three types of resilience-promoting experiences. These are: 1) warm and supportive family relationships, 2) stability and security at home and in the community, and 3) expectations, opportunities and encouragement to participate and succeed in some area of their lives (Werner & Smith, 1982; 1992).

To enable children and families to be resilient in the face of challenges and difficulties, the society in which they live must provide them with basic protection. Stated simply by Ann Maston "When adversity is relieved and basic human needs are restored, then resilience has a chance to emerge" (1994). This means that resilience is possible, when destitution is averted, when people can take control of their own lives through employment and income, and when they can access health care, education and other services that they and their children need. Maston (2001) also speaks about the "ordinary magic" of protective and resilience-promoting factors – interested and loving parents and a functional family that is part of a community that accepts and helps each other. These are not "interventions"; they are the product of secure and meaningful lives.

These are the necessary conditions for young children to develop to their full potential, but they are not always sufficient. Some children need additional assistance in the form of nutritional, psychosocial and educational interventions.

Interventions to support early child development

As indicated above, despite susceptibility of the brain to insult, remarkable recovery is possible with interventions, and the earlier the intervention the greater the benefit (Bredy et al., 2003; Rutter & O'Connor, 2004).

There has long existed good evidence that early childhood interventions in resource-rich countries– nutritional, psychological and educational – render benefits far exceeding their investment costs, and that these benefits endure well into adulthood (Campbell, 2012; Nores & Barnett, 2010; Reynolds et al., 2011). However, only fairly recently has the evidence from low- and middle-income countries been carefully analysed (Engle et al., 2007; Engle et al., 2011). The results of these analyses can be summarised as follows:

1. Improving the diets of pregnant women, infants and toddlers can prevent stunting (Gillespie & Allen, 2002) and promote psychological development (Pollitt et al., 1993).
2. Combined nutrition and stimulation programmes produce the most beneficial effects for under-nourished children (Myers, 1992).

3. Quality preschool programmes that provide comprehensive nutrition, stimulation and social services have benefits for children's health, growth and school performance (Engle, 2007).
4. Factors consistently associated with successful early child development interventions are (Jaramillo & Mingat, 2003):
    a. A focus on disadvantaged children;
    b. An integration of health, nutrition, education, social and economic development in programmes;
    c. Sufficient intensity and duration of intervention, and beginning with children early in life;
    d. Involving parents as partners in interventions to support children's development;
    e. Encouraging play, exploration and initiative by children;
    f. Preserving and incorporating traditional child-rearing practices and cultural beliefs into scientifically based health and development messages;
    g. Training, supervision and ongoing management of practitioners.
    h. Quality programmes.

Other issues to consider include the following. Reviews have identified parent education and mass media messaging as an important avenue yet to be fully utilised in low- and middle-income countries (Engle et al., 2011). Several studies in low-income countries have also found benefits for women's work, household income and child growth of quality childcare programmes (Nachara et al., 2010).

As a result of intensive literature and programme reviews of early child development policies and interventions undertaken by the International Child Development Steering Group[1] (Engle et al., 2007; Engle et al., 2011), the following policy recommendations were made:

1. Implement early child development interventions in infancy through families and caregivers, and add group learning experiences from 3 to 6 years.
2. Ensure that all children are adequately nourished.
3. Incorporate learning from programme successes (see list above)
4. Incorporate early child development interventions into existing services and programmes to increase coverage.
5. Monitor the effectiveness of programmes.
6. Increase advocacy on the importance of early child development and the consequences of the loss of developmental potential to individuals and to society.
7. Ensure adequate national and local funding for programmes.
8. Create coordinating mechanisms for ministries that share the responsibility for early child development.

All these factors have been incorporated into the findings and recommendations of the Diagnostic Review.

[1] Of which Professor Richter is a member.

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Background Paper 2

The role of the State: Legal obligations to provide comprehensive early childhood development services

Patricia Martin

Contents

Key Points

Issues:

International law obliges the State to take the necessary legislative and financial steps to ensure that all infants and young children (0-9 years) are assured of their rights to birth registration, health care, food and nutrition, shelter, water and sanitation; protection from abuse, neglect and exploitation; social assistance and education. There is a heightened obligation to ensure that especially vulnerable young children enjoy these rights, including those living in poverty, in rural areas and children with a disability (UNCRC; the Committee on the Rights of the Child, General Recommendation 7(2006) paragraphs V 22 and 24; CEDAW, ACRWC).

The most vulnerable young children, including those living in poverty, in rural areas, and children with a disability, are not yet assured of these rights. In addition, many of the services that are accessed by the majority of children are not yet of an adequate quality.

Children in marginalised communities are unable to access a number of key ECD services because services in the affected communities are not available. Poor quality of services is associated with insufficient state capacity to manage, monitor and enforce services in relation to its acknowledged legal obligations.

Filling the access gap for the most vulnerable children is a State obligation. The State must put in place laws, funding, infrastructure and programmes to bridge the gap in access for the most marginalised children. At present, the State has taken the necessary measures to fulfill its obligation to assure access for the most marginalised communities to health care through the National Health Insurance plan (NHI) and school preparation through Grade R. In these services, the State has undertaken to provide the necessary infrastructure and services, and to monitor quality. However, when it comes to access by the most vulnerable children aged 0-4 to early childhood care, early childhood education services, and access to food and nutrition (as opposed to therapeutic treatment of malnutrition), there is no legal obligation on the State to ensure the provision of infrastructure and the required services; nor is there an obligation on the State to fund either the infrastructure or the services.

Recommendations:

The lack of provision of ECD services and the inequitable realisation of the rights of marginalised children must and can be addressed by acknowledging the State's obligation to provide infrastructure and services for early childhood care and education, and food and nutrition, for the poorest children in under-serviced areas. This will require:

a. The amendment of the Children's Act to provide that national and provincial government "must", rather than "may" provide and fund ECD services and programmes for the poorest children and children with disabilities.

b. The creation of an obligation on the State to ensure the provision of the infrastructure and basic services necessary for the provision of ECD (including ECCE) services to children in the poorest quintiles and in rural areas, as well as children with disabilities. This can be achieved by the State linking ECD services to existing infrastructure and systems, building or developing community-based centres, the funding of home- or community-based programmes and the coordination of State-supported home-based services to deliver ECD services.

c. The creation of an obligation to provide ECCE learning and support materials for children living in under-serviced and under-resourced areas.

d. The creation of an obligation on the State to ensure a system is in place to identify children experiencing hunger and at risk of malnutrition and stunting, and the creation of an obligation to ensure at risk children receive daily adequate nutrition.

With regards to the provision of services of adequate quality, for the most part, the laws and budgets are in place. However there is a need to improve monitoring systems, capacity, infrastructure, and institutional arrangements to ensure adequate implementation of the current legal and regulatory framework.

The role of the State: Legal obligations to provide comprehensive early childhood development services

1. Introduction

As is evident from the earlier annotated timeline of relevant policies and laws in South Africa, early childhood development (ECD) has acquired an elevated status over the last two decades. The reasons for this elevation are rooted in science and law. There are compelling scientific, economic, human development and legal imperatives on the State to prioritise the realisation of the comprehensive development rights of young children.

The science is conclusive – investments in early childhood development yield strong development returns for the child and society. The Lancet recently published a series of articles documenting the scientific evidence supporting the argument that childhood is the most effective time and ECD the most effective vehicle for addressing inequities, especially for the poorest children, and that investment in ECD has lifetime benefits for the child and society (Engle et al., 2011; Walker et al., 2011).

Investments in early health, nutrition, social assistance and other poverty alleviation interventions for pregnant women, infants and young children impact positively on children's health, development and cognitive functioning. Conversely, a failure to do so can cause irreversible development delays in children.

Poor investments in maternal, infant and child health results in high mortality/morbidity due to preventable causes. Moreover, poor health and inadequate nutrition in early childhood, starting while the mother is pregnant, often leads to long-term health and development issues. The importance of investing in strong nutritional support from conception until the age of two is critical, given that poor nutrition in these crucial years can lead to irreversible developmental stunting and delays (Naudeau, Kataoka, Valerio, Neuman, & Elder, 2010). In addition, science supports the provision of social assistance and other forms of poverty redress to families with young children. A recent study found that income poverty has a 'strong and significant negative effect' on cognitive functioning of children at the age of five years, and that persistent, cumulative poverty and exposure to hardship in the first year of life have a 'detrimental effect on cognitive functioning'. The effect of poverty appears to be stronger on verbal, compared to non-verbal, skills. Housing conditions, especially overcrowding, present a significant risk factor undermining children's cognitive attainment (Schoon, Jones, Cheng, & Maughan, 2011). On the education front, ECD investments have a positive impact on children's cognitive development and their school results. A recent study presents empirical evidence in support of the conclusion that 'attending preschool is by large the most important variable explaining the children's performance in their first year at primary school' (Aguilar & Tansini, 2012). The World Bank report on policy dialogue and project preparation also shows that pre-school education has a

positive impact on older girls' and women's education and participation in the labour force (Naudeau, et al., 2010). The extent of the positive impact of early childhood education is dependent on the quality of the intervention provided (Center on the Developing Child at Harvard University, 2007).

In addition, a safe, secure, protective and nurturing family environment in the early years is intrinsically linked to the child's neurological, physical, and emotional development and well-being. Foetal exposure, and exposure by infants and young children to severe stress from ongoing child abuse, neglect, severe maternal depression, substance abuse, or family violence can cause irreversible damage to the developing architecture of the foetus or infant's brain. This can in turn lead to lifelong problems in learning, behaviour, and both physical and mental health (Center on the Developing Child at Harvard University, 2007). In sum, the science provides a compelling argument that investments in comprehensive social security measures for the infant and young child and his or her family, especially the most vulnerable, will yield returns that are hard to match through other choices. Securing the right conditions for healthy development in early childhood is a sound investment which is likely to be more effective than treating problems at a later stage (Center on the Developing Child at Harvard University, 2007). Neuroscience provides strong evidence for beginning the following programmes at birth, if not even earlier in the ante-natal period:

1. Access to basic medical care for pregnant women and children prevents health threats to development and provides early diagnosis and intervention when a problem is discovered.

2. Nutritional support for pregnant and lactating women, infants and young children.

3. Early and intensive support by trained home visitors to vulnerable families, beginning prenatally and continuing until the age of three.

4. Participation in high-quality centre-based early education by young children, especially those from low-income families improves the child's cognitive and social development. This impact is even greater if these are conducted as two-generation programmes that simultaneously provide support for parents.

5. The risk of disruption of brain development and delayed or compromised development in young children experiencing toxic stress from recurrent child abuse or neglect, severe maternal depression, parental substance abuse or family violence can be prevented by interventions that provide intensive social services matched to the specific problem.

6. Income support for parents living in poverty.

7. Strong environmental policies that protect foetuses and young children from exposure to harmful substances that damage their developing brains.

2. The legal foundation: Clear international and regional obligations on the State to provide a comprehensive ECD package of care and support

International and regional rights instruments, taking their lead from science, impose clear obligations on the State to prioritise investments in comprehensive social services and support in the early years. Children's rights to health, food and nutrition, water and sanitation, birth registration, education, protection from abuse, neglect and exploitation, social security and social assistance which are recognised and protected by international and regional legal instruments such as the United Nations Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) acquire a unique and elevated status in the context of young children.

In view of their heightened vulnerability, and in view of the intrinsic link between these rights and the realisation of their overarching and fundamental survival and development rights, the UNCRC requires all State parties to prioritise the recognition, protection and realisation of each of these rights for young children. Moreover, in view of the interdependence of these rights, State parties are required to ensure the realisation of all of the rights collectively through adequately resourced rights-based, coordinated multi-sectoral strategies and to take special measures to realise them for young children subject to multiple vulnerabilities, including those living in poverty, and/or in rural areas, and/or with a disability, and/or with a chronic illness (Committee on the Rights of the Child, 2006, para. V 22 & 24). In summary, what is required of the State in order to meet its ECD obligations is to provide a:

1. Rights-based;
2. Multi-sectoral;
3. Coordinated;
4. Integrated;
5. Adequately resourced;
6. Pro-vulnerable child targeted ECD strategy that guarantees access to the full complement of ECD rights for all young children aged 0-6, especially those subject to multiple vulnerabilities.

3. A review of the State's fulfilment of its ECD obligations

This paper aims to identify the scope of the obligations imposed on the State by the relevant international and regional instruments relevant to early childhood development and to provide a summative review of the extent to which the State has fulfilled these obligations. The results of the identification and review are documented in the table that follows.

3.1. Overarching international and regional ECD obligations
Implement comprehensive and integrated national early childhood development policies and programmes for children aged 0-9 to ensure the enhancement of physical, social, emotional, spiritual and cognitive development (General Comment 7: Implementing Child Rights in Early Childhood,Committee on the Rights of the Child, 2004; UNCRC, United Nations General Assembly, 1989; 'A World Fit for Children', United Nations General Assembly, 2002).
Eradicate extreme hunger by halving the prevalence of underweight children under five years of age (UN MDGs, United Nations General Assembly, 2000).
Reduce maternal and child malnutrition, with special attention to children under the age of two ('A World Fit for Children', United Nations General Assembly, 2002).
Provide health care services, including ante-and post-natal care for pregnant and lactating women, infants and children (African Charter on the Rights and Welfare of the Child (ACRWC), 1990; UNCRC, United Nations General Assembly, 1989).
Reduce child mortality (UN MDGs, United Nations General Assembly, 2000; 'A World Fit for Children', United Nations General Assembly, 2002).
Reduce maternal mortality (UN MDGs, United Nations General Assembly, 2000; 'A World Fit for Children', United Nations General Assembly, 2002).
Provide adequate water and sanitation services to all children (UN MDGs, United Nations General Assembly, 2000; 'A World Fit for Children', United Nations General Assembly, 2002).
Learning begins at birth. Early childhood care and initial education must be provided, and this can be done through families, communities or institutional programmes (General Recommendation 7: Implementing child rights in early childhood, Committee on the Rights of the Child, 2006; World Conference on Education for All: Meeting Basic Learning Needs, 1990)
Expand and improve comprehensive early childhood care and education for all children, especially for the most vulnerable and disadvantaged children, including children with disabilities (The Dakar framework for action, education for all, UNESCO, 2000; 'A World Fit for Children', United Nations General Assembly, 2002; World Conference on Education for All: Meeting Basic Learning Needs, 1990).

Provide support to enable parents to balance family obligations and work responsibilities (The Convention on the Elimination of All Forms of Discrimination against Women [CEDAW], United Nations General Assembly, 1979).

Take special measures to provide support and services to children with disabilities (including young children) to enable their physical, social, emotional, spiritual and cognitive development (African Charter on the Rights and Welfare of the Child (ACRWC), 1990; General Comment 7: Implementing Child Rights in Early Childhood, Committee on the Rights of the Child, 2004; General Recommendation 7: Implementing child rights in early childhood, Committee on the Rights of the Child, 2006; UNCRC, United Nations General Assembly, 1989; 'A World Fit for Children', United Nations General Assembly, 2002; The Convention on the Rights of Persons with Disabilities [UNCRPD], United Nations General Assembly, 2006).

Address inequities in access to services and support by children and women in marginalised areas such as rural areas - that are necessary for the physical, social, emotional, spiritual and cognitive development of children (General Comment 7: Implementing Child Rights in Early Childhood, Committee on the Rights of the Child, 2004; CEDAW, United Nations General Assembly, 1979; 'A World Fit for Children', United Nations General Assembly, 2002).

3.2. Specific ECD obligations necessary to give effect to overarching legal obligations

The State must provide[1]:

- Comprehensive and integrated multi-sectoral ECD policy-making and programme development and implementation,
- Maternal health care and nutrition,
- Infant and child health care and nutrition,
- Birth registration,
- Clean water, sanitation and hygiene,
- Protection from abuse, neglect and exploitation,
- Provide social assistance and social security to reduce poverty in early childhood,
- Early childhood care and education for children, and
- The equal provision of all ECD services and support to children with disabilities and other vulnerable young children.

[1] The specific obligations are derived from a number of international and regional legal instruments, including the UNCRC (United Nations General Assembly, 1989), General Comment 7: Implementing Child Rights in Early Childhood (Committee on the Rights of the Child, 2004), A Guide to General Comment 7: Implementing Child Rights in Early Childhood (UNICEF, United Nations Committee on the Rights of the Child, & Bernard van Leer Foundation, 2006), the ACRWC (African Charter on the Rights and Welfare of the Child (ACRWC), 1990), the CEDAW (United Nations General Assembly, 1979) and the UNCRPD (United Nations General Assembly, 2006)

3.2.1. The provision of rights-based comprehensive and integrated multi-sectoral ECD a) Including comprehensive and integrated strategies, policies and programmes and the necessary institutional arrangements to oversee collaboration[2] b) Including the provision of integrated and effective health, nutrition and childcare in families, communities, schools, and primary health care facilities to reach especially marginalised children[3]				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The National Integrated Plan for ECD (NIP for ECD, also referred to as 'the Plan') (Government of SA & UNICEF, 2005) is a national plan committing to the provision of integrated basic ECD services for improved child care, early stimulation and learning, health and nutrition, water and sanitation for children aged 0-4, expectant and nursing mothers. The mechanisms of the Plan for attaining an integrated approach to ECD services include: • Intersectoral collaborative planning and service delivery for ECD • Seeking agreement	The Plan establishes various coordinating structures at political and administrative levels and at national, provincial and local levels. 1. MEC Committees of the Social Cluster through which provincial programmes are discussed is the designated structure through which political leadership, guidance and support will be provided for the implementation of the NIP for ECD. 2. ECD Intersectoral Committees are established in terms of the NIP for ECD as a component of the Presidency's National Advisory Council on Children's Rights. This locates all matters relating to this committee in the	More details about the qualitative and quantitative successes and challenges will be provided through the concurrent, but independent review of the NIP for ECD. **Successes:** A national Inter-Departmental Committee and ECD Intersectoral Committees (known as ECD forums) have been established at national and provincial levels. **Challenges:** Some initial observations about the challenges facing integration and collaboration which should be explored in more details during the review of the NIP for ECD include the following: 1. Lack of participation by key departments such as DoH in the National Inter-departmental Committee for ECD creates a significant gap in the cross-departmental collaboration envisaged by the NIP for ECD at a planning, monitoring, budgeting and accountability level (Giese & Sanders, 2008). 2. There is no evidence of an integrated monitoring and evaluation process or framework as envisaged by the NIP for ECD	To be determined through the NIP for ECD review. At this preliminary stage it does not appear as if the NIP for ECD has been costed by the relevant departments or collectively, nor have there been budgets allocated for the realisation of the bulk of the departmentally assigned responsibilities. (Background Paper 8: Government funding for ECDE in South Africa).	To be determined through the NIP for ECD review.

[2] UNCRC (United Nations General Assembly, 1989), General Comment 7: Implementing Child Rights in Early Childhood, Paragraph V22 (Committee on the Rights of the Child, 2004)
[3] A World Fit for Children', Paragraph 14 (United Nations General Assembly, 2002)

on the target of the services • Ensuring that each department makes a budgetary commitment to the task at hand • Co-ordination and monitoring of the comprehensive programme for children from birth to five. Integration is envisaged as resulting in: • An ability to expand service delivery • Cost cutting through sharing of resources • A more efficient and speedy delivery of services The Plan recognises: • That different departments and stakeholders are responsible for the different components, but that they should work collaboratively and cooperatively to "achieve a certain development goal"; • That, at a structural and systems level, the	Presidency at a national level and the Premier's office at provincial level. Membership is made up of government and non-government representatives in the ECD sector. 3. A National Inter-departmental Committee for ECD has been established led by the DSD and represented by key departments, including Health, Education, Home Affairs, the Presidency and others to facilitate the planning and implementation of integrated services in terms of the NIP for ECD (Giese & Sanders, 2008)	against which the various departments and stakeholders plan and report on progress to the NIP's coordinating structures. 3. There is little evidence of costing and budgeting for the roles and responsibilities of the different departments assigned by the Plan. 4. A review of policies and programmes across the different departments reveals that the NIP for ECD components[4] do not appear to have been translated into departmental ECD plans, programmes and budgets for fulfilment of assigned departmental obligations, other than by DSD and Basic Education. Local government is not obliged at law, and nor has it created an obligation to build ECD centres in areas of most need, or to provide infrastructure to ensure an environemnt conducive for effective learning and care at ECD centres, or to provide sufficient water and sanitation to ECD sites. At a local government level there is little evidence of support for ECD services envisaged by the NIP for ECD such as upgrading ECD services or building ECD centres in areas of most need (Budlender, Giese, Berry, Motala, & Zide, 2011). Whilst the Department of Health has numerous programmes that target and benefit young children, Health's policies and programmes are not identified as ECD policies and programmes and are not, in their design or evaluation, linked to the NIP for ECD. Moreover, the obligation on the DoH as the lead department to "Ensure that all children have access to daily balanced nutrition" remains unrealised in policy and implementation.		

[4] See pages 18-20 of the NIP for ECD to view the Plan Components and the broader Matrix of Roles and Responsibilities.

plan "requires an intersectoral and interdepartmental system and mechanisms for it to be realised" • That "the intersectoral coordination mechanism of the integrated plan is the most critical aspect to the success of the implementation of the plan."		5. There is little evidence of a common ECD agenda or goal across the relevant departments to align with the NIP objectives – especially in the departments beyond Social Development and Basic Education. Targets and plans in the water and sanitation sectors do not, on the face of it, include ECD targets or goals such as the provision of water and sanitation to ECD centres or prioritising households with infants and young children in terms of indigent policies or infrastructure development plans. In short, ECD objectives do not appear to have been mainstreamed into all relevant sectoral policies and programmes. 6. A 2008 review of coordinating structures in South Africa revealed that "The most critical challenge is in the realization of the practical implementation of the NIP for ECD using appropriate integrated approaches and systems from national, provincial and district levels" (Giese & Sanders, 2008). This challenge is evident in a review of the outputs of the Interdepartmental Committee as measured against the objectives of the Plan as documented in the 2008 review of coordinating structures. The outputs delivered by the Inter-Departmental Committee for ECD include raising awareness around the NIP for ECD and the development of guidelines for the NIP for ECD, an ECD site registration campaign and the development of early learning and stimulation curriculum and programmes. There are no recorded outputs that take the implementation of the integrated delivery objectives of the plan forward (Giese & Sanders, 2008). The outputs realised by the Interdepartmental		

		committee as recorded by Giese and Sanders (2008) are linked to departmentally specific mandates. These outputs do not necessarily require collaboration, but are the responsibility of the departments of Social Development and Basic Education respectively. This prompts a question about the effectiveness of the match between the design and location of the current structure responsible for oversight of the NIP for ECD and the NIP's objectives, budget and outputs. In the review by Giese and Sanders (2008), a reoccurring concern raised by participants in various coordinating structures was the perceived inappropriate location of a multi-sectoral coordinating structure within a specific lead department, as opposed to a truly representative structure independent of any specific department. In the case of a departmental lead, the structure was seen by various respondents as a departmental, rather than a coordinating structure with insufficient power and authority to hold other departments to account for specific deliverables. In addition, and perhaps linked, was a concern that structures that are led by a department with insufficient political will and power lacked the capacity to drive a multi-sectoral programme of action. The Giese and Saunders review (2008) did not examine the extent to which these concerns applied to specific structures like the Interdepartmental Committee for ECD, nor the extent to which these concerns undermined the ability of this (or other structures) to deliver on their mandate of integrated comprehensive packages of care and support for vulnerable children. *It is important that the NIP for ECD review include questions that will allow for further examination of these challenges,*		

		limitations and implications for the current ECD coordinating structure. There ought to be a frank review of whether the location of responsibility for the NIP for ECD and the Interdepartmental Committee for ECD within the Department of Social Development as the lead (and primary) department has hampered the success of the realisation of the State's obligations to ensure integrated and multi-sectoral ECD policy and programme development and implementation. Some three years after the review by Giese and Saunders (2008) there are few, if any, instances of integrated and multi-sectoral policies and programmes designed within the framework of the NIP for ECD, of the sharing of resources, or of more efficient and speedy delivery of services through collaboration by the different departments within the NIP for ECD framework. This issue is discussed in more detail below.		
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The model of implementation envisaged by the Plan is the provision of integrated ECD services along a continuum of interventions, including family and community structures community development workers, and professional staff of the different departments. The NIP for ECD	1. The NIP for ECD envisages Community Development Workers (CDWs) playing a central role in the delivery of integrated community-based ECD services. CDWs are a 2003 initiative housed within the Department of Public Service and Administration. The aim is to bring government services, including birth	**Successes:** **CDWs** In 2011/12 there is a focus on realigning the CDW programme to support the War on Poverty Programme through support for improving household food security and linking children in households with state-funded ECD centres and linking unregistered ECD sites with DSD to ensure registration. There are just over 3000 CDWs across the country. CDWs have successfully facilitated access to birth registrations, through participation in the National Population Registration Campaign, and	*CDWs* The national CDW budget for coverage of the whole country is R494,000,000 (Department of Public Service Administration, 2010). *Integrated home and Community-Based services* Home and	*CDWs* Inadequate funding leads to inadequate reach and spread of CDW services (Department of Public Service Administration, 2010). *Integrated Home and*

envisages that 50 percent of young children's ECD interventions take place in the home, 30 percent through community structures like play groups and community centres and 16-20 percent through formal centres such as ECD centres, crèches and pre-schools.	registration, social grants, food security and early childhood development services closer to rural communities. 2. In addition, there are a number of other HIV and AIDS and child protection policies and programmes that envisage the provision of integrated services through home and community based care (HCBC) workers (other than CDWs) to children (including young children) which include services antiticapted by the NIP for ECD. Policies and plans that govern HCBC include the National Integrated Plan for Children Affected by HIV/AIDS (2000); the National Action Plan for Orphans and Other Children Made Vulnerable by HIV and AIDS 2009-2012 (Department of Social Development, 2009a); the Children's Act No 38 of 2005, as amended; the National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016 and the National Health Insurance Green Paper.[5]	to social grants (Department of Public Service Administration, 2010). *Home and community-based care* Numerous models of community and home-based care for the provision of integrated care, services and support to all children (and their families) made vulnerable by HIV and AIDS and other causes are provided for in terms of the Plans and Green Paper mentioned. The programmes target vulnerable children from age 0 to 18, not specifically young children. Models include: 1. Home and community-based care workers providing basic needs for people and children infected and affected by HIV and AIDS - such as HIV testing, counselling, nutritional support and advice (including breastfeeding advice and advice on infant feeding options), referral services to access grants, identification documentation and alternate care and protection; 2. District-based health care workers providing nutritional and health advice to households, and referring them to primary health care services; 3. Childcare forums which provide the services listed under number one as well as parenting support, after-school care and holiday programmes and community-based multi-purpose centres; 4. Drop-in centres which provide basic services to meet the emotional, physical, and social development needs of vulnerable children.[6] Services provided by the drop-in centres include the preceding services as well as	community-based services for children affected by HIV and AIDS are provided by NGO's, some of whom are funded by government. Those who are funded do not receive full funding and must raise additional donor funds to sustain their services. Almost all home and community-based ECD programmes do not receive funding from any of the provincial governments (D Budlender, 2010). Unlike HIV and AIDS and Health outreach programmes, there is no obligation on the Department of Social Development (or any other department) to fund ECD Home and Community-based services. *Thusong centres* The funding, development	*Community-Based services* Funding is completely inadequate to provide the necessary number and quality of home and community-based child protection services regulated by the Children's Act in all 9 provinces (Budlender, 2010). The situation is far worse for ECD HCB programmes – none of the provinces funds these programmes. However, Margot Davids of the national Department of Social Development has advised that plans are in development for funding ECD HCB

[5] National Health Insurance in South Africa Policy Paper, 2011, Department of Health, Pretoria

	3. In addition to integrated home and community-based care, there are various departmental one-stop delivery models in terms of which some of the services contemplated by the NIP for ECD are provided to children and their caregivers through centralised and coordinated single points of delivery. These initiatives do not seem to have been framed within the context of the NIP for ECD, but rather as departmental initiatives. These include the Department of Home Affairs' National Population Registration Campaign; Local Government Thusong Centres; the Department of Social Development's one-stop development centres; and Gauteng's Bana Pele programme (discussed in more detail alongside).	primary healthcare in collaboration with the local health clinic, and prevention and early intervention services. The latter services may include early childhood development.[7] From the preceding list, it is apparent that the services provided through these models of integrated care and support include a number of ECD services contemplated in the NIP for ECD – such as access to grants and birth certificates, nutritional support and feeding advice, access to primary health care, psychosocial support, and others. Through these models, under-serviced and remote rural communities and households are brought into the service delivery net providing these ECD (and other) services. *Departmental integrated services* A number of departments offer some of the services contemplated by the NIP for ECD through integrated service delivery models to children and their caregivers. The initiatives do not appear to have been framed within the context of the NIP for ECD, but rather as departmental initiatives targeting all vulnerable children (0-18) in marginalised under-serviced areas (with an emphasis on rural areas). These include: 1. The Department of Home Affairs' National Population Registration Campaign which includes the delivery of on-line birth registration at hospitals, mobile documentation services, Thusong centres, and through community network initiatives (Department of Home Affairs, 2011). Further details provided under the topic of "birth	operationalisation and manageof Thusong multi-purpose centres is a local government responsibility (Government of South Africa, n.d.). There is thus not a national budget, but multiple municipal budgets for the centres - the sums of which we were unable to establish at the time of writing. There is however evidence that budgets are insufficient, as documented in the column alongside. *Bana Pele programme* The Bana Pele programme is funded by the Gauteng Provincial Government. It is limited to the Gauteng province and its effectiveness is limited by insufficient resources.	programmes that are linked to NGOs in targeted communities[9]. *Thusong Centres* Inadequate funding and planning of the location of centres to match highest levels of demand results in too few centres, centres that are not optimally located, resulting in insufficiently close proximity to needy rural communities, poor infrastructure, and low quality services (Department of Public Service Administration, 2009; Government of South Africa, n.d.).

[6] Section 213, Children's Act
[7] Section 144(2)(e) of the Children's Act
[9] Personal communication between Margot Davids and the author, November 2011

		registration". Thusong centres or multi-purpose service centres are local government-driven one-stop, integrated community development centres providing access to government services and programmes to marginalised people to improve their lives. As at March 2011, there were 165 Thusong Centres providing services offered by the Departments of Home Affairs, Labour, Social Development, Health, and Agricultural extension services. In addition, CDWs, South African Police Service (SAPS), NGOs and CBOs also offer services through the centres. Services provided include grant applications, housing applications, Adult Basic Education and Training (ABET), and Further Education and Training (FET) services. There is no record of the centres providing any early childhood development services). 2. Gauteng's Bana Pele programme headed by DSD is a one-stop service programme providing a basket of services administered by the Departments of Social Development, Health, Education, Provincial and Local Government. The aim is to reduce childhood poverty and ensure children's education rights. The health, educational, poverty situation, and other domains of well-being of children from the poorest quintiles is documented on one referral form which has been designed for use in different settings (Rispel, Molomo, & Dumela, 2008). Services offered include school fee exemptions, school nutrition, scholar transport, social grants, school uniforms, psychosocial support, free health services,	*KwaZulu-Natal one stop development centres* Six centres have been established in targeted rural districts with high levels of poverty at a cost of R62.6 million rand (KwaZulu-Natal Department of Social Development, n.d.-b).	*Bana Pele Programme* Implementation of the Bana Pele programme is challenged because of insufficient resources, lack of capacity, and duplication of efforts (Rispel, et al., 2008).

		free screening for the early detection of disabilities; and free basic services from provincial and local government (Gauteng Department of Education, 2007). The original targeted beneficiaries appear to have been children of school-going age. However, the programme has, according to Margot Davids of the National Department of Social Development, been extended to young children through ECD centres.[8] In 2007, 487,545 children under the age of six were benefitting from the Bana Pele programme (Rispel, et al., 2008). By 2008, the programme saw 40,066 children enrolled in ECD facilities; 229,556 children receiving care through subsidised créches and 12,468 children receiving care through home-based programmes run by NGOs (Gauteng Provincial Government, 2010). 3. The KwaZulu-Natal Department of Social Development has established one-stop service development centres to facilitate access to services for people living in poverty, especially in rural areas. Facilities available at the centres include clinics, Home Affairs offices, Labour offices, SASSA offices as well as ECD facilities which provide stimulation, physical care and support to children younger than six years. In addition, services are also provided to those needing nutrition, physical and psychosocial support, as well as services for people with disabilities. The programme encourages and allows women to participate in ECD centres which create an enabling environment for women to participate in the socio-economic transformation of the province (KwaZulu-		

[8] Personal communication between Margot Davids and the author, November 2011

		Natal Department of Social Development, n.d.-a). The KwaZulu-Natal Department of Social Development reports that that this model has been adopted by the national Department of Social Development, although no further information about the scaling up of this initiative was found on the national DSD website. **Challenges:** *CDWs* 1. Despite the 2005 NIP for ECD targeting the CDW programme as a delivery vehicle for integrated ECD services, there is no mention in the 2010 CDW progress report of any facilitation of access to early childhood care and education services by CDWs. In addition, whilst the report does indicate that CDWs facilitated access to birth certificates and grants, there is no indication of targeting of pregnant women and/or infants and young children. In addition, there are not enough CDWs to reach all communities and wards (Department of Public Service Administration, 2010). *Home and community-based services* 2. Whilst there are numerous community and home-based models of care and support, there is insufficient alignment between the governing integrated plans and the NIP for ECD and, as a result, there is insufficient clarity, focus and emphasis on the provision of ECD services (including ECCE) to young children made vulnerable by their circumstances. 3. Not only is there insufficient synergy between the NIP for ECD and other programmes, there is no clear linking across the different home		

		and community-based programmes, or an understanding of how they fit together (Streak, 2005). 4. A lack of coordination and synergy has resulted in a fragmentation of home and community-based services and a duplication of energy and services – resulting in one area or household being serviced by numerous workers, and other communities and households without support (Departments of Health and Social Development, 2009). 5. There is recognition of the need for better coordination of home- and community-based programmes and the subsequent development of a draft National Policy Framework for Home and Community Based Care and Support Programmes (Departments of Health and Social Development, 2009). The draft applies to any "worker who delivers services under the auspices of Home and Community Based Care and Support Programmes both in support of health and social development programmes". However, it is limited to programmes and servcices in the homes of those who are directly infected and affected by HIV and AIDS and other chronic conditions. As such it excludes ECD and child protection services, and thus cannot be termed a comprehensive national HCBC framework. The need for a comprehensive national HCBC framework remains – one which will provide guidance on the core services, quality standards, qualifications and related matters governing the design, funding and implementation of HCBC programmes. Any such plan should provide clarity on the core services and role to be played by HCBC workers in meeting children's ECD rights (See commentary below and recommendations for		

		further discussion). *Departmental integrated service delivery centres and programmes* 6. There is a lack of synergy between integrated service delivery progarmmes run through departments such as Home Affairs, Local Government, and the Gauteng Department of Education and the framework, outputs and targets of the NIP for ECD. This appears to contribute to an insufficient focus on, or targeting of young children within these programmes, and/or an insufficent provision of certain core ECD services through the programmes in question. Where young children are targeted (as in the case of the Department of Social Development's one stop programme and Guateng's Bana Pele programme), there is little clarity on how the programme objectives and interventions are aligned with the NIP for ECD objectives. Very few of the programmes in question provide access to ECCE services (except for the Department of Social Development's one stop programme and Gauteng's Bana Pele programme), a key focus area and objective of the NIP for ECD. 7. There are key missed opportunities for collaboration and integration amongst core NIP for ECD departments. There is, for example little, if any, evidence of collaboration between DSD and DoH for the delivery of integrated services such as grant registration or early childhood care programme through health sites; or of health services through ECD sites (except for Gauteng's Bana Pele programme). There is little integration of extended ECD services (such as immunization, parent programmes, grant		

		registration) through ECD centres at a community level (Biersteker, Dawes, Hendricks, & Tredoux, 2009). Even within existing integrated programmes such as Gauteng's Bana Pele Programme, hospitals have not been well integrated into the referral system, "creating many missed opportunities for referrals and for ensuring a safety net for children" (Rispel, et al., 2008). 8. There is, in the main, no government funding of integrated home and community-based ECD programmes and services (Budlender, 2010). 9. Overall, there is no legal obligation on any one or more department to provide integrated one-stop services, nor is there a common framework for integrated services providing for a minimum set of core services that ought framework. 10. The lack of a national integrated plan guiding the complementary design, bundle of services provided, funding, location, and targeting of the various integrated programmes results in sporadic reach, duplication of services in the same areas, and neglect of some areas in need (Department of Public Service Administration, 2009; Rispel, et al., 2008). 11. Many of the integrated one-stop programmes are marked by, especially in remote areas, inadequate funding and a lack of human, electronic and management capacity, stymying their effectiveness to ensure sufficiently scaled up and guaranteed access to government services through central nodes of access (Department of Public Service Administration, 2010; Rispel, et al., 2008).		

3.2.2 Provide maternal health care and nutrition Specifically: 1. Pre-natal care and maternal nutrition[10] 2. PMTCT and HIV and AIDS treatment and support[11]				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The Constitution provides that everyone has the right to health care services, including reproductive health care[12]. The NIP for ECD includes, as part of the national comprehensive ECD package, the promotion, by the DoH (together with local authorities) of healthy pregnancy, birth and infancy through strengthened access to antenatal care[13]. The Free Primary Health Care Policy (1996) commits to providing free ante-natal care and maternal nutrition to women.	Free maternal health care is available for pregnant and lactating women. The services provided include free primary and secondary health care for women from the time of diagnosis of the pregnancy until the child reaches the age of six years[14].	**<u>Successes</u>** Since 1996 there have been significant policy and programmatic developments to address maternal health in South Africa. This has resulted in an increase in maternal health care infrastructure and increased access and usage of the services by pregnant and lactating women. The percentage of women in South Africa who gave birth in a health facility increased from 76.6 percent in 2001 to 94.1 percent in 2009. And in 2009, 97percent of pregnant women utilized antenatal care (Republic of South Africa, 2010), though few attend the recommended four antenatal visits. **<u>Challenges</u>** Unfortunately the commitments to date have not resulted in reduced maternal mortality rates. South Africa's maternal mortality rate is high. It increased from 369 to 625 per 100,000 live	Yes	These details will be provided in the section of the report dealing with health care. In effect however, because of the way in which the health budget is made up, it is difficult to identify the budget for the specific services in question.

[10] CEDAW, Article 12(1) (United Nations General Assembly, 1979); UNCRC, Article 24(2)(d) (United Nations General Assembly, 1989); ACRWC, Article 14(2)(e) (African Charter on the Rights and Welfare of the Child (ACRWC), 1990); MDG No. 5 (United Nations General Assembly, 2000); 'A World Fit for Children' Paragraphs 1 and 4 (United Nations General Assembly, 2002)

[11] MDG No 6 (United Nations General Assembly, 2000); UNCRC (United Nations General Assembly, 1989); General Recommendation 7, paragraph 27(c) (Committee on the Rights of the Child, 2006)

[12] Article 27(1)(a)

[13] 3.2 Matrix of roles and responsibilities

[14] National Health Act No 61 of 2003

		births between 2001 and 2007 (Republic of South Africa, 2010); 1,600 mothers die each year (Department of Health, Medical Research Council (South Africa), University of Pretoria, Save the Children, & UNICEF, 2008). The 2010 South African MDG report concludes that is unlikely that the 2015 MDG maternal mortality target of 38 deaths per 100,000 live births will be attained. Harrison (2009) observes that 60 percent of maternal deaths are avoidable and 55 percent are caused by health system failures in the form of mismanagement of health care or poor health care provider action. The leading cause of maternal death is non-pregnancy related infections, mainly HIV (Republic of South Africa, 2010). In addition, socio-economic conditions are an intrinsic barrier to maternal health (Republic of South Africa, 2010). Access to good or adequate health care is inequitably distributed. Women living in poverty and in rural districts are much less likely than their wealthier and urban counterparts to access health care. For example only 71 percent of women deliver in health facilities in the Eastern Cape, compared to 98 percent in the Western Cape (Sanders, Bradshaw, & Ngashi, 2010; Westwood, Shung-King, & Lake, 2010). Many districts do not provide the recommended package of care and support. There is a marked insufficiency of health expenditure in the poorest districts. For example, per capita health expenditure is below the national average in seven of the ten most deprived districts (Department of Health, et al., 2008). Whilst the policy terrain for the promotion of maternal health is generally strong, there is a		

		policy weakness which is linked to poor maternal and infant health – poor maternal nutrition. Poor maternal nutrition contributes to underweight infants, yet there is little evidence within the current policies of pro-active maternal nutritional interventions. The current health policy does not provide for nutritional supplementation for pregnant women. In addition, pregnant women living in poverty do not qualify for the Child Support Grant which is intended to provide support to purchase essential items such as food. It only becomes available when the child is born.		
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
PMTCT and HIV and AIDS treatment and support for pregnant and lactating women in South Africa was recently strengthened through a series of intensified PMTCT and HIV and AIDS treatment policies.[15]	Strengthened PMTCT and treatment guidelines have introduced routine offers of HIV testing and counselling through ante-natal services, earlier, and more effective ARV treatments starting earlier, counselling on, and support for safer infant feeding options and micronutrient support for pregnant women that are HIV positive.[16]	**Successes** South Africa has achieved almost 90 percent coverage of PMTCT and a consequent reduction in transmission to infants (UNAIDS, 2010). **Challenges** As in the case of general maternal health services, poor management and quality of services, especially in marginalised communities, undermines access to and the potential benefits of the policy developments to provide PMTCT and HIV and AIDS treatment and support for pregnant and lactating women.	Yes	Details will be provided in the section of the report dealing with health care. However, because of the way in which the health budget is made up, it is difficult to identify the budget for these specific services.

[15] The South African Antiretroviral Treatment Guidelines, 2010; Clinical Guidelines for the Management of HIV and AIDS in Adults and Adolescents, 2010; and Policy and Guidelines for the Implementation of the PMTCT Programme, 2008 as amended and expanded by the Clinical Guidelines: PMTCT 2010

[16] Policy and Guidelines for the Implementation of the PMTCT Programme, 2008 as amended and expanded by the Clinical Guidelines: PMTCT 2010

3.2.3 Provide infant and child health care and nutrition 1. Provide good daily nutrition to maintain an adequate standard of living[17] 2. Provide child nutritional advice[18] 3. Combat malnutrition through the provision of adequate nutrition, supplementation and treatment[19] 4. Immunization[20] 5. PMTCT and HIV and AIDS treatment and support[21] 6. Medical services essential for young children[22]				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The Constitution provides that every child has the right to basic nutrition and health care services.[23] The 1996 Free Primary Health Care Policy for All provides for free health care for children aged 0-6. The NIP for ECD includes within the comprehensive national ECD package, and to be led by the DoH, the: 1. Integrated Management of	In principle, the full health package required by international law, including infant and child nutritional advice, support and supplementation, immunization, PMTCT and HIV and AIDS treatment and support, and essential medical services – is provided free of charge at primary, secondary and tertiary levels to all children under the age of six years[24]. The package of services for infants and young children	**<u>Successes</u>** As in the case of maternal health, South Africa has taken a number of bold policy steps to improve the availability and accessibility of health care for young children aged 0-6 since 1994. There has been some progress in improving the health status and outcomes for young children. The immunization coverage rate is generally quite high (84 percent) (Department of Health, et al., 2008). In addition, whilst the infant mortality rate increased, largely as a result of HIV and AIDS in South Africa between 2001 and 2008, it has since shown signs of decreasing and was estimated to be 47 per 1,000 live births in 2010	The health and nutrition programmes are funded, but it is difficult to assess the extent and adequacy of the budgets because the programmes in question do not have dedicated budgeted line items (Department of Women Children and People with Disabilities, 2011).	These details will be provided in the section of the report dealing with health care. In effect, however, because of the way in which the health budget is made up, it is difficult to identify and assess the adequacy of the budget for the

[17] UNCRC, Article 27(1) and 24(2); General Recommendation 7, paragraph 27(a); ACRWC, Articles 14(2)(c) and 20(2)(a)
[18] ACRWC, Article 14(2)(h); UNCRC, Article 24 (2)(e), General Recommendation 7, Paragraph 27(b)
[19] ACRWC, Article 14(2)(d); Article 24(2)(c); MDG Goal 1
[20] ACRWC, Article 14; UNCRC, Article 24; General recommendation 7, Paragraph 27 (a); MDG no. 4
[21] General recommendation 7, Paragraph 27 (c); MDG nos. 4 and 6
[22] ACRWC, Article 14(2)(d); Article 24(2)(c); General Recommendation 7, Paragraph 27 (a)
[23] Article 28(1)(c)
[24] The National Health Act No 61 of 2003; Policy and Guidelines for the Implementation of the PMTCT Programme, 2008 as amended and expanded by the Clinical Guidelines: PMTCT 2010; Guidelines for the Management of HIV in Children, 2nd edition, 2010; Integrated Nutrition Programme, 2002; Infant and Young Child Feeding Policy, 2007

Childhood Illnesses (IMCI) through the prevention treatment, care and support for children. 2. Immunisation. 3. Nutrition through the promotion of breastfeeding and supplementation and ensuring that all children have access to daily balanced nutrition.	is extensive. It makes provision for immunization services, micronutrient supplementation, growth monitoring, nutritional supplementation, specialist medical care, developmental screening, the provision of assistive devices to children with disabilities, IMCI, PMTCT and HIV and AIDS treatment, and other essential medical services, amongst others.	(Department of Health, 2011). **Challenges** Despite the infant and child health services available to children in South Africa, and the progress that has been made in their delivery, the survival and health status of young children is poor. South Africa's infant mortality rate of 47 per 1,000 births and its under-five mortality rate of 67 per 1,000 live births remain unacceptably high. There is little chance that South Africa will achieve its MDG target of reducing the under-five mortality rate to 20 per 1,000 live births by 2015 (Sanders, et al., 2010). The nutritional status of young children in South Africa is also poor. One in five children in South Africa is stunted as a result of chronic nutritional deprivation and one in ten children are underweight (UNICEF South Africa, 2011). The prevalence of stunting among children 0-9 is 18 percent, and 9 percent of children in the same age group are underweight (UNICEF South Africa, 2011). Nearly three million children live in households reporting hunger, with the Eastern Cape and the Free State reporting the highest levels of hunger (Roman & Hall, 2011); 52 percent of children aged 1-9 years experience hunger, 28 percent are at risk of hunger and 20 percent are food insecure as estimated by the National Food Consumption Survey-Fortification Baseline (NFCS-FB) (Hendricks & Bourne, 2010). As in the case of poor maternal health outcomes, poor health and nutritional status is a burden borne by more African children living poverty and those living in rural areas and poorer, less well-resourced provinces. They too enjoy less acess to health care, a lower quality		specific services in question.

		of health care, and poorer health outcomes (National Planning Commission, 2011; Sanders, et al., 2010; UNICEF South Africa, 2011; Westwood, et al., 2010). Poor nutritional status is more common in rural areas (Hendricks & Bourne, 2010). The underlying causes of the inequitable access to and enjoyment of health services in South Africa are poor management and implementation of the good policies we have, especially in under-resourced and rural areas (Harrison, 2009; Republic of South Africa, 2010; Sanders, et al., 2010). In addition to the service delivery impediments, there are a number of policy and programmatic gaps. A key gap is the absence of a clear, pro-active and funded hunger and under-nutrition policy for South Africa's youngest children. The international and regional obligations on the State to realise children's nutritional rights are three-fold. The obligation encompasses inteventions to: 1. Provide adequate nutrition and food[25] to ensure an adequate standard of living for children;[26] 2. Provide nutritional advice and support to caregivers;[27] and 3. Combat malnutrition through the provision of adequate nutritious food and application of technology[28] The current programme terrain covers only obligations 2 and 3, but fails to ensure the provision of adequate nutrition and food to ensure an adequate standard of living for		

[25] UNCRC, Article 14(2)(c) and General Comment 7, Paragraphs 27(a) and (b)
[26] ACRWC, Article 20(2)(a); UNCRC, Article 27(3)
[27] ACRWC, Article 14(2)(h), UNCRC, Article 24(2)(e), General Recommendation 7, paragraph 27(b)
[28] UNCRC, Article 24 (2) (c); ACRWC, Article 14(2)

		children whose parents cannot afford to do so. There is no health (or other) policy in place, as is required by the NIP for ECD, to ensure that all children under the age of four, have access to daily balanced nutrition where their parents cannot provide this.[29] Whilst the National School Nutrition Programme ensures a daily meal for children of school-going age who are living in poverty, and the ECD subsidy ensures some food for children in poverty attending an ECD centre, there is no comparable measure in place for ensuring daily food for infants and young children not particiapting in any programme, and/or those in community-and family-based ECD programmes – either through the departments of Health, Social Development or Education. The current policy responses to nutrition only apply once a child is showing signs of malnutrition; there is no legal obligation on health workers at facilities or in the community to monitor the circumstances of pregnant women, infants and young children to determine if they are living with hunger and/or are at risk of malnutrition (at present they only monitor for signs of mal or under-nutrition), nor are there systems in place within the health system, education, and social security system for the referral of at-risk children and their caregivers to social, agricultural and other support and services to prevent malnutrition from ocurring. A primary intervention which has the capacity to prevent hunger and malnutrition in especially young children is the Child Support Grant (coupled with counselling on how to use the money to acheive optimal nutritional outcomes).		

[29] See the Matrix of Roles and Responsibilities in the NIP for ECD

		The Child Support Grant (CSG) has been shown to have significant positive nutritional benefits when paid to caregivers of young children, especially in their first two years of life. It significantly reduces the prevalence of stunting (Aguero, Carter, & Woolard, 2007). Aguero et al, (2007) argue therefore that nutritional policies and programmes in South Africa must ensure that children living in poverty receive the child support grant as early as possible in the first two years of their lives. The reality is that take-up rates in the earlier years are lower than for older children (Hall, 2011; Peters & Williams, 2009). The current health system for monitoring malnutrition – the Road to Health booklet does not include any questions in the ante-natal, post-natal or infant care visits that allow for the health worker to assess the infant's eligibility for the CSG during ante-or post-natal visits (and risk of hunger malnutrition based on socio-economic status), or a referral system between the health and grant administration system to ensure the earliest possible registration of the infant's caregiver for receipt of the grant together with advice on how to make use of the funds for optimal nutritonal benefit of the infant. Similarly, there is no provision made for the pre-registration of the pregnant caregiver for the child support grant before the child is born (a process which could be facilitated through ante-natal care visits to the clinic) as is the case for employed pregnant women who qualify for payment of maternity benefits through the UIF. Pre-registration would allow for quick and easy access to the CSG once the child is born.		

3.2.4 Provide birth registration 1. Provide birth registration immediately after birth[30]				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate / inadequate**
The Constitution provides that every child has the right to a name and a nationality from birth.[31] The NIP for ECD includes, within the national comprehensive ECD package, universal birth registration. In terms of the Births and Deaths Registration Act No. 51 of 1992 as amended, the births of all children must be registered within 30 days of birth.	The Department of Home Affair's National Population Registration campaign offers various on-site and coordinated and integrated sites to facilitate birth registration in under-serviced remote areas, including on-line registration in hospitals, through Thusong Centres and through community-based networks of support (Department of Home Affairs, 2011).	**Successes** There has been a significant improvement in birth registration rates. The number of births registered within the first year of life increased from 47.9 percent in 2002 to 83.3 percent in 2010 (Statistics SA, 2011). **Challenges** Despite the relatively high national birth registration rate, the rate for young children 0-2 is lower than for older children. Whilst 93 percent of children aged 0-6 had birth certificates in 2008, only 86 percent of children aged 0-2 were in possession of this critical document (National Income Dynamics Survey (NIDS), 2008). In addition, young children living in rural areas are especially vulnerable. Children aged 0-1 in rural areas have a much lower rate of access to birth certificates. The rates have historically been as low as 40 percent[32] (Peters & Williams, 2009).	Yes	Yes

[30] UNCRC, Article 7(1); General Recommendation 7, paragraph 25; ACRWC, Article 6(2)
[31] Article 28(1)
[32] The 40% figure is based on studies conducted in mid 2000. These figures are likely to have improved in these rural areas given the Department of Home Affairs' National Population Registration Campaign. Unfortunately no data has been published providing updated figures and requests to the Department for updated figures remained unanswered at the time of writing this report.

3.2.5 Provide social assistance and social security to reduce poverty in early childhood 1. Provide social security in early childhood, including social insurance, to enable parents and caregivers to maintain their children provide their children with an adequate standard of living[33] 2. Provide paid maternity leave or comparable social benefits[34]				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The Constitution provides that everyone (including children) has the right to social security, including if they are unable to support themselves and their dependents.[35] In addition, every child has the right to social services[36]. The NIP for ECD includes, within the national comprehensive ECD package, referral services to ensure that all eligible children have access to an appropriate grant with accompanying services. In addition, it recognises the need for strengthened labour and employment practices to promote healthy pregnancies, birth and infancy.	South Africa makes provision for both non-contributory and contributory social assistance for the caregivers of infants and young children. In terms of the Social Assistance Act No. 13 of 2004 and various amendments thereto, the caregivers of children living in poverty, with disabilities and those living with foster parents are entitled to receive either a monthly Child Support Grant (CSG) to cover the costs of children's basic needs, a Care Dependency Grant (CDG) for caregivers of children with severe disabilities, or a Foster Care Grant (FCG) for those living	**<u>Successes</u>** *Non-contributory social assistance* It is estimated that 73 percent of eligible children are receiving the CSG in South Africa (Chennells & Hall, 2011). Of these children, 474,000 are 0-1 years, 645,000 are 1-2, 698,000 2-3 and 730,992 between 3 and 4 years old (South African Social Security Agency, 2011). **<u>Challenges</u>** *Non-contributory social assistance* Young children aged 0-6 have a lower rate of access to the CSG than older children. According to the 2010 General Household Survey (Statistics SA, 2010), only 62 percent of eligible children aged 0-6 access the CSG, and this rate drops lower the younger the child. For example, only 56 percent of eligible children aged 0-2 access the CSG, whereas 66 percent of 3-4 year olds and 68 percent of 5-6 year olds. Young children in rural areas are even more prejudiced, with even lower rates of access. Whilst the data is less recent, it illustrates the point - as few as 20 percent of young children	Yes	Yes

[33] ACRWC, Article 20 (2); UNCRC, Articles 26 and 27(3); General Recommendation 7, paragraph 26
[34] CEDAW, Article 11(2)(b)
[35] Article 27(1)(c)
[36] Article 28(1)(c)

	with foster parents. In addition, the UIF pays maternity benefits to contributing members.[37]	(0-1) in rural areas received the CSG in 2005 (Noble et al., 2005). <u>Contributory social security</u> Whilst maternity benefits are paid to contributing employed members, the higher levels of unemployment amongst women, especially those with children under the age of six (Berg, 2007), places this benefit beyond the reach of many vulnerable women.		
3.2.6 Provide clean water, sanitation and hygiene				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
Section 27(b) of the South African Bill of Rights states that everyone (including children), has the right to access to sufficient food and water. The 2001 White Paper on Basic Household Sanitation has as its goal the provision of adequate sanitation to all and the elimination of the bucket system. The South African Government has committed to ensuring that "everyone, including children, has access to functioning basic water-supply services and that everyone has access to a	The Municipal Infrastructure Grant programme aims to provide bulk water-services (Department of Women Children and People with Disabilities, 2011). The 2000 Free Basic Waer Policy and Free 2001 Basic Water Implementation Strategy requires local governments to provide up to 6*kl* of water per month to indigent households, subject to the availability of means to do so.	**<u>Successes</u>** Children's access to sanitation in their homes has improved between 2002 and 2009 from 47 percent to 63 percent (Hall, 2011). Within ECD centres, in 2001, 53 percent of ECD sites had mains electricity, piped water and flushing toilets (Department of Education, 2001). In 2010, a subsequent three province study of ECD provisioning shows that this figure has improved. The study found that approximately 60 percent of ECD facilities had flush toilets, with pit latrines found at 41 percent of ECD facilities at public schools, 35 percent at registered ECD centres and 28 percent at unregistered centres (Department of Basic Education, Department of Social Development, & UNICEF, 2011). **<u>Challenges</u>** Despite the progress that has been made, in 2009 6,8 million children were still using inadequate sanitation facilities. 1,5 million	*Bulk water services* Yes. In 2007/08, R1,9 billion was allocated for bulk water-services infrastructure and substantial resources were allocated to municipalities between 2007/08 and 2011/12 through the Municipal Infrastructure Grant programme (Department of Women Children and People with Disabilities, 2011; SAHRC, 2006; UNICEF South	*Bulk water services* Yes *Free basic water programme* No *Household sanitation* No *Water and sanitation in ECD centres and facilities* No

[37] The Unemployment Insurance Fund Act. No 63 of 2001 as amended by Act No 32 of 2003

functioning basic sanitation facility by 2010". Government committed to eradicate, by 2010: • The bucket-system in informal settlements • Water and sanitation backlogs in clinics • The backlog in schools • Water-supply backlogs • The general sanitation backlogs In addition, the NIP for ECD foresees the Department of Water Affairs and Forestry as being responsible for the provision of sufficient water and sanitation to ECD sites. The Policy for the Provision of Basic Refuse Removal Services to Indigent Households establishes a framework for the identification and enrolment of indigent households for free basic refuse removal services (Department of Environmental Affairs, 2010).		children (8 percent of all children) live in households that have no toilet facilities at all (UNICEF South Africa, 2011). A substantial number of these households without toilet facilities house young children aged 0-6; 10-12 percent of all households with children aged between 0 and 6 years do not have any toilet facilities at all (Statistics SA, 2010). Statistics for refuse removal services are even poorer; 58 percent of households have their refuse removed by a local authority (Statistics SA, 2010). The greatest deprivation is experienced by children living in rural locations – for example, only 37 percent of children in Limpopo had access to adequate sanitation in 2009 (Hall, 2011). Likewise, 41 percent, 32 percent and 12 percent of children living in households with no toilet facility live in the rural provinces of the Eastern Cape, KwaZulu-Natal and Limpopo respectively, whereas only 16 percent live in the remaining provinces (UNICEF South Africa, 2011). Only 11.6 percent of households in Limpopo province have their refuse removed by a local authority (Statistics SA, 2010). In a recent three province study, only 50 percent of Grade R public school facilities, and 50 percent of registered community-based ECD centres have access to piped water inside the building (Department of Basic Education, et al., 2011). A number of unregistered centres had no toilet facilities. Approximately 75 percent of public school ECD facilities complied with the standard of one toilet per 20 children, but only 63 percent of registered community facilities and 57 percent of unregistered community facilities complied with this standard (Department of Basic Education, et al., 2011).	Africa, 2011). *Free basic water programme* Local government is only obliged to fund the programme if they have funds to do so. Many, especially those serving the poorest communities, do not have sufficient funds to support the programme adequately (SAHRC, 2006). *Household sanitation* There is no national free/subsidised household sanitation policy and hence no budget to follow. *Water and sanitation in ECD centres and facilities* There is no legal obligation on any State department or functionary to provide free/subsidised water and sanitation facilities to ECD centres and facilities serving poor, under-serviced and/or rural communities.	

		Poor sanitation and hygiene is a cause of diarrhoea, cholera, malaria, bilharzia and other ailments that are key causes of infant and child morbidity and mortality in South Africa (Department of Health, 2011). *Sanitation* In light of policy intentions, it is surprising that there is no legal obligation on any government agency – whether nationally, provincially or locally – to provide free/subsidised sanitation facilities in homes and within that framework, to prioritise addressing the sanitation backlogs in households with infants and young children and. There is at present no implementable and enforceable free/subsidised sanitation programme for homes in poor communities. *Water* Whilst there is a free basic water programme, it is not legally enforceable. Local government is only obliged to implement the policy in accordance with its available resources. Where it lacks the means, the programme is only partially implemented, or not implemented at all (SAHRC, 2006). There is also no obligation in terms of indigent policies, to prioritise the delivery of free basic water services to households with pregnant women, infants and small children. *Refuse removal* The Policy for the Provision of Basic Refuse Removal Services to Indigent Households establishes a framework for the identification and enrolment of indigent households for free basic refuse removal services (Department of Environmental Affairs, 2010). The policy directs local governments to prioritise child-headed households, elderly-headed households and households with disabled people, but does not	Consequently there is no budget allocated.	

		direct the similar prioritisation of households with pregnant women, infants and young children. In addition, the Policy, as in the case of the Free Basic Water programme, makes the provision of free basic refuse services dependent on local government resources, opening the door for poor and poorly managed local governments not to implement the policy. *Sanitation, hygiene and water in ECD sites* There is no enforceable obligation on any department or local government to provide free/ subsidised water, sanitation and refuse removal services at ECD centres in vulnerable communities. There is also no government commitment in terms of current targets, goals and undertakings to address this infrastructural inadequacy in centres. Not only is there no legal obligation, there is also no assumption of the responsibility by local government for these services (Budlender, et al., 2011). At present, the lack of such facilities is policed by local government. Where it is found that a centre is non-compliant the centre may not become registered. There is no legal obligation on the relevant local government to support the centre to obtain the necessary infrastructure or facilities to enable it to meet municipal criteria for registration. *Looking forward* The recently published draft National Environmental Health Policy holds the potential for the promotion of more child-friendly sanitation and hygiene policies in the future – given its recognition of the vulnerability of infants and young children to the impact of environmental pollutants. Given this recognition, it is surprising that the draft policy does not expressly direct responsible government		

		agencies to prioritise funding to eliminate sanitation, hygiene and water backlogs in homes and ECD centres and facilities with pregnant women, infants and young children through future programmes.		
3.2.7 Protection from abuse, neglect and exploitation				
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The Constitution recognises and protects the rights of children to be protected from maltreatment, neglect or abuse (Section 28(1) (d)). The Children's Act creates a sophisticated national child protection framework. The NIP for ECD does not include child protection services as one of its essential components in the Matrix of Roles and Responsibilities.	The Children's Act seeks to provide a range of protection services ranging from prevention and early intervention services to removal and reintegration services. In addition, the Sexual Offences Act No. 23 of 1957, the Prevention of Family Violence Act, No. 133 of 1993 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 provide a range of investigative, treatment and prosecution protective services.	**Successes** The enactment of the Children's Act together with the range of criminal offences laws provides a sound, though reactive rather than preventive, protective policy environment for children in South Africa. **Challenges** Crimes against women and children have increased over the last years. Sexual offences against children increased by 3% in 2010 to 20,141 cases; 61% of these offences were committed against children younger than 15 years of age; 25% involved young children aged 0-10 years (South African Police Service, 2011). In addition, 13% of households in South Africa do not have an adult at home at all times when children under the age of 10 years are at home (Statistics SA, 2011). Primary challenges include: 1. Inadequate implementation due to insufficient human and financial resources (D. Budlender, 2010); 2. The provision of reactive and punitive rather than preventive supportive services for high risk children and situations, for example, lack of adequate child care.	Yes	No

3.2.8 Early childhood care and education (ECCE) for children

1. Promote and provide a network of child-care facilities and other supportive social services to enable parents to combine family obligations with work responsibilities.[38]
2. Render support and assistance to parents and extended families in the performance of their child-rearing responsibilities, including the promotion of living conditions necessary for the children's development and the provision of adequate protection and care. This includes parenting education, parenting counselling and other quality services for mothers, fathers, siblings and grandparents.[39]
3. Provide early childhood education for children from birth through family, community, centre and school-based stimulation and development programmes and centres.[40]
4. Provide support to parents to fulfil their role as primary duty-bearers for the early development and education of their children.[41]

Policy response / commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The State's obligation to provide ECCE finds expression in the National Integrated Plan for ECD and the Children's Act No. 38 of 2005. They contemplate the delivery of early childhood care and education in multiple sites – in the home, community, through centres, institutions and other sites. The NIP for ECD targets the provision of ECCE services to children aged 0-4 in underserviced rural and informal urban areas, anticipating the provision of services by various State agents and	The NIP for ECD targets increasing access to ECD services, including ECCE for young children aged 0-4. The ECCE objective, which gives special focus to children in marginalised areas, has found legislative expression in the Children's Act. The Children's Act obliges the Minister of Social Development to, in consultation with other relevant departments, including Education, Finance, Health, Provincial and Local Government and Transport, develop a comprehensive national strategy aimed at securing	**Successes** According the General Household Survey 43 percent of children under the age of five were exposed to early childhood interventions in 2009. This figure jumped to 63 percent in 2010 (Statistics SA, 2009, 2010). **Key challenges** Despite the prioritisation by the Children's Act and the NIP for ECD of children living in poverty and other under-serviced communities, as well as those living with disabilities, these children continue to have significantly less access, and access to poorer quality ECD services. Children living in the poorest households are only half as likely to benefit from ECD as children in the richest households (Department of Women Children and People with Disabilities, 2011; UNICEF South Africa, 2011). The exclusion of children living in poverty is entrenched by a number of policy and funding	*Centre-based per child subsidy* Yes, partial funding by way of a per-child subsidy for children attending registered ECD centres. However; there is no obligation to provide this funding, and it could, in the event of competing demands and pressures be reduced or stopped. *Home and community-based programmes* There is no funding for home and community-based services (although	*Centre-based per child subsidy* No *Home and community-based programmes* No, none at all.

[38] CEDAW, Article 11(2)(c); ILO Convention (no 156) on Workers with Family Responsibilities (Article 5(b))
[39] General Comment No.7, Paragraphs 19 and 20
[40] ACRWC, Article 11; UNCRC, Articles 28 and 29; General comment No.7, paragraphs 28 – 30; A World Fit for Children
[41] ACRWC, Article 20; UNCRC, Articles 5 and 18(1); General Comment No. 7, paragraph 30

departments in order to realise this objective, including[42]: The DoE leads increased access to quality early learning programmes by expanding and strengthening programmes for children aged 0-4; The DoE leads the development of the capacity of teachers, caregivers and practitioners to deliver integrated ECD programmes for children It is envisaged that municipalities will build ECD centres in areas of most need and to upgrade ECD centres to offer an environment conducive for effective learning and care.	a properly resourced, co-ordinated and managed early childhood development system, giving due consideration to children with disabilities and chronic illnesses (Section 92(1)). Provincially, the Act obliges the MEC for Social Development to register and to maintain a record of all ECD programmes registered in the province; and within the national strategy, to develop a provincial strategy aimed at a properly resourced, co-ordinated and managed early childhood development system. (Sections 92(2) and 95(1)). When it comes to the actual provision of ECD programmes, the Act does not oblige, but affords the MEC for Social Development the discretionary (unenforceable) power to provide and fund ECD services. Section 93(1) of the Act provides that the MEC "***may***, provide and fund early childhood development programmes for that province".	disjunctures and gaps, including the following: 1. The goals and outputs of the NIP for ECD related to the extension of ECCE by local government by building more sites and improving the infrastructure of poorly resourced sites have not been translated into legally enforceable obligations on the various government departments, appropriate policies and laws. The goals and outputs to provide, support or fund services remain aspirational. 2. The insufficiency of the current subsidy means that most ECD sites charge fees, which bars poor children from accessing registered (and higher quality) ECD care and education services and programmes (Berg, 2007; Department of Basic Education, et al., 2011). Those too poor to pay fees rely on informal child care arrangements if their cargivers need to work. Those fortunate enough to have sufficient money to pay fees are not guaranteed quality ECD services as end-user fees that are charged and paid in poor communities are not enough to provide quality services. Poor families "do not have enough to pay for the full range of quality services required for strong integrated ECD provision" (Llifa Labantwana, 2011). The quality of ECCE interventions and activities in centres receiving a subsidy, as well as those not recieving a subsidy, is generally very poor (Biersteker, et al., 2009; Department of Basic Education, et al., 2011). The funds made available through the subsidy are insufficient to enable the delivery of quality ECCE services, and the funds generated through user-fees are not sufficient, in poor communities, to remedy	Margot Davis from the Department of Social Development says that there is a plan in development for the payment of a subsidy to children participating in home and community-based programmes that are linked to an established NGO or CBO). Once again this leaves out the most marginalised communities, most of whom have little formal NGO presence. **Centre infrastructure, centre structures, equipment, and salaries** There is no obligation to fund centre infrastructure or build centres.	

[42] 3.2 Matrix for Roles and Responsibilities, pages 18 - 20

	The regulation of the quality of services is provided through the proviso that registration and funding of ECD programmes is dependent on compliance with national ECD norms and standards (Section 93(2)). Section 93(4) obliges the MEC to prioritise the funding of programmes in under-resourced communities where families lack the means to provide proper shelter, food and other basic necessities and to make ECD programmes available to children with disabilities. The DSD does not provide any of the services itself., but it regulates and partially funds registered sites of service delivery and some programmes.	this deficiency. In addition, there are few mechanisms in place to monitor and ensure the provision of quality ECCE in either subsidised or non-subsidised, registered or unregistered ECD centres (Biersteker, et al., 2009; Department of Basic Education, et al., 2011; Llifa Labantwana, 2011). Insufficient funding, and the lack of a legal obligation on any government agency has frustrated the scale up of ECD services, sites and programmes as contemplated by the EPWP (Streak & Norushe, 2008). Scaling up of services has further been hampered by poor levels of infrastructure in centres in poor areas and the difficulties of registering sites in terms of the Children's Act (Proudlock & Jamieson, 2008). There is currently no obligation on any State agency, specifically local government, to fill the infrastructure gap in ECD centres, or to build more ECD sites, as contemplated by the NIP for ECD. Moreover, there has been no volunatry assumption by local, provincial or national government to fill these gaps (Budlender, et al., 2011). The responsibility for filling this gap and meeting this demand - which is essential to ensuring equitable access to ECD servcies for children in poor and underserviced areas - is left entirely to inadequately funded NGOs (National Planning Commission, 2011). The system is inherently inequitable and perpetuates inequity. NPOs in poor underserviced areas are the least likely to have sufficient funds to build sites, procure and maintain the necessary infrastructure, employ, train and pay qualified staff, and deliver quality programmes. They are hence least likely to be able to register their sites and at least obtain the ECD subsidy. It is likely to become more inequitable in the current economic climate		

		which is subjecting NPOs to severe financial constraints. Whilst this gap could be filled through more home and community-based programmes, an almost complete absence of State funding, alongside the absence of a coherent home and community-based State-led and supported ECD programme, has stalled the roll out of this delivery vehicle. In addition to the exclusion of children living in poverty and in rural areas, children with disabilities are simply not catered for in terms of current policy and programmatic interventions. This is dealt with in more detail later. There is no consideration of the roles of traditional leadership and traditional leadership infrastructure and their community development role and the provision of ECD services and programmes in rural areas.		
Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The White Paper on Early Childhood Education (2001) introduces universal Grade R for all five year olds in South Africa.	The Department of Education provides one year of pre-school through the reception year programme	**Successes** There has been significant growth in the number of children, especially poor children, aged five accessing an educational institution. According to the DBE, in 2009, 78.3% of children aged five attended an educational institution in South Africa, compared to 39.3%in 2002. Provincially, access varies from 66.8% in the North West province to 92.7% in Limpopo (Department of Basic Education, 2011). **Challenges** The primary challenge with regards to Grade R is the poor quality of the service provided (Biersteker, 2008; DBE, 2011).	Yes	No

3.2.9 Provide ECD services and support to children with disabilities

1. Adopt special measures to ensure that children with disabilities have equal enjoyment of all their rights, including their rights to education, health care, and development[43]
2. Provide health services for people with disabilities including early screening and identification and the provision of free early support and treatment for children with disabilities to minimize the impact of the disability and prevent further disabilities[44]
3. Provide assistance for children and their caregivers with disabilities, including social assistance, free assistive devices and rehabilitation services[45]
4. Ensure an inclusive education system at all levels of education, including early childhood education by ensuring that children are not excluded from the general education system on the basis of their disability and can receive support within the general education system[46]

Policy response/ commitment/ undertaking in response to obligation	**State supported ECD programme to fulfil commitment/undertaking**	**Quantitative and qualitative successes and challenges**	**State-funded mandate: yes/no**	**Funding adequate/ inadequate**
The Constitution provides that everyone has a right to equality, which means that they are entitled to full and equal enjoyment of all rights and freedoms. In addition, the State may not unfairly discriminate, directly or indirectly against anyone, on the grounds of their disability.[47] The Children's Act highlights the need for special measures to be taken and priority to be given to children with disabilities in the provision of ECD services, and	*Education* White Paper 6 on inclusive education obliges the inclusion/enrolment of children with disabilities in mainstream schools and the provision of special schools by the Department of Education for children with severe disabilities. *Health* Free health care is provided to children with disabilities in terms of the Free Health Care for Disabled People programme (2003), including access to assistive devices.	**<u>Successes</u>** Education White Paper 6 on Inclusive Education formalizes the mainstreaming of children with disabilities in primary and secondary schools and requires the State to provide special schools to accommodate children with severe disabilities. In addition, it establishes a support structure within the education system to support parents, children and educators of children with disabilities to maximize children's development. **<u>Challenges</u>** The lack of up-to-date, accurate, comparable data makes the assessment of the situation of children with disabilities very difficult. The data that is available, although dated, indicates a lack of access to ECD services, programmes and facilities for children with disabilities.	*Education* Yes *Health* Yes *Social security* Yes *Early childhood care and education* No, no specific targeted funding.	*Education* No *Health* No *Social security* Yes *Early childhood care and education* No

[43] ACRWC, Article 13; UNCRC Article 23; A World Fit for Children, Paragraph 17
[44] UNCRPD, Article 25(b)
[45] UNCRPD, Article 23(2) and (3) and Article 25(b)
[46] UNCRPD, Article 24(1)
[47] Article 9 (1) and (2)

support to children with disabilities so as to ensure they enjoy guaranteed access to ECD services. Section 92 requires the Minister to take due account and priority to children with disabilities in the departmental ECD strategy he or she is obliged to develop. Section 11 of the Act indicates what special measures are required when developing plans so as to ensure children with disabilities are prioritised. It provides that in any matter concerning a child with a disability, due consideration must be given to providing the child with special care as and when required, making it possible for the child to participate in social, cultural, religious and educational activities, and provide the child and his or her caregiver with the necessary support services. Section 94(3) of the Act requires the development of national ECD norms and standards for all children, including those with disabilities.	In addition, basic developmental screening is included in the routine post-partum visits to the clinic and is managed and recorded through the Road to Health clinic card. *Social security* The CDG is paid to the primary caregiver of a child who requires or receives permanent home care due to his or her disability. *Early childhood care and education* There are no DSD programmes for the provision of ECCE for children aged 0-4 with a disability. The DoH apparently provides a subsidy to NGOs that provide care and education to severely disabled children. Although no further detail is available ("Western Cape Forum for Intellectual Disability v Government of RSA and one other, 18678/2007 ", 2010).	*Early childhood care and education* Only 1 percent of children enrolled at ECD centres in 2001 had one or more disability, and many of those that were enrolled were seven years and older, indicating that they were in ECD centres in the absence of their being enrolled in schools (Department of Education, 2001). Overall, it is estimated that only 1 percent of children with disabilities attend ECD centres (Department of Social Development, 2009b). Despite the requirement in terms of the Children's Act that ECD services be prioritised for children with disabilities, there are no DSD funded programmes for ECCE for children with disabilities, nor is there provision made for an additional subisdy or additional materials and equipment to address the additional needs of young children in registered ECD sites. There is little, if any guidance provided by the DSD, DoE or other departments for the development and provision of ECCE services for young children with disabilities. The ECD norms and standards developed in terms of the Children's Act are silent on the norms and standards necessary for children with disabilities; the Guidelines for ECD services developed by the DSD and UNICEF list the rights of children with disabilities but provide no guidance on how to secure these rights in an ECD service context. Education White Paper 5 on ECD is silent on children with disabilities, and the National Early Learning and Development Standards for Children Birth to Four Years (NELDS) provides minimal guidance on children facing barriers to learning, for example, advising that practitioners "Take into account the special needs of children with barriers to development when planning activities and progress"; and provides some guidance on development		

The NIP for ECD calls for viable and integrated service delivery to young children, with a focus on vulnerable children. Amongst identified vulnerable children are those with physical disabilities. There is, however, not further mention of disability in the NIP and no indication of any specific ECD needs and how to meet them for children with disabilities. The Department of Social Development's Policy on Disability (undated), provides guidance and direction to DSD programme developers to ensure the provision of economic and social protection to people and children with disabilities. It recognises that children in rural areas and in informal settlements are the most vulnerable to disablement, in addition because facilities for early detection, diagnosis and support are inadequate. Accountability is identified as a key principle, intimating that the department must assume responsibility for the delivery of social,		milestones, but little concrete guidance on what the programmes/activities should look like or seek to achieve. Whilst the position is better in the case of children of school-going age, given the formalisation of education for children with disabilities through White Paper 6, which does apply to Grade R, there is little data about the extent to which the policy is applied in the Reception year. *Health* There is no routine and/or early screening for disabilities such as hearing loss, other than basic developmental screening through the clinics (Torbeck & Moodley, 2011). Even basic developmental screening is poorly applied. A study conducted in the Western Cape in 2003 found that developmental screening in PHC clinics was not effective. Difficulties with implementation included: • At a quarter of the facilities no developmental screening was provided, • The standardized protocol was used at only one out of nine facilities, • Few children with developmental disability were identified and appropriate intervention was problematic, • The findings were not accurately recorded or transcribed onto the Road-to-Health Chart, • Referral practices did not follow protocol and standard referral forms were not used, and • The programme was not effectively monitored (Children's Institute, 2003) *Social security*		

economic and ECD services to children with disabilities. A key strategy proposed by the policy is for the mainstreaming of the needs and rights of children with disabilities into ECD programmes. The policy does not provide further information about what ECD programmes should mainstream disability or how this should be done. The draft Integrated National Strategy for People with Disabilities recognises the heightened vulnerability of children aged 0-5 (who tend to have multiple impairments with greater severity than older children; rural areas, where children are twice as likely to have more than one disability and have more severe disabilities, and those in informal areas which have the highest concentration of children with disabilities (Department of Social Development, 2009b). It further recognises, in view of this heightened vulnerability, the critical importance of integrating disability into all ECD policies, laws and		Less than half of children with a disability access the Care Dependency Grant (CDG). In Mpumalanga, only 43 percent and in Gauteng less than half of children with disabilities access the CDG (Department of Social Development, 2009b). And whilst 1 percent of children aged 0-6 are understood to be disabled, only 0.2 percent of children in this age group access the CDG (Statistics SA, 2010). *The unlawful absence of a rights-based framework for ECD for children with disabilities* At the heart of the problem is a lack of legal responsibility and accountability of the State to provide, support and fund core ECD services such as screening and ECCE services and support for children with disabilities. There are a huge array of policies and strategies recognising the rights of children with disabilities and the obligation on the State to take special measures to ensure they enjoy equal access to their rights. There is, however, an inversely disproportionate lack of concrete laws and programmes obliging any specific government department or agency to be responsible for the special measures. One simply has to have regard to the difference in length and detail between columns one (dealing with broad policies) and two (dealing with actual concrete laws and programmes obliging State action to ensure ECD services for children with disabilities. At present the current ECD framework is characterised by the lack of a mandatory obligation on the State to act to ensure the inclusion of and access to ECD services for children with disabilities, leaving children and people with disabilities with no legal recourse to pursue their legal entitlements. The presence of a framework which creates mandatory		

programmes so as to address the mutiple vulnerabilities, multiple causes and mutiple solutions at all stages of development. In order to realise this, the Strategy calls for a rights-based, versus a needs-based approach to children with disabilities in the ECD context. The strategy calls on all ECD programmes to ensure equality of access by targeting actions to prevent disabilities through: early identification and interventions; parental support; habilitation and rehabilitation; and through formal compulsory education in schools and ECD sites.		obligations on the State is the hallmark of a rights-based framework; the absence of this and the presence of discretionary voluntary action casts the framework as something other than a rights-based framework (Save the Children Sweden (2005) *Child Rights Programming: How to Apply Rights-Based Approaches to Programming* - A Handbook for International Save the Children Alliance Members in the Department of Social Development, 2009 (Revised draft)). The Western Cape High Court has ruled that the failure to assume legal responsibility for the delivery of essential legally prescribed services to children with disabilities by the State is unlawful and a transgression of the rights of children with disabilities ("Western Cape Forum for Intellectual Disability v Government of RSA and one other, 18678/2007 ", 2010).		

4. Commentary on the State's realisation of its ECD obligations

4.1 A multi-sectoral approach

There is wide-spread consensus that:

> *Development in early childhood development is a multi-dimensional process in which progress in one domain often acts as a catalyst for progress in other domains. Conversely, delays in one area of development can trigger delays in other areas as well. For example, poor nutrition in the early years not only leads to poor physical growth, but is also highly predictive of delayed cognitive development and low academic achievement....Lack of adult attention and stimulation in the early years not only leads to poor socio-emotional and cognitive development, but also is linked to poor health and physical growth* (Naudeau, et al., 2010).

Therefore, in order to ensure the optimal development of young children and attain maximum returns on investments in early childhood, it is necessary that the full complement of children's rights, as guaranteed by the Constitution, the UNCRC and the ACRWC and other local and international instruments, be secured through the national ECD strategy.

The rights in question – including the right to participation, birth registration, health care, food and nutrition, shelter, basic services such as water and sanitation, protection from abuse, neglect and exploitation, social assistance and education – are recognised and protected for all children, including young children, by the Constitution of the Republic of South Africa Act No. 108 of 1996[48].

South Africa has taken measures to fulfil its international obligations and responded to the economic and social arguments, and has sought to provide an integrated package of care and support for young children, aged 0-6 through various policies and laws which seek to realise these constitutionally protected rights for young children, either directly or as part of a broader group of beneficiaries such as vulnerable children or households.

Two of the key overarching policies which aim to provide a multi-sectoral framework within which the various sectoral policies and programmes are located are the National Integrated Plan for ECD, 2005-2010 and the Children's Act No. 38 of 2005, as amended. These two instruments seek to guide the development of the local and international vision of comprehensive multi-sectoral early childhood development, defined by the Children's Act No. 38 of 2005 as "the process of emotional, cognitive, sensory, spiritual, moral, physical, and social and communication development of children from birth to school-going age".

Accumulatively, the current policy framework does, to varying degrees, provide for most of the essential rights. The ECD landscape has, over the last decade, seen significant progress

[48] Section 28

towards realising the necessary comprehensive ECD package – on the policy front, that is. On this front, numerous policies have been developed which recognise and aspire to realising the multi-sectoral ECD package covering the essential services deemed necessary to realise the optimal holistic development of young children. However, as was revealed in some length in the preceding tabular analysis, there is still a significant way to go to fully realising the multi-sectoral package required by law and still some rights for which there are not yet legal obligations.

The results of the preceding analysis are summarised below and show that there are still a number of policy, resource and implementation gaps that must be addressed if the State is to comply with its obligation to provide a full multi-sectoral ECD package. The national track record in translating the national policy recognition and commitment into a comprehensive ECD package is less exemplary when it comes to translating the commitments into clear, unambiguous government programmes and obligations to provide the relevant services to young children and their families; further, where the policies have been translated into programmes, implementation of the programmes is often frustrated by insufficient resources, poor management and inferior quality.

Summary of progress made by the State in meeting its obligation to recognize and protect the individual ECD rights for young children		
Red = no policies or programmes in place translates into failure to assume prescribed legal responsibility and no guarantee that children can access the right in question.	Orange = policies and programmes in place, but they create inadequate levels of State responsibility, and/or are not adequately resourced, and/or poorly implemented. As a result, some children, but not the most marginalised young children, access the right.	Green = policies and programmes in place and the majority of young children, including the most marginalised, access the right.
Health	Policies and programmes are in place, but frustrated by poor implementation and lack of integration of services.	
Nutrition	Health policies and programmes are in place, but frustrated by poor implementation and lack of integration of services.	
Food	No health policy or programme in place to secure adequate daily food for young children, especially those aged 0-2. CSG is available, but poorly accessed in the first two years of life and no system in place to guarantee early registration.	

Water in households	Insufficient policies and programmes to secure water in vulnerable households due to lack of prioritisation of young children and lack of resources.
Water in ECD centres	No policies or programmes in place to oblige and secure the provision of water in poor ECD centres.
Sanitation in households and ECD centres	No free basic sanitation policy or programme in place to secure sanitation in vulnerable households with young children or in ECD centres.
Protection	Protection policies and programmes are in place, but are hampered by inadequate resources, and they are reactive rather than preventive.
Early childhood care and education	Insufficient and inequitable policies and programmes exclude children in poverty and rural areas from ECCE services, with no obligation on the State to provide these services. Obligation rests in inadequately funded NPOs, and delivers poor quality ECCE to vulnerable children.
Social assistance	Policies and programmes in place, but poor implementation frustrates early access for the most vulnerable young children, especially those in rural areas and young children with disabilities.
Birth registration	Policies and programmes in place and innovative implementation has secured the registration of the majority of children, including marginalised children.
Special measures to ensure ECD services for children with disabilities	No special programmes in place to secure early identification and prevention of disabilities or early childhood care and education for young children (aged 0-4) with disabilities.

4.2 Guaranteed access to ECD rights for the most vulnerable and marginalised

The international legal ECD framework has a strong equity focus. Various instruments, including the UN's 'A World Fit for Children' (United Nations General Assembly, 2002), the CEDAW (United Nations General Assembly, 1979), General Recommendation 7 (Committee on the Rights of the Child, 2006), and the UNCRPWD (United Nations General Assembly, 2006)

emphasise correcting past imbalances and requires the State to take special measures to ensure that young children living in circumstances which have frustrated their ECD rights access the full ECD package. It is not just the law which compels these special measures, but science too. As previously discussed, the evidence suggests that targeted comprehensive care for children in poverty and other vulnerable circumstances in the early years is a determinant of equity in later outcomes, without which these vulnerable children are destined to a life of irreversible discrimination.

Despite the national policy recognition of the law and science and the resultant policy aspirations and prioritisation of the delivery of ECD services to vulnerable young children living in poverty, underserviced areas, rural areas, informal settlements and those with disabilities in, inter alia, the Children's Acts, the NIP for ECD, national disability policies and numerous others, these are precisely the children that continue to experience the least access to quality ECD services in South Africa.

The preceding detailed tabular analysis shows a consistent failure of access to all ECD services - from health, to food and nutrition, to social assistance, to early childhood care and education - by vulnerable young children living in poverty, those living in rural locations, in informal settlements and/or those with a disability. Access to and the quality of all ECD services is compromised and of much poorer quality for children and mothers living in poverty, living in rural areas, living in informal urban areas and those with disabilities - compared to their wealthier counterparts, their urban counterparts and their non-disabled counterparts.

The reasons for the consistency in this failing across the full spectrum of ECD rights are linked to a failure by the State to comply with a number of its other international ECD obligations, including the obligations to provide ECD services within a rights-based framework, to secure integrated and coordinated policy and programme development and implementation, and to adequately resource all ECD programmes.

4.3 A rights-based ECD framework

What is required when the Committee of Experts on Children's Rights calls for a rights-based ECD framework? Save the Children identifies the presence of a legal obligation on the State, as opposed to a discretionary power, to deliver the services necessary to realise the right in question as a defining feature of a rights-based framework. The Western Cape High Court and the Constitutional Court have confirmed that a rights-based framework requires that the State must bear and fulfil the primary responsibility for the realisation of services necessary to give effect to rights protected by the Constitution (and by extension, by international and regional legal instruments). In the case in question, the Western Cape High Court found that the State's lack of responsibility for the provision of education to profoundly disabled children in the presence of a constitutional obligation to do so, and the deferral of that responsibility (albeit partially funded by the State) to NPOs amounted to a failure by the State to meet its legal obligations and a transgression of the rights of children with disabilities to education, equality and dignity.

This finding implies that where there is a constitutional (or international) legal obligation created, for example the provision of ECD services - the State is obliged to fund and ensure the

provsiion of the service. It is unreasonable for the State to disacharge its obligations by deferring this responsibility to a private entity ("President of the Republic of South Africa and another v Modderklip Boerdery (Pty) Ltd, 2005 (5) SA 3 (CC) ", 2005; "Western Cape Forum for Intellectual Disability v Government of RSA and one other, 18678/2007 ", 2010).

The extent and persistence of abiding policy and programmatic gaps, marking as they do, a consistent failure by the State to create legally enforecable obligations on government departments to provide key ECD services; the consistent lack of monitoring and evaluation systems holding duty bearers to account for the delivery of quality ECD services and the national ECD plan; and the lack of an obligation on the State to adequately fund all ECD services (discussed in more detaill in the Funding paper) casts the current ECD framework within a service- or benefit-based, rather than a rights-based paradigm.

Key policy and programmatic gaps include:

1. The absence of a hunger-prevention/under-nutrition risk-aversion policy and related obligations to identify the risk of hunger, under-nutrition and an obligation to provide daily nutrition to young children at risk.
2. The absence of a maternal nutrition supplementation programme and other forms of material support for all vulnerable pregnant and lactating women.
3. The absence of a legally enforceable free water and refuse removal policy for poor households with pregnant and lactating women, infants and young children and the absence of a legally enforceable obligation on local government to provide free basic water and refuse removal to ECD centres servicing poor communities.
4. The absence of a free basic sanitation policy for poor households and the prioritisation of households with young children within that policy, as well as for ECD centres servicing poor communities.
5. The absence of an obligation on any government department or agency to provide early screening and identification of children with disabilities and to provide all children with disabilities with quality ECCE.
6. The failure by the Children’s Act to impose an enforceable obligation on the national, provincial or local governments/departments to fund and/or provide and/or secure the delivery of early childhood care and education services. The wording of the current Children’s Act does not create a sufficiently strong legal obligation. From a legal perspective, all one can hold national and provincial government to account for is the delivery of a national and provincial ECD plan aimed at securing ECD services, but not for the provision of the services themselves. The Children’s Act only obliges the Minister of Social Development to develop a comprehensive national strategy aimed at securing a properly resourced, co-ordinated and managed early childhood development system, giving due consideration to children with disabilities and chronic illnesses (Section 92(1)). Provincially, the Act obliges the MEC for Social Development to register and to maintain a record of all early childhood development programmes registered in the province; and within the national strategy, to develop a provincial strategy aimed at a properly resourced, co-ordinated and managed early childhood development system (Sections 92(2) and 95(1)). When it comes to the actual provision of ECD programmes, the Act does not oblige, but affords the MEC for social development the discretionary

(unenforceable) power to provide and fund ECD services. Section 93(1) of the Act provides that the MEC "***may***, provide and fund early childhood development programmes for that province."

7. The failure by the Children's Act or any other act to oblige municipalities to build ECD centres, or develop existing buildings into viable ECCE centres in areas of need, or to require municipalities to improve the infrastructure and basic amenities at ECD centres servicing poor communities, as is envisaged by the NIP for ECD, constitutes a contravention of the State's obligations to provide ECCE.

At present, in very few instances, some of these services are provided in terms of a discretionary power by government departments. In the main however, where they are provided, this is done by the private sector, NPOs or development agencies. Not only does this model of service delivery amount to a transgression of the obligation on the State to provide a rights-based ECD framework, it is also fundamentally inequitable and perpetuates the current patterns of historical and inter-generational inequity which consistently excludes the most vulnerable young children from accessing ECD services.

The current funding and service delivery models, especially for the provision of early childhood care and education, food and nutritional support, and access to basic water and sanitation services in the home and in centres perpetuates and drives inequities. It tasks a huge number of disparate voluntary groups, NGOs, CBOs, and home-based agents – namely those with the least capacity, resources, infrastructure – to provide the most difficult services, the most complex services, and to reach those hardest to reach. They not only lack the resources, management, planning and M&E skills needed, but crucially lack the infrastructure and financial resources to provide and sustain quality services. There is an in-built inequity in this model. The rights of the most marginalised young children depend on the fundraising ability of local organisations (in a climate where funding is leaving the country and organisations are folding daily). Where the funds are not sufficient, as is the case with most of them, it impacts on the quality of the service, and where it dries up, the service simply ceases. Herein lies the nub of the problem – the government is not responsible and therefore cannot, in terms of the current model, be held accountable for the delivery, the poor quality of, or cessation of the service or, for that matter, the lack of a service in a particular area. The current ECD policy framework does not create accountability of government, and if government is not accountable, no one else can be held accountable. Without accountability (created by clear and meaningful legal obligations), the rights in the UNCRC, the NIP for ECD and other instruments will remain meaningless and inequity will persist as a dominant feature of the ECD landscape.

The scale of inequity and the number of marginalised children alongside the complexity of their ECD needs means that the cost of reaching them, the level of infrastructure needed, the complexity of the design of the programmes, and the type of service delivery model needed to reach them is higher, more difficult, requires significant infrastructure and multiple service delivery feelers which are all connected to a centralised sustainable management, funding and evaluation vehicle to allow for connection of all at once to the national ECD policy mainframe. All of this requires significant service delivery planning, infrastructure, management capacity – and most of all – it requires significant and sustained and sustainable financial and human resources.

The only agency with the requisite level of infrastructure, capacity, management and planning skills, access to specialist advice and curriculum developers, ability to reach and sustain reach (in partnership with local and community based structures etc), is government. There are national precedents to support this conclusion as well as the argument that government must be obliged in terms of the current ECD framework to fund, support and ensure the provision of ECD services in order to meet, not only the obligation to provide a rights-based framework, but also to ensure sustained quality ECD services to all marginalised children.

To some extent, this realisation has occurred in relation to the universalisation of Grade R. Once Grade R became a legislated, funded government obligation delivered through an existing State institution, enrolment increased. Admittedly, quality is still an issue, but there are increasing mechanisms in place to improve on this and the possibility of further legal action if government fails to meet its quality responsibilities.

This realisation is also taking place in the health sector. The National Health Insurance policy has emerged to deal with inequities in the health system through stronger centralised management, planning, provisioning, funding and accountability

There is thus a need to interrogate the level of accountability created by the policies on government to realise ECD services and to ensure that the services are equitably available to the most marginalised. There is a need to interrogate the current service delivery model and look at shifting to a model that can deliver infrastructure in the hardest to reach places, that can provide a quality service that is regularly monitored and assessed against national standards, that can provide the care, teaching, services and support that is needed by all children with additional needs (such as those with chronic illnesses, disabilities, etc.) and that, most importantly, can provide a service 365 days a year, every year. Given the immensity of the task – the only agency with the legal responsibility and the reach, money and infrastructure (or ability to create the infrastructure), is government.

Mechanisms must be in place to enable parents to demand ECD services, and where there is a failure of service, to hold government accountable for that failure and expect some resolution through legal channels. This requires mechanisms to ensure accountability, not just in terms of access, but also quality. Mechanisms must be in place to not only develop minimum standards of services and care and education, but also to guarantee compliance with these standard, as well as systems to ensure ongoing monitoring.

4.4 Integration and coordination

Integration and coordination is recognised as key to the delivery of the multi-faceted ECD package necessary for the optimal development of young children. The NIP for ECD recognises it as a key service delivery strategy to facilitate access to services by marginalised young children, especially those in rural areas.

Integration is not just critical for facilitating access to multiple services through centralised multiple service delivery centres/programmes in remote areas where the multiple service sites are not available. It is also critical because of the close interrelationship of risk factors that need to be simultaneously addressed to glean the full benefit of any programme. For example, because the CSG is critical to optimal nutrition in young children, access to the CSG must be a

key component of any nutrition programme in South Africa (Aguero, et al., 2007). Likewise, the broader socio-economic factors that inhibit access to and enjoyment of health services requires a more “comprehensive, integrated approach to sexual and reproductive health within the context of improved socio-economic conditions and enhanced performance of the primary health care system” rather than merely ensuring improvements in the medical health services (Republic of South Africa, 2010).

Despite the fact that the NIP for ECD recognises integrated service delivery models as key to reaching marginalised children, there is little evidence of successful integrated service delivery as yet between the core departments responsible for ECD services in terms of the NIP for ECD, namely the Departments of Social Development, Health and Education. In addition, there has been little, if any documentation of best integration practices to inform planning and development of integration to improve access to ECD services.

There are numerous examples of integrated service delivery models falling outside of the NIP for ECD framework to facilitate access to services for children, especially those in rural areas (discussed in detail in the preceding tabular analysis). Whilst the bulk of the models do not have an ECD focus, and indeed some do not offer access to any ECD services, there is much to learn from the successes that have been achieved by, for example, the Department of Home Affairs in improving access to services such as birth registration rate in rural areas. These successes have only been achievable through integrated and collaborative models of service delivery such as on-line registration in hospitals, the use of community networks and Thusong centres, amongst others. These success stories provide strong support for the view, promoted in the NIP for ECD that reaching the most vulnerable and marginalised children depends on meaningful integrated service delivery.

As indicated above, most of these models do not provide ECD services or have an ECD focus, but there is no reason why they should not do so. Not only is there much to learn from the models that are in place in South Africa, but they can serve as vehicles for extending the reach of ECD services. There has been no audit of all integrated service delivery vehicles and an attempt to mainstream ECD services into these. The reach and targeting of the current array of integrated models of service delivery offers a unique opportunity to extend the reach of ECD services by integrating ECD services into all such vehicles and ensuring that all such programmes provide at the least, a basic package of core ECD services. This appears to be a missed opportunity. Were a national integrated ECD delivery framework to be developed, making provision for the essential services that all such models should provide (including ECD services), and ensuring that the planning and positioning of the various centres and programmes target agreed national nodes with the highest levels of deprivation so as to avoid duplication and adequate spread of services to areas of greatest need, ECD and other crucial services would reach more marginalised children than is currently the case.

There are many positive lessons to be learned from the various integrated models of service delivery, but there are also some cautionary lessons to be learned. A key lesson is that whilst integrated models of service delivery reach the most marginalised and thus ought to be priority vehicles in honouring international, regional and national equity commitments, they are poorly resourced and, in many cases, poorly planned within departments and across departments, resulting in their sporadic and haphazard location and targeting. Given that integrated service

delivery models are one of the only effective, tried and tested, and practised service delivery models that are used nationally to reach marginalized children, the model should be accorded greater priority, funding, planning and evaluative attention. There is an urgent need for a national integrated service delivery plan of action that can guide the development, planning, position, content and funding of integrated service delivery vehicles. The plan should, inter alia, provide a map of areas requiring integrated services (based on a needs-assessment), guidance on priority areas where such services should be provided and where they are already provided (to avoid duplication and ensure a sound targeting and spread of further services), to ensure a minimum content of services (including ECD services), and a common monitoring and evaluation framework so as to ensure ongoing review of the efficacy of the model against equity targets. All integrated models, regardless of their departmental lineage should then be planned, implemented and monitored against the national plan of action. Together with a higher planning priority, sufficient resources must be allocated to these models to ensure that the quality of the services provided to marginalised communities is of a high quality and that they are sustained.

Similar principles can be argued in relation to home and community-based care models of delivery. They, like the one-stop-shop integrated models of delivery, provide a vehicle to reach the most marginalised of communities. They are, however, also marked by the lack of a national unifying plan prescribing minimum core services to be provided and insufficient resources to ensure reach, quality and sustainability.

A key principle informing the reasoning behind integration, as identified by the NIP for ECD, is the sharing of existing resources and facilities and preventing the duplication of services. We have argued, on the basis of the science, that integrated services are what young children must receive to benefit from them. This principle invites the better and shared use of existing integrated models and one-stop service centres initiated by non-ECD department to meet ECD needs. Having regard to the same principle of optimizing existing resources in marginalised areas to facilitate access to multiple services, there are a number of key missed opportunities for integration of services to reach marginalised young children. One such missed opportunity dates back to the time of the Lund review of the State Maintenance Grant - the failure to make use of the district health system to facilitate access to multiple early childhood services (Lund, 2008). Access to the services provided within the district health system is high amongst pregnant women, infants and young children, including those in rural areas, compared to these group’s access to other government services . The Lund Committee considered (and advocated) for the use of the Road to Health Card in clinics to facilitate access to grants and other basic services. However, in 1996 the then Minister of Health insisted that there be no such collaboration (Lund, 2008). This refusal was repeated in 2009 at the time that the Road to Health Card was revised to provide a more comprehensive infant and young child well-being management tool. Organisations like the Alliance for Children’s Entitlement to Social Security requested that the Department of Health consider the incorporation of questions about the child’s birth registration and eligibility for the Child Support Grant (CSG), given the direct link between access to these two government services and children’s nutritional status and well-being. A 2002 study in Mt Frere in the Eastern Cape showed the clear link between lack of access to birth certificates, identity documents, the Child Support Grant and high and repeat cases of child malnutrition (Samson, 2002). This link makes a strong argument for for the

integration of this collection of ECD services into a programme designed primarily to monitor children's nutritional status and prevent malnutrition. However, the Department of Health declined the request made by the Lund committee and then again in 2009, despite the fact that it is a member of the National Interdepartmental Committee for ECD, and is one of the three departments responsible for ECD services, provides essential service components of ECD and is seen as a key role player in the NIP for ECD. The use of the district health system as an entry point for access to core ECD services needs to be interrogated, especially in the light of the renewed emphasis on prevention and health promotion strategies – a category into which many of the ECD services, such as birth registration and grant access fall.

The historical and ongoing difficulties in facilitating cross-departmental collaboration between the Departments of Health and Social Development and Education reveals an ongoing fragmentation of services, which in turn speaks to cracks in the necessary levels of coordination and collaboration required between core ECD departments to deliver the necessary comprehensive ECD package prescribed by the law. Whilst the NIP for ECD speaks and aspires to coordination between core departments at the level of policy making, implementation, and monitoring and accountability so as to ensure, inter alia, the mainstreaming of common ECD objectives within departmental polices and programmes and accountability by the different departments to a common vision – there are signs that the requisite levels of coordination have not been realised, and that not all sectors are committed to the common national ECD agenda as framed in the NIP for ECD.

The fact that the Department of Health is not a regular participant at the Interdepartmental Committee meetings (Giese & Sanders, 2008), and the lack of integration of ECD services through the district health system tends to point to a fundamental weakness in the assumptions upon which the NIP for ECD rest – that is, that the Departments of Health, Social Development and Education are linked through the NIP for ECD to deliver holistic and comprehensive ECD services. The Department of Health does not refer to, or contextualise, any of its services as early childhood development services and does not associate itself with the national early childhood development imperatives and framework. In fact, reports made as recently as 2008 indicate that the Road to Health Card remains a barrier, rather than a vehicle, to access the Child Support Grant in vulnerable rural areas in South Africa (Peters & Williams, 2009). Likewise, the fact that the Departments of Water, Human Settlements, Transport and local government have not integrated ECD services or prioritised ECD services to young children and their families, is indicative of the failure of coordination envisaged by the NIP for ECD.

There is a need to explore the extent to which the three core ECD departments (and supporting departments) indeed do consider themselves partners in attaining early childhood development goals according to the governing national ECD framework, and to interrogate the necessary steps to engender a common sense of purpose, goals and truly collaborative initaitives amongst the the three (and the supporting) agencies.

The overarching coordinating mechanisms and structures (such as the NIP for ECD and the Interdepartmental ECD Committee) need to be examined with a view to assessing whether or not they are aiding or, in fact, inhibiting meaningful integration and coordination across all sectors and levels of government responsible for services necessary for early childhood development. This inquiry should form part of the concurrent review of the NIP for ECD which

has been commissioned alongside the ECD Diagnostic Review for which this report has been written.

Summary of progress made by the State in meeting its ECD obligations to marginalized children, to provide a rights-based paradigm, and towards integrated and coordinated ECD	
Guaranteed ECD rights and services for marginalised children	There are insufficient policies and programmes creating enforceable legal obligations on government to fund and secure the provision of ECD services for marginalised children in South Africa.
Rights-based ECD paradigm	The lack of policies, programmes, monitoring and compliance systems making government responsible and holdng it accountable for ECD services locates the the current ECD framework within a service-driven, rather than a rights-based paradigm.
Integrated and coordinated ECD	There is policy recognition of the need for integration and coordination across all relevant sectors. However, there is little integration of ECD imperatives into departmental plans and programmes at local government level, and within departments other than Social Development, Education and Health. There is also little evidence of integrated service delivery models providing ECD services. Also, the Department of Health does not appear to operate within the collective NIP for ECD framework in collaboration with the Departments of Social Development and Education.

5. Recommendations

5.1 Paradigm shift towards a rights-based ECD framework and assumption of provisioning responsibility

5.1.1 There must be a shift towards a rights-based ECD framework. There are clear legal obligations on the State to promote, realise and protect the right of all children to early childhood development. The fulfilment of these obligations requires the legal imposition (and fulfilment) of an enforceable obligation on the State to ensure the provision of ECD to all children, especially the most marginalised.

This requires the imposition of a duty by the State for the development of necessary policies and programmes to create these obligations and for the funding, implementation (directly or through agencies) and monitoring of the sites, services and programmes necessary to realise the guaranteed ECD package.

This does not mean the State must provide only one form of service, or that the actual services cannot be delivered by NPOs or community-based structures. The national ECD plan can make provision for a diversity of programmes and a diversity of delivery vehicles working as sub-contractors of State departments. The State must however be accountable for, fund and ensure the delivery of quality ECD sites, services, and programmes (as comprehensively defined).

As long as NPOs remain primarily legally responsible for the delivery of services, the State is not only in transgression of its obligation to provide ECD services, but also of its obligation to sustain these services within a rights-based framework. The current model does not guarantee sustainability. Should the NPO not be able to raise funds, or should a poor quality service be offered, the service in question is no longer available and there is no one who can be held legally accountable for this omission – resulting in a highly inequitable situation arising in communities often needing support the most, such as communities lacking basic services and infrastructure where NPOs are the only service providers. For this reason, equity dictates that where there is no existing infrastructure, sites or services, the State must be obliged to provide the infrastructures and facilities, and if there is no NPO available to provide the services, the State must provide these as well.

5.1.2 This will require some of the following policy changes:

a. The amendment of the Children's Act to provide that national and provincial government "must", rather than "may" provide and fund ECD services and programmes.
b. The creation of an obligation on the State to provide the infrastructure and basic services necessary for provision of ECD services to all children, especially those in marginalised areas and subject to additional vulnerabilities (over and above their young age).
c. The creation of an obligation to provide learning and support materials, training and personnel to provide quality ECD services to all children, with a specific focus on children living in underserviced and under-resourced areas.
d. The creation of an obligation to identify children experiencing hunger and at risk of malnutrition and the creation of an obligation to ensure at risk children receive daily adequate nutrition.
e. The creation of an obligation for the provision of material, nutritional and related support to pregnant women, including pre-birth CSG registration for women living in poverty so as to ensure the CSG is paid out from the first month of birth.
f. The creation of an enforceable obligation on all employers (starting with the State) to provide paid maternity leave to employed mothers and to offer breastfeeding support for mothers returning to work.
g. The creation of a costed and state-funded ECD policy and plan of action for children with disabilities.
h. The revision of overarching national policies which articulate the State's goals and priorities in relation to core socio-economic rights such as the water,

sanitation and nutrition so as to recognise the heightened priority and prior obligations to realise these rights for pregnant women and young children.

5.2 Integrated ECD must become a reality

5.2.1 The realisation of integrated ECD is legally prescribed. The necessary frameworks, mechanisms, institutions and service delivery models must be in place to realise this obligation. It is not only that integration is legally prescribed; it is also a proven service delivery strategy (as shown by programmes such as Home Affairs' National Population Registration Campaign and others) for reaching children in underserviced rural communities.

The current national integrated ECD vision does not meaningfully include departments other than Social Development and Education. Notably, the Departments of Health, Human Settlement, Home Affairs, Water, Rural Development, Local Government and Traditional Affairs do not identify or locate themselves, or their policies and programmes, within the national integrated ECD framework.

To remedy this, the new NIP for ECD should be developed with the prior and full cooperation and participation of all affected parties – and should be opened for public participation. It should specify the national vision, goals, targets and objectives for comprehensive ECD and document the negotiated role of each of the departments/stakeholders in realising this. The plan must constitute the framework for synergised planning and for subsequent reporting by the various departments within a common ECD framework. Each department should be required thereafter to develop a departmental ECD policy and plan of action for planning, budgeting and reporting purposes.

There national ECD framework must be overseen and coordinated by an independent coordinating structure that enjoys credibility and the power and authority to hold all participating departments accountable to their ECD commitments as articulated and agreed to in the national ECD plan. The State must establish, fund and otherwise adequately resource this national coordinating structure.

5.2.2 Integration manifests at different levels. In addition to integrated national policy development and planning which does not involve shared operationalisation and budgeting, there is also integrated service delivery. Integrated service delivery is a proven vehicle for reaching marginalised and underserviced communities. It is already taking place through various, but disconnected programmes run by different departments and NPOs. The dominant models are one-stop service centres and home and community-based outreach programmes.

There is a need to bring these programmes within the national ECD framework and to synergise them so as to ensure they all provide a minimum package of core ECD services; that they are located in and spread equitably to reach areas of greatest need; that their reach and services are not duplicated; and that they provide quality services benchmarked against, and accountable to a national standard. Funding and resources

for these programmes need to be scaled up and made sustainable so that inequities are not perpetuated.

All one-stop-shop centres and all community care workers – whether within social development, health, local government or NPOs – should work within a common policy framework and provide a common body of essential support and services to ensure that their reach into rural communities is capitalised on. Their programme of action and curricula should include a common, and a comprehensive ECD component. This should cover access to birth registration, identity documents for parents, grant registration (and registration preparation in case of pregnant women), nutritional support in the way of infant feeding advice and observation for signs of nutritional risk in the household, signs of under- or mal-nutrition, referrals for nutritional and agricultural support, and referral to ECD programmes.

5.2.3 There is a need to innovate new models of ECD integrated service delivery that are capable of realising the delivery of essential targeted ECD services through existing sites of delivery in underserviced areas. Innovation should be premised on identifying existing resources and infrastructure and requiring the provision of multiple services through existing sites where such integration furthers common service provider objectives.

Some examples include:

a. In underserviced areas, building an ECD support centre onto every clinic and every Grade R public school facility which could offer: (1) support and information on ECD services (2) birth registration facilitation (3) nutritional risk monitoring (4) access to food for young children (5) early childhood education and care services, and 6) parenting and family support . The centre could take the form of a traditional, but expanded ECD centre providing ECD services (for children 2/3-4) and programme support for home and community based partial care for children 0-4.
b. Using traditional authority structures in rural communities as basic infrastructure for ECD centres.
c. Ante- and post-natal clinics should work collaboratively with the SASSA and the Department of Labour to facilitate the pre-registration of pregnant women for social security (either the Child Support Grant or UIF maternity benefits) and/or the prompt registration of new mothers for social security as soon as possible after her infant is born. The current complementary preventative focus in the Children's Act and the new National Health Plan on prevention and early intervention provides strong motivation for collaboration between the two responsible departments through the inclusion of preventative welfare measures into the provision of health services in the early years that contribute to improved child health and well-being.
d. Collaboration between the SASSA and the Departments of Social Development and Health to ensure that caregivers receiving the Child Support Grant are

provided with information and advice on how to make optimal use of the funds to ensure good nutritional, health and educational outcomes for their children.

5.3 Local government's role must be clarified and strengthened

5.3.1 The ECD role of municipalities must be clarified and clear and enforceable obligations must be imposed on local government (and be supported by adequate funding) to fulfil the assigned roles.

5.3.2 There must be a local level needs-assessment conducted by municipalities within the context of national ECD objectives, to assess geographical areas of need and possible services and infrastructure that can be used to fill the identified gaps. Where there is a shortage, municipalities must be obliged (in collaboration with provincial DSD) to either build ECD centres in underserviced areas, to scale up existing programmes, and/or to facilitate the use of existing community structures, such as traditional authority structures, church structures, clinics or schools, and to provide the necessary infrastructure, water and sanitation to create a safe, nurturing environment amenable to development of the child.

5.3.3 ECD sites established by NPOs that do not meet local government requirements or Children's Act norms and standards and hence cannot register and apply for subsidies, must be able to apply to the local government for support to develop their basic infrastructure and amenities to meet the requisite standards. The current policing role played by the Municipality must be transformed into a collaborative partnership to increase the number of ECD sites that are adequately equipped in under-serviced areas.

5.4 Water, sanitation and hygiene

5.4.1 ECD sites providing services to subsidised children should qualify for free basic water and refuse removal.

5.4.2 Municipalities should be obliged to include households with pregnant women, infants and young children in their indigent policies and in the delivery of free basic services.

5.4.3 A national free basic sanitation policy must be developed and must require the prioritisation of households with pregnant women and young children at all levels of government.

5.5 ECD for children with disabilities

5.5.1 There is a great deal of policy recognition of the rights, challenges and needs for appropriate and integrated responses for ECD for children with disabilities. However, there is very little in terms of concrete obligations on the State, plans, budgets and programmes for ECD for children with disabilities. This must be remedied through a shift towards a rights-based ECD disability framework supported by a targeted ECD disability plan, programmes, budgets, and monitoring and evaluation systems. The framework must cover prevention in the ante-natal phase, early identification and appropriate early interventions, rehabilitation and habilitation, parental and community support,

guaranteed access to ECD programmes and sites as well as formal education in schools.

5.5.2 ECD integration is critical for children with disabilities, given the multiple causes of disability and multiple vulnerabilities faced by children with disabilities, especially those in the most marginalised rural and urban informal areas where poverty is higher, nutritional access is lower, prevalence of disabilities in young children is higher, children tend to have multiple disabilities, and where access to all relevant services is more compromised. The scale and complexity of the problem calls for a dedicated national integrated ECD disability strategy to identify State role players and their respective, collective or collaborative roles. In the case of ECD for children with disabilities, integrated planning and service delivery must be mandatory.

5.5.3 Mandatory sensory and motor developmental screening must be introduced from birth and made available through clinics, hospitals, ECD programmes and centres and schools at appropriate stages and levels.

5.5.4 There is a need for an ECD inclusive early childhood care and education policy and supporting programmes and budgets. The State must assume the legally enforceable responsibility for the provision of early childhood care and education for all children with disabilities through a combination of specialised centres and programmes for children with severe disabilities and mainstreaming of children with mild to moderate disabilities in ordinary ECD programmes and centres which are enabled and supported, through the provision of training, funding and monitoring, to meet their needs.

5.5.5 The current medical, as opposed to a social, approach to disability translates into a medical curative emphasis in terms of policies and programmes. It manifests in the location of obligations to provide care for young children with disabilities exclusively within the Department of Health - which provides medical care to children with disabilities and a subsidy to NGOs providing care for children with severe disabilities.

There is however no comparable obligation on the Department of Social Development (or Education) to provide a grant or subsidy for the early care and education of young children with disabilities in centres or through programmes (other than the CDG for children requiring permanent home care), nor is there an obligation to provide training and support to ECD practitioners or to provide appropriate infrastructure to enable young children with disabilities to access and enjoy ECCE in centres and programmes.

There is a need to shift away from the medical, to a joint medical/social, model of state provisioning of ECD for children with disabilities and the imposition of appropriate obligations on the Departments of Social Development (and Education) to ensure the realisation of the ECD rights of all children with disabilities.

6. Conclusion

In 2012, South Africa's ECD framework remains largely subject to the criticisms raised by the UN Committee on the Rights of the Child in 2005 that:

> In many countries and regions, early childhood has received low priority in the development of quality services. These services have often been fragmented. They have frequently been the responsibility of several government departments at central and local levels, and their planning has often been piecemeal and uncoordinated. In some cases, they have also been largely provided by the private and voluntary sector, without adequate resources, regulation or quality assurance (Committee on the Rights of the Child, 2005: Paragrpah V22).

The Committee's response to this situation remains to be heeded by the State. It must shift the current ECD framework to a umabiguous rights-based framework by developing:

> rights-based, coordinated, multi-sectoral strategies in order to ensure that children's best interests are always the starting point for service planning and provision. These should be based around a systematic and integrated approach to law and policy development in relation to all children up to 8 years old. A comprehensive framework for early chidlhood services, provisions and facilities is required, backed up by information and monitoring systems (Committee on the Rights of the Child, 2004: Paragraph V22).

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Background Paper 3

An overview of the ECD policy framework in South Africa

Patricia Martin

Contents

Key Points

A review of the overarching polices and laws governing ECD in South Africa reveal a number of anomalies that, if addressed, would strengthen the governing legal framework.

Issue: A limited paradigm

By comparison to the policies and programmes of the other two departments with the main responsibility for ECD in South Africa (Education and Social Development), very few of the Health Department policies are identified as ECD policies and programmes. The same may be said of the water, sanitation and other sectors.

This tends to indicate parallel visions of ECD, policies, and processes. On the one hand there is a joint holistic vision shared by Education and Social Development, but one that is limited in scope to early education and stimulation services and programmes delivered through centres. On the other hand, there is the health and related streams such as infrastructure, which are not sufficiently identified as contributing to ECD, but which are fundamental to early childhood development.

Recommendation:

There is a need for a more inclusive national ECD framework against which all sectors regard themselves as accountable.

Issue: Varying age definitions for ECD

The review of ECD policies from an international and national perspective indicate a lack of agreement about the age of children falling within the ECD framework in South Africa. The health sector focuses on children from pre-birth to age six, whereas the education sector includes children up to the age of nine years which is in line with the international position set out in General Recommendation No. 7. The NIP for ECD identifies young children up to the age of nine, but prioritises services for children aged 0-4 years. The Children's Act adopts a definition of ECD as children from birth up until school-going age.

Recommendations:

The national ECD policy must clarify the applicable age for ECD in South Africa.

An overview of the ECD policy framework in South Africa

1. Introduction: An emerging national ECD policy framework

The pre-1994 policy terrain was marked by racially-biased social and economic programmes which impacted negatively on the well-being of the majority of South Africa's children, especially African children. This impact was felt from conception and had devastating consequences for the survival, health, well-being and development of children in their early years. In addition, this made it more difficult to take advantage of what few opportunities they had at a later stage. Atmore describes the life of the young African child in *Apartheid* South Africa as follows:

> *From conception the black child's life is characterised by hunger and malnutrition, insecurity and trauma, instability, family breakdown and dislocation of communities, a lack of primary health care and educational opportunities; and the absence of adequate housing, electricity, running water and sanitation* (Atmore, 1992).

While preparations began some time before, 1994 marked a turning point in the political trajectory of South Africa as well as the lives of children in South Africa. The first newly elected democratic government prioritised improving the lives of children; a priority driven in many respects by President Nelson Mandela's commitment to children. This commitment found expression in the highest law of the country - the Constitution of the Republic of South Africa - which accords express protection to children's social and economic, and protection rights. The rights protected in Section 28 range from the right to a name and nationality, to protection, to nutrition and health care and social services. This range of socio-economic rights, unlike their "adult" counterparts in the Constitution, are given the highest priority; they are not made subject to the qualification of "progressive realisation" and are not limited to the right of "access to", but realisation of the substantive right in question.

This recognition and prioritisation, together with South Africa's ratification of the United Nations Convention on the Rights of the Child, created an obligation on government to develop policies to realise children's rights through programmes benefiting children from conception until the age of 18 years so as to remedy the *Apartheid* situation and close the gaps through which the majority of children in South Africa were falling through.

In the ensuing years of policy and programmatic development, the prioritisation of infants and young children was not initially an express priority of the incoming democratic government; instead children as a holistic group were prioritised. Many of the policies however naturally focused on interventions benefiting the youngest children, pregnant and lactating women. However, as the policy terrain progressed and science and law called for the prioritisation of young children, there has been a clear and marked progression in the development of more

focussed ECD policies targeting the realisation of holistic early childhood development services for children aged 0-9, with a specific focus on those aged 0-4 living in poverty.

This paper provides an annotated overview of policy progression in South Africa between 1994 and 2011, documenting key policy developments that have shaped the Early Childhood Development (ECD) and Early Childhood Care and Education (ECCE) environment for infants and young children in South Africa. ECD refers to a broad perspective across the full range of social, economic, environmental and cultural influences on children from conception to the foundation phase of school. ECCE refers to a range of activities to promote the development of young children, particularly with respect to the social, emotional, cognitive and language capacities needed to make the transition to formal schooling.

2. Time line of key national ECD policy developments relevant to the rights of young children

Year and policy/ programme	Summary of relevant development	Summary of ECD provisions	Definition of ECD/age cohort covered	ECCE focus	Health focus	Other focus
Reconstruction and Development Programme, 1994	Whilst not a specific ECD policy, this foundational document setting the first development path for post-*Apartheid* South Africa recognises the link between the transformation of South Africa and meeting basic needs, with a focus on children as per the requirements of the United Nations Convention on the Rights of the Child's First Call for Children	The RDP identifies and prioritises two relevant lead programmes which impact on young children: 1. Primary School Nutrition Programme 2. Provision of Free Health Care to children under the age of 6 and mothers pre- and post-natal at public health facilities	None	Yes	Yes	No
The United Nations Convention on the Rights of the Child (UNCRC), ratified by South Africa in 1995	The UNCRC commits member states to protect a range of rights of all children 0-17 years of age. Rights protected by the UNCRC include the rights to health, education, social security, parental care, protection from abuse, neglect and exploitation, and other rights.	Whilst all rights apply to all children there are certain rights that are expressly linked to the development and well-being of young children in the UNCRC directly, such as the right to health care. In addition, a number of other rights, including the rights to birth registration, parental care to ensure an adequate standard of living and early childhood development and education,	None	Not directly, but does so by virtue of the later General Recommendation No.7	Yes	Not directly, but does so by virtue of the later General Recommendation No.7

		education, social security and other forms of parental assistance where parents are unable to meet their obligations, as well as the right to legally regulated alternative care where parents are not in a position to care for their children are highlighted as particularly relevant to ECD and ECCE through General Recommendation No.7				
The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) ratified by South Africa in 2005	The CEDAW commits member states to take all necessary steps to ensure the equal enjoyment of all women of all rights.	The CEDAW requires member states to take all necessary steps to support women to be able to fulfil parenting and work responsibilities, including the provision of paid maternity leave and a network of childcare facilities. It specifically links this right to women's rights to equality in the workplace and the family. It provides that: In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, State Parties shall take appropriate measures: To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the	None	Yes	Yes	No

		establishment and development of a network of childcare facilities. On the health front, the CEDAW requires that women enjoy equal access to health care, including pregnancy, confinement and post-natal health care as well as nutrition during pregnancy and lactation. It specifically requires that services be made available to women in rural areas.				
White Paper on Education and Training, 1995	This policy describes government's recognition of the importance of child well-being in the early years and the consequent need for providing adequate nutrition, good health, early childhood stimulation and a secure environment.	Within this context, the White Paper formalises, standardises and subsidises the reception programme for children aged five.	Defines ECD as birth to nine years. It as an "umbrella term which applies to the process by which children from birth to nine years grow and thrive, physically, mentally, emotionally, morally and socially."	Yes	No	No
Interim Department of Education Policy for Early Childhood Development, 1996	Whilst this policy recognises that ECD is a multi-faceted concept requiring a wide range of services and strategies, it makes provision for a national ECD pilot project of rolling out a universal reception year.	Establishes a pilot project for a universal reception year.	Defines ECD as birth to nine years and sees it as an "umbrella term which applies to the process by which children from birth to nine years grow and	Yes	No	No

			thrive, physically, mentally, emotionally, morally and socially."			
National Programme of Action for Children in South Africa, 1996	A National Programme of Action was required and developed subsequent to ratification of the UNCRC in 1995.	The Plan prioritises nutrition, child health, water and sanitation, ECD and basic education, social welfare development, leisure and cultural activities and child protection measures for all children. ECD is strongly associated with early childhood education, rather than being associated with a comprehensive range of rights necessary for the holistic well being and development of the child. The goal in terms of the plan is the expansion of ECD activities, including low-cost family community-based interventions.	ECD is strongly associated with early childhood education, rather than conceptualising ECD as a comprehensive package of all rights.	Yes	Yes	Yes
White Paper for Social Welfare, 1997	The White Paper recognises early childhood development as key to the vision of social development vision for the country. It commits to the development of a national ECD strategy to provide ECD services which will foster the physical, material,	The White Paper recognises that no single model or programme is appropriate. Services envisaged include childcare, stimulation programmes, health and nutrition programmes, and family and education programmes.	ECD is defined as an "Umbrella term which applies to the process by which children from birth to nine years grow and thrive, physically, mentally, emotionally, morally and socially."	Yes	Yes	Yes

	emotional, moral and social development of children aged 0-9.		Children aged 0-9 are recognised, but the White Paper commits to prioritising disadvantaged children under the age of five years.			
White Paper for the Transformation of the Health system in South Africa, 1997	The White Paper seeks to provide a framework for a transformed inclusive health system to reach all South Africans.	Relevant chapters include the chapters committing to nutritional support, maternal, child and women's health.	The White Paper does not refer to or define Early Childhood Development	No	Yes	No
The Child Support Grant is introduced for children in poverty aged 0-6 through the Welfare Laws Amendment Act, 1998	The State Maintenance Grant is terminated and replaced with a more expansive form of social assistance targeting caregivers of young children aged 0-6.	A monthly means tested social assistance grant is paid to the primary caregivers of young children aged 0-6 to cover their basic needs.	ECD or ECCE is not mentioned	No	No	Yes
UN Millennium Declaration adopted, 2000	The government of South Africa commits to achieving the Millennium Development Goals (MDGs) by 2015	MDG 1: Halve the proportion of people, including children, who suffer from hunger from hunger MDG 4: Reduce by two thirds the under-five mortality rate. MDG 5: Reduce by three quarters the maternal mortality ratio MDG 6: Halt and begin to reverse the spread of HIV and AIDS MDG 7: Halve the proportion of people, including children, without	ECD is not defined but is implicit in the MDGs listed	No	Yes	Yes

		sustainable access to safe drinking water and basic sanitation.				
South Africa ratifies the African Charter on the Rights and Welfare of the Child in 2000	The ACRWC commits member states to protect a range of rights of all children (including young children). Rights protected include the rights to health, education, social security, parental care, protection from abuse, neglect and exploitation, and other rights.	Whilst all rights apply to all children, the right to health is expressly linked to the development and well-being of young children. Member States are committed to reducing the infant and child mortality rate and appropriate health care for expectant and nursing mothers (Article 14).	ECD is not defined	No	Yes	No
South Africa commits to UNESCO's Education for All 2000	UNESCO's Education for All goals commit members states to ensure equal enjoyment of the right to education for all, especially the most marginalised of children.	EFA goal 1: To expand and improve comprehensive early childhood care and education, especially for the most marginalised children. The EFA framework recognises that comprehensive early childhood care is intrinsically linked to the realisation of the right to education in later years and member states are committed to providing nutrition, maternal and child health and early childhood education.	ECD is not defined.	Yes	Yes	No
HIV & AIDS and STI Strategic Plan 2000-2005	The Department of Health develops the country's first HIV and AIDS strategic plan	The Plan provides for treatment and prevention of HIV and AIDS in infants and children.	ECD is not defined or referred to	No	Yes	No

White Paper 5 on Early Childhood Development, 2001	The White Paper recognises the strength of the science linking early childhood development and child well-being, cognitive and other development, school achievement and other developmental advantages.	The White Paper commits to addressing inequitable provisioning of ECD programmes, access to ECD services and the variable quality of ECD programmes and the incomplete and fragmentary legislative and policy framework by creating a national Reception year in all public schools and the subsidisation of community-based Reception programmes. The White Paper commits the Department of Education to developing a strategic plan for inter-sectoral collaboration which will focus on the delivery of appropriate, inclusive and integrated programmes to address the development needs of children 0-4, including health, nutrition, physical development, and access to basic services.	ECD is defined as an "umbrella term which applies to the process by which children from birth to nine years grow and thrive, physically, mentally, emotionally, morally and socially". ECD is further defined as a comprehensive approach to policies and programmes for children aged 0-9 years. The purpose of which is to advance the child's right to develop his or her cognitive, emotional, social and physical potential.	Yes	Yes	Yes
White Paper 6: Inclusive Education, 2011	The White Paper aims to ensure an inclusive education system for children with a diversity of learning needs, including those with disabilities.	The policy seeks to establish procedures for early identification and interventions, as well as for addressing barriers to learning in the foundation phase (Grades R-3).	The policy does not define or refer to ECD	Yes	No	No

Adoption by the 180 member states of the UN General Assembly of "A World Fit for Children", 2002	The plan, which was adopted by South Africa, represented a revised agenda for the world's children, with a focus on achieving 21 goals related to health, quality education, protection of children and combating HIV and AIDS. A World Fit for Children Commits the state to the "implementation of national early childhood development policies and programmes to ensure the enhancement of physical, social, emotional, spiritual and cognitive development."	Commitments are diverse and cover health care and early childhood care and education including the provision maternal and infant health care, water and sanitation, maternal and child nutrition, early learning and stimulation.	There is no definition of ECD	Yes	Yes	Yes
Expanded Public Works Programme, 2004	The EPWP is introduced to create low paid and temporary employment in the social sector, with a focus on ECD services and home and community based care.	The focus of the EPWP in the ECD context was two-fold (Giese et al, 2011): 1. Increasing the number of registered ECD centres, the number of children subsidised by the Department of Social Development and the value of the per child subsidy. 2. Training of ECD practitioners for children aged 0-4.	The focus of the programme was on children aged 0-4.	Yes	No	No

UN General Recommendation No. 7: Implementing Child Rights in Early Childhood, adopted in 2005	General Recommendation No 7 confirms that all the rights contained in the UNCRC apply equally to young children; that services must ensure these rights for young children; and that they must be provided through a multi-coordinated, multi-sectoral comprehensive, rights-based ECD framework supported by appropriate institutional arrangements.	It calls on member states to take all necessary measures to ensure that all young children enjoy access to quality services, especially their health, welfare and other services. As such it provides guidance on the steps necessary to realise young children's rights to care, education, health and welfare.	All young children including at birth and throughout infancy, during the pre-school years, as well as the transition to school up to the age of eight years.	Yes	Yes	Yes
National Integrated Plan for ECD 2005-2010	This is the first national multi-sectoral plan of action for the realisation of a comprehensive package of ECD services.	Services contemplated include birth registration, child and maternal health, nutrition, immunisation, referral services for health and social services, early learning programmes, water and sanitation to ECD sites. The NIP for ECD emphasises that services are to be provided through a variety of vehicles and programmes, not just ECD centres.	ECD refers to a comprehensive approach to policies and programmes for children from birth to nine years, with the active participation of their parents and caregivers. Its purpose is to protect the child's right to develop his or her full cognitive, emotional, social and physical	Yes	Yes	Yes

			development. However, the Plan targets children aged 0-4.			
United Nation's Convention on the Rights of People with Disabilities ratified in 2006	The Convention commits member states to protect and promote the full and equal enjoyment of all rights by people (including children) with disabilities.	Article 7 specifically commits governments to promote and protect equal enjoyment of the rights of children (including young children) with disabilities. Article 24 requires all member states to ensure inclusive education at all levels. The Convention specifically requires that health services ensure the early identification of disabilities and appropriate interventions. These services must be provided as close to communities as possible, including in rural areas.	No definition of ECD	Yes	Yes	No
Guidelines for Early Childhood Development Services, 2006	The Department of Social Development developed these guidelines to aid organisations in understanding and navigating the registration procedures for ECD centres and how to access the per child subsidy.	Services contemplated and in respect of which guidance is provided are largely centre-based early child care and education (ECCE) services as provided for the by the then Child Care Act of 1983.	The ECD cohort is defined as children aged 0-9, but the focus of the guidelines is on children aged 0-3.	Yes	No	Yes
HIV & AIDS and STI Strategic Plan 2007 - 2011	A more expansive national plan for HIV and AIDS is developed with a	Prevention, treatment, care and support for HIV positive pregnant women, infants and children.	ECD is not defined or mentioned	No	Yes	No

	focus on prevention, treatment, care and support	The Plan prioritises: • The reduction of mother-to-child transmission of HIV through broadening existing services and scaling up coverage and improving quality to reduce MTCT to less than 5 percent. • Addressing the special needs of pregnant women and children through, inter alia, the determination of the HIV status of infants and children as early as possible and the provision of a comprehensive package of services to HIV-affected, -infected and-exposed children.				
Cabinet identifies ECD identified as a national apex priority, 2008	ECD is named a national apex priority to be advanced through the intensification of the Expanded Public Works Programme	Goal of the elevation of the ECD as an apex priority is the doubling of the number of children enrolled in ECD through 1,000 new sites with more than 3,500 practitioners trained and employed.	Not defined	Yes	No	No
Norms and Standards for Grade R funding are promulgated, 2008	The Department of Education introduced pro-poor funding norms and registration procedures for public school Grade R services and community-based Grade R centres.	Public schools are paid per child registered for Grade R and subsidies to community based Grade R either in the form of a per child subsidy or a salary for Grade R teacher/s.	Children aged 5	Yes	No	No

National Early Learning and Development Standards for Children Birth to Four Years (NELDS), 2009	The Department of Education publishes a curriculum development guide for developing early learning programmes for children aged 0-4.	The focus is on the development of quality early learning programmes	Children aged 0-4	Yes	No	No
Children's Act No 38 of 2005 comes into effect, 2010	The Children's Act provides a comprehensive child protection framework for South Africa, which includes a dedicated chapter (6) on early childhood development.	The Children's Act obliges the Minister of Social Development, in consultation with other relevant departments, including Education, Finance, Health, Provincial and Local Government and Transport, to develop a comprehensive national strategy aimed at securing a properly resourced, co-ordinated and managed early childhood development system, giving due consideration to children with disabilities and chronic illnesses (Section 92(1)). Provincially, the Act obliges the MEC for Social Development to register and to maintain a record of all early childhood development programmes registered in the province; and within the national strategy, to develop a provincial strategy aimed at a properly resourced, co-ordinated and managed early childhood development system. (Sections 92(2) and 95(1)) When it comes to the actual provision of ECD programmes,	ECD is defined as the process of emotional, cognitive, sensory, spiritual, moral, physical, and social and communication development of children from birth to school-going age.	Yes	No	Yes

		the Act does not oblige, but affords the MEC for social development the discretionary (unenforceable) power to provide ECD services. Section 93(1) of the Act provides that the MEC "***may***, provide and fund early childhood development programmes for that province". The regulation of the quality of services is provided through the proviso that registration and funding of ECD programmes is dependent on compliance with national ECD norms and standards. (Section 93(2)).				
Minimum Requirements for Teacher Education Qualifications, 2011	The policy seeks to increase the qualification levels of all teachers from Grade R to Grade 12	The policy sets minimum qualifications for all teachers, including Grade R teachers The minimum qualification for all teachers, including those teaching Grade R, is a Bachelor of Education Degree or an Advanced Diploma in Teaching. The policy provides a pathway for upgrading historical educator qualifications to comply with the new minimum qualifications. For example, a Grade R teacher who holds a level 4 ECD qualification must do a Diploma in Grade R teaching to be able to continue to teach this Grade.	Children aged 5	Yes	No	No

Minister of Social Development commits to expanding ECD access and quality, 2011	The Minister commits to remedying long-standing access problems for children in marginalised communities and to standardise a quality ECD curriculum	The Minister committed to: • A Rural and Informal Settlement Strategy for ECD • 1 million 0-5 year olds accessing ECD Services and programmes • Standardisation of ECD Subsidies to R15.00 per child per day over MTEF • Improving ECD infrastructure • Ensuring completion of the ECD Curriculum for 0-5 years	Children 0- 5	Yes	No	No
National Planning Commission's Diagnostic Overview in preparation for Vision Statement 2030, published in June 2011	The diagnostic document identifies the main challenges facing the country. The Report singles out the need to improve the quality of Early Childhood Education and stimulation. It recognises that South Africa has taken a bold step in the introduction of Grade R to fill the early stimulation and development gap.	Report concludes that the quality of early childhood education and care for poor black communities is inadequate and generally very poor. The reason is largely because ECD is underfunded by government and is largely provided through support by donors to NGOs. In addition, despite the policy commitment to ECD, implementation in the poorest communities lags behind.	Primarily Grade R and early stimulation for children aged 0-4.	Yes	No	No
An exclusive breastfeeding strategy for South Africa, August 2011	The Minister of Health announced that South Africa will, in an endeavour to reduce infant mortality rates in South Africa and	This means government will discontinue providing milk formula through hospitals and clinics, except when this is recommended by an authorised health practitioner.	Infants are targeted. There is no mention of ECD.	No	Yes	No

	improve child well-being, adopt an exclusive breastfeeding strategy.					
National Health Insurance Green Paper published for comment, August 2011	The Minister of Health has published a series of policies for comment which relate to the transformation of the health care system in South Africa, which transformation will be underpinned by a National Health Insurance (NHI) scheme.	The policy paper states that "NHI is an innovative system of healthcare financing with far reaching consequences for the health of South Africa [which] will ensure that everyone has access to appropriate, efficient and quality health services."	ECD is not mentioned but access to services for pregnant women, infants and children will be improved by enhanced access to quality district health services.	No	Yes	No
Vision 2030 published for public consultation, November 2011	The Vision 2030 for South Africa spells out the interventions necessary to eradicate poverty and ensure equality in South Africa by the year 2030. Early Childhood Development is central to the realisation of this vision.	Key goals and interventions include universal access to two years of pre-school, nutrition interventions for pregnant women and young children, family planning and material and emotional support for pregnant women. The focus in on ensuring equitable and secure access to quality ECD services for all young children, with a focus on those living in poverty and with a disability	ECD is recognised as comprising a range of development services and programmes that support the holistic development of the child.	Yes	Yes	Yes – nutrition in the first two years of life features prominently

3. General closing commentary on policy developments between 1994 and 2011

3.1 Key international instruments remain unratified

Whilst South Africa has signed and ratified numerous international and regional instruments, there are two key instruments which remain unratified which could further compel the realisation of core ECD rights. These are the International Covenant on Economic, Social and Cultural Rights (1996) (ICESCR) which obliges member states to protect and promote various relevant rights, including the right to work and family. Article 10 provides that special measures should be taken to provide special protection for women for a reasonable period before and after childbirth to protect their right to work and their families, including paid maternity leave.

The ICESCR also obliges member states to provide and protect the right of every person and their family to an adequate standard of living, including adequate food, clothing and housing. More specifically, steps must be taken to ensure all people are free from hunger[1], to ensure access to the highest standard of health care, including the reduction of infant mortality, improved environmental hygiene, protection and treatment of diseases and access to medical care in the event of sickness[2].

In addition, the ILO Convention (no 156) on Workers with Family Responsibilities calls on governments to implement measures to develop or promote community services, public or private, such as childcare and family services and facilities[3].

3.2 A limited paradigm

Whilst the developing policy framework reflects a consistent and growing theoretical recognition of ECD as the holistic emotional, physical, cognitive and related development of children requiring a comprehensive range of services to ensure maximum development of children to their fullest potential, the reality is that the concrete advances and developments in the policies reveal a narrow association within the national ECD framework with early childhood care and education (ECCE). The services linked to these features of ECD are found in the various policies expressly identified as ECD policies and plans, whereas health and nutrition policies are not identified as ECD policies and do not feature prominently in the policies and plans marked as ECD policies.

Thus, on reflection, whilst ECD is a clear policy priority, it is perhaps more accurate to say that to date, it is a specific element of ECD that is a priority - namely early childhood care and education (ECCE) that has evolved conceptually within the express ECD framework. The prevalence of this narrow prioritisation of the ECD is evidenced in the following statement by the Minister of Social Development, Ms Bathabile Dlamini at the opening if the South African Early

[1] Article 11(2)
[2] Article 12
[3] Article 5(b)

Childhood Development Awards, 8 November 2010 which speaks only to the educational component as the bedrock of ECD:

> *Early Childhood Development is one of the strategies to tackle child poverty and contributes towards human capital development. South Africa will only defeat the social and economic challenges it faces through consistent investment in education, which begins at the early ages of children's lives. With education considered the highest priority of our government, we have placed ECD as our apex priority that needs special attention in many facets including resources and skills development.*

In the case of health, very few of the Health Department policies are identified as early childhood development policies and programmes, by comparison to the policies and programmes of the other two departments with the responsibility for ECD in South Africa (Education and Social Development). This tends to indicate parallel ECD policies, processes and visions in South Africa. On the one hand there is a joint holistic vision shared by Education and Social Development, but one that is limited in scope to early education and stimulation services and programmes through centres. On the other hand there is the health stream which is not identified as contributing to ECD, but which is fundamental to early childhood development.

3.3 Varying age definitions for ECD

The review of ECD policies – from an international and national perspective indicate a lack of agreement as to the age of children falling within the ECD framework in South Africa. The health sector focuses on children from pre-birth to age six, whereas the education sector includes children up to the age of nine years which is in line with the international position set out in General Recommendation No. 7. The NIP for ECD on the other hand defines young children as those up to the age of nine, but prioritises services for children aged 0-4. The Children's Act adopts a different definition - children from birth up until school-going age.

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Background Paper 4

Maternal and child health and nutrition

Haroon Saloojee

Wiedaad Slemming

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Key Points

A child's body and brain, together with their cognitive, emotional and social behaviour, develops rapidly during pregnancy and the first two years of life, and is influenced by the emotional and physical environment as well as by genetic factors. There is a compelling need for bold action to translate new thinking and advances in developmental science into more effective maternal and child health interventions. Although there are many evidence-based interventions, we prioritise six health sector-led actions that are essential to promoting optimal health and development outcomes for children, particularly in the critical early years, in South Africa.

Issue: Planned, healthy pregnancies

Unwanted and unplanned pregnancy (particularly among women younger than 16 years) is strongly associated with adverse newborn and child outcomes such as low birth weight, preterm delivery, and being small for gestational age. Each of these significantly worsens child outcomes.

Recommendation:

Early and appropriate education for school-aged children on sexual and reproductive health issues should be implemented routinely as part of the school 'Life Orientation' curriculum. Youth-friendly clinics should operate as such, and the health service should consider alternative delivery mechanisms for adolescent health services (for example through school health services). There is a need for improved access to, and integration of, quality reproductive health services.

Issue: Good maternal and child nutrition

Effective evidence-based nutritional interventions (such as breastfeeding; iron, folate, vitamin, micronutrient, and food supplements; and fortification) improve maternal health, newborn survival and child health and development. The consequences of inadequate early foetal and child nutrition include impaired health, education and economic performance later in life. However, coverage varies and there is limited evidence of the individual and overall effectiveness of these interventions in South Africa.

Recommendation:

Counselling and support for breastfeeding, and fortification or supplementation with vitamin A and zinc, has the greatest potential to reduce the burden of child morbidity and mortality. Improvement of complementary feeding through strategies such as better nutrition counselling and food supplements for food-insecure populations, as well as responsive feeding of young children and appropriate feeding of children when ill could substantially reduce stunting and the related burden of disease .

Issue: Integrated maternal, newborn and child health packages along the continuum of care

Reproductive, HIV, maternal and child health services are currently delivered through separate programmes. There is inadequate integration of interventions which can be better packaged to meet the needs of women and children, e.g. HIV and antenatal care, or well-child care and contraceptive services.

Recommendation:

There is increased support for the use of a 'continuum of care' approach for maternal, newborn, and child health. Continuity of care is necessary throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and also between places of caregiving (including hospital, primary care and community/family). This approach allows for better linking and integration of key interventions into existing services thereby reducing costs, increasing efficiency and achieving better maternal, newborn and child health and development outcomes.

Issue: Early identification, referral and intervention for children who require additional support for health, development and social problems

Currently, children requiring support and intervention for developmental problems or disabilities are identified too late, often only at school-going age. Once identified, there are numerous difficulties in ensuring that these children receive the intervention and support they require within the health and education systems. Developmental screening programmes are poorly implemented.

Recommendation:

An alternative approach to addressing the same need - and to complement existing screening programmes - would be to expand the implementation of the 'Care for Development' component of the Integrated Management of Childhood Illness (IMCI) programme. This is based on the IMCI model of nutrition counselling (Assess, Counsel, and Refer if necessary). However, these approaches require increased resources such as additional personnel, as well as training, supervision and mentoring for staff at primary care clinics in order to meet the needs of children with developmental problems and disabilities.

Issue: Community-based intervention strategies

Many of the health promotion and prevention strategies within the 'continuum of care' packages are envisaged to be delivered through community-based interventions. The Community Health Worker (CHW) cadre is being introduced to spearhead this component. There is a danger that the responsibilities entrusted to these individuals may be unrealistic and overwhelming, since their roles will not be restricted to maternal and child health.

Recommendation:

To ensure that the needs of pregnant women and children are being met, it is critical that the CHW focus attention on this group and be supported by a team of health professionals, including medical and rehabilitation practitioners, across the health service. The new district clinician teams also have a key role in offering support.

Issue: Progressive universalism

ECD is currently implemented largely through targeted interventions and activities aimed at vulnerable children, usually the poorest. Due to the many stressors (biological, environmental, psychosocial etc.) to which the majority of mothers and young children are exposed in SA, it is necessary to shift the way in which we view ECD in our setting.

Recommendation:

ECD should be viewed as a progressive universal service. That is, it comprises a universal core service such as immunisation or provision of basic assistive devices, which is offered to all young children and families; with progressively expanding services for those with specific additional needs and risks. One of ECD's key roles is the early identification of children with high risk and low protective factors and to ensure that these children and their families receive a personalised service. The concept of a common assessment framework needs consideration for children with multiple difficulties and/or vulnerabilities (e.g. food insecurity, maternal depression, exposure to domestic violence or substance abuse, disability etc.). This would be most useful where multi-agency support is required and, of course, is only helpful if collaborative relationships exist between local services to address the identified concerns.

Maternal and child health and nutrition

1. Introduction

New discoveries and developments in a broad range of biological, behavioural, and social sciences have changed our understanding of how genetic predisposition (biology) and early environmental influences (ecology) are closely linked and affect physical and mental health, learning capacities, adaptive behaviours and adult productivity. Developmental, behavioural, educational, and family problems in childhood can have both lifelong and intergenerational effects.

A child's body and brain develops rapidly during pregnancy and the first two years of life. Complex interactions between personal experiences (e.g. family and social relationships), environmental influences (e.g. exposures to toxic chemicals) and genetic predispositions, beginning before conception, directly affect the way the brain is wired and how important regulatory systems are established. These early relationships set the 'thermostat' for later health and well-being. This critical period has been referred to as the "first 1,000 days of life".

The health and well-being of women, newborns and children are closely linked and should be addressed in a unified way when discussing child health and development in the early years. This "continuum of care" approach towards reproductive, maternal, newborn and child health has been adopted as a framework for this section of the report. Such an approach encompasses integrated service delivery for women of reproductive age, pregnant women, and children; extending from pre-pregnancy to delivery, the immediate postnatal period, and the early days and years of life (Figure 1).

Figure 1: Connecting care giving across the continuum for reproductive, maternal, newborn and child health

Such care is provided at home by families, in the community (through health workers, for instance) and at clinics and other health facilities (Figure 2). The continuum of care approach recognises that a good start in life is an essential step towards a healthy childhood and a productive life. This approach reduces costs by allowing greater efficiency, increasing uptake

and providing opportunities for promoting related healthcare elements (e.g. postpartum, postnatal and newborn care).

Figure 2: Connecting care giving between households and health facilities to improve maternal, newborn, and child health

This chapter of the report describes some important conditions, diseases and disorders that contribute to child ill-health and neurocognitive disadvantage and highlights the negative consequences of these conditions. An outline of service provision for pregnant women and children is provided, describing basic coverage of key interventions or programmes, impact or change over time and the proposed gaps in the continuum of care. This is followed by an assessment of institutional and human resource issues (including inter-sectoral collaboration and the role of the state), funding issues and in conclusion, the identification of priority issues which need to be addressed to improve health and development outcomes for children in the early years.

1.1 Pre-conception

Factors originating in the pre-conception period that are strongly associated with adverse newborn and child outcomes include HIV infection, maternal undernutrition and micronutrient deficiencies, unwanted and unplanned pregnancy and short birth intervals (time between subsequent births).

1.1.1 HIV

Although HIV does not directly affect fertility except in people with advanced AIDS illness, its presence affects the biopsychosocial environment of the infected person in ways that can profoundly influence the future well-being of any offspring.

1.1.2 Maternal nutrition

Poor nutrition amongst women of reproductive age is the most important cause of intra-uterine growth restriction globally, leading to an increased risk of poor infant and child outcomes, including childhood disabilities (Davidson, Dewey, & Adu-Afarwuah, 2008; Lawn, McCarthy, & Rae Ross, 2001). Both maternal underweight and overweight, as well as

micronutrient deficiencies are associated with foetal and newborn birth weight, which in turn influences child and adult health and developmental outcomes.

Providing women of child-bearing age with folic acid and iron before and around conception can reduce the incidence of neural tube defects and can improve the likelihood of newborn health, survival and development (Bhutta, Darmstadt, & Ransom, 2003).

1.1.3 Pregnancy in young women

Pregnancy among women younger than 18 years is associated with adverse neonatal outcomes such as low birth weight (<2500g), preterm delivery (birth before 37 completed weeks of gestation), small for gestational age (low weight for gestational age) and congenital malformations (Gortzak-Uzan, Hallak, Press, Katz, & Shoham-Vardi, 2001; Reddy et al., 2010). In a study conducted in the Western Cape, children born to such young women were 10 percent more likely to be underweight at birth and between 13-16 percent more likely to be stunted (low height for age [being 'short']) than children born to older mothers (Branson, Ardington, & Leibbrandt, 2011).

1.1.4 Short birth interval

A child born three to five years after the birth of its sibling is about two and a half times more likely to survive than children born at shorter intervals; the child is less likely to be born low birth weight or preterm, to be malnourished during infancy and through age five, and less likely to suffer from stunting and underweight (low weight for age) (Gipson, Koening, & Hindin, 2008; Setty-Venugopal & Upadhyay, 2002).

1.2 Antenatal care

1.2.1 Maternal malnutrition

Maternal malnutrition increases the risk of stillbirths and newborn deaths, intrauterine growth restriction, low birth weight, preterm birth, and birth defects, all of which increase the risk of disability. Babies of malnourished mothers are more likely to be stunted and wasted (low weight for height) and are at higher risk of child death.

Inadequate maternal nutrition during pregnancy is associated with poor physical development, including essential brain development of the foetus, impaired development of the foetal and infant immune system, obesity in childhood and adulthood, subsequent hypertension and cardiovascular disease and increased risk for diabetes in later life (Barker, 2004; Cutfield, Jefferies, & Hofman, 2006; Gluckman & Hanson, 2006; Langley-Evans & Carrington, 2006).

Pregnant women are encouraged to be immunised against tetanus, and to commence and/or continue folate and iron supplementation to prevent birth defects and infant cognitive impairment. Promoting adequate intake of iodine among pregnant women improves child survival and prevents damage to cognitive development (Bhutta et al., 2003).

1.2.2 HIV and sexually transmitted infections

All pregnant women in South Africa are expected to be screened for syphilis through a blood test and to receive testing and counselling for HIV, and are eligible for prompt appropriate treatment if positive. These measures prevent infant death, low birth weight, congenital

malformations and mother to child transmission of HIV (Bhutta et al., 2003; Tinker & Ransom, 2002).

1.2.3 Substance abuse

Smoking significantly increases the risk of the two leading causes of perinatal death - preterm labour and abruptio placentae (Odendaal, Van Schig, & De Jeu, 2001); yet only 12 percent of pregnant smokers presenting at a South African hospital were aware of these risks (Viljoen & Odendaal, 2005). Smoking also contributes to low birth weight.

South Africa has the highest prevalence of foetal alcohol syndrome in the world, with rates as high as 67-100 per 1,000 children in certain areas (Urban et al., 2008). The most severely affected children on the spectrum show a characteristic pattern of anomalies consisting of prenatal and/or postnatal growth retardation, a unique cluster of facial malformations and neurodevelopmental disabilities. Additionally, individuals on the spectrum who do not meet full criteria for the syndrome, nevertheless display significant neurocognitive difficulties (O'Connor et al., 2011).

1.3 Labour/ Perinatal care

1.3.1 Emergency obstetric care

Managing obstructed labour and severe antepartum bleeding can prevent asphyxia in newborns (Tinker & Ransom, 2002). Providing a clean delivery, including clean cutting of the umbilical cord, is essential for the health of mothers and neonates as it protects against sepsis in mothers and neonatal tetanus and sepsis in newborns.

The risk of death for a child aged less than five years is doubled if his/her mother dies in childbirth. At least a fifth of the burden of disease among children younger than five years is attributable to conditions directly associated with poor maternal survival, reproductive health, nutrition and quality of obstetric and newborn care (Lule et al., 2005).

Immediate drying and warming of newborns through skin-to-skin contact is an effective way to prevent hypothermia and to promote immediate breastfeeding. Functioning referral care and transport systems must be available for managing maternal and newborn complications.

1.3.2 Support during labour (birth companions)

Women allocated to continuous support are more likely to have a spontaneous vaginal birth, and less likely to require intrapartum analgesia or to report dissatisfaction with their childbirth experiences. In addition, labours are shorter and caesarean sections or instrumental vaginal births less likely to be needed (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011). Despite the availability of this evidence, having continuous support during labour is the exception rather than the norm in most health facilities offering maternity services across the world.

This is particularly the case in low- and middle-income countries such as South Africa, where companions during childbirth are infrequently encouraged by state maternity services. In a South African study conducted across ten state hospitals offering maternity services, 85 percent of women reported not being allowed to have birth companions present during labour (Brown, Hofmeyr, Nikodem, Smith, & Garner, 2007).

1.4 Postnatal care and newborn care (up to 1 month after birth)

1.4.1 Routine care

Interventions such as 'kangaroo mother care', which promote skin-to-skin contact and early bonding provide a highly cost-effective way to prevent hypothermia, especially for low birth weight infants (Bhutta et al., 2003). Clean cord care and timely recognition and antibiotic treatment of serious infections such as pneumonia, sepsis and meningitis can prevent maternal and neonatal mortality, morbidity and disability (Bhutta et al., 2003). Administering high-dose Vitamin A to mothers postpartum prevents maternal night blindness and morbidity as well as neonatal infection (Lawn et al., 2001).

1.4.2 Counselling and support

Counselling and support on appropriate feeding practices should be provided to all mothers postnatally. This should include advice and counselling on optimal feeding practices (exclusive breastfeeding for six months), adequate maternal nutrition, preventing infection, providing tetanus toxoid immunization if a woman has not previously completed the series, exploring options for social and emotional support for the mother and family planning options and optimal birth spacing (World Health Organization, 2010).

1.4.3 Maternal depression

All mothers should be assessed for depression since risk factors for maternal depression such as poverty, low education, high stress, lack of empowerment and poor social support, are also risk factors for poor child development (Walker, Chang, Powell, Simonoff, & Grantham-McGregor, 2006; Walker et al., 2011). In a South African setting, the two strongest independent predictors of postnatal depression were exposure to extreme societal stressors (such as witnessing a violent crime or being in danger of being killed) and reporting difficulties with a partner (Ramchandani, Richter, Stein, & Norris, 2009).

In the 'Birth to Twenty' longitudinal cohort study in Johannesburg, maternal postnatal depression was significantly associated with child behaviour problems at age two, independent of socioeconomic status; with some evidence that children of depressed mothers were also at increased risk for having stunted growth, compared to non-depressed mothers (Avan, Richter, Ramchandani, Norris, & Stein, 2010).

1.4.4 Breastfeeding

The role of breastfeeding in improving child survival, reducing infectious disease mortality and other conditions such as allergies, and in promoting emotional health is well known (American Academy of Pediatrics, 2005). There is mounting evidence of its longer-term cognitive benefits too, particularly in preterm infants, with breastfed children about one to six months ahead of children who were never breastfed, in their cognitive development (Quigley et al., 2012)

1.5 Infants and children

1.5.1 Anaemia- iron deficiency

Children's risk for iron deficiency (ID) and iron deficiency anaemia (IDA) is particularly high during the second six months of life when prenatal stores are depleted. Longitudinal studies

from infancy through adolescence and early adulthood suggest that socio-emotional development is uniquely vulnerable to ID and IDA, perhaps being associated with shared neural pathways, and that the effects of early iron deficiency may be irreversible.

In addition to direct effects on brain function, ID and IDA may also affect child development indirectly through non-responsive mother-child interactions. Maternal ID is a global problem that may contribute to high rates of maternal depression and non-responsive caregiving.

Developmental loss associated with ID and IDA can be reduced by preventing preterm birth, delayed cord clamping, ensuring adequate maternal iron status, providing infant's with iron-rich complementary foods, and promoting responsive mother-infant interaction patterns and early learning opportunities for infants (Black, Quigg, Hurley, & Pepper, 2011).

1.5.2 Stunting

Stunting indicates a failure to achieve one's genetic potential for height. The main causes of stunting include intrauterine growth retardation, inadequate nutrition to support the rapid growth and development of infants and young children, and frequent infections during early life (Frongillo, 1999).

Stunting rates increase during the first two years of life with little change thereafter until adolescence, when delayed maturation and an extended growth period result in some compensatory growth, provided the child has sufficient good quality nutrition (Bosch, Baqui, & van Ginneken, 2008).

It is likely that the process of growth stunting is harmful and not necessarily short stature itself. The process of becoming stunted, owing to restricted nutrient supply and/or frequent infection, is likely a common cause of both short stature and structural and functional damage to the brain, resulting in delay in the development of cognitive functions as well as permanent cognitive impairments (Kar, Rao, & Chandramouli, 2008).

Stunting often goes unrecognized by families who live in communities where short stature is so common that it seems normal. Even among health workers, stunting generally does not receive the same attention as underweight (low weight for age) or wasting (low weight for height), since height is not routinely measured at clinics or in community programmes. However, stunting is a better indicator of long-term adverse consequence than low weight for age. Ideally, length/height as well as weight should be part of growth monitoring, particularly since height drop-off begins at about 8-9 months of age.

There is growing evidence of the connections between poor height gain early in life and impaired health, educational and economic performance later in life. Stunting can have long-term effects on cognitive development, school achievement, and economic productivity in adulthood, as well as maternal reproductive outcomes (Dewey & Begum, 2011).Children born to stunted women are at greater risk of dying than children of mothers of normal height (Ozaltin, Hill, & Subramanian, 2010).

The Maternal and Child Undernutrition Study Group reviewed cohort studies involving long-term follow-up of children into late adolescence and adulthood, from five low- and middle-income countries: Brazil, Guatemala, India, Philippines and South Africa (Victoria et al., 2008).Small size at birth and childhood stunting were linked with short adult stature, reduced lean body mass, fewer years of schooling, diminished intellectual functioning, reduced

earnings and lower birth weight of infants born to women who themselves had been stunted as children.

Growth restriction in early life is associated not only with short adult height but also with certain metabolic disorders and chronic diseases in adulthood (Victoria et al., 2008). Lower birth weight (which is strongly correlated with birth length) and undernutrition in childhood are risk factors for high glucose concentrations, high blood pressure and harmful lipid profiles in adulthood. These signs are associated with the metabolic syndrome of weight gain, cardiovascular and diabetes risk.

The 'developmental origins of health and disease' hypothesis posits that the intrauterine and early postnatal environment can modify expression of the foetal genome and lead to lifelong alterations in metabolic, endocrine and cardiovascular function (Gluckman, Hanson, & Buklijas, 2010)

Intervention needs to occur during the period when stunting usually occurs - the prenatal period and the first 2-3 years of life – in order to have a significant impact. Specifically, interventions need to be targeted at the 'window of opportunity'- the first 1,000 days of life (Bhutta et al., 2008; Davidson et al., 2008; Dewey & Huffman, 2009; Victoria, de Onis, Hallal, Blossner, & Shrimpton, 2010).

1.5.3 Parasites (worms)

Most of the intestinal parasite (worm) load is carried by children living in poverty and other conditions of disadvantage, particularly those who live in densely populated and under-serviced urban informal settlements, as well as in some rural areas. Chronic worm infection can contribute to stunting and underweight and lead to long-term retardation of mental and physical development

In 1999, more than 90 percent of the children attending 12 primary schools serving two large informal settlements in Cape Town were found to be infected with worms (Fincham & Dharsay, 2006). A study of worm infection in children aged 2–10 years living in ten areas described as 'slums' in Durban indicated a prevalence of *Ascaris* (roundworm) and *Trichuris* (whipworm) of 89 percent and 72 percent respectively, with most children infected with both worms. In Limpopo, 80 percent of school children enrolled in a study had bilharzia (Fincham & Dharsay, 2006).

Regular deworming improves school attendance and learning (Disease Control Priorities Project, 2008).

1.5.4 Micronutrient deficiencies

Micronutrient malnutrition affects approximately two billion people worldwide; mostly children. Micronutrients deemed worthy of global and national prevention activities include iron, folate, vitamin A, iodine, zinc, and some Vitamin B sub-types. The adverse effects of micronutrient deficiencies are profound and include both functional and health outcomes involving growth and development, mental and neuro-motor performance, learning disabilities, immune-competence, blindness, physical working capacity, and premature death (in infants, children and mothers) (Viteri & Gonzalez, 2002).

Deficiencies rarely occur singly. It is accepted that an integrated approach is required to tackle many vitamin and mineral deficiencies; including dietary diversification, fortification

and supplementation integrated into programs to control intestinal worms, as well as environmental and sanitary interventions.

Several studies have examined the effects of multiple micronutrient interventions in settings where micronutrient deficiencies are widespread. Two studies found no effects on child mortality. The effects on diarrhoea and respiratory illness were variable, although beneficial when micronutrients were provided as fortified foods. Multiple micronutrient interventions improve haemoglobin concentrations and reduce anaemia, but the additional effects are small when compared to providing only iron or iron with folic acid. Multiple micronutrient interventions also improve linear growth compared to providing a placebo or single nutrients. Less is known about the effects of multiple micronutrients on motor and mental development in early childhood (Ramakrishnan, Goldenberg, & Allen, 2011).

The World Bank estimates that the human and social cost of micronutrient deficiencies might be up to 5 percent of gross national product (GNP) whereas interventions might only cost 0.3 percent of the GNP (McGuire & Galloway, 1994). The "Copenhagen Consensus" was an attempt by economists to set priorities among a series of proposals for confronting ten major global challenges, by prioritising the use of a hypothetical $50 billion made available to governments in developing countries. Providing micronutrients through a combination of public health and private sector programmes ranked second, after control of HIV/AIDS (Behrman, Alderman, & Hoddinott, 2004).

1.5.5 HIV

HIV/AIDS is the commonest cause of under-5 deaths in South Africa, accounting for about 40 percent of deaths (Bradshaw, Bourne, & Nannan, 2000). It is also responsible for a third of hospital admissions. It is associated with diarrhoea, pneumonia and tuberculosis among others. It also accounts for about half of all severe malnutrition in children (De Maayer & Saloojee, 2011).

Antiretroviral therapy in children is as successful as in adults and is associated with better survival, improved growth and neurocognitive function, fewer opportunistic infections and better quality of life. However, despite antiretroviral therapy, HIV-infected children may continue to lag behind their uninfected peers in growth and development. Outcomes for concurrent conditions such as malnutrition, tuberculosis and malaria are poorer; and disease worsening quicker in HIV-infected children (Heidari et al., 2011).

Children affected, but not infected, with HIV are themselves exposed to various risks. These include exposure to the virus and to antiretroviral drugs with known toxicity, and extend to issues regarding economic and food security, psychosocial care, education, health, family composition and stability of care. Young children in affected households with caregiver illness or death are prone to bullying, mental health problems, abuse, and emotional and behavioural problems. The combined effects of poverty and HIV/AIDS can cause significant social disruption including school drop-out, child labour abuses and the sexual exploitation and trafficking of children (Richter, 2005).

1.5.6 Burden of disease

There are no estimates of the burden of disease attributable to the diseases and conditions described in the sections above. Table 1 presents a rough estimate of what the cognitive “fall-out” of selected conditions may be in the South African context, extrapolating from local and international data. The prevalence is based on local studies, the number of cases based

on potentially at-risk school-aged children in the population, while the IQ loss and additional cases of IQ <70 is extrapolated from international data. Seventy is the IQ cut-off for severe mental retardation.

While the precision of the estimates are open to debate, the calculations highlight the large number of children affected by three common conditions – worms, stunting and anaemia. More importantly, the estimates emphasise the extraordinarily large scale of effect on intelligence of what are easily preventable disorders.

Table 1: Estimated effects of selected diseases on cognition in school-aged SA children

Common diseases	Prevalence (%)	Total cases (millions)	IQ points lost per child	Additional cases of IQ <70
Worms	30	3.7	3.7	346,000
Stunting	18	2.2	3	163,000
Anaemia	28	3.4	6	520,000

Authors' estimates based on initial calculations and assumptions made by (Jukes, Drake, & Bundy, 2008)

1.5.7 Impact of intervention

There is a large evidence base supporting the value of various interventions such as preventing and treating anaemia or malaria, and providing nutritional or cognitive stimulation to children. Table 2 summarises some evidence from resource-poor countries regarding the benefits of nutritional supplementation, as an example. Benefits include improvements in motor skills, behaviour, cognitive function and educational achievement.

Table 2: Impact of nutritional supplementation on cognitive development in young children

Country	Activity	Consequent improvement
Taiwan	Nutritional supplementation in pregnancy and infancy	Motor development
Guatemala	Nutritional supplementation (0-24 months of age)	Cognitive function at 3 to 7 years; increased adult earnings
Mexico	Supplementation after birth to 3 years	School performance, language, motor skills, adaptive behaviour, personal and social behaviour
Colombia	Supplementation	Motor development at 18 months and language at 36 months
Kenya	School feeding	Educational achievement, but not cognitive function, and only in classes with experienced teacher
West Java	Nutritional supplementation	Motor development only after 90 days of supplementation
Jamaica	Children 9-24 months intervention for 2 years. Nutrition, stimulation, both, none	Effects of the two interventions were additive (both better than single)

Source: Adapted and extracted from (Jukes et al., 2008).

2. Innovations in maternal, reproductive and child health

Some healthcare innovations that have had an impact on maternal and women's health in South Africa since 1994 include the provision of free antenatal care for all pregnant women, the Choice on Termination of Pregnancy Act of 1996, the confidential enquiry into maternal deaths, food fortification, the continued expansion of the prevention of mother to child HIV transmission (PMTCT) programme, revisions to antiretroviral therapy (ART) regimens for HIV positive expectant mothers, expanded HIV testing and preventive and therapeutic treatment for children.

South Africa is a signatory to most international child health conventions, charters and initiatives such as the Millennium Development Goals, the African Union Charter on the Rights and Welfare of Children and "A World Fit for Children" among others. A new Children's Bill was gazetted in 2008.

Compensating for the disadvantages of poverty is a governmental priority. Child social support grants are available to the guardians of all poor children under 18 years of age to address the social disadvantage of poverty. It is estimated that 73 percent of eligible children are receiving the Child Support Grant (CSG) in South Africa (Chennells & Hall, 2011). The CSG has shown to have some positive impact on growth, nutrition and the incidence of hunger in South African children (Hall, 2011).

In 1994, Nelson Mandela, the State President, declared that all health care for children under the age of six years and for pregnant and breastfeeding women would be free. This policy aimed to improve access to health care for women and children by removing the barrier of health services fees at public sector health facilities. The policy guaranteed free primary, secondary and tertiary healthcare for pregnant women extending from the time of the diagnosis of the pregnancy; or if a complication occurs, for up to 42 days after termination of the pregnancy or until such time as the complication has been cured or the condition stabilised.

In 1995, the Department of Health initiated the Integrated Nutrition Programme (INP) to address and prevent malnutrition with the vision of optimal nutrition for all, with maternal nutrition identified as a special focus area. It sought to address nutritional deficiencies at a health service, household, and community level. The INP has the following main focus areas viz. (i) maternal nutrition; (ii) infant and young child feeding; (iii) youth and adolescent nutrition; (iv) micronutrient malnutrition control; (v) disease-specific nutrition support, treatment and counselling; (vi) nutrition promotion, education and advocacy; (vii) food service management; and (viii) community-based interventions.

By 2009, the National School Nutrition Programme provided one meal per school day, comprising a snack and a drink, to more than seven million learners in over 20,000 schools (six million primary school learners, one million secondary school learners) (Department of Basic Education, 2011). The Protein Energy Malnutrition (PEM) scheme, (now renamed the Integrated Nutrition Programme) was implemented at primary healthcare facilities to address chronic energy deficiency in pregnant and lactating women, patients with HIV/AIDS, TB and other debilitating conditions. In conjunction with the food supplementation, dietary counselling and nutrition education are also provided

In 1996, The Choice on Termination of Pregnancy Act was introduced in response to the high number of 'backstreet abortions', estimated at about 44,000 per year, which resulted in

a large number of preventable deaths due to unsafe abortions (Barron, Day, & Monticelli, 2009). The Act provides for termination of pregnancy on request of any woman of reproductive age up to 12 weeks of pregnancy, and at the discretion of a medical practitioner (for a variety of reasons) until 20 weeks of gestation. The Choice on Termination of Pregnancy Act has resulted in widespread access to safe abortions, with approximately 60,000 women terminating pregnancies safely each year, while mortality from unsafe abortion has declined by 90 percent (Jewkes & Rees, 2005).

In 1997, The National Department of Health (DoH) established a National Committee into the Confidential Enquiries into Maternal Deaths (NCCEMD) and ensured that maternal deaths are notifiable by law. One of the objectives of this initiative was to publish a regular report (*Saving Mothers*) on the status of maternal deaths nationally, with the first report published in 1998. Subsequently, a report has been published every triennium. *Saving Mothers* offers a review of the healthcare provided to mothers with information on the cause of death and avoidable factors. These together create a health profile of mothers who died in health facilities, giving insight into the quality of care they received in the South African health system. The report synthesises audit information to help guide priority setting for the DoH and all levels of health service delivery.

Mandatory food fortification legislation was implemented in October 2003. Regulations requiring fortification of maize and bread flour with zinc, iron and six vitamins (vitamin A, thiamine, riboflavin, niacin, pyridoxine and folic acid) were implemented in order to reduce micronutrient deficiencies. In addition, iodisation of salt has also become mandatory. Fortification with folate has resulted in a 30 percent decrease in the incidence of neural tube defects, whilst mandatory iodisation of salt has dramatically reduced the prevalence of iodine deficiency in the country, and thus associated mental handicap (Harrison, 2009).

In 2009, new interventions to improve ART access for priority groups in order to decrease the disease burden of AIDS, to address maternal and child mortality, and to improve life expectancy were announced. This led to the development of the 2010 Clinical Guidelines for the Prevention of Mother to Child Transmission of HIV. All HIV-positive pregnant women with a CD4 count 350/mm^3 or less commence lifelong ART; prophylactic ART is initiated at 14 weeks of pregnancy for women who are not eligible for lifelong ART. HIV-positive women can now safely breastfeed their children provided the mother is taking ART, or the child is taking prophylactic Nevirapine, during the breastfeeding period.

The burden of communicable diseases is decreasing, thanks to measurable improvements in the provision of safe, potable water (available in 87 percent of homes), adequate sanitation (available in 67 percent of homes), and electricity (70 percent of homes use electricity for lighting) to poorer communities (Statistics South Africa, 2011). There have been notable successes in reducing vaccine-preventable diseases, despite only 89.5 percent of children completing their year-one immunisation schedule (Department of Health, 2009). Since 2009, rotavirus and pneumococcal vaccines have been added to the Expanded Programme on Immunization (EPI) schedule.

Service-related innovations implemented include the Baby-Friendly hospital initiative and kangaroo mother care units, the Child Healthcare Problem Identification Programme (Child PIP), adolescent-friendly public health clinics, and an Essential Drugs List.

The Department of Health's 10 Point Plan aims to improve the functioning of the health system, an essential step needed to improve maternal and child care service delivery.

Forthcoming health system initiatives, such as the implementation of National Health Insurance, the updating of the Human Resource Plan for Health, the revitalisation of primary health care and the proposed revisions to the qualifications framework and scope of practice for nurses and midwives, will undoubtedly impact on maternal and child health services.

3. Framework of service provision (including coverage, impact and gaps)

Programme(s)/ service(s)	Description of services and beneficiaries	Delivery mechanism (who provides the service)	Coverage	Impact (or change over time)	Main gaps
Maternal and Reproductive Health					
Family planning	Targets all women of reproductive age and consists of contraceptive services, emergency contraception, and counselling on birth spacing, termination of pregnancy and planned pregnancy.	All public sector health facilities, particularly primary care clinics	60% contraceptive usage by sexually active women (UNICEF, 2011). Almost half of all women typically have their first birth before 21 years of age; approximately one in seven South African women have a birth before their 18th birthday (SA strategic plan MWNCH 2009-14) 2.5 total fertility rate (UNICEF, 2011). Approximately 60,000 women terminating pregnancies safely each year (Jewkes & Rees, 2005).	Condom use among people aged 15–49 has risen from 31.3% in 2002 to 64.8% in 2008 (Shisana et al., 2010). National data indicative of a decline in the total fertility rate and pregnancy among women under 18 years of age. No reliable national data available on birth spacing. Mortality from unsafe abortion has declined by 90% (Jewkes & Rees, 2005).	The unmet need for family planning (the proportion of women who do not want to become pregnant and are not able to access contraception) is 13.8% (SADHS 2003). Still gaps ensuring improved access and utilization of contraceptive services amongst some groups, particularly adolescent girls. Negative attitudes of health professionals - 20% of women nationally reported that the healthcare provider shouted or scolded the patient in a family planning setting (WHO2001). Lack of integration between family planning and HIV prevention programmes, particularly for adolescents, is a missed opportunity.

Antenatal care (ANC) visits	All pregnant women are eligible for free antenatal monitoring and care for the duration of their pregnancy Recommended - 4 visits, starting at first suspicion of pregnancy (after first missed period; can be as early as 5-6 weeks gestation)	All primary, secondary and tertiary public health facilities	97% of pregnant women had at least one ANC visit. Only 56% of pregnant women had ≥4 ANC visits (Shisana et al., 2010). 46% had their first visit before 20 weeks (Department of Health, 2007). 85% of white women compared to only 44% of black women have their first antenatal care visit before 20 weeks (Blaauw & Penn-Kekana, 2010).	Proportion of women attending more than four antenatal care visits declined from 1998 to 2003, while the proportion having their first visit before 20 weeks stayed much the same. (Blaauw & Penn-Kekana 2010)	Although antenatal coverage is high, there is little critical analysis of the timing of visits or the quality and scope of services offered at antenatal visits Almost certainly antenatal care provides an opportunity for integrated support and health promotion for women, children and families.
Maternal nutrition	Iron and folate supplementation (during first trimester) are routinely provided at ANC clinics to all pregnant women	All public sector health facilities	5% of women are underweight (Grantham-McGregor et al., 2007; Labadarios, 2007). 52% of women aged 16 – 35 years are overweight or obese (Labadarios, 2007).	No available data to gauge progress or change in maternal micronutrient status. There appears to be a 40% decrease in the	Low prioritisation of maternal nutritional status during antenatal care and lack of supportive interventions for mothers with identified nutritional problems.

			29% of women are anaemic (Labadarios, 2007). 1 out of 4 women have poor Vitamin A status; yet only 57% of women receive Vitamin A postpartum (Labadarios, 2007).	prevalence of neural tube defects nationally which may be attributed to improved folic acid status (Labadarios, 2007).	
Screening for syphilis and immunisation during pregnancy	All pregnant women undergo screening for syphilis at antenatal care visits Tetanus toxoid is administered to pregnant women from the 24th week of pregnancy onwards (3 doses given at 4 week intervals)	All primary, secondary and tertiary public health facilities	A study in KZN reported an 18% record of syphilis screening for pregnant women at their first antenatal visit; dropping to 2% at 36 weeks (Hoque, Hoque, & Kader, 2008). 55% of pregnant women had ≥1 tetanus toxoid injections (Department of Health, 2007).	No national data on syphilis screening for antenatal attendees. National syphilis prevalence among antenatal attendees is steadily declining – decrease from 4.9% in 2000 to 2.8% in 2008 (Department of Health, 2010).	Very low levels of syphilis notification from health facilities. No national data on how many women complete all 3 doses of tetanus toxoid immunisation –local studies estimate that only half of all women complete the 3-dose immunisation schedule.

Toxin exposure	All pregnant women should receive counselling on substance use during pregnancy as part of antenatal care.	All primary, secondary and tertiary public health facilities.	Local studies report that over 1 in 4 women reported drinking alcohol post conception (before pregnancy recognition); while only 71.1% of women reported that they had stopped drinking at pregnancy recognition (O'Connor et al., 2011). SA has the highest prevalence of foetal alcohol syndrome (FAS) in the world (as high as between 67-100 per 1,000 children in the Northern Cape (Urban et al., 2008). Approximately 20% of women in SA smoke during pregnancy (Steyn, Yach, Standon, &	No national prevalence data on FAS. However, on-going research in the Western Cape indicates that the number of affected children has nearly doubled between 1997 and 2001: from 46 to 88 out of every 1,000 children (Marais, 2006). Training of clinical nurses, in the Western Cape, on the prevention of FAS and identification of high risk groups had little effect on the levels of alcohol use during pregnancy (Marais, 2006).	Lack of attention to the high prevalence of alcohol abuse, especially among pregnant women. More targeted interventions that go beyond merely raising awareness and information sharing about the risks of alcohol use during pregnancy is required. Although it has been recommended that pregnant smokers attending antenatal services should receive appropriate information, advice and support throughout their pregnancy, this rarely occurs.

			Fourie, 1997).	There is the highest prevalence of smoking amongst coloured and white pregnant women (~30%), with much lower rates among black and Indian women (Guthrie, Shung-King, Steyn, & Mathambo, 2001).	
Care during childbirth	All pregnant women should have access to care for normal and high-risk deliveries and immediate newborn care including neonatal resuscitation	All public sector health facilities providing maternity and obstetric care	Lack of ICU facilities in tertiary institutions = 9% (Department of Health, 2008b) Lack of appropriately trained staff at birth = 9% (Department of Health, 2008b) A Johannesburg study reported that deliveries with potentially avoidable causes of birth asphyxia accounted	No significant trend change over time.	Traditional indicators do not measure access to or the unmet need for, emergency obstetric care, a critical component required to decrease maternal and newborn mortality and morbidity.

			for 83% of neonatal deaths and 40% of cerebral palsy cases (Gregersen, Ballott, Guidozzi, & Cooper, 1999)		
Postnatal care	All women and babies should have access to postnatal care, including early detection and referral of complications, support for infant feeding choices and HIV testing for infants at 6 weeks (see HIV section below) National guidelines stipulate postnatal care intervals are 6 hours, 3-6 days and 6 weeks after birth	Outpatient and maternity units at primary, secondary and tertiary health care facilities	84% of clinics provide postnatal care (Viljoen et al., 2000) Only 30% of babies and 27% of mothers were reviewed within 6 days postnatally during 2010/2011 (Department of Health, 2011b)	Very little change in breastfeeding initiation and exclusive breastfeeding rates nationally. .	No data on whether mothers are assessed or counselled for postnatal depression. Also, limited support systems in place for mothers requiring referral or support for depression. Very little and erratic provision of support systems for new mothers who are breastfeeding. No data for whether women attend the 6 week postnatal visit as per policy guidelines. Often women only attend the 6 week well-baby visit and there is very little or no attention given to maternal health and well-being at this visit.

Primary Health Care					
Integrated Management of Childhood Illness (IMCI)	Targets the major causes of mortality and morbidity in children from birth to 5 years of age.	Health professionals at primary care clinics. Community IMCI through community health workers (NGOs)	Variable coverage in provinces and districts. No national or provincial statistics of coverage by clinic or individuals.	No impact statistics (e.g. under 5 mortality reduction).	While strategy accepted, no national or provincial drive demanding universal implementation. High number of health professionals trained, but many (most) do not implement on their return to clinics. Inadequate workplace supervision and mentoring of trainees post-completion of course. Lack of integration of child development as part of IMCI management, i.e. Care for Development Community IMCI only practiced in a few settings.
Expanded Programme on Immunisation (EPI)	Available to all children from birth to 12 years of age.	Primary care clinics. Some private clinics and practitioners. Intermittent mass	89% full immunization coverage by one year of age (Department of Health, 2009)	Polio eradicated in SA. Measles significantly reduced, though recent epidemic.	Inadequate coverage of poor and marginalised children to achieve 95% full one-year coverage. Eradication efforts dependent on mass

		immunisation campaigns.		Recent reduction in severe diarrhoea and pneumonia.	immunisation, rather than good routine immunisation services.
Developmental screening	All children under the age of five years should receive developmental screening at well-baby visits	Primary health care nurses using developmental screening tool in the Road to Health Card/ Booklet (RTHC/B)	No national data available. In the Western Cape – 22% of PHC facilities do not deliver any developmental screening; of the 78% facilities delivering some aspect of developmental screening, only 11% are doing so according to protocol (Michelson, Adnams, & Shung-King, 2003)	Prior to launch of new RTHC/B, Western Cape only province that incorporated developmental screening into policy.	No national data available on practice of developmental screening in PHC's. No developmental surveillance system for young children. No co-ordinated early identification and early intervention system or framework. Large variation in services available to children at risk and those with established developmental difficulties or disabilities, and few services available in poor, marginalised and rural settings. HIV and developmental problems/ disabilities – not emphasised and often not assessed as part of routine HIV care

Deworming	All children aged 1-5 years should receive a 6 monthly Mebendazole or Albendazole dose. School-aged children in high worm areas should be considered for same.	Primary care clinics	No data	No dta	Programme poorly implemented because few children between 18 months and 5 years routinely visit clinics for “well- child care”. Deworming ignored during sick visits. Programme not prioritised within primary health care. Preschools and schools do not provide this service despite school-children having the highest worm burden.
Integrated Nutrition Programme					
Growth monitoring and promotion	Children from birth to 5 years of age get weighed regularly and their caregivers offered advice.	Primary care clinics	No reliable trend data	No evidence of change in anthropometric status of children, or reduction in severe malnutrition rates.	Activity conducted sporadically at clinics, and usually only at “well child” visits. Little or no response to growth faltering by staff Clinic based food supplementation non-existent in most provinces. No community based growth monitoring and promotion.

Breastfeeding, including exclusive breastfeeding for 6 months	Breastfeeding encouraged for all infants and young children	Promotion at clinics and hospitals	90% breastfeeding initiation rate (Department of Health, 2007) 12% exclusive breastfeeding at 4 months and 1.5% at 6 months of age (SADHS, 2003).	Lower breastfeeding rates in HIV era.	Lack of clear provincial policies or, where present variable implementation. Inconsistent messaging by health staff Poor support for practice with birthing centres (clinics and hospitals). Promotion of exclusive breast-feeding up to the age of six months of life, followed by appropriate complementary feeding should be key components of nutrition education.
Baby friendly hospital initiative	Promotion of 10 key steps at birth to facilitate breastfeeding	Birthing centres (public and private)	231/545 (42%) of birthing centres accredited as "baby friendly"	Increased accreditation of centres during past 3-5 years	Limited ability to support non-accredited centres. Continued compliance wanes in accredited centres.
Infant and young child feeding support	0-2 years	Primary care clinics	Stunting and underweight affect 18% and 10% of children respectively (Labadarios, 2007)	Stunting in 12–71 month children decreased from 21.6% in 1999 to 18% in 2005	Limited focus on preventive and therapeutic activities at health facility level. Caregivers receive little or no guidance and/ or education on the importance of

			Almost a third of children are anaemic based on haemoglobin result (Labadarios, 2007) 10% of children overweight and 4% obese (Labadarios, 2007)	(Labadarios, 2007) Deterioration in the iron status of children aged 1–5 years between 1994 and 2005 (Labadarios, 2007)	responsive feeding for young children. Limited focus on feeding support at community level. Staff at child care centres not trained in menu planning, food purchasing and preparation, food hygiene and responsive feeding practices.
Nutrition supplementation	Children 0-5 years offered food supplementation if failing to thrive	Primary care clinics	No data available. Anecdotal data suggests few, if any, districts implement programme.	No data	Nutrition supplementation programme dysfunctional. Lack of intensive treatment, supervision and follow-up of moderately and severely malnourished children. Supplementary food interventions should consider micronutrient composition as well as energy content.
Vitamin A supplementation	Children 0-5 years offered 6-monthly vitamin A supplementation	Primary care clinics	Nationally, 21% of children aged 12–59 months received a high-dose vitamin A supplement from the health services	Prevalence of poor vitamin A status in young children worsened to 66% in 2005 compared to	Few children attend “well child” visits after 18 months of age. Missed opportunities during well- and sick child visits. Need to consider alternative

			within the last six months (Labadarios, 2007)	33% in 1994 (Labadarios, 2007)	delivery mechanisms for Vitamin A supplementation to improve coverage, e.g. through ECD centres or community health workers.
Food fortification	Mandatory to add iron, zinc, vitamin A, thiamine, riboflavin and vitamin B6 to maize and wheat bread flour.	Food manufacturers	Near universal salt fortification of iodine. High prevalence of vitamin A deficiency (66%) (Labadarios, 2007) High prevalence of poor zinc status among children 1-9 years of age (70%) (Labadarios, 2007)	Virtual elimination of iodine deficiency in the country. Adequate folate status in children and women of child bearing age. Positive knowledge, attitude and behaviour of public towards food fortification. Wide purchase and use of fortified products at the household level (Labadarios, 2007)	Unclear if manufacturers of premixes and millers are strictly complying with legislation. Recent report raises serious concerns about manufacturers' compliance. Need for continued attention to expanding and ensuring quality control of fortification programmes. More attention to the ecological, economic, and cultural factors that influence the local consumption of food (nutrients) is also required.

Primary school feeding programme	Primary school children at poor schools offered a meal and drink at school each day	At schools through Department of Education.	Roughly 7 of the 12 million total public school students in the 2008-09 school year benefitted from school feeding (Buhl, 2010)	Increased school attendance. Better concentration of learners at school.	Quality of food provided variable. Maladministration resulting in failure to provide programme at all eligible schools. Insufficient involvement of community members in food provision.
HIV					
HIV Counselling and testing	HIV testing following individual counselling. All sexually active individuals including pregnant women.	Primary care clinics and hospitals	Approximately 80-90% of pregnant women tested for HIV (Barron et al., 2009) 12 million South Africans tested in 2010-11 (South Africa.Info, 2011)	HIV status of most pregnant women known. About one-half of sexually active adults know their status.	Better uptake among women compared to males. Most participants tested once rather than regularly. Testing of young children (0-18 months) requires a different test (PCR) that is also more difficult to do and more expensive.
Maternal HIV	All pregnant women attending antenatal care receive routine offer of HIV counselling and testing services	All primary, secondary and tertiary public health facilities	Approximately 1 in 3 pregnant women HIV positive (Department of Health, 2010) 65% of HIV positive antenatal clients were on	The proportion of pregnant women receiving HIV counselling and testing increased from approximately 7% in 2001/02 to	No data on ART for eligible women. Despite high reported rates of pregnant women tested for HIV, only 60% of maternal deaths had HIV result in 2005-7.

			AZT for any period before labour uptake (Department of Health, 2011a)	81% in 2007/08 (Johnson & Hall, 2010) This is mainly due to the expansion of the PMTCT programme. Proportion of HIV positive antenatal clients who had been on AZT for any period before labour uptake rate increased from 10% (in 2009) to 65% in 2010 (Department of Health, 2011a). Proportion of women testing HIV positive who receive Nevirapine during labour is approximately 76% (Department of Health, 2011b).	The District Health Barometer data suggest highly erratic trends in the provision of Nevirapine to pregnant women and their babies. This may be a reflection of changes in record-keeping practices rather than real changes in quality of service.

Prevention of mother to child transmission of HIV	Provision of prophylactic antiretroviral therapy to infant at birth and for 6 weeks thereafter, and to mother during pregnancy and thereafter	Primary care clinics and hospitals	About 88% of HIV positive mother-infant pair received antiretroviral prophylaxis (UNICEF, 2010) No reliable data on dual therapy uptake. No reliable data on HIV testing of infants. No data on Nevirapine prophylaxis for breastfeeding.	Evidence that perinatal transmission of HIV decreasing (to 3.5% at 6 weeks) (Medical Research Council (South Africa), 2011) Infant and under-5 mortality rate decreasing in SA since 2006 (Medical Research Council (South Africa), 2011)	Limited provincial monitoring of success of the programme. Many pregnant women requiring triple ART not receiving it. Some HIV exposed infants still not receiving any prophylaxis (mainly because mother not identified as positive). Dual therapy uptake variable in different provinces.
Antiretroviral therapy	Provision of antiretroviral therapy to infants and children with HIV as soon as diagnosis made	Primary care clinics and hospitals	PCR testing of infants varies from 20-80% in provinces (anecdotal) Less than half (37%) of newly eligible children < 15 years on ARTs (Department of Health, 2008a)	Reduction in U5MR and hospitalization rates (Medical Research Council (South Africa), 2011)	Identification of eligible children at 6 weeks of age still problematic. Still catching up on backlog of ART for older HIV infected children.

Infant feeding	Exclusive breastfeeding for 6 months, together with Nevirapine or maternal antiretroviral therapy	Primary care clinics and hospitals	Policy recently introduced	None	Implementation of new policy has simultaneously resulted in removal of provision of free infant formula provision.
Disability					
Rehabilitation services	All children with disabilities have access to free health care and appropriate rehabilitation services	All public sector health facilities	No reliable national data. Local study in Johannesburg reported that only a quarter of children in need of rehabilitation services received such services (Saloojee, Phohole, Saloojee, & Ijsselnuiden, 2006) In Mpumalanga, 67% of children with disabilities did not have any assistive device	No data available to track progress	Rehabilitation services remain largely a specialised service at tertiary level. Thus, issues with access to services remain as it is not seen as part of PHC services. Although there is free health care for children under 6 years of age, this does not include assistive devices. The budgets for assistive devices are not ring-fenced so allocation within provincial budgets for purchasing these devices is discretionary. This often means that there is no

			(Department of Social Development, 2009)		budget available for the provision of these services to children with disabilities. Lack of disability prevalence data results inadequate budgeting for rehabilitation service provision. There is no routine (and/or early) screening for disabilities such as hearing loss, other than basic developmental screening through the clinics. This results in late identification of sensory or developmental difficulties/ deficits and leaves many eligible children without the necessary assistive and adaptive devices they need.
School Health					
Health promoting schools	Schools where all members of the learning community work together to	School health services; primary and secondary schools	Approximately 1,800 health promoting schools nationally (Slemming &	No significant trend data.	No data on the number of primary schools per province implementing primary preventative health programme.

	provide learners with integrated and positive experience and structures which promote and protect their well-being.		Saloojee, 2011)		
School health services	School health services are provided to all children (Grades R-12) attending public sector schools.	School health nurses employed at district level; primary healthcare nurses.	Only 60 out of the 232 sub-districts implemented any form of school health services by 2011 (Slemming & Saloojee, 2011)	Consistently poor and inequitable coverage of school health services. No data assessing impact of service provision.	There is too much dependence on school nurses to implement the national school health policy, which currently consists mainly of health screening activities for Grade R/1 learners in the poorest schools. Secondary schools are largely ignored. There is a need for stronger intersectoral collaboration and clearer identification and clarification of roles and responsibilities for all involved sectors, particularly the DoH, DBE and DSD.

Adolescent Health					
Youth friendly services	NAFCI seeks to make healthcare facilities more accessible and acceptable to adolescents.	Primary health care clinics	47% of PHC facilities were implementing the Youth Friendly Services approach (Department of Health, 2011b)	NAFCI clinics show an increase in service utilisation and VCT for young people (Department of Education, 2009) No difference between NAFCI clinics and ordinary clinics regarding visits for STI treatment, pregnancy or contraception (Department of Education, 2009) Also no difference in the quality of care provided by NAFCI clinics compared to ordinary clinics (Department of Education, 2009)	Research shows that many young women feel alienated from South Africa's public healthcare facilities and site health professionals' attitudes as a significant barrier to service utilisation, especially regarding sexual health issues. Although, there is an increase in the number of NAFCI clinics not all are operating as NAFCI clinics.

3.1 Gaps in the continuum of care

Figures 3 and 4 below summarise the coverage levels of interventions, considered to have "good" and "poor" coverage respectively. Although coverage does not equate to quality of care, there is satisfactory coverage of various interventions through the continuum of care, such as access to antenatal care, skilled birth attendance and immunisation coverage (Figure 3). When quality of care indicators are considered, such as early access to antenatal care, or exclusive breastfeeding for at least three months, coverage deteriorates (Figure 4). There are data gaps for a number of important interventions where coverage indicators are available, such as access to emergency obstetric care and implementation of developmental screening or food supplementation programmes at primary care centres.

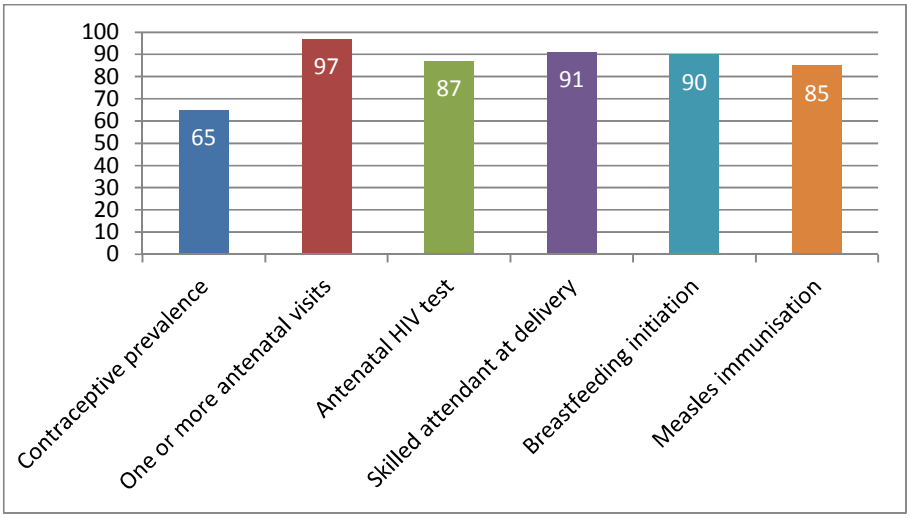

Figure 3: Estimates for interventions with good coverage across the continuum of care in SA

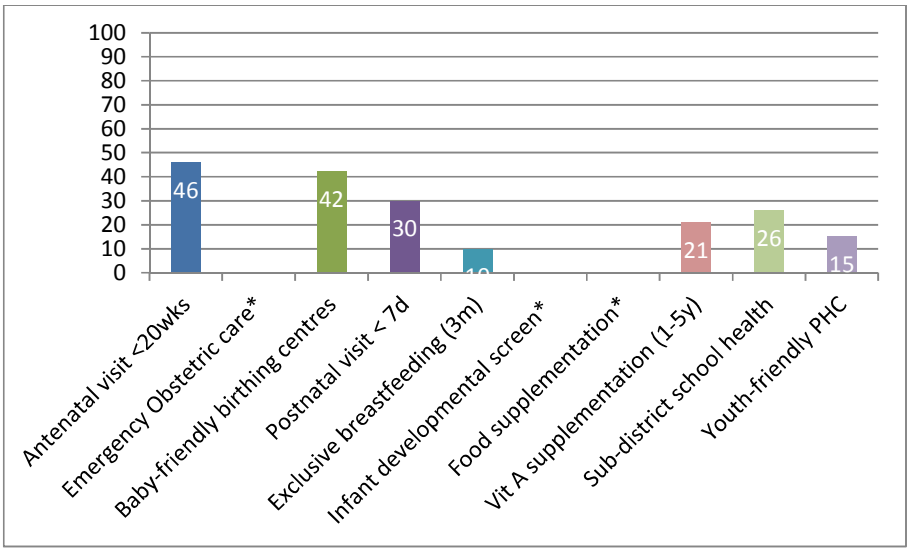

Figure 4: Estimates for interventions with poor coverage across the continuum of care in SA

* no reliable estimates available

4. Institutional issues, human resources, inter-sectoral collaboration, the role of the state

The prevention of maternal and child mortality, morbidity and disability requires synchronization and appropriate functioning of the entire health system, together with other sectors in the community, extending from community care, to primary health care clinics providing effective care, to tertiary hospitals with sufficient intensive care unit (ICU) beds and higher level technology.

There has been no national audit of the resources available for providing maternal and child health care services in South Africa. For instance, data are unavailable on the distribution of hospitals able to perform a caesarean section, or the availability of skilled midwives working in labour wards, or the performance of ambulance services. Similarly, there is no information, for example, on the implementation of the IMCI strategy at clinics, the number of kangaroo mother beds at hospitals, or the number of neonatal and paediatric ICU beds in provinces or nationally.

The table below attempts to categorise the relevant institutional, human resource or collaboration issues, identify the gaps/ problems, and present some possible solutions to address these (Table 3).

Table 3: Institutional/human resources/collaboration issues, gaps and problems, and proposed solutions

Institutional/ human resource/ collaboration related issue	Gaps/problems	Proposed solution/s
Community-based care	• Need to scale-up community-based health interventions • Lack and variability in implementation of c-IMCI within and between provinces • Community Care Worker (CCW) role defined, but programme slow to be implemented • Lack of child development focus in proposed outline of role of CCW • Lack of home-based/ community-based support interventions for young mothers/ at-risk families/	• Expansion of c-IMCI implementation – need to co-ordinate and standardise key implementation elements across provinces but requires national leadership and is currently a low priority • Explore expansion of role of CCW to include early identification and referral of children with developmental problems; and delivery of basic health interventions • Consider expansion of Community-based Rehabilitation workers for home-based support for children with disabilities

	vulnerable children	(CWD) • Portage/ home-based parent/ caregiver support initiatives to skill and empower parents to provide age-appropriate stimulation and play opportunities for their children, with a special focus on at risk families and children
Outreach of health services/ interventions	• Increased dependence on mothers and children accessing health facilities for preventive and promotive health interventions which results in sub-optimal coverage of key services and interventions especially in the antenatal period and after the first year of life. • Lack of active surveillance mechanisms/ systems for child health and development • Late identification of children with developmental problems or disabilities	• Increased use of child/community centres for outreach activities and ECD centres as resource nodes in communities and as hubs where health professionals can perform screening activities and deliver basic interventions for children at the centres but also for the surrounding communities. • Improved linkages and working in partnership with ECD centres and schools by health services to ensure that children requiring additional support receive it. • Need to develop home visitation models for early intervention programmes and expand the use of community-based rehabilitation workers
Need to consider alternate mechanisms of delivery for basic health interventions/ task-sharing/ task-shifting	• Currently, coverage of certain key intervention is not sufficient, e.g. deworming and micronutrient supplementation • Many children are not accessing or receiving required therapeutic and rehabilitation services • Inequitable and inconsistent coverage of key maternal and child health services and	• Postnatal follow-up/ Care of the newborn at home, support for health promotion and prevention activities could best be delivered through home visitation programmes. • Using deworming as an example of alternative delivery mechanisms - it may be difficult for the National Department of Health to prevent chronic worm infection in children

	interventions are the norm	on its own, because of its many competing priorities and limited capacity. It has been well established in several countries that participatory health care by non-health personnel such as educators, community health workers, non-governmental organisations (NGOs) and volunteering parents is the most effective way to implement regular, sustainable deworming at schools.
Need for improved information systems	• No co-ordinated way of ensuring that children who require additional support services are referred and followed-up and that their transition of care from tertiary/ hospital level to primary level care is facilitated. • Currently no national prevalence data on children with disabilities	• Electronic record systems for health facilities at a provincial or district level which are linked and allow health professionals to access patient records and details of all contacts with various health professionals at all clinics. • Explore use of mobile technologies for data collection by community care and rehab workers • Establish disability registers for each district/ sub-district
Primary health care facility organisation and service delivery	• All primary healthcare clinics are required to operate for at least eight hours a day, five days a week, with CHC's operating on a 24-hour basis and on weekends. These opening hours do not facilitate access of PHC services for working parents/ caregivers for services other than emergency care. • In addition, clinic surveys have found that almost a quarter of clinics do not provide immunisation every weekday, only half offer antenatal care and that rehabilitation services are	• Key services, such as immunisation, should be provided everyday • Extended opening hours and on weekends to allow improved access for working parents/ caregivers • Improve implementation of clinical IMCI and integrated service delivery – must be pushed as a minimum standard of care. • Implement food supplementation programme for children at risk of malnutrition at home, community and health facility level.

	few and far between. • Food supplementation for at risk mothers and children is often not available at clinics. • Services are delivered in silos – lack of maternal focus at well-baby visits.	• Establish new delivery modes such as through ECD centres. Identify ways to influence or standardise quantity and quality of food provided at ECD centres.

Need for linkages and partnerships between sectors/ intersectoral collaboration	• Currently, there are no clear, consistent funding and regulatory mechanisms for collaboration and partnership working between public sector services and NGOs in many areas.
	• Many health interventions require collaboration between different sectors, e.g. health and social development/ health and education/ all three or more.
	• In many instances, there are no clear roles and responsibilities outlined for stakeholders which results in poor implementation, management and leadership.
	• Lack of common outcomes/ goals for young children (in ECD) that all stakeholders agree upon to facilitate integration and that focus intervention/ programme/ policy for young children in SA – i.e. the 'glue' that binds everything together is missing.
		• We should consider the need for a common outcomes framework for children in South Africa, which all relevant bodies or stakeholders agree and adhere to but that is relevant to the SA context, to facilitate co-ordination, integration and collaborative working at all levels.
		• Examples of countries that have adopted this approach are England and Wales. The Every Child Matters framework aims to improve outcomes for all children and young people. Its main aims are for every child, whatever their background or circumstances, to have the support they need to:
		  • Be healthy
		  • Stay safe
		  • Enjoy and achieve
		  • Make a positive contribution
		  • Achieve economic well-being
		• Each theme has a detailed framework attached whose outcomes require multi-agency partnerships working together in order to achieve them.

Financing/ budget allocation	• No clearly defined budgetary allocation for maternal, newborn and child health. • More specifically, need	• Discussions with Treasury and individual departments about ring-fencing budgets related to children's needs.

	provision for children with disabilities, e.g. there is no dedicated budget for assistive devices which results in children often not receiving the devices they require to facilitate their functional independence.	
Monitoring and evaluation	• SA has ongoing issues with incomplete or poor data, particularly for maternal and child health services (and especially at the primary healthcare level). For example, there is little data to give reliable provincial information on nutritional status of children for monitoring purposes. • This means that there is limited ability redress iniquitous provision and access, as well to evaluate impact over time. • Often incorrect denominators are used; thereby leading to measurement errors. • Often inappropriate indicators or indicators that are difficult to measure are used and thus serve little purpose • Data collection at facility level is often poor and inaccurately captured. • Services collect data and 'statistics' on an ongoing basis but often do not capture the relevant/ meaningful data necessary to use for service development and improvement. This is true for not only clinical services but also often district level data for some implementation programmes.	• Improved national and district health information systems • Review current data collection tools, including indicators • Electronic record keeping which would facilitate information sharing between professionals • Disability/ at risk register to facilitate tracking of children in need of additional support services at each level of care.

Need for improved hospital management, governance and service delivery	• Poorly skilled hospital managers, with little or no management training • Poorly organised hospitals • Lack of accountability and governance • Poor management of resources • Fraud and corruption amongst all cadres of staff • Hospital-centric (especially tertiary level) approach to the management of children with disabilities and those with long-term health conditions • Poorly co-ordinated mechanisms and systems of referral downward to PHC level for routine management and follow-up of children requiring ongoing care for health and development concerns. • Specialists are all concentrated in tertiary level facilities with little or no outreach to regional and district hospitals • Poor discharge planning and transitioning of care from tertiary level/ hospital to clinic/ community-based care for children with disabilities or long-term health conditions.	• Improved governance, management and accountability mechanisms at all levels of healthcare. • Develop mechanisms for routine outreach and support by specialists to lower levels of care. • Improved referral systems and transition/ discharge planning at tertiary level down to secondary and primary levels; as well as from hospital to community/ primary levels of care, especially for children with long-term health conditions and disabilities.
Paradigm shift is required in health sector regarding child development	• Low priority for developmental screening and surveillance in the health system. • Development is often overlooked as part of assessment, care and intervention for child health. • Health system is responsive rather than proactive with	• ECD should be viewed with a life course perspective, i.e. as a phase in a child's life (in terms of growth and development), in order to move away from the strong current focus on early childhood and education. • From a health system perspective, poor child development outcomes (and

	regards to child development. • Necessary services to address developmental concerns through the health system are often inaccessible and understaffed. • Consistently poor and inequitable coverage of rehabilitation services. • Low community awareness and health promotion focus around child development.	disability) should be considered a public health issue in the same way as child ill-health (or mortality and morbidity). • Change the 'opportunistic' and 'responsive' approach to health, focussed on short-term interventions/gains. An example is the proposed "new" school health service. • Should consider expanded implementation of the Care for Development component of IMCI.
Human Resources	• Number and distribution of critical staff • Staff motivation, performance • Lack of key skills. • Inability to implement training/ translate training into effective practice. • Inadequate supervision and mentoring for staff. • Inadequate staffing ratios. • Staff attitudes, especially regarding adolescent sexual health.	• Outcomes orientated approach –staff have to deliver in accordance with the resources available to them. • Enhancing the clinical skills of health workers and improving the use of clinical guidelines and protocols
Generating public demand for better service delivery for maternal and child health, and development	• Lack of public awareness regarding typical child development and when to seek help for developmental problems • Lack of public awareness and demand regarding ECD service provision • Lack of a co-ordinated advocacy voice for ECD • Insufficient parent support programmes available for at risk families – often didactic approach used in existing programmes.	• Creating public awareness and demand – use of mass media and mobile technologies • Parent and community empowerment – parent support programmes, parent education and information provision • Advocacy for better ECD provisioning and support and prioritisation of child developmental issues within the DoH.

Inclusion	• Low number of children with disabilities attending formal early childhood care and education (ECCE) settings. Lack of policy and guideline provision for children with additional needs and disabilities within early childhood care and education settings • Needs of children with disabilities (CWD) or developmental problems in schools are often not met due to lack of therapists and psychologists employed within the mainstream education sector. Most therapists are based at special needs schools and thus only provide services to a small number of eligible children. • The problem is compounded by therapists in the health sector not being 'allowed' to assess and treat children in formal education. • Poor transition of care form health services to education services. • Slow implementation of inclusive education, including the establishment and roll-out of the district-based support team (DBST) per education district. • Lack of integrated approach with school health services.	• Closer partnership working between health and education services and implementation of the National Strategy on Screening, Identification, Assessment and Support (SIAS) • Training of practitioners - incorporate child development (typical and atypical development, developmental surveillance, promoting optimal age-appropriate development, etc.) in a standardised way – currently variable extent and quality of training on this. • Better outlined provisioning for CWD in ECCE settings, including staffing norms, etc. • Inclusive education – staff, accelerate roll-out Health services to link with school health service and DBST to facilitate transition of care. • Each child requiring additional support in school should benefit from the processes outlined in the SIAS, e.g. an individualised support plan.

5. Funding

5.1 Current health spending

South Africa spends 8.3 percent of its gross domestic product (GDP) on health (National Health Act (61/2003), 2011), and easily meets the World Health Organization's informal recommendation that so-called developing countries spend at least 5 percent of their GDP on health (World Health Organization, 2003). Highly- resourced countries spend an average of 7.7

percent of their GDP on health, while middle-income countries spend 5.8 percent (National Health Act (61/2003), 2011). However, only 4.2 percent of South Africa's GDP was spent in the public sector, with 4.1 percent of GDP expended in the private sector which covers only 16 percent of the population (National Health Act (61/2003), 2011). In per capita terms R11,150 was spent per private medical scheme beneficiary, while the public sector spent R2,766 per uninsured person (National Health Act (61/2003), 2011).

Children comprise nearly 40 percent of the population, but it is unlikely that a similar proportion of the health budget is being spent on child health. No reliable data exist, as government departmental budgets do not specifically delineate expenditure on children, easily allowing this constituency to be short-changed or ignored.

The expectation would be that as the introduction of National Health Insurance (NHI) demands the establishment of health priorities and service packages, deficiencies in child health expenditure will become obvious, resulting in children being offered a bigger slice of the health budget. Improved future monitoring and evaluation of fiscal resources should ensure that any lapses in child health spending are promptly reversed.

5.2 Inequity

Inequities and inequalities abound in South African health care spending generally, and specifically regarding children's health. Of the R192 billion spent on health care in 2008/09, 58 percent was spent in the private sector (McIntyre, 2010). Although this sector only provides care to an estimated 15 percent of children, two-thirds of paediatricians service their needs (Colleges of Medicine of South Africa 2009). Furthermore, of the R81 billion public health sector budget, about 14 percent is spent on central (tertiary) hospital services (Financial and Fiscal Commission, 2009), which primarily benefits children residing in urban settings and wealthier provinces such as the Western Cape and Gauteng.

The inequities between public and private health and between urban and rural areas result in widely differing access to quality health care. Although primary health care should be available at no cost to everyone, and uninsured children under the age of six years are exempted from hospital fees, out-of-pocket payments had to be made by 17 percent of uninsured children attending public hospitals and 8 percent of children attending a PHC clinic. This undermines the equity objectives of government's exemption policies, and also demonstrates the 'discretionary power' of providers and bureaucrats to determine who qualifies for exemptions and health care. Further, unaffordable transport obstructed immediate care for 18 percent of children under the age of six years, but for only 1 percent of insured persons (Harris et al., 2011).

Other than meeting the huge deficit in nurse availability, the NHI will also have to address the deficiencies in other categories of health staff. Integration of the public and private sectors will allow about 400 paediatricians currently in the private sector to augment the services provided by 250 public sector paediatricians. However, even this measure cannot overcome the existing gross provincial inequity in this resource, with one paediatrician being available for 8,600 children in the Western Cape but one paediatrician needing to serve over 200,000 children in Limpopo (Colleges of Medicine of South Africa 2009). Undoubtedly, many more doctors and paediatricians have to be trained to meet the current need. More importantly,

smarter mechanisms will need to be identified to attract and retain health professionals in under-resourced settings.

5.3 Inefficiencies

The over-dependence on hospital-based care in South Africa not only makes the health care system expensive and inefficient, but also precludes much-needed investments in effective primary and preventive care. However, despite funding for primary health care increasing more than three-fold since 1994, this has not resulted in an improved ability of clinics to serve children, primarily because most of the money was spent on infrastructure development rather than service delivery expansion and quality of care improvements. Simultaneously, the private health care sector is riddled with its own set of inefficiencies, excessive administrative expenses, bloated prices and continued over-servicing of patients on a fee-for-service basis.

5.4 How much money is needed?

A 2009 modelling exercise conducted in Gauteng, based on the UNICEF 'Marginal budgeting for bottlenecks' approach, estimated that an additional (marginal) investment of R4 billion over five years (or R70 per capita) in maternal and child health could save the lives of 14,283 children and reduce the under-5 mortality rate by 50 percent, almost meeting the provincial Millennium Development Goal target for 2015 (Gauteng Department of Health, 2009a). This additional investment required less than 5 percent of the existing provincial health budget (Gauteng Department of Health, 2009b). Not all of this needed to be 'new' money – much, but not all, of the money could be obtained through reducing health system inefficiencies. The hope is that data of this kind, which have been largely ignored to date, will be used to quickly remedy fiscal deficiencies as the NHI takes hold.

5.5 Cost of child health interventions

There are no readily available cost estimates of maternal and child health interventions in South African settings. Table 4 provides some comparative annual cost per capita for various interventions. However, these are based on international costs and are somewhat dated.

Table 4: Annual cost per capita of various child health interventions

Condition	Intervention	Cost US$	Cost R
Intestinal worms	Albendazole or Mebendazole	0.03-0.20	0.21-1.40
Bilharzia	Praziquantel	0.20-0.71	1.40-5.00
Vitamin A deficiency	Vitamin A supplementation	0.04	0.28
Iron deficiency and anaemia	Iron and folate supplementation	0.10	0.70
Refractive errors of vision	Spectacles	2.50-3.50	17.5-24.5
Clinically diagnosed conditions	Physical examination	11.5	81.50
Undernutrition, hunger	School feeding	21.6-151.2	152-1059

Extracted and adapted from: Del Rosso, 1999

5.6 Cost-effectiveness

A useful measure to compare the value of different interventions is cost-effectiveness. Table 5 provides relative cost per disability adjusted life gain (DALY) gained data for some maternal and child health interventions, based on international data (Jukes et al., 2008).

Table 5: Cost per disability adjusted life gain (DALY) gained

Health Intervention	Cost per DALY gained (US$)
Expanded Programme on Immunization Plus	12-30
School Health and Nutrition Programmes	30-34
Family Planning Services	20-150
Integrated Management of Childhood Illness	30-150
Prenatal and Delivery Care	30-100
Tobacco and Alcohol prevention programmes	35-55

6. Priority issues

The current response to prioritising maternal and child care is dominated globally and in South Africa by the need to achieve the Millennium Development Goals (MDG). These goals prioritise maternal and child survival. In 2009, South Africa was one of only 12 countries where deterioration, rather than progress, was noted in reducing under-5 mortality rates since 1990. Because there were no reliable estimates of 1990 under-5 mortality rates, the 1998 under-5 mortality rate of 60 per 1,000 live births was used as the MDG baseline in South Africa, with a target of fewer than 20 deaths per 1,000 births by 2015.

There is uncertainty about exact infant and under-5 mortality rates in South Africa and various estimates have been offered. This is because vital registration is incomplete, and there has not been a reliable household survey collecting detailed birth history information since 1998. A recent (and yet unpublished) Medical Research Council initiative to reconcile the different data suggests that child deaths increased steadily since 1997 and peaked in 2006. There was a particularly marked rise in infection-related deaths including diarrhoea and pneumonia, related to increasing HIV/AIDS associated deaths. The under-5 mortality rate was estimated to be 64 (per thousand) in 1997, rising to 75 in 2006, with a slight decrease to 72 in 2007 (Nannan et al., 2012).

The Health Data Advisory and Co-ordination Committee (HDACC), established by the national health department, estimated that the South African under-5 mortality was 56 per 1000 live births in 2009. Infant and neonatal mortality rates were estimated to be 40 and 14 per 1000, respectively (Dept. of Health, 2011c).

The causes and precipitants of problems in both learning and health frequently originate in families and communities, thus the boundaries of child health concern have to move beyond providing acute medical care in clinics and hospitals to the larger ecology of the community, state, and society. This call for a more comprehensive and contextual approach to health is not new in the South African setting. However, the track record of matching rhetoric with effective action is limited. Thus, there is a compelling need for bold, new thinking to translate advances in developmental science into more effective maternal and child health interventions.

Priority challenges include (1) limited caregiver and community awareness of typical child growth and development and when to seek help; (2) the need for more extensive training of health professionals on the adverse effects of excessive stress on the developing brain, as well as on the cardiovascular, immune, and metabolic regulatory systems; (3) the inability of existing, clinic- and hospital-based approaches to address the underlying morbidities effectively; (4) the relatively limited availability of evidence-based strategies, within the health service and across the full array of existing early childhood service systems, that have been shown to reduce sources of toxic stress in the lives of young children or to attenuate their adverse consequences; and (5) the additional human and financial resources required to incorporate evidence-based health and developmental strategies into state provided services.

Incorporating early child development activities into the health system - through improved pre-conception and antenatal care, breastfeeding promotion, well child visits, sick child consultations, parenting support, and early intervention for at-risk children - might provide the best opportunities for reaching children younger than three years of age.

Although there are a wide range of recognised and evidence-based interventions that could improve child outcomes, we prioritise six health sector-led actions that we believe are critical to accelerating positive early childhood development in South Africa.

6.1 Planned, healthy pregnancies

- Early and appropriate education to school-aged children on sexual and reproductive health issues should be routinely implemented as part of the school ‘Life Orientation’ curriculum.
- Youth-friendly clinics should operate as such, and the health service should consider alternative delivery mechanisms for adolescent health services, for e.g. through school health services/ schools.
- Increased and appropriate access to family planning services and contraception (especially condoms) particularly for adolescents.
- Birth spacing – encourage at least two years between pregnancies to reduce intra-uterine growth retardation.

6.2 Good maternal and child nutrition

Effective interventions are available to reduce stunting, micronutrient deficiencies, and maternal and child deaths. The Lancet Maternal and Child Undernutrition group have identified ‘core’ and ‘optional’ interventions (Bhutta et al., 2008). Many of the ‘core’ options are already offered in SA, although coverage and quality vary. However, there are some ‘core’ interventions that should be incorporated (Table 6).

Table 6: Core nutritional interventions to be considered in SA

	Existing interventions	Comment
Maternal	Iron and folate supplementation	No programme data
	Maternal iodine through iodization of salt	Iodised salt widely consumed in SA
Newborn	Promotion of breastfeeding (individual and group counselling)	Support for breastfeeding has been weak. New (Tshwane) declaration of support by National Department of Health
Infant/ child	Zinc in management of diarrhoea	Severe constraints in zinc availability related to registration as a drug by Medicines Control Council
	Vitamin A fortification or supplementation	Good implementation in infants, but poor carry through to 1-5 years
	Universal salt iodization	Iodised salt widely consumed in SA
	Treatment of severe acute malnutrition (using WHO guidelines)	Variable implementation of guidelines. Poor outcomes generally at most SA hospitals
	New Interventions	**Comment**
Maternal	Maternal calcium supplementation	Should be relatively easy to append to current iron/folate supplementation
	Balanced supplements of energy and protein in pregnancy	Would be made available to women in districts where >10% of women have a body mass index <18.5 kg/m^2
	Behaviour-change communication to reduce substance abuse, particularly alcohol and smoking	Strategies would target high-risk communities and districts, and include individual counselling.
Infant/child	Behaviour-change communication for improved exclusive breastfeeding and complementary feeding practices	Few efforts currently in this field. Will require substantial resource investment.
	Hand-washing or hygiene interventions (water quality treatment, sanitation)	Ignored. Not viewed as a health system responsibility.

Interventions for maternal nutrition (such as iron, folate, multiple micronutrients, calcium, and balanced energy and protein supplements) improve outcomes for maternal health and births, but few have been assessed at sufficient scale in South Africa.

- Counselling about breastfeeding, and fortification or supplementation with vitamin A and zinc, has the greatest potential to reduce the burden of child morbidity and mortality.
- Improvement of complementary feeding through strategies such as counselling about nutrition for food-secure populations, and nutrition counselling and food supplements in food-insecure populations, as well as responsive feeding of young children and appropriate feeding of children when ill could substantially reduce stunting and the related burden of disease.
- About a third of SA households are food insecure so food supplementation should be offered in some provinces/districts, at least. Data from a large programmatic intervention in Haiti indicated that a preventive strategy of behaviour-change communication and food supplements for all children aged 6–23 months reduced underweight or stunting more than a targeted recuperative and food-support strategy that focused on underweight children under five years (Ruel et al., 2011).
- The type of food supplementation to be offered requires further discussion. Ready-to-use foods have become popular and are likely to have a role, although a number of alternatives exist.
- SA has a well-developed food fortification programme. However, in the absence of monitoring, some food manufacturers appear to have fraudulently absconded on their responsibility.
- While available interventions can improve stunting rates, elimination of stunting will also require long-term investments to empower women and improve education and reduce poverty.
- Evidence is accumulating internationally to show that interventions in other sectors such as agriculture and social protection that incorporate nutrition can have powerful effects on child nutrition. The same is likely to be true in SA.

6.3 Integrated maternal, newborn and child health packages along the continuum of care

The concept of essential health packages for pregnant women, neonates and children which are integrated has some appeal. Figure 5 offers an example of one such generic integrated package offered across the continuum of care and delivered at the hospital, primary care and community/family levels. A similar model could be developed to be specific for the South African situation.

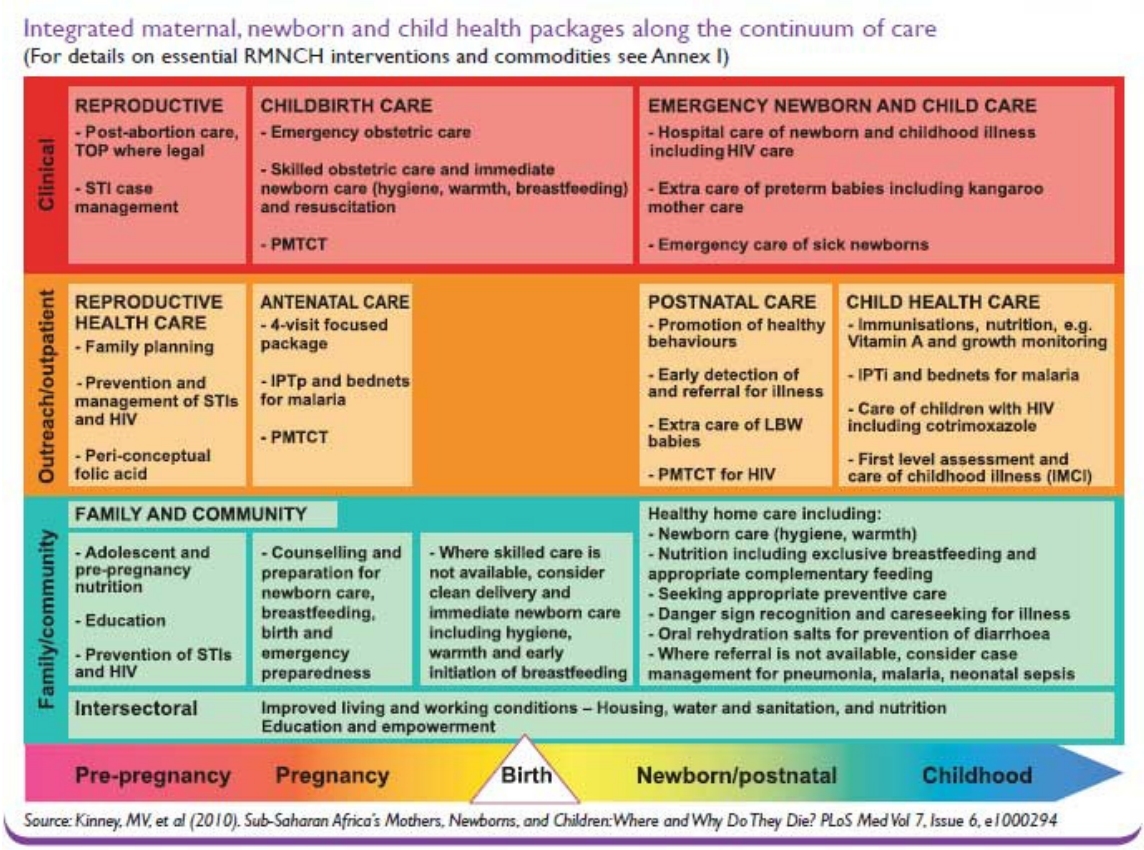

Figure 5: Integrated maternal, newborn and child health packages along the continuum of care (Kinney, 2010)

An essential package of interventions for addressing maternal, newborn and child health could include access to contraception and safe abortion services, effective screening during antenatal care, and nutrition support together with counselling about substance use during pregnancy, institutional delivery by a skilled birth attendant, emergency obstetric care for those that need it, and good postpartum care (Blaauw & Penn-Kekana, 2010).

Early postnatal care could include assessment, anticipatory guidance, and management of issues such as attachment and bonding, breastfeeding support and counselling, maternal nutrition, maternal depression, prevention of maternal and neonatal infections, family planning and social support for the mother/parents.

These could be delivered through home visits rather than depending on women to access health facilities (uptake of postnatal care visits is low) in order to benefit from these interventions. Equally as important are subsequent counselling, guidance and support on the introduction of appropriate complementary foods, age-appropriate feeding for children (quality, quantity, types of foods, responsive feeding etc.), and age-appropriate communication, play and stimulation for young children.

An HIV package would include HIV and TB prevention strategies, voluntary counselling and testing for HIV and TB diagnosis, treatment for both conditions including ART for pregnant women, and PMTCT interventions.

A community package would have measures to increase women's empowerment, community education and steps to increase service availability, affordability and acceptability, for instance.

6.4 Early identification, referral and intervention for children who require additional support for health, development and social problems

Currently children requiring support and intervention for developmental problems or disabilities are identified too late, often only at school-going age. This is especially true for children with learning and cognitive difficulties. Once identified, there are numerous difficulties in ensuring that these children (within the health and education system) receive the intervention and support they require. This is largely due to the lack of relevant health professionals employed within the health sector and the mainstream education sector, the inability of the health system to provide for the needs of these children once they are in formal education settings (Grade R/1 onwards) and poor transition from services provided within the health sector to services within the education sector for school-aged children.

Identifying high-risk or vulnerable children is the first step in providing targeted support for them, their parents/caregivers and families. One way in which this could be achieved is the establishment and expansion of routine screening programmes. This initial, and relatively easy, step needs to be followed by the increasing complexities of diagnostic evaluations, sharing of information by practitioners, formulating joint action plans with parents, locating needed services within and beyond the clinic or hospital, arranging successful referrals, and conducting on-going monitoring and assessment of intervention impacts.

There is no evidence in a South African public sector setting of these activities happening at scale within a district or sub-district. Only the Western Cape has attempted to introduce the basics of developmental screening, routine referral, and on-going collaboration with community-based programmes outside the medical system – but without great success (Shung-King, 2006). All districts confront the limited availability of accessible and affordable preventive support, other than social grants, for children and families experiencing significant adversity.

The following are the most appropriate formal opportunities for screening tests and developmental surveillance, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early year's services:

- by the 12th week of pregnancy,
- the neonatal examination,
- the new baby review (by day 7 of life),
- the baby's six to 14-week examination,
- by the time the child is one year old, and
- between two and two-and-a-half years of age.

However, there are many possible limitations and barriers to the implementation of a successful universal screening programme for child development, many of which have been discussed previously. An alternative approach to addressing the same need (and to complement existing screening programmes) in the South African context, would be to implement and expand the 'Care for Development' component of the IMCI programme, which is based on the IMCI model

of nutrition counselling. Although IMCI has been implemented in South Africa for more than a decade, we have been slow to integrate 'Care for Development' into the IMCI package. 'Care for Development' promotes a counselling approach and is generally regarded by the WHO as the most efficient strategy to support a child's development.

A counselling approach focuses on what caregivers can do to respond to the needs of their children for care and assists families to solve problems in providing care for their children. It provides guidance on activities to stimulate physical growth and intellectual and social development. Where specialised services are available, children who have difficulties, delays or deficits in their learning or development should be referred for appropriate assessment, support and intervention from trained health professionals. Key features of 'Care for Development' are:

1. It targets children most at risk, i.e. children with anaemia or low weight for age, and all children less than two years old.
2. It aims to improve the knowledge and skills of mothers/ primary caregivers and others who care for children.
3. It strengthens active and responsive feeding to improve nutrition and growth.
4. It introduces activities to improve interaction with children, to stimulate growth and learning, and to promote responsive care for the child's health
5. It recommends specific play and communication activities to help children move to the next stage in their development.
6. It aids families to solve problems in providing care for young children.

This approach is attractive in the South African setting as it does not rely on the availability of appropriate developmental screening tools (which often only identify children with moderate to severe developmental problems), appropriate testing environments and the availability of test resources/ tools, the level of skill (and training), and experience of the health professional conducting the test and the availability of appropriate responses when a problem is detected or a child's growth or development falters. Working from an asset-based perspective and building on the skills and strengths within the caregiving and family unit, enables all parents/caregivers to be empowered in providing age-appropriate and responsive care to their young children.

However, utilising these opportunities will require a substantial and fundamental shift in the approach taken by health staff undertaking, and the health service providing, these activities currently. It requires a movement away from performing a quick and simple clinical task such as abdominal palpation or immunisation delivery to questioning a caregiver about a child's development, for instance, performing basic assessment procedures, offering counselling and initiating a referral if warranted. Although this might appear to be exactly what should be expected of any competent health worker, resistance to this "shift" is predictable for a multitude of reasons, including health workers aversion to counselling activities (Chopra, Patel, Sanders, & Peterson, 2005).

An attractive idea is to introduce standardised assessment/screening tools that extend beyond developmental milestones or need but that identify family or community level factors that make children vulnerable to toxic stress (e.g., food insecurity, maternal depression, parental substance abuse, domestic or community violence, poor social connectedness). The

implementation difficulty may lie in assigning this task to a particularly agency. Health professionals, such as nurses, would argue that time constraints prevent this becoming a routine clinic-based activity. Of course, routine screening for increased vulnerability is only helpful if collaborative relationships exist with local services to address the identified concerns.

Measures that would be required to allow early identification, referral and intervention for children requiring additional support may include:

- Increased caregiver and community awareness of typical child development and when to seek help
- Input into ECD practitioner or community health worker training for early identification and referral of children
- Better referral systems between different levels of health care
- Better use of Road to Health Booklet developmental screening tool at primary health care level
- Integration and expansion of the 'Care for Development' component of IMCI at the primary care level, with a stronger counselling focus
- Development of a co-ordinated and integrated early intervention framework/system for children with identified disabilities, developmental difficulties and targeted activities/ interventions for those children most at risk of developmental problems.
- Collaborative working and transition planning for children with identified disabilities and developmental difficulties between health and education services
- A rapid increase in the number of therapists, psychologists and support staff within the health and education (particularly mainstream education) sectors.

Practitioners carrying out child health and development reviews are expected to have knowledge and understanding of child development, and of the factors that influence health and well-being. They need to be able to recognise the range of normal development.

For children with multiple difficulties and/or vulnerabilities, the concept of a common assessment framework needs to be developed and implemented. This would be most useful where there are issues that might require support to be provided by more than one agency. Professionals who are involved in assessing the child's and the family's needs should work in partnership, and share relevant information as required.

6.5 Community-based intervention strategies

Many of the health promotion and prevention strategies within the continuum packages are envisaged to be delivered through community-based interventions that are implemented in homes, preschools and schools, as well as through an extended array of programmes organised by faith-based organizations, social groups, and recreational centres.

Primary responsibility for this activity will lie with the newly developed Community Health Worker (CHW) cadre. Among the skills expected of this individual is the ability to:

- Promote appropriate care seeking and breastfeeding support

- Provide contraceptives, cord care, iron and folate supplementation during pregnancy, anti-retrovirals, vitamin A supplementation in children, preventive zinc supplementation
- Improve diarrhoea management (zinc and oral rehydration therapy)
- Detect and manage pneumonia
- Recognise, triage and treat severe acute malnutrition in affected children in community settings.

There is a danger that the responsibilities entrusted to these individuals may be unrealistic and overwhelming, since their roles will not be restricted to maternal and child health. Ensuring the quality of care delivered by CHW's is adequate requires increased training, supplies and equipment, increased supervision by health professionals, changes in referral processes, and incentives.

There are no reliable data on the number of CHWs in the country. In 2004 there were an estimated 44,000 lay workers (home-based carers, lay counsellors, DOT supporters, etc.) in South Africa (Department of Health, 2004). Since then government introduced the umbrella term 'Community Health Worker' for these and all other community workers in the health sector. While the health department's CHW framework is oriented to the notion of a generalist CHW, the majority of CHWs in South Africa currently serve a more limited role as HIV/TB workers.

The national health department has already drawn up plans on the training and functioning of CHWS. To ensure that the needs of women and children are being met, it is critical that the CHW be supported by a team of health practitioners across the health service. Clearly, the delivery of community-based services is not the sole responsibility of CHWs.

Evidence that CHW are contributing to ECD services within a sub-district could be provided by data that there is:

- a reduction in the under-18 conception rate per 1,000 females aged 15–17;
- an increase in the percentage of women who have visited an antenatal clinic or seen a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy,
- an increase in the percentage of infants being exclusively breastfed at three months,
- an increase in the proportion of children who complete immunisation by the recommended ages,
- a decrease in stunting in children under three years,
- a reduction in obesity among primary school age children,
- a reduction in smoking prevalence or alcohol abuse among people aged 16 or over, and
- increased referrals and access to intervention for children with disabilities.

6.6 Progressive universalism

ECD should be viewed as a progressive universal service, i.e. it includes a universal service that is offered to all young children and families, with additional services for those with specific needs and risks. A progressive universal ECD service is one that offers a range of preventive and early intervention services for different levels of risk, need and protective factors.

If inequalities in children's health, well-being and achievement are to be addressed, increasing attention will need to be directed to the most vulnerable children and families, and resources allocated accordingly. One of ECD's key roles is to identify children with high risk and low protective factors, and to ensure that these families receive a personalised service. Poverty is the biggest risk factors linked to poorer health outcomes in SA.

Table 7 outlines a vision of health care delivery within the continuum of care framework of ECD services. It outlines the current situation, the situation that could be achieved fairly quickly if there is a response to the recommendations made in this report and the necessary investments made, and the ideal situation if ECD was to realise its potential.

Table 7: The current, possible and future state of maternal and child health care delivery within an ECD framework

Current situation	Possible situation	Future situation
No core programme or package of services supporting maternal and child health and development	Minimum core programme or set of activities (universal package of services)	Universal core package , plus programme and services to meet different need and risk (progressive universalism)
Variation of service provision according to location	Less provincial and district variation in service provision (greater equity)	Variation in provision according to individual need and risk
No focus on maternal and children's services	A greater focus on maternal (antenatal) and children's health (MCH) services	Greater integration of MCH, with family services being offered
Separation of maternal and child health services	Integration of maternal and child health services	Better integration and information sharing between maternal and child services, as well as reproductive, school health and adolescent services, and child and adolescent mental health services
A programme that deals opportunistically with problems	A programme that looks for problems, deficits and risks	A programme that looks for and builds on strengths and protective factors – as well as risks
A focus on treatment	A focus on surveillance and health promotion and prevention	A greater focus on parenting/ caregiving and family support, as well as surveillance and health promotion/prevention

Current situation	Possible situation	Future situation
Little focus on individual needs during consultation	A focus on individual health promotion during face-to-face contact	Consultations to use skills and tools that promote behaviour change. Better use of media and social communication tools.
Well-child service centred around immunisation	Well-child schedule influenced by physical developmental stages and screening tests	Well-child schedule determined by social and emotional developmental stages, parental receptiveness and parents' priorities
Limited needs assessment	Active assessment of current need	Assessment of current need and future risk
Programme delivered by nurses (and by doctors for a few)	Programme delivered by a team of health practitioners (e.g., doctors, dentists, nurses, allied professionals, community health workers)	Programme managed by home visitors (nurses, CHW), drawing on a range of practitioners, and delivered through home visits, primary health care centres and early childhood care and education settings.
Limited supervision. Little focus on quality improvement and outcomes.	Increased supervision. Focus on quality improvement and outcomes.	Regular supervision. Monitoring of quality and outcomes of teams and individual practitioners
Limited integration between key sectors and agencies at all levels of planning and implementation for ECD, e.g. National (and provincial) Departments of Health, Education and Social Development	Increased levels of integration between key sectors and agencies responsible for ECD planning and provisioning	Collaborative working between all relevant sectors responsible for ECD (e.g. Health, Basic Education, Social Development, Public Works, Water and Sanitation, Agriculture etc.) and integrated service delivery wherever possible.

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Background Paper 5

Parenting

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Key Points

Issues

- Parenting is the most important influence on the health and development of young children. Positive parenting is facilitated by economic and social security, social support, harmonious relationships with partners, and access to services to deal with challenges.
- Nearly two thirds of young children in South Africa live only with their mother, and little is known about support from fathers.
- Parenting can be promoted through media programmes, group programmes working out of health and educational facilities, and home visiting.
- Welfare White Paper, Children's Act and NIPECD recognise support to families as a key component of ECD programming and there is movement in this direction. However, currently the bulk of resources are directed at ECD centres. Financial resources, including the child subsidy, subsidised training opportunities and departmental staff are primarily engaged with site and programme registration.
- Norms, standards and regulations under the Children's Act do not adequately capture the range of home- and community-based programmes supporting parents so that these can be resourced and monitored. The NELDS cuts across settings but there are aspects that may not be covered in all programmes supporting parenting, depending on the specific focus of programmes.
- Home visiting and other forms of parenting support can reach very vulnerable families and link them to holistic ECD services. However, there are no funding norms for home- and community-based programmes, and this is challenging for budgeting and roll out.
- Many community development workers responsible to different departments are in touch with primary carers of young children in the course of their work but this opportunity has not been used to promote and support parenting, to link young children to services and to deliver key messages to promote the development and health of very young children.

Recommendations

- Mount on-going media campaigns to promote and support parenting and to deliver messages to help parents be more confident, engaged and effective in the care of their young children.
- Make use of community-based workers, especially those who visit homes, to reach the most vulnerable families and support parents. Such workers should be in sufficient concentration to have reach and they should be linked to supportive and functional nodes for oversight and training, such as clinics, ECD centres, schools, churches and NGOs.

- Amend norms and standards, develop funding and provisioning formulae and an appropriate funded human resource development strategy to allow for the scale up of parenting programmes.
- Develop an integrated framework for the range of community-based workers from different sectors who interface with children in their work, so that they can be trained in and deliver simple key messages in support of parents and young children and refer them to appropriate services when needed.

Parenting

1. The importance of parenting and the family for young children's health and development

Parenting is a generic term for describing the processes of promoting and supporting the development and socialization of a child. Under most circumstances, children will be parented by their mother and/or their father; but the process can also be independent of biological parenting, so that a child may also be parented by a grandmother, an aunt, a foster-mother and so on. In many non-Western cultures, children are parented by several people with all of whom they have intimate and secure relationships. This is true in southern Africa, where African families regard the siblings of a mother or father as "big mother" or "little father" to the child, depending on birth order (Chirwa, 2002; Verhoef, 2005).

For the earliest period after birth, the vast majority of children will be cared for by their biological mother, especially while the baby is being breastfed. However, infants develop attachments to all the people with whom they have regular loving contact, including their father, if he is present, siblings and other people living in the household (Levitt & Cici-Gokaltun, 2011). And these people develop parenting motivations and emotions – the desire to care for and protect – towards the infant (Papousek & Papousek, 1987).

This circle of people usually constitutes "the family" for the child, and may comprise both biologically related and non-related people, depending on the cultural, social and individual circumstances (Demo & Allen, 2000). In the first three years of life, the family is the most important determinant of the child's experiences of the world. And, for most people, their family remains a fundamental influence on their behaviour, values, and achievements for all of their lives. This is conceptualised in Bronfenbrenner's (1986) biopsychosocial ecological model (see Figure 1), with the child at the centre of parents and family, called the proximal or near environment. The family, in turn, is nested amongst kin and neighbourhood, and interfaces with a variety of services and other institutions, such as schools and clinics. This constitutes the social and economic context in which a child develops, and all are situated within a broad cultural environment, such as pertains in a country or a region.

The proximal environment of the young child is the family - materially, socially and psychologically. Parents and family directly influence the child's growth and development by what they do or not do. They also mediate the impact of the broader environment on the young child (Richter, 2004a). A clinic per se only impacts on a child in a limited way in terms of the quality of drugs available or the competence of the staff. The substantial impact on the child occurs through the way the parent interacts with the clinic – how often they go to the clinic, how they understand and implement the advice they are given and so on. Similarly, while many families may have to live in unsanitary conditions, some parents are able to take precautions to protect their children, by washing their hands often, boiling water before using it, disposing of faeces etc., all of which protects a child from infection.

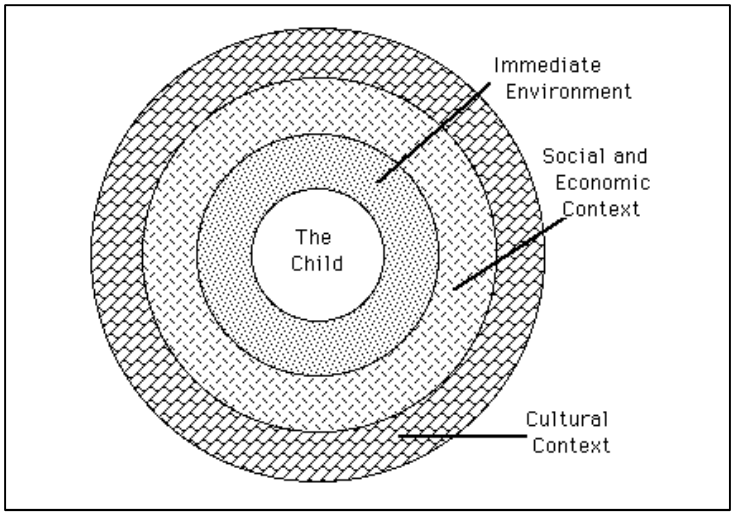

Figure 1: Bronfenbrenner's (1986) biopsychosocial ecological model

Whatever the material conditions in which a family lives, or their specific cultural child care practices, children's healthy neurophysiological, physical and psychological development of a child requires nurturing, consistent caregiving by responsive parents (Richter, 2004b). Inadequate, disrupted and neglectful parenting has immediate and long-term adverse consequences for young children's survival, health and development (Shonkoff et al., 2012).

2. The importance of consistent caregiving by responsive parents

Two aspects of parenting are especially important for young children – consistency and responsiveness (Bowlby, 1988).

Consistency, or stability, of caregivers' presence and behaviour is very important for young children because they develop and consolidate their perceptions of the material and social world, and their sense of self, through their ongoing interactions with their intimate caregivers. This process, called attachment, is highly susceptible to disruption in the first two years of life (Ainsworth, 1979). Children who are separated from their parents at a young age, or whose parents behave in inconsistent, unpredictable or punitive ways develop insecure attachments. Such children may be inconsolable when they are separated from their caregivers, generally fretful, and are often not able to explore the world cognitively with the same confidence as securely attached children (Grossmann et al., 2008). Their internal working model of other people's social behaviour is also not secure and they may become distrustful of others, disrupting their ability to develop mutually rewarding personal relationships (Mikulincer, 1998). The quality of children's early attachment relationships is predictive of their competence by school-age and later (Hartup, 1989).

Responsiveness to a young child refers to the emotional availability of an adult to be sensitively aware of a young child's needs, as well as the capacity to respond in an appropriate way that facilitates the child's adaptation and development (Dunst & Kassow, 2008). Sensitivity and responsiveness are key components of the development of secure attachment in young children (De Wolff & van Ijzendoorn, 2006). Emotional availability of caregivers - the ability to observe

and respond to a young child without emotional distortions and distractions - is the critical component of parent-child emotional engagement and parenting as a whole (Biringen & Easterbrooks, 2012). In fact, emotional and motivational states drive parenting (Dix, 1991). The overall beneficence of parenting intentions – the desire to promote a child's wellbeing with love and caring – frequently guides parents to respond in the most developmentally appropriate way towards young children.

Because parenting is so fundamental to children's development, a primary aim of ECD programmes is to promote and support positive parenting. Because parenting is an emotionally driven process which is influenced by parents' own experiences, beliefs and expectations, a number of factors are known to affect parenting. These include:

1. Socioeconomic status – poverty exerts a pervasive influence on parents' capacity to be emotionally available to a young child and very low levels of parental education affect parenting skill (Walker et al., 2007). Long work hours, stresses associated with unpredictable circumstances and persistent worry are associated with irritability, a tendency to restrictiveness and physical punishment and lower levels of verbal interaction with young children (Richter, 2004a; Richter, 2004b & McLoyd, 2011). Nearly two thirds of South African families experience the material stresses associated with poverty.
2. Adolescent childbearing – because of their own ongoing psychological maturation, young parents don't always have the skill or capacity to accommodate a young child's needs and demands (Klein, 2005). Available evidence from the 1998 South Africa Demographic and Health Survey is that by the age of 19 years, more than one-third of women (35.1 percent) had been pregnant.
3. Lack of social support – single parenting, minority status and social exclusion are also associated with parenting stress and socio-emotional withdrawal from young children (Armstrong et al., 2005). The General Household Survey 2010 indicates that 63 percent of children under six years of age live only with their mothers because their fathers are not in the same household.
4. Domestic violence and substance abuse – parental social or psychological disorder, including when it is expressed as substance abuse and domestic violence is associated with unpredictable and erratic parenting which may be life-threatening to young children as well as psychologically damaging (Levendovsky et al., 2011; Palmiere et al., 2010). One study in Soweto, of antenatal clinic attendees, found that more than half of all women aged 15 to 30 years had experienced physical and/or sexual violence from male partners (Dunkle et al., 2004). A national study found that about 14 percent of South Africans have a substance use disorder (Herman et al., 2009).
5. Parental mental illness – depression debilitates parenting through self-preoccupation, emotional withdrawal and inconsistent responsiveness. High levels of depression (>30 percent) have been reported amongst South African mothers (Cooper et al.,1999).
6. Children with chronic illnesses and disabilities – parenting is significantly challenged by a young child with special needs, including the stresses of care, treatment, the difficulties of maintaining routines, and anxiety about the future (Reichman et al., 2008).

A substantial body of research on adverse experiences in early childhood, including exposure to parental mental illness, substance use, domestic violence and the experience of abuse and neglect, demonstrate serious challenges to health, mental health and social adjustment well into adulthood. People exposed to adverse childhood experiences have a higher likelihood of a range of chronic diseases, psychological disorders, and social maladjustments (Brown et al., 2009; Schilling et al., 2007).

Figure 2, adapted from Walker et al. (2007), illustrates the way in which risk factors affect early child development. Parental and caregiver health and well-being which is of critical importance in early development has been added (Dawes & Biersteker, 2008).

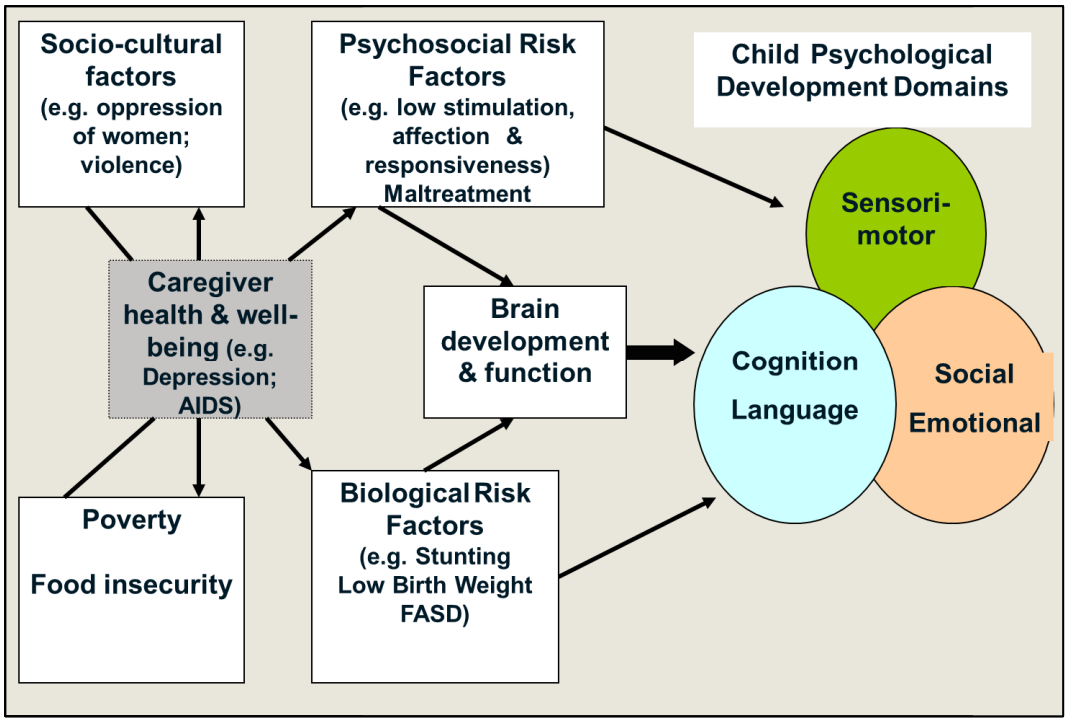

Figure 2: A Conceptual Model of How Risk Factors Affect Early Childhood Psychological Development

Principal aspects of parenting of young children have been conceptualised as caregiving actions in five areas: sustenance, stimulation, support, structure and surveillance. The latter involves ongoing parental monitoring for signs of illness, changes of mood, frustrations, attempts to accomplish goals etc. (Bradley & Caldwell, 2002). Specific parent actions in each of these areas change with children's emerging capacities. Stimulation at age three months may involve moving brightly coloured objects in front of the infant and encouraging the child to reach for them. Stimulation at three years, in contrast, may involve showing pictures to a child and asking simple questions about the images, telling the child a story or singing a simple rhyme.

Caregiver warmth, responsiveness, opportunities for play, setting controls without severe physical punishment and language stimulation are all critical for early child development and need to be included in ECD programmes to promote and support parenting; as are programmes to reinforce parental engagement, acknowledge strengths and capabilities, and foster a sense

of self-efficacy among parents of young children (Jones & Prinz, 2005). Different cultural expectations for child development and methods of childrearing may not be well aligned to the needs of the schooling system (Nsamenang, 2008) and this is an area in which parenting programmes can help parents and children make this transition.

3. Parenting in early child development programmes

The evidence for the importance of engaging parents and promoting and supporting parenting to improve child development outcomes is clear. However, in South Africa, ECD services tend to delivered directly to children and less has been done to promote parenting. This provides a significant opportunity for expanded ECD services. For all services directed at young children should to be maximally effective, they should involve parenting promotion.

Parenting promotion, or the promotion of positive parenting, can occur on several levels, including:

- Mass media campaigns to highlight the importance of parents in children's development and to communicate simple health, education and childrearing messages (Sanders & Prinz, 2008). Mass media campaigns are frequently used by the health sector, such as for HIV prevention and hand washing (http://www.wsscc.org/countries/africa/south-africa/wash-coalition-overview). But they lend themselves equally well to messaging to encourage parents to talk to their young children and to read to them, to reduce severe physical punishment of young children, to urge parents to get involved in their child's schooling and the like. In South Africa, Soul City (www.soulcity.org.za) and Heartlines (www.heartlines.org.za), among others, address some aspects of parenting, but not specifically, of very young children. A great potential exists to expand parent messaging in community radio and community newspapers.
- Parent education and support programmes can be run independently or in conjunction with health, education or early child development services (Churchill & Clarke, 2009). Many of these programmes have been developed and implemented on a large scale to address socioeconomic disparities in conjunction with early child development centres and services; for example, Head Start in the United States (Zhai et al., 2011), Sure Start in the United Kingdom (Eisenstadt, 2012) and Triple P in Australia (Sanders, 2008). Parent programmes are also sometimes timed to coincide with particular family and child transitions, for example, becoming a first time parent, having a second child, when children enter preschool or formal schooling, etc.
- Home visiting programmes for especially suitable for vulnerable groups, including marginalised parents, very young parents, parents of children with special needs, and other groups of parents at high risk for family problems that will affect a young child's development. One of the best examples of a demonstrably effective home visiting programme is that devised by David Olds, called the Nurse Family Partnership. The programme targets first-time, low-income mothers from pregnancy through to the child's second birthday. It employs well-trained qualified nurses who use manualised guidelines during their weekly, and sometimes bi-weekly visits (Olds, 2006). A home-visiting

programme for low birth weight babies in South Africa conducted by mentor mothers found that children in the intervention group grew significantly better than the controls (le Roux et al., 2011).

- Community-based parent support groups can take many forms, including play groups led by volunteer mothers or community workers (Rahman et al., 2008).

In all types of programmes, the aims are to:

- Help parents develop and improve their parenting knowledge and skills;
- Enhance the family environment for children's adjustment and learning;
- Foster a sense of competence among parents, and
- Strengthen the ability of parents to use available services and resources to maintain their wellbeing and that of their children (Chandan & Richter, 2009; Rodrigo et al., 2012).

Evaluations of parenting programmes show that, to be effective, interventions need to be sustained over time, to occur frequently, be appropriately targeted, conducted by well-trained staff, and involve parents as partners in the process (Dawes, Biersteker & Irvine 2008; Shonkoff & Meisels, 2000).

Parenting programmes frequently aim to improve cognitive stimulation and problem behaviours among children. In the ECD sector in South Africa parenting programmes are generally much more holistic, bar those serving middle to upper income groups.[1] Even where an ECD parenting intervention may have an educational focus as its primary aim, in work with vulnerable families, circumstances necessitate additional assistance with basic needs and psychosocial support. Parenting programmes in South Africa, and particularly those delivered through home visiting, have a strong focus on supporting families to be able to manage child nutrition better, provide a safe and hygienic environment, stimulate their children's curiosity and intellect, and cope practically with childrearing. Linking to social grants and services is also a key component of South African ECD parenting programmes. In 2007 two thirds of programmes identified in a rapid appraisal facilitated access to documents and grants and referred families to health and social services. Fifty percent assisted families to obtain basic necessities through income generating activities, self-help groups and food gardens (Biersteker, 2007).

4. Innovations since 1994

This section summarises key policy and programming milestones for children under five in the Departments of Education and Social Development. These policies are informed by the Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child, and Sections 28 and 29 of the South African Constitution.

[1] Personal Communication, Inge Wessels, UCT Psychology masters student developing a local data base of parenting programmes.

The Moscow Framework for Action and Cooperation (2010) was developed to address challenges of implementing Education for All Goal No 1. To increase access and scale up services it calls on governments to:

> *"Develop and expand parenting programmes to orient families in good ECCE practice, with particular emphasis on the 0-3 year old age group."* (Section 11 ii)

> *"Empower and strengthen the capacity of parents, families and service providers, so that they can provide protective relationships, quality care and education to the young child"* (Section 12 ii).

The summary in Table 1 below makes a judgement on whether progress has been good, fair or poor. The basis for these assessments is presented in the subsequent sections.

Table 1: Summary of Progress with Policy Implementation related to Parenting Programmes for Primary Carers of Children 0–4 Years

Good progress	Fair progress	Poor progress	
White Paper on Education and Training 1995			
"Education of parents going hand in hand with that of the education of children"			
Integrated definition and servicing perspective of ECD, recognising that service delivery depends on partnerships both intra-governmental and with other stakeholders.			
"Effective integration and promotion of ECD services for young children and their families".			
Interim Policy for Early Childhood Development 1996			
Took a broad integrative approach to ECD services (following the 1995 White Paper), including "programmes aimed at reconstruction and development which address the basic needs of families for shelter, water and sanitation, primary health care, nutrition, employment and adult basic education".			
White Paper on Social Welfare 1997			
Primary target for ECD services would be given to disadvantaged children under five years. Within this group urgent attention would be given to children birth to three years and disabled children.			
Accepted that no single model or programme is appropriate to meet the varied ECD needs of families and a range of options will be made available including centre-based services, part day programmes and family programmes.			
Reinforcing programmes would be offered by existing role players (government, local government, NGOs, CBOs and parents). In under-serviced areas ECD services would be initiated through community development interventions.			
Promoting subsidisation of varied ECD programmes: centre-, community- and home-based, with means-test as a criterion			
Rooting ECD services within the community			
Increasing access of young children to ECD programmes (through promotion of home based and community based facilities for day care, targeting at risk communities, sustaining programmes in communities that are remote and isolated).			

Good progress	Fair progress	Poor progress
Providing appropriate ECD programme options (day care, stimulation, health and nutrition programmes)	
Inclusion of children with special needs in the mainstream	
Inter-Ministerial Committee on Children and Youth at Risk (1995 - 1999)	
Identified four levels of intervention: Prevention, Early Intervention, Statutory Process, Continuum of Care.	
Some strategies at the level of prevention with relevance to the children under 5 included: A range of early childhood care and development programmes in each community Parent education and support Sufficient day care	
National Integrated Plan for ECD, 2005 (DoH, DoE, DoSD)	
Interdepartmental initiative (led by DoSD) to coordinate and integrate service delivery to young children at home, in the community and at centres including access to social security, primary health care and nutrition, birth registration, psychosocial support and early stimulation.	
Access target of 2.5 million to 3 million poor children: Social security & birth registration Primary health care and nutrition Psychosocial support & early stimulation	
Explicit provision for working within family providing psychosocial support	
Children's Act No 38 of 2005 as amended (key points only)	
ECD age definition: children up to school going age (ie. DoSD mandate)	
Recognises multiple forms of ECD programming (Chapter 6)	
Chapter 8 Prevention and Early Intervention focus on supporting the family - developing appropriate parenting skills and the capacity of parents and care-givers to support best interests of child ECD identified as one possible Prevention and early intervention programme	
National Early Learning Development Standards (NELDS) DBE 2009	
Curriculum-related policy initiative focusing on the early learning needs of children from birth to four: Stakeholders involved in validation process (practitioners, parents) and an age validation Specifies desired results (competencies to be achieved in formal programmes and at home	
Minister of Social Development's commitments launched as part of the ECD Awareness campaign 2011.	
Rural and informal settlement strategy for ECD. 1 million 0-5 year olds accessing ECD services and programmes.	
Green paper: Promoting family life and strengthening families in South Africa 2011	
Family support refers to mobilising support for children's normal development in adverse circumstances. Recognises that developmental family support includes parent education and that	

Good progress		Fair progress		Poor progress	
compensatory programmes to help with disadvantage and diversity include high quality day nursery programmes for preschoolers. Recognises role of professionals or para-professionals, in health, social services or education as service facilitators or deliverers					

5. Current provision – services and programmes

In this Diagnostic Review, we have conceptualised three overlapping aspects of ECD provisioning – childcare, parenting and the provision of learning opportunities for young children, as illustrated in Figure 3.

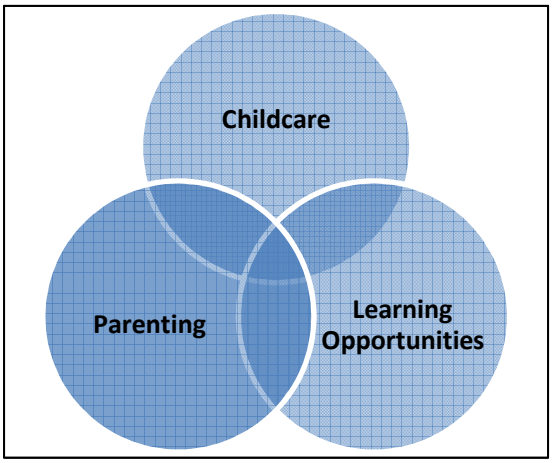

Figure 3: Components of ECD provisioning

While this input paper focuses on parenting in ECD, it overlaps with other key aspects of ECD provisioning, particularly childcare and children's opportunities to learn. Parents should be assisted to provide childcare and learning opportunities themselves, which may be complemented by external services. There is frequently a combination of approaches, when children participate in childcare programmes with a stimulation component and parents attend a parenting programme to enhance their skills and capacities and to receive social support.

5.1 Coverage

There is no information on the extent of parenting programmes of different types in South Africa. Many are run by faith groups, volunteer groups and NGOs. This will remain the case until ECD programme registration is fully operational or there is a national audit; though many private activities will continue to operate under the radar as community and neighbourhood activities. One of the challenges is how to measure the target of such programmes. If the primary carer is targeted the reach may be all current and future children up to five years for whom the caregiver will be responsible. Many programmes talk of children directly and indirectly reached.

Since 2009, the General Household Survey has attempted to capture the number of children benefitting from an ECD programme in centres, at home and elsewhere. The at home category

appears to be an attempt to answer the question of how many children are reached through non-centre programmes, some of which would be parenting programmes. However the question is vague as to what exposure constitutes - “Is (child 0-4) exposed to an early childhood development programme in any way? ECD refers to the emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of a child”. The information that can be derived from this is unclear.

Table 2 summarises GHS 2009 and 2010 responses about ECD exposure.

Table 2: Percentage of Children 0 – 4 Years exposed to an ECD programme by age and location

Age	0-2 years		3-4 years		0-4 years	
	2009	2010	2009	2010	2009	2010
Exposure to ECD programme	35	56	56	74	43	63
At home	24	49	26	52	25	50
In a centre	8	6	29	20	17	12
Not applicable	65	44	44	26	57	37

Source: Statistics South Africa (2010, 2011)

Discrepancies in responses between the two years (2009 and 2010) as well as the very low proportion who responded that the child was exposed to an ECD programme in a centre, suggest that respondents were uncertain about what they were answering. Accepting that 43 percent of children were exposed to an ECD programme in 2009 and 63 percent in 2010 would, in all likelihood, significantly inflate the numbers of children who are exposed in terms of the definition of ECD programmes in the Children’s Act.

Supporting and educating primary caregivers is much less well developed as an ECD strategy in South Africa than programmes directly targeting children, even though it is a policy priority of the National Integrated Plan. However it is growing, stimulated by donor interest and in some provinces, notably the Western Cape, provincial departments have been allocating programme funding for this.

In 2007, a study involving snowball sampling identified 45 projects in all provinces (five offered more than one model), mostly targeting vulnerable young children via their primary caregivers (Biersteker, 2007). Over 70 percent had been initiated post-2000. Since then, there has been expansion and, in particular, the inclusion of an ECD component in many other programmes targeting households; for example, in the National Association of Childcare Workers *Isibindi* programme, in HIV and AIDS support initiatives and in community development approaches.

In addition, the Department of Social Development with support from UNICEF, in recognition of the importance of parenting, produced a manual and offered training of trainers for all provinces in 2008. However, no funding or support and monitoring structure was put into place for NGOs who were trained to roll this out, and it is unclear whether or how widely this resource is being used.

5.2 Programmes

Parenting programmes are often spoken of without distinguishing the different levels of intensity and duration. It may be useful to think of programmes in three categories:

- *Awareness Programmes* – light touch programmes, aimed at the general public or local communities as a whole, through information sharing meetings, media campaigns, and workshops with very large numbers of participants**.** These are essential for raising awareness, creating demand for services, and facilitating an enabling environment for children's development.
- *Education Programmes* – programmes with several sessions offered over a period of time to particular target groups in a group setting. Participants are the primary carer. The focus may include health and nutrition information, behaviour management, toy making and stimulation and other ideas for promoting children's development.
- *Capacity Building and Support Programmes* – are more intensive programmes delivered either on a one-to-one basis or in groups. They usually combine inputs to primary carers and children. It is in this category that there is the strongest focus on practical support to caregivers in areas such as managing nutrition better, coping with childrearing (including facilitating attachment between parent and child), providing a safe and hygienic environment, and stimulating their children's curiosity and intellect. Some of these programmes are targeted to very high risk groups and situations.

In a targeted strategy, these types of parenting interventions can be depicted as follows in Figure 4.

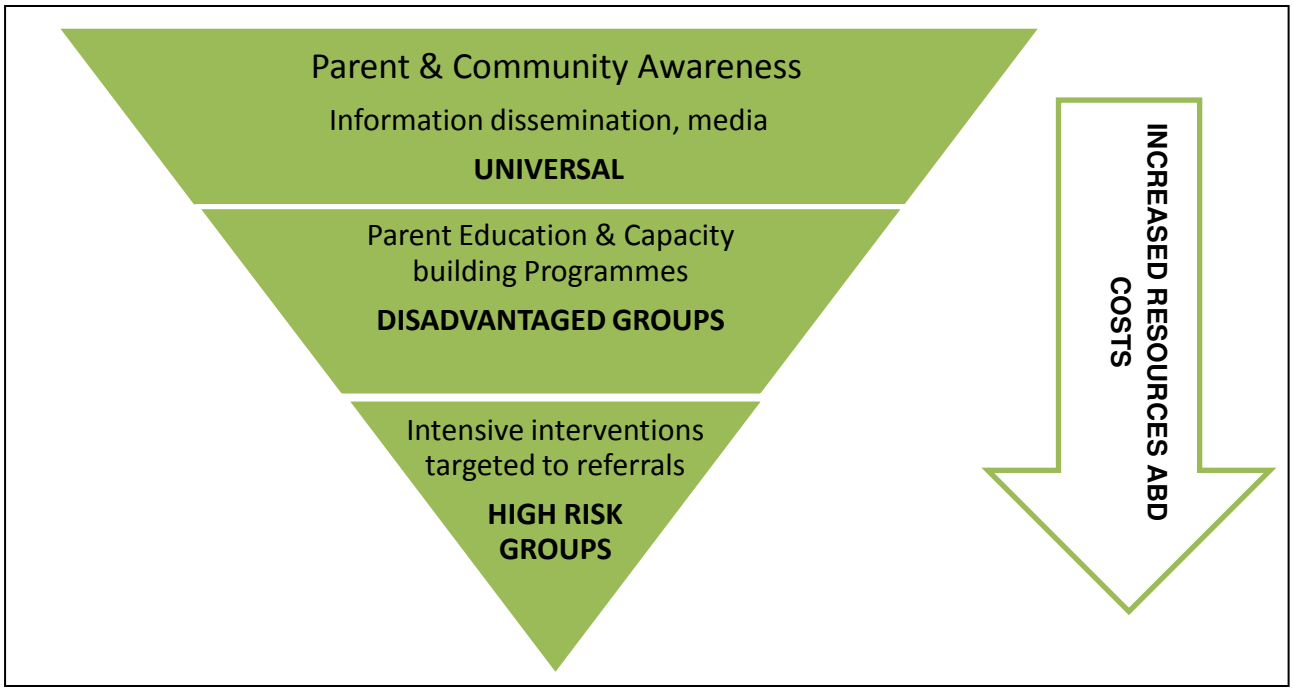

Figure 4: Parenting Interventions at Different Levels of Scale and Intensity

Targeted programmes may not be taken up because of stigma. There is also the danger that they may not reach those who need them most because screening procedures are costly and fraught with difficulties in a context of scarce services and limited human resources. However, there are families who are in greater need for both prevention and early intervention services and the evidence is that it is these who will benefit most from programmes. Cost and staffing considerations also make targeting essential. Among possible modes of delivery are media programmes, home visiting and group sessions.

Interventions often include combinations of approaches and delivery mechanisms with some group activities accompanying home visiting approach or some home visits to support a group activity (Biersteker, 2007). A parenting component may also be available for parents of children attending ECD centres. In the context of this input paper, this is restricted to more substantial parenting inputs and does not include involvement in governance or support for the ECD centre or awareness activities.

5.2.1 Parent and community awareness programmes

The purpose of these programmes is to develop and raise awareness of the importance of the early years and of how to support early development, simultaneously creating a demand for services.

1. Media initiatives aim at wider awareness raising for parents. A study to inform SABC Education ECD content in 2006 identified the following examples:
    a. A television series sponsored by Nestle broadcast in the mornings which key informants felt was well structured and good on babycare, health and nutrition;
    b. The DoE ECD Media Campaign 2003/4 which included TV, radio and pamphlets aimed at helping parents and the overall community to understand the importance of involvement in ECD had generated a keen response with phone calls from parents, ECD practitioners and schools asking questions about where to place children, admission ages, programme quality etc.;
    c. Radio Lesedi in the Free State has broadcast ECD messages on activities for children for many years;
    d. NGOs in the Western Cape raised grant money in 2004 for broadcasting radio slots in Xhosa for parents. Half-hour programmes at 8pm in the evening included inputs on different topics e.g. child abuse, fathers' involvement with children, discipline, special needs followed by a phone-in for questions and comments. The response was very good with many phone calls from parents, including fathers. The majority of the calls were from the rural Eastern Cape.
2. Several ECD service providers engage with multiple stakeholders at local level (e.g. Lesedi, ELRU, Khululeka, TREE, LETCEE, Golang Kulani) through community meetings, and may set up childcare forums or other structures to create a safety net for young children. This can be effective in creating demand for services as well as for improving government service delivery (e.g. Dawes & Biersteker, 2011).

3. Another approach has been to spread messages to captive audiences of parents, for example, while waiting at health facilities e.g. ALLSA toy libraries on treatment days at some Johannesburg clinics, the Grassroots *Queue Education* programme.
4. The suggestion that basic parenting skills are included in the schooling curriculum has been put forward a number of times and could be included in the life orientation curriculum. Child-to-child programmes with older children taking a role in support of younger children have been effective in spreading health messages in KwaZulu-Natal (Radebe, 1997) and with school readiness activities in Botswana (Bernard van Leer Foundation, n.d.) and Ethiopia.[2]

5.2.2 Parent education programmes

While there are parent education components in both *Awareness* and *Capacity Building and Support* Programmes, this group of programmes works only with parents/primary caregivers, usually for a limited number of group sessions.

Examples which illustrate different goals include:

- The Ntataise Parent Support Programme for parents of children at preschools, is based on the Abecedarian learning games with caregiver support elements and information on brain development. It is a 10-session programme delivered by trained ECD centre supervisors. Parent attendance is too inconsistent to assess parenting and child outcomes (Dawes & Biersteker, 2011).
- COUNT which offers training workshops on family maths, literacy and lifeskills for caregivers.
- Toy library programmes where parents are instructed on the use of the educational materials.
- The Parent Centre's Teen Parenting programme aimed at young parents with their own children or those heading households. This is offered at schools and in community venues and has been valuable in providing support not only for parenting but for young people who continue to pursue their studies.

For other examples, see Biersteker (2007).

Attendance at parent education programmes has often been found to be irregular and this is a serious limitation with curricula that cumulatively build on previous sessions. In the Sobambisana interventions, which all targeted vulnerable caregivers in three different parent education programmes, between a quarter and two thirds of parents attended more than half of the sessions (Biersteker, Dawes et al., 2011). Reasons for this included distance, caregiver responsibilities or health, and conflict with piece work opportunities. Attendance is reported to have been better for more motivated, coping carers (Dawes & Biersteker, 2011). However, attendance has been more regular in other projects, for example, in three sites as part of the Integrated Serviced Land Project ECD Pilot (Biersteker, 2006).

[2] https://ccie-media.s3.amazonaws.com/wf09_agenda/38_waninge.pdf, Accessed 21/12/2011

5.2.3 Capacity building and support programmes

Home visiting has been the most effective way to identify and reach vulnerable families with 90 percent or more participation in three recent interventions (Biersteker et al., 2011). Despite the cautions about its outcomes, it is a promising strategy for helping parents cope and promoting the growth and development of young children, including their school readiness (Lewin et al., 2010; Paulsell et al., 2010; Weiss & Klein, 2006). Two-generational programmes that involve direct activities with the child and training with the parent, plus joint activity with both, are considered promising approaches to improve children's cognitive and language development (Dawes, Biersteker & Irvine, 2008).

South African programmes include various forms of home visiting in which trained community members visit vulnerable households to provide support to children and their caregivers. The actual support usually has an educational component the for primary caregiver and/or child, as well as psychosocial and instrumental support to the caregiver, for example, accessing documents, grants and services. The degree to which particular service elements are prioritised depends on the focus of the programme e.g. Community-IMCI, nutrition rehabilitation, interventions to support attachment and prevent neglect and maltreatment, or educational home visiting programmes.

Examples of home visiting programmes for which there is some evaluation data include:

- HIPPY South Africa is Gauteng- based, and is an adaptation of an international educationally focused programme for 4-6 year olds and their caregivers. It runs 30 weeks a year for two years. This model has not yet been evaluated in South Africa but the well-known version of HIPPY, the Turkish Early Enrichment Programme (TEEP) showed a range of positive improvements, including enhanced maternal sensitivity and responsiveness to their children and improved cognitive development among children (Kagitcibasi, 1996).
- The Parent Centre Infant Home Visiting Programme which is targeted at high risk mothers during pregnancy and the first six months has had positive outcomes in facilitating maternal-child attachment (Cooper, et al., 2002)
- The ELRU Family and Community Motivator Programme and Khululeka Family Home Visiting Programmes have a focus on caregiver support, child stimulation and linking families to services. The Sobambisana evaluation (Dawes & Biersteker, 2011) has shown improvements in service access, significant changes in hygiene and safety in the home, caregiver coping, and significant improvements on the Academic Motivation, Language and Responsivity subscales of a home environment measure.
- The Philani Nutrition Programme focuses on nutrition and caregiver support using mentor mothers as home visitors. It has had promising outcomes in relation to nutrition rehabilitation (le Roux et al., 2011).
- The Family Literacy Programme in Underberg focuses on caregiver and child literacy and Community IMCI. An external evaluation indicates that caregiver health practices have changed and that caregivers are able to share the key messages (Kerry, 2006).

- In the disability sector there are a number of home visiting support initiatives. High Hopes is an early intervention and support programme for families of deaf and hard-of-hearing infants (0-3 years). Parent advisors (professionals from different fields including education, social work, audiology) are trained in ECD, the needs of the deaf child and home-based intervention. During weekly home visits for about one hour, parents are supported and given information on language and communication options, play, amplification, behaviour and child development. Results of a small pilot study show expressive language increased by 5.1 months and receptive language increased by 4.2 months over four-month language assessment cycles (Störbeck & Pittman, 2008). Family support was particularly key to the success of the intervention and might also be applied to early intervention for children with multiple disabilities[3].

Carer and Child Playgroups are programmes which primary caregivers are expected to attend with their children to learn how to reinforce the programme at home. Some local examples are:

- The Lesedi Playgroup and Toy Bus programme in which parents, children and trained community development practitioners facilitate play (Ebrahim, Killian &, Rule; 2008; Waldie, 2009).
- Ntataise's Mosupatsela Come and Play Programme is a structured programme designed by an occupational therapist and is offered for two hours once a week. Caregivers are meant to attend with their children for input and participation. However, it was difficult to achieve regular parent participation, though children who attended more than 15 of 27 sessions showed favourable cognitive outcomes relative to children who attended less frequently.
- The Foundation for Community Work's Family in Focus programme operates in urban areas and on farms in the Western Cape and also uses play-buses to support a home visiting approach.

5.3 Providers

Parent ECD support and education services are largely provided by NGOs in poor communities or by private businesses and consultants for wealthier paying clients.[4] Some ECD centres may offer an organised programme as part of a comprehensive package. The lack of public provisioning has limited development of parenting programmes.

In order to increase the supply of providers the use of non-traditional vehicles for ECD provisioning is being explored. For example, ECD parenting support has been added to other community-level infrastructure such as Child and Youth Care Workers in the Isibindi programme, HIV and AIDS and Home-Based Care projects, and Philani Child Health and Nutrition Projects. However the effectiveness of this strategy has not yet been evaluated. It is important that the ECD focus is maintained and not diluted. In particular, attention needs to be given to what is manageable for a community care worker (often an elected community member

[3] Personal communication with Dr Störbeck, Hi Hopes (21/12/2011).
[4] Personal communication Inge Wessels, UCT

without high levels of formal education). However, the parenting component may be limited to key messages or picking up problems and referrals. Health visitors are an obvious potential group for supporting caregivers and providing stimulation messages. This is the approach taken in the Care for Development module of the Integrated Management of Childhood Illness (IMCI). A more integrated method of training in the ECD sector is essential to promote this kind of methodology.

6. Policy and resource requirements for scaling up effective parenting programmes

6.1 Policy

Regulations, norms and standards under the Children's Act need adjusting to adequately cover the range of home and community programmes with an ECD focus, so that these can be registered and monitored. The National Early Learning Development Standards (NELDS) will be the basis for programme registration with the Department of Social Development. While the desired results include children in home settings as well as centres, parenting programmes often target specific areas of development and it is unlikely that they will all offer a general programme. This therefore needs to be addressed as part of the current Review of the Children's Act.

6.2 Human resources for parenting programmes[5]

This is a relatively new area of ECD programme delivery which is intended to achieve large coverage so the need to provide for training is critical. Key points are:

- There are different types of home- and community-based programmes which vary in purpose, duration and intensity and there is no simple model of provisioning (number of groups or households per worker) against which to estimate training needs. It is urgent to determine a basic range of programmes so that this can be done.
- SAQA accredited Community Development Qualifications with ECD specialisation options have been developed at GETC (Community Development ABET), Levels 3, 4 and 5.
- There needs to be far greater integration between initiatives of the Health and Welfare Services SETA and Education Training and Development Practices SETA, because some ECD workers are pursuing the social auxiliary route and others the community development practice route to qualifications. Furthermore there are many community health workers and community development workers who could potentially offer more input to parents and families on early child development.
- To date there have been no funded learnerships with an ECD specialisation for this emerging category of workers, nor are these workers referred to in the Draft ETDP

[5] HR issues are dealt with in more detail in the separate input in Human Resource Development for ECD Programmes and Services

SETA Sector Skills Plan 2011-2016. These workers are usually elected from the communities in which they live and cannot afford the costs of training.

- Because this aspect of ECD programme delivery is relatively new and largely unfunded, there are relatively few training providers who offer these qualifications but a small and growing number have been accredited to offer some of them.
- As there is no post provisioning for home and community ECD practitioners many are stipended workers or volunteers with the result that there are high attrition rates and the loss of investments in capacity building. Skills courses with a strong practical component may be a better option until there is greater workforce stability.
- In terms of occupational registration, home- and community-ECD workers who are clearly working in ECD might best fit within an ECD Occupational Board falling under the Social Services Professions Council or alternatively in terms of a recent initiative to professionalise Community Development work, in a Professional Body for Community Development. Pros and cons need to be debated.

6.3 Systems required for programme-based support

Community-based workers must be in sufficient concentration in order to have significant reach. As they are generally locally selected and often have fairly low levels of education, it is essential to ensure that the programmes are delivered to standard. It is also critical for community-based workers to be linked to supportive and functioning health and social services system. A key question for scale up of ECD programmes targeting families is the location of support and supervisory staff.

For the short to medium term we propose that the management function is outsourced to appropriate NGOs who have experience in implementing these programmes and who can capacitate appropriate public sector personnel (e.g. health, local government, social development or education depending on the focus of the intervention) to take this on as service delivery expands.

Use of CBOs, clinics, ECD centres, churches and schools as nodes of support for units of family based workers needs to be fully explored. NGOs could provide overarching support through these. To date most programmes are supported by NGOs and CBOs, often through the infrastructure of faith-based organisations. The use of ECD centres has also been piloted. While this can be very challenging to achieve (Biersteker, 2006), the Lesedi project has successfully used 41 community development facilitators each linked with an ECD centre to provide support for 3,750 children outside of those centres (Waldie, 2009) and 900 vulnerable families. There needs to be careful examination of the feasibility of scaling up this type of initiative as well as investigation of other potential service nodes.

Some have suggested that ECD link to the current Care and Support for Teaching and Learning which is schools-based. Clinics too are an obvious service point for the needs of young children, and especially with the focus on 0-2 year olds proposed in the National Plan. Should some sort of ECD agency be set up, including district level structures, this could house field managers supported by appropriate NGOs or departments.

Currently Kidzpositive which supports care delivery to 1,500 children on ARVs in the Western Province public health system provides one example of using clinics as a node of support. An ECD support component is being piloted which includes clinic based support groups to train mothers of infants in how to engage, provides materials for age-appropriate play and stimulation in toddlers and pre-school children and support groups for mothers of young children to demonstrate methods of play to be carried out at home. In addition social auxiliaries are being trained and mentored to assist with broader issues facing the families.[6]

6.4 Financing of parenting programmes

Currently there is no funding policy or norms for the provision of parenting programmes. If these are funded by DSD it is via programme-specific service level agreements which are cumbersome for both the applicant and the DSD officials who process them. A difficulty has been that there is not a single type of programme on which to base a funding formula. Budlender (2008) has proposed a simplified application method. Ultimately though the formula will need to be per capita-based, differentiated by mode of delivery and with provision for specialist care for those with extra needs. Additional funding would need to be available for the other programme components such as training, monitoring and quality assurance.

Recognition of this cadre of workers and secure funding flows are critical to stabilise this workforce. Biersteker (2007) found that low or no stipends are a factor in high turnover of field staff which disrupts the programme and is a loss of the initial training investment. Longer hours and higher stipends tend to assist with retention of fieldworkers. In urban areas particularly, there tends otherwise to be a flow into permanent jobs, or the part time fieldworker has other piece jobs which have to be balanced with her or his tasks.

Departmental budget allocations will need to be increased, primarily within DSD as the main service provider, but also DBE for capacity building and curriculum, and in local authority budgets. There is currently a programme and funding focus on improving access to better quality subsidised ECD centres.

Funding for programmes targeting primary caregivers at community and household level is urgently needed to ensure that the services reach the most vulnerable children and families. Currently centre-based services absorb most of the ECD budget. This needs to be capped and increasing provision made available for home- and community- based ECD interventions.

7. Outcomes

Parent and child outcomes associated with specific programmes have been referred to earlier. At a more general level, many qualitative reports and case studies (e.g. Biersteker, 2006; 2007; Ndingi, Biersteker & Schaffer, 2008) suggest that there are benefits to caregivers in terms of their feeling less stressed, supported and having greater understanding and closer bonds with their young children, as well being connected with local services.

[6] Personal communication Dr Paul Roux, University of Cape Town.

However insufficient is known about what is needed to implement promising models effectively at scale. Selected interventions (based on promising evidence) in selected districts should be piloted and then progressively scaled up over a period of five years if these prove to be successful. These pilots will allow exploration of adopting less costly programme designs or technology e.g. changing ratios, reduced hours or duration of intervention, less costly human resources and the use of new technologies (Biersteker & Motala, 2011).

Key interventions to pilot include:

- Home visiting programmes for infants and children with health, nutrition and stimulation elements as the key focus areas, with parent support, using auxiliary workers and child and community care workers. Ilifa Labantwana in partnership with ELRU is currently supporting the roll-out of home-visiting in two districts of North West province, using social auxiliary workers as field managers.
- Parent and child playgroups, playbus or toy library programmes for children from three years on a part time basis (e.g. weekly or twice a week) in areas where communities cannot support full daycare.

8. Concluding points

- ECD parenting programmes, particularly home visiting, are a successful strategy for reaching very vulnerable families and linking them to holistic ECD services.
- The proposed focus on 0-2 year olds in the National Plan should include caregiver support elements.
- Parent involvement should be promoted as part of all early childhood education programmes, both formal and community-based.
- There is a need to develop a broad ECD awareness programme aimed at parents using a variety of media and building on existing platforms such as the proposed SABC Network for Education and Development which includes a Moms and Pops section.
- Promising parenting programmes should be tested at district level, not rolled out before exploratory work has been done. This should include research on the role of community care workers and service nodes.
- Norms and standards must be amended, funding and provisioning formula developed and an appropriate human resource development strategy devised to allow for the scale up of parenting programmes.

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Background Paper 6

Safe and affordable childcare

Linda Biersteker

Contents

List of Tables & Figures

Key Points

Issues:

- There is an undersupply of safe and affordable childcare, full day or after-school care, for those families who need it. This includes working or work-seeking parents, parents in full time education, parents of children with disabilities and those children whose families cannot care for them without assistance. While about 56 percent of 3-and 4-year-olds have access to out-of-home care, only 18 percent of children under 3 years and fewer than 1 percent of children with disabilities.
- Childcare is often custodial and does not always include opportunities for learning. Service quality is strongly related to fees paid, and poor children tend to have lower quality care which does not necessarily promote their development.
- There is no mechanism for regulating or supporting childminding for fewer than six children in home care, even though this is a common and appropriate form of care for very young children.
- Employer support and trade union demand for childcare is only now emerging. There are no legislative requirements or incentives for employers to provide child care facilities or support. The Public Service Draft Policy on Childcare is a welcome development.

Recommendations:

- Recognise that good quality affordable childcare is key to increasing women's participation in employment and subsistence activities, that this raises household income and simultaneously creates job opportunities in the service sector**.**
- Improve access to affordable childcare by making funding available for non–profit registered sites that do not receive the subsidy and increase the supply of registered sites through conditional registration under the Children's Act for those that meet the basic standards.
- Poor children whose parents cannot care for them without assistance and children with disabilities should receive priority for childcare and admission into subsidised centres.
- Improve quality through human resource development, regular support and monitoring including a focus on educational programmes as well as nutrition.
- Strengthen community childminding especially for infants and toddlers by drawing childminders into networks and associations run by NPOs or overseen by local authorities and funded to provide monitoring, management support, training and access to resources such as bulk buying, toy and book libraries. This could also include linking satellite homes to ECD sites, including childminders in home visiting programmes.

- Explore the role of employers (including the public service) and trade unions in stimulating demand for daycare. Consider incentives for employers providing childcare facilities, or linking with community based facilities, or other forms of support such as childcare vouchers.
- Explore legislative requirements and incentives for employers to provide childcare facilities or support.

Safe and affordable child care

1. Introduction

The National Planning Commission's target of 11 million new jobs by 2030 will require expansion of affordable, high-quality childcare to enable caregivers to look for and secure work. Paid work benefits women and, if safe and affordable childcare is available, it also benefits children. Access to childcare is a fundamental part of enabling parents to seek, enter and remain in employment (Doherty et al., 1995), and is associated with increased maternal employment and enrolment in educational activities (Ficano, Gennetian & Morris, 2006; Hofferth & Collins, 2000), and childcare not only increases women's access to employment and raises household income, but also increases employment opportunities in childcare, and contributes to job creation in the service sector. Publicly funded or subsidised childcare programs promote women's economic and social equality, enable families to become economically self-reliant and thus represent an opportunity to reduce poverty and inequality.

In creating conditions conducive to work-seeking and employment, childcare for working parents needs to be linked with other enablers, such as employment security, maternity leave (which is very extended in some countries), flexible working arrangements such as family leave, flexi-time, job sharing as well as care arrangements for children and other dependents (e.g. Grosswald, Ragland et al., 2001; Lewis & Campbell (2007); Strachan & Burgess, n.d.).

The challenge for parents enrolled in education and working or work-seeking parents is to find affordable, convenient childcare which is of good quality. In Finland, for example, local authorities must guarantee a place for every child under three. The service is free for poor parents, and better-off families pay. The centres are open for the full day and provide meals. In countries where there is little public provision of subsidisation of costs, and parents have to pay most of the costs themselves, the cost of childcare is prohibitive and poor children are likely to receive poor quality care (e.g. Dawes, Biersteker, Hendricks & Tredoux, 2010; Penn, 2008). In turn, this compromises their growth and development and puts them at risk of infection.

Being in the care of an engaged and responsive parent is the optimum care arrangement for children under two. After that, good quality opportunities to socialise with other children in structured group programmes have positive health, adjustment and schooling outcomes for children (e.g. Peisner-Feinberg & Burchinall, 1997; Whitebook, Howes & Phillips, 1990; Loeb, Fuller, Kagan & Carroll, 2004; NICHD Early Child Care Research Network, 2000). But poor quality services can be harmful to young children's development and adjustment, (e.g. Belsky, Vandell et al., 2007) which raises serious concerns about the expansion of daycare without quality. As Woodhead (1996) comments:

> "Quality issues are especially important for the very youngest children, spanning a very wide developmental range, from birth to three years. As the pressures increase on family-based care giving, so the demand for

> extended day care grows, especially for the youngest and most vulnerable children. Frequently they are accommodated within programmes intended for older pre-school children, in large groups, where there is little scope for close attention from an adult."
> Woodhead (1996:15)

The inputs necessary to ensure quality ECD programmes and service are dealt with in Background Paper 6: Opportunities for Learning input paper for this review. It is important to recognise that childcare is a component of a comprehensive national ECD programme and that full-day programmes require the same attention to educational components, in addition to care, supervision, support, nutrition, hygiene and health, as part time preschool programmes.

Whether or not parents take up childcare services is influenced by affordability in relation to their earnings, convenience in terms of location and hours and the quality of care (Hein & Cassiner, 2010). In a recent Western Cape study (Dawes et al., 2010) centre supervisors indicated that parents' understanding of quality was a programme which provided love and care, an educational programme and nutrition. Facilities for different ages, and costs, often fall short of parents' needs.

For children whose primary caregivers are not working or work-seeking, assistance with childcare may also be needed for a variety of other reasons, including:

- Parents of children with severe disabilities who need support with the continuous care of the child
- Children whose family cannot care for them (e.g. caregivers are chronically ill or disabled, or homeless)

1.1 Childcare choices

Childcare choices other than by family members, which may be unpaid or compensated in-kind include:

- *Care at home (nannies, au-pairs, domestics)*: Where income disparities are great and there are large numbers of unemployed or under-employed women, the employment of domestic workers is frequent. In South Africa, 16 percent of working women are employed in households as domestic workers, many of whom provide childcare among other services (Statistics South Africa, 2007).
- *Childminders (day mothers/family daycare providers)* who care for children in their own homes. This is often preferred for infants and toddlers and for parents who need flexible or long hours. In South Africa, the care of less than six children falls into this category. It is not regulated and childminders may not be trained to provide safe, hygienic and stimulating care.
- *ECD centres*. Care for babies and toddlers is more expensive than for older children because of adult-child ratios, and fees often reflect this.

- *Pre-primary classes*. This is an increasingly common form of provision but, as it is educationally focused, hours may be limited in which case after-care becomes a need for some children. In South Africa, Grade R is now available to about 78 percent of young children.

1.2 Workplace childcare programmes

Workplace programmes are one mechanism for making childcare more accessible and available to working parents in the formal sector. However these seldom reach lower occupational levels and exclude the informal sector. Some types of workplace assistance include:

- Company or on-site childcare centre
- Facility or facilities in the community which are linked to the workplace
- Some form of financial support (childcare vouchers, funds or subsidies)
- Advice and referral

Table 1, adapted from a recent ILO review of workplace solutions for child care (Hein & Cassiner, 2010) summarises these options and the pros and cons of each.

Table 1: Evaluation of different types of workplace support

Type of support	When appropriate	Advantages	Disadvantages
1. Company or on-site facilities	• Many workers at the same location • Feasible if most workers can bring children to work • Lack of day care facilities in community • Atypical hours or shifts which make community facilities inadequate • Focus on the breastfeeding needs of new mothers	*For workers:* • Appreciate having children nearby • Hours are often more convenient • Relation to working hours • Addresses problem of finding childcare • Can save on travel time to childcare • Facilitates breastfeeding *For employers:* • Can be useful for attracting and retaining staff and women after maternity leave	*For workers:* • May be difficult to bring the child to work • Little choice of provider • Can be waiting lists in order to access *For employers:* • Can be expensive • May be difficult to manage • Number of places is fixed so may be too many or not enough

Type of support	When appropriate	Advantages	Disadvantages
2. Linking with facilities in the community (reserving or buying places, discounts)	• When workforce is scattered • When it is difficult to bring children to work • When the workplace and surroundings are not a good environment for children • When facilities exist in community	*For workers:* • May offer more choice of provider than on-site and be more convenient • Discounts are always welcome *For employers:* • Avoids investment in own site • Gives more flexibility to adapt to the changing needs of staff • Ensures all eligible staff have access	*For workers:* • Choices are often limited to specific providers • Financial advantage may be less than with a company facility *For employers:* • May be time consuming to negotiate with different providers • May be difficult to ensure the quality of partner facilities
3. Financial support (income tax exemptions, funds, vouchers)	• When a company is small, with insufficient staff to justify more a complex system, vouchers could be appropriate • Funds as established in some US companies, for example require significant numbers of employees of one employer or of a group of employers • Possibilities and advantages are influenced by national fiscal policies affecting the employer and employee (e.g. if there is a government	*For workers:* • Allows choice of childcare arrangement • Often includes school-age children and provides after-school care • Not limited by waiting lists (available to all who are eligible) *For employers:* • Less administrative effort is needed • Can modulate the amount of support and cover all who are eligible • Can actually gain when on salary reduction basis	*For workers:* • Financial gain may be limited when based on salary reduction • Must still find an appropriate care facility *For employers:* • Have less control on how money is spent

Type of support	When appropriate	Advantages	Disadvantages
	subsidy for childcare or tax benefit for employers or employees)		
4. Advice and referral	• When different types of facilities are available in the community • When workers may be eligible for government benefits but do not profit • When workers are having difficulty finding facilities	*For workers:* • Can help when it is difficult to find or choose childcare • Useful when advice on government benefits is needed *For employers:* • Can be low cost • Less work time lost finding solutions	*For workers:* • May not help with the cost of care nor with ensuring that care facilities are available *For employers:* • May not be useful for employees and therefore underused and an unnecessary expense

Biersteker (1990) observed that in South Africa availability of suitable space for an on- or near-site facility was seen as a major challenge by some employers. A further consideration is the observation that lower wage workers may not use workplace facilities depending on the cost and hours or distance from home due to the impracticality of moving children to the workplace by public transport, early in the morning and at rush hour in the evenings. In these cases other provisioning options could be considered. These include employers forming a relationship with community childcare providers, either home- or centre-based, supporting a system of childminders to care for workers' children, voucher systems or simply supporting existing programmes in the community which also provides a benefit to parents not employed by the company (Biersteker, 1990). A further role for employers and unions could be providing parent education programmes for workers to assist them in supporting their children's development and selecting suitable out-of-home care.

The initiative by the Department of Public Service and Administration to development child care options for state employees (2011) – mainly to retain women in employment and facilitate their promotion within the system as a principle of equity – is a significant impetus for employers to consider childcare options as part of a package of incentives for employees in the formal sector.

1.3 Funding arrangements

The ILO review found that in most countries childcare provisioning costs and responsibilities are shared among various partners (Hein & Cassirer, 2010). These include workers' organisations, employers' organisations, local and national governments, and organisations specialising in providing childcare. Parents often pay a high proportion of the costs, in some cases receiving

some financial help from governments and/or their employers. Diverse systems for sharing the costs, including, in some cases, government grants or tax exemptions, mean that the actual costs of childcare to parents and employers are highly variable.

Basically, there are two main strategies for government funding of childcare:

- Subsidising services: governments sometimes provide subsidies to registered facilities based on the income of parents, the subsidy being only for low-income parents or more for them;
- Subsidies direct to parents through tax deductions on childcare expenses or transfers for those using approved childcare services with higher allowances to poor parents, often paid through vouchers. However, the value of vouchers does not usually cover the full costs of high quality care. OECD (2006) suggests that funding childcare through parental subsidies weakens government control and tends to lead to the proliferation of family daycare, characterised by lower standards and lower quality than is found in professional childcare centres.

The choice of funding strategy depends on whether there is a market-based approach to childcare; in which case funding support goes directly to parents who decide on their childcare arrangements of facility. Financing childcare demand is seen as a way of stimulating the creation of childcare services which, in this case would be mainly private, reducing government expenditure and making the sector more efficient. Canada is one example of market-provided child care with limited public provision, though some tax concessions are offered which disproportionately benefit high-income earners. Parents are the primary spenders. Costs are largely privatised and the quality of care is related to fees (Prentice, 1999). This parallels the situation in South Africa where a tax concession would benefit very few parents.

On the basis of its analysis of 20 countries, the OECD Starting Strong 11 Review Team (OECD, 2006) concluded that sustained public investment is needed in childcare (either directly to services or indirectly through parent subsidies) in order to ensure both affordability to parents and quality of services. The OECD report makes the points that if services for very young children are seen only as an adjunct to labour market policies, infants and toddlers may receive services that are weak with respect to promoting child development.

In countries with a higher government commitment to childcare (such as France, Hungary and Thailand), pre-primary school hours tend to be full day, and so can meet the needs of working parents**.** However, if government services are rooted in an education context, the needs of working parents may be overlooked. In many countries, as in South Africa with its Grade R, early childhood education programmes have expanded rapidly, but with the aim of school preparedness and with little consideration for the needs of working parents in terms of duration and flexibility of programme hours.

Employers who provide childcare support usually do so in order to attract and retain staff, reduce absenteeism and improve productivity (Biersteker, 1990; Hein & Cassirer, 2010). Evidence is stronger on the childcare attracting and retaining staff, and increasing morale, than

on desired benefits for productivity (e.g. Dawson et al, 1984; Ezra & Deckman, 1996; Goff, Mount et al., 1990; Kossek, & Nichol, 1992).

Factors influencing whether employers are sensitive to childcare issues include size and stability of the workforce (Biersteker, 1990; Glass & Fujimoto, 1995), a high percentage of female workers (Biersteker, 1990), and unionisation and worker demand (Biersteker, 1990; Glass & Fujimoto, 1995). Casualisation of labour mitigates against employer support for childcare.

Other roles that employer organisations and groups can play are to engage in policy advocacy to improve public measures for childcare. In some countries, trade unions have played a major role in raising the issue of childcare and obtaining benefits. In South Africa, NUMSA played a key role in initiating the BMW childcare facilities in Rosslyn (Biersteker 1990; Hein & Cassirer, 2010). The former Garment Workers' Union supported the formation of Grassroots Education Trust in the 1970s. This assumed a more general role in developing and supporting community ECD centres in Greater Cape Town, which served communities from which their workers were drawn.

2. Child care policy in South Africa since 1994

Table 2: Summary of progress with policies related to child care for learners, workers and work-seekers

Good progress	**Fair progress**	**Poor progress**
Children's Act 38 of 2005 – Ch.5 (Partial care) and Ch. (6 ECD programmes).		
There are no legislative requirements or incentives for employers to provide childcare facilities or support.		
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)		
Ratified by South Africa. Among the measures foreseen to prevent discrimination and ensure women's effective right to work is Article 11 2(c) which requires that "State Parties take appropriate measures to encourage provision of supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities".		
The ILO Convention (no 156) on Workers with Family Responsibilities		
Calls on government to implement measures to develop or promote community services, public or private, such as childcare and family services and facilities (Article 5(b)). **South Africa has not endorsed this.**		

Good progress	Fair progress	Poor progress

Public Service Draft Policy on Childcare
Currently in development by the Department of Public Service and Administration through a consultation process. This is a welcome development as there has been little government engagement with work and family issues

3. Current provision, services and programmes

3.1 Child care provision in South Africa

Daycare needs have shaped the form of ECD provisioning in South Africa and the majority of centre-based provision is full day. In 2000, ECD centres or crèches providing 8-12 hours of care accounted for 91 percent of provision (Department of Education, 2001). Recent data from the Western Cape found 92 percent of 1,450 ECD sites operated for eight or more hours a day (Biersteker & Hendricks, forthcoming).

General Household Survey data for 2010 gives some indication of the use of formal ECD for day care: access to centres is lower for children aged 0-4 in the poorest households where parents are least likely to be employed (only 17 percent for children in households expending less than R800 per month, compared with 40 percent in households expending R10,000 or more).

Table 3: Percentage of children with access to ECD centres by age in 2009/2010

	0 - 2 years		3 - 4 years	
	GHS 2009	GHS 2010	GHS 2009	GHS 2010
RSA	16	18	56	56

Source: Statistics South Africa, General Household Survey 2009/ 2010

Table 3 above shows that there is very limited access to out-of-home care for children 0 to 2 years, but this increases sharply for 3 and 4 year olds. Children in the 5-6 year group are not covered by this question in the GHS but a portion of them are in Grade R programmes in community sites, in many of which their daycare or after-school needs would be covered.

After-school care is an important consideration for all children in public Grade R classes and indeed for the whole Foundation Phase.

According to the 2008 NIDS in Table 4 below, 35 percent of 0-2 year olds were in out-of-home care and education settings and 50 percent of 3-4 year olds. The number for 3-4 year olds is comparable to the GHS but access for 0-2 year olds is considerably higher. What is useful is

that the NIDS gives an indication of the number of children in the care of day mothers/gogos which is much higher at 26 percent for infants and toddlers than for 3-4 year olds at 14 percent.

Table 4: Number and percentage (%) of children (0-4 years) in out-of-home care and education

Educational institution attended by child	Children age 0-2	Children age 3-4
Primary school (Grade 1 or above)	0% (1,422)	0% (4,453)
Grade R	0% (5,680)	4% (66,422)
Pre-primary/Pre-school	0% (5,826)	5% (82,851)
Crèche /Educare centre	8% (178,613)	27% (484,304)
Day-mother/Gogo	26% (543,914)	14% (244,927)
Other	1% (21,215)	1% (10,625)
None	64% (1,360,240)	50% (886,146)

Source: NIDS, 2008.

Table 4 gives the location of children 0-4 years who are not in centres during the day. According to the GHS 2009 and 2010 around 10 percent of children not in a centre are cared for at home with an adult other than the parent (probably relatives, nannies and domestic workers) and only 2-3 percent in another dwelling. This suggests that private childminders, even those with very small groups of children, may have been aggregated into the responses to the question about centres in the GHS, and Table 3 probably overestimates formal provision of ECD. Further evidence for this is the number of small providers caring for fewer than six children found in the Western Cape audit of unregistered centres in the third quarter of 2011 (Biersteker & Hendricks, forthcoming).

Table 5: Whereabouts of children not attending a centre during the day (%)

CHILDREN AGED 0-4 years	GHS 2009	GHS 2010
At home with parent, foster parent or guardian	87%	89%
At home with another adult	10%	9%
At home with someone younger than 18 yrs	0%	0%
At someone else's dwelling	3%	2%
Other	0%	0%

Source: Statistics South Africa, 2010; 2011.

3.2 Who needs daycare?

Good quality daycare is an expensive programming option, and it is important that public support is well targeted to those who need it. This could include:

- Working or work-seeking parents and parents in engaged in full-time education
- Parents of children with severe disabilities need support with their continuous care
- Children whose family cannot care for them (e.g. caregivers are chronically ill, disabled, or homeless)

3.2.1 Working parents

The 2008 NIDS data in Table 5 below provides some insight into the potential demand for care support from working mothers. Matching mothers to their children in the household, the data suggests that 21 percent of children aged 0-6 have a mother who in 2008 was being paid a wage or salary to work on a regular basis for an employer, whether fulltime or part time. This data is consistent with the subsequent trends we see in the 2009 and 2010 GHS surveys. Moreover, it would appear that most of these mothers are working fulltime.

In contrast, only five percent of children aged 0-6 have a mother who is reported as being self-employed. Whilst average hours worked by self-employed mothers is lower, given the flexibility that self-employed individuals have in determining hours of work, hours worked are still quite high. Similar data is provided for fathers.

Table 6: Number and percentage of children of working parents by child

NIDS 2008: Employment and work hours of parents	Child age 0-6	Child age 0-2	Child age 3-4	Child age 5-6
Mother is employed	21% (1,046,181)	20% (400,656)	20% (300,394)	22% (345,131)
Average hours worked per week	42	43	42	42
Mother is self-employed	5% (274,997)	5% (98,237)	6% (84,253)	6% (92,507)
Average hours in self-employment per week	29	35	30	23
Father is employed	28% (680,870)	28% (248,048)	31% (231,752)	26% (201,071)
Average hours worked per week	42	40	44	43
Father is self-employed	6% (141,189)	5% (40,943)	8% (62,186)	5% (38,060)
Average hours in self-employment per week	36	26	41	42

Source NIDS 2008

It therefore appears that up to a quarter of children from birth to the Reception Year may require childcare of some kind. There is an unknown number of work-seeking parents who may also require child care.

3.2.2 Children whose parents are in full time education

Family commitments are one factor keeping parents from attending an educational institution and disproportionately affects women. Table 6 below, presents estimates from General Household Survey data of the fraction of children below age six whose mothers have indicated that they are not currently enrolled in an educational institution due to family commitments (of which childcare will be a major consideration). Amongst those children age 0-6 whose parents were not currently attending an educational facility, 24 percent of these children had mothers who said the reason for this was due to family commitments. Safe and affordable childcare could enable those who are not studying due to childcare needs to complete their education.

Table 7: The percentage and number of children (0-6 years) whose mothers are not enrolled in an educational institution due to family commitments

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Mother not currently attending educational institution due to family commitment (e.g. childminding)	24% (1,146,087)	28% (591,407)	21% (276,632)	21% (2,780,481)

Source: Statistics South Africa, 2011

3.2.3 Disability

While experts differ about the value of daycare for children with moderate to severe disabilities, a strong case can be made for the need for daycare support for parents.[1] Many of these are single mothers abandoned by fathers who refuse to care for children with a disability and who are dependent on the Care Dependency Grant. Daycare allows these women to gain some relief from continuous care, look for work or pursue a career path which is otherwise impossible because of the level of dependency of many children with disabilities. It also allows women to spend time with their other children. Centres can also facilitate children's access to multi-disciplinary therapeutic teams and give support to carers on how to manage a disabled child. Although family programmes are an important part of provisions for children with disabilities, childcare, part- or full-time is an important part of the service spectrum (Philpott, 2011).

Prevalence rates for disability are notorious for their variation. The 2009 situational analysis of children in South Africa estimates a prevalence of three percent of children in the 0-4 year age group who have moderate to severe disabilities (Government of South Africa, 2009).

Access to daycare for children with moderate to severe disabilities is extremely low. According to the National Audit done in 2000, only 11,858 children or one percent of the enrolment was made up of children with disabilities (including specialist services). Age data was not available for all these children, but where it was, 31 percent were seven years and older (indicating that they were over-age for ECD sites). Only 35 percent were younger than five years (Biersteker &

[1] Personal communication: Melinda Cupido, Director Sunshine Children's Association.

Dawes 2008). Similarly low access has been found recently in the Western Cape where disabled children make up only 0.04 percent of the enrolment of unregistered centres (Biersteker & Hendricks, forthcoming).

3.2.4 Children whose families are unable to provide adequate care due to vulnerability

An unknown number of young children are raised in families who are unable to provide adequate care due to vulnerability. Data is not available to enable us to estimate this but Table 7 indicates the percentage and number of children whose parents are unable to care for them due to disability. This is another group for whom safe and affordable daycare is important.

Table 8: Provision of care by parents: Parents unable to care due to

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Neither parent able to provide care without assistance	3% (19,731)	3% (7,944)	3% (5,209)	4% (6,578)
Mother not able to provide care without assistance	2% (14,290)	2% (5,980)	2% (3,698)	3% (4,613)

Source: Statistics South Africa (2011) Population totals in brackets.

3.3 Types of child care programmes

- ECD services
  - Partial care centres registered in terms of Children's Act, also have to register as an ECD programme which requires a developmental component. ECD centres or crèches providing full day care with or without an educational component are the main form of provision. Most centres, operate 8-12 hours a day, and some do full-time boarding.
- After care programmes for children in Grade R and other grades.
  - A disadvantage of public Grade R is lack of after-care. Relatively few programmes are registered though these are also Partial Care programmes as defined by the Children's Act. Even fewer receive the Department of Social Development subsidy.[2]
- Community childminding for fewer than six children.
  - This is a common informal form of childcare in areas where there are employment opportunities for women and formal childcare is either not available or too expensive. It needs to be distinguished from larger group programmes offered from homes, converted garages, containers etc. It is also an option in areas where numbers of children are too low to sustain a centre. Because this form of provision is not regulated by the Children's Act, little is known about its extent and quality except that it is popular because it is convenient, flexible and often more affordable than centre care. Properly supported to ensure safe, hygienic, responsive and stimulating care, this form of provision could be grown

[2]Personal communication, Margot Davids, Dept of Social Development, after care subsidies not yet paid. In W Cape some facilities receive an after care subsidy

and would provide not only employment but also convenient, flexible family-style care especially beneficial for infants and toddlers. In countries in Europe and North America, as well as the UK and Australia. this is the prevalent form of provision for the youngest children and is carefully regulated by local authorities.

- Childcare cooperatives
    - Little is known about this form of community childminding but there are examples of women getting together for income generating purposes and some of their members are designated to care for children. This might also be a possibility for childcare needs of parents who are not in full-time employment.

WHO PROVIDES CHILDCARE?

- ECD sites mainly run by private providers or NGOs
- Limited public provision e.g. Tshwane Municipality runs 10 centres
- Some public programmes have encouraged childcare for workers. There are some examples in the current Community Works Programme, and previously in the Working for Water Programme
- Farms owners often provide childcare for their workers on a seasonal or permanent basis
- Hospitals which employ many women on a shift basis sometimes provide childcare services on site
- Many universities have a childcare centre for students and staff
- Corporates who hope to retain professional staff and have a large female staff complement have started to offer on- or near-site facilities. IDC, Old Mutual and First National Bank are examples, as is the initiative of the Department of Public Works and Administration.
- Manufacturing sector facilities are less common, BMW's Rosslyn Factory is a well-known example. This, and later an early learning centre at the Midrand office, resulted from NUMSA intervention in the late 1980s when large numbers of women were employed.

While Table 3 indicates that there is low access to ECD centres for children under five and especially 0-3 year olds, increasing provision of daycare in centres is not necessarily the best strategy for meeting the needs of this target group. While group experience is valuable for

socialisation of children after three years of age, the needs of younger children are best met in family-style or small-group care.

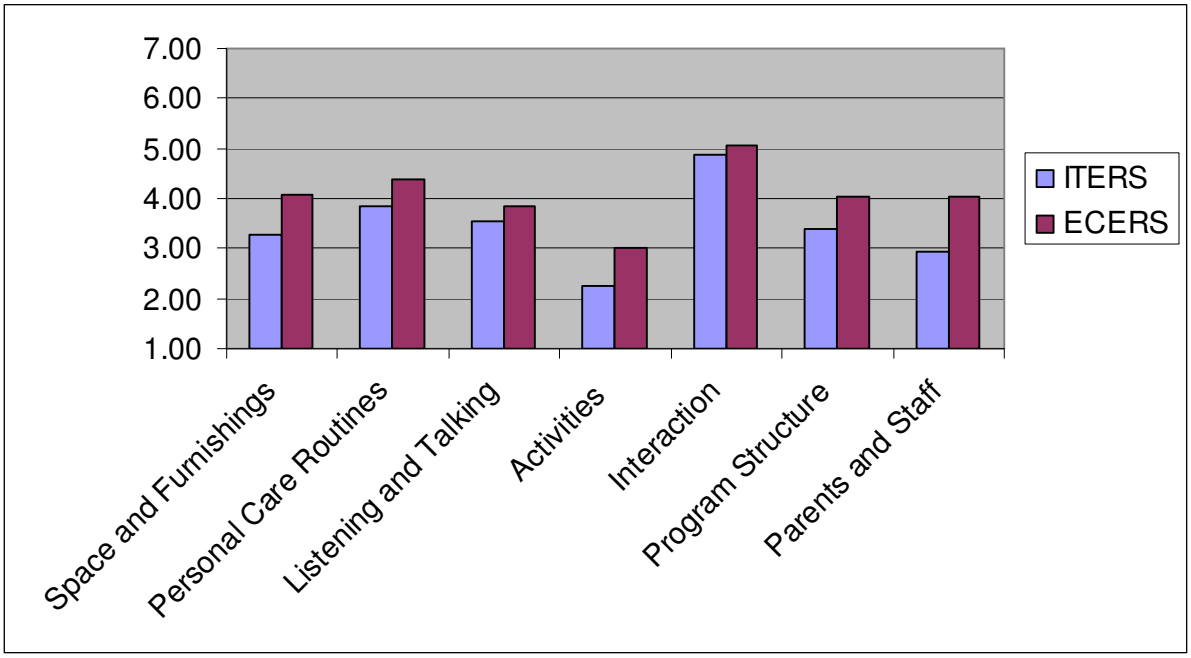
3.4 Quality issues of particular relevance for daycare

The quality issues for ECD programmes are largely covered in Background Paper 6: Opportunities for Learning paper. However there are two issues which are particularly important in regard to child care.

3.4.1 Programmes for infants and toddlers

Providing safe, high quality daycare for the youngest children is far more expensive than programmes for older children because of the higher ratio of adults to children needed and additional needs such as separate milk kitchens. There are fewer slots in daycare centres for children under three and fees are higher. In addition, quality for this most important and vulnerable age group is generally lower than for older children. Figure 1 below compares subscale totals for various dimensions of classroom quality for infants and toddlers and older children in a Western Cape sample. The Infant and Toddler Environmental Rating Scales mirror the Early Childhood Environmental Rating Scales for older children. A rating of 1 reflects that the basics are not available, 3 that the minimum standards for daycare have been met, while a 5 is good. What Figure 1 shows is that a particular area of weakness for babies is stimulation (Activities subscale). Only interaction (which includes supervision and affectional care) approaches good (Dawes et al 2010).

Figure 1:Quality of the Care and Learning Environment assessed by ITERS-R and ECERS-R Subscales



These findings reflect a prevailing tendency to put the least educated, trained and experienced staff with the baby groups. In addition, available training prioritises those working with the preschool age and Grade R classes.

3.4.2 Ensuring a quality childminding service

Care for fewer than six children is not regulated, though in the past some local authorities had mechanisms for monitoring quality and by-laws covering provision. At present, the Department of Social Development acknowledges that they do not have the capacity to monitor this form of provision. In countries with many childminders such as the UK, Australia and in North America, comprehensive support structures have emerged in addition to government registration requirements. In the UK, the National Childminders' Association has registered 40,000 childminders and nannies organised in local branches. It offers services such as information sharing and an advice line, training and quality inspections, referrals and it sells materials and resources and plays a key advocacy role on behalf of its members. Family Day Care Australia offers similar services to its 12,500 members.

There have been attempts to set up support services in South Africa including the National Childminders' Association, which is predominantly Soweto-based, and assists with training, equipment etc. Financial sustainability has been very challenging and services available have been dependent upon the funding situation at any given time. In the 1980s there were a number of NGO projects which worked with childminders in different ways including:

- The Kleinvlei model – satellite homes were organised around a community centre and children and their childminders took turns to come in, have a play experience and a meal once a week.
- In Cape Town, Grassroots developed a different satellite model around ECD sites. Food was prepared and taken to homes, and training and equipment provided. For a time children accessed a Department of Social Development per child subsidy via the site.
- Other small associations were formed in Ravensmead, Blackheath and Belhar, where an NGO offered or organised training, administrative support and in some cases bulk buying of groceries and equipment. Members of these associations developed reciprocal relief arrangements in case one of the childminders was ill or had to be called away.
- Some home visiting programmes offer support to childminders as well as to primary caregivers.

While it is understood that childminding is privatised and a means of income generation for many women, ensuring that young children are receiving an adequate service which is both protective and developmental, is critical. Much needed support could also be given to these members of the ECD workforce. Some possibilities include:

- Setting up local associations with the support of local authorities to procure or provide training, monitoring and assist with bulk buying and information sharing.
- Local associations could act as conduits for NPO funding from DoSD for services for poor children.

- Local authorities and associations could develop a database of approved childminders to assist parents with finding suitable childcare. This could also be linked to Employer Childcare Support, either through a direct subsidy to workers using approved minders, or corporate subsidisation to the association for its support functions. This would be a way of making child care accessible to all classes of workers.
- Home visitors can also provide support to childminders in the same way that they support individual households (see *Parenting* paper). This model has operated in a variety of areas in the Western Cape.
- As part of the concept of ECD centres as Nodes of Care and Support, centres could have satellite childminders to whom they offer various services e.g. play days at the centre, assistance with buying, toy library services, or a more formal satellite arrangement such as the those described above.

3.5 Advocating for the development of childcare services

It is clear from the form that ECD provisioning has taken that childcare is a public need. However, there has been very little advocacy for it, with ECD advocacy largely focused on educational needs.

COSATU has periodically referred to the lack of childcare provisions, for example, at its 2003 Congress and in a 2007 Women's Day statement. However, a survey of nearly 3,000 formal economy workers in metropolitan areas (NALEDI, 2006)[3] found that only 7 percent of women (and 1 percent of men) mentioned childcare facilities as something they wanted from their employers. Only 1 percent of the sample reported having childcare at work. While only 16 percent of women were satisfied with their union's work on childcare, 90 percent were satisfied with their childcare arrangements. The use of relatives or preschools for childcare was about equal, while hired helpers were used by others. Childcare was a low priority as an area of Union work for most respondents.

The importance of an organised collective for not only providing childcare but also in accessing government resources is exemplified by the Self Employed Women's Association (SEWA) in India whose members have registered childcare cooperatives to support their members (Anandalakshmy, 2011) and this is a model that could be explored as a way of supporting childcare needs of those in the informal sector.

Currently, the Department of Public Service and Administration is engaging in consultations around guidelines for childcare facilities in the public service (DPSA, 2011). This arises from the 2008 Employee Health and Wellness (EHW) Strategic Framework for the Public Service. A survey of nearly 300 Department of Health and Social Development employees drawn from three provinces found 83 percent of respondents were in favour of work-based childcare facilities. However, it should be noted that these were higher post levels 6, 7 and 8 and not lower category workers. The draft document outlines worker rights in pregnancy and for breastfeeding support in the workplace and raises the possibility of providing care or after-school care.

[3] Random sample metro areas, half men, half women, average income under R10,000 a month per household – no self-employed, unemployed etc.

4. Institutional issues

Childcare takes place in partial care facilities and the challenges for ensuring registration, compliance, monitoring and support are covered in the Background Paper 6: Opportunities for Learning paper.

The only exception is for childminders caring for fewer than six children and this has been covered above.

5. Human resources

In addition to what was outlined with regard to training needs in the Background Paper 7: Human resource development for ECD programmes and services for 0–4-year-olds paper, the need to include baby unit workers in training programmes should be stressed. Further, training for child minders/nannies needs to be accelerated. Currently it is mostly provided on a private for-profit basis for carers serving middle and higher income groups – au pairs, nannies etc. A health and nutrition focus is common and when courses claim that they are accredited, this generally refers to First Aid aspects or to the use of international training packages.

Further if daycare services are targeted to high-risk groups such as children who have been neglected or maltreated for a variety of reasons or those with chronic conditions and disabilities, staff require appropriate training to support their needs. Currently there is little focus on this or on inclusive educational environments.

6. Inter-sectoral collaboration

The importance of drawing together the health and nutrition, safety and protection and strengthening the educational aspects of daycare is evident. This is especially so, if childcare is to also function as a preventive and remedial strategy for high-risk children from very vulnerable families. The use of ECD centres as nodes of support for poor and vulnerable families has been mooted (Departments of Social Development & Education, 2006) and operated by certain NGOs e.g. Lesedi, LETCEE and TREE. In order to take on this role, centres need support and incentives.

7. Funding

This is covered in other papers which deal with the adequacy and reach of government per child subsidies through DoSD. Access to affordable childcare should be facilitated by making funding available for non–profit registered sites that do not receive the subsidy and increasing the supply of registered sites through conditional registration under the Children's Act for those that meet the basic standards.

Parent contributions are the greatest source of daycare funding and should continue to be so for working parents who can afford this. However, there needs to be additional support for parents

in the informal sector or those children who should receive targeted childcare services as a prevention, early intervention or remedial intervention. Poor children whose parents cannot care for them and children with disabilities should receive priority for childcare and admission policies of subsidised centres should prioritise them.

A question to explore is the extent to which employers or unions might unlock additional sources of funding.

Old Mutual is exploring options with the South African Revenue Services (SARS) to allow childcare to be a pre-tax benefit for Old Mutual employees utilising this service (Hein & Cassirer, 2010).

Other employer support for childcare strategies outlined above could bring additional funding into the sector for a group of families and children needing child care. This would benefit others needing the service, if employer support could be directed beyond employees, for example, to childcare facilities serving the wider community.

8. Impact and available data

There is a large body of international evidence of the positive child outcomes after participation in high quality daycare programmes for children three years and older. There is no unequivocal local evidence.

9. Gaps

The amount and quality of daycare available is not known. There is data from only one large survey, and a full onsite audit of facilities and services is overdue. Administrative data collected by the Department of Social Development as part of their quality assurance process is not currently used to generate a district, provincial and national picture of provisioning but this should ideally form the basis for service planning and budgets. The PETS and Western Cape Province DoSD quality studies are the only recent sources of information about quality. There needs to be further investigation about what corporates and other employers, as well as unions are doing in relation to childcare benefits.

10. Key points

- Target full daycare to those who need it (parents in education, working, work-seeking and parents in high risk groups).
- Include after-school care for Grade R and Foundation Phase children who need and would benefit from it.
- Explore role of employers (including public sector) and Unions in stimulating demand for daycare.
- Support community childminding, especially for infants and toddlers, through associations, satellite homes attached to ECD centres with support from Local Authorities or outsourced to NGOs.

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Background Paper 7

Opportunities for learning (ECCE)

David Harrison

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Key Points

Issue: Shift to population- and programme-based planning for ECD provision

Despite an increase in the number of subsidies to early childhood development (ECD) centres, only one third of young children are exposed to formal childcare or education outside of the home. Among the poorest 40 percent of our population, that proportion drops to one fifth.

Recommendations:

Planning for early childhood development should aim to achieve universal coverage of all eligible children in a defined geographical area, starting with the poorest municipal wards in each province.

Programme-based planning should ensure that the necessary human, physical and financial resources are in place to support and monitor implementation.

Multiple nodes of support including clinics, ECD centres, NPOs, one-stop centres as well as municipal and provincial service points should be used as outreach service delivery hubs to ensure coverage to the most vulnerable young children.

Issue: Define a clear-age differentiated strategy for early childhood care and education

The National Integrated Plan gives priority to home- and community-based approaches to early childhood development. Yet the current system is geared around the inspection and registration of centres.

Recommendations:

Programmes for 0-2 year olds should focus on the quality of parent-child interaction that promotes cognitive and language development, as well as psychosocial support for parents. Given the vital role of primary caregivers in this age-group, delivery should be principally through home-visiting and community programmes that dovetail with other community-level programmes.

In addition to the above, programmes for 2-3-year-olds should focus on socialisation, achieved largely through group-interactions such as community playgroups.

Children aged 3-4 years of age will benefit from home-visiting and community programmes, together with a clear plan to expand access to centre-based programmes. This could be on a part time basis unless full day childcare is required.

A minimum package of ECD interventions should be defined for each of the modes of delivery described above. This should include specific structured interventions related to nutrition,

parenting and psychosocial support, cognitive and language stimulation, literacy and numeracy development, and access to health and social services.

Issue: Break the cycle of exclusion of the poorest children

Centre registration is a precondition for registration. At present, the poorest communities get locked into a vicious cycle of exclusion. They either don't have centres or they don't have the finances to improve their buildings, so they can't meet infrastructural standards for registration. Most of the fees paid by parents are spent on food for children. That means less money for teachers and fewer teaching materials, and little chance of meeting the quality standards for learning that are required for registration.

The administrative complexity of registration is a further obstacle. ECD centres must register through two separate systems within the Department of Social Development, and meet municipal quality standards as well.

Recommendations:

Access for poor children can be improved immediately by making available funding for the approximately 25 percent of registered facilities that receive no subsidy.

Section 98 of the Children's Act, which makes provision for conditional registration, should be used to further expand access to subsidies for children in facilities in areas classified as quintiles 4 and 5. This can be done by conditionally registering facilities that meet basic safety standards, and which require resources to meet other quality standards.

The requirement that facilities should register as both an ECD programme and facility should be abolished. There should be a single registration process for all ECD programmes, with specified sections dealing with centre- and non-centre-based programmes.

Issue: Establish a funding formula for non-centre-based programmes

Currently, there is no funding formula for non-centre based provision. The means-tested per capita subsidy for learners applies only to children in ECD centres.

Recommendations:

A financing mechanism for community- and home-based ECD programmes must be devised, based on a specified allocation per child per month. To facilitate this, monitoring systems must be improved to allow for tracking of individual children, both for financing purposes and to ensure participation. This will require the use of unique identifiers for every child, namely the identity number, supplemented by a substitute number where the ID number is not available.

Issue: Ensure that there is sufficient capacity at provincial level to provide programme support

Responsibility for ECD is spread thinly across three government departments (DSD, DBE and DoH), and delegated to relatively junior officials in most provinces.

Recommendation:

Just as a single agency is required at national level to coordinate implementation of an integrated programme, so a single agency should be replicated at provincial level. This agency (department or stand-alone agency) should be capacitated to provide the level of support required to implement a province-wide strategy for early childhood development, as contemplated in Section 93 of the Children's Act. The focus of the support should be to improve access to quality ECD services.

Issue: Define a clear staffing structure and career path for ECD practitioners

There are few opportunities for further educational development and career path progression of ECD and ECCE practitioners. There are no accredited courses for non-centre based programmes, and the links between community-based ECD practitioners and other cadres of community workers have not been clarified.

Recommendation:

The shift to a programme-based approach to ECD provides the opportunity to define a clear framework for human resource development, including different levels of workers at community- and facility levels, with opportunities for progression into programme support and management positions. This structure should be supported by appropriate accredited training for all levels and positions. Community level workers should have clear means of articulating with other cadres of community-workers (such as community health workers and auxiliary social workers).

Issue: Monitoring

There is no reliable monitoring system.

Recommendation:

Implement a monitoring system based on unique child identifiers for both centre- and non-centre-based programmes

Opportunities for learning (ECCE)

Major gaps in quality ECD learning opportunities in South Africa 2012

	COVERAGE	PROGRAMMES	FINANCES	HUMAN	QUALITY
	ENSURE THAT ALL CHILDREN IN POOREST QUINTILES HAVE ACCESS TO ECD PROGRAMMES	**SHIFT FOCUS FROM SITES TO PROGRAMMES THAT COMBINE VARIOUS MODES OF DELIVERY**	**ENOUGH MONEY TARGETED – BOTH IN POLICY AND PRACTICE - TO THE POOREST**	**ENOUGH, SKILLED MOTIVATED STAFF WITH CLEAR CAREER PATHS AND OPTIONS**	**SHIFT FROM INSPECTION TO PROGRESSIVE QUALITY IMPROVEMENT**
POLICIES	• No coverage targets and no national implementation strategy, as required by the Children's Act, to put into effect the National Integrated Plan for ECD • Age-differentiated strategy for ECD scale-up (clarifying modes of provision) not in place	• There is no strong central agency for ECD to facilitate implementation of quality programmes at scale. Current arrangements for intersectoral collaboration are insufficient and constrain effective scale-up. • The specific elements of 'comprehensive ECD' and the systems required to implement them are not well-defined.	• State spending on learning opportunities for 0-4 yr olds is <1% of spending on basic education. This is a missed opportunity to improve child health, development and educational outcomes • No obligation on provinces to fund ECD provision • Facility-linked subsidies constrain expansion of ECD	• Cognitive stimulation & literacy/numeracy fundamentals in Level 4 curriculum for ECCE practitioners are inadequate. • Few opportunities for career progression for ECD practitioners • No career path for community- and home-based practitioners • Very low salaries, not related to experience or qualifications	• Current application of norms and standards further disadvantages the poorest • Infrastructural standards are often major barrier to registration of centres, despite the fact that children live in similar conditions • Access to learning & training resource material is a major barrier to quality
MANAGEMENT	• ECD management is not structured for scale-up • Criteria for registration and site-based financing effectively exclude those children most in need	• ECD management in provinces is typically delegated to junior ranks, with different sections responsible for subsidy payment and programme support • Planning is focused on inspection, registration and subsidies for facilities – instead of systems support for a population-based ECD programme	• Budget lines for ECD are not standardised across provinces, leading to opacity and double counting of expenditure. • Contracts with NGOs tend to be piecemeal and not focused on sustainable high coverage provision • Monitoring systems open to fraud.	• No learnerships for home-and community-based ECD practitioners, despite accredited training. • Generally weak leadership and management of ECD facilities and programmes	• Dual registration requirement (partial care facility & ECD programme) is onerous • Inspectorate system viewed as punitive and not conducive to progressive quality improvement

National priorities to expand access to quality ECD learning opportunities 2012-2015

	COVERAGE	PROGRAMMES	FINANCES	HUMAN	QUALITY
	ENSURE THAT ALL CHILDREN IN POOREST QUINTILES HAVE ACCESS TO ECD PROGRAMMES	**SHIFT FOCUS FROM SITES TO PROGRAMMES THAT COMBINE VARIOUS MODES OF DELIVERY**	**ENOUGH MONEY TARGETED – BOTH IN POLICY AND PRACTICE - TO THE POOREST**	**ENOUGH, SKILLED MOTIVATED STAFF WITH CLEAR CAREER PATHS AND OPTIONS**	**SHIFT FROM INSPECTION TO PROGRESSIVE QUALITY IMPROVEMENT**
POLICIES	• Section 92(1) of Children's Act 2007 to be implemented: DSD to develop a comprehensive national strategy for a 'properly resourced, coordinated and managed ECD system' • Implement age-differentiated strategies: 0-2 yrs home-based and parenting focus; 3-4 yrs expand access to group services	• Establish a national agency for ECD • Shift from site- to population-based planning for ECD scale-up • Define minimum ECD package as nutrition support, cognitive stimulation, language development, numeracy & literacy, psychosocial support and access to health & social services	• Address the immediate funding gap for those qualifying ECD facilities that are registered but not subsidised. • Introduce a per capita subsidy for non-centre based service provision • Separate subsidy for personnel from other (protected) expenses • Allocate funds for ECD programme support.	• Develop a complete national Level 4 ECD training curriculum • Introduce a Level 5 National Diploma for ECD (0-4yrs) • Create career paths for practitioners linked to programme expansion • Define ECD specialty for auxiliary social workers and community development workers • Establish minimum salaries linked to qualification & experience	• Introduce context-cognizant norms & standards at local government level to expand access to poorest, with supported time goals for improvement • Separate basic safety and environmental standards from others to be progressively achieved • Register and fund all programmes that meet basic standards • Provide basic learner & training support material
MANAGEMENT	• Design & support innovative mechanisms for scale-up (eg. social franchises, ECD 'plug-ins' to other home-based programmes, umbrella-body support for networks of local ECD programmes and facilities) • Define municipalities' role and capacitate	• Strengthen ECD management capacity in provinces with an ECD unit/chief directorate in DSD • Planning should include coverage targets, modes of provision, human resources, access to training materials, in-service support and monitoring	• Establish standardised budget lines for ECD in provincial budgets • Contract with NGOs to provide high-coverage services in defined geographical areas of highest need and greatest disadvantage • Implement a monitoring system with unique identifiers	• Expand access to learnerships for home- and community-based ECD practitioners • Develop strong leadership and management training for both facility and training managers	• Stop dual registration requirement and introduce single DSD registration system • Implement a quality improvement system based on self-assessment, facilitated improvement and external assessments linked to incentives

1. Relationship to early childhood development

The first few years of life determine the long-term trajectories of school attainment and learning. Brain development is extremely rapid in early childhood, and opportunities for learning - together with good health and nutrition - can break the cycle of poverty and lay the foundation for the social and economic wellbeing of subsequent generations (Walker et al., 2011). Even among children who do not get enough food, cognitive stimulation can improve learning outcomes to some extent (Walker et al., 2005). In South Africa, there are encouraging signs from the National Income Dynamics Survey of 2008 that preschool participation improves Grade 4 outcomes among children living in urban areas as well poorer rural children (Gustaffson, 2010).

However, cognitive stimulation does not happen automatically in all situations of childcare, although motivated and caregivers intuitively provide opportunities for learning for children through their interest and engagement. Where these processes are suppressed or interrupted, as can occur in conditions of poverty, stress and disadvantage, opportunities for learning need to be created. Supervised, creative play is important to stimulation, socialisation, language acquisition and cognitive development (Irwin, Siddiqi, & Hertzman, 2007). An explicit, appropriate and interactive curriculum is similarly important (Peralta 2008); and children need to be able to participate regularly and intensively throughout the year, interacting with their peers (Biersteker & Kvalsvig, 2007). Such experiences need to be built in to a national programme of early learning that reaches all children – and most particularly children from poorer communities. This programme should include support to parents who are critically important to early learning; and opportunities for group interaction and learning that can occur in both playgroup and facility-based settings

In South Africa, analysis of the 2007 SACMEQ survey of a large sample of Grade 6 school children across all nine provinces found significantly higher literacy and numeracy scores among those who had attended preschool compared to those who had not (Moloi & Chetty, 2011). Similarly, there are encouraging signs from the National Income Dynamics Survey of 2008 that preschool participation improves Grade 4 outcomes among children living in urban areas as well poorer rural children (Gustaffson, 2010).

2. Innovations since 1994

This section summarises key policy and programming milestones for children under five emanating from the Departments of Education and Social Development, which together with the Department of Health have the major service responsibility for this age group. These policies should be understood within the framework created by the ratification of the Convention on the Rights of the Child (CRC) in 1996 and the African Charter on the Rights and Welfare of the Child in 2000, as well as inclusion of guaranteed child rights in Sections 28 and 29 of the South African Constitution of 1996 which prioritises children in service delivery.

The summary makes a judgement on whether progress has been good, fair or poor (Table 1). The basis for these assessments is presented in the subsequent sections.

Table 1: Summary of progress with policy implementation related to learning opportunities for children 0-5 years old

Good progress	**Fair progress**	**Poor progress**
White Paper on Education and Training 1995		
Early childhood as the starting point for human resource development		
Commitment to providing 10 years of free and compulsory schooling per child, starting with a reception year for 5 year-olds		
An integrated definition and servicing perspective of ECD, recognizing that service delivery depends on partnerships both intra-governmental and with other stakeholders.		
Recognized that the participation of local authority representatives would also be essential		
Interim Policy for Early Childhood Development 1996		
Covered children 0-9 years, but had a particular focus on phasing in a reception year for 5 year-olds to facilitate the transition to formal schooling.		
Took a broad integrative approach to ECD services (following the 1995 White Paper), including "(p)rogrammes aimed at reconstruction and development which address the basic needs of families for shelter, water and sanitation, primary health care, nutrition, employment and adult basic education.		
White Paper on Social Welfare 1997		
Primary target for ECD services would be given to disadvantaged children under five years. Within this group urgent attention would be given to children birth to three years and disabled children.		
Accepted that no single model or programme is appropriate to meet the varied ECD needs of families and a range of options will be made available including centre-based services, part day programmes and family programmes.		
Reinforcing programmes would be offered by existing role players (government, local government, NGOs, CBOs and parents). In under-serviced areas ECD services would be initiated through community development interventions.		
Department of Social Development Draft Issue Paper on the Transformation of the ECD System in South Africa 1998		
Promoting subsidisation of varied ECD programmes: centre-, community- and home-based, with means-test as a criterion		
Rooting ECD services within the community		
Education programmes for parents as part of ECD programmes for children		

Table 1: Summary of progress with policy implementation related to learning opportunities for children 0-5 years old

Good progress	**Fair progress**	**Poor progress**
Increasing access of young children to ECD programmes (through promotion of home based and community based facilities for daycare, targeting at risk communities, sustaining programmes in communities that are remote and isolated).		
Targeting disadvantaged children in a variety of programmes		
Providing appropriate ECD programme options (daycare, stimulation, health and nutrition programmes)		
Inclusion of children with special needs in the mainstream		
Inter-ministerial Committee on Children and Youth at Risk (1995 - 1999)		
Identified four levels of intervention: Prevention, Early Intervention, Statutory Process, Continuum of Care.		
Some strategies at the level of prevention with relevance to the children under 5 included - A range of early childhood care and development programmes in each community - Parent education and support - Sufficient daycare		
White Paper No 5, Early Childhood Development (2001)		
Prioritised the development of a strategic plan for intersectoral collaboration through the ECD priority group of the National Plan of Action for Children.		
During the period up to 2010 plan will prioritise subsidisation of early learning programmes for 4 year olds from poor rural and urban families, HIV positive children and children with special learning needs		
Improve the quality of Pre Grade R programmes, inclusion of health and nutrition aspects and appropriate curricula.		
Practitioner development		
Career pathing		
National Integrated Plan for ECD, 2005 (DoH, DoE, DoSD)		
Interdepartmental initiative (led by DoSD) to coordinate and integrate service delivery to young children at home, in the community and at centres including access to social security, primary health care and nutrition, birth registration, psychosocial support and early stimulation.		
Access target of 2.5 to 3 million poor children: Social security & birth registration		
Primary health care and nutrition		
Psychosocial support & early stimulation		

Table 1: Summary of progress with policy implementation related to learning opportunities for children 0-5 years old

Good progress	**Fair progress**	**Poor progress**
Children's Act No 38 of 2005 as amended (*key points only*)		
ECD age definition: children up to school going age (i.e. DoSD mandate)		
Defines tiers of Government responsibility for ECD: Provinces to develop ECD programmes		
Regulates ECD centre services and programmes and provides for norms and standards and recognises multiple forms of ECD programming.		
Government Apex Priorities 2008		
Massively speed up implementation of ECD programme: expand the number trained staff and double number of sites and child beneficiaries by end of 2009; (changed in 2009 to 2014)		
National Early Learning Development Standards (NELDS) DBE 2009		
Curriculum-related policy initiative focusing on the early learning needs of children from birth to four: • Stakeholders involved in validation process (practitioners, parents) and an age validation • Specifies desired results (competencies to be achieved in formal programmes and at home) • learning standards (with age indications)		
Minister of Social Development's commitments launched as part of the ECD Awareness campaign 2011.		
• Commitment to a Rural and Informal Settlement Strategy for ECD. • 1 million 0-5 year olds accessing ECD Services and programmes. • Standardisation of ECD Subsidies to R15.00 per child per day over MTEF • Improving ECD infrastructure • Ensuring completion of the ECD Curriculum for 0-5 years.		

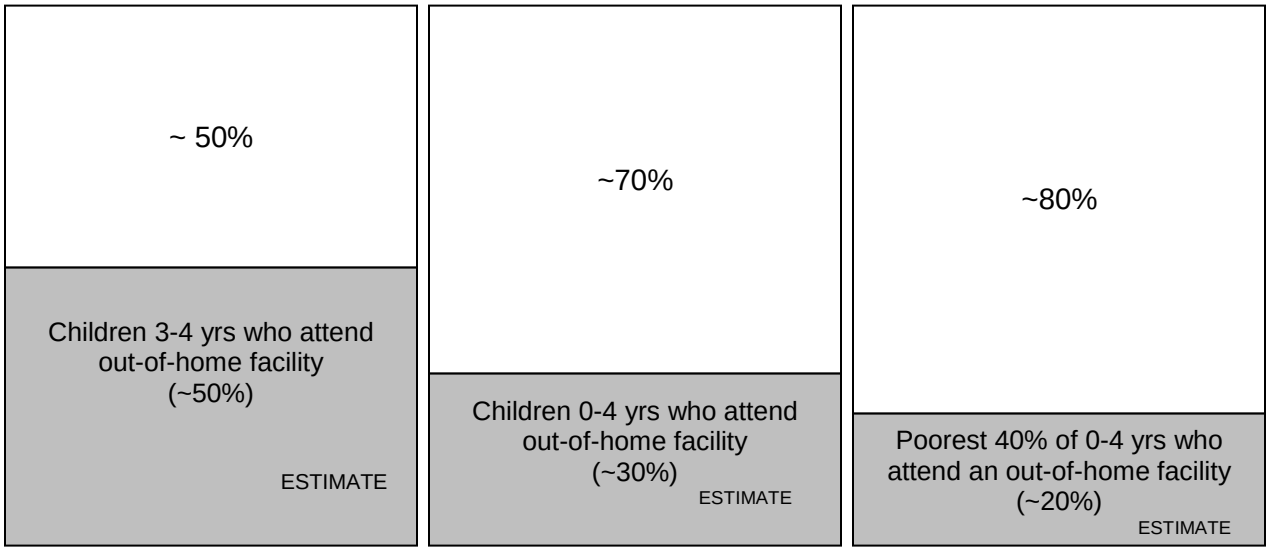
3. Current provision – services and programmes

3.1 Coverage

We are missing a major opportunity to improve health, educational and social developmental prospects in South Africa, in that at least 70 percent of children still do not participate in structured early childhood development services (whether centre- or non-centre-based). Participation in ECD programmes has been shown to be particularly beneficial for children from

low income communities (as higher income children generally receive adequate nutrition and the type of home stimulation that facilitates the transition to schooling). Yet poorer children have the least access (Figure 1).

Figure 1: Participation in out-of-home child care or ECD service



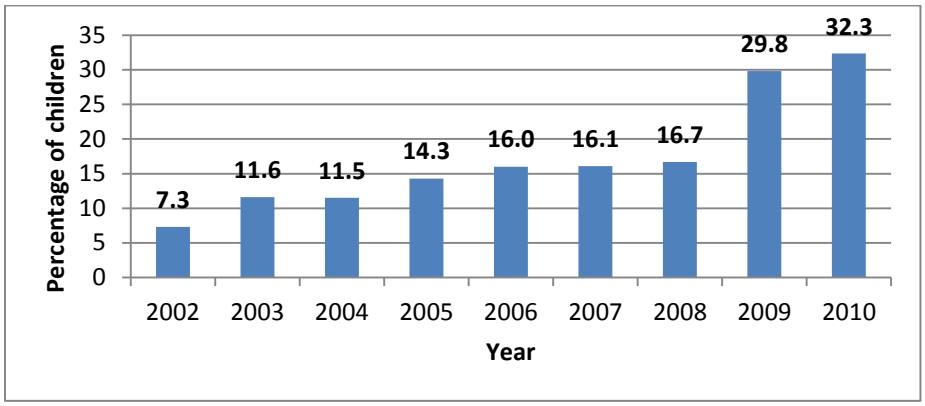
Data on access to ECD facilities is derived from i) a national ECD facilities audit conducted in 2001 and ii) population-based surveys (National Income Dynamics Study of 2008 and the General Household Surveys 2002-2010). Note that the analysis does not include Grade R provisioning.

- The proportion of 0-4 years old attending some form of out-of-home facility has more-or-less doubled from about 16 percent over the past decade, linked to a marked increase in learner subsidies over that time (Figure 2).
- However, attendance among the poorest 40 percent of the population is low, with only about one-fifth of children 0-4 years in out-of-home facilities (Figure 3)[1]. Roughly two-fifths of children aged 3-4 years from households with incomes < R1,200 attend some form of ECD facility; attendance is highest in Gauteng (43 percent) and the Western Cape (39 percent), and lowest in KwaZulu-Natal (25 percent) and the Northern Cape (21 percent) (Figure 4).
- Attendance in formal preschool is low among 0-4 year olds (about 6 percent), with most children who attend an ECD facility accommodated in crèches[2] (about 22 percent).
- Coverage of non-centre-based programmes is very low, and we estimate it at no more than 3 percent.

[1] Note that the questions related to exposure to Early Childhood Development in the General Household Surveys are too broad to be of use in assessing participation in ECD programmes, as they do not exclude cognitive stimulation offered by caregivers at home.

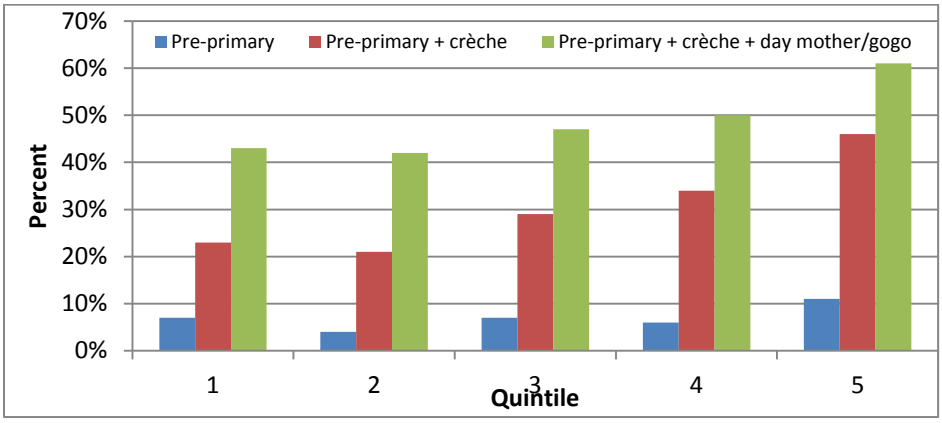
[2] Formal preschools are typically stand-alone structures accommodating twenty to sixty children, while crèches typically offer child care to fewer children in the home of a child care provider.

Figure 2: Percentage of 0-4 year old children attending an ECD facility, 2002 – 2010



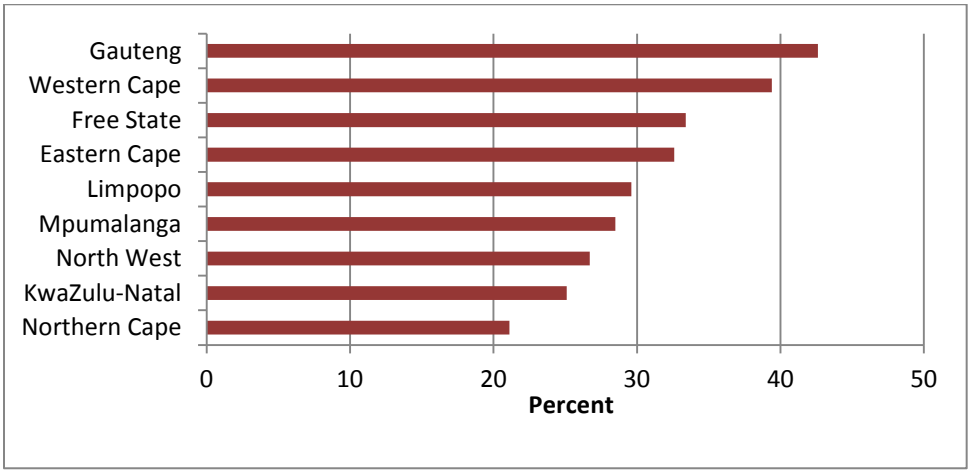
Source: *Statistics South Africa, General Household Surveys, 2002-2010*

Figure 3: Percentage of children 0-4 years attending an ECD facility, 2008



Source: *National Income Dynamics Survey 2008*

Figure 4: Percentage of 0-4 year old children attending out-of-home facility, by province

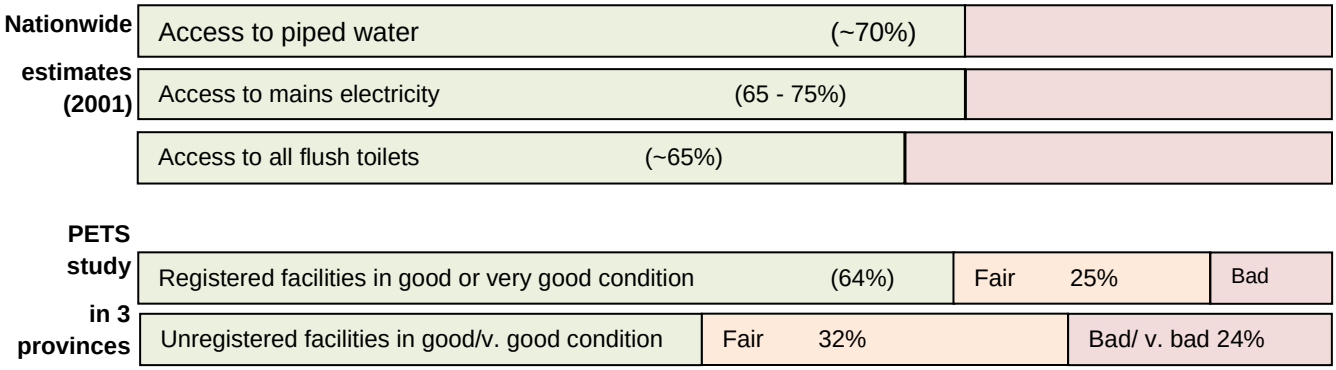


Source: *Statistics South Africa, General Household Surveys, 2002-2010*

3.2 Infrastructure

We do not have a current picture of the state of ECD facilities. The most recent nationwide data is now a decade old. However, the Public Expenditure Tracking Survey (PETS) conducted in 2008 described the state of infrastructure in a representative sample of 390 community-based ECD facilities in three provinces. The provinces (the names of which have not been made public) included a relatively well-resourced province, a large and poorly resourced province and one in-between. The following estimates are based on the Nationwide ECD Facilities Audit of 2001 and the PETS studies (Figure 5).

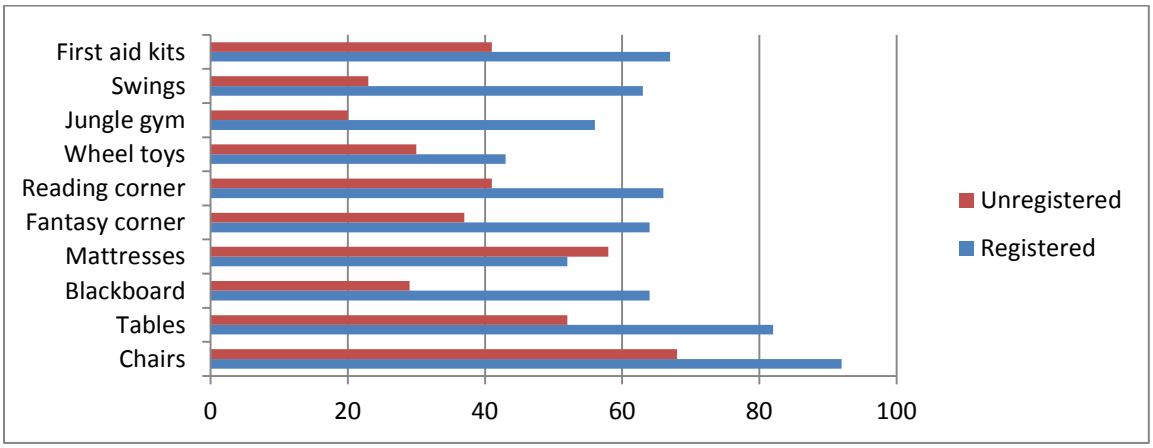
Figure 5: Estimates of the state of infrastructure for early child care and education



3.3 Availability of learning and training support material in ECD facilities

We do not have a national picture of the availability of learning and training support material (LTSM) in ECD facilities. However, the PETS survey of three provinces in 2008 presents a bleak picture, with fewer than half of facilities having basic play equipment (Figure 6). The situation is particularly bad in unregistered facilities, where less than half have access to books, toys and puzzles - and even paper (Figure 7).

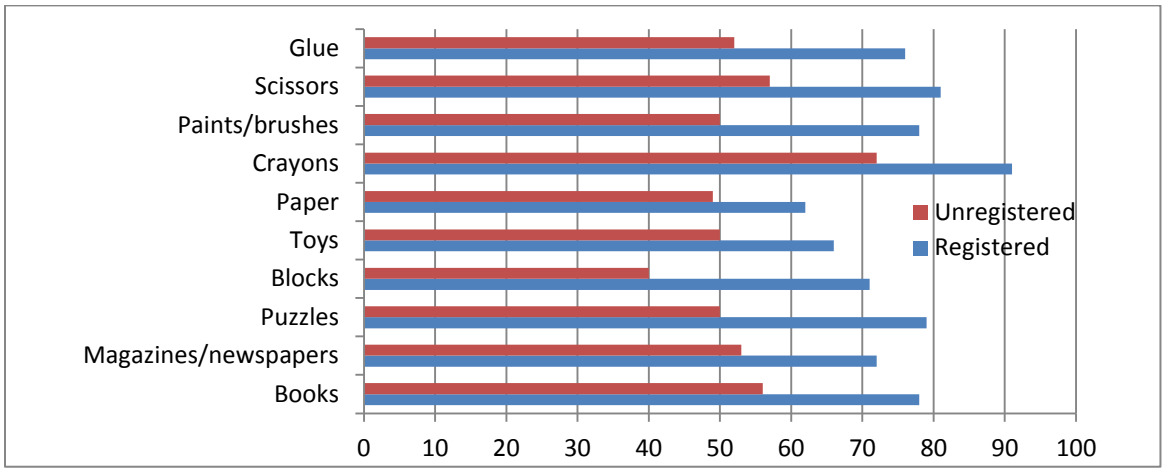
Figure 6: Presence of various LTSM furniture and equipment by type of facility (2008)



percentages not weighted by province

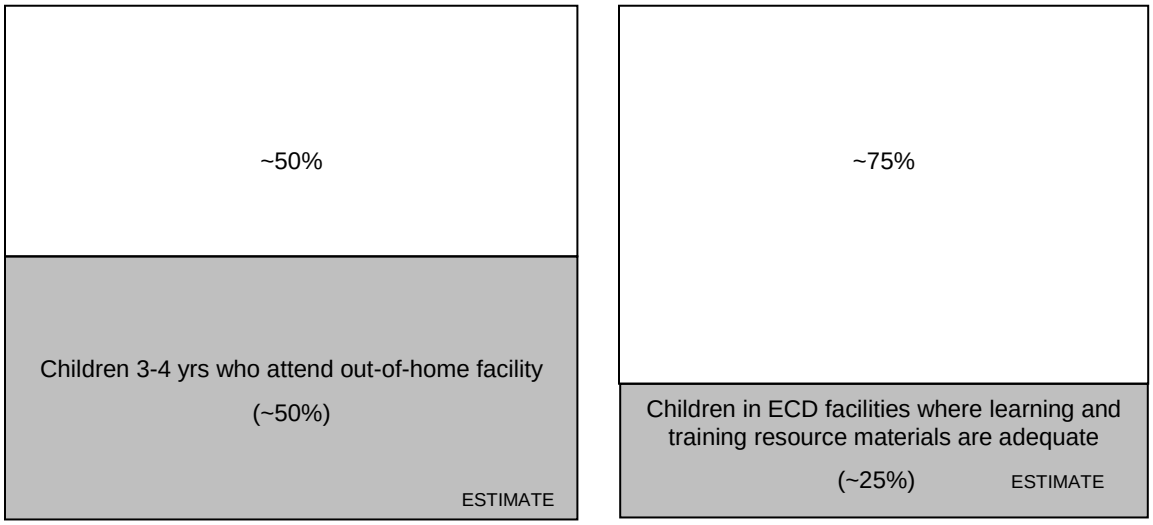
Source: Source: Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch

Figure 7: Presence of various LTSM, by type of facility (2008)



Extrapolating from the above, we can conclude that, at most a quarter of children aged 3-4 years of age attend facilities that expose them to experiences that may stimulate their cognitive and educational development. Another quarter may be in out-of-home facilities providing essential services of keeping children safe while parents work and providing some nutrition. The other half is not exposed to any regular out-of-home ECD experience (Figure 8).

Figure 8: Estimated exposure to resource environments that facilitate structured cognitive and educational development



3.4 Essential elements of provision

Early learning opportunities for all children require at least the following elements:

- Nutrition support
- Cognitive and language stimulation
- Early literacy & numeracy development
- Mediated group social experiences

- Basic companionship and psychosocial support
- Access to health & social services

In addition, there are specific learning-support needs for children with disabilities.

3.4.1 Nutrition support

In centres where per capita subsidy is paid, part of this subsidy is intended to cover nutrition. However, the PETS study indicates that far less was expended on food annually than the food menus provided by the Nutrition Directorate of the Department of Health actually cost to buy. The Early Learning Resource Unit (ELRU) calculated that, in Feb 2011, it cost R4.12 per day for the stipulated ingredients to feed a 1-3 year old child and R4.54 for a 4-6 year old child. The PETS study found expenditure on food averaged for the bottom two quintiles of R511 per child per year – 43 percent of the costed menu (Figure 9).

WHAT NUTRITION SUPPORT IS NEEDED

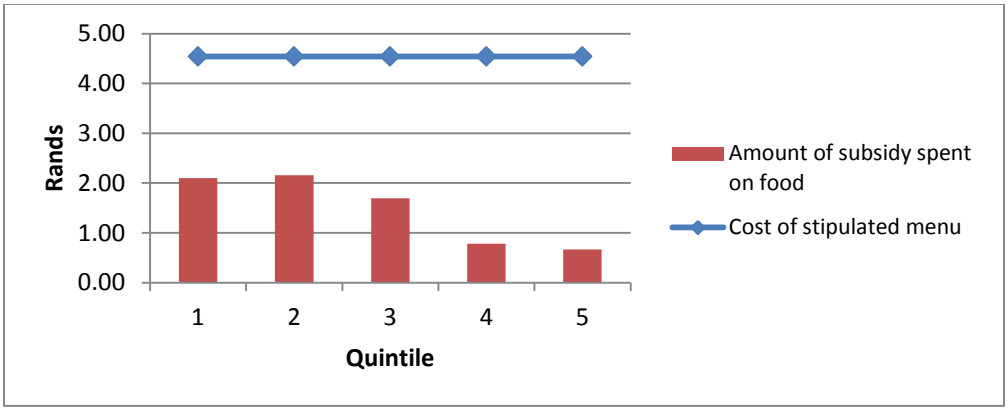
For all children in ECD programmes

- Regular growth monitoring
- Regular deworming
- Vit. A & iron supplementation
- Where practicable, promote vegetable gardens
- Advice and counselling for caregivers
- Early referral to health and social services, when needed

At ECD centres

- Provision of snacks and meals
- Training for cooks

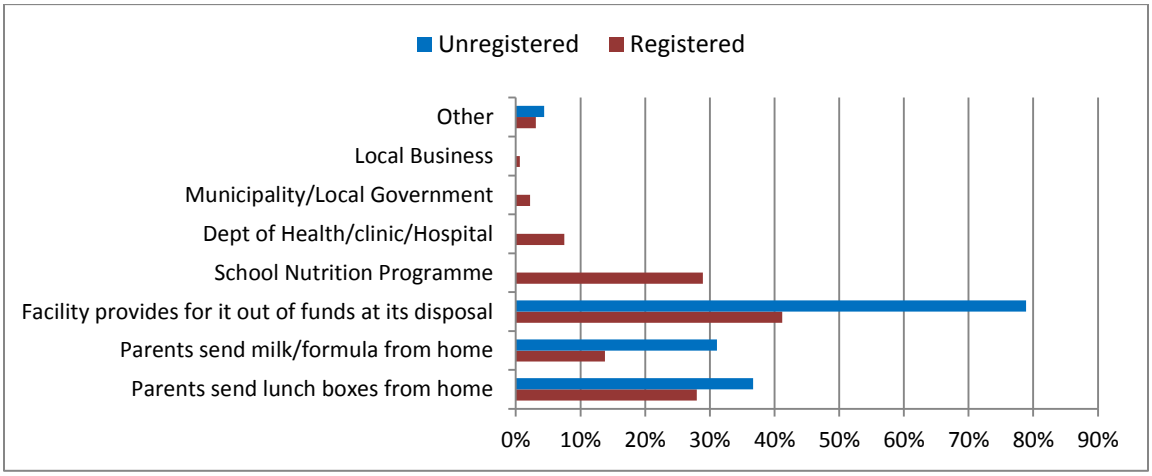
Figure 9: Daily cost of food (based on DoH stipulated menu) compared to amount of per capita subsidy spent on food in registered ECD facilities in three provinces, 2008



Source: *ELRU costings of DoH menus (Feb 2011) and PETS Survey 2008*

The lower expenditure on food in wealthier communities reflects the fact that parents tend to provide food from home (enabling more of the subsidy to be spent on staff salaries, equipment and learning materials). Children in poorer registered facilities are thus triply disadvantaged by: i) the scarcity of food at home; ii) the relative lack of money for teachers; iii) and poorer infrastructure and learning materials. Children in unregistered facilities are even worse off, in that they are more likely to come to the ECD facility hungry, receive food for which no State subsidy is received, leaving even less to fund the salaries of teachers (Figure 10).

Figure 10: Source of funding for food for children in ECD facilities in three provinces, 2008



Source: Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch

In many cases, a nutritious snack is provided at community playgroups (i.e. non-centre based services), often as an incentive to attend. But most community playgroups operate infrequently and the snack does not contribute significantly to nutritional security. Many home-visiting type programmes distribute food fortification products (sometimes on behalf of the clinic, as in Lusikisiki). In addition, home visiting programmes also assist in accessing grants, and poverty relief food parcels.

Vegetable gardens, at the scale and setup of most food garden projects, are not able to address the increased energy consumption requirements needed to overcome the high level of stunting among South African children. However they do have the potential to provide an important source of increased micronutrient intake, to fill the gaps not met by supplementation and fortification, and therefore support improved nutritional status and immunity to disease. They also have a proven ability to act as a buffer against extreme poverty and therefore play an important food security role.

WHAT MAKES A GOOD VEGETABLE GARDEN?

- All round harvesting of Vitamin A rich foods
- Adequate, safe & affordable water
- Continuing access to quality seed & seedlings
- Fencing
- Rural and farm localities

There is no data on the extent of food gardens linked to ECD services, but some centres and many home and community based ECD interventions encourage gardens. The Community Works Programme of the Expanded Public Works Programme has established food gardens at a number of ECD centres.

3.4.2 Cognitive and language stimulation

According to the norms and standards regulated by the Children's Act (as amended), all ECD partial care and programmes should include a cognitive stimulation component and the National

Early Learning Development Standards (NELDS) are currently the basis for this. They have been designed to cover the range of programmes of the National Integrated Plan, from what should be done at home to more formal settings.

The intention is to develop an explicit national curriculum for 3 to 4 year olds based on NELDS norms and standards. However, we caution that a single *compulsory* curriculum could stifle the creativity and diversity of programmes for early childhood development. A curriculum will only be helpful if it is flexible, practitioners have been trained in the principles of child development that enable them to adopts a variety of approaches which are consistent with the NELDS, and if implementation is supported (with materials as well if necessary). We need to avoid a situation of regulation without assistance and support.

NATIONAL EARLY LEARNING DEVELOPMENT STANDARDS: CHILDREN WHO CAN…

Think critically, solve problems and form concepts	Have a positive self-image and manage their own behaviour
Be aware of diversity and respect and care for others	Use language and communicate effectively
Learn about mathematical concepts	Develop physical and motor skills and understand a healthy lifestyle

Table 2 show the proportion of ECD facilities surveyed in three provinces in 2008 (PETS) which have a structured daily programme of cognitive stimulation, play, reading, resting and feeding. The high proportion of registered and unregistered facilities that follow a structured programme is impressive, and reinforces the point that adequate provision of learning and training material could significant enhance learning outcomes.

Table 2: Presence of a formal daily programme at ECD facilities in three provinces, 2008

	Registered	Unregistered
Yes, observed	84.0	72.2
Yes, but not observed	9.7	8.9
No	6.3	18.9

Source: Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch

Table 3 shows the proportion of ECD facilities in the PETS survey which differentiated their programme by age group (to facilitate age-appropriate learning).

Table 3: Differentiation of the daily programme by age group in ECD facilities in 3 provinces, 2008

	Registered	Unregistered
Yes, observed	57.9	52.2
Yes, but not observed	12.9	4.4
No	29.2	43.3

Source: Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch

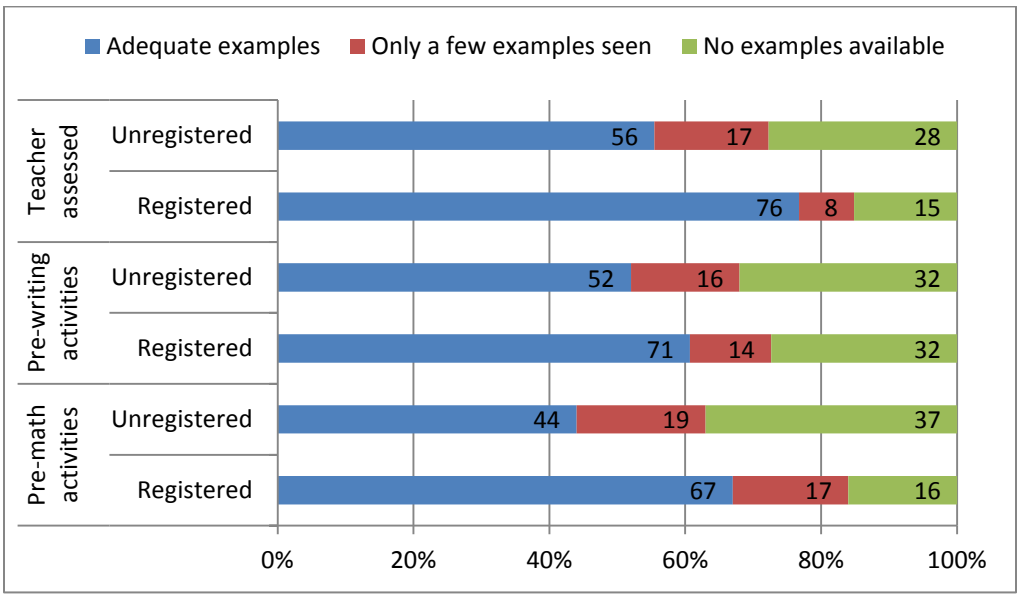
The majority of registered and unregistered community sites have a daily programme including play and care routines. Over half of community-based facilities have programmes differentiated for younger and older children. Language development activities (e.g. story time, language games, reading of picture story books, rhymes and singing) and creative activities (drawing, painting, perception games, puzzles, fantasy play, etc.) were common at registered community facilities.

3.4.3 Early literacy & numeracy development

It is clear from both province-specific and local data that activities related to literacy and numeracy development are weakly formulated in most early learning programmes. The Western Cape Audit Study showed that scores on the Language and Reasoning and Activities subscales of the Early Childhood Environmental Rating Scale (Revised), that measures provisions that promote language and cognitive and mathematical skills, are relatively weak (Dawes et al, 2010). An evaluation of a multi-site non-centre based ECD initiative (Sobambisana) found similarly low baselines in Eastern Cape, and Western Cape (Biersteker and Dawes, forthcoming).

Figure 11 shows the prevalence of pre-maths and pre-writing activities in ECD facilities in the three provinces surveyed as part of PETS 2008. It shows that over a third of facilities did not show required evidence of pre-writing and pre-maths activities.

Figure 11: Learning activities assessed in ECD facilities across three provinces, 2008



Source: Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch

Centres: There is need for a big focus on providing a range of activities, support for language, literacy and numeracy development and practitioner-child interaction to scaffold and mediate learning. This will require training, follow up and support and ensuring that there is equipment some of which could be improvised.

The creative aspects of exploration and choice of activity which promote active learning through child initiatives - which are strong in programmes such as Montessori and HighScope (among others) - need to be strengthened across the board.

Families: As part of interventions targeting primary carers, interaction with children should be encouraged, using household activities as learning opportunities. In particular, talking to children, telling stories and, where possible reading to them, are vital for cognitive and language development. Programmes should build on local childrearing practices and games, and find ways to involve older children as well as parents and grandparents.

3.4.4 Mediated group experiences

Preschool services provide obvious platforms for mediated group experiences that are critical for socialisation and peer-stimulation. Numerous resource training organisations across South Africa have developed models for providing group experiences to children who are not in centres. A number of these models have recently been evaluated as part of the Sobambisana initiative of Ilifa labantwana. The most promising of these models combine child-child interaction with a parent education component (Biersteker & Dawes, forthcoming).

3.4.5 Basic companionship and psychosocial support

ECD programmes involving parents and particularly those delivered through home visiting have a strong focus on supporting the caregiver to be able to manage nutrition better, cope with childrearing, provide a safe and hygienic environment, stimulate their children's curiosity and intellect, and provide counselling with respect to child protection. This is covered in the section on parenting. Alcohol abuse is a major risk factor for children, and community workers should also be trained to provide specific counselling, and know when to refer for professional help.

3.4.6 Access to health & social services

Registered centres require health records for admission (Dept of Social Development/UNICEF, 2007), so this is a point at which immunisation default should be detected and remedied. Similarly, children should be referred to social services in the case of poor home circumstances or suspected abuse. However, it seems that many ECD centres do not refer children appropriately and do not know what to do in cases of child abuse, despite their statutory duty to report (Dawes et al., 2010).

ECD practitioners should be trained to be able to refer families, not only to clinics and for social grants, but to other community support services as well. This responsibility should be reinforced by integrating child protection measures into the norms and standards of quality ECD provision.

As community- and home-visiting programmes are expanded, routine health assessment though growth measurement, review of Road-to-Health cards and basic screening should be inbuilt.

3.4.7 Children with special needs

Both the PETS survey of 2008 and the Nationwide Facilities Audit of 2001 found a prevalence of disability of 1 percent among children attending ECD facilities (Figure 4). The 2001 Census

estimated a disability prevalence of 2.1 percent among 0-9 year olds. Based on general coverage of about 30 percent, this suggests that only about 15 percent of disabled children aged 0-4 years of age are in ECD facilities. Given the paucity of community-based services for disabled children, this is an area that requires urgent attention.

Table 4: Prevalence of disability among children attending ECD facilities, 2001

Variable	Sub-variable	Number*	% within category	% range across (provinces)	
				Lowest	Highest
Disability	Overall	11,779	1		
	Physical disability	6,395	55	43 (NW)	67 (KZN)
	Mental disability	3356	28	9 (NC)	46 (NW)
	Behavioural/ autistic	828	7	2 (NW)	10 (EC)
	Multiple disability	1,200	10	1 (MP)	25 (FS)

Source: Williams T, Samuels M-L, The Nationwide Audit of ECD Provisioning in South Africa, Pretoria: National Department of Education, 2001.

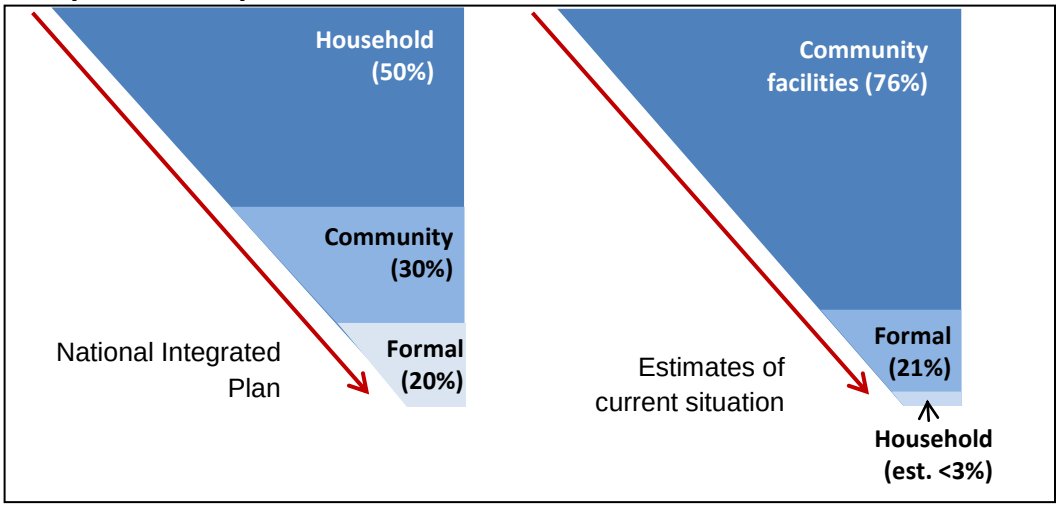
3.3 Programmes and services

The National Integrated Plan for ECD 2005 – 2010 (p35) committed Government to a continuum of intervention for early childhood development.

- The primary level of intervention for care and support is with the family at a household level. This includes quality care, nutrition, hygiene, safe shelter, water provision, primary health care and many other key caregiving practices.
- The community level includes access to services at clinics, community help groups and care centres, one-stop service centres, playgroups, parental support programmes, community management of childhood illnesses, etc.
- Formal services include crèches, day-care centres and preschools.

Actual ECD provisioning support by the DSD is largely centre-based, which is inconsistent with the weighting given to home and community levels interventions in the National Integrated Plan for ECD (Figure 12).

Figure 12: Service provision weightings as described in the National Integrated Plan for ECD (2005 – 2010) vs. current situation



Source: *National Integrated Plan for ECD, 2005 and National Income Dynamics Survey, 2008*

Improving supply: Substantial expansion of ECD services in South Africa will only be feasible if several modes of integrated delivery are combined to reach all the eligible children in any defined geographical area. Our view is that provision for children up to two years of age should focus on home-visiting, while that for 3-4 year olds should aim to provide opportunities for group interaction and learning. What is critical is substantially higher levels of coverage, and in the phase of accelerated scale-up, service provision for 3-4 year olds should focus on: i) extending subsidies to facilities that are registered but not subsidised; ii) improving access to resources of existing facilities; and iii) expanding non-centre-based services (including home visitation and community playgroups).

An effective strategy will be to: i) define the modes of service delivery (home-based programmes, community outreach and group activities, and centre-based services); ii) define per capita allocations per mode; iii) set specific targets for coverage with quality; and iv) implement the most appropriate mix of the modes of delivery to achieve high levels of exposure to one or more modes of delivery.

Creating demand: Educational programmes on radio and television are now widely used to reach children directly and engage caregivers in different countries (e.g. Philippines). Takalani Sesame, a partnership between Children's Television Workshop and the Department of Education initiated in 2000 is probably the best known programme in South Africa. In a study of media habits 69 percent of South African children (3-9 years) sampled in urban areas and 49 percent of sampled rural children view Takalani Sesame (Nielsen, 2003). A household survey in rural areas (Bub, 2005) indicated that children 3-9 years were familiar with the Takalani Sesame radio insert, and that the programme enjoyed the highest level of spontaneous recall of any children's radio programme amongst rural caregivers. This suggests that media do reach potentially large numbers of children and their caregivers who do not have ready access to other supports. Takalani has also had a community component using caregivers as mediators. Pre-post assessments of Season 1 show that children under five years show some improvement in the areas of literacy and numeracy, and life skills gains which were greatest when mediated by a caregiver or teacher (HSRC, 2003). An impact assessment of Season 2 (Khulisa Management Services, 2005) showed gains across all learning areas tested: literacy, numeracy, and life skills. The greatest improvements were evident among children exposed to television, both by itself or in a mediated condition. Radio had a greater effect on literacy than numeracy.

Sponsored newspaper supplements have also been quite widely used to provide ideas and resource materials such as books (e.g. Read Right Supplement). New forms of social media should be explored (especially cellphone technology) as a means of raising parent and community awareness of young children's needs.

Public education is required on the needs of young children, the important roles that parents and other caregivers play in their day-to-day interactions with young children, and the necessity to promote language and cognitive development, and the damaging nature of harsh punishment.

4. Institutional issues

Three fifths of children in the poorest two quintiles have no exposure to early childhood development services or even daycare (See Figure 3 on page 11). Despite significant attention to policy-related issues, access for poorer children has not improved significantly in the past 18 years. A critical reason is that current arrangements for ECD are not structured for scale-up. This section describes some of the key structural constraints and ways to restructure ECD provision in South Africa to enable scale-up to happen.

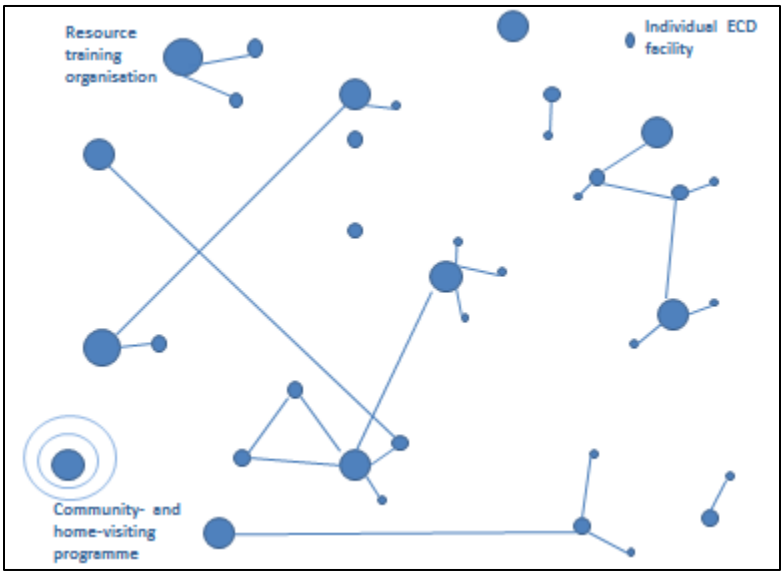
An immediate question is whether scale-up can happen while retaining quality of service provision. In the short-term, it is unlikely that accelerated scale-up will achieve the same quality as is achieved in formal, registered preschools. Unfortunately, the stalemate in the quality/scale-up debate has contributed to the low coverage of ECD in South Africa. What we need is a quantum leap in ECD provision, and good but pragmatic systems of quality assurance for the different types of programmes implemented.

4.1 Structure of ECD provision in South Africa

4.1.1 Service provision

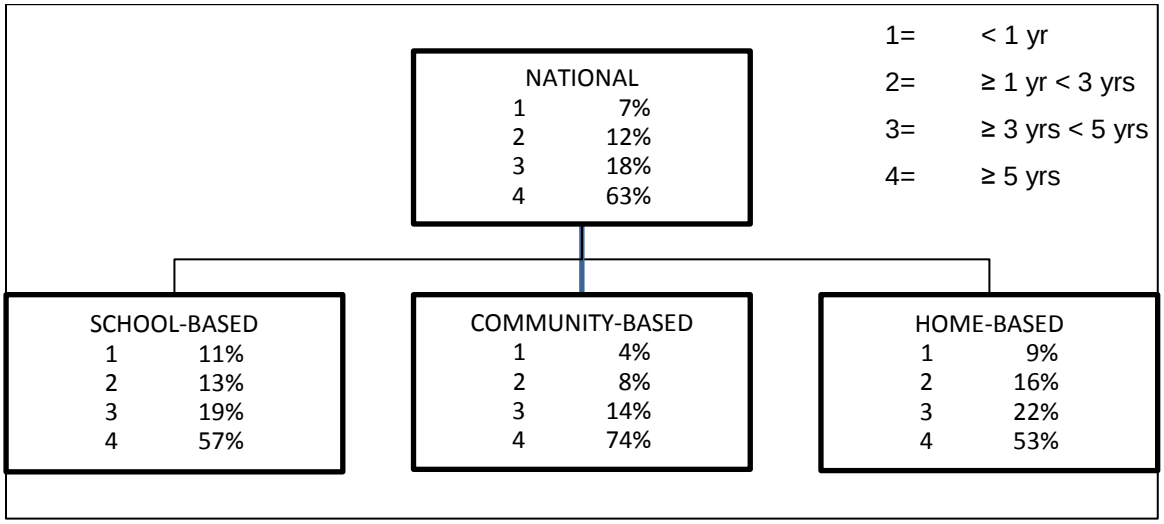
ECD services are largely provided by the non-profit sector. Resource Training Organisations (RTOs) provide training and in-service support to smaller community-based organisations (CBOs) and to individual crèches that provide ECD services. There are about 75 established RTOs in South Africa. They provide a solid grounding for ECD provision in South Africa, but the problem is that many children falls between the gaps – especially in communities where there are no RTOS, but even in communities where they are RTOs. Many individual childcare facilities have no relationship with an RTO. Few RTOs, and the CBOs they support, have attempted to achieve high levels of coverage for the most needy children in their catchment area; and few provide the comprehensive programme of support required to ensure quality (Figure 13).

Figure 13: Current organisation of ECD provision in South Africa



Despite the piecemeal nature of ECD provision, there is relative stability in terms of the durability of individual facilities. **Error! Reference source not found.** shows the time that ECD sites surveyed had been in existence at the time of the Nationwide Audit in 2000. The relatively low proportion of school-based ECD sites that had existed for longer than five years reflects the fact that Grade R was not yet implemented as national policy at the time of the survey. But it is notable that three-quarters of community-based sites had operated for five years or more. The remainder tend to come and go quite rapidly, usually as a result of financial unpredictability.

Figure 14: Duration of existence of ECD sites (National Audit 2001)



4.1.2 Government support and oversight

The Children's Act makes provision for the delivery of a national programme of early childhood development in South Africa. Further, it tasks provincial departments to develop ECD strategies to meet the early learning needs of children (although it places no obligation on provinces to fund them). An effective national programme will require a strong, central co-ordinating agency to set clear targets for expanded coverage and develop financing, human resource, management, monitoring and quality assurance strategies to achieve them.

National: There is no single Government department responsible for early learning opportunities for young children. The Department of Health is principally responsible for the nutrition and development of children to two years of age. The Department of Social Development is responsible for ECD for 3-4 year olds, while the Department of Basic Education is responsible for Grade R provision and above. It also is responsible for the education and training related aspects of all ECD provision. Relative to the need, the capacity of the respective Departments is very limited – currently with an ECD directorate in DSD and a Chief Directorate in the DBE, both under-resourced relative to their national responsibilities.

Provincial: Provincial responsibilities are still largely focused on the processes associated with learner subsidies in registered ECD facilities. In most relevant provincial departments, there are two or three officials (generally at deputy director level or below) responsible for ECD. In

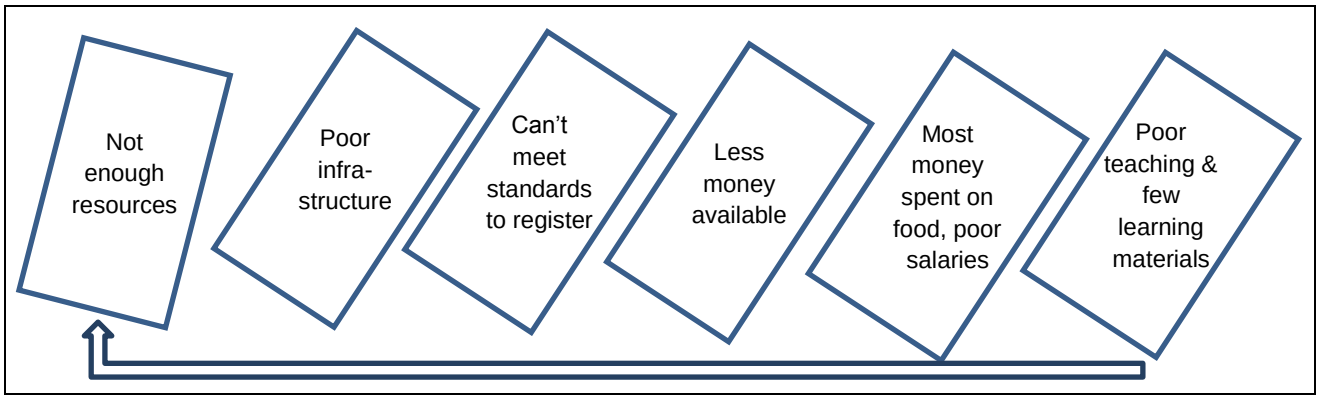
consequence, there is little authority, initiative or impetus to expand coverage, nor to implement a programmatic approach to ECD, as envisaged by the Children's Act.

Local authorities: Municipalities are required to ensure that ECD centres comply with Municipal Health and Safety By-Laws. They may include ECD within their Integrated Development Plans but there is no obligation on local government to fund ECD activities. Local government involvement in ECD varies from very little, to the provision of land and basic infrastructure, to support for ECD practitioner training and even limited subsidies for programme-related activities (Budlender & Giese, 2011). In future, their role in ECD should be specifically set out in their Integrated Development Plans, and at least include support for infrastructure provision and monitoring of basic health and safety standards as part of processes of continuing quality improvement.

4.2 Quality improvement

There is strong and consistent evidence that the current process of quality assessment and management discriminates against the poorest children and excludes them from the learner subsidy. This has a domino effect, with poor parents having to contribute more, children having less food, and less funding available for learning support material and teacher salaries (Figure 15). The net result is that the poorest children, who have the greatest need to supplement learning acquired in the home, have least access to quality ECD services. Many of the quality shortcomings in unregistered facilities relate to the lack of resources that could be addressed by provision of learner and training support materials.

Figure 15: Domino effect of unattainable standards for ECD facilities in poor communities



The focus needs to shift from inspection to continuing quality improvement. This process should include:

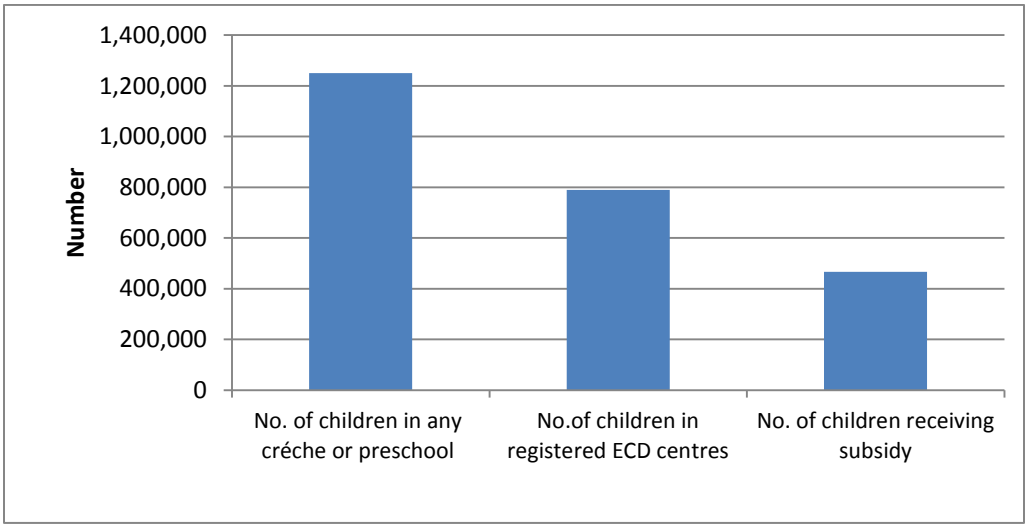
- Re-orientation of ECD practitioners and Government officials (local and Social Development) away from inspection models to processes of facilitated quality improvement;
- Establishment of baselines through facilitated self-assessment;
- Reward-driven processes of external assessment.

Further, processes of site registration are so cumbersome that poorer communities lose out. This section reviews the appropriateness of current norms and standards and approaches to quality assurance. It looks at the effects on access of current processes of site registration.

4.2.1 Site and programme registration

Of the children reported to be in preschool or crèches, about 40 percent have access to the means-tested learner subsidy (Figure 16).

Figure 16: About 40% of children in crèches or preschools receive a learner subsidy



Source: *Estimates of attendance based on National Income Dynamics Survey, 2008 & registration figures from L. Erasmus, DSD, 2011*

In terms of the Children's Act (as effective from April 2011), all ECD facilities and programmes need to be registered in order to operate. If this provision were implemented, it is likely that about a third of all ECD facilities would have to shut down (estimate based on number of children in registered centres compared with number of 0-4 year olds in any preschool or crèche). There has however been a significant (76 percent) increase in the number of learner subsidies over the past six years.

Even if sites are registered, it does not necessarily mean that they will receive the subsidy. Table 1 shows that two-fifths of children in registered facilities do not receive a subsidy. The PETS survey in three provinces found that over 40 percent of ECD facilities had to wait more than two years to receive funding after registration (Van den Berg et al., 2010).

The administrative requirements for registration are onerous: All ECD service providers (centre and non-centre based) are legally required to register their ECD programme with the provincial DSD (or delegated authority). In addition, ECD centres are legally required to register as a partial care facility. This dual registration - as a partial care facility and ECD programme - is a prerequisite for non-profit organisations to access the DSD subsidy but in no way guarantees receiving it (Table 6).

Table 5: Status of registration of ECD facilities (as of April 2011)

Province	No. of registered ECD centres	No. of children receiving subsidy	No. of children in registered ECD centres	% of children in registered ECD centres who receive subsidy
TOTAL	18 826	466 217	789 424	59
EC	2 911	75 880	82 336	92
FS	2 979	42 969	97 031	44
GT	3 473	56 082	151 649	37
KZN	3 167	70 815	123 545	57
LP	2 184	52 813	96 053	55
MPU	1 144	42 444	49 393	86
NW	980	30 732	64 161	48
NC	571	25 617	30 191	85
WC	1 417	68 865	95 060	72
TOTAL	18 826	466 217	789 424	59

Source: *Louise Erasmus, Dept of Social Development (April 2011)*

Table 6: Supporting documents to be submitted with each application for registration

Registration as part of partial care facility (Form 11)	Registration of ECD programme (Form 16)
Proof of relevant staff qualifications	Staff composition and proof of skills
A report by a social service professional on the viability of the application	Overview of ECD programme
A business plan	Implementation plan for ECD programme
A constitution	Clearance certificate that name of applicant does not appear on National Register for Sex Offenders
Original copy of approved building plans or plans submitted for approval	
Emergency plan	

Source: *Budlender D, Giese S, Berry L, Motlala S, Zide H, Government funding for early childhood development: Can those who need it get it? 2011, Cape Town: Ilifa labantwana*

In the PETS study, three quarters of ECD facilities that had registered stated that they had found it difficult to apply for funding, with the poorest province experiencing the greatest difficulty (Table 7).

Table 7: Proportion of registered community based ECD facilities finding it difficult to apply for DSD or DoE funding

	Province 1	Province 2	Province 3 (poorest)	Total
DSD funding	68.0%	66.7%	78.7%	74.9%

Source: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

4.2.2 Quality inspection versus continuing quality improvement processes.

In order to secure the per-capita subsidy, individual crèches and preschools are assessed according to a set of norms and standards which are often incompatible with the realities of communities that need the subsidy most. Implementing high standards of fire, safety and sanitation may seem non-negotiable, but fact is that children being cared for at home during the day in these same communities are exposed to serious environmental hazards every day. There is a need to review the norms and standards for registration to make them more appropriate to the realities of day-to-day living, while ensuring that children are adequately protected from risk, with time-bound plans for assistance and support to bring facilities up to desired standards.

The current norms and standards are listed in Table 8. While most appear reasonable, many are unattainable for community-based facilities without the financing that would be secured through registration. Provisional registration of facilities helps to unclog this bottleneck, and often the main sticking point is the set of standards imposed by local authorities. This 'chicken-and-egg' situation could be resolved by separating out non-negotiable but realistic standards of environmental and physical protection, from other standards that could be incrementally attained over a defined time period. As community playgroups expand as part of the mix of district-based interventions, infrastructural requirements for ECD will not be appropriate for this mode of delivery, and specific criteria for programme registration will need to be developed.

Table 8: Norms and standards for registration at ECD centres

- A safe environment for children within the facility and while travelling to and from the facility.
- Proper care for sick children or children who become ill.
- Adequate space and ventilation in compliance with building standards.
- Access to safe drinking water.
- Hygienic and adequate toilet facilities, including one potty for every child under the age of 3 years, and one toilet for every 20 children aged 3-6 years.
- Access to refuse disposal.
- Hygienic area for food preparation, including cooling facilities and covered containers.
- Measures for the separation of children of different age groups.
- Action plans for emergency situations.
- Norms and standards for ECD programmes include requirements for:
- Appropriate developmental opportunities delivered by staff trained in ECD programmes, basic health care and first aid.
- Programmes aimed at helping children to realise their full potential and ensuring positive social behaviour.
- Minimum staff - child ratios of:
  - 1:6 for children between the ages one month and 18 months, plus an assistant where possible*
  - 1:12 for children between the ages 18 months and three years, plus an assistant where possible
  - 1:20 for children between the ages three and four years, plus an assistant where possible
  - 1:30 for children between the ages five and six years, plus an assistant where possible
- Respect for and nurturing of the culture, spirit, dignity, individuality, language and development of each child, including assistance with birth registration.
- Programmes which meet the emotional, cognitive, sensory, spiritual, moral, physical, social and communication development needs of children, including support to caregivers and household visits.

Source: *Summarised from Dept of Social Development & UNICEF, 2006*

* Note that the norms and standards of the Children's Act have eliminated the qualification 'where possible' and now require mandatory compliance. This is impractical and will impose further barriers to registration.

4.3 Human resources for ECD provision

Human resources for ECD provision are characterised by:

- Reasonable learner: staff ratios in registered ECD facilities, but insufficient trained personnel in unregistered facilities
- Low levels of pay for ECD practitioners, particularly in poorer communities;
- A trade-off between payment of practitioners and allocation of Government subsidies for the nutritional and learning needs of children in ECD facilities;
- Training focused on facility-based ECD. SAQA standards for non-centre based service provision exist as part of community development qualifications, but there are few opportunities for training; and
- No clear career path for ECD practitioners.

4.3.1 Adequacy of personnel numbers

As adequate staff numbers is a prerequisite for registration, it is not surprising that learner:staff ratios are reasonable in registered facilities. In the Nationwide Audit of 2001, the ratio varied from 16:1 in Gauteng to 24:1 in the Eastern Cape and Northern Cape. The 2008 PETS survey found, on average, 2.7 ECD practitioners or teachers employed in each of the registered facilities, and 2.4 administrative and support staff. This translated into staff child ratios of 1:11, well within the national norms. There were 0.8 volunteers per facility, reducing the work load, as volunteers worked an average of almost 18 hours per week (it should be noted that some (40 percent) of the volunteers received a stipend). As normative staff-child ratios are a condition of registration, compliance is not unexpected. The learner:staff ratios in unregistered ECD facilities are unknown, but are likely to be far higher.

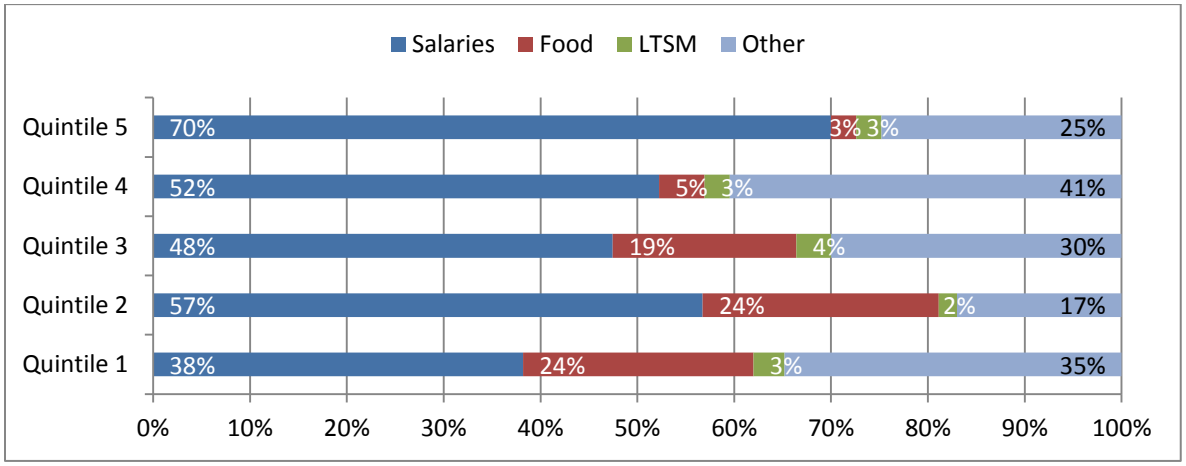
Norms and Standards are still being revised for practitioners working with children birth to four years. Assuming a learner: teacher ratio of 20:1, about 50,000 ECD practitioners would be needed to provide universal coverage for children aged 3-4 years of age in the two lowest income quintiles. A ballpark target for ECD practitioners (for children 0-4 years of age) would be in order of 100-120,000. We do not know how many ECD practitioners there are currently, but the 2001 survey found a total of 44,653. This figure concurs with the current estimates of learner coverage of roughly one-third, suggesting that human resource planning should aim to address the shortfall of 50-70,000 ECD practitioners (for both centre and non-centre-based provision).

4.3.2 Remuneration for ECD practitioners

Remuneration for ECD practitioners is very low. The PETS survey found that salaries averaged R2,383 per month (R2,849 at 2011 prices). There is no significant relationship between qualification and remuneration (Table 9).

Figure 17: Use of learner subsidies in registered ECD facilities in three provinces, by quintile (2008) illustrates that ECD facilities in the poorest communities spend a smaller proportion of the learner subsidies on salaries, as food constitutes a significant proportion of budget. This finding emphasises the importance of de-linking funding for staff remuneration from funding for nutrition, learning and training support material and other programme-related activities.

Figure 17: Use of learner subsidies in registered ECD facilities in three provinces, by quintile (2008)



Source: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

4.3.3 Training and accreditation

Practitioners working in centres: There are accredited courses for ECD practitioners at Levels 1, 4 and 6. However, about half of practitioners are under-qualified or not qualified (Table 1).

Table 9: Teacher post-school and ECD-related qualifications of practitioners in community-based ECD facilities

PETS 2008			National Audit 2001	
Qualification	**%**		**Qualification status**	**%**
Not specified/ no training	14.0%		No training	23%
Short courses on ECD	15.3%		Under-qualified	15%
ECD Certificate Level 1	17.4%		NGO-trained (not accredited)	43%
ECD Certificate Level 4	19.6%		Qualified in fields other than ECD	7%
ECD Certificate Level 5	12.8%		Qualified in ECD	12%
Other ECD or unspecified certificate	7.5%			
Diploma	6.7%			
University degree	2.2%			
Postgraduate diploma	3.9%			
Postgraduate degree	0.6%			

Source: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

Williams T, Samuels M-L, The Nationwide Audit of ECD Provisioning in South Africa, Pretoria: National Department of Education, 2001.

The Expanded Public Works Programme (EPWP) ECD Programme is the training component of the National Integrated Plan and has been the major initiator of supported practitioner training since 2004. The DBE is responsible for the human resource development aspects of the service provision for 0-4 year olds; DSD identifies practitioners in registered ECD sites and the DBE selects, offers training and pays a stipend during the training.

- The current target set in the EPWP Social Sector Plan is to train 80,000 practitioners and Grade R teachers at Levels 4 and 5 for the period 2009/10 to 2013/14. Unfortunately, EPWP reporting is difficult to understand and relate to individuals. For example, its five year report for the year ending 2008/9 states that 356,665 ECD training days were funded and 31,000 work opportunities were created during this period (Dept of Public Works 2010). However, it is not clear how many ECD practitioners were trained, and the 'work opportunities' cited refers to stipends provided during training.
- At present much of EPWP-funded training addresses backlogs in the sector, which is essential for expanding quality but not sufficient for expanding access to services. Grade R, which offers a better salary package, tends to draw practitioners currently working with pre-Grade R children once they have been trained.

In addition, there is donor supported accredited training through NGOs registered as private FET institutions but this kind of support has declined due to public sector involvement in training. Opportunities exist for those who can afford to pay the fees through FET and private colleges or UNISA.

A number of skills courses which are not accredited but which can improve performance and work efficiency are offered by different providers e.g. Financial Management, Governance and Leadership Training, HIV AIDS Awareness, Legalities and Childcare, and basic classroom enrichment. The extent of this is not known.

Home and Community Based ECD Practitioners: As early childhood development services are extended, it will be critical to expand the number of community development workers with an ECD specialisation, and to provide for ECD specialisation among other cadres of community-level workers such as auxiliary social workers.

There are SAQA accredited Community Development Qualifications with ECD specialisation options at GETC (Community Development ABET), Level 3, 4, 5 and 6. However, to date there have been no funded learnerships with an ECD specialisation for this emerging category of workers. These workers are usually elected from the communities in which they live and cannot afford the costs of training.

As there is no post provisioning for home and community ECD practitioners many are stipended workers or volunteers with the result that there are high attrition rates and the loss of capacity building investments. Skills courses with a strong practical component may be a better option until there is greater workforce stability.

There is a need to develop capacity for Recognition of Prior Learning (RPL) to accelerate the training process. The ETDP SETA has a new focus on RPL and ECD practitioners are a target group for this, but currently public and private training providers are reluctant to take this on because it is challenging, expensive and has not been funded.

Furthermore, there is a need to articulate ECD training with other child-oriented initiatives such as child and youth care workers, and home and community workers. In this regard, a number of initiatives (such as incorporation of ECD training into the *Isibindi* model are currently being trialled.

Progression: There is a need for higher level qualifications for ECD personnel working with 0-4 year olds at higher, given the crucial importance of development in the early years. At present only Grade R is receiving consideration and a Level 5 National Diploma in Reception Year training will be phased in. The B Ed Degree focuses only on Foundation Phase. There are no specialist post graduate degree courses in South Africa. There is an urgent need for higher qualification and specialisation opportunities for personnel working with 0-4 year olds. In this regard, the requirements for access to higher educational institutions for learners who have completed Level 4 and Level 5 need to be addressed, so that vertical progression is enabled and achievements credited.

Management: For principals/supervisors training, a management component should be included in the training. Studies indicate the significant role that leadership and management and governance plays in centre quality (Dawes et al., 2010) and the recent ECD Public Expenditure Tracking Study indicates that weak bookkeeping is endemic in community facilities. An HSRC study also found that centres with poor administration and financial management systems were less likely to access in kind or financial donor support (Carter et al., 2008). Leadership and management training is also a critical area for development for those in supervisory and training positions in ECD sector, including government officials and training providers. Ilifa labantwana[3] has recently funded 130 leaders of resource training organisations to participate in a one-year leadership and management programme provided by Regenesys, as part of an effort to build the capacity of RTOs and ensure solid leadership succession planning.

Overall: Training supply is uneven, both geographically and in terms of access to higher levels of qualification starting at Level 5. A strategy will have to be developed to provide greater training access through distance learning, satellite campuses and increased allocations for learnerships and skills

Language proficiency and literacy levels have been identified as a key challenge at all levels of training. Quality assurance of training provision should monitor the availability of bridging programmes and the availability of home language instruction where appropriate, and ensure that the lower skill categories are able to cope with the training programmes offered.

Information on ECD practitioner education and qualification levels should be collected and regularly updated to facilitate planning and budgeting

4.3.4 Working conditions and professionalisation

There needs to be a comprehensive plan to expand and upgrade the ECD sector.

The uptake of higher-level qualifications and the retention of trained ECD practitioners in the sector depend on sustainable jobs and opportunities for career pathing and progression. It is

[3] Ilifa labantwana is a national initiative to expand access to quality ECD. It is spearheaded by three funders, namely the DG Murray Trust, the ELMA Foundation and the UBS Optimus Foundation

urgent that government and civil society stakeholders initiate a process to determine minimum salaries for the ECD sector and make recommendations for salaries linked to qualifications and responsibility. Professionalisation of ECD has generally been associated with better outcomes in other countries (Biersteker 2008) and ECD sector advocates are actively pursuing options with the DSD.

Training on its own is not sufficient to improve quality service delivery. Very high priority should be given to providing on-going monitoring and support to ECD services by provincial and local government staff conversant with what a quality service for young children entails.

Career progression and job stability is also required for ECD practitioners in community outreach and home-visitation programmes, and there are currently several initiatives to integrate family and community-based ECD workers into the formal Social Auxiliary Worker (SAW) programmes.

4.4 Systems required for programme-based support

The programmatic approach to ECD provision contemplated in the Children's Act is not supported by current organisational structures.

4.4.1 ECD planning and management

Population-based planning: ECD management within Government departments is framed in terms of site assessment, subsidisation and inspection. A central shift in thinking is required to envisage and develop programmes aimed at reaching the majority of children in a defined geographical area through a combination of centre-based provision, community-outreach and clinic and home-based programmes, including home-visitation.

Establishment of a central ECD agency: Given the intersectoral nature of ECD provisioning, we recommend the creation of a central agency for early childhood development. This agency should be responsible for assisting provinces to develop comprehensive ECD programmes aimed at achieving universal coverage of ECD services (centre- and/or non-centre-based) for 3-4 year olds, and clinic, community- and home-based programmes for 0-2 year olds in poorer communities.

The agency of the Department of Social Development should have delegated responsibility for:

- Development of a national strategy for properly resourced, co-ordinated and managed early childhood development (as per Section 92(1) of the Children's Act);
- Development of a national communication strategy for ECD;
- Technical support to provinces in designing and implementing provincial ECD strategies;
- Monitoring of ECD implementation nationally.

This should be done in conjunction with the Department of Basic Education, which will continue to take responsibility for the curriculum and training.

Consolidation of provincial capacities: ECD management capacity within provincial departments of social development should be strengthened to enable them to implement province-wide programmes, in conjunction with municipalities. We envisage an ECD unit at

Chief Directorate level. These units should have the management and financial capacity to contract with, ensure timely payment and effective oversight of programmes aimed at reaching all children from poor and disadvantaged children within each province.

Contract with sub-agencies: We recommend a policy of universal provision of ECD for 3-4 year olds. We propose that the ECD units within each provinces contract non-profit agencies to provide ECD services. We do not believe that there is a role for for-profit agencies to be contracted by the State at this time (although this may be phased in at a later time). Those resource training organisations that are willing and able should be supported to expand their areas of operation, and develop mechanisms to achieve rapid scale up.

Develop mechanisms for scale-up with quality: Such mechanisms may include social franchising and 'umbrella-body' supervision. In addition, there are other organisations – not traditionally viewed as ECD providers - with an extensive community footprint that can be used to expand access to a structured package of cognitive stimulation and literacy/numeracy support. These include the National Association of Child and Youth Care Workers and health-related programmes such as Aids Foundation of South Africa, Kheth'impilo and Philani Nutrition Programme, as well as other child-oriented community worker initiatives.

4.4.2 In-service support and training

At present, the principal interaction between Government and service providers is as inspector, administrator and financier. Systems of registration and accountability can and need to be simplified, and greater focus should be placed on progressive quality improvement and support. Several resource training organisations have developed quality improvement programmes that could serve as examples.

4.4.3 Resource materials provision

The dire shortage of learner training and support materials (LTSM) is described in Section 3.3 above. We will not improve educational outcomes in South Africa while 40-50 percent of ECD facilities do not have books to read or paper to write on (see **Error! Reference source not ound.** on page 13).

As part of the programme rollout, funding must be made available to expand access to LTSM. Innovative collaboration with print media houses can increase access to materials at marginal costs. Systems of toy libraries can be developed and implemented in conjunction with municipalities. This is an area in which the private sector can directly support the expansion of ECD.

4.4.4 Monitoring

A robust monitoring system should be developed, using identification numbers (and temporary assigned numbers where these are not available) as unique identifiers. This is necessary to reduce the risk of overstatement of enrolment in ECD programmes. The PETS survey of 2008 found an absentee rate of nearly 20 percent in the 318 facilities it surveyed (Table 10). Although it concluded that the incentives for fraud are not great at the present time, the expansion of financing ECD may create incentives for new entrants into the field who attempt to

exploit subsidy funding for personal gain. Interestingly, absentee rates were substantially lower in ECD facilities serving the poorest children, suggesting that perverse incentives may not be strong for service providers in these areas (Van den Berg et al., 2010).

Table 10: Average enrolment and absenteeism

	Enrolled 2009	Present 2009	% absent 2009
Total	**64.6**	**51.9**	**19.6%**
Quintile 1	56.3	49.4	12.3%
Quintile 2	63.7	53.3	16.2%
Quintile 3	66.2	52.1	21.4%
Quintile 4	72.6	55.0	24.3%
Quintile 5	62.0	46.0	25.9%

Note: Unweighted data.

Source: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

5. Financing of ECD provision

Government spending on learning opportunities for children 0-4 years of age is less than 1 percent of its spending on basic education. Given the importance of ECD in determining long-term learning potential, this is a major missed opportunity to improve educational outcomes in South Africa.

In terms of current spending on ECD, the fiscal incidence is highly progressive i.e. subsidies are well targeted towards children in the poorest quintiles (concentration coefficient -0.219, PETS 2008). However, we should not lose sight of the fact that the majority (>80 percent) of children in the poorest 40 percent of the population are still entirely excluded from registered ECD provision and thus do not feature in calculations of fiscal incidence.

The DSD subsidy was introduced in terms of regulation 38 of the Child Care Act of 1983 and has increased steadily over time.The government target for subsidised children is to double the number of children receiving subsidies to 600,000 by 2014. In March 2011, 476,000 children were receiving a subsidy, a significant increase from 270,000 in 2004/5. Subsidies have increased annually from a minimum of R9 per child per day in 2008 to R12 in 2010/11 and will be increased to R15 in the next budget cycle. (However, the actual amount varies from province to province: Free State, Limpopo and the Western Cape paid R9 in the 2008/9 financial year, the Northern Cape R10 and Gauteng R11. The means test also varied from province to province – from R1,800 in Mpumalanga and R2,460 in the Western Cape (Martin, 2011).

5.1 Provincial funding flows

Unlike the Department of Basic Education - which has standardised budget line items for ECD training and Grade R provision, the provincial Departments of Social Development do not. For that reason, it is very difficult to calculate total budget and spending on ECD. Most of the expenditure is recorded within the Child Care and Protection sub-programme, but is allocated against different line items. In order to manage and monitor ECD provision as an apex provision, budget line items for ECD within the key departments of Health, Basic Education and Social Development should be standardised across all provinces and nationally.

Table 11 describes the provincial budgets for ECD centres and programmes, based on information derived from the provincial budgets for social development for 2011/12.

Table 11: Available data: Social Development provincial budgets for ECD centres and programmes (2011/12)

Category	EC	FS	GT	KZN	LP	MPU	NC	NW	WC	TOTAL
Transfers to NGOs	134.9	172.3	162.0	274.3	-	212.8	54.2	N/A	87.8*	**1 098.3**
Other programme support	-	3.9	-	-	-	-	-	15.0*	3.7	**18.9**

* Data reported for 2010/11

Error! Reference source not found. Table 12 shows the ECD-related expenditure reported under the Expanded Public Works Programme (EPWP) in 2010/11. It should be noted that some of the expenditure listed in Table 11 above may be also reported as EPWP expenditure, resulting in double counting of actual expenditure.

Table 12: ECD-related expenditure reported under Expanded Public Works Programme (2010/11)

Category	EC	FS	GT	KZN	LP	MPU	NC	NW	WC	TOTAL
EPWP*	5.7	17.7	-	-	10.2	0.1	-	-	63.2	**96.9**

* Data reported for 2010/11

***Sources**: Budlender D, Giese S, Berry L, Motlala S, Zide H, Government funding for early childhood development: Can those who need it get it? 2011, Cape Town: Ilifa labantwana*

Budlender D, Proudlock P, Funding the Children's Act: Assessing the adequacy of the 2011/12 budgets of the provincial departments of social development, 2011, Cape Town, Children's Institute, University of Cape Town. http://www.ci.org.za/depts/ci/pubs/pdf/researchreports/2011/ca_funding_2011-12_budgets_report.pdf

It should be repeated that roughly a quarter of registered ECD facilities do not receive a government subsidy at present. Table 13 shows the percentage of registered community-based sites that receive Government funding in the three provinces surveyed as part of the PETS survey, 2008.

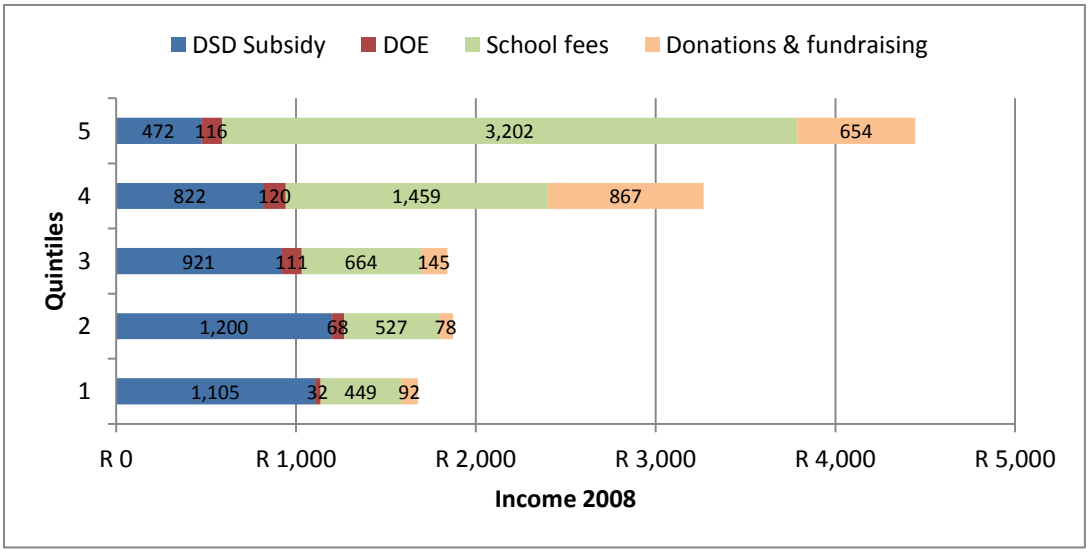
Table 13: Type of registered community based ECD facility and which Government department funds it, PETS survey 2009

	DSD	DoE	DSD & DoE	Neither
Grade R only	7%	83%	5%	5%
Pre-Grade R only	56%	4%	14%	26%
Both Grade R & Pre-Grade R	35%	15%	26%	25%
% of total	38%	20%	20%	23%

Sources: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

The lack of funding available for non-profit sites that are already registered – let alone those that are not – is a matter of great concern, particularly as the DoSD subsidy provides most of the funding available in the poorest communities (**Error! Reference source not found.**). On verage, ECD facilities in the highest income quintile spend 2½ times as much on those in the lowest quintile.

Figure 18: Sources of income in registered community-based ECD facilities, 2008 (income per enrolled child per year)



Sources: *Van den Berg S, Williams B, Burger C et al, Tracking public expenditure and assessing service quality in Early Childhood Development: Insights from a survey of three provinces, August 2010, Department of Economics, University of Stellenbosch*

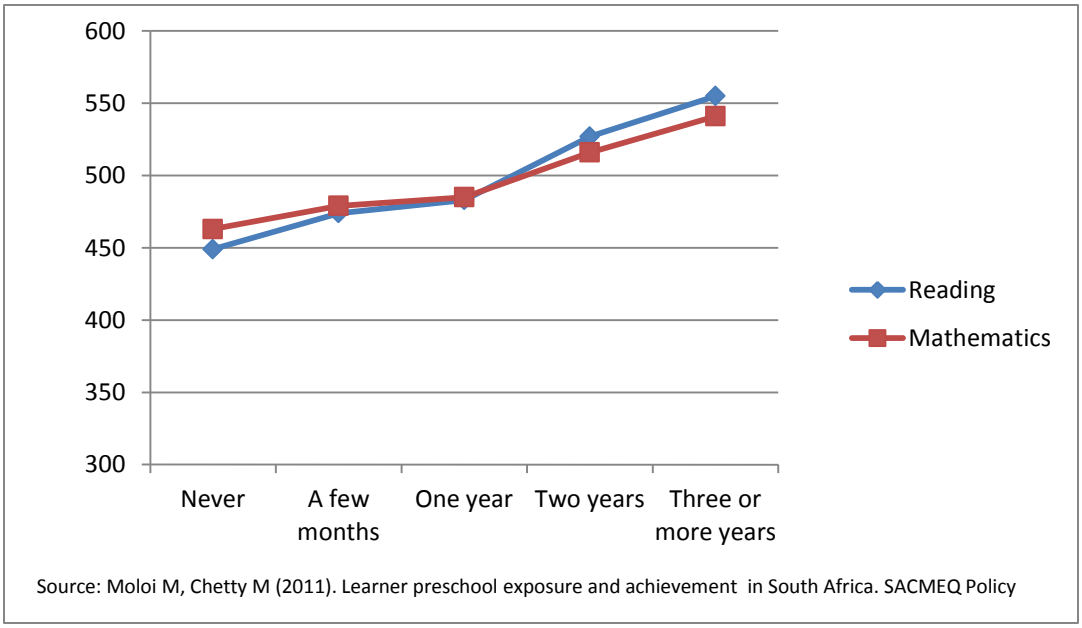
6. Impact

6.1 School readiness and ability to learn

There is strong international evidence linking preschool attendance with improved educational outcomes. However, few studies linking the two have been done in South Africa.

The 2007 SACMEQ survey (n=9071) found that Grade 6 children with three or more years of preschool experience achieved mean reading scores that were 23.6 percent higher than children who had never attended preschool. Similarly, the scores for mathematics were 16.8 percent higher among those who had attended preschool for three years or more (**Error! eference source not found.**).

Figure 19: Learner performance by preschool exposure, SACMEQ Study 2007



Source: Moloi M, Chetty M (2011). Learner preschool exposure and achievement in South Africa. SACMEQ Policy

The 2008 wave of the National Income Dynamics Study included the testing of numeracy competencies among respondents using four tests with differing levels of difficulty, depending on school grade. However, survey participants were asked whether they would like to participate and it is not clear whether the grade of test was consistently applied. The results must thus be interpreted with considerable caution as there exists a potential selection and measurement bias. There does however appear to be a positive impact of preschooling in a rural informal context, which is statistically robust and independent of home background (Gustaffson, 2010)

6.2 Assessment of non-centre based models of provision

The Sobambisana Programme evaluated non-centre-based interventions in five sites in different areas of South Africa. Its findings were limited by sample size and lack of an adequate control group for some measures. It should therefore be noted that non-significant findings do not

necessarily mean that the programme had no effect on those outcomes, but that the study lacked statistical power to demonstrate effect – either positive or negative. Following is a summary of the findings, where rating of impact is shown in terms of statistically significant findings.

Consistent statistically significant findings	**Variable findings: some significant; some no effect**	**No effect shown**

6.2.1 Outcomes for Home-Based Programmes (Visiting)		**No. of programmes assessed**	**Rating**
Reach	Vulnerable children and caregivers were reached by all three partners.	3	
Access to Social Grants and Services for children.	Access increased significantly in Lusikisiki where a strong holistic community development approach was used.	3	
Safety and Hygiene in the home.	Where this was low at baseline, programmes improved safety and hygiene in the home.	3	
Knowledge of early development and improved stimulation of young children.	Findings are variable. Programmes of longer duration with good oversight improved parenting and early stimulation in the home.	3	
Caregiver coping.	Significant improvement was achieved in caregiver coping over time	1	
Child cognitive, numeracy, language and emotional development.	Home visiting could not be shown to have an impact on these outcomes.	1	
	Home visiting could not be shown to have an impact on Grade R outcomes	3	

6.2.2 Community Playgroups with Parent Education Components		**No. of programmes assessed**	**Rating**
Improved Safety and Hygiene in the home.	Significant positive change was achieved.	1	
Knowledge of early development and improved stimulation of young children.	Significant positive change was achieved.	1	
Access to Social Grants and Services for children.	Access increased in the programme where a strong holistic community development approach was used.	2	
	Significant positive change in cognitive and language development was achieved in children who had high rates of participation.	2	

	Promising impacts on cognition and school readiness in Grade R are evident for playgroup programmes where inputs are highly aligned to schooling.	2	
Community Playgroups without Parent Education Components			
Child cognitive, numeracy, language and emotional development.	Impact data for Grade R is available. No impact was evident.	1	
6.2.3 Centre- and school-based interventions to improve quality		**No. of programmes assessed**	**Rating**
ECD site and classroom quality.	Regardless of the type of intervention, classroom quality improved in almost all cases, sometimes substantially.	5	
Impact of training and enrichment on children in Grade R on child cognitive, numeracy, language and emotional development.	Children who had attended classrooms where teachers were trained by partners achieved better scores on all outcome measures than children who had not been exposed to an ECD programme, or who had been exposed to a home visiting or playgroup programme. Academic readiness, cognitive, numeracy – highly significant compared with no intervention. Not significant for vocabulary or resilience.	5	
6.2.4 Advocacy and service integration (Engagement with Government, NGOs and Community Members to facilitate integration and access to services)		**No. of programmes assessed**	**Rating**
Access to Social Grants and Integration of Services for children. **Community awareness of the rights and needs of young children.**	Advocacy was most successful when efforts were sustained, had a clear purpose, and where officials and community members came together at meetings to discuss the actions that needed to be taken to improve access to child services.	4	

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Background Paper 8

Human resource development for ECD programmes and services for 0-4-year-olds

Linda Biersteker

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Key Points

Issues:

- Suitably qualified staff is critical for service quality, and Children's Act regulations require this. There is no new national data on numbers or training levels of ECD practitioners but recent local studies indicate that the ongoing problem of very large numbers of un- or under-qualified practitioners identified in the 2000 National Audit.
- Registered qualifications at Levels 1, 4 and 5 are suitable for practitioners working in the 0–4 year-old cohort. Higher qualifications tend to be focused on Grade R. Community Development Qualifications include an ECD specialisation suitable for ECD practitioners working in outreach programmes targeting primary caregivers and children. The lack of articulation of ECD qualifications at levels 4 and 5 with those offered by Higher Education Institutions needs addressing.
- The Department of Basic Education working with the Department of Social Development has provided for a large scale learnership programme to address the training backlog in the sector, mostly through the Expanded Public Works Programme. By mid 2011 27,419 ECD qualifications had been verified by the ETDP SETA. The current target for 2014 is to train 80,000 practitioners and Grade R teachers at Levels 4 and 5. Between 2009 and 2011, 26,032 learnerships had been made available highlighting the limited capacity of training providers to meet current needs and those of an expanding system of provision. Further, large numbers of those trained are being absorbed by Grade R classes. No subsidised training has been made available for ECD outreach workers.
- Other human resources issues affecting the quality of service delivery are limited support and monitoring of implementation by appropriately trained departmental officials, as well as poor wages, service conditions and opportunities for career progression in the sector. These result in high staff turnover and low motivation.

Recommendations:

- Develop a human resource development strategy to improve staff qualifications and retention for ECD. This must include an audit of existing staff qualifications and resourcing for initial training and upgrading for all workers in the sector, including those in support and monitoring positions and centre and outreach ECD practitioners.
- Continue with provision of subsidised training opportunities and expand these to all categories of ECD practitioner. By creating the demand, the training supply will increase.
- Professionalise ECD by enabling practitioners at all levels to register through appropriate occupational bodies which will assist with developing job hierarchies and career progression and linking to incentives.

- Development of a core package of ECD messages for inclusion in the training of home- and community-based workers employed in different sectors who reach young children. These include Community Development Workers (DPSA), Community Health Workers (DoH), Community Caregivers (CCGs) trained by the DSD, and there are unknown numbers of Community Care Workers, Child Care Workers and other categories of home and community-based workers. These people comprise a significant human resource and all interface with children, especially young children, in the home and community. If there was an overall framework under which such groups work in communities, and some common conditions, training, qualifications and remuneration, it would be possible to advocate for training in and delivery of basic early child development principles and practice for all cadres.

Human resource development for ECD programmes and services for 0-4 year olds

1. Human Resource Development for ECD Programmes and Services for 0 – 4 year olds (prior to Grade R)

Note: This input covers the HRD requirements for all those working in ECD programmes and their management, i.e. it relates to input papers on Safe and Affordable Childcare (Background Paper 5), Parenting and Opportunities for Learning (Background Paper 6). It does not cover HRD for health workers who deliver services for young children and their mothers, though the need to consider a core component of training for all whose work includes a focus on 0-4 year olds is raised.

1.1 Introduction

Policy and legislation refer to a range of services to support children's holistic development delivered at different sites of care. These include home and community services, as well as the formal ECD services we know as ECD sites, preschools or crèches.

- Qualifications of practitioners have been found to be associated with improved child outcomes over a range of countries and contexts and are often used as a service quality indicator (Dlamini, Ebrahim, Ntshingila-Khosa & Soobrayan, 1996; Biersteker & Kvalsvig, 2007; Fukkink & Lont, 2007; Love, Schochet & Meckstroth 2002; Myers, 2001; Tarullo, 2002 and Weikart, Olmstead & Montie, 2003).
- However, Early et al. (2007) found contradictory associations between teacher education levels and classroom quality, suggesting that raising the effectiveness of ECD services would require a broad range of professional development activities and supports. Dawes et al. (2010) found that qualification level (ECD Levels 1, 4 or 5) was not a significant determinant of classroom quality for 3–5 year olds, though it was for baby and toddler classes in a sample of Western Cape ECD classes.
- While training alone may not be sufficient for achieving high quality early learning environments, a supply of of accessible and appropriate training opportunities at different levels for different jobs in respect of ECD programmes and services is critical.
- Almost all ECD training for practitioners working with the birth to four cohort falls under the ETDP SETA either through ECD qualifications for those working in centres or ECD specialisations of Community Development qualifications for those working in home and community based contexts. The Draft Sector Skills Plan 2011-2016 (ETDP SETA, 2011a) which is informed by the National Skills Development Strategy 111 of 2010 is aimed at

ensuring access to training and skills development, opportunities for employment in the sector.

2. Practitioners Working in Centres

2.1 Estimating the demand for training

- There is no comprehensive data source available on either numbers or training levels of practitioners working in the ECD sector. According to the Nationwide Audit in 2000 (Department of Education, 2001) there were 48,561 ECD practitioners working in ECD facilities (including Grade R classes) and most of them were unqualified or under-qualified. Services have since expanded dramatically. In 2008 there were over 10,000 practitioners in the Western Cape alone, but 57 percent of them did not have an accredited qualification (September, 2009).
- This does not take account of upgrading needs. A similar proportion of about two thirds of practitioners in unregistered sites audited in 2011 were untrained and 81 percent of those with training required upgrading (Biersteker & Hendricks, 2012). If one considers that the Western Cape has several well established ECD training providers it is likely that the situation in some other provinces is more challenging.
- Norms and Standards are still being revised for practitioners working with children birth to four years. Were the training and registration requirement for the Department of Social Development (DSD) set at Level 4 or Level 5, about 87,000 practitioners would be required if only the poorest of the poor households are considered of the birth to four age cohort (2,600,000 children). Not all children will or should be in a centre-based environment, and financing models must be considered for alternative provision (ETDP SETA, 2011a). If the estimate for training is based on the 30 percent of 1.5 million children under five years who are already in ECD centre programmes, between 75 and 100,000 practitioners would need training or upgrading (estimated at ratios of 20:1 or 15:1).
- It is important to remember that current training demand for ECD qualifications at Levels 4 and 5 also includes training of Grade R educators. The Draft Sector Skills plan has identified that approximately 33,000 practitioners will be required for universal access at a learner/educator ratio of 30:1.

2.2 Qualifications and other training programmes

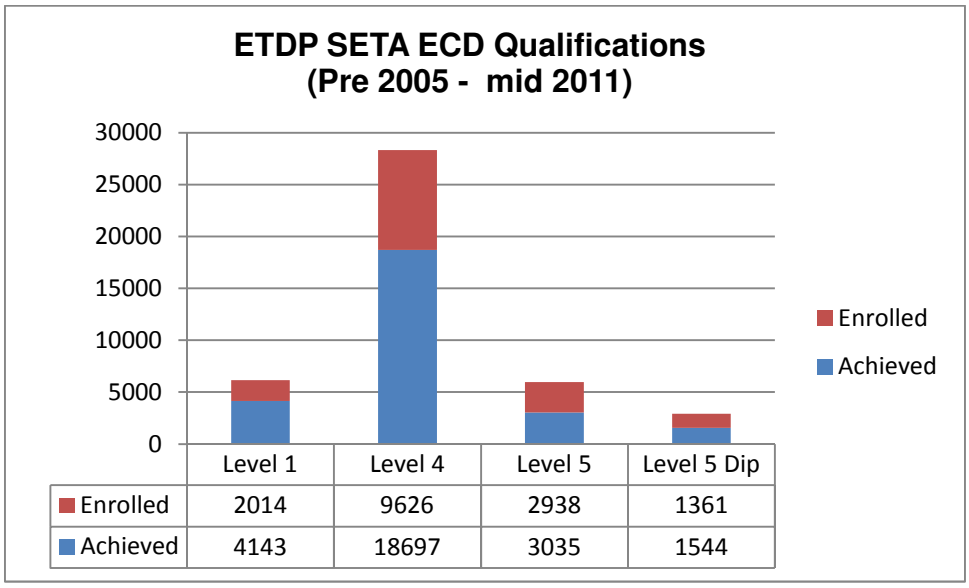
SAQA accredited ECD qualifications include:

- Levels 1 (Basic Certificate in ECD), 4 (National Certificate in ECD replaced by the FETC in ECD) and Level 5 (Higher Certificate and 240 credit Diploma)
- The National Certificate Vocational (NCV) with an ECD specialisation phased in by some Further Education and Training Colleges from 2007.
- A 360 credit Diploma in Grade R is in the process of development.

- There is talk of a similar diploma for practitioners working with 0-4 year olds but no details are available.
- For Grade R practitioners the B Ed Foundation Phase includes a Grade R component and there are various specialised DHET accredited diplomas and certificates mostly for Grade R.

Figure 1 gives the numbers of ECD practitioners who have achieved qualifications from the ETDP SETA or are currently enrolled according to the National Learning Records Database (NLRD). It is apparent that both enrolments and achievements are too low to service the needs of an expanding sector.

Figure 1: Numbers of ECD Qualifications and Enrolments by 2011



	Level 1	Level 4	Level 5	Level 5 Dip
Enrolled	2014	9626	2938	1361
Achieved	4143	18697	3035	1544

Source: ETDP SETA Data December 2011

The numbers in Figure 1 constitute the bulk of ECD training for those working in the 0-4 year sector as well as those in Grade R classes. It is possible for providers of ECD Level 5 qualifications to be registered with the Council for Higher Education but this is very limited. The NCV (ECD component) has been recently phased in at some colleges but it s a three year programme and is unlikely to have produced many ECD assistants as yet[1].

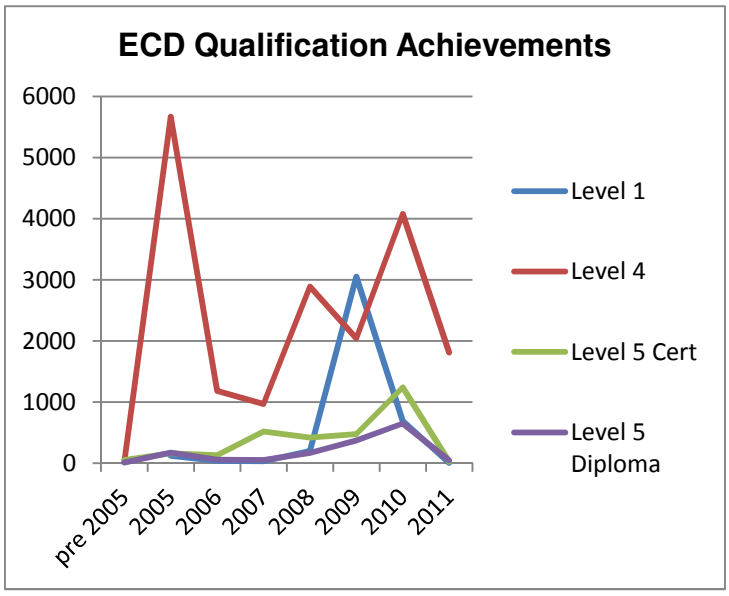
A number of skills courses which are not accredited but which can improve performance and work efficiency are offered by different providers e.g. Financial Management, Governance and Leadership Training, HIV/AIDS Awareness, Legalities and Childcare, and Classroom enrichment, literacy and numeracy electives. Numbers of practitioners who have completed part qualifications and skills programmes are not readily accessible.

Figure 2 below indicates the achievement pattern for ETDP SETA qualifications. There is no discernible pattern largely because of migration from one ETDP data upload system to another and the fact that NLRD data is uploaded twice a year. The large number of Level 4

[1] Interview Josie Singaram, ETDP SETA Constituency Support, 20 December 2011.

achievements in 2005 was as a result of a Department of Education (DBE) funded programme to skill Grade R practitioners.

Figure 2: ECD Qualification Achievements by Year



Source: ETDP SETA Data December 2011

- To address the demand for ECD training and in acknowledgement of the long experience of many practitioners working in the sector, as well as in-service training they have received, the ETDP SETA plans a focus on Recognition of Prior Learning (ETDP SETA 2001b). The aim will be to pilot RPL for the ECD NQF Level 1 qualification to assist practitioners to access the NQF level 4 qualification. This will take place in 2012 and 2013.

2.3 The Expanded Public Works Programme ECD Programme (EPWP)

The EPWP ECD Programme is the training component of the National Integrated Plan and has been the major initiator of supported practitioner training since 2004.

- The DBE is responsible for the human resource development aspects of the service provision for 0-4 year olds. DoSD identifies practitioners in registered ECD sites and DBE selects, offers training and pays a stipend during the training.
- The current target set in the EPWP Social Sector Plan is to train 80,000 ECD practitioners and Grade R teachers at Levels 4 and 5 for the period from 2009/10 to 2013/14. According to information provided at the EPWP Summit on Social Sector Training in October 2011, achievements are set out in Table 1. Clearly, training will have to be accelerated to meet the target.

Table 1: EPWP ECD Training Opportunities 2009 - 2011

Province	Number of ECD Learnerships
Eastern Cape	2,000
Gauteng	4,000
Limpopo	3,400
Northern Cape	1,046
Western Cape	7,608
Free State	652
KZN	4,496
Mpumalanga	500
North West	1,970
TOTAL	**26,032**

Source: Department of Public Works, 2011

- At present much of EPWP-funded training is addressing backlogs in the sector, which is essential for expanding quality but not sufficient for expanding access to services. Practitioners working with pre-Grade R classes often move to Grade R which offers a better salary package, once they have been trained.

2.4 Providers

Table 2 indicates the number of providers accredited to offer different ECD Qualifications

Table 2: Number of Accredited by Providers by Qualification

Qualification	Accredited Providers
Level 1	94
Level 4	147
FETC	77
Level 5 Certificate	35
Level 5 Diploma	62

Source: ETDP SETA December 2011.

There is no current data available on the infrastructure and human resource capacity of suppliers of ECD educator qualifications. Nor would all accredited providers offer all the qualifications, depending on needs and funding. Training providers include:

- Public FET Colleges, who are increasingly taking on training according to Department of Higher Education policy, but at present there are too few offering ECD.

- NGOs that are registered as private FET institutions also provide some learnerships and qualifications. The requirements for registration with Umalusi have been challenging for NGO providers. These include changes to governance structures, proof of financial surety, occupational health, and safety and staff qualifications. As a result, many providers have not registered, which reduces the pool of providers. In addition, NGO training has been largely funded from donor sources, but this support has declined due to public sector involvement in training.
- Universities: A longstanding concern has been the lack of opportunity for university qualifications in ECD except for Grade R, which comprises a small part of the B.Ed Foundation Phase curriculum or specialised certificates and diplomas. This resulted partly from a lack of demand for such qualifications because of limited career development opportunities in the sector and also because universities offering ECD qualifications do not receive the teacher training subsidy. This has meant a lack of suitably qualified persons to staff training institutions and the ECD functions of government. Recently, with the resurgence of interest in ECD, some universities have indicated that they will be offering higher qualifications. These include UNISA, University of Johannesburg who are developing a diploma course, and the School of Education at the University of the Witwatersrand is reintroducing the ECD component as an optional three year sub-major for Foundation Phase B.Ed students in 2012, a post graduate diploma in 2013 as well as an Honours and an M.Ed in Early Childhood Education (birth to nine).[2]

2.5 Issues

- *Leadership and management training* needs significantly more focus for those working in the ECD sector both in direct service delivery and in a support capacity. Studies indicate the significant role that leadership, management and governance plays in centre quality (e.g. Dawes et al., 2010, OECD 2001, Love et al.,1996) and the recent ECD Public Expenditure Tracking Study indicates that weak bookkeeping is endemic in community facilities (UNICEF, 2011). Carter, Biersteker and Streak (2008) also found that centres with poor administration and financial management systems were less likely to access in-kind or financial donor support. Leadership and management training is also a critical area for development for those in supervisory and training positions in the ECD sector, including government officials and training providers. Ilifa labantwana[3] has recently funded 130 leaders of resource training organisations to participate in a one-year leadership and management programme provided by Regenesys, as part of an effort to build the capacity of RTOs and ensure solid leadership succession planning.
- The ETDP SETA scarce and critical skills list (2010-2011) identifies *Special Needs Teachers* as a scarce skill (ETDP SETA 2011c). It also indicates that remedial skills are required critical skills. A more coordinated and focused strategy to meet training needs on disability is being developed and, in particular, the ETDP SETA is concerned to relating to

[2] Personal communications with ECD staff from these institutions.
[3] Ilifa labantwana is a national initiative to expand access to quality ECD. It is spearheaded by three funders, namely the DG Murray Trust, the ELMA Foundation and the UBS Optimus Foundation

the different ECD service delivery contexts. The ECD component of the SETA Skills Plan indicates the need to include disability training in all ECD capacity building programmes.

- *Training supply is uneven*, both geographically and in terms of access to higher levels of qualification starting at Level 5. A strategy will have to be developed and possibilities of distance learning, satellite campuses and increased allocations for learnerships and skills programmes in remote and under-serviced areas considered.
- *Requirements for access to Higher Education* institutions for learners who have completed Level 4 and Level 5 need to be addressed urgently so that vertical progression is enabled and achievements credited. Level 5 qualifications have not been articulated with the B.Ed degree and Level 4 is not recognised for University entrance by many institutions.
- *Language and literacy levels* have been identified as a key challenge at all levels of training. Quality assurance of training provision should monitor the availability of bridging programmes and of home language instruction where appropriate, to ensure that the lower skill categories are able to cope with the training programmes offered.
- *Information on ECD practitioner education and qualification levels* is held in different databases, is not easily available, and should be collected and regularly updated to facilitate planning and budgeting.
- The historical backlog in training has been exacerbated by attrition and rapid expansion of both Grade R as well as programmes for 0-4 year olds. Furthermore, ECD expertise is aging because of the phasing out of dedicated ECD diplomas during the 1990s. This makes it difficult to provide experienced trainers and mentors for the sector.
- All ECD-related qualifications should be reviewed to ensure that they sufficiently allow for the holistic nature of ECD and do not focus solely on Early Childhood Care and Education (ECCE) concerns.

3. Home- and Community-Based ECD Practitioners

The focus on training of practitioners in ECD centres only addresses one of the ECD settings identified in the National Integrated Plan for ECD (NIP). Training opportunities should also be extended to practitioners working in home- and community-based services and programmes. The ETDP SETA Sector Skills Plan 2011-2016 makes no reference to the training needs of these practitioners, despite the fact that the majority of ECD services will be provided in these settings as the NIP rolls out.

3.1 Training supply

- SAQA accredited Community Development Qualifications with ECD specialisation options have been developed at GETC (Community Development ABET), Levels 3, 4 and 5. There have been no funded learnerships or completed qualifications with an ECD specialisation for this emerging category of workers. These workers are usually elected from the communities in which they live and cannot afford the costs of training.

- Because this aspect of ECD programme delivery is rather new and largely unfunded, there are relatively few ECD training providers who offer these qualifications; but a small and growing number have been accredited to offer some of them (four known to the author).
- There are different types of home- and community-based programmes which vary in purpose, duration and intensity. There is no simple model of provisioning (number of groups or households per worker) against which to estimate training needs. It is urgent to determine a basic range of programmes so that this can be done.

3.2 Issues relating to home- and community-based ECD workers

- As there is *no post provisioning or subsidy* for home- and community-ECD practitioners, many are stipended workers or volunteers with the result that there are high attrition rates and the loss of investments in capacity building. Skills courses with a strong practical component may be a better option until there is greater workforce stability.
- The integrated nature of ECD servicing is not recognised in the current qualifications and standards available. While the ETDP SETA-accredited Community Development qualifications are intended for this group of workers, there are other workers – community health workers, child and youth care workers, social auxiliary workers, local government community development workers (e.g. Isibindi) with a range of qualifications, who all have contact with families with young children in the course of their duties. Over 3,000 Community Development Workers employed by provincial governments and based at local ward level have had their focus areas streamlined to include food security, ECD, HIV and AIDS and Social Protection (DPSA, 2010). The ECD component will involve identifying children who are not in ECD programmes and linking them to grants, services and DoSD funded crèches. They will also link centres to departmental processes of registration and quality assurance. It is important to recognise that CDWs are thinly spread (one per municipal ward). Nevertheless, they could play a valuable role for young children and their families, provided that they have sufficient understanding of the needs of young children[4].
- It is urgent that the Health and Welfare SETA responsible for the development of Social Auxiliary Workers, Child and Youth Care Workers and Community Care Qualifications and the ETDP SETA, which has registered ECD practitioner and Community Development qualifications, as well as others involved with CDWs such as the Local Government SETA, have a joint frame of reference in which to locate their community worker qualifications. It is important to specify particular roles and core components as it is likely that these occupations will co-exist.
- A *common core component*[5] e.g. Human Development (already in many of these qualifications) which contains sufficient information about young children and also equips workers to identify simple problems for referral, would be a way to orientate community care

[4] At least one NGO has been approached to train CDWs who are not clear about what they should be doing in relation to ECD. WHO IS THE "WHO ARE NOT CLEAR"

[5] All qualifications include required fundamental (language and numeracy) and core components and then elective specialisations e.g. ECD, local government etc.

workers of all kinds to ECD. A checklist of priority issues and guidance, as part of a basic package would also be useful. Such a checklist could include birth registration, nutrition, immunisation, grant access, disability, parenting, child care and opportunities to learn.

4. Working Conditions and Professionalisation

Training on its own is not sufficient to improve quality service delivery. Successful expansion of training opportunities and sustainability of training inputs need to be located within a comprehensive approach to upgrading the ECD sector. Career pathing, professionalisation, adequate conditions of service, regular monitoring and support, supervision and management, are all critical parts of the human resources strategy.

- The take-up of higher-level qualifications and the retention of trained ECD practitioners in the sector are dependent on sustainable jobs and opportunities for career pathing and progression. Wage and service conditions are a critical factor in attracting and retaining workers in the sector. This applies to practitioners working in centres and even more so to the home- and community-based workers who are often on short term stipends. It is urgent that government and civil society stakeholders initiate a process to determine minimum salaries for the ECD sector and make recommendations for salaries linked to qualifications and responsibilities. This will assist with upgrading quality by attracting and retaining better educated and motivated staff but needs to be balanced with the huge gaps in access to ECD services for children 0-4 years and the job creation opportunity that the sector provides, particularly for low-skilled women (Biersteker, 2008a).
- Professionalisation of ECD has generally been associated with better outcomes in other countries (Biersteker, 2008b), and ECD sector advocates are actively pursuing options with the Department of Social Development (SSPAN, 2011). Grade R educators register with the South African Council of Educators (SACE) and one of the issues for exploration is whether ECD practitioners working with pre-Grade R classes should also do so or whether they should be registered with an ECD Occupational Board under the South African Social Service Professions Council.
- A similar debate may be emerging for Home- and Community-based ECD workers who are clearly working in a might best fit within an ECD Occupational Board or whether in terms of a recent initiative to professionalise Community Development work, they would better fit in a Professional Body for Community Development.
- Finally, very high priority should be given to providing on-going monitoring and support to ECD services by provincial and local government staff *conversant with what a quality service for young children entails*. Numbers of provincial and district level officials for all departments involved in delivery or oversight of delivery of services for 0-4 year olds should be increased. If necessary, some support and monitoring functions should be outsourced to intermediary organisations.

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Background Paper 9

Grade R

Nosisi Feza

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Key Points

Issues:

- South African students' poor performance in national and international studies has increased concern to improve the quality of early preparation for learning.
- Access to Grade R has rolled out rapidly to include many of the poorest children (80 percent enrolment) but service quality remains a challenge. While infrastructure, administration, support and monitoring, as well as learning and training support material (LTSM) tend to be better than in community schools, there are still gaps, particularly in the poorer provinces.
- There is no overall data available on practitioner education and ECD qualification levels, but indications are that education levels of a substantial proportion of the Grade R workforce will not equip them for upgrading to the new minimum teacher qualification of a 360 credit Diploma. Further, qualified educators working in Grade R classes may not have specialist pre-primary qualifications.
- Remuneration packages for Grade R are lower in many cases than a Grade 1 educator's with the same qualification, and this does not attract qualified staff to stay in Grade R classes.
- Grade R is not yet fully integrated into the schooling system though, for curriculum purposes, it is part of the Foundation Phase. It is not compulsory and there is no post provisioning.
- The informal play-based preparation for formal schooling envisaged in departmental programming tends to be lacking in practice, especially in primary school-based Grade R classes.
- Inadequate data on Grade R classes and on aspects of provisioning, including staff qualifications and minimum inputs is a challenge to comprehensive planning.

Recommendations

The Department of Basic Education should proceed with its plans to:

- Develop Grade R infrastructure in new and upgraded schools
- Improve the qualifications of Grade R practitioners as per the new Higher Education Qualifications Framework in collaboration with the Teacher Education Plan and the DHET. In the short- to medium-term, the upgrading strategy will also need to provide for practitioners who do not have the entry requirements for the Diploma.
- Include data on subsidised community-based Grade R sites in the EMIS for accurate reporting on access.

- Establish a common monitoring system to report adequately on delivery.
- Review the norms and standards for funding Grade R (50-70 percent of the Grade 1 cost), for alignment with school funding norms. The common monitoring system and aligned funding norms and standards should be used to standardise conditions across provinces.
- Finalise a strategy for the improvement of the conditions of service for practitioners in line with their qualifications and the proposed scenarios for employment.
- Develop national policy for Universal Access to Grade R.

The last two initiatives should be resolved in such a way as to regularise Grade R as part of formal schooling.

In addition, attention needs to be given to:

- Promoting a developmental rather than solely educational approach to Grade R by ensuring that an appropriate curriculum for Grade R children is followed. This will involve creating a supportive play-based environment sensitive to home-school transition and ensuring that preparation for formal schooling is not itself formal schooling.
- Strengthening coordination with the Departments of Health and Social Development to ensure that children receive appropriate holistic support, including aftercare services, feeding, transport and support for children with special needs and those whose families are vulnerable.

Grade R

1. Introduction

> *In promoting our pro-poor education policies, Honourable Members, we are investing in children and the youth from toddlers to tertiary. In addition to the Grade R enrolments which have doubled, which we mentioned in the State of the Nation Address, our Early Childhood Development programme is also growing* (President Zuma State of the Nation Address, 9 February 2012).

The President's address refers to the success of rolling out Grade R nationally. Grade R enrolment has risen in South Africa since the year 2000 at 80 percent in 2011 of five- to six-year-old children enrolled in accredited Grade R programmes. Grade R rollout has been rapid in needy areas, including rural areas and poor provinces with large numbers of people dependent on social grants. It has been a considerable achievement in a relatively short period. This review aims to explore this rapid access in addressing equity and providing school readiness for poor children.

Grade R is clearly conceptualised as preparation for the schooling system. Most recently this is expressed in the Policy on Minimum Requirements for Teacher Education Qualifications (DHET, 2011). This states that "Grade R is the first year of the Foundation Phase in the formal schooling system. In this grade, young children (4-5 years of age) are prepared for formal schooling" (Section 9.1). This poses some challenges in terms of the holistic definition of ECD in the White Paper on Education and Training, though Grade R children in public schools do access the Primary School Nutrition Programme and would benefit from school health services were these are operating on a wide enough scale.

This review has been organised as follows: A summary of key policy developments regarding Grade R education since publication of the 1995 White Paper on Education and Training, which first mooted ten years of compulsory education; discussion of common conceptualisations of the role of Grade R in education and research on reception year education (often referred to as kindergarten education); the status of Grade R provisioning; key issues faced by Grade R in South Africa in terms of policy, infrastructure, human resources, classroom ratios, curriculum and funding; and finally data gaps.

2. Grade R policy in South Africa since 1994

The key milestones in Grade R policy development are outlined in Table 1 below.

Table 1: Key milestones of Grade R policy development

Year	Policy and Action Plan
1995	ECD is acknowledged as a starting point for human development (DoE White Paper on Education and Training 1995). Government committed to providing the first 10 years of compulsory education starting with reception year at 5 years of age.
1996	The 1995 White Paper's proposal to provide compulsory education for the first 10 years of education including Grade R was not confirmed by the National Education Policy Act of 1996. Instead, Grade R was made universally accessible, but not compulsory, enabling enrolment of 5-year-old children or children turning 6 in the year of admission in ECD centres or public schools (National Education Policy Act of 1996).
2001	White Paper 5 on Early Childhood Education provides for a reception year as a national priority for 5-year-old children. Grade R was phased in as the first year of schooling from 2001 although it was not compulsory, though it became policy that it should be so. White Paper 5 emphasizes phase-in by 2010, with 85% enrolment in public schools. According to this policy, all public primary schools will provide accredited Grade R programmes by 2010 particularly targeting the most vulnerable children. Development of a qualification framework and career path for reception year educators and ECD practitioners/educators, and their registration with the South African Council of Educators, was also to be put in place.
2008	Norms and standards for Grade R funding became operational in 2009 and provided a legislative springboard for roll out of Grade R. Provisions include a pro-poor funding formula which provides additional funding to schools in the two poorest quintiles, and specifying provincial MTEF budgets as the primary source of funding for public and independent Grade R services. Other provisions were the level of per learner funding, an option of establishment posts for Grade R; registration of community based sties receiving public funding as independent schools, and the requirement that each Provincial Education Department formulate a roll-out plan for public school Grade R.
2010	Of those children who could be accounted for, 78% were enrolled in Grade R in private centres and school-based classrooms. The DBE Strategic plan of 2011-2014 states that by 2014 the process of universalising Grade R would be complete.
2011	Government Notice 583 on Minimum Requirements for Teacher Education asserts that the appropriate qualifications for Grade R teaching are a Diploma in Grade R Teaching and Bachelor of Education in Foundation Phase Teaching.

3. The role of the reception year in early childhood development

South African students' poor performance in national and international studies has increased concerns to improve the quality of early preparation for learning in the country (Reddy, 2007; Howie, 2003; van der Berg & Louw, 2006). Pretorius and Naude (2002) found that Black South African children between the ages of five and a half and seven years from six daycare centres in informal settlements had low literacy skills and poor fine motor development, visual analysis and synthesis. However, Vinjevold (1996) reported that Black children from farm schools and townships involved in the Ntataise preschool programme between the ages of six years and six years and nine months old demonstrated better fine motor skills, better concentration skills and more confidence. These results highlight that preschool programmes can address some of the inequities that originate from socioeconomic imbalances in South African society (Penn, 2008; Biersteker, 2010), and also point to the importance of preschool education for future learning success.

More recently SACMEQ findings have shown that preschool attendance positively influences reading performance of South African children as shown in Table 2.

Table 2: Learner performance by preschool exposure

Duration of preschool experience	Reading Score	Mathematics Score
Never	449	463
A few months	474	479
One year	483	485
Two years	527	516
Three or more years	555	541
Total	495	495

Source: Moloi, M.Q., & Chetty, M. (April 2011) SACMEQ: Policy brief number 4 (p.3)

This study indicates performance increases influenced by Grade R attendance. However Moloi and Chetty (2011) do not specify who benefits from preschool. Their study implies that access to Grade R with further access to pre-Grade R facilities would benefit South African children.

Young children disadvantaged by poverty have most to gain from inclusion in a pre-primary year and this is only possible when it is a free service, which requires a substantial commitment of public funding. In South Africa there are pro-poor subsidies for children in Grade R classes and children benefit from a feeding scheme if they are in Grade R classes at public primary schools (Biersteker, Ngauriya, Sebatane & Gudyanga, 2008). However a significant number of Grade R classes are in community facilities which, though subsidised, have to charge fees to cover food and maintenance costs.

While government is clear that Grade R is preparation for formal schooling (e.g. DHET, 2011), some ambiguity still exists as to Grade R's place in the South African education system. SAIDE's (2011) study of Grade R suggests that the role of Grade R is not explicit as to whether Grade R is a formal part of the schooling structure, as are the other foundation phase grades, or whether it is a bridging class between formal and informal education and exists to increase levels of literacy. However, there is consensus that Grade R children need to use their senses to explore through experimentation and developmental play at their appropriate level, and that they need to be exposed to a literacy-rich environment (SAIDE 2011). Also, the CAPS (2010) document and the curriculum for the foundation phase, which includes Grade R, encourage a literacy rich environment. Research world-wide confirms that school readiness is the role of Grade R (or kindergarten, in international terminology).

School readiness involves a range of competencies:

> *When children enter kindergarten, they encounter many first-time expectations: to complete independent work, to adhere to strict time schedule, and to acquire basic literacy and math skills.*
> (Li-Grining et al., 2010, p.1062).

School readiness encompasses all the expectations listed above and therefore fully conceptualises and defines the role of the reception year. Li-Grinning asserts that approaches to learning (ATL) reflect school readiness for kindergarten children. For example, children who are ready for formal schooling demonstrate perseverance, self-regulation, and attentiveness. Research has shown that early ATL has a positive association with subsequent reading and mathematics performance regardless of race and socioeconomic background (Li-Grinning et al., 2010; Hooper et al., 2010; Duncan et al., 2007; Pagani et al., 2010). Duncan et al. (2007) and Pagani et al. (2010) found that mathematics performance is stronger than reading among children who were exposed to ATL. A question for consideration, then, is the extent to which current Grade R takes a more holistic ATL approach compared with a narrow literacy- and numeracy-based approach.

Research on early childhood development services highlights the importance of providing quality services for young children in shaping future learning experiences and achievements. Grade R services in South Africa have to prepare children for formal schooling by providing them with such quality learning experiences. As Sylva et al. (2011) emphasize, there are slight, if any advantages, to be gained from poor quality services.

South Africa lags behind in research on this year of schooling but international evidence is clear that disadvantaged children have most to gain from ECD interventions. For example Stephen indicated that early childhood education "makes a difference in the lives of the disadvantaged children" (2006, p.28))and this was also found in Dhuey's (2011) meta-analysis of the outcomes of access to publicly subsidised kindergarten in the United States. The findings indicted that kindergarten benefited most, but not all groups. Stephen's findings offer insights on important aspects of early childhood provision such as matching delivery with the needs of the child, paying more attention to orientation and ways of familiarizing children with their new environment, and introducing a new curriculum in developmentally appropriate ways. They also

indicate the limitations of current practices of assessing readiness, and that age as a criterion for readiness does not ensure developmentally appropriate educational provision.

South Africa can learn three things from these studies:

1. Grade R access improves learning progress;
2. However, Grade R alone does not ensure high school completion and college attendance for all children, and
3. One size does not fit all.

Defining access in a child rights context determines the kind of delivery that is responsible and progressive. Biersteker and Dawes (2008) highlight the weakness of the South African system in capturing data that will make it possible to assess quality in Grade R implementation. Rapid access does not guarantee quality and, according to Biersteker and Dawes (2008) access to quality Grade R is still skewed towards privileged children leaving the poor behind.

4. Grade R Service Provisioning

In addressing historical discrepancies, the White Paper on Education (1995) proposed national provision of a reception year for children aged five as part of a compulsory first ten years of schooling. However, the South African Schools Act of 1996 states that compulsory education in South Africa spans the age of seven to the age of fifteen, with compulsory education from Grade 1 to Grade 9. After a period of piloting a Grade R provisioning model, the 2001 White Paper on ECD provided for the roll out of the Grade R year, largely in the public schooling system.

Grade R enrolments have increased steadily since 2001. It is also important to note that school-based Grade R provision was only 17 percent of the relevant age cohort in 2001 but 62 percent by 2009, indicating a very rapid increase (Biersteker, 2010; Department of Education, 2009). However, the intended goal of universal enrolment of five-year-olds in a Grade R class by 2010 was not achievable and has been extended to the year 2014 (Department of Education, 2011). In total, 707,203 learners at 16,020 schools were enrolled in Grade R classes in 2010 (DBE, Presentation to the Education Portfolio committee, June 2011).

Table 3 below shows the increase in access per province highlighting the high enrolment rates in the Eastern Cape, Limpopo and KwaZulu-Natal[1] (Department of Education, 2010). These three provinces are predominantly rural, and this is a tribute to the role played by the DoE and provincial education departments in reaching those areas of the country where children and parents often lack resources such as food and early childhood facilities. The fact that there is no accurate reporting on subsidised community-based Grade R classes (or stand-alone ECD sites) limits the potential of Table 3 to give a true reflection of provinces with larger numbers of such

[1] KwaZulu-Natal, in its Annual Performance Plan (2011/12), reported 92 percent Grade R enrolment and the provincial authorities stated to the media that they had exceeded the 85 percent national target in enrolling Grade R. According to this release they had 3,881 schools offering 6,070 Grade R classes. Enrolment has reached 90 percent of the five year old population in KwaZulu-Natal.

sites; this includes the Western Cape which has 441 registered stand-alone sites that offer Grade R. In Gauteng, in addition to those classes at schools, 412 mobile classes fully equipped with learner and teacher support material deliver Grade R as a way of improving access and quality (Department of Health, 2011).

Table 3: Gross Enrolment Rate in Grade R in ordinary schools by province, 2002-2009

Province	2002	2003	2004	2005	2006	2007	2008	2009
Eastern Cape	13.9	30.3	48.3	70.1	72.9	77.9	94.4	107.9
Free State	28.1	26.7	27.1	30.6	30.7	38	39.8	39
Gauteng	18.3	19.8	21	24.1	23.3	28	26.9	34
KwaZulu-Natal	30.7	32.6	31.9	35.1	35.7	53.8	57.5	66.1
Limpopo	63.6	65	66.9	75.7	78.1	75.7	78.2	81.5
Mpumalanga	14.3	16.4	28.2	17.0	17.1	40.8	47.4	57.9
North West	13.0	17.8	23.1	40	39.9	66	38.4	46.5
North Cape	5.4	7.8	8.3	9.3	9.2	11.9	29.8	40.8
Western Cape	33.4	36.3	35.7	35.7	34.9	33.2	29.1	36.5
National	27.2	31.2	35.2	40.3	40.5	48.8	51.9	60.3

Sources: (2002-2007) Education Statistics in South Africa; (2008-2009) School Realities. (cited by DoE Country Report,2010,9)

General Household Survey data was used to get an estimation of the total access including community sites, though the limitations of this data (discussed in BP 12) are acknowledged. According to GHS (2010) statistics, the total number of children eligible to be in Grade R was 2.2 million. From this figure 1.9 million are reported to be attending an educational institution, 200,000 not attending an educational institution and 42,000 not specified. Therefore, by 2010 87.7 percent of eligible children appear to have been attending Grade R, 10 percent were not attending any form of schooling and it is not specified what 2 percent were doing (GHS, 2010). This supports the KwaZulu-Natal and Gauteng media releases claiming that the stipulated 85 percent universal access required in White Paper 5, has been exceeded in KZN at 92 percent by 2011 and 2012 (KwaZulu-Natal Department of Education, 2011). Nonetheless, the data suggests that approximately 22 percent of 5-year-olds in South Africa still lacked access to Grade R in 2010. Table 4 below examines enrolment by population group. These figures reveal that 9 percent of Black African children, 20 percent of Coloured children, approximately 2 percent of Indian/Asian children and 16 percent of White children of the relevant age were not attending any educational institution in 2010. This means that the largest number of children not in Grade R is Black African children and a small number of Coloured children. Lack of financial resources for fees and transportation are the reasons for not enrolling in educational institutions especially in the Eastern Cape, KwaZulu-Natal and Mpumalanga (GHS, 2010).

Table 4: Age-eligible children (in thousands) attending and not attending Grade R institutions by group, 2011

Group	Attending	Not attending	Not known	Unspecified	Total
ALL	1,932	229	0	42	2,203
Black	1,678	178	0	37	1,893
Coloured	132	35	0	3	171
Indian/Asian	38	*	0	1	39
White	84	14	0	*	100

*=under a thousand *Sources: (2010) General Household Statistics retrieved at* http://www.statssa.gov.za/publications/P0318/P0318June2010.pdf

Reasons for lack of enrolment include problems of distance and shortages of ECD centres, lack of infrastructure in primary schools to enable the enrolment of more children, and the fact that community-based sites have to charge fees as they provide additional daycare services. In addition, as Grade R is not compulsory, some parents may not see the need to enrol their children.

Table 5 gives the number of public schools per province that did not yet have Grade R classes by June 2011. Grade R will be included in the infrastructure plans for new and upgraded schools.

Table 5: Number of schools without Grade R per province

Province	Independent	Public	Total
Eastern Cape	15	364	379
Free State	20	646	666
Gauteng	71	318	389
KwaZulu-Natal	24	328	352
Limpopo	12	300	312
Mpumalanga	15	350	365
Northern Cape	3	147	150
North West	4	414	418
Western Cape	21	356	377
Total	185	3223	3408

Source: DBE Presentation to the Education Portfolio Committee June 2011

4.1 Funding

In order to support the rapid increase in access, the Grade R budget has been the fastest growing education programme in budgetary terms, increasing from R932 million in 2007/8 to R3.2 billion in the 2010/11 financial year, as shown in Table 6.

Table 6. ECD budgets by provincial education departments

Province	2006/7 R'000	2007/8 R'000	2008/9 R'000	2009/10 R'000	2010/11 R'000
Eastern Cape	64,346	91,513	274,397	395,539	539,922
Free State	49,632	56,338	70,324	77,337	81,727
Gauteng	79,000	152,739	214,571	310,146	583,746
KwaZulu-Natal	102,658	167,736	208,234	336,202	608,363
Limpopo	68,868	63,935	155,759	228,615	445,775
Mpumalanga	41,827	64,211	91,551	143,375	243,195
North West	151,510	146,512	164,165	210,088	302,866
Northern Cape	18,141	24,692	57,251	73,350	115,264
Western Cape	107,397	164,804	226,792	274,011	320,922
National	683,379	9,324,80	1,463,044	2,048,663	3,241,780

Biersteker (2009)

5. Issues

In this section, key issues identified in the 2008 Grade R Diagnostic Review undertaken for National Treasury (CEPD, 2008) as impeding the roll out of a quality Grade R programme are revisited to determine progress made.

5.1 Policy and legislative clarifications needed

The ambiguity continues about whether Grade R is to be universally available or compulsory, as identified as an issue for resolution in the Treasury Review (CEPD, 2008). This derives, in all probability, from the incremental approach to roll out. While Education White Papers 1 and 5 suggest that Grade R is intended to meet the obligation for a preschool year of compulsory schooling and the Norms and Standards for Grade R Funding (2008) talk about Grade R becoming universal and compulsory by 2010 (Section 203), neither the latest departmental documents nor interviews with departmental officials suggest a move to a compulsory Grade R in 2014. Development of a National Policy on universal access to Grade R is an area to which DBE is giving attention (Presentation to the Education Portfolio Committee, June 2011).

A further area of ambiguity at the policy level is the question of whether Grade R is part of formal schooling or not. It is included in the national curriculum yet a separation is made in the funding formulae. Furthermore Grade R practitioners are not state employees, and even with provision in the Norms and Standards for grants to be converted to establishment posts on the request of the school, these practitioners/educators are not on the same footing as other educators. Given that many of them do not have the minimum qualifications for recognition as educators, this is extremely complex. However the DBE has been moving to regularise Grade R as part of the schooling system and Action Plan 2014 includes not only reviewing the funding norms and standards but also "finalising the draft strategy for improving the conditions of service for practitioners in line with their qualifications and the proposed scenarios for employment" (Presentation to the Portfolio Committee on Education, June 2011).

The urgency of resolving these policy issues is indicated in a current press report on ANC Policy discussion documents, which states that "The ANC suggested that Grade R be compulsory and that government should embark on an intensive training and employment programme for Grade R teachers" (Cape Argus, March 6, 2012).

5.2 Funding

In the early years of roll out of Grade R there were many inconsistencies in the use of Grade R funds with money budgeted for Grade R in some provinces remaining unspent or redirected to other priorities (Biersteker, 2010). The implementation of the Norms and Standards for Grade R funding from 2009, provides clearer requirements but a loophole in those guidelines - providing for a 50-70 percent of the per Grade 1 learner cost to be expended in the early years of roll out - still allows for a lack of standardisation across provinces. Wildeman & Nomdo, in their response to the 2005 Draft Funding Norms and Standards for the reception year, cautioned that "The rapid expansion of Grade R at the cost of a reduction in the proposed per learner expenditure undermines the claims about the link between adequate funding and quality Grade R services delivery propounded in the policy" (2006, p. 2). Their caution appears to have been justified in relation to the numbers of Grade R classrooms, access and challenges reported in the Eastern Cape of unacceptable conditions provided for Grade R (SAIDE, 2011).

A review of the 50-70 percent per learner cost with a view to aligning funding with the norms and standards for schooling is planned by the DBE.

5.3 Infrastructure

The lack of suitable infrastructure for the expansion of Grade R has been a concern for the DBE and has been included in departmental plans since 2003 (Biersteker, 2010; CEPD, 2008). The Department faces an infrastructure backlog for all grades and, in addition, Grade R classrooms should preferably be placed close to toilets, have more space for indoor play activities and separated outside play areas. Recent data from the Public Expenditure Tracking Study (Van der Berg et al., 2011) indicates continuing challenges, with only 29 percent and 6 percent of public schools in the two poorer provinces achieving a good quality infrastructure score. The generally poor quality of schools - which effectively remain solely for Black children even in the new political and social dispensation - impacts on Grade R implementation in public schools. Lack of

basic resources like water, sanitation, electricity and transport for long distances made it difficult to roll out Grade R.

5.4 Qualifications and training

An historical lack of training opportunities for the ECD sector is a significant problem, also for appropriate staffing of Grade R programmes. While there have been concerted efforts to improve ECD practitioner qualifications since SAQA accredited qualifications became available in 2002, including the provision of learnerships, this has not yet been able to address the backlog in teacher qualifications for Grade R. For example, the 2009 Teacher Qualifications Survey conducted but the HSRC (Department of Education, 2009) found that only 42 percent of Grade R teachers in sample schools had a professional qualification (most often at REQV Level 10), and the majority of these did not have a pre-primary qualification though they were teaching Grade R classes. A quarter of the 374 Grade R teachers in the sample had an ECD Level 4 Certificate and 17 percent a Level 1.

The more recent PETS study (Van der Berg, 2011) found that 39 percent of Grade R teachers in public schools had a diploma, and about 11 percent each, a degree or postgraduate diploma. Thirteen percent had the ECD Level 4 and 15 percent the ECD Level 5 Certificate.

These studies provide an indication of the training backlog for Grade R practitioners, especially given the recently adopted Minimum Requirements for Teacher Education Qualifications. These require a level 6, 360 credit, Diploma in Grade R Teaching as the minimum qualification for teaching Grade R, while the B Ed Foundation Phase is the long term goal. This new qualification, which will phase in 2013, will allow level 4 and level 5 teachers to upgrade their qualifications and those new to the field to enrol for the level 6 Diploma (SAIDE 2011). However, this will only allow for 180 credits towards the B Ed degree (DHET, 2011). This makes upgrading from the diploma to a B Ed a dauntingly long commitment and is a concern for career pathing.

It should be noted that both the Teacher Qualification Survey and the PETS study identified a substantial proportion of Grade R practitioners who do not have Matric and would therefore not meet the minimum admission level for the Diploma, of Matric and a diploma level endorsement. Only 17 percent of Grade R respondents in the Teacher Qualification Survey had a Grade 12 certificate with endorsement or exemption, and in the PETS sample only 61 percent had achieved Matric.

Given that the ETDP SETA Draft Sector Skills plan (ETDP SETA, 2011) has identified that approximately 33,000 practitioners will be required for universal access to Grade R at a learner/educator ratio of 30:1, there is still much to be done in terms of both initial training and upgrading. While both FET providers and Higher Education Institutions are gearing up to offer more training, their capacity to do so in the short term is questionable, and the DBE has indicated that this is a serious challenge.

Qualifications of Grade R practitioners currently vary widely from those without matriculation to post-graduate degrees. An ongoing challenge for attracting well qualified teachers is the ECD remuneration structure and lack of standardisation across provinces. This was identified as an issue in the National Treasury, Technical Assistance Unit review in 2008. The more recent

PETS study in three provinces noted that there are still considerable variations by province, linked to the source of the funds for salaries (Van der Berg et al. 2011). For example, Province 1 had an average salary of R5,347 per month for Grade R practitioners because more salaries were paid by School Governing Bodies through parent contributions. In Province 2, practitioners received an average of R8,553 and those in Province 3 an average of R9,524 per month. In these provinces larger numbers of practitioners were paid by government through Persal, the Public sector salary system. Table 7 below gives details of the remuneration structure.

Table 7: Grade R: Teacher salaries (in Rands) by source of funds from the three provinces

	Paid through Persal		Paid from State Subsidy		Paid by SGB		Paid from State Subsidy and School Funds		Total	
Province	**No. of teachers**	**Average Salary (p/m)**	**No. of teachers**	**Average Salary**	**No. of teachers**	**Average Salary**	**No. of teachers**	**Average Salary**	**No. of teachers**	**Average Salary**
Province 1	30	10,863	12	5,325	120	4,426	34	3,738	196	5,347
Province 2	134	10,665	12	6,243	62	4,674	4	4,870	212	8,553
Province 3	144	10,508	12	6,251	15	3,133	1	3,000	172	9,524
All	308	10,611	36	5,940	197	4,404	39	3,832	530	7,757

Source: van der Berg et al. (2011:15) 'Tracking public expenditure and assessing service quality in Early childhood development in South Africa'.

In January 2011 the KwaZulu-Natal Education Department decided to raise the Grade R practitioner salary from R2,500 to R3,000 a month. The Northern Cape offers a stipend of R1,350 a month and Western Cape offers R5,000 a month. These remunerations are standard per province, leaving highly qualified teachers at a big disadvantage and also making it difficult to attract new candidates to teach Grade R classes.

Post provisioning is a key challenge and, as indicated above, is an area in which the DBE is developing plans.

5.5 Classroom ratios

The Norms and Standards for Grade R Funding (RSA, 2008) indicate a ratio of 1:30 for Grade R classes, though the additional allocation to the poorest two quintiles may be used for additional staff to provide for the extra needs of the poorest children. The PETS study notes that a large number of Grade R classes have on average in excess of 40 children (Van der Berg et al., 2011). KwaZulu-Natal has an average of 1:39 according to their Performance Plan (KwaZulu-Natal Department of Education, 2011). Gauteng's class ratio is 1:33 (Gauteng Deaprtment of Education, 2011).The Western Cape class ratio is 1:30 (Circular 0029/2011). The Eastern Cape does not disaggregate Grade R from primary school ratios.

5.6 Grade R curriculum

Grade R falls within the Foundation Phase curriculum and the Curriculum Assessment Policy Statement (CAPS) which is currently being put in place. This replaces the National Curriculum Statement with clearer specifications to improve implementation.

For Grade R, CAPS encourages “play with a purpose” and “the CAPS curriculum document makes provision for the teacher-directed planned class activities and many examples” (CAPS, 2010 p.7). Revised Grade R resource packs have been prepared in line with the CAPS.

The focus on play in Grade R also comes through in the Minimum Requirements for Teacher Education which expresses the focus of this grade “on learning through play, developing physical coordination, as well as developing spoken language competence and fundamental ideas that will form a basis for further development of number sense and literacy” (9.1).

As is common in pre-primary classes attached to primary schools, pre-primary education is likely to be more formal than a play-based experience focused on holistic development. This is exacerbated by insufficiently trained teachers or the use of trained teachers who do not have a preprimary specialization (Biersteker, Ngaruiya , Sebatane & Gudyanga, 2008).

South Africa needs to emphasize appropriate approaches to mediating the cognitive development role of Grade R to avoid reported adverse experiences of early childhood practitioners in formal schools. Some of these have been placed under heads of department who do not understand the cognitive development of young children and who may insist on strategies inappropriate for young children (Biersteker, 2010).

Research by the University of Witwatersrand School of Education has highlighted the need to counter a narrow interpretation of the curriculum framework which results from a lack of understanding of the unique requirements of Grade R (WSOE, 2009, Excel & Linington, 2011). These should not be a watered down Grade 1. Instead, a Grade R programme sensitive to contextual factors, informed by a pedagogy of play should be implemented.

5.7 Learning and Teaching Support Materials (LTSM)

The availability of materials is a key quality indicator (Biersteker & Kvalvig, 2007). The PETS study found that the public schools in their sample were more likely to have these materials, including furniture and outdoor equipment as well as puzzles, books, paper, etc. (Van der Berg et al., 2011). Nevertheless, 37 percent of the public schools in the sample were rated as having poor LTSM. Furthermore, a higher percentage of registered community-based facilities than public schools had a variety of materials promoting learning through play, an indication of the more formal curriculum in public schools.

5.8 An Education Focus or Holistic Support with Welfare Elements

A focus on preparing children for formal schooling poses challenges in terms of the holistic definition of ECD in the White Paper on Education and Training used in DBE documents. Access for children in public schools to the Primary School Nutrition Programme is an important support to poor children’s broader needs, and it is hoped that the School Health Programme, will assist with this role. The lack of after-care for Grade R children in most public schools has been identified as a protection issue (see BP 6). Closer integration with the Department of

Health and Social Development would strengthen child outcomes and wellbeing - especially for vulnerable groups and children with additional needs such as those with chronic illnesses and disabilities and those living in difficult family circumstances. This is an area for urgent attention.

6. Data Gaps

A challenge in carrying out this review was the lack of data on Grade R in registered stand-alone sites. Currently the EMIS collects information on Grade R in ordinary schools (public and independent). Non-registered ECD sites offering a class for five-year-olds are also not documented. This review thus had to draw on telephonic interviews with DBE and DSD officials. This gap has been recognised by DBE for some time and needs to be addressed.

While the Norms and Standards provide for minimum inputs in terms of Learner and Teacher Support Materials, it is not clear if this data is collected. While this is a very basic indication of programme quality, together with information about teacher qualifications and teacher child ratios, it would provide a valuable point of comparison for monitoring across quintiles, districts and provinces.

7. Conclusion

The introduction of Grade R has been a significant achievement bringing large numbers of children previously without services into the schooling system in a relatively short space of time. Scale up will be completed when Grader R is compulsory and universal, with provisions in place to ensure that all learners have access, and when educators, programmes and facilities meet prescribed standards. Access issues will have to be addressed relatively quickly, but building quality will be a work in progress. In the quality project two things stand out as particularly important for ensuring that children have the best possible outcomes. Firstly, there will have to be strenuous efforts to ensure that a developmentally appropriate play-based approach is taken to preparation for the demands of formal schooling and, secondly, greater efforts must be made to address the holistic needs of Grade R children for health, nutrition and social support as well as care and protection through coordination with other departments.

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Background Paper 10

Government funding for ECD in South Africa

Patricia Martin

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List of Tables & Figures

Key Points

Issues:

Tracking ECD funding in South Africa is difficult because it cuts across multiple departments. Many do not have specific ECD budget line items and in the case of others, their descriptions of services do not coincide with the terminology of current ECD policy.

It is possible to determine two primary sources of ECD funding. The Department of Social Development's per child subsidy paid to registered ECD centres and Grade R funding provided by the Department of Basic Education. Both sources of funding have increased substantially over the last decade and Grade R funding is well targeted. While the per-child subsidy is targeted to children from poor families, targeting is constrained by availability of and access to registered centres. In addition, the subsidy system is insufficient to reach all children living in poverty and other vulnerable circumstances.

There is thus built-in inequity in the current model which prejudices young children not in centres, urban and rural children living in poverty, and children with disabilities. There is no meaningful and secure funding provision for programme-based, as opposed to centre-based ECD services. In addition, whether programme- or centre-based, services for these marginalised groups are the responsibility of small, underfunded and oft under-powered NGOs. Many lack the funds to provide and sustain adequate infrastructure. This prejudices children in terms of the quality and safety of the care environment and it means that many centres cannot register and access the per child subsidy. Even for those able to access the subsidy, the amount given is insufficient-to provide sustainable and quality services. This leaves many NGOs with the responsibility to raise funds even when they lack the capacity to do so. And to levy fees for parents who can ill-afford them.

Where there are no charitable funds or parent fees, there simply is no service. Herein lies the heart of the problem. In terms of the current model, the state is not held accountable for the poor quality of, or cessation of the service or, for that matter the lack of service in many particular.

Recommendations:

The State must assume responsibility for ensuring that ECD services are provided and sufficiently funded to ensure that quality ECD services are available for all children, with priority given to marginalised children.

This requires:

- The costing and budgeting of a national ECD plan of action which is shaped by the level of need and deprivation in South Africa

- That funding is made available by the State for infrastructure and services for ECD programmes and centres for the most marginalised children living in poverty in rural and urban areas and children with disabilities.

- Funding to be made available to ensure the necessary human and institutional capacity to meaningfully manage, coordinate and ensure compliance by all service providers with quality ECD standards.

Government funding for ECD in South Africa

1. Introduction

The UN Committee on the Rights of the Child made a number of recommendations to realise the commitment made by Member States in terms of the Plan of Action – "A World Fit for Children"– to the "implementation of national early childhood development policies and programmes to ensure the enhancement of physical, social, emotional, spiritual and cognitive development" (United Nations, 2002).

A key recommendation was that Member States adopt comprehensive and strategic plans on ECD within a rights-based framework and increase their human and financial resource allocations for ECD programmes and services. The Committee stressed the importance of ensuring sufficient allocation of the public fiscus to services, infrastructure and overall resources for ECD. Moreover, it was recommended that State Parties develop partnerships between government, public services, families and the private sector to finance ECD and early education. Notably, the Committee stressed that determinations about resourcing must respect the four general principles of the convention, including the equity-driven principle of non-discrimination (UNICEF, UN Committee on the Rights of the Child, BVL, 2006).

This legally prescribed ECD imperative translates into an obligation on the South African government to ensure the provision of adequate and accessible funding to guarantee:

1. The implementation of policies, programmes and services for children aged 0-9, pregnant and lactating women, that cut across multiple sectors - including health, home affairs, education, child protection, water, sanitation and energy (United Nations, 2002 & UN Committee on the Rights of the Child in UNICEF; UN Committee on the Rights of the Child, BVL, 2006; General Recommendation 7 & Government of South Africa, 2005);
2. Delivery through a variety of vehicles – including the home, within the community through NPOs and community workers, through government department officials and offices (UN Committee on the Rights of the Child in UNICEF, UN Committee on the Rights of the Child, BVL, 2006 & General Recommendation 7 & Government of South Africa, 2005 & Children's Act No 38 of 2005); and
3. Equitable access to ECD services. Given the historical and societal patterns of discrimination against young African children living in poverty, in rural areas, in informal urban areas, and children with disabilities, this requirement translates into an obligation to prioritise the allocation of funding and other resources to guarantee access to ECD services for these marginalised children (UN Committee on the Rights of the Child in UNICEF, UN Committee on the Rights of the Child, BVL, 2006 & General Recommendation 7 & Government of South Africa, 2005 & Children's Act No 38 of 2005)

2. Assessing the adequacy of ECD funding

On the whole, whilst there have been increases in ECD funding, the South African government has not met these obligations. In 2011, the National Planning Commission (NPC) observed that funding inadequacy has resulted in a failure of ECD for the most marginalised children in South Africa. It noted that underfunding of ECD and the inadequate funding model has resulted in poor quality early childhood education and care, especially for poor black communities where services are inadequate and implementation lags behind (NPC, 2011).

3. Tracking ECD funding in South Africa

Budlender et al. observe that "It is difficult, if not impossible, to get accurate estimates of allocations and expenditure on early childhood development, even for the relatively simple category of the DSD's per child-per-day subsidy for centres" (Budlender et al., 2011).

The reasons for this difficulty are diverse, but three of the primary causes are:

1. ECD cuts across multiple departments including Health, Social Development, Home Affairs, Education, Water and Sanitation. In addition, ECD services, as defined, cut across different levels of government from national, to provincial to local. The different departments and levels are not guided in their planning, description of services and budgeting by a common ECD framework, terminology, or interventions.
2. There is no identifiable and dedicated ECD line item running across the different departmental budgets. And indeed, some of the departments, such as Health and Home Affairs do not even, in terms of their programme descriptions related to services for young children, identify themselves as ECD service providers or align the description and budgeting of their programme with the descriptions contained in the NIP for ECD and other instruments. There is a clear disjuncture between these departments and the NIP. In the case of departments such as Water and Human Settlements (responsible for sanitation and housing) there is an even greater disjuncture given the absence of young-child focused programmes, or even child-focused programmes for that matter, within their domains of service. Similarly, local government budgets (and correlating Integrated Development Plans (IDPs) do not identify ECD services as a specific line item, and in the main do not fund ECD services (Budlender et al., 2011) (Van der Berg et al., 2011). This review has relied largely on secondary sources and the existing multiple reviews of ECD in South Africa. Whilst there are numerous reviews of the adequacy of early childhood and care budgets within the Departments of Social Development and Education, there were no comparable analyses to be found of the ECD budgets within the Departments of Health, Home Affairs, Water, Sanitation and Housing – all of which are viewed as contributing to ECD services in terms of the NIP.
3. Even within the departments that recognise their ECD mandate and obligations, such as the Department of Social Development, there is no correlation in its provincial budgeted programmes, line items and the categorisation and description of the ECD services as provided for in the Children's Act. In other words, DSD planning and budgeting does not

follow the priorities and structure of the Children's Act, making assessments of ECD allocations and budgets very difficult (Budlender & Proudlock, 2010, Budlender et al., 2011).

Given the preceding, it is very difficult to provide an overall estimate, based on existing analysis and estimations, of the national ECD budget in South Africa.

Linked to this is the fact that that there is no national resource benchmark against which to assess the adequacy of the national ECD budget. Despite the fact that the NIP provides that

> *…..costing will be done through calculations for the five-year period, using categories derived from the primary ECD services being rendered, and the secondary components, including infrastructure development, human resource development, research, and the monitoring and evaluating of the programme* (Government of South Africa, 2005).

The NIP requires that targeted categories of services (nutrition, Integrated Management of Childhood Illnesses, immunization, referral services, early learning stimulation, erection and upgrading of ECD centres, water and sanitation, training of parents, caregivers and community development workers) be costed by each lead department. Moreover it provides that each lead department is responsible for ensuring that the budgets are secured, either through the Provincial Equitable Share, Conditional Grants, municipal budgets or donor funding.

There has apparently been no costing of the ECD package of services, either in terms of the individual components of the package or the package as a whole. Similarly, there has been no mapping of the need for ECD services highlighting the areas of backlog and deprivation, nor is there a clear statement of what number and nature of services are required to ensure access for the most marginalised young children. This is despite the proposed strategy, in terms of the NIP that there be a needs analysis conducted in all municipalities to assess the level of need for upgraded ECD centres and basic services (to provide an information base for the upgrading of ECD centres to offer an environment conducive for effective learning and care and building ECD centres in the areas of most need and to provide sufficient water and sanitation to ECD sites. (Government of South Africa, 2005, pp 19-20).

For example, the author could find no mapping of the degree of deprivation in rural areas in terms of lack of existing ECD infrastructure, poverty barriers, lack of transport impeding access; or the numbers of young children living with disabilities. Nor could any mapping be found as to what is required in terms of the ECD package to meet their specific needs, nor any calculation of the cost of providing the ECD package for these targeted groups in South Africa. This is despite the fact that the NIP states that the national plan would be costed and that both the NIP and Children's Act call for prioritisation of ECD services to underserviced areas and children with disabilities.

4. Sporadic ECD targets – no national ECD goal and accompanying costing

There have been a number of ECD targets set in relation to early childhood care and education services (ECCE) through various policy instruments and statements.

Goals include the following:

- The NIP targets 2.5 to 3 million children aged 0-4 receiving ECD services through both centre, community and family-based programmes and services.
- In terms of Apex Priority 11, the aim is to double the number of children receiving subsidies to 600,000 and to double the number of children enrolled in ECD through 1,000 new sites and the training and employment of more than 3,500 practitioners.
- The DSD budget vote 2011/12 aims to have 26,062 centres registered and captured on the national data base (Budlender et al., 2011).
- The Minister of Social Development committed in 2011 to (1) developing a Rural and Informal Settlement Strategy for ECD, (2) have 1 million 0-5 year olds accessing ECD services and programmes, (3) standardise ECD subsidies to R15 per child per day over the MTEF, (4) improve ECD infrastructure, and (5) ensure completion of the ECD curriculum for 0-5 years.

The multiple sources and the apparent difference in goals and commitments related to the same services creates significant uncertainty in terms of what the national ECD goal is for South Africa. There is some uncertainty as to how these goals, many emanating from different sources, are connected in terms of common plans and budgets, or whether they will be monitored by one agency or by separate agencies, and ultimately where accountability lies for the realisation of the different goals.

In addition, nowhere is there a projection as to how much the different goals and commitments will cost to bring to fruition. Except, perhaps, for the standardisation of per child subsidy, there seems to have been no costing to inform the realisation of these goals. There has been no assessment of the cost of scaling up existing centres to meet demand (and no calculation of what that demand is), providing new centres, or the cost of rolling out community-and family-based services, how many services are required in rural and informal urban areas, how much it will cost to fill the rural and informal urban gap, the extent of infrastructure deficiencies, how much it will cost to address these inadequacies and which agency (department and level of government) is responsible for filling this gap.

5. Current ECCE funding streams and models to meet these and other targets

Whilst it is not possible to estimate funding allocated to cover the full and comprehensive ECD package, it is possible to estimate the government funding streams and models for early childhood care and education (ECCE) within the Departments of Social Development (DSD) and Education. Most of these budgets are allocated at a provincial level.

There are five possible sources of ECCE funding in South Africa (Budlender et al., 2011):

A. Within Social Development:

1. Per child subsidy for registered ECD centres for children aged 0-4 whose caregivers pass a means test. The means test is based on the joint income of the child's parents. The actual mean differs between provinces. For example, it is R1,800 per month in the North West and R3,000 per month in the Western Cape. The budget for this stream appears to have increased from R422 million in 2007/8 to more than R1 billion in 2011/12.
2. Programme funding for NPOs for ECD programmes providing training, home and community-based ECD, ECD practitioner stipends, training, travel, venue, catering, management and supervision costs. Programme funding amounted to approximately R19 million in 2011/12.
3. Funding of infrastructure is only provided in one of the nine provincial budgets, that of the North West province.
4. The EPWP budget for ECD. This budget is estimated to be in the order of R97 million. However, some provinces have relabelled subsidies and program funding as EPWP, therefore this budget is often only a sub-category of 1 and 2 and not additional money.

The total DSD budget cutting across these categories is summarised in the table below which was developed by David Harrison and Chris Desmond, based on the information provided.

Table 1: Available data: Social Development provincial budgets for ECD centres and programmes (2011/12) and actual expenditure reported under Expanded Public Works Programme (2010/11)

Category	EC	FS	GT	KZN	LP	MPU	NC	NW	WC	TOTAL
Transfers to NGOs	134.9	172.3	162.0	274.3	-	212.8	54.2	-	87.8*	**1 098.3**
Other programme support	-	3.9	-	-	-	-	-	15.0*	-	**18.9**
Total	**134.9**	**176.2**	**162**	**274.3**	**0**	**212.8**	**54.2**	**15**	**87.8**	**1 117.2**
EPWP*	5.7	17.7	-	-	10.2	0.1	-	-	63.2	**96.9**

* Data reported for 2010/11

B. Department of Basic Education (DBE)

Budlender et al. (2011) note that tracking ECD funding in the DBE is easier because the provincial budgets have a distinct programme, with several sub-programmes, devoted to ECD. ECD funding in the DBE includes:

1. The provision of Grade R in public schools through the education/school budgeting process.
2. Subsidies for community-based Grade R services, either through a per-child subsidy or payment of the salaries of Grade R teachers.
3. Funding of materials.
4. Funding the training of practitioners for young children pre-Grade R, including the payment of stipends to those on learnerships under the social sector EPWP.

The following table, taken from Budlender et al's (2011) report shows the full DBE ECD budget.

Table 2: Full DBE ECD Budget

	2009/10			2010/11	2011/12	2012/13
	Main appro.	Adjusted appro.	Revised estimate	Medium-term estimates		
Eastern Cape	367,316	307,816	290,486	528,492	652,168	676,000
Free State	80,555	82,122	82,122	957,38	100,978	105,717
Gauteng	309,146	28,0785	280,785	557,541	660,215	679,843
KwaZulu-Natal	336,299	326,704	264,963	598,678	722,054	758,157
Limpopo	228,615	171,515	144,116	237,423	249,253	267,750
Mpumalanga	96,922	97,922	97,922	124,553	155,718	134,667
Northern Cape	63,350	58,284	50,337	47,930	51,655	55,673
North West	193,156	194,503	194,503	209,020	224,109	239,553
Western Cape	313,468	305,489	305,489	342,657	363,593	384,764
Total	1,988,827	1,825,140	1,710,723	2,742,032	3,179,743	3,302,124

6. Increases in ECCE funding and progress towards attaining targets

All commentators agree that whilst it is difficult to estimate the ECCE budget in South Africa, it has increased substantially over the last decade (Budlender et al., 2011; Biersteker, 2008).

6.1 Social Development

The Social Development ECCE budget for children aged 0-4 has, over the period 2007,8 & 9, increased by an additional R2.4 billion to subsidise almost 500,000[i] children in ECD centres and a further R722 million was added for the training of practitioners for the 0-4 age groups. This growth stalled after 2009 with no further increases (Budlender et al., 2011).

Despite the uncertainty as to which target to use as a benchmark, there has been some progress towards meeting the various ECCE targets. There is nonetheless still some way to go to realise the ECD targets for children aged 0-4:

- 18,826 of the targeted 26,062 centres have been registered[ii];
- Of the 2.5-3 million children targeted for ECD services by the NIP, in 2008 1.4 million (28 percent) of children in the 0-4 age cohort were accessing ECD services through pre-primary centres and crèches according to 2008 NIDS data (Van der Berg et al., 2011). In 2009 (using a different data set – the General Household Survey), this number increased to 30 percent (up from 7 percent in 2002) (Department of Basic Education, 2011).
- The NIP goal of reaching children aged 0-4 through community and home-based programmes remains almost entirely unrealised given that almost all of the extra R2.5 billion ECD budget has been allocated to centre-based provisioning through the per-child ECD subsidy (Budlender, 2010). Moreover, there is no policy or plan to fund or support the scale-up of these models in the years ahead (Biersteker, 2008).

Whilst the current per-child subsidy is well targeted to reach children living in poverty and improve either their ability to afford ECD services and the overall quality of the services provided, the current funding model does not:

1. Make regulatory or funding provision for home and community-based ECCE services.
2. Ensure equal access to ECCE services for all children, with poorer children and children in rural and informal urban areas suffering the greatest inequities. Children living in poverty and other under-serviced communities are far less likely to access early childhood education and care services. Children living in the poorest households are only half as likely to benefit from ECCE as children in the richest households (Department of Women, Children and People with Disabilities et al., 2011 & Van der Berg et al., 2011). Three quarters (75 percent) of ECD funding comes from private sources – mostly through user-fees and most centres do not allow fee exemptions for children receiving the per-child subsidy (Van der Berg et al., 2011). One of the reasons for the inequitable exclusion of children living in poverty is because the state does not provide sufficient funding to cover the cost of providing the service, nor does it oblige the

provision of resources (or indeed provide such resources to ensure the inclusion of children whose caregivers are too poor to pay user fees (Berg, 2007; Biersteker et al., 2009; Van der Berg et al., 2011).

3. Provide, support or fund ECCE services, infrastructure or materials specific to the needs of young children aged 0-4 with disabilities, nor does the current model oblige provisioning of ECCE services for children with disabilities aged 0-4. There is no additional subsidy or other form of funding paid to ECD centres to cover the cost of the additional needs of children with disabilities, nor is there any obligation on the state to provide appropriate centres, programmes or services for children with disabilities, especially in under-serviced rural areas where ECD services are not even adequate in terms of reach, infrastructure and quality for ordinarily abled young children and where the evidence shows that young children experience a greater multiplicity of disabilities and disabilities of a greater severity than their urban counterparts (Department of Social Development, 2009, Revised draft).
4. Provide sufficient funds to provide quality ECCE services (Biersteker et al., 2009; Van der Berg et al., 2011). Quality is worse in poor areas (Biersteker et al., 2009; Van der Berg et al., 2011).
5. Pay practitioners in community-based centres for children aged 0-4 adequate salaries, especially when compared to the salaries paid to Grade R teachers in community-based centres by the Department of Basic Education (Van der Berg et al., 2011).
6. Secure the provision of safe and sufficient buildings, infrastructure or learning and teaching support materials, especially in centres in the poorest areas (Van der Berg et al., 2011). There is currently no obligation and currently no voluntary assumption by the DSD or local government of the responsibility to fund infrastructure development, maintenance, or materials (Budlender et al., 2011). Instead, the cost must be covered by either the subsidy or fees generated by the centre – a funding option that is inherently inequitable for centres servicing poor communities that cannot afford any, or higher user fees. In under-serviced areas where there is no, or very little service infrastructure, the current model relies on community-based organisations to establish the infrastructure, and to ensure that it meets the minimum standards in the Children's Act to qualify for registration and funding. This model of ECCE infrastructure development and growth keeps poor and underserviced communities trapped into cycles of under-servicing as they are least able to find the funds for even the most basic infrastructure development, never mind infrastructure that meets minimum standards. In the absence of state provisioning these areas have remained underserviced despite progress in extending the reach of the subsidy, as the subsidy requires existing infrastructure.
7. Oblige provincial departments to fund and support the provision of ECCE services. The mandate is discretionary as the Children's Act (Section 93(1)) states that early childhood development programmes "may" rather than "must" be provided by the provincial departments. There is thus no enforceable state responsibility or accountability and hence no legal grounds on which to compel the provision of ECCE services to children aged 0-4.

8. Apply funding equitably and evenly in different provinces. Where funding is provided through the per child subsidy, there is provincial variability and inequity in terms of the sum of the subsidy paid in different provinces, the means test used to determine eligibility and the criteria for payment of the subsidy. The criteria for registration in some provinces is registration and for some it is attendance of the child at the centre. As previously mentioned, there is substantial difference in the means test used by different provinces. There are also differences in the amount of the subsidy paid. For example, it is R12 per day per child in the North West and R15 per day in the Western and Eastern Cape. Whilst the Eastern and Western Cape pay the same sum per day, the total number of days for which it is paid differs from 264 in the Western Cape to 171 days in the Eastern Cape (Budlender et al., 2011).
9. Provide national minimum norms specifying how the subsidy funds should be used and in what proportions for specific items. Some provinces have introduced such norms, however they lack the staff or systems to monitor compliance (Biersteker, 2008; Van der Berg et al., 2011)
10. Hold recipients of funding accountable for proper and ethical management of funds in the best interests of the children in centres (Van der Berg et al., 2011).

6.2 Basic Education

The growth in the Grade R budget from R932 million in 2007/8 to R3.2 billion in 2010/11 makes it the fastest growing education programme in budgetary terms (Biersteker, 2008). Whilst it accounts for a small share of the overall education budget, that share has increased markedly over time. Budlender and Proudlock note that by 2012/13 it is set to be 2.1 percent of the combined education budgets whereas in 2006/07 it accounted for only 0.7 percent (Budlender & Proudlock, 2010).

There has been a comparably significant growth in the number of children, especially poor children, aged five accessing an educational institution. In 2009, 78.3 percent of children aged five attended an educational institution in South Africa, compared to 39.3 percent in 2002. Provincially, access varies from 66.8 percent in the North West province to 92.7 percent in Limpopo (Department of Basic Education, 2011).

Whilst Grade R funding lagged behind other grades in 2005 (when it was 7 times less than for other grades), this inequity has been resolved in part through the promulgation of the National Norms and Standards for Grade R funding (Government Gazette, Vol 30679). This formal regulation, which introduced minimum provisioning guidelines, created an obligation to fund Grade R, especially targeting children living in poverty, and at a minimum level. This laid the foundation for an increase in state funding of Grade R with better per-learner funding for poorer schools to make provision for additional materials and improved educator:learner ratios (Biersteker, 2008).

Whilst there are concerns about the adequacy of the provisioning for Grade R in public schools (and in community centres) to provide a quality service, on the whole the assumption by the state for this provisioning, the grafting of the service onto the existing school system with its existing infrastructure and systems, and its firm policy-based regulation of the level and quality

of service average has resulted in a significant and equitable scaling up of this ECCE service. In addition to the improved reach of the service, the quality of the programmes, the quality of the basic services and infrastructure, the salaries of staff, and financial management and accountability in Grade R in public schools are higher than 0-4 and Grade R community-based (less funded and regulated) services (Van der Berg et al., 2011).

7. Key overarching funding concerns

1. The insufficiency of national legal obligations on government departments and a resultant lack of government accountability to fund ECCE services for children aged 0-4, and the failure to oblige adequate provisioning to ensure equitable access, infrastructure and quality is a key cause of the slow pace of development and scaling up of ECD services for children aged 0-4, especially in poor and under-serviced areas.
2. The lack of adequate mapping of need and targets and the complementary costing of the necessary services means there is no national baseline against which to plan and budget for the provision of ECCE services for children aged 0-4. There is not a sufficiently clear picture of what must be provided, how many children need it, where the hard to reach children are and how much it will cost to reach them – and ultimately what the cost will be to meet these needs – at national, provincial and local levels to cover these costs.
3. Within the current lead departments such as Social Development, the ECD divisions are under-resourced. This has resulted in insufficient capacity to undertake evidence-based planning, monitoring and regulation of ECD services.
4. In the absence of clear obligations on the state to provide ECCE services, there is a heavy reliance on NPOs and donors to fund and provide these services. This is inherently inequitable in poor and underserviced areas where there is limited NPO activity, insufficient resources and the greatest infrastructural and related challenges that in fact require the greatest levels of investment of human and financial resources.
5. Where budgets are allocated, they are insufficient to meet demand and provide quality ECD services and do not make provision for ensuring safe and necessary infrastructure. There is no infrastructure or equipment budget for children aged 0-4 and for children in Grade R in community-based facilities.
6. The vision for non-centre-based programmes remains unfunded. In addition, there is no plan in place with regards to how these services will be rolled out through non-centre-based programmes (Budlender, 2010).
7. There is no local government funding for ECD centres, infrastructure or programmes, despite the NIP and the Constitution of the Republic of South Africa requiring local government support of ECD in terms of financing and infrastructure.

8. Conclusion and preliminary recommendations

8.1 Conclusions

We do not have one common ECD plan with common national targets and objectives, supported by one national plan of action and an accompanying budget based on actual costing of the services in question.

Access to and the quality of ECCE services is insufficient and much poorer for children and mothers living in poverty, living in rural areas, living in informal urban areas and those with disabilities – compared to their wealthier counterparts, their urban counterparts and their non-disabled counterparts.

The current funding and service delivery mechanisms for ECCE for children aged 0-4 and those aged five in community-based centres drives and perpetuate these inequities that were inherited by the democratic state. The current model tasks a huge number of disparate NGOs, CBOs, and home-based agents – namely those with the least capacity, resources and infrastructure – to provide the most difficult services, the most complex services, and to reach those hardest to reach. They not only lack the resources, management, planning, monitoring and evaluation skills, but crucially lack the infrastructure and financial resources to provide quality services, develop infrastructure and centres where they are most needed, and to sustain these services.

Remedying this situation requires the guaranteed provisioning by the state of quality ECD services and infrastructure for large numbers of young children in hard to reach areas.

The scale, scope and complexity of the unfulfilled obligations requires state accountability for, coordination and oversight of the multiple service delivery feelers tasked with the implementation of the national ECD objectives and services. This requires significant planning, infrastructure, management, and evaluation capacity. Most of all however, it requires significant and sustained and sustainable financial and human resources.

There is a lesson to be learned in the approach and successes in relation to breaking the cycle of deprivation and poor access to Grade R which faced similar challenges to the apparently intractable provisioning of services for children aged 0-4. Whilst there are ongoing concerns about the adequacy of the provisioning for Grade R in public schools (and in community centres), on the whole, the assumption by the state for this provisioning, the grafting of the service onto the school system with its existing infrastructure and systems, and its firm policy-based regulation of the level and quality of service average has resulted in significant and equitable scaling up of this ECD service. In addition to the improved reach of the service, the quality of the programmes, the quality of the basic services and infrastructure, the salaries of staff, and financial management and accountability in Grade R in public schools are much higher than 0-4 and Grade R community-based services (Van der Berg et al., 2011).

By comparison to the state-funded and state-implementation model for Grade R, there is an in-built inequity in the model for children aged 0-4 and Grade R in community-based centres. Services are the responsibility of many small, poorly managed and underfunded NGOs. The rights of the most marginalised young children depend on the fundraising ability of local organisations, in a climate where funding is leaving the country and organisations are folding

daily. Where the funds are not sufficient, as is the case with most of them, it impacts on the quality of the service, and where funds dry up, the service simply ceases. Herein lies the heart of the problem - the state cannot, in terms of the current model, be held accountable for the poor quality of, or cessation of the service or, for that matter, the lack of a service in a particular area. In short, the inequitable and inadequate funding and service delivery model is intrinsically linked to the current location of ECCE and ECD more broadly within a service-based, rather than a rights-based paradigm (discussed in greater detail in Background Paper 2: An overview of the ECD policy framework in South Africa).

The current ECD policy framework does not create a responsible and accountable government, and if government is not accountable, no one else can be held accountable. Without legal responsibility and accountability (created by clear and meaningful legal obligations), it is unlikely that adequate and appropriate funding flows will be unlocked – and the rights in the CRC, the NIP and other instruments will remain meaningless. And inequity in ECD will remain a dominant feature of the South African landscape which no one can legally do anything about.

8.2 Preliminary recommendations

1. There is a need for a decisive paradigm shift towards a rights-based ECD framework and accompanying funding model that recognises and is capable of realising the state's legal obligations to provide ECD services to all children, especially the most marginalized living in rural areas, informal urban areas and children with disabilities. This requires an interrogation of the level of responsibility on, and accountability of the state to provide, support and fund ECD services and to ensure that the services are equitably available to the most marginalised children.
2. There is a need to interrogate the current service delivery model and look at shifting to a model that can:

   2.1 Deliver infrastructure in the hardest to reach places;

   2.2 Provide a quality service that is regularly monitored and assessed against national standards;

   2.3 Provide the care, teaching, services and support that is needed by all children with additional needs (such as those with chronic illnesses, disabilities etc); and

   2.4 Provide a service 365 days a year every year.

   Given the immensity of the task, the only agency with the legal responsibility and the reach, money and infrastructure (or ability to create the infrastructure) is the state.
3. There is a need to interrogate the current funding model and move towards one that is predominantly government-funded and – driven, which is properly costed in terms of needs, numbers and quality, and which is pro-equity. **It must start with and prioritise the provisioning of services for the hardest to reach children.** This does not mean the state must necessarily directly provide all services. It does however mean that it must be legally responsible and accountable for the provisioning of all services. This in turn means that it should provide adequate funds and support to providers of services,

as well as provide some of the services itself where there are no alternative and viable NPO service providers. It also does not mean that the state cannot raise funds from external donors, but it must be accountable for finding the necessary funds to meet its legal responsibilities. This is an area where business and donors can play a key role within the broader national ECD campaign. They should, as in the case of all other role players, commit to a common national ECD plan and contribute their funds to the delivery of the national ECD policies and standards etc. in a coordinated manner so as to ensure an equitable spread of quality essential ECCE and other ECD services.

4. Mechanisms must be in place to allow parents to demand ECD for their children and, where there is a failure of service, mechanisms must be in place to allow parents to hold the state accountable for that failure and be able to pursue resolution through legal channels. This requires mechanisms to ensure accountability, not just in terms of access, but also quality. Mechanisms must be in place to not only develop minimum standards of services, care and education, but also to guarantee compliance with these. Once again, it is only the state that has the capacity to create and sustain the requisite level of infrastructure, capacity, management, resources, and mechanisms to hold itself to account for ECD in South Africa.
5. In addition, there is a need for a shared costed NIP, in the same way that the current NSP is being costed, against which all sectoral role-players plan, budget and report. The plan must create clear legal obligations on the state to fund and take responsibility for the implementation of ECD services in South Africa. There must be a clear indication of which department and level of government is responsible for what elements, and the relevant overarching coordinating structure must be empowered and capacitated to hold the various role players accountable to their roles and responsibilities.
6. There is a need to map the location and needs of the most marginalised young children in South Africa and to develop a targeted and costed equity-driven plan within the broader NIP for ECD. The plan must indicate what must be provided by the different departments and levels of government.
7. There is a need to develop, cost and fund a national inclusive ECD programme of action for children aged 0-4 which can ensure that all children with disabilities are identified through early screening and are guaranteed access to state funded and/or provided, and/or supported ECCE services.
8. The human and financial resources of the current departmental ECD directorates and the overarching coordinating ECD structure(s) must be strengthened to meet the size and complexity of the ECD challenge and to develop and implement appropriate systems to ensure adequate planning, monitoring and evaluation.

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[i] Figure provided by Louise Erasmus of the National Department of Social Development to the researchers in December 2011

[ii] Ibid

Background Paper 11

Cost & impact

Chris Desmond

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List of Figures

Key points

Issues:

- Allocative efficiency: Investments in ECD are low relative to related sectors. Child development is a cumulative process and, as a result, investments at younger ages tend to generate higher returns than later investments. Missing the opportunity to invest in ECD, therefore, can lead to significant losses. As ECD is a public good these losses will cost not only the child and their family, but also broader society. Within ECD budgets, investment opportunities focusing on very young children are being missed. Emphasis has been placed on reaching 3-4-year-olds through ECCE centres and 5-year-olds through Grade R, leaving 0-2-year-olds and their families with few services other than health care. Missing such opportunities is a missed opportunity given that the younger the child, the higher the potential returns.
- Impact studies: Very few studies have examined the impact of ECD services on child outcomes in South Africa. The studies that have been done to report benefits for children, particularly with regard to nutrition and growth outcomes. However, all these studies have been hindered by a lack of objective data. Children are non-randomly assigned to receive ECD services which introduce biases and appropriate measures to control for such biases is limited.

Recommendations

- ECD is a public good and investments in young children will generate high returns. Given these two factors, current levels of investment in ECD seem low and should be increased by an order of magnitude. The cost-effectiveness and efficiency of early intervention is grounds for a focus on very young children, but it does not negate the need for later intervention. It is imperative that we give every child the best possible 'first chance'. However, every child deserves a second chance, especially if they were deprived of the most optimal conditions to begin with.
- The quality of evidence on the impact of ECD services could be enhanced by a) improving the quality of questions in existing national surveys; b) randomised control trials, and c) longitudinal cohort studies. Future impact studies need to address a) selection effects, attributed to more motivated and engaged parents enrolling their children in services; b) assessment of the quality of services which is important in itself, but also to prevent averaging out the effects of services which differ widely in quality; c) direct measurement of outcomes to prevent distortions arising from the use of administrative data which is often incomplete or inaccurate, and d) evaluation of more than one outcome for interventions. For example, nutrition interventions not only affect growth, but attention and activity levels; sociability, play and peer relations; exploration and school performance, and health.

Cost & Impact

1. Evidence of impact

A number of studies have examined the impact of ECD services on child outcomes in South Africa. These have included examinations of the impact of ECCE on subsequent academic performance, and of the child support grant (CSG) on nutrition outcomes. Although there are only a few studies, and there are data concerns, the results suggest that ECD services have a positive impact on these outcomes.

Gustafsson (2010) uses data from the 2008 National Income Dynamics Survey (NIDS) to examine the impact of participation in preschool programs on subsequent academic performance. The NIDS asks if children went through preschool, and includes numeracy tests for children (three tests of varying difficulty). The analysis aimed to examine the extent to which reporting passing through preschool was associated with higher scores in the numeracy tests. Gustafsson (2010) found that for children living in rural informal areas and for children living in urban formal areas, prior preschool attendance was associated with higher test scores; no relationship was observed for children living in rural formal areas or urban informal areas. Interestingly, when controls for household characteristics (such as income) were introduced, the relationship between preschool attendance for children living in urban formal areas and numeracy scores was no longer statistically significant. The author suggests that this shows that the effect attributed to urban formal preschool attendance was actually the effect of higher socio-economic status: households in urban formal areas tend to send their children to preschool and tend to be wealthier; moreover children from wealthier households tend to do better at school. Even when household variables were controlled for, prior preschool attendance was still associated with better test scores for children living in rural informal areas. The author takes this as evidence to support the current policy of targeting poorer areas.

Gustafsson (2010), however, notes a number of limitations with the data and analyses based on it; the sample size was small and non-random because households were given the option to decide if they wanted the child to take the test of not. Moreover, the guidelines for which test should be taken by which children were unclear and different tests were used for children in the same grade – as a result, Gustafsson (2010) only used the results from one test (test 2), further shrinking the sample. An additional concern is that the participation in preschool is also non-random. The relationship observed may be a result of a selection effect – parents with greater interest in education may be more likely to send their children to preschool and may also be more likely to be more supportive of education in the future. Children who attend preschool, therefore, would do better than those who do not, even if they did not attend. Finally, there was no control for quality of preschool. Children may have attended very different preschools, if it were possible to isolate those who attended quality programs from those who did not, this group may be seen to have benefited more.

Spaull (2011) used 2007 data from SACMEQ III to examine the relationship between a range of variables, and scores of grade 6 children on reading, math and health knowledge assessments.

As the dataset included information on length of preschool attendance, Spaull (2011) was able to examine if length of attendance was related to test scores. After controlling for a range of household variables and child characteristics, the author found a particularly strong relationship between attendance at preschool for a year or more, and reading scores. Math and health knowledge scores were also positively related to having attended preschool for a year of more, but the relationship was not as strong. The analysis suggested that the first year of preschool attendance was associated with the largest increase in test scores. While additional years led to larger impacts, there was evidence of diminishing marginal returns.

The primary problem with the Spaull (2011) study is again that the children were not randomly allocated to attend preschool or not. As mentioned above, children whose parents send them to preschool may be more supportive of subsequent education. Consequently, it is not clear if the positive association is a result of preschool attendance or parental attitudes towards education. If there were a variable to measure or instrument for parental attitudes, this limitation could be addressed. The regressions estimated do include variables on maternal education and the number of books in the home, both of which are likely related to positive attitude towards education and so arguably address this limitation to some extent, but it remains a concern. In addition to the non-random allocation of children to receive preschool services, there is again no control for quality. Children who attended preschools which were better equipped, or which had lower staff-to-child ratios, or more highly trained staff, may do better than children who sat together in a dark room with one untrained preschool teacher to 50 or more children.

To fully assess the effects of preschool on subsequent school performance would require either a randomized control trial or collection of appropriate data to instrument for parental attitudes towards education and measure quality/type of service received. The former would be more robust, but the latter would arguably be more ethical, given the overwhelming evidence of the benefits of ECD. Randomizing children into a no-preschool group would be difficult to defend, unless it resulted from a natural experiment related to roll-out of services.

An example of the use of instrumental variables is provided by Agüero, Carter and Woolard (2006). They used the KwaZulu-Natal Income Dynamics Study (KIDS) to examine the effect of the child support grant (CSG) on nutrition outcomes (measured by height-for-age z-scores (HAZ)). Specifically they wanted to know if receipt of the grant during the first 36 months of a child's life had a significant impact on HAZ. Again, there is likely to be a selection effect. Otherwise similar caregivers who enrol their children for the CSG at a younger age may do so because they are more aware of the importance of early nutrition. To address this potential bias, the authors controlled for what they refer to as the 'eagerness' of the caregiver to enrol their child – that is, the difference in the delay to enrolment (days from when a child is eligible until they apply) compared to the average delay in the geographical area in which they reside. Having controlled for this, and other household characteristics, they found that receipt of the CSG during the first 36-months of a child's life had a significant impact on HAZ i.e. receiving the CSG is associated with a lower probability of stunting.

2. Future impact studies

To fully appreciate the potential impact of ECD services, and how different types of service may benefit children in different circumstances variably, further analyses are needed. Existing datasets, however, make the examination of the impact of ECD services difficult. Children are not randomly assigned to receive an ECD service or not, or to receive one type of service as opposed to another. Moreover, the datasets typically do not collect appropriate information on attitudes (or proxies for them) to make instrumentation for such caregiver attitudes possible. As a result, we cannot tell what effect is arising because of the ECD service, and what effect is arising because children who are sent to receive ECD services would have likely done better anyway (because of caregiver attitudes to education, nutrition, health etc.).

A further limitation with existing datasets is that they typically do not contain data on service quality. Assessing the quality of ECD services is a specialized task and it is highly unlikely to be possible to include such data collection in national surveys which rely on household responses. However, more detail on at least what type of ECD services children are receiving would be useful. Currently national surveys make is difficult or impossible to differentiate what type of ECD service was received/is being received by a child – for example, Sunday school attendance and weeklong fulltime centre-based care could elicit the same response.

Three avenues for improving the quality of evidence on the impact of ECD services are available:

a. Improve existing national surveys

b. Randomized control trials (RCT)

c. Longitudinal data collection without randomization

As mentioned, national surveys could improve the collection of data on ECD services received. Clearer and more detailed questioning on the types of services being received and previously received would allow for more appropriate analysis. Moreover, the development of questions to create instrumental variables to control for caregiver attitudes would be helpful.

A RCT could be used to examine the impact of ECD services. This would be appropriate if there was to be a marked change from the current approach to service delivery. If there were going to be a marked change, this could be rolled out first in randomly selected communities and the results compared to control groups who would receive the new service only later.

A RCT may, however, not be necessary. If a cohort of children is followed and appropriate data on ECD quality and caregiver attitudes is collected, these factors can be controlled for thus negating (at least partially) the effects of non-random allocation.

An advantage of both an RCT and a non-randomized longitudinal dataset is the opportunity to examine a range of outcomes. These outcomes could include: developmental outcomes (incidence of behavioural problems, motor skills, cognitive skills etc.), nutrition outcomes (stunting, wasting etc.), health outcomes (vaccination rates, mortality, morbidity etc.), and education outcomes (grade repetition and completion, reading levels, math levels etc.).

3. Economic arguments for ECD investment

ECD services have benefits for children in the form of improvements in their health, cognitive development and general wellbeing. From a human rights perspective these benefits are sufficient to justify the provision or subsidization of services by the state, particularly for children whose families cannot afford to access privately provided services.

Additional benefits which accrue over the longer term provide further justification for state intervention. As these longer term benefits are often valuable not only to the child, but broader society, ECD can be considered a public good. For example, quality ECCE services have been shown to improve academic performance, increase future earnings, and reduce reliance on state provided services (Shonkoff, Richter, Van Der Gaag, & Bhutta, 2011, in press). Economic theory suggests that if public goods are not subsidized, they will be underprovided. Under provision will occur because families are unlikely to consider the benefits to others when deciding how much to invest in their children's early development, leading to lower than optimal investments.

The magnitude of the long-term benefits of ECD services is determined by the quality of those services, and the availability of opportunities and complementary services later in children's lives to build on early gains (Heckman, 2006; Shonkoff, et al., 2011, in press). The importance of quality provision is well established, but the importance of complementary services is not as frequently examined. Complementarity takes many forms, for example, a child cannot fully benefit from any increased capacity to learn, as a benefit of healthy growth, engaged parenting or quality preschool, if they are not enrolled in school, and if the school is not good enough to extend the child's learning. Similarly, increased earning potential will only be realized if the child can find a job in the future.

In general, then, benefits of ECD will be greater when complementary services are available. However, ECD may be even more important when complementary services are not available. This occurs because ECD prepares children to respond better to difficult circumstances (Shonkoff, et al., 2011, in press), and lack of complementary services constitutes difficult circumstances. For example, children who have received quality ECD services will be better able to learn independently and respond to other challenges they encounter when attending a low quality school. ECD may not always improve IQ, but it improves confidence, resourcefulness, and the desire and ability to learn, which is critical, for example, when your teacher is not that interested in you (Shonkoff, et al., 2011, in press). Indeed, ECD provides an opportunity to compensate for both the past and the future disadvantages accruing in the home from poor socioeconomic status or parental incapacity, and the low quality of education many children receive. This, however, should not distract from the fact that the total benefits from ECD services will be greater if recipient children come from homes which foresee their health and wellbeing, and go on to attend good schools.

Many of the long term benefits of ECD arise as a result of their impact on brain architecture. Brain development is a cumulative process, meaning that interventions which improve outcomes at one stage go on to affect outcomes at all subsequent stages. The cumulative nature of child development leads to high rates of return on investments in ECD (Heckman,

2006). Moreover, the impact of ECD on children's ability to learn and benefit from later services increases returns on investments in these subsequent services (Heckman, 2006). For example, a child who receives ECD will benefit more from school – leading to higher rates of return, not only on ECD, but also on existing investments in schooling. Studies in the wealthy world suggest that because the first few years of a child's life are so critical for their brain development, and that all further brain development is influenced by what happens during this period, no other period generates higher rates of return on (Heckman, 2006; Reynolds, Temple, White, Ou, & Robertson, 2011).

4. Low investment in ECD

Although ECD services have the potential to generate high returns, investments in this sector remain low. ECCE budgets (discussed in detail elsewhere in this report), for example, are not very large. This is partially due to low coverage of ECCE services. It is also due to low levels of investment per child who is covered. The following figure compares the level of state investment per child 0-4 years of age who is receiving ECCE services supported by the state with government spending per child enrolled in grade R, primary school, secondary school or attending a tertiary institution. It is important to note that data on ECCE spending is difficult to collect and estimates vary widely. The following figure is intended only to provide an approximation of the differences in the level of spending per children receiving services; precise estimates were not possible. The assumptions and methods of making the calculations are given in the annex. The data problems are a concern, but the magnitude of the difference in spending is such that data refinements are unlikely to make a difference to the general conclusions – per child, relatively little is spent on ECCE.

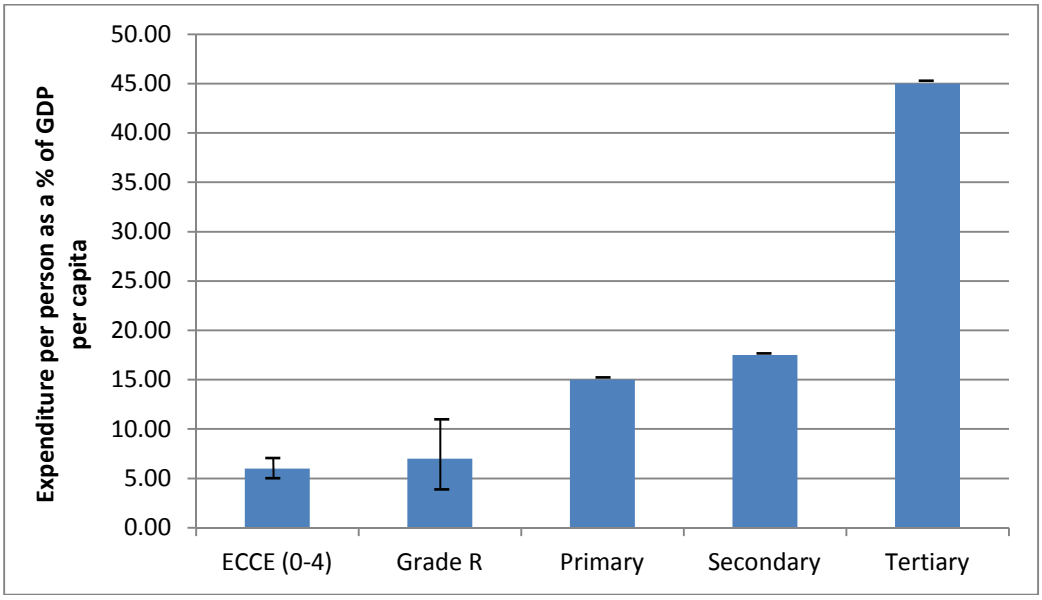

Figure 1: Expenditure per child/student enrolled in education as a percentage of GDP per capita

Figure notes: ECCE (0-4) based on the average of the total subsidy payable in the Free State and the Western Cape plus a 20% overhead. Grade R based on average of reported expenditure on grade R divided by the number of children reported to be enrolled in grade R and 70% of the cost per child in primary school. Primary and secondary school data are taken from World Development Indicators 2011. Tertiary expenditure is based on the Ministry of Higher Education budget for university subsidies plus a 10% overhead, divided by the number of students in enrolled tertiary institutions. Full details of the calculations are provided in the annex.

The above figure includes expenditures on ECCE by the Departments of Social Development (excluding grants) and Education. Expenditures by other departments, such as health, are not included. This is appropriate for this comparison as the expenditures for the primary, secondary and tertiary students do not include health, and other expenditures made for these age groups. Although the point estimates must be treated with caution (given the data limitations) they clearly demonstrate that the funding for ECCE is low, not only because of limited coverage, but because spending per child is low. This despite the high returns associated with ECD argued above. Although health expenditures cannot be included because of lack of data, expenditures on the child support grant can added. The figure below includes these expenditures, again the figure is for those who receive the grant, and does not take account of the differential coverage between age groups.

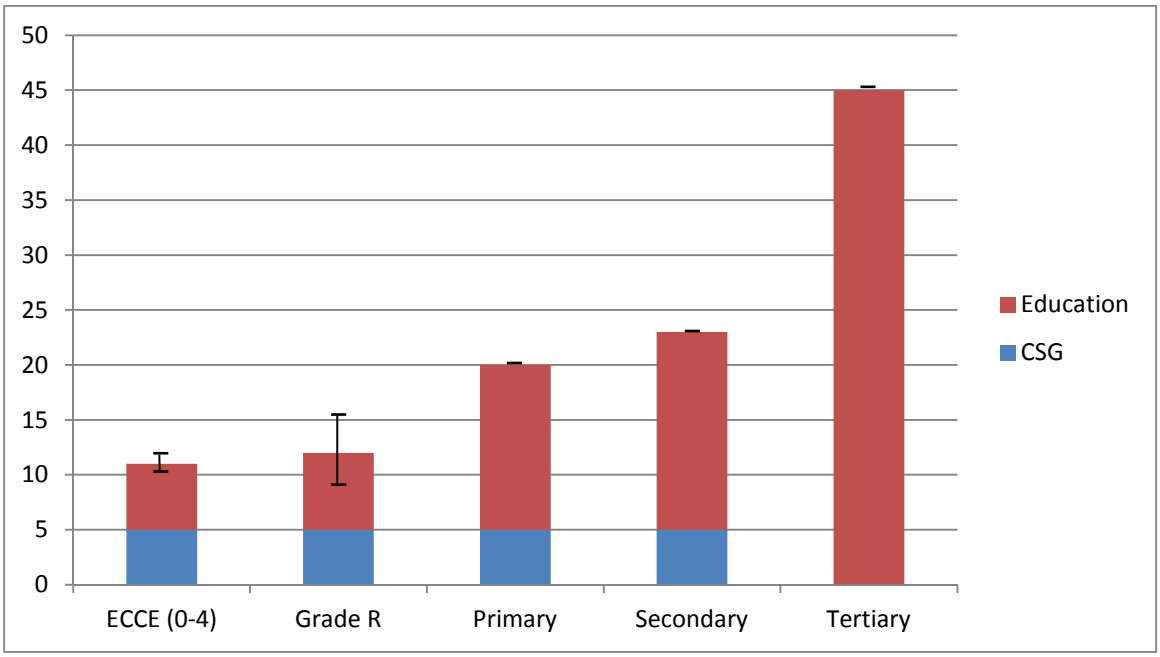

Figure 2: ECCE and CSG expenditure by level of education (age) as a percentage of GDP per capita

The above figures prompt two questions:

a. Does the above figure suggest funding to primary, secondary and tertiary education is too high?

b. Should ECCE funding per child be increased?

Expenditure is measured as a percentage of GDP per capita because this allows for comparisons with other countries. Comparing expenditures on primary, secondary and tertiary education in other countries demonstrates that South Africa is not spending excessively on primary and secondary education. South African spending on tertiary education (measured as a percentage of GDP per capita) is high relative to higher income countries, but low relative to other African countries. Spending per child/student as a percentage of GDP per capita in Botswana is 12 percent, 38 percent and 25 percent for primary, secondary and tertiary,

respectively. In Brazil the figures are 17 percent, 18 percent and 30 percent respectively and in the UK they are 23 percent, 28 percent and 22 percent (World Bank, 2011).

It would appear obvious that spending per child enrolled in an ECD service should be increased. We know that investments in ECD can generate high returns, and we know that relatively little is being invested per child. However, we also know that coverage is low. It may be more appropriate to expand coverage first and then increase spending per child – unless sufficient resources were made available to increase both simultaneously. A focus on increasing subsidies to existing centers first would magnify the inequalities their uneven provision already produce.

5. Prioritizing between ECD interventions

It is easier to make the argument for investments in ECD than it is to determine which aspects of ECD should be the focus. The difficulty arises for a number of reasons:

The nature of ECD outcomes makes cost effectiveness analysis (CEA) difficult. CEA seeks to identify the intervention which leads to a given outcome for the lowest cost (e.g. the intervention with the lowest cost per HIV infection avoided). ECD aims to improve health, psychological wellbeing, educational readiness, and civic mindedness, amongst other things. Because ECD cannot be defined by a single outcome measure, interventions cannot be ranked according to their efficiency at generating that outcome.

- The nature of ECD outcomes also makes cost benefit analysis (CBA) difficult. CBA seeks to identify the intervention with the highest net present value. That is, the intervention which leads to the greats benefits (measured in monetary terms), relative to its cost (also measured in money terms). Benefits from ECD services such as improved health and reduced stress, do not lend themselves to measurement in money terms. An evaluator can, therefore, either not use CBA or make value judgments (which are often difficult to defend).
- ECD is affected by various types of interventions. Interventions to improve access to clean water, clinics and home visitation programs can all benefit ECD, but do not lend themselves to easy comparison as other benefits associated with these programs are very different.

Despite the difficulties, there is a place for economic evaluation in supporting the efficient allocation of resources within ECD programs. Once an ECD outcome, such as reduced stunting or educational progress, has been identified as a priority, then CEA can assist in identifying the most efficient interventions to achieve the given outcome.

Efficiency is, however, not the only concern. Equity considerations must be kept in mind. This is particularly important when different populations are involved. An intervention in an urban area may be more efficient than an intervention in a rural area where travel costs are higher. This does not mean that the urban intervention should always be selected. If it did, the urban area may end up getting every intervention and the rural area nothing.

ECD services tend to be complementary. For example, education interventions work better when nutrition interventions are also provided. In such situations it is appropriate to evaluate a set of interventions rather than individual interventions. Failure to do so may again lead to inequitable outcomes. Interventions will appear to work better when there happens to be another intervention already in place and worse when complementary interventions are not available. For example, children living in remote areas where there is limited access to the CSG may be too hungry to benefit from ECCE services. If only the ECCE service is evaluated it may be concluded that it is ineffectual in remote areas, but works well in urban areas. If a set of interventions including improving access to the CSG and ECCE is evaluated, ECCE may be seen to have more effect in the remote area.

The literature is clear that interventions early in a child's life are almost always more cost-effective than later interventions. This is because of the foundational nature of ECD. Trying to improve outcomes for children who have suffered during early childhood requires trying to undo a cumulative adverse impact. Doing so is typically expensive.

The efficiency of early intervention is grounds to argue for a focus on very young children. Two critical clarifications must, however, be noted:

- The efficiency of early intervention does not negate the need for later intervention. Rather, early intervention improves children's ability to benefit from later intervention and therefore makes subsequent investments more desirable.
- The efficiency of early intervention should not be inappropriately used to justify ignoring older children. If the opportunity to intervene in the early days of a child's life is missed, then intervening now is the next best option. If early intervention for a new born is 0-2 years, then early intervention for a 3 year old who has not yet received ECD services is 3-5 years.

6. Summary of main points

The main points of the above discussion are summarized by the following points:

- South African data suggest that ECCE service improve subsequent academic performance.
- South African data suggest that the CSG reduces the chances of stunting among children under 36 months.
- South African national surveys could be made more useful to the ECD sector by collecting more nuanced data on ECD services received.
- Further research is required to better understand the impacts of ECD services in South Africa. This research could take the form of a RCT or a non-randomized longitudinal study which collects appropriate data on quality and caregiver attitudes.
- ECD provides immediate benefits to children and this alone can be used to justify intervention.

- ECD has many additional benefits which are valuable to broader society. Therefore, ECD can be considered a public good which warrants state investment to ensure adequate supply.
- The foundational nature of ECD leads to high rates of return on ECD investments.
- Despite high rates of return, South Africa is currently investing much less in ECD than in other areas of the education system.
- It is difficult to determine priorities within ECD as there is a wide range of desired outcomes. Prioritizing requires the discussion of the relative importance of different outcomes.
- CEA can be used to identify efficient interventions for an outcome which has already been identified as a priority.
- It is important to consider complementary sets of interventions to avoid entrenching inequalities.
- Early intervention is more efficient than later intervention.
- What constitutes early intervention is determined by the child's age.

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Annex A – Expenditure graph

Expenditures per child receiving services were estimated for ECD (0-4 years of age), grade R, primary school, secondary school and tertiary students, i.e. the average amount expended by government per child/student currently enrolled in each level of education. It is not the average expenditure per child in a particularly age group as not all children are enrolled in a program (particularly at the ECD and tertiary levels). Similarly, the CSG amount is the amount per child who is receiving a grant; it does not consider differential coverage between age groups.

These expenditure figures are reported as a percentage of GDP per capita. This is common practice as it allows for comparison across countries while accounting for the differential availability of funds. Expenditures can be more or less than a 100 percent of GDP per capita; GDP per capita is simply used as a reference point.

Data are limited and a number of assumptions had to be made. Given the number of assumptions, the estimates should be considered as being merely representative of the magnitude of the differences in expenditure.

The CSG figures are simply the annual grant amount measured as a percentage of GDP per capita. This figure is included at all levels except for the tertiary level, as students are too old to receive the grant. The assumptions made for each level of education expenditure are summarized below:

ECD (0-4 years of age): The lower-estimate of expenditure per enrolled child was taken to be the per-child subsidy provided in the Free State i.e. R15 per day for 171 days per annum, plus a 20 percent overhead. The upper-expenditure estimate was taken to be the per-child subsidy provided in the Western Cape i.e. R12 per day for 264 days per annum. The expenditure estimate presented in the graph is the average of the lower and upper estimates reported as a percentage of GDP per capita. GDP per capita was taken from the World Development Indicators database and converted to Rand at R8 per US$.

Grade R: The lower-estimate of expenditure was taken to be the reported expenditure on grade R (discussed in the finding section of this report), divided by the number of learners in school based and subsidized center based grade R programs as reported by the Department of Basic Education. The upper-estimate was taken to be 80 percent of the estimate of expenditure per child in primary school. The expenditure estimate presented in the graph is the average of the lower and upper estimates as a percentage of GDP per capita. GDP per capita was taken from the World Development Indicators database and converted to Rand at R8 per US$.

Primary and secondary school: Estimates taken directly from the World Development Indicators 2011 database. The figures reported are estimates for 2010.

Tertiary: The expenditure estimate is taken to be the budget for university subsidies reported by the Department of Higher Education plus 10 percent for administration divided by the number of students enrolled. The administrative overhead was set lower than the 20 percent used for ECD on the assumption that it is easier to pay subsidies to a few universities than it is to pay them to numerous ECD centers. The figure for the number of students enrolled does not distinguish between full-time and part-time students. It would have been preferable to estimate

the expenditure per full-time equivalent, but this was not possible with the available data. As a result, the estimate of expenditure per student at the tertiary level is an underestimate. The graph presents the expenditure estimate as a percentage of GDP per capita.

Background Paper 12

South African data

Justine Burns

Contents

List of Tables & Figures

Key Points

Issues:

Accurate, age-disaggregated data at the provincial and even the district levels is required to plan and provision resources to enhance early child development. There are already a large number of widely available nationally representative data sets collected regularly in South Africa. In their current form, these surveys go some way to facilitating these aims, though information more targeted to answering key questions about young children is still desperately needed.

Recommendations:

Key areas for consideration are:

- Current data present very limited possibilities for estimating the demand for care by working caregivers, or for understanding how the employment status of caregivers impacts on the well-being of young children. Inclusion of person codes of the parents for each child in the household in the Labour Force Survey (LFS) would facilitate this.
- The measurement of disabilities needs to be re-thought in relation to what would be appropriate for young children. When questions are asked in terms of whether an individual experiences difficulty engaging in a specific task (e.g. self-care, walking, talking), age-appropriate standards should be adopted.
- Current survey data provide a good indication of the fraction of an age cohort that receive a grant, but do not give accurate information about eligibility. Ensuring that receipt of the CSG as well as the FCG or CDG is linked to child recipients would be a start. Capturing data on foster status would also be helpful.
- Measurement of participation in ECD activities in survey data needs to accord with the relevant age-definition adopted by policy makers. Currently, ECD questions in GHS are asked only of children aged 0-4, and should be extended to include at least ages 0-6. Moreover, the GHS asks questions about fees paid, bursaries or fee waivers received and so on, but these are only asked in relation to individuals aged five years and older. Since financing is a key issue in ensuring access for young children to ECD, it would be helpful to ask this question in relation to all household members.
- The current definition of ECD exposure in GHS is inadequate, due to its very broad nature. The definition includes children in ECD centres, crèches and daycare, and it is unclear what is envisaged by each of these terms. At best, we think the existing surveys are able to yield insight on the number of children in “out-of-home-care”, but additional questions are required to assess whether this amounts to experiences that promote early child development as opposed to childminding environments with little educational stimulation.
- Finally, DSD should set up the necessary data infrastructure to conduct regular audits of the ECD sector, so that ultimately, information on centres could be updated annually (much like the EMIS database)

South African Data

1. Introduction

1.1 Data on young children in South Africa

In order to plan and provision resources for efforts to enhance early child development, it is necessary to have accurate, age-disaggregated data at the provincial and even the district levels. In addition, if early childhood development is to become a national policy priority, then regular collection of meaningful data is needed to be able to reflect the extent to which progress towards policy goals has been made. There are already a large number of widely available nationally representative data sets collected regularly in South Africa that, in their current form, go some way to facilitating these aims, though information more targeted to answering key questions about young children is still desperately needed.

In this report, we pull together data from existing data sets to provide a snapshot of the lives of young children in South Africa, and to gauge the need for early child development services and programmes. Specifically, we draw on the General Household Survey (GHS) 2005-2010 (Statistics South Africa, 2005, 2006, 2007b, 2008, 2009, 2010a), Wave 1 of the National Income Dynamics Study (NIDS) 2008 (The South African Labour and Development Research Unit, 2008), the Labour Force Survey (LFS) 2010 (Statistics South Africa, 2010b), and the 2007 Community Survey (CS) (Statistics South Africa, 2007a). Below, we provide a brief description of each of these data sets.

1.1.1 The 2007 Community Survey (Census))

The Community Survey (CS) is a nationally representative, large-scale household survey which was conducted from February to March 2007, and replaced the Census for that year. The Community Survey was designed to provide information on demographic and socioeconomic data, such as population size and distribution; the extent of poor households; access to facilities and services, and the levels of employment/unemployment at national, provincial and municipality level. The targeted population for the Community Survey was the entire South Africa – excluding those living in institutions and recreational areas.

As such, the CS provides data that allows one to examine the demographic characteristics of those individuals who are age-eligible for ECCE services, and whether there are any significant differences in characteristics between those children who already attend some form of pre-school, and those who are age-eligible yet do not. A positive aspect of the CS, apart from its sheer size giving statistical power to any analysis, is that it is possible to link parents to their children in the household data. On the downside, since the focus of the CS is understandably not on early childhood development, the extent of analysis possible is somewhat limited. Moreover, the Census/CS does not happen at regular intervals, and given the sheer size of the undertaking, the time lag between data collection and data analysis is often too long to allow for meaningful input into current policy debates.

1.1.2 The General Household Survey (GHS)

The GHS is a nationally representative annual household survey of about 30,000 households, designed to measure different aspects of the living conditions of South African households. It was implemented to track the progress of development in the country, as well as the performance of government programmes and projects. The GHS covers six broad areas: education, health, social development, housing, household access to services and facilities, food security and agriculture. The sampling procedure explicitly stratifies the sample by province, and then within province, by urban and non-urban areas. As such, this data provides a more regular means of updating demographic profiles of young children and their households in South Africa, as compared to the Census. As with the Census data, it is possible to match biological children to their parents, so long as both are resident in the same household, thereby making multivariate statistical analysis of the impact of family and neighbourhood characteristics on child outcomes possible, where such exposures and outcomes are accurately measured.

In this report, where possible, we provide comparative data from the GHS for 2005-2010. However, it should be noted that the GHS questionnaire has undergone some revisions over time, mainly in response to shifts in government programmes. The 2002-2004 questionnaires are very similar. Changes in GHS 2005 included additional questions on education, and between 2006 and 2008 the questionnaire remained virtually unchanged. In preparation for GHS 2009, extensive stakeholder consultation took place and the questionnaire was revised to be more in line with the monitoring and evaluation frameworks of the relevant governments departments. The sections on education, social development, housing, agriculture and food security were modified substantially. GHS 2010 was also extensively revised and not all questions are directly comparable to previous rounds. These will be noted at the relevant points in this report.

1.1.3 The Labour Force Survey

The Labour Force Survey is a bi-annual survey of approximately 30,000 households, and as the name implies, it's primary focus is to document the working conditions of household members. A strength of the LFS is that it has been designed as a rotating panel, that is, in each round of the survey, 20 percent of households from the previous round are dropped, and replaced with a fresh sample. However, the remaining 80 percent of households from the previous survey round are revisited. Thus, the LFS panel provides some longitudinal data for analysis, although it must be noted that the time between panels is quite short, namely six months.

Since the primary focus of the LFS is to document the changing labour market experience of South Africans, there is very little focus on questions that might inform analysis of the ECD sector. However, the survey does collect demographic data on all household members, as well as whether any household individual currently attends a pre-school or crèche. As such, this data can be used to provide more regular snapshots of the demographic profiles of children in one or other form of out-of-home care.

A downside of the LFS data is that, unlike the Census or GHS, it is not possible to match biological children to their parents in the household, thereby limiting the extent of any

multivariate statistical analysis that might be conducted. This is a real shortcoming in the data, and one that could easily be rectified simply by recording the person code of each resident child's parents. If this minor adjustment were to be made, the LFS data would allow for a proper analysis of the needs of working caregivers and their children.

1.1.4 The National Income Dynamics Survey (NIDS)

NIDS is the first South African panel survey with a wave of data collection undertaken in 2008 and 2010, and a third wave in preparation for 2012. Like the GHS, NIDS uses a nationally representative probability sample. The strata in NIDS are the 53 District Councils (DCs), from which 400 Primary Sampling Units (PSUs) were selected from the 3,000 in the StatsSA Master Sample. The target sample is private households, as well as hostels, convents and monasteries, but excludes student hostels, old age homes, prisons, hospitals and military barracks. While households are selected from all nine provinces, the sample was not designed to be representative at the provincial level.

NIDS includes all household members resident at a selected dwelling unit. The final NIDS Wave 1 (2008) sample consists of 7,305 households and 28,255 individuals. Wave 2 data will only be available in a limited form at the end of January 2012.

1.1.5 Other data sources

There are, of course, possible other sources of data that might be exploited, including smaller specialised surveys on health and nutrition, as well as the Income and Expenditure data sets, although the extent to which the latter are able to speak directly to issues of early childhood development is limited to a characterisation of household income and expenditure patterns for households with young children compared to those without. Since the demographic profiles of these two groups of households is quite distinct, the effectiveness of such comparisons is not immediately clear.

The Birth to Twenty study is a longitudinal birth cohort study of more than 3,200 children born in 1990 and their families in Soweto-Johannesburg, conducted by the University of the Witwatersrand and Human Sciences Research Council (HSRC) (Richter, Norris, Pettifor, Yach, & Cameron, 2007). This study has collected extensive data on the determinants of health, psychological adjustment and educational achievement of children in an urban environment, including socioeconomic, household, family, peer and psychological factors. Data on pregnancy, infancy and the preschool period is available for the years 1989 to 1995 and is available for analysis through negotiation with the Principal Investigators.

Finally, there are a wide range of summary data reports, produced by various NGOs and other research organisations, that provide insight into the lives of young children in South Africa. Examples include the Child Gauge, and the Heath Systems Trust annual report amongst others. The benefit of these reports is they have a very strong focus on early child development, making them a useful reference point.

2. Notes on the data

Surveys

In general, data is extracted from one or more of the General Household Surveys from 2005 to 2010 as well as Wave 1 (2008) of the National Income Dynamics Survey. In some cases the two sources produce unique data, for example, whether a child has a birth certificate (NIDS) and, in other cases, they can be compared albeit with some caveats, for example, whether children attend some form of out-of-home care.

Age categories

Data on children is seldom disaggregated to distinguish categories of young children from one another. We have variously used the categories: children 0-6 years, children 0-2 years, children 3-4 years and children 5-6 years. Our rationale is that the period 0-6 years describes the period from birth to the end of the first foundation year of formal schooling; 0-2 years covers infancy, which is normally the responsibility of the Department of Health; 3-4 years covers the period for which the Department of Social Development has primary responsibility, and 5-6 years the period when children fall under the Department of Basic Education.

Expenditure

We chose to disaggregate household socioeconomic status by examining categories of monthly expenditure or consumption, rather than by income, given the arguments that consumption renders a more robust and accurate measure of poverty than income (Deaton & Grosh, 2000; Meyer & Sullivan, 2006). We provide the data in five Monthly Expenditure Groups, as stipulated in the GHS questionnaire. The questions to assess household expenditure are the same for GHS 2005 (4.20) through GHS 2010 (4.17) *What was the total household expenditure in the last month? Include everything that the household and its members spent money on, including food, clothing, transport, rent and rates, alcohol and tobacco, school fees, entertainment and any other expenses.*

Parents versus caregivers

The GHS does not allow for the identification of the caregiver as distinct from the parent. References to parent or parents is based on whether or not the mother or father is resident in the household.

Survey respondents

As with any survey, the quality of data on a particular issue depends on the knowledge of the survey respondent. The potential for bias to affect responses is particularly acute in relation to questions concerning young children, if someone other than the primary caregiver answers on their behalf. For example, the GHS, the LFS and the Census/CS all require that the questionnaire be completed by interview with the head of household (or acting head), the next person to the head, or otherwise any available competent household member aged 15 years and older. In a report based on the 2010 GHS which specifically reports on the “Educational profile of learners aged 0-4 years”, based on the Department of Basic Education’s commitment to increase access to a Reception Year and Early Childhood Development (ECD) provisioning of services for children 0-4 years, StatsSA acknowledges the difficulties in drawing conclusions

about ECCE services from interviewees who might not know what kind of centre or programme a child attends, how it is characterised and who funds it. For this reason, the questions aim to: 1) measure attendance in general and, 2) to enquire about the extent to which a child is exposed to ECD activities at home, in a centre or elsewhere. This problem is germane across all of the available large datasets, with the exception of NIDS. This problem is ameliorated in NIDS, since the questionnaire explicitly states that the questionnaire is to be administered to the mother/caregiver of the child or another household member who is knowledgeable about the child.

From percentages to numbers

The tables presented in this document report, for the most part, mean percentages of children in particular age cohorts. However, in some instances, it may be desirable to convert those percentages into actual numbers. For example, if one wanted to know the actual number of children who might require specialized care due to a severe disability. To this end, the table below provides the population figures for the number of children in each age cohort across the different surveys. These can be used in conjunction with the tables in this report to convert percentages to actual numbers.

Table 1: Population totals by age cohort

	Children aged 0-6	Children aged 0-2	Children aged 3-4	Children aged 5-6	Children aged 7-17
GHS 2005	6,989,735	3,034,261	2,027,620	1,927,853	11,100,000
GHS 2006	7,171,046	3,068,985	2,090,522	2,011,539	11,100,000
GHS 2007	7,075,957	3,107,514	2,062,636	1,905,807	11,200,000
GHS 2008	7,180,753	3,017,889	2,121,956	2,040,908	11,600,000
GHS 2009	7,175,818	3,015,465	2,048,035	2,112,318	11,400,000
GHS 2010	7,223,748	2,989,496	2,031,903	2,202,349	11,300,000
CS 2007	7,009,889	3,0748,99	1,910,277	2,024,713	11,200,000
NIDS 2008	6,195,688	2,319,963	1,921,471	1,954,254	8,814,175

3. General conditions of young children in South Africa

3.1 Socioeconomic conditions of households with young children

The tables in this section describe the socioeconomic conditions of households with young children. In documenting household conditions, we rely on GHS 2010 to provide the most up-to-date information.

3.1.1 Main source of income in household

From GHS 2005 to 2008, the same question is posed (Question numbers 4.78 and 4.68), *What is the main source of income for this household?* In GHS 2009 and 2010, the question (4.15) is *Which one of the above income sources is the main source of income?*

Table 2 demonstrates that in households with at least one child aged 0-6, 46 percent of household income in 2010 comes from salaries, wages or commission, while 35 percent of income comes from grants. This is the same as households with at least one child aged 7 to 17 years of age, but is lower than the 57 percent of households with no children, whose main source of income is salaries and wages.

Grants are the main source of income in 34-40 percent of households with children, but only 27 percent in households with no children.

Table 2: Main source of income in household GHS 2010

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child 7-17
Salaries/wages/ commission	51%	57%	46%	45%	43%	40%	46%
Income from a business	6%	7%	5%	4%	4%	5%	5%
Remittances	8%	8%	7%	7%	6%	7%	8%
Pensions	1%	2%	1%	1%	1%	1%	1%
Grants	27%	19%	35%	35%	39%	40%	34%
Other income e.g. rental income, interest	1%	1%	1%	1%	1%	0%	1%
No income	0%	1%	0%	0%	0%	0%	0%
Unspecified	5%	4%	5%	7%	7%	6%	5%

Table 3 below presents data from NIDS 2008. It presents the distribution of children across household per capita income quintiles. For example, in 2008, 28 percent of children aged 0-6 lived in households in quintile 1. More starkly, the majority of children aged 0-6 (55 percent) lived in households in the bottom two income quintiles, compared to 52 percent of children 7 to 17 years of age.

Table 3: Household per capita income status of households with young children (NIDS, 2008)

Per capita household income quintile	Age 0-6	Aged 0-2	Aged 3-4	Aged 5-6	Age 7-17
1st	28%	29%	28%	28%	27%
2nd	27%	26%	29%	25%	25%
3rd	19%	19%	18%	21%	20%
4th	14%	14%	14%	14%	15%
5th	12%	12%	11%	12%	12%

Table 4 uses data from GHS 2005-2010 to present the distribution of young children across household expenditure categories as collected in GHS. For example, in 2010, 45 percent of children aged 0-6 were living in households with a monthly household expenditure of less than R1,200 per month. This is roughly equivalent to a two-person household being below the "ultra" poverty line of R552 per person per month in 2009.

Table 4: Household expenditure status of households with young children (GHS)

Monthly household expenditure	2005	2006	2007	2008	2009	2010
HH exp less than R1,200 per month	67%	68%	61%	56%	49%	45%
HH exp R1,200-R2,499	17%	17%	22%	24%	27%	27%
HH exp R2,500-R4,999	9%	8%	10%	10%	11%	12%
HH exp R5,000-R9,999	5%	5%	5%	6%	8%	10%
HH exp R10,000 or more	2%	3%	3%	4%	5%	6%

3.1.2 Economic activity of parents

Below we present data on the work activities of parents. We present two different sets of estimates, using different combinations of questions available in the GHS.

The GHS asks a series of questions about work activities. These are as follows:

1. *During the last calendar week (Sunday to Saturday) did … work for a wage, salary, commission or any payment in kind (including paid domestic work), even if it was for only one hour? Examples: a regular job, contract, casual or piece work for pay, work in exchange for food or housing, paid domestic work.*

2. *During the last calendar week (Sunday to Saturday) did … run or do any kind of business, big or small, for yourself or with one or more partners, even if it was for only one hour? Examples: Commercial farming, selling things, making things for sale, construction, repairing things, guarding cars, brewing beer, collecting wood or water for sale, hairdressing, crèche businesses, taxi or other transport business, having a legal or medical practice, performing In public, having a public phone shop, etc.*
3. *During the last calendar week (Sunday to Saturday) did … help without being paid in any kind of business, even if it was for only one hour? Examples: Commercial farming, production of agricultural produce to sell, help to sell things, make things for sale or exchange, doing the accounts, cleaning up for the business, etc.*
4. *In the past calendar week (Sunday to Saturday), even though you did not do any work for pay or profit, do you have a job or business that you would definitely return to? Work is assessed in two ways. Firstly, it is assessed by the conduct of any kind of business and secondly, by any form of wage or in-kind earning. Both are considered even if the person engaged in business or work for only one hour during the last week.*

We construct two measures of work activity. The first is a broad measure that includes any individual who answered "Yes" to questions 1, 2, or 4 above. In other words, any individual who indicated that they had worked for a wage, salary or commission during the previous week OR had helped run a business OR who might not have been at work but indicated they had a job they would definitely be returning to is recorded as being engaged in some sort of economic activity. Our second measure is much narrower and includes only those individuals who respond in the affirmative to Question 2 above, namely that they had worked for a wage, salary or commission during the previous week. We do not include individuals who indicate they had engaged in activities for no remuneration (Q3 above).

Economic activity of fathers

Measure 1: In the last week, father did work for wage, salary, commission or payment or ran some kind business even if only for one hour OR has a job they will return to (even though not there in last week)

Table 5 suggests that in 2010, 76 percent of children aged 0-6 had co-resident fathers who reported being engaged in some sort of economic activity during the past week. The corresponding figure for children aged 0-2 in 2010 is 77 percent.

Table 5: Father business (various), even if for only one hour during the last week (GHS)

2009			2010		
All children (0-6 years)					
78%			76%		
0-2y	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
78%	79%	76%	77%	77%	75%
Note: The corresponding figures for children aged 7-17 are 73% in both 2009 and 2010.					

Table 6: Father business (various), even if for only one house, by race (GHS)

Year	2009			2010		
Race – All children (0-6 years)						
Black African	73%			71%		
Coloured	81%			84%		
Indian/Asian	91%			94%		
White	96%			96%		
Race	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
Black African	74%	75%	71%	73%	71%	69%
Coloured	81%	82%	80%	85%	84%	81%
Indian/Asian	92%	88%	93%	91%	95%	98%
White	97%	95%	95%	95%	98%	96%

Table 7: Father business (various), even if for only one hour, by household expenditure category (GHS)

Year	2009			2010		
Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	63%			59%		
HH exp R1,200-R2,499	77%			79%		
HH exp R2,500-R4,999	88%			83%		
HH exp R5,000-R9,999	97%			91%		
HH exp R10,000 or more	96%			96%		
Household expenditure	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
HH exp less than R1,200 per month	63%	64%	60%	62%	57%	54%
HH exp R1,200-R2,499	78%	78%	74%	79%	80%	78%
HH exp R2,500-R4,999	90%	85%	88%	80%	86%	83%
HH exp R5,000-R9,999	96%	99%	96%	90%	94%	90%
HH exp R10,000 or more	95%	95%	98%	97%	97%	95%

Measure 2 (narrow): Father engaged in activity for wage, salary or commission in previous week. This variable measures whether in the last week, father did work for wage, salary, commission or payment even if only for one hour.

This table suggests that in 2010, 66 percent of children aged 0-6 had co-resident fathers who reported that they had worked for pay (wage, salary or commission) in the previous week.

Table 8: Father work for pay even if for only one hour during the last week (GHS)

2009			2010		
All children (0-6 years)					
66%			66%		
0-2y	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
66%	66%	66%	67%	67%	64%
Note: Corresponding figures for children aged 7-17 are 61% in 2009, and 60% in 2010.					

Table 9: Father work for pay even if for only one hour, by race (GHS)

Year	**2009**			**2010**		
Race – All children (0-6 years)						
Black African	61%			61%		
Coloured	71%			79%		
Indian/Asian	85%			80%		
White	81%			84%		
Race	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
Black African	61%	62%	61%	63%	60%	59%
Coloured	72%	69%	72%	78%	82%	76%
Indian/Asian	87%	78%	88%	76%	79%	88%
White	84%	78%	80%	87%	86%	78%

Table 10: Father work for pay even if for only one hour, by household expenditure category (GHS)

Year	2009			2010		
Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	52%			50%		
HH exp R1,200-R2,499	70%			70%		
HH exp R2,500-R4,999	74%			74%		
HH exp R5,000-R9,999	84%			75%		
HH exp R10,000 or more	77%			85%		
Household expenditure	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
HH exp less than R1,200 per month	53%	53%	50%	54%	48%	47%
HH exp R1,200-R2,499	67%	71%	67%	69%	73%	67%
HH exp R2,500-R4,999	71%	70%	82%	72%	79%	73%
HH exp R5,000-R9,999	84%	83%	84%	74%	75%	77%
HH exp R10,000 or more	83%	68%	77%	89%	84%	80%

Economic activity of Mothers

Measure 1: In the last week, mother worked for wage, salary, commission or payment or ran some kind business even if only for one hour OR has a job they will return to (even though not there in last week)

The table below demonstrates that in 2010, 33 percent of children aged 0-6 had co-resident mothers who reported being engaged in some sort of economic activity in the previous week. The data suggests that women with older children (7-17 years of age) and those with children between 3 and 6 years of age, are more likely to be engaged in some form of economic activity as compared to women with children 0-2 years of age. As indicated in Table 12, these age-related differences in economic activity are most clear amongst African women, as compared to White, Indian/Asian and Coloured women – who have higher levels of economic activity overall than their African counterparts..

Table 11: Mother business (various), even if for only one hour during the last week (GHS)

2009			2010		
All children (0-6 years)					
32%			33%		
0-2y	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
27%	36%	38%	28%	35%	37%
Note: corresponding figures for children aged 7-17 are 43% in 2009 and 44% in 2010.					

Table 12: Mother business (various), even if for only one hour, by race (GHS)

Year	**2009**			**2010**		
Race – All children (0-6 years)						
Black African	28%			28%		
Coloured	46%			46%		
Indian/Asian	60%			54%		
White	73%			75%		
Race	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
Black African	22%	32%	33%	24%	30%	32%
Coloured	42%	46%	51%	42%	48%	49%
Indian/Asian	66%	45%	64%	57%	47%	49%
White	70%	69%	78%	71%	80%	77%

Table 13: Mother business (various), even if for only one hour, by household expenditure category (GHS)

Year	2009			2010		
Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	21%			19%		
HH exp R1,200-R2,499	31%			30%		
HH exp R2,500-R4,999	40%			45%		
HH exp R5,000-R9,999	65%			49%		
HH exp R10,000 or more	71%			79%		
Household expenditure	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
HH exp less than R1,200 per month	17%	24%	26%	17%	21%	21%
HH exp R1,200-R2,499	24%	36%	37%	24%	34%	36%
HH exp R2,500-R4,999	35%	44%	48%	39%	47%	50%
HH exp R5,000-R9,999	60%	67%	70%	44%	47%	59%
HH exp R10,000 or more	66%	73%	77%	77%	84%	77%

Measure 2 (narrow): In the last week, mother did work for wage, salary, commission or payment even if only for one hour

The table below suggests that in 2010, 27 percent of children aged 0-6 had mothers who reported doing work for pay in the previous week – 23 percent of African children, 42 percent Coloured, 49 percent Indian/Asian and 64 percent of White children. The figures for children in the youngest age category, 0-2 years, are 20 percent, 38 percent, 53 percent and 60 percent.

Table 14: Mother work for pay even if for only one hour during the last week (GHS)

2009			2010		
All children (0-6 years)					
27%			27%		
0-2y	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
22%	29%	32%	24%	30%	31%
Note: Corresponding figures for children aged 7-17 are 34% in 2009 and 36% in 2010.					

Table 15: Mother work for pay even if for only one hour, by race (GHS)

Year	2009			2010		
Race – All children (0-6 years)						
Black African	22%			23%		
Coloured	40%			42%		
Indian/Asian	56%			49%		
White	66%			64%		
Race	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
Black African	17%	25%	26%	20%	24%	26%
Coloured	37%	40%	47%	38%	46%	44%
Indian/Asian	61%	44%	60%	53%	38%	49%
White	64%	64%	72%	60%	74%	65%

Table 16: Mother work for pay even if for only one hour, by household expenditure group (GHS)

Year	2009			2010		
Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	16%			14%		
HH exp R1,200-R2,499	26%			25%		
HH exp R2,500-R4,999	36%			39%		
HH exp R5,000-R9,999	56%			42%		
HH exp R10,000 or more	63%			70%		
Household expenditure	**0-2y**	**3-4y**	**5-6y**	**0-2y**	**3-4y**	**5-6y**
HH exp less than R1,200 per month	12%	18%	19%	13%	15%	15%
HH exp R1,200-R2,499	20%	31%	32%	21%	29%	30%
HH exp R2,500-R4,999	30%	40%	43%	35%	42%	43%
HH exp R5,000-R9,999	50%	58%	63%	37%	40%	53%
HH exp R10,000 or more	61%	64%	65%	67%	76%	66%

Since it is not possible to link parents to their children in the LFS, we use the 2008 NIDS data to gain more insight into the potential demand for care support by working mothers. Matching mothers to their children in the household, the data suggest that 21 percent of children aged 0-6 have a co-resident mother who in 2008 was being paid a wage or salary to work on a regular basis for an employer, whether full-time or part-time. This data is consistent with the subsequent trends we see in the 2009 and 2010 GHS surveys (see above). Moreover, it would appear that most of these working mothers (in NIDS) are working fulltime, given their reported work hours.

In contrast, only 5 percent of children aged 0-6 have a co-resident mother who is reported as being self-employed. Whilst average hours worked by self-employed mothers is lower, as one would expect given the flexibility that self-employed individuals have in determining hours of work, hours worked are still quite high.

Similar data is provided for fathers.

Table 17: Economic activity of parents (NIDS, 2008)

NIDS 2008: Employment and work hours of parents	Child age 0-6	Child age 0-2	Child age 3-4	Child age 5-6	Child age 7-17
Mother is employed	21%	20%	20%	22%	23%
Average hours worked per week	42	43	42	42	39
Mother is self-employed	5%	5%	6%	6%	6%
Average hours in self-employment per week	29	35	30	23	30
Father is employed	28%	28%	31%	26%	27%
Average hours worked per week	42	40	44	43	43
Father is self-employed	6%	5%	8%	5%	7%
Average hours in self-employment per week	36	26	41	42	31

3.1.3 Reason for lack of economic activity

The GHS 2009 and 2010 asks whether individuals who are not currently working are willing or able to work. Individuals who indicate that they are not willing or able to work are asked to provide a reason for this.

The answer codes include the following:

Why is …. not willing and or able to work?

1 = Pensioner/retired/too old
2 = Disabled and unable to work

3 = Housewife or taking care of home based tasks full-time
4 = Not interested to work
5 = Student
6 = Too young to work
7 = Other (specify in block below)

In the 2010 GHS, of those women aged 15-64 who report they are not willing or able to work, 21 percent report that the reason for this is because they are a fulltime housewife or engaged in fulltime care activities in the home (1,822 sampled women). Applying the relevant weights, this translates into 937,211 women aged 15-64 in the population who report that they are unwilling or unable to work because of fulltime care activities in the home.

Of these 1,822 women sampled in 2010 GHS, 52 percent (938 women) are resident in a household with at least one child aged 0-6[1]. Moreover, 49 percent of these women are in fact resident in households with at least one child aged 0-2. Applying the relevant weights to arrive at population estimates, this suggests that there are 515,637 children aged 0-6 are co-resident with a mother who is unwilling or unable to work due to caregiving responsibilities in the home.

Table 18: Lack of economic activity due to caregiving responsibilities (GHS 2010)

	n	%	Population figures
No. women 15-65 not able or willing to work	1,822	-	937,211
No. children linked to resident mothers who have indicated they can't work due to care responsibilities	1,812	-	-
Of these:			
Children aged 0-6	938	52%	515,637
Of these:			
Children aged 0-2	458	49%	247,535
Children aged 3-4	234	25%	115,463
Children aged 5-6	256	27%	152,639

Similar questions are asked in the 2010 Labour Force Survey. However, since it is not possible to link mothers to their children, below we report the reasons given by women for their lack of economic activity. These responses come from three separate questions in the LFS, namely:

1. *What was the main reason you did not want to work last week*
2. *What was the main reason you did not try to find work or start a business in last 4 weeks*
3. *What was main reason you were not available for work last week*.

[1] The other 48 percent of are women not willing to work because of their caregiver responsibilities but they are not resident in a house with any children aged 0-6.

The tabulation below shows that 28 percent of women who are inactive cite home-maker (which would include caregiving responsibilities) as the reason for their inactivity.

Table 19: Reasons for economic inactivity (LFS 2010)

Inactivity reason	Percent	Cumulative Percent
Scholar/student	32%	32%
Home-maker	28%	60%
Health reasons	12%	73%
Too young/old/retired	11%	83%
Discouraged work-seekers	12%	96%
Other	4%	100%
Total	100%	-

Finally, it is worth noting that the GHS asks individuals who are not currently attending an educational institution to provide a reason for why they are not engaged in studies. One possible response code is that the individual is unable to study due to family commitments, namely child-minding. In the table below, we present the estimates for the fraction of children below age 6 whose parents have indicated that they are not currently enrolled in an educational institution due to family commitments. Amongst those children age 0-6 whose parents were not currently attending an educational facility, 24 percent of these children had mothers who said the reason for this was due to family commitments. In population terms, this translates to 11,460,873 children whose mothers cite family commitments as a reason for not being engaged in study.

Table 20: Reasons for lack of enrolment in educational institution (GHS 2010)

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Father not currently attending educational institution due to family commitment (e.g. childminding)	3% (593,253)	3% (259,165)	3% (156,927)	3% (177,160)
Mother not currently attending educational institution due to family commitment (e.g. childminding)	24% (11,460,873)	28% (5,914,071)	21% (2,766,321)	21% (2,780,481)

Population totals in brackets

3.1.4 Food security

Household food security was assessed between 2005 and 2010 in the GHS by the question *In the past 12 months, did any child (17 or younger) in this household go hungry because there wasn't enough food?* (GHS 2005 4.75, GHS 2006-2008 4.65 and GHS 2009-2010 3.57).

As can be seen, about 13 percent of households reported that a young child had sometimes gone hungry because of lack of food.

Table 21: Food security by presence and age of children in the households (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child 7-17
Never	62%	47%	73%	71%	70%	72%	74%
Seldom	5%	3%	6%	6%	6%	7%	6%
Sometimes	10%	6%	13%	14%	15%	14%	13%
Often	2%	1%	3%	3%	3%	4%	3%
Always	1%	0%	1%	1%	1%	1%	1%
No children in HH (n/a)	19%	41%	1%	1%	0%	0%	0%
Unspecified	2%	1%	3%	4%	5%	4%	3%

3.1.5 Receipt of the Child Support Grant

Assessing the extent to which social grants, especially the child support grant (CSG) are reaching eligible young children is an important indicator of policy success in this area. Below, we present estimates of CSG receipt from the GHS 2005-2010, as well as NIDS.

However, a few important points need to be made about the GHS data over time since there are important differences in the way the information about grants was collected from 2005-2008, compared to 2009 and 2010. Prior to 2009, the question was posed as follows:

> *Now I am going to ask you about social grants for each member in the household.*
> *1.37. Does "X" receive any of the following Welfare grants? Child Support Grant? Pension? Foster Care Grant? Etc.*

The response codes allowed for a Yes/No answer. The result is that the "No" category includes individuals who do not receive the particular grant because they are not eligible as well as eligible individuals who do not receive the grant. Hence, the 2005-2008 GHS estimates of grant receipt simply tell us about the fraction of individuals in an age cohort who are receiving a grant

relative to those who are not (including those who are ineligible). The same problem applies to the 2007 Community Survey and to NIDS Wave 1.

In GHS 2009 and GHS 2010, the question (1.36a) was altered to incorporate the notion of eligibility more directly. It read as follows:

> *Does anyone in this household receive a social grant, pension or social relief assistance from the Government? If "Yes",*
>
> *Does … receive an ……? Answer for each person who qualified for the grant and NOT for the person who applied on behalf of/physically receives the money. Someone who used to work for the Government and receive a pension do not get an old age grant. Read all the options*
>
> *1 = Old-age grant (60+; R1,080)*
> *2 = Disability grant (<60; R1,080)*
> *3 = Child support grant (0-16; R250)*
> *4 = Care dependency grant (0-17; R1,080)*
> *5 = Foster child grant (<22; R710)*
> *6 =War veterans grant (60+; R1,100)*
> *7 = Grant-in-aid (R250 and should have another grant)*
> *8 = Social relief of distress*

The response codes in the 2009 and 2010 GHS allow for a “Not applicable” response. As such, one is able to generate two different statistics. In the first instance, it is possible to mimic the numbers as per 2005-2008 i.e. simply reflect the fraction of a particular age cohort that is receiving a grant. However, if one assumes that those individuals who chose “Not applicable” as their response did so because they were not eligible for the grant, then by excluding these individuals, one is able to generate a second measure that should indicate what fraction of eligible children are receiving the grant. This hinges on the credibility of the assumption that “*Not applicable*” indicates ineligibility for the grant by some objective measure, as opposed to reflecting the survey respondent’s uninformed assumption about the household’s ineligibility for the grant.(i.e. respondents may assume that since the household does not currently receive the grant, this must mean they are ineligible.)

In NIDS Wave 1, the question regarding grants is asked of the caregiver, and is phrased as follows:

> *Does anyone currently receive a child support grant, foster care grant or care dependency grant for this child?*
>
> *Yes 1*
> *No → SKIP TO F5 2*
>
> *F2 What type of grant is this?*
> *Child support grant 1*
> *Foster care grant 2*
> *Care dependency grant*

Below we present estimates for receipt of the CSG.

In 2010, 62 percent of all children aged 0-6 were receiving the CSG. However, if one excludes the “Not applicable” responses, then the results suggest that 98 percent of eligible children aged 0-6 were receiving the grant.

Table 22: Child receives the Child Support Grant

	0-2y	3-4y	5-6y	All children 0-6y	Children age 7-16
2005	42%	55%	55%	49%	23%
2006	43%	55%	53%	49%	27%
2007	48%	59%	58%	54%	36%
CS 2007	49%	61%	60%	55%	35%
2008	51%	59%	60%	56%	38%
NIDS 2008	57%	46%	62%	67%	56%
2009	55%	66%	66%	61%	46%
2009 eligible	98%	98%	98%	98%	92%
2010	56%	66%	68%	62%	52%
2010 eligible	99%	98%	97%	98%	94%

Note: For all years except GHS 2009 and 2010, the results show the fraction of the age cohort that receive the CSG. Two estimates are provided for 2009 and 2010.

Table 23: Child receives the Child Support Grant, by race (GHS data)

Year		2005	2006	2007	2008	2009*	2010*
CSG and Race – All children (0-6 years)							
Black African		55%	55%	60%	63%	68%	69%
Coloured		30%	28%	33%	27%	39%	44%
Indian/ Asian		19%	17%	14%	9%	9%	5%
White		1%	1%	1%	4%	2%	2%
CSG and Race by age categories							
Race		**Black African**	**Coloured**	**Indian/Asian**	**White**		
2005	0-2y	47%	26%	17%	1%		
	3-4y	62%	31%	28%	1%		
	5-6y	62%	35%	13%	1%		
2006	0-2y	49%	23%	13%	1%		
	3-4y	61%	35%	19%	0%		
	5-6y	59%	30%	20%	1%		
2007	0-2y	53%	26%	11%	0%		
	3-4y	65%	38%	17%	3%		
	5-6y	64%	38%	15%	0%		
2008	0-2y	57%	24%	9%	4%		
	3-4y	66%	30%	6%	2%		
	5-6y	67%	30%	13%	6%		
2009	0-2y	61%	33%	5%	2%		
	3-4y	73%	46%	15%	1%		
	5-6y	73%	41%	9%	1%		
2010	0-2y	61%	38%	3%	2%		
	3-4y	74%	48%	11%	1%		
	5-6y	74%	48%	2%	2%		

* *Sample too small.* Note: For all years, the results show the fraction of the age cohort that receive the CSG.

Table 24: Child receives the Child Support Grant by household expenditure (GHS)

Year	2005	2006	2007	2008	2009	2010
CSG and household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	61%	60%	66%	69%	74% (99)	76% (99)
HH exp R1,200-R2,499	41%	39%	51%	56%	67%(98)	70% (98)
HH exp R2,500-R4,999	17%	21%	23%	32%	44% (95)	49% (97)
HH exp R5,000-R9,999	7%	4%	6%	13%	18% (85)	38% (98)
HH exp R10,000 or more	3%	2%	1%	2%	6% (90)	3% (*)

Figures in brackets represent the percentage of eligible children receiving the grant

Table 25: Child receives the Child Support Grant by household expenditure and age cohort (GHS)

Household expenditure		HH exp. Less than R1200 per month	HH exp. R1200-R2400 per month	HH exp. 2500-R4999	HH exp. R5000-R9999	HH exp. R10000 or more
2005	0-2y	51%	35%	16%	7%	4%
	3-4y	69%	45%	19%	6%	2%
	5-6y	68%	45%	16%	7%	3%
2006	0-2y	52%	34%	23%	4%	3%
	3-4y	67%	43%	21%	5%	2%
	5-6y	65%	42%	18%	4%	1%
2007	0-2y	58%	44%	21%	4%	2%
	3-4y	73%	54%	25%	10%	2%
	5-6y	71%	58%	23%	4%	0%
2008	0-2y	63%	50%	29%	11%	1%
	3-4y	74%	60%	30%	18%	3%
	5-6y	74%	62%	39%	10%	3%
2009	0-2y	65% (99)	62% (99)	39% (94)	15% (87)	9% (*)
	3-4y	79% (99)	71% (97)	47% (95)	22% (91)	4% (80)
	5-6y	8%1(99)	71% (97)	47% (97)	18% (79)	4% (76)
2010	0-2y	67% (99)	62% (99)	45% (99)	35% (99)	4%(*)
	3-4y	80% (99)	76% (98)	55% (95)	43% (97)	2%(*)
	5-6y	83% (98)	75% (97)	51% (95)	36% (96)	4%(*)

Note: For all years except GHS 2009 and 2010, the results show the fraction of the age cohort that receive the CSG. In 2009 and 2010, the figures in brackets show the fraction of the eligible children in the age cohort who receive the CSG.

3.1.6 Reasons for lack of Child Support Grant receipt

NIDS Wave 1 has a few additional questions that try to probe why some children aged 0-6 are not in receipt of a CSG. For those children not currently receiving a CSG, the question is asked as to whether a CSG has been applied for on behalf of the child, and if not, why such application has not been made. The results are presented in Table 26.

Table 26: Reasons for lack of CSG receipt for children aged 0-6 (NIDS, 2008)

For children aged 0-6	%
Has a CSG been applied for on behalf of this child	
Yes	11%
No	89%
Reason why CSG not been applied for	
Caregiver has not heard of CSG	0%
Caregiver does not know how to apply for CSG	3%
CSG applied for by someone in another household	0%
Ineligible because the child is too old	0%
Caregiver cannot apply as not the child's mother	2%
Child is not eligible as receives a different grant (foster care/ care	1%
Child is not eligible as caregiver income too high	28%
Caregiver doesn't have the right documentation (e.g. birth certificate, ID) 08	20%
Cost of application is too high	2%
Application process is too complicated or too time consuming	3%
In process of applying or getting relevant documentation	3%
Haven't got round to it yet	12%
Cannot be bothered	12%
Other	0.14%

3.1.7 Pension receipt

Pension receipt also represents a significant flow of resources into households. The table below provides data on pension receipt amongst households with young children. The data suggest that in 2010, 24 percent of households that contained at least one child age 0-6 also contained at least one individual receiving a pension.

Table 27: Pension receipt in households with young children

	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
GHS 2005	22%	22%	23%	24%	24%
GHS 2006	22%	20%	23%	24%	24%
GHS 2007	21%	21%	22%	23%	23%
CS 2007	22%	22%	23%	23%	23%
GHS 2008	21%	21%	23%	23%	22%
NIDS 2008	-	-	-	-	-
GHS 2009	21%	22%	23%	24%	22%
GHS 2010	24%	24%	27%	26%	25%

3.1.8 Birth certification

NIDS Wave 1 (2008) asks (D3) Does the child have a birth certificate? And do you have a clinic (Road to Health) card for this child? (D4).

Table 28: Child has birth certificate and/or clinic card (NIDS)

	Children age 0-6	Children age 0-2	Children age 3-4	Children age 5-6
Child has a birth certificate	93%	86%	96%	98%
Child has a health clinic card which is available	69%	75%	65%	64%
Child has a clinic card but it is not available	29%	22%	33%	32%

3.2 Material circumstances of households with young children

The tables that follow present the most recently available data (namely GHS 2010) on the material circumstances of households with young children. Note that in each table, the first column "All" provides the mean for all households in the data set, namely those with and without young children. Column 2 provides the mean estimate for households that do not contain any children aged 0-6 (although they may contain children aged 7-17). Similarly, the subsequent entries in each row may overlap somewhat. For example, the mean estimate for households that contain at least one child aged 0-6 will include the households that have at least one child aged 0-2 years.

3.2.1 Construction of the main dwelling

From GHS 2005 (4.1) to GHS 2009 and GHS 2010 (3.1), the question asked *is Indicate the type of main dwelling and other dwelling that the household occupies?* In 2010, 69 percent of households that had at least one child aged 0-6 lived in a dwelling or house or brick/concrete structure.

Table 29: Construction of the main dwelling (GHS 2010)

Construction of Main Dwelling	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child 7-17
Dwelling/house or brick/concrete block structure	69%	69%	69%	68%	67%	68%	72%
Traditional dwelling/hut/ structure made of traditional materials	12%	8%	16%	16%	19%	20%	16%
Flat or apartment in block of flats	3%	4%	2%	2%	2%	2%	2%
Cluster house in complex	0%	1%	0%	0%	0%	0%	0%
Townhouse	1%	1%	1%	1%	0%	0%	0%
Semi-detached house	1%	1%	1%	1%	1%	1%	1%
Dwelling/house/flat/ room in backyard	2%	2%	1%	1%	1%	1%	1%
Informal dwelling/shack in backyard	4%	4%	4%	4%	3%	3%	3%
Informal dwelling/shack not in backyard	6%	6%	6%	5%	5%	4%	5%
Room/flatlet on a property/granny flat/servants quarters	1%	2%	1%	1%	1%	0%	1%
Caravan/tent	-	0	0	0	0	0	0
Other	-	0	0	0	0	0	0

3.2.2 Tenure status of household

In GHS 2009 and GHS 2010, question 3.6 read as *What is the tenure status of the dwelling that the household occupies at present?* Read all the options:

1 = Rented
2 = Owned, but not yet paid off to bank/financial institution
3 = Owned, but no yet paid off to private lender
4 = Owned and fully paid off
5 = Occupied rent-free
6 = Other
7 = Do not know

In 2010, 72 percent of households that had at least one child aged 0-6 had fully paid off their home, 7 percent had purchased their home but not paid it off, 8 percent were in subsidised homes, and 12 percent rented their accommodation.

Table 30: Tenure status of household (GHS 2010)

Tenure status of HH	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Rented	15%	18%	12%	14%	12%	10%	10%
Owned but not yet paid off to bank/financial institution	8%	9%	6%	5%	6%	5%	7%
Owned but not yet paid off to private lender	1%	2%	1%	1%	1%	1%	1%
Owned and fully paid off	67%	61%	72%	70%	73%	75%	74%
Occupied rent free	9%	10%	8%	9%	7%	8%	8%
Other	-	1%	1%	1%	1%	1%	1%

3.2.3 Subsidised housing

In GHS 2009 and GHS 2010, question (3.10a) is *Is the dwelling you live in an RDP or state subsidised dwelling? Do not include housing subsidies for government employees* and Question 3.11 is *Did any member of this household receive a government housing subsidy, such as an*

RDP housing subsidy, to obtain this dwelling or any other dwelling? Do not include housing subsidies for government employees.

In 2010, 21 percent of households that had at least one child aged 0-6 lived in a RDP house or state subsidised dwelling.

Table 31: Subsidised housing (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Is house RDP house or government subsidy	20%	18%	21%	21%	19%	19%	20%

3.2.4 Water source, distance and safety

Water source

In GHS 2009 and GHS 2010, question 3.13 asks *What is the household's main source of drinking water?*

Based on this data, 10 percent of households that contain at least one child aged 0-6 are using unsafe water supplies, and only 32 percent have access to piped tap water in their dwelling or house.

Table 32: Household water source (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Piped(tap) in dwelling/house	40%	49%	32%	30%	29%	28%	34%
Piped(tap) water in yard	29%	26%	31%	31%	30%	31%	29%
Borehole in yard	1%	1%	1%	1%	1%	1%	1%
Rainwater tank in yard	0%	0%	0%	0%	1%	0%	0%

Table 32: Household water source (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Neighbours tap	2%	2%	3%	3%	3%	2%	3%
Public/communal tap	16%	14%	19%	19%	20%	20%	18%
Water carrier/tanker	1%	1%	2%	2%	2%	1%	2%
Borehole outside yard	2%	1%	2%	2%	2%	3%	2%
Flowing water/stream/river	5%	3%	6%	6%	6%	7%	6%
Stagnant water/dam/pool	0%	0%	1%	0%	0%	1%	1%
Well	0%	0%	0%	0%	1%	0%	0%
Spring	2%	1%	3%	3%	4%	5%	3%
Other	1%	1%	0%	1%	1%	1%	1%

Distance to water supply

For those households without piped water, in GHS 2005 to GHS 2008, question 4.20 asked *How long does it take members of the household to walk to the main water source if not in dwelling, yard or on site?*

In GHS 2009 and GHS 2010, question 3.14a. was *How far is the water source from the dwelling or yard (200m is equal to the length of two football/soccer fields)?*

In 2010, 18 percent of households that contained at least one child aged 0-6 had to walk between more than 200 metres to the nearest water supply.

Table 33: Distance to water supply (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child age 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Less than 200 metres	13%	12%	14%	14%	14%	14%	13%
201-500 metres	8%	6%	11%	10%	11%	12%	10%
501m-1.km	3%	2%	4%	4%	4%	5%	4%
More than 1km	2%	1%	3%	3%	3%	3%	3%

Water safety

In GHS 2009 and GHS 2010, question 3.15 was phrased as *Is the water from the main source of drinking water before any treatment…*

Read all the options:

1 = Safe to drink?
2 = Clear (has no colour / free of mud)?
3 = Good in taste?
4 = Free from bad smells?

This data is used to construct a number of variables concerning the quality of water. The data in the table below reflect whether the respondent indicated that the water was safe to drink or not. In 2010, 13 percent of households that contained at least one child aged 0-6 indicated that the water they had access to was not safe to drink.

Table 34: Water safety (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Water is safe to drink	89%	92%	87%	84%	84%	85%	87%

3.2.5 Sanitation

In GHS 2005 (4.39) and GHS 2006 to GHS 2008 (4.30) respondents were asked *What type of toilet facility is available in/for this household?* (main type).

In GHS 2009 to GHS 2010 (3.24), respondents were asked *What type of toilet facility is used by this household?*

In 2010, 30 percent of households that contained at least one child aged 0-6 did not have access to hygienic sanitation, while 45 percent had access to a flush toilet connected to a public sewerage system..

Table 35: Sanitation (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Flush toilet connected to public sewerage system	53%	62%	45%	43%	41%	40%	46%
Flush toilet connected to septic tank	3%	4%	2%	2%	2%	2%	2%
Chemical toilet	0%	0%	0%	0%	0%	0%	0%
Pit latrine/toilet with ventilation pipe	14%	10%	18%	18%	20%	20%	17%
Pit latrine/toilet without ventilation pipe	20%	16%	23%	24%	24%	25%	23%
Bucket toilet	1%	1%	1%	0%	0%	1%	1%
None	5%	4%	6%	6%	7%	7%	6%
Other	0%	0%	0%	0%	0%	0%	0%
Unspecified	4%	3%	5%	6%	6%	5%	4%

3.2.6 Electrification

In GHS 2005 (4.43), GHS 2006 to GHS 2008 (4.34) and GHS 2009 (3.30a), the question asked was *Does this household have a connection to the MAINS electricity supply?*

In GHS 2010, the question (3.30a) was changed to *Does this household presently have a connection to the MAINS electricity supply?*

In 2010, 82 percent of households that contained at least one child aged 0-6 had a mains electricity connection.

Table 36: Electricity supply (GHS 2010)

	All	HH has no childre n 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
HH has connection to MAINS electricity	84%	86%	82%	81%	81%	82%	85%

3.2.7 Telephone in the dwelling

Information is available for both landlines and cell phones.

Landline telephone

In GHS 2005 (4.63), GHS 2006 to GHS 2008 (4.54) and GHS 2009 to GHS 2010, the question is *Does this household have a functional/working landline telephone in the dwelling?*

In 2010, 10 percent of households that had at east one child aged 0-6 had a functional/working landline in their dwelling.

Table 37: Landline telephone in the dwelling (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child 0-2	HH has at least one child 3-4	HH has at least one child 5-6	HH has at least one child 7-17
HH has functional/ working landline telephone in dwelling	16%	22%	10%	8%	9%	10%	12%

Cellular telephone

In GHS 2005 (4.64), GHS 2006 to GHS 2008 (4.54) and GHS 2009 to GHS 2010 (3.44), the question is asked *Is there a cellular telephone available to this household for regular use?*

In 2010, 90 percent of households that contained at least one child aged 0-6 had a functional/working cellphone available in the household.

Table 38: Cellular telephone available for regular use (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
HH has functional/ working cellular telephone available in HH	89%	88%	90%	90%	89%	89%	90%
HH has neither a functional cellular phone nor landline available in HH	7%	9%	6%	6%	6%	7%	6%

3.2.8 Travel time to clinic

In GHS 2005 (4.69) and GHS 2006 to GHS 2008 (4.60), the question was *How long in minutes does it take or would it take, from here to reach the nearest ..... using the usual means of transport?* In GHS 2009 and 2010 (3.52), the question asked was *How long does it take when using the usual means of transport to get to the health institution that your household normally goes to? Specify for one direction only, using the usual means of transport*

In 2010, 41 percent of households that contained at least one child aged 0-6 reported that it took 15-29 minutes to travel to the nearest health facility using their usual means of transport.

Table 39: Travel time to clinic (GHS 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child age 7-17
Less than 5 minutes	0%	0%	0%	0%	0%	0%	0%
15-29 minutes	41%	41%	41%	41%	40%	39%	41%
30-89 mins	17%	15%	20%	20%	20%	22%	20%
90mins plus	3%	2%	3%	4%	4%	4%	3%
Unspecified	39%	42%	36%	35%	36%	35%	36%

3.3 Social characteristics of households with young children

3.3.1 Parent residence

Given below is separate data for whether the father lives in the household, the mother, and both parents, and also whether only the mother or father live in the household.

Father in household

This is assessed by the question in GHS 2005 to 2010 (1.3b) *Is "X's" biological father part of this household?* Similarly, NIDS Wave 1 2008 posed the question (E9) as *Does the child's biological father live in this household?*

These results suggest that in 2010, 37 percent of children aged 0-6 had a father resident in the household (Note: this need not reflect the absence of a mother; it simply indicates the presence of a father).

Table 40: Child's biological father is part of household

Father resident in household				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	40%	39%	40%	40%
2006	40%	40%	39%	39%
2007	39%	38%	39%	38%
2008	39%	39%	38%	38%
NIDS 2008	40%	40%	43%	41%
2009	37%	38%	39%	37%
2010	38%	38%	35%	37%

NIDS Wave 1 (2008) has two additional questions (E10 & E11) which are asked only of non-resident fathers. These questions are:

How often does this child's father see the child?
Does the child's biological father provide any financial support to look after the child? This question is only asked in relation to fathers who are not co-resident.

Based on the responses, 44 percent of children aged 0-6 receive financial support from their biological fathers who are not co-resident.

Table 41: Child's non-resident biological father provides support (NIDS, 2008)

Non-resident father provides support (NIDS 2008)				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
How often does non-resident father see child?				
Every day	11%	7%	3%	8%
Several times a week	23%	14%	11%	17%
Several times a month	25%	26%	30%	27%
Several times a year	20%	26%	24%	23%
Never	21%	27%	32%	26%
Father provides financial support	49%	41%	40%	44%

Mother in household

This is assessed by the question in GHS 2005 to 2010 (1.4b) *Is "X's" biological mother part of this household?*

In NIDS Wave 1 2008, the question (E9) is *Does the child's biological mother live in this household?*

In 2010, 80 percent of children aged 0-6 lived in a household where their mothers were present.

Table 42: Child's biological mother is part of house

Mother lives in household				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	89%	81%	77%	83%
2006	87%	78%	76%	81%
2007	87%	79%	76%	82%
2008	88%	80%	75%	82%
NIDS 2008	90%	81%	82%	85%
2009	85%	76%	72%	78%
2010	85%	79%	73%	80%

NIDS Wave 1 2008 has an additional question (E11) which is *Does the child's biological mother provide any financial support to look after the child?*

Based on the responses, 49 percent of children aged 0-6 received financial support from their biological mothers.

Table 43: Child's non-resident biological mother provides support (NIDS, 2008)

Mother provides support				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
How often does non-resident mother see child?				
Every day	7%	5%	5%	5%
Several times a week	22%	15%	13%	16%
Several times a month	41%	41%	41%	41%
Several times a year	25%	34%	35%	32%
Never	5%	5%	6%	6%
Non-resident mother provides financial support	50%	47%	51%	49%

Child is resident with both parents

This is assessed by combining questions 1.3b and 1.4b, *mother and father*.

Table 44: Child is resident with both biological parents (GHS)

Resident with both parents				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	38%	36%	37%	37%
2006	38%	36%	37%	37%
2007	37%	36%	36%	36%
2008	37%	37%	35%	37%
2009	34%	34%	33%	34%
2010	34%	36%	32%	34%

Table 45: Child is resident with both parents, by race and age (GHS)

Year		2005	2006	2007	2008	2009	2010
Resident with both parents and race – All children (0-6 years)							
Black African		31%	31%	31%	31%	28%	29%
Coloured		52%	50%	50%	55%	49%	51%
Indian/Asian		79%	91%	84%	92%	90%	79%
White		92%	86%	84%	87%	83%	86%
Resident with both parents by age categories							
Race		**Black African**		**Coloured**	**Indian/Asian**		**White**
2005	0-2y	32%		51%	85%		95%
	3-4y	30%		54%	68%		90%
	5-6y	31%		51%	80%		91%
2006	0-2y	32%		52%	92%		90%
	3-4y	30%		47%	89%		80%
	5-6y	31%		51%	91%		89%
2007	0-2y	32%		54%	85%		82%
	3-4y	30%		48%	90%		87%
	5-6y	30%		47%	76%		85%
2008	0-2y	32%		56%	93%		89%
	3-4y	31%		56%	97%		85%
	5-6y	30%		52%	83%		86%
2009	0-2y	29%		47%	91%		88%
	3-4y	28%		53%	98%		78%
	5-6y	27%		47%	82%		81%
2010	0-2y	31%		48%	78%		85%
	3-4y	29%		51%	81%		88%
	5-6y	26%		54%	80%		85%

Table 46: Child is resident with both parents, by household expenditure category (GHS)

Year	2005	2006	2007	2008	2009	2010
Resident with both parents and household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	30%	28%	28%	28%	25%	28%
HH exp R1,200-R2,499	43%	46%	42%	34%	27%	28%
HH exp R2,500-R4,999	63%	62%	50%	50%	33%	40%
HH exp R5,000-R9,999	78%	77%	72%	66%	41%	48%
HH exp R10,000 or more	89%	83%	79%	86%	60%	78%

Table 47: Child is resident with both parents, by household expenditure category and age cohort (GHS)

Household expenditure		HH exp less than R1,200 per month	HH exp R1,200-R2,400 per month	HH exp R2,500-R4,999	HH exp R5,000-R9,999	HH exp R10,000 or more
2005	0-2y	31%	43%	63%	80%	93%
	3-4y	28%	43%	63%	72%	88%
	5-6y	31%	43%	63%	80%	93%
2006	0-2y	30%	47%	62%	78%	81%
	3-4y	26%	45%	63%	78%	86%
	5-6y	30%	47%	62%	78%	81%
2007	0-2y	28%	43%	52%	72%	76%
	3-4y	28%	41%	43%	68%	84%
	5-6y	28%	43%	52%	72%	76%
2008	0-2y	29%	35%	50	66	89
	3-4y	27%	34%	53	65	86
	5-6y	27%	33%	47	67	82
2009	0-2y	29%	30%	41%	61%	82%
	3-4y	25%	33%	41%	62%	78%
	5-6y	29%	30%	41%	61%	82%
2010	0-2y	28%	29%	41%	50%	76%
	3-4y	30%	28%	39%	44%	81%
	5-6y	28%	29%	41%	50%	24%

Only mother lives in household

The tables below provide data on the proportion of children by age cohort who live in a household where their mother is resident but their father is not (the father could be deceased, or non-resident, or no longer part of the household in any way). Based on this, 45 percent of children aged 0-6 are resident with their mother but not their father in 2010.

Table 48: Only mother lives in the household (GHS)

Only mother lives in household				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	51%	44%	40%	46%
2006	49%	42%	39%	44%
2007	50%	44%	40%	46%
2008	50%	43%	40%	45%
2009	50%	42%	39%	45%
2010	50%	44%	41%	45%

Table 49: Only mother lives in the household, by race and age

Year		**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Only mother lives in household by race – All children (0-6 years)							
Black African		50%	48%	49%	49%	48%	49%
Coloured		40%	36%	42%	35%	35%	39%
Indian/ Asian		18%	8%	8%	5%	7%	13%
White		6%	11%	10%	11%	8%	9%
Only mother lives in household by age categories							
Race		**Black African**	**Coloured**	**Indian/Asian**	**White**		
2005	0-2y	56%	44%	14%	4%		
	3-4y	48%	35%	28%	10%		
	5-6y	43%	38%	13%	6%		
2006	0-2y	53%	40%	7%	10%		
	3-4y	46%	34%	10%	14%		
	5-6y	43%	32%	6%	9%		

Only mother lives in household by age categories					
Race		**Black African**	**Coloured**	**Indian/Asian**	**White**
2007	0-2y	54%	42%	9%	14%
	3-4y	47%	42%	6%	6%
	5-6y	43%	41%	11%	8%
2008	0-2y	55%	38%	7%	9%
	3-4y	47%	33%	0%	12%
	5-6y	43%	33%	11%	11%
2009	0-2y	54%	40%	8%	4%
	3-4y	47%	32%	0%	10%
	5-6y	42%	32%	11%	11%
2010	0-2y	54%	43%	1%3	12%
	3-4y	47%	39%	15%	6%
	5-6y	44%	35%	13%	10%

Table 50: Only mother lives in the household, household expenditure category

Year	2005	2006	2007	2008	2009	2010
Only mother lives in household and household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	52%	51%	52%	52%	51%	51%
HH exp R1,200-R2,499	42%	37%	44%	48%	46%	48%
HH exp R2,500-R4,999	29%	29%	36%	36%	40%	42%
HH exp R5,000-R9,999	19%	20%	21%	25%	24%	37%
HH exp R10,000 or more	8%	11%	9%	9%	11%	14%

Table 51: Only mother lives in the household, household expenditure category and age cohort (GHS)

Household expenditure		HH exp < R1,200 per month	HH exp R1,200-R2,499	HH exp R2,500-R4,999	HH exp R5,000-R9,999	HH exp R10,000 or more
2005	0-2y	57%	49%	30%	17%	6%
	3-4y	50%	38%	31%	23%	11%
	5-6y	46%	35%	25%	18%	7%
2006	0-2y	54%	43%	31%	19%	10%
	3-4y	49%	35%	27%	17%	10%
	5-6y	47%	31%	27%	22%	16%
2007	0-2y	58%	48%	37%	23%	11%
	3-4y	49%	42%	40%	22%	7%
	5-6y	46%	39%	29%	14%	8%
2008	0-2y	57%	53%	40%	26%	9%
	3-4y	50%	46%	34%	25%	7%
	5-6y	45%	43%	32%	23%	9%
2009	0-2y	56%	54%	45%	27%	10%
	3-4y	51%	42%	36%	19%	12%
	5-6y	44%	40%	34%	23%	12%
2010	0-2y	56%	54%	47%	37%	17%
	3-4y	48%	47%	37%	41%	12%
	5-6y	47%	43%	40%	30%	14%

Only father lives in household

The tables below provide data on the fraction of children by age cohort who live in a household where their father is resident but their mother is not. The mother could be deceased, or non-resident, or no longer part of the household in any way. Based on this, 3 percent of children aged 0-6 are resident with their father but not their mother in 2010.

Table 52: Only father lives in the household

Only father lives in household				
	0-2y	3-4y	5-6y	All children 0-6
2005	2%	3%	3%	2%
2006	2%	3%	2%	2%
2007	2%	2%	3%	2%
2008	2%	2%	2%	2%
2009	2%	4%	3%	3%
2010	2%	3%	3%	3%

Table 53: Only father lives in the household, by race and age

Year	2005	2006	2007	2008	2009	2010
Only father lives in household, by race – All children (0-6 years)						
Black African	2%	2%	2%	2%	3%	3%
Coloured	2%	3%	2%	2%	6%	2%
Indian/ Asian	2%	0%	5%	1%	2%	1%
White	0%	1%	5%	1%	4%	1%

Since the aggregate data suggests that the incidence of young children living with their fathers only is very low, we do not disaggregate any further by age.

Table 54: Only father lives in the household, by household expenditure category

Year	2005	2006	2007	2008	2009	2010
Only father lives in household and household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	3%	2%	2%	2%	3%	3%
HH exp R1,200-R2,499	4%	3%	2%	2%	4%	3%
HH exp R2,500-R4,999	2%	3%	3%	2%	5%	3%
HH exp R5,000-R9,999	1%	0%	3%	1%	5%	3%
HH exp R10,000 or more	2%	4%	9%	2%	4%	2%

Since the aggregate data suggests that the incidence of young children living with their fathers only is very low, we do not disaggregate any further.

Neither parent lives in household

These data indicate the fraction of children by age cohort living in a household where neither parent is resident. In 2010, 18 percent of children aged 0-6 were living in households where neither parent was resident.

Table 55: Neither parent lives in household

Neither parent lives in household				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	9%	17%	20%	14%
2006	11%	19%	22%	16%
2007	11%	19%	21%	16%
2008	11%	18%	22%	16%
2009	13%	20%	25%	18%
2010	12%	19%	24%	18%

Table 56: Neither parent lives in the household, by race and age

Year		**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Neither parent lives in household, by race – All children (0-6 years)							
Black African		16%	18%	18%	18%	20%	20%
Coloured		6%	11%	6%	7%	10%	8%
Indian/ Asian		2%	1%	2%	1%	1%	6%
White		1%	2%	1%	2%	5%	4%
Neither parent lives in household by age categories							
Race		**Black African**		**Coloured**	**Indian/Asian**		**White**
2005	0-2y	10%		4%	1%		0%
	3-4y	19%		7%	5%		0%
	5-6y	23%		10%	0%		3%

Neither parent lives in household by age categories					
Race		**Black African**	**Coloured**	**Indian/Asian**	**White**
2006	0-2y	12%	6%	0%	0%
	3-4y	21%	16%	1%	4%
	5-6y	24%	13%	3%	2%
2007	0-2y	13%	4%	1%	1%
	3-4y	21%	8%	0%	1%
	5-6y	24%	7%	6%	1%
2008	0-2y	12%	4%	0%	2%
	3-4y	20%	8%	2%	1%
	5-6y	25%	12%	3%	3%
2009	0-2y	14%	8%	1%	4%
	3-4y	22%	11%	2%	6%
	5-6y	28%	13%	1%	5%
2010	0-2y	13%	7%	7%	3%
	3-4y	21%	7%	5%	5%
	5-6y	27%	9%	6%	3%

Table 57: Neither parent lives in the household, by household expenditure category

Year	2005	2006	2007	2008	2009	2010
Neither parent lives in household and Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	17%	20%	19%	19%	21%	20%
HH exp R1,200-R2,499	12%	14%	13%	15%	20%	20%
HH exp R2,500-R4,999	6%	7%	11%	12%	15%	15%
HH exp R5,000-R9,999	2%	2%	4%	8%	5%	6%
HH exp R10,000 or more	2%	2%	4%	4%	5%	6%

Table 58: Neither parent lives in the household, by household expenditure category and age

Household expenditure		HH exp < R1,200 per month	HH exp R1,200-R2,499	HH exp R2,500-R4,999	HH exp R5,000-R9,999	HH exp R10,000 or more
2005	0-2y	12%	8%	6%	2%	2%
	3-4y	21%	13%	5%	3%	0%
	5-6y	24%	18%	9%	2%	3%
2006	0-2y	15%	9%	4%	3%	4%
	3-4y	23%	16%	7%	6%	0%
	5-6y	24%	22%	12%	3%	0%
2007	0-2y	13%	10%	10%	4%	1%
	3-4y	22%	16%	11%	5%	9%
	5-6y	25%	17%	13%	5%	2%
2008	0-2y	13%	11%	9%	7%	2%
	3-4y	22%	17%	11%	7%	4%
	5-6y	26%	21%	19%	10%	7%
2009	0-2y	15%	14%	11%	8%	3%
	3-4y	22%	22%	17%	13%	5%
	5-6y	30%	26%	19%	16%	7%
2010	0-2y	14%	14%	9%	1%	7%
	3-4y	20%	23%	20%	12%	4%
	5-6y	28%	27%	18%	16%	6%

Finally, NIDS Wave 1 also provides some data on the nature of the relationship between a child's parents. This data, presented below, shows that 31 percent of children aged 0-6 have parents who are married, while a quarter have parents who are girlfriend/boyfriend but not living together.

Table 59: Relationship status of parents (NIDS, 2008)

Relationship between parents of child	Child aged 0-6	Child aged 0-2	Child aged 3-4	Child aged 5-6	Child aged 7-17
Married	31%	29%	30%	34%	38%
Divorced	1%	1%	1%	1%	5%
Engaged	1%	1%	1%	1%	1%
Girlfriend/boyfriend living together	14%	16%	15%	12%	8%
Girlfriend/boyfriend not living together	25%	34%	23%	17%	10%
Ex-boyfriend/girlfriend	18%	13%	20%	22%	17%
Never had romantic relationship	3%	2%	3%	4%	4%
Not applicable - one or both parents deceased	7%	3%	8%	9%	19%

3.3.2 Child receives a Foster Care Grant

The same caveats concerning the data on grants as contained in section 3.1.5 above pertain to the data on foster care grants. In order to understand the data issues, please refer to section 3.1.5.

There are virtually no Foster Care Grants recorded as being received for children aged 0-6 in any of the data sets used (GHS, Community Survey or NIDS). This may reflect low take-up, or it may reflect that Foster Care Grants are recorded against adults as opposed to children (as is the case for CSG). Even in NIDS Wave 1, however, where the question of FCG receipt is asked directly in relation to the child (namely *Does anyone currently receive a child support grant, foster care grant or care dependency grant for this child?*…), the incidence of FCG receipt is very low.

The numbers suggest that in 2010, 1 percent of all children aged 0-6 received a foster care grant.

Table 60: Child receives a Foster Care Grant

Child receives foster care grant				
	0-2y	3-4y	5-6y	All children 0-6
2005	0%	0%	1%	0%
2006	0%	0%	0%	0%
2007	0%	0%	0%	0%
CS 2007	0%	0%	0%	0%
2008	0%	1%	1%	1%
NIDS 2008	1%	1%	1%	1%
2009	1%	1%	2%	1%
2010	0%	1%	2%	1%

Note that in the 2007 Community Survey, there are no children recorded as receiving FCG or disability grant. The only grants recorded as being received by children are the Child Support Grant and the Care Dependency Grant.

3.3.3 Household size and number of rooms

In GHS 2009 and GHS 2010, the question (3.5) was *Specify how many rooms the household occupies in each of the categories below? Exclude garages and outbuildings unless a household member is living in them*. We use this data in the table below.

Table 61: Household size and number of rooms (GHS, 2010)

	All	HH has no children 0-6	HH has at least one child 0-6	HH has at least one child age 0-2	HH has at least one child aged 3-4	HH has at least one child age 5-6	HH has at least one child 7-17
HH size	5.13	3.56	6.52	6.99	7.2	7.2	6.26
Total no of rooms in house	5.64	5.66	5.62	5.57	5.79	5.75	5.88
Total no. of bedrooms in house	2.48	2.4	2.54	2.56	2.67	2.63	2.62
Household density (Persons per room)	1.2	0.87	1.48	1.58	1.54	1.56	1.33
People per bedroom	2.53	1.81	3.12	3.29	3.31	3.32	2.92

The table below provides mean household size over time, using GHS data, by household monthly expenditure category. The data suggest that poorer households tend to be larger. In 2010, households with monthly expenditure of less than R1,200 had 5.22 people in the household on average, compared to 4.32 for households in the highest expenditure category.

Table 62: Household size by expenditure category

	2005	2006	2007	2008	2009	2010
HH exp less than R1,200 per month	5.46	5.32	5.23	5.77	5.16	5.22
HH exp R1,200-R2,499	5.61	5.48	5.72	6.38	5.99	6.03
HH exp R2,500-R4,999	4.89	4.74	5.25	5.97	5.5	5.93
HH exp R5,000-R9,999	4.33	4.34	4.28	5.02	4.72	6.24
HH exp R10,000 or more	4.19	4.22	4.54	4.67	4.59	4.32

3.3.4 Dependency ratios

The table below presents various measures of dependency ratios for all households in the GHS (i.e. those with and without children present). In 2010, average household size was 5.13. On average, each household contained one child (0.9) aged 0-6 years. Note that this figure includes households with no children aged 0-6, which will tend to pull the average down. In contrast, on average, households contained 1.3 children aged 7-17 and three working age adults (3.09).

The child dependency ratio suggests that there were three working age adults present in a household for every child aged 0-6 in 2010. However, the usual dependency ratio (which includes children aged 0-6 as well as the elderly in the numerator) suggests that for every dependent in the household, there were 2-3 working age adults, on average.

Table 63: Household size and dependency ratios, all households (GHS 2010)

All households (with and without children)				
	2007	**2008**	**2009**	**2010**
HH size	5.2	5.8	5.38	5.13
Total number of children age 0-6	0.9	0.99	0.93	0.9
Total no. children age 0-2	0.39	0.41	0.39	0.39
Total number children 3-4	0.26	0.29	0.26	0.26
Total number children age 5-6	0.24	0.28	0.27	0.25

Table 63: Household size and dependency ratios, all households (GHS 2010)

All households (with and without children)				
	2007	2008	2009	2010
Total number children 7-17	1.44	1.56	1.44	1.3
Total working age adults (15-64)	3.06	3.45	3.18	3.09
Total elderly (65yrs plus)	0.23	0.22	0.22	0.22
Child dep. Ratio (No. children 0-6/No. adults 15-64)	0.34	0.33	0.33	0.32
Children: Elderly ratio (no. kids 0-6/no. adults 65 over)	0.87	1	0.93	0.87
Dependency ratio (no. kids 0-6 and elderly/No. working age adults)	0.44	0.41	0.41	0.41

The table below presents the same dependency ratio data as above, but is limited to households that have at least one child aged 0-6. In other words, households with no children aged 0-6 are excluded from the sample. Dependency ratios are significantly higher in households with young children.

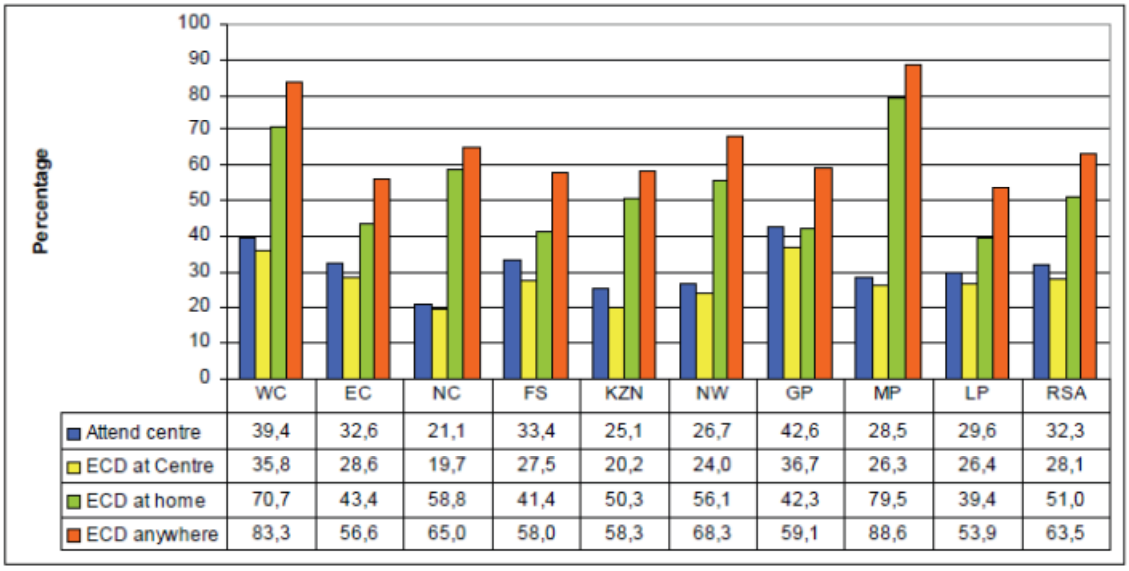
Table 64: Household size and dependency ratios, for households with at least one child aged 0-6 (GHS 2010)

Household has at least one child age 0-6				
	2007	2008	2009	2010
HH size	6.46	7.12	6.73	6.52
Total number of children age 0-6	1.62	1.74	1.7	1.68
Total no. children age 0-2	0.71	0.73	0.72	0.72
Total number children 3-4	0.47	0.51	0.49	0.5
Total number children age 5-6	0.44	0.5	0.5	0.46
Total number children 7-17	0.72	1.85	1.74	1.6
Total working age adults (15-64)	3.33	3.78	3.51	3.46
Total elderly (65yrs plus)	0.23	0.2	0.21	0.2
Child dep. ratio (no. children 0-6/no. of adults 65 and over)	0.6	0.57	0.59	0.6
Children: Elderly ratio (no. kids 0-6/no. adults 65 and over)	1.57	1.84	1.76	1.71
Dependency ratio (no. kids 0-6 and elderly/no. working age adults)	0.69	0.64	0.67	0.67

4. Participation in Early Child Development Programmes

The data in the GHS surveys do not unambiguously allow a comparison across time of participation in ECD programmes. From the broadest perspective, *the proportion of children in some form of out-of-home environment for an unknown proportion of the day* can be compared across 2005 to 2010. In GHS 2009 and GHS 2010, a question is asked specifically about whether the child participates in a child development programme in any way, but this is left to the informant to judge.

The summary analyses on young children's care and education in 2010 published by Stats SA are reproduced below. The data show the percentage of children attending what are presumed to be "learning centres" (strictly speaking child care centres, defined as day care centres, crèches, early childhood development centre, play groups, nursery school, pre-primary school) in addition to the whereabouts of children 0-4 years who are not attending child care centres specifically, but may be at home or elsewhere (Statistics South Africa, 2010a). Note that these figures relate only to children aged 0-4, as the questionnaire directs that these questions only be asked in relation to children aged 0-4. The data suggest that about a third of children aged 0-4 attend an ECD centre, with enrolments being highest in the Western Cape and Gauteng. While most children at centres appear to receive some sort of ECD exposure, this is not universally the case. In addition to ECD exposure in a centre, the majority of children are reported to be receiving some sort of ECD exposure at home. However, it is difficult to assess the quality of this exposure and what it might entail.



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Attend centre	39,4	32,6	21,1	33,4	25,1	26,7	42,6	28,5	29,6	32,3
ECD at Centre	35,8	28,6	19,7	27,5	20,2	24,0	36,7	26,3	26,4	28,1
ECD at home	70,7	43,4	58,8	41,4	50,3	56,1	42,3	79,5	39,4	51,0
ECD anywhere	83,3	56,6	65,0	58,0	58,3	68,3	59,1	88,6	53,9	63,5

Figure 1: Percentage of children attending learning centres and being exposed to early childhood development per province, 2010 (Statistics South Africa, 2010a)

	Province									
	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Whereabouts of children not attending a centre during the day										
% at home with parent, foster parent/guardian	87,1	93,3	94,5	91,2	87,0	93,3	86,8	85,0	86,5	88,6
% home with other adult	9,0	4,6	3,7	4,9	10,9	4,9	11,0	12,1	11,6	9,1
% home with someone younger than 18 years	0,0	0,1	0,0	0,0	0,0	0,4	0,0	0,0	0,1	0,1
% another dwelling	3,9	2,0	1,8	4,0	1,9	1,4	2,1	2,8	1,3	2,2
% other	0,0	0,0	0,0	0,0	0,2	0,0	0,0	0,1	0,5	0,1
Communication frequency with child's caregiver										
% daily	57,8	37,5	35,8	46,7	44,2	43,2	53,8	59,2	36,8	47,6
% weekly	20,5	16,9	14,5	13,2	17,0	21,0	14,3	15,3	16,1	16,5
% monthly	9,8	29,3	26,1	24,3	21,0	16,3	23,8	12,4	22,1	20,9
% seldom	8,6	12,6	13,3	13,1	7,4	8,1	5,9	5,0	10,0	8,4
% never	3,3	3,9	10,3	2,7	10,4	11,5	2,2	8,1	15,1	6,6

Figure 2: Whereabouts of children aged 0-4 years who were not attending child care centres and communication frequency with child's caregiver if not parent or guardian by province, 2010 (in percentages)

4.1 Children in out-of-home environments for some proportion of the day

Questions in the GHS about early childhood development experiences change between GHS 2005 and GHS 2009 and 2010. Prior to 2009, the questions 'predispose' towards educational experience, but include the option of daycare. In GHS 2005 to GHS 2008 (1.10 and 1.11), a question is asked as followed: *Is "X" currently attending school or any other educational institution? If yes, which of the following educational institutions does "X" attend . One of the possible answer codes is "Pre-school (including day care, crèche, pre-primary).* **Importantly, this question is asked in relation to ALL household members.**

In 2009 and 2010, this same question is included, but importantly, the question is now **only asked in relation to household members who are five years or older.** A separate series of questions concerning ECD participation is asked specifically in relation to household members aged 0-4. The GHS 2009 and 2010 question refers to all forms of group out-of-home care. No frequency (e.g. number of days a week) or duration (e.g. hours in the day) information is included**.** In GHS 2009 and 2010, the question (1.7) is *Does "X" attend a daycare centre, crèche, Early Childhood Development Centre (ECD), play group, nursery school, or pre-primary school?*

Hence, to get an estimate of ECD participation over time, we use the data as is for GHS 2005-2008. All children aged 0-6 who are recorded as being at pre-school are included in our estimates below, for 2005-2008. Note that the way the response codes are given, these estimates include daycare, crèche and pre-primary. Grade R is not specifically mentioned in any of the response codes, so there is some ambiguity as to whether children in Grade R would have been included in this group, or would have been recorded as being at school. For 2009 and 2010, we obtain our estimates of ECD participation for children aged 0-4 years from the

new questions introduced that explicitly ask whether a child aged 0-4 attends a daycare, crèche, ECD centre, playgroup, etc. Our estimates for the cohort aged 5-6 years come from the standard question (*Which educational institution does X attend*) which is asked for all household members aged five and above. As for 2005-2008, given the response codes, these estimates include children aged five and six who attend daycare, crèche and pre-primary. Unlike 2005-2008, however, Grade R is specifically excluded from this category. Grade R is explicitly mentioned alongside the code for School. Thus, in 2009 and 2010, these estimates exclude children in Grade R.

Table 65: Children in out-of-home environments for some proportion of the day

Children attending				
	0-2y	**3-4y**	**5-6y**	**All children 0-6**
2005	5%	29%	32%	20%
2006	6%	30%	34%	21%
2007	6%	31%	28%	19%
2008	7%	31%	41%	24%
2009	16%	50%	21%**	27%**
2010	18%	52%	20%**	28%**

** Excludes Grade R

Table 66: Children (aged 0-6) in out-of-home environments for some proportion of the day, by race

Year	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Race – All children (0-6 years)						
Black African	19%	20%	19%	23%	26%	27%
Coloured	16%	19%	14%	21%	24%	25%
Indian/ Asian	15%	12%	16%	18%	29%	33%
White	33%	36%	32%	35%	47%	50%

Table 67: Children in out-of-home environments for some proportion of the day, by race and age categories

Race		Black African	Coloured	Indian/Asian	White
2005	0-2y	5%	5%	5%	16%
	3-4y	29%	19%	6%	47%
	5-6y	31%	31%	45%	45%
2006	0-2y	6%	5%	3%	19%
	3-4y	30%	21%	15%	46%
	5-6y	32%	38%	22%	48%
2007	0-2y	6%	5%	5%	16%
	3-4y	31%	19%	11%	47%
	5-6y	27%	21%	37%	44%
2008	0-2y	7%	7%	4%	12%
	3-4y	30%	26%	19%	47%
	5-6y	41%	39%	33%	56%
2009	0-2y	14%	15%	18%	37%
	3-4y	50%	31%	43%	74%
	5-6y**	19%	29%	32%	34%
2010	0-2y	17%	19%	13%	46%
	3-4y	52%	39%	72%	64%
	5-6y*	18%	22%	24%	36%

** Excludes Grade R

Table 68: Children in out-of-home environments for some proportion of the day, by household expenditure categories

Year	2005	2006	2007	2008	2009	2010
Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	17%	18%	17%	20%	23%	23%
HH exp R1,200-R2,499	23%	24%	22%	24%	26%	27%
HH exp R2,500-R4,999	26%	29%	26%	30%	29%	33%
HH exp R5,000-R9,999	33%	38%	30%	31%	39%	37%
HH exp R10,000 or more	48%	36%	44%	42%	47%	50%

** Excludes Grade R

Table 69: Children in out-of-home environments for some proportion of the day, by household expenditure categories and age cohort

Household expenditure		HH exp < R1,200 per month	HH exp R1,200-R2,499	HH exp R2,500-R4,999	HH exp R5,000-R9,999	HH exp R10,000 or more
2005	0-2y	4%	7%	10%	16%	21%
	3-4y	24%	38%	33%	44%	79%
	5-6y	29%	34%	45%	48%	51%
2006	0-2y	5%	9%	10%	12%	27%
	3-4y	25%	34%	44%	67%	40%
	5-6y	32%	35%	41%	50%	49%
2007	0-2y	4%	8%	12%	11%	27%
	3-4y	27%	36%	33%	48%	70%
	5-6y	24%	30%	39%	37%	42%
2008	0-2y	5%	8%	13%	10%	17%
	3-4y	25%	30%	39%	45%	58%
	5-6y	38%	43%	44%	48%	56%
2009	0-2y	11%	15%	17%	29%	40%
	3-4y	46%	50%	51%	63%	74%
	5-6y*	18%	18%	25%	32%	31%
2010	0-2y	13%	18%	22%	27%	45%
	3-4y	45%	52%	61%	64%	69%
	5-6y*	16%	18%	23%	26%	33%

* Excludes Grade R

4.2 Exposure to Early Childhood Development programmes

This question was only asked in GHS 2009 and GHS 2010. The question was (1.10a) *Is "X" exposed to an early childhood development programme in any way? ECD refers to the emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of a child.*

Table 70: Reported exposure to an ECD programme

2009		2010	
All children (0-4 years)			
43%		63%	
0-2y	**3-4y**	**0-2y**	**3-4y**
35%	56%	56%	74%

Table 71: Care outside of the home (GHS 2010)

Care outside the home (%)										
Children Aged 0-4										
	All	**Western Cape**	**Eastern Cape**	**Northern Cape**	**Free State**	**KZN**	**North West**	**Gauteng**	**Mpumu-langa**	**Limpopo**
At home with parent, foster parent or guardian	0.89	0.08	0.13	0.03	0.05	0.21	0.07	0.14	0.07	0.10
At home with another adult	0.09	0.01	0.01	0.00	0.00	0.03	0.00	0.02	0.01	0.01
At home with someone younger than 18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
At someone else's dwelling	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	1.00	0.10	0.14	0.03	0.05	0.24	0.08	0.17	0.08	0.12
Children Aged 0-2										
	All	**Western Cape**	**Eastern Cape**	**Northern Cape**	**Free State**	**KZN**	**North West**	**Gauteng**	**Mpumu-langa**	**Limpopo**
At home with parent, foster parent or guardian	0.89	0.08	0.13	0.03	0.05	0.19	0.07	0.16	0.07	0.11

At home with another adult	0.09	0.01	0.01	0.00	0.00	0.03	0.00	0.01	0.01	0.01
At home with someone younger than 18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
At someone else's dwelling	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	1.00	0.10	0.14	0.03	0.06	0.22	0.07	0.18	0.08	0.13
Children Aged 3-4										
	All	**Western Cape**	**Eastern Cape**	**Northern Cape**	**Free State**	**KZN**	**North West**	**Gauteng**	**Mpumu-langa**	**Limpopo**
At home with parent, foster parent or guardian	0.88	0.08	0.13	0.03	0.05	0.24	0.08	0.11	0.07	0.09
At home with another adult	0.10	0.01	0.01	0.00	0.00	0.03	0.00	0.03	0.01	0.01
At home with someone younger than 18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
At someone else's dwelling	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	1.00	0.09	0.14	0.03	0.05	0.27	0.08	0.14	0.08	0.11

Table 72: Reported exposure to an ECD programme, by race

Year	2009		2010	
Race – All children (0-4 years)				
Black African	42%		61%	
Coloured	40%		74%	
Indian/Asian	54%		74%	
White	69%		79%	
Race	**0-2y**	**3-4y**	**0-2y**	**3-4y**
Black African	33%	54%	55%	73%
Coloured	36%	70%	47%	80%
Indian/Asian	50%	68%	59%	83%
White	57%	77%	84%	81%

Table 73: Reported exposure to an ECD programme, by household expenditure category

Year	2009	2010
Household expenditure – All children (0-4 years)		
HH exp less than R1,200 per month	39%	59%
HH exp R1,200-R2,499	41%	62%
HH exp R2,500-R4,999	47%	69%
HH exp R5,000-R9,999	56%	70%
HH exp R10,000 or more	74%	82%

Table 74: Reported exposure to an ECD programme, by household expenditure category and age cohort

Year	2009		2010	
Household expenditure	**0-2y**	**3-4y**	**0-2y**	**3-4y**
HH exp less than R1,200 per month	29%	54%	50%	71%
HH exp R1,200-R2,499	32%	52%	56%	73%
HH exp R2,500-R4,999	41%	56%	60%	82%
HH exp R5,000-R9,999	48%	69%	64%	80%
HH exp R10,000 or more	65%	88%	80%	85%

NIDS Wave 1 2008 asks (C2) *Which of the following does the child currently attend? The possible responses are:*

Primary school (Grade 1 or above)
Grade R
Pre-primary / pre-school
Creche / Edu-care centre
Day-mother / gogo
Other(specify)

By this data, 32 percent of children 3-4 years attend an "educational" centre.

Table 75: NIDS Out-of-home care and education of children 0-6 years

Educational institution attended by child	Children age 0-6	Children age 0-2	Children age 3-4	Children age 5-6
Primary school (Grade 1 or above)	8%	0%	0%	26%
Grade R	9%	0%	4%	23%
Pre-primary/Pre-school	5%	0%	5%	11%
Crèche /Educare centre	18%	8%	27%	21%
Day-mother/Gogo	16%	26%	14%	6%
Other	1%	1%	1%	0%
None	43%	64%	50%	12%

4.2.1 Location of Early Child Development programme

In GHS 2009 and GHS 2010 the question (1.10) is asked *Where does the early childhood development programme take place?*

Read all the options

1 = At home

2 = At ECD centre e.g. day care, crèche, pre-primary school, play group

3 = Other (specify in the block)

Table 76: Location of ECD activity, by age cohort

Year	2009		2010	
Location of ECD programme – All children (0-4 years)				
At home	25%		50%	
At ECD centre	23%		28%	
Other	1%		1%	
Location of ECD programme	**0-2y**	**3-4y**	**0-2y**	**3-4y**
At home	24%	26%	49%	52%
At ECD Centre	12%	40%	15%	46%
Other	1%	1%	1%	1%

Multiple responses are allowed

4.2.2 Expanded Public Works Programme: ECD skills

In GHS 2005, and then 2007-2010, a question (2.19) is asked about job creation programmes. The question is as follows: *Has …… participated in a job creation programme or expanded public works programme in the past 6 months?.* For those that respond in the affirmative, there is a follow-up question that asks:

What kind of skills did …….acquire during the programme?

a) Construction related
b) Home based care
c) Early childhood development
d) Forestry
e) Agriculture and animal husbandry
f) Numeracy /literacy
g) HIV/AIDS awareness
h) Environmental awareness
i) Career awareness
j) Business skills
k) Other

In 2005, only 1 percent of respondents reported having participated in a government job creation or expanded public works programme (EPWP). Applying the population weights, this translates into 318,422 individuals. Of these, 0.06 percent said that they had learned skills applicable to Early Childhood Development.

The question is not asked in GHS 2006. Although the question reappears in 2007 and remains in subsequent questionnaires, there is no data related to the question in GHS 2007 or GHS

2008. While there is a question in GHS 2009 and GHS 2010 about whether a person has participated in a job creation scheme or EPWP, there is no information on the type of skills gained. In any case, the numbers are very small. In 2009, 1.25 percent reported that they had participated in such a scheme, and in 2010, less than 1 percent reported participating. Applying the population weights, this translates into 604,814 individuals in 2009, and 487,798 individuals in 2010.

5. Care needs of young children

5.1 Parent work, illness and/or disability

In trying to assess the extent to which parents are not able to provide care for their own children without assistance or support, we consider how many parents are unavailable to care for their children because they are: (a) disabled (b) chronically ill (c) engaged in some sort of economic activity or (d) engaged in education. To construct this measure, we use the following questions in the 2010 GHS:

The disability figures come from a derived variable based on the following question:

Does… have difficulty in doing any of the following? Read all the options; use the codes below to indicate the degree of problems.

a = Seeing (even with glasses if he/she wears them)
b = Hearing (even with a hearing aid, if he/she wears one)
c = Walking a kilometer or climbing a flight of steps
d = Remembering and concentrating
e = With self-care, such as washing or dressing
f = In communicating in his/her usual language including sign language (understanding others and being understood by others)

CODES 1 = No difficulty
2 = Some difficulty
3 = A lot of difficulty
4 = Unable to do
5 = Do not know
6 = Cannot yet be determined

If an individual has 'Some difficulty' (1) for two or more of the six categories, they are coded as disabled. If an individual has 'A lot of difficulty' (3) or chose 'Unable to do so'(4) for one or more categories, they are classified as disabled.

Regarding chronic illness, GHS 2010 asks: (1.32a) *Has "X" been informed by a medical practitioner or nurse that he/she suffers from any of the following chronic illnesses or conditions? Diabetes, asthma, cancer, HIV, hypertension/high blood pressure, arthritis*.

If an individual responds "Yes" to any one of these, they are included as being chronically ill.

The data on economic activity is the same as that presented in Section 3.1.2 earlier. Any mother or father who indicates that they worked for pay for at least one hour in the preceding week is recorded as being engaged in economic activity.

Finally, any parent who indicated they were still currently attending an educational facility is recorded as being engaged in studies.

Taking these four measures together, we construct a variable that takes on a value of 1 if any individual indicated that they were disabled OR chronically ill OR engaged in economic activity OR educational studies. As such, this variable represents an upper bound on the number of parents who are, in some way, unable to provide care for their own children without some assistance or support.

As per the table below, the data suggest that 57 percent of children aged 0-6 have parents who are not able to provide care for them without assistance or support because the parent/s are either disabled, chronically ill, engaged in economic activity or in some sort of study. These figures are much higher for co-resident fathers than mothers, and this is driven by the high rates of economic activity for fathers (see Tables 5-10).

Table 77: Provision of care by parents

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Neither parent able to provide care without assistance	57% (3,454,880)	54% (1,458,596)	59% (982,391)	60% (1,013,894)
Father not able to provide care without assistance	73% (1,964,354)	74% (829,537)	74% (579,517)	72% (555,301)
Mother not able to provide care without assistance	41% (2,418,608)	38% (990,786)	43% (691,373)	45% (736,449)

Population totals in brackets

Since the economic activity figures are likely to over-inflate the estimates of the inability of parents to care for their children without assistance or support (since if work for an hour a week should not act as a constraint on care giving activities), we re-calculate the measure, excluding the employment component. The table below presents estimates of the number of parents who may be unable to provide care for their children without assistance or support because the parent/s are disabled, chronically ill or engaged in educational studies. The data suggest that about one fifth of children aged 0-6 have parents who need assistance or support to care for their children. Moreover, 18 percent of children aged 0-6 have mothers who require assistance or support to care for their children due to these constraints.

Table 78: Provision of care by parents (Parents unable to care due to disability, chronic illness or enrolment in education)

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Neither parent able to provide care without assistance	21% (1,272,352)	2% (538,043)	21% (344,159)	23% (390,150)
Father not able to provide care without assistance	14% (363,810)	12% (140,000)	13% (103,924)	15% (119,886)
Mother not able to provide care without assistance	18% (1,041,089)	17% (447,610)	17% (276,463)	19% (317,016)

Population totals in brackets

Next, we provide a table that estimates the fraction of children with parents who may be unable to care properly for them because the parents are either chronically ill or disabled. Thus, the table below suggests that in 2010, 15 percent of children aged 0-6 had parents who were both either chronically ill or disabled.

Table 79: Provision of care by parents (Parents unable to care due to disability or chronic illness)

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Neither parent able to provide care without assistance	15% (916,714)	13% (344,435)	15% (254,949)	19% (317,329)
Father not able to provide care without assistance	12% (320,776)	11% (121,311)	12% (93,154)	14% (106,311)
Mother not able to provide care without assistance	12% (708,225)	10% (262,147)	12% (193,484)	15% (252,594)

Population totals in brackets

Finally, we provide a table that estimates the fraction of children with parents who may be unable to care properly for them because the parents are disabled. Thus, the table below suggests that in 2010, 3 percent of children aged 0-6 had parents who were both disabled.

Table 80: Provision of care by parents: (Parents unable to care due to disability)

	Children 0-6	Children 0-2	Children 3-4	Children 5-6
Neither parent able to provide care without assistance	3% (197,314)	3% (79,443)	3% (52,090)	4% (65,781)
Father not able to provide care without assistance	3% (70,821)	2% (25,560)	3% (21,071)	3% (24,190)
Mother not able to provide care without assistance	2% (142,925)	2% (59,807)	2% (36,987)	3% (46,132)

Population totals in brackets

5.2 Childcare outside home

In GHS 2009 and GHS 2010 (1.8), the question was asked *Where is he/she during the day for most of the time?*

1 = At home with parent, foster parent or guardian
2 = At home with another adult
3 = At home with someone younger than 18 years
4 = At someone else's dwelling
5 = Other

Table 81: Child is at home with a parent, foster parent or guardian

2009		2010	
At home with parent, foster parent or guardian – All children (0-4 years)			
87%		89%	
0-2y	**3-4y**	**0-2y**	**3-4y**
87%	85%	89%	88%

Year	**2009**	**2010**
At home with parent, foster parent or guardian by province and age		
Western Cape	9%	8%
Eastern Cape	14%	13%
Northern Cape	3%	3%
Free State	5%	5%
KwaZulu-Natal	20%	21%
North-west	8%	7%
Gauteng	13%	14%
Mpumalanga	7%	7%
Limpopo	10%	10%

Province	**0-2y**	**3-4y**	**0-2y**	**3-4y**
Western Cape	9%	9%	8%	8%
Eastern Cape	14%	12%	13%	13%
Northern Cape	3%	3%	3%	3%

Table 81: Child is at home with a parent, foster parent or guardian

2009			2010	
Free State	5%	4%	5%	5%
KwaZulu-Natal	18%	23%	19%	24%
North-west	7%	8%	7%	8%
Gauteng	14%	10%	16%	11%
Mpumalanga	6%	9%	7%	7%
Limpopo	11%	9%	11%	9%

Table 82: Child is at home with an adult other than parent, foster parent or guardian

2009		2010	
At home with another adult – All children (0-4 years)			
10%		9%	
0-2y	**3-4y**	**0-2y**	**3-4y**
8%	12%	9%	10%

Table 83: Child is at home with an adult other than parent, foster parent or guardian, by province

Year	2009	2010
At home with another adult by province and age		
Western Cape	1%	1%
Eastern Cape	1%	1%
Northern Cape	0%	0%
Free State	0%	0%
KwaZulu-Natal	4%	3%
North-west	0%	0%
Gauteng	1%	2%
Mpumalanga	1%	1%
Limpopo	1%	1%

Table 83: Child is at home with an adult other than parent, foster parent or guardian, by province

Province	0-2y	3-4y	0-2y	3-4y
Western Cape	1%	1%	1%	1%
Eastern Cape	1%	1%	1%	1%
Northern Cape	0%	0%	0%	0%
Free State	0%	0%	0%	0%
KwaZulu-Natal	3%	5%	3%	3%
North-west	0%	1%	0%	0%
Gauteng	1%	1%	1%	3%
Mpumalanga	1%	1%	1%	1%
Limpopo	2%	1%	1%	1%

Table 84: Child spends most of the day at someone else's dwelling

2009		2010	
Child is at someone else's dwelling – All children (0-4 years)			
3%		2%	
0-2y	**3-4y**	**0-2y**	**3-4y**
3%	2%	2%	2%

Year	2009	2010
Child is at someone else's dwelling, by province and age		
Western Cape	1%	0%
Eastern Cape	0%	0%
Northern Cape	0%	0%
Free State	0%	0%
KwaZulu-Natal	0%	0%
North-west	0%	0%

Table 84: Child spends most of the day at someone else's dwelling

2009			2010	
Gauteng	1%		0%	
Mpumalanga	0%		0%	
Limpopo	0%		0%	
Province	**0-2y**	**3-4y**	**0-2y**	**3-4y**
Western Cape	1%	0%	0%	0%
Eastern Cape	0%	0%	0%	0%
Northern Cape	0%	0%	0%	0%
Free State	0%	0%	0%	0%
KwaZulu-Natal	1%	0%	0%	0%
North-west	0%	0%	0%	0%
Gauteng	1%	0%	0%	0%
Mpumalanga	0%	0%	0%	0%
Limpopo	0%	0%	0%	0%

6. Child health, illness and disability

Information on child reported health, disability, receipt of a disability grant and receipt of a child dependency grant are given below.

6.1 Health status of child

NIDS Wave 1 (2008) asks *Overall, how is this child's health at this point in time*? (D1) and *Has this child been ill for at least 3 days during the past 30 days*? (D13). The data indicate that less than half (43 percent) of children aged 0-6 are perceived to be in excellent health, with 13 percent of children aged 0-6 being reported as being ill for at least 3 days in the previous month.

Table 85: Perceived child health status

Perceived health status of child	Children age 0-6	Children age 0-2	Children age 3-4	Children age 5-6
Excellent	43%	43%	43%	43%
Very good	31%	31%	32%	30%
Good	20%	21%	17%	21%
Fair	4%	4%	6%	4%
Poor	2%	1%	2%	2%

Table 86: Child illness in the prior month

	Children age 0-6	Children age 0-2	Children age 3-4	Children age 5-6
Child has been ill at least 3 days in last month	13%	17%	11%	9%

6.2 Child has a disability

In GHS 2005 to GHS 2008, the following question (1.28) was asked *Read out: I am now going to ask about disabilities experienced by any persons within the household. Is "X" limited in his/her daily activities, at home, at work or at school, because of a long-term physical, sensory, hearing, intellectual, or psychological condition, lasting six months or more? Response codes include a Yes/No answer.*

In GHS 2009 and GHS 2010, the question (1.34) was phrased *as Does "X" have difficulty in doing any of the following? Read all the options; use the codes below to indicate the degree of problems.*

a = Seeing (even with glasses if he/she wears them)
b = Hearing (even with a hearing aid, if he/she wears one)
c =Walking a kilometre or climbing a flight of steps
d = Remembering and concentrating
e = With self-care, such as washing or dressing
f = In communicating in his/her usual language including sign language (understanding others and being understood by others)

Codes

1 = No difficulty
2 = Some difficulty
3 = A lot of difficulty
4 = Unable to do
5 = Do not know
6 = Cannot yet be determined

The GHS provides a derived disability variable as follows: If an individual has 'Some difficulty' (1) for two or more of the six categories, they are coded as disabled. If an individual has 'A lot of difficulty' (3) or chose 'Unable to do so'(4) for one or more categories, they are classified as disabled.

As such, the way that disability is measured differs fundamentally between 2005-2008 and 2009-2010. The disability measure prior to 2008 provides a more accurate assessment of the percentage of individuals who might need some sort of full time care or specialist programmes to help deal with their disability. In 2009-2010, the measure is much broader, and would also include any individuals who might be at risk for any kind of learning difficulty, or might need assistance in the form of occupational therapy or remedial teaching.

Arguably, both measures provide usefuls kinds of information. However, there is an additional caveat in relation the derived disability measure for 2009 and 2010. Consideration needs to be given to whether or not the degree of difficulty which an individual is recorded as exhibiting in relation to a particular activity is child-appropriate or not. For example, one would not expect children aged 0-6 to be able to care for themselves, and indeed, in 2010, almost 25 percent of children aged 0-6 are recorded as being unable to fulfil this obligation. If children are being coded as disabled because they are unable to care for themselves, this over-inflates the disability measure because the criteria being used are not appropriate for young children. This needs to be revisited in future rounds of GHS in terms of the way that these questions are formulated, and in the way that the derived variables are constructed. As such, in the case of 2009 and 2010, the disability figures represent an upper bound on children who might need some form of assistance

The caveats discussed above probably, in large measure, account for the massive increase in reported disability among young children in GHS 2009 and 2010, although it is not clear why 2010 data is so much higher than 2009.

Table 87: Child is reported to have a disability

Child has a disability				
	0-2y	**3-4y**	**5-6y**	**All children 0-6y**
2005	0.3%	0.3%	1%	1%
2006	1%	1%	1%	1%
2007	1%	1%	1%	1%
CS 2007	0%	0%	0%	0%
2008	0.4%	1%	1%	1%
2009	27%	28%	16%	24%
2010	42%	44%	23%	37%

Table 88: Child has a disability, by race

Year	2005	2006	2007	2008	2009	2010
Child is disabled and Race – All children (0-6 years)						
Black African	1%	1%	1%	1%	24%	37%
Coloured	0.2%	1%	2%	1%	24%	38%
Indian/ Asian	0%	1%	3%	2%	20%	21%
White	1%	0%	0%	1%	22%	30%

Child has a disability by race and age					
Race		**Black African**	**Coloured**	**Indian/Asian**	**White**
2009	0-2y	27%	35%	18%	23%
	3-4y	29%	23%	25%	24%
	5-6y	17%	8%	*	19%
2010	0-2y	42%	46%	17%	39%
	3-4y	44%	45%	30%	37%
	5-6y	25%	18%	18%	11%

* Sample too small

Since the numbers are so small for 2005-2008, we do not disaggregate any further.

Table 89: Child has a disability by household expenditure category

Year	2005	2006	2007	2008	2009	2010
Child is disabled and Household expenditure – All children (0-6 years)						
HH exp less than R1,200 per month	1%	1%	3%	1%	26%	40%
HH exp R1,200-R2,499	1%	1%	1%	1%	23%	35%
HH exp R2,500-R4,999	1%	0%	1%	0%	24%	32%
HH exp R5,000-R9,999	1%	0%	1%	1%	21%	35%
HH exp R10,000 or more	1%	0%	1%	0%	22%	30%

Table 90: Child has a disability by household expenditure category and age cohort

Household expenditure		HH exp < R800 per month	HH exp R800-R1,199	HH exp R1,200-R1,799	HH exp R1,800-R2,499	HH exp R2,500-R4,999	HH exp R5,000-R9,999	HH exp R10,000 or more
2009	0-2y	31%	25%	25%	26%	29%	23%	25%
	3-4y	37%	32%	30%	27%	25%	27%	25%
	5-6y	18%	15%	18%	13%	14%	13%	15%
2010	0-2y	47%	44%	40%	39%	37%	41%	38%
	3-4y	67%	46%	48%	42%	41%	39%	38%
	5-6y	28%	25%	23%	25%	18%	21%	10%

Since the numbers are so small for 2005-2008, we do not disaggregate any further.

NIDS Wave 1 asks whether the child has had any serious illness or disability. (D9). This is followed by a question that asks what the main illness or disability is (D10) and then D11 asks whether the child was born with the disability or not. These data are presented in the table below.

Table 91: Child has a disability/serious illness (NIDS)

Illness/Disability in children aged 0-6	%	n
Child has a disability or serious illness	5.39	179.00
Of these		
Tuberculosis	8%	19.00
Other respiratory problems (asthma, bronchitis)	31%	60.00
Physical handicap	7%	13.00
Problems with sight, hearing or speech	15%	26.00
Mental problem	4%	3.00
HIV/AIDS	5%	11.00
Heart disease	2%	3.00
Cancer	1%	1.00
Epilepsy	9%	9.00
Other	19%	27.00
Was child born with disability/condition		
Yes	53	95
No	47	78

6.3 Child receives a Disability Grant

In GHS 2005 (1.37) and GHS 2006 to GHS 2008 (1.33), the question asked was *Now I am going to ask you about social grants for each member in the household 1.37. Does "X" receive any of the following welfare grants? Disability grant.*

In GHS 2009 and GHS 2010, the question (1.36) was *Does anyone in this household receive a social grant, pension or social relief assistance from the Government?*

If Yes, Does … receive an ……? Answer for each person who qualified for the grant and NOT for the person who applied on behalf of/physically receives the money. Someone who used to work for the Government and receive a pension does not get an old age grant. Read all the options

1 = Old-age grant (60+; R1,080)
2 = Disability grant (<60; R1,080)
3 = Child support grant (0-16; R250)
4 = Care dependency grant (0-17; R1,080)
5 = Foster child grant (<22; R710)
6 =War veterans grant (60+; R1,100)
7 = Grant-in-aid (R250 and should have another grant)
8 = Social relief of distress

It is important to note that NIDS Wave 1 does not have a response code to indicate that a child receives a disability grant (See Section 3.1.5 above).

The differences in the way that disability is defined and coded in the different GHS surveys over time also has an impact on the extent to which children recorded as being disabled are recorded as receiving a Disability Grant. The data from 2005-2008 are more likely to be an accurate reflection of the extent to which children with severe disabilities/impairments are receiving a disability grant. Of course, there is the added caveat that Disability Grants may have been recorded as being received by parents as opposed to children. However, in 2009 and 2010, the incidence of children with a disability receiving a grant is exceptionally low. This probably reflects the fact that the broad definition of a disability now includes individuals with moderate difficulties in some areas, where such difficulties are insufficient to make them eligible for the grant.

Table 92: Child with a disability receives a disability grant (GHS data, children aged 0-6)

	Children aged 0-6 receiving disability grant	Children 0-6 with disability receiving grant
2005	1%	8%
2006	1%	24%
2007	1%	7%
2008	1%	20%
2009	24%	1%
2010	37%	1%

Table 93: Child with a disability receives a disability grant, by race

Year	2005	2006	2007	2008	2009	2010
Child is disabled and receives disability grant by race – All children (0-6 years)						
Black African	*	*	8%	21%	1%	1%
Coloured	*	*	1%	*	1%	0.3%
Indian/ Asian	*	*	3%	*	*	*
White	*	*		*	1%	1%

* Sample too small

Since reported rates of disability are so low, we do not disaggregate any further.

6.4 Child receives a Care Dependency Grant

The data for receipt of Care Dependency Grants is drawn from the same question on social grants as discussed in section 3.1.5 All the same caveats apply. Note that while the NIDS Wave 1 questionnaire provides a response code for receipt of a Care Dependency Grant, there are no cases recorded.

Table 94: Child receives a care dependency grant

	0-2y	3-4y	5-6y	All children 0-6y	Children 7-16
2005	0%	0%	0%	0%	2%
2006	0%	0%	0%	0%	1%
2007	0%	0%	0%	0%	1%
CS 2007	0%	1%	1%	1%	1%
2008	0%	0%	0%	0%	0%
2009	0%	0%	0%	0%	1%
2010	0%	0%	0%	0%	1%

The Child Gauge 2010/2011 puts the total number of children (up to 18 years of age) receiving a Care Dependency Grant at over 100,000. It thus seems that young children with disabilities are less likely to receive a grant than older children.

Province	Number of child beneficiaries					
	2005	2006	2007	2008	2009	2010
Eastern Cape	19,925	20,367	20,253	19,269	19,452	18,523
Free State	3,401	3,679	3,924	4,187	4,325	4,501
Gauteng	11,468	12,140	12,667	12,740	13,020	13,381
KwaZulu-Natal	20,994	24,098	27,855	30,878	32,798	33,551
Limpopo	9,609	10,553	11,396	12,004	12,475	12,098
Mpumalanga	4,273	4,532	5,018	5,449	5,758	5,755
North West	6,961	7,791	7,795	8,542	9,022	8,891
Northern Cape	2,186	2,582	3,403	3,642	3,873	3,911
Western Cape	6,881	7,111	7,310	7,503	8,365	8,892
South Africa	85,698	92,853	99,621	104,214	109,088	109,503

Source: South African Social Security Agency (2005 – 2010) SOCPEN database – special request. Pretoria: SASSA.

Notes: ① SOCPEN figures are taken from mid-year to coincide with data collection for the annual General Household Survey. ② Strengths and limitations of the data are described on pp. 104 – 106. ③ See www.childrencount.ci.org.za for more information. Social grant statistics are updated each month.

Figure 3: The number of children receiving the Care Dependency Grant, 2005-2010

7. Utilising existing data more effectively and new data needs

There is clearly a wealth of data that is already available for policy makers who wish to assess the state of play concerning young children in South Africa. However, in our review, in which we have examined multiple data sources, a number of inconsistencies have emerged in the way that questions have been asked over time, and a number of areas have been highlighted where simple changes or additions to existing surveys could yield more accurate data and additional data at relatively low cost.

Below, we highlight some of the key areas to be revisited:

1. In relation to the LFS, simply recording the person codes of the parents for each child in the household would provide an enormous amount of additional information. This is particularly important since the LFS provides detailed data on labour markets, and understanding how the employment status of caregivers impacts on the well-being of young children is vitally important. Moreover, this would allow one to produce good estimates of the demand for care by working caregivers.

2. The measurement of disabilities needs to be re-thought in relation to what would be appropriate for young children. Moreover, as the shift in the definition over time in the GHS demonstrates, two different measures are possible, and both are useful. The first, based on GHS 2005-08 provide a measure of children with disabilities who might require full-time specialist care. This is an important statistic worth knowing. However, the data generated in 2009-2010 which adopts a broader definition is also potentially useful in terms of identifying children who might be at risk for learning difficulties. Finally, when questions are asked in terms of whether an individual experiences difficulty engaging in a specific task (e.g. self-care, walking, talking), care needs to be taken that when these are asked in relation to children, age-appropriate standards are adopted.

3. In the current surveys, it is difficult to identify the extent to which eligible children are receiving grants. Whilst the 2009-10 GHS surveys do make reference to individuals who "qualify" for the grant, it is not clear how parents/respondents have interpreted this, or whether they are even aware of the grant and their eligibility status in the first place. As such, the current surveys provide a good indication of the fraction of an age cohort that receive a grant, but do not speak convincingly to issues of eligibility. In addition, while most existing surveys link CSG receipt to the child and not the caregiver, the same is not true in relation to receipt of FCG or CDG. Simply ensuring that data pertaining to FCG and CDG are accorded the same importance as the CSG, and are linked to the child recipient (even if the grant is collected by an adult) would require relatively minor changes to existing surveys, but would yield a great deal of valuable information, especially concerning vulnerable groups, such as foster children and children with disabilities.

4. A further issue that arises in relation to existing survey data on young children and ECD relates to the age categorisations adopted by the different surveys. For example, whilst the 2009 and 2010 GHS surveys have been adapted to improve data collection on ECD attendance by young children, all of the questions relevant to ECD activities are asked only in relation to children aged 0-4, thereby excluding young children (5-6) not yet in the formal schooling system. If ECD activities are to be taken seriously, the measurement in terms of survey data needs to accord with the relevant age-definition adopted by policy makers. For example, the GHS asks questions about fees paid, bursaries or fee waivers received and so on, but these are only asked in relation to individuals aged five and older. Since financing is a key issue in ensuring access for young children, it would be preferable to ask this question in relation to all household members. For our purposes, we have examined children aged 0-6 and think this is a useful classification.

5. The current definition of ECD exposure in GHS is inadequate, due to its very broad nature. The definition includes children in ECD centers, crèches and daycare, and it is unclear what is envisaged by each of these terms. At best, we think the existing surveys are able to yield insight on the number of children in "out-of-home-care", but additional questions are required to assess whether this amounts to ECD as opposed to childminding activities.

6. Finally, if ECD is to become a central policy platform in the next decade, then a few additional, well-targeted questions should be added to the GHS, Census and LFS. We do not advocate for many additional questions, but a few simple changes that would provide a lot of additional data. The forerunner to the GHS, namely the old October Household Surveys, included a few additional questions that might be useful to consider. Finally, DSD should set up the necessary data infrastructure to conduct regular audits of the ECD sector, so that ultimately, information on centers could be updated annually (much like the EMIS database).

8. References

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Amendments to the Children's Act to give effect to ECD priorities

Patricia Martin and Linda Biersteker

The Diagnostic Review makes a strong recommendation for a broader definition of ECD services and programmes in the Children's Act (Act No 30 of 2005 as amended, Chapter 6 Early Childhood Development), and thereby a broader conceptualization of ECD that embraces the contribution of many sectors. As shown in the extract from the Act, given below, early childhood development and early childhood development services are defined in a broad, enabling way to promote the health, development and wellbeing of young children. However, early childhood development programmes are defined as providing learning and support appropriate to the child's developmental age and stage. By its phrasing, the Act inadvertently limits ECD programmes to education (and support, which is undefined).

CHAPTER 6

EARLY CHILDHOOD DEVELOPMENT

91(1) Early childhood development, for the purposes of this Act, means the process of emotional, cognitive, sensory, spiritual, moral, physical, social and communication development of children from birth to school-going age.

(2) Early childhood development services means services-

(a) intended to promote early childhood development; and

(b) provided by a person, other than a child's parent or caregiver, on a regular basis to children up to school-going age.

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

Section 91(3) should be amended to provide that:

An early childhood development programme means a programme that provides services and support to a child or his or her caregiver to further the emotional, cognitive, sensory, spiritual, moral, physical, and social and communication development of the child. These programmes include, but are not limited to:

(a) Parenting support and education programmes;

(b) Outreach programmes for young children and their caregivers at a household and community level;

(c) Early childhood development programmes provided at partial care facilities and child and youth care centres as contemplated in section 93(5);

(d) Any other programme that primarily focuses on the health, nutrition care, development and education of children from birth to school going age and/or their families.

The DR calls for, and the resolutions adopted at the national ECD conference (26-29th March 2012) commit to, an accelerated programme of action which would, inter alia:

1. Move towards universal access to ECD;
2. Strengthen the role of parents/caregivers, families and communities in the provision of ECD service;
3. Include children with special needs and deliberately extend services to children in rural and other neglected areas;
4. Provide adequate resources and infrastructure.

A. Universal access, adequate resources and prioritization of vulnerable children

The Constitutional Court (Government of the Republic of South Africa v Grootboom, 2001 (1) SA 46 (CC)) has ruled that a progressive plan of action to realise a longer-term goal is permissible. However, that plan must be concrete and realisable. In other words, it must contemplate the full realisation of the objective at a determined date in the future and make provision for the steps necessary to realise the stated objective.

In addition, the objective must be practically realisable through the allocation of funding and an accompanying plan of action for the provision and implementation of the services in question. These too can be progressive, but must nonetheless oblige action to realise the broader overarching objectives within the contemplated time periods. Without the latter, the overarching objective or plan of action will be rendered meaningless.

Access and the provision of adequate resources and infrastructure for all children with specific prioritisation of children in rural areas and children with disabilities, will require an express obligation on the State to assume responsibility for ensuring the availability of sufficient services – in spread and number.

These requirements translate into the need for a law to legally oblige the development of national and provincial ECD plans by the Minister and MEC (as well as local government where relevant) that will secure universal availability within a reasonable period of time and that will ensure the prioritisation of rural children and children with disabilities in the roll out of the plan. Moreover it requires that the plans be secured through an adequate budget allocation and implementation plan. This requirement will be rendered meaningless in the absence of a legal duty on provincial MECs (and local government) to allocate sufficient funds to support the national and provincial plans.

Given the significant gaps in availability, this will require that the State (national and provincial departments of Social Development and local government) be obliged to increase the ECD footstep year on year and be obliged to ensure that sufficient funds are available to support the necessary growth in ECD services and ultimate universal availability. In addition, it will require an express and unambiguous obligation on policy makers and financiers to develop their plans, programmes and budgets in such a way as to first secure services for children in rural areas and children with disabilities.

In short, the realisation of the Conference objectives requires a legal and enforceable obligation on the State to develop a progressive, time-bound realisable stepped plan of action to ensure universal availability of the services in question and an accompanying budget allocation that moves the State decisively closer towards universal access, starting with securing the services in question for rural children and children with disabilities.

The Children's Act

It is necessary that the Children's Act be amended. When it is reviewed against the preceding requirements, it is clear that a number of sections of the Children's Act are likely to frustrate realisation of the objectives articulated at the ECD conference. This is primarily because the Act does not create an enforceable obligation on provincial and local stakeholders to take the necessary policy, programmatic and budgeting steps.

At the moment, the Minister and MECs for Social Development are not obliged to take the necessary action to make the conference objectives a reality. Whilst they are obliged to develop a comprehensive plan of action that aims to secure an "appropriate spread" of partial care facilities and "a properly resourced, co-ordinated and managed early childhood development system", they are not obliged to develop a time bound plan that aims to secure universal coverage within a reasonable period of time, nor are they obliged to prioritise rural or other under-serviced children.

Whilst they are obliged to prioritise children with disabilities and chronic illnesses, that obligation is rendered ineffective because there is no prior obligation to fund and/or provide the services in question. It is only where they choose to fund and/or provide services that the obligation to prioritise comes into effect. As long as they choose not to fund and/or provide the service, there can be no prioritisation of especially vulnerable children.

Partial care – Chapter 5

Section 77(1) provides that the Minister must develop a national and departmental strategy "aimed at ensuring an appropriate spread of partial care facilities throughout the Republic" and the MEC must, in terms of Section 77(2) develop a provincial strategy to ensure an appropriate spread of partial care facilities.

There is no definition of what constitutes an *appropriate spread* of partial care facilities. Given that the objective is to move towards universal access, the term *appropriate spread* should be replaced with "universal access or availability". It should provide that the "*Minister must develop a national and departmental strategy aimed at ensuring universally available partial care facilities and services for all children within a reasonable period of time. The plan must prioritise the availability of services for children living in rural areas and children with disabilities and chronic illnesses*."

Universal should be defined in the Act as "*sufficient services and facilities to ensure availability to all children within a defined geographical area*".

At present there is no clear and unambiguous obligation on the MEC to provide funds to support the implementation of the partial care plan.

Section 78(1) provides that "The MEC for social development *may,* from money appropriated by the relevant provincial legislature, provide and fund partial care facilities and services".

The wording at present can result in the MEC never allocating any, or a sufficient percentage of the provincial budget, to secure sufficient partial care facilities to ensure more, never mind universal, availability. Where no funds or insufficient funds are allocated, there can be no prioritisation of services for children with disabilities or children in rural or other under-serviced areas.

Therefore Section 78(1) should be amended to provide that "The MEC for social development *must* from money appropriated by the relevant provincial legislature, provide and fund partial care facilities *to ensure universal availability of services and facilities as defined, and within the timeframes determined, by the national and provincial partial care strategies contemplated in section 77(1) and (2)*".

The national and provincial plan and ensuing strategies will then provide the necessary information about where service gaps, as determined by population–based analyses, currently exist and where they need to be filled to achieve universal availability; who (the State, development partners, or NGOs) will fill the identified gaps, and by when all such gaps should be filled. Further, it will specifically identify the gaps in rural areas and for children with disabilities and chronic illnesses and will direct that resources, provisioning, etc. be applied to fill these gaps first.

The plan would also prioritise the roll out of the universal plan so as to give priority to filling gaps in rural areas and for children with disabilities or chronic illnesses.

<u>Early childhood development – Chapter 6</u>

The relevant sections related to early childhood development are similarly, but even more problematic. They are weaker than the partial care provisions and less able to decisively move the State towards universal access and adequate resourcing.

<u>Sections 92(1) and (2)</u> provide that the Minister and MEC must develop a national and provincial ECD plan "*aimed at securing a properly resourced, co-ordinated and managed early childhood development system*". It does not, as in the case of the partial care provision, oblige the plan to consider scope or reach of the services in question or to ensure an appropriate spread. There is thus no obligation on the Minister or MEC to take into account the current gaps in availability of the service, or the filling of those gaps – which are large.

<u>Section 92(1) and (2</u>) should thus be amended to provide that the Minister and MEC must develop a national and provincial plan that is "*Aimed at securing, within a reasonable period of time, a universally available, properly resourced, co-ordinated and managed early childhood development system, giving due priority to children living in rural areas, children with disabilities and children with chronic illnesses*".

Section 93(1) should be amended. It currently provides that the "MEC for social development may, from money appropriated by the relevant provincial legislature, provide and fund early childhood development programmes for that province". Instead, it should provide that "*The MEC for social development must, from money appropriated by the relevant provincial legislature, provide and fund early childhood development programmes to ensure their universal availability within the timeframes determined by the national and provincial ECD plan contemplated in sections 92(1) and (2)*".

Section 93 (4) must be amended to include an express obligation to prioritise funding of early childhood development programmes in rural areas. At present it requires prioritisation of "communities where families lack the means of providing proper shelter, food, and other basic necessities of life to their children". This targeting measure is appropriate but it also needs to target communities that lack access to ECD services and that are living in poverty, and rural communities where poverty and lack of ECD services is rife, but where some families are still able to provide proper shelter, food and other basic necessities for their children.

The provisions must be simple and target appropriately.

It should require prioritisation of ECD funding *and provisioning* for:

1. Children with disabilities;
2. Children in rural communities that are marked by poverty, and
3. Children living in poverty.

These comments apply equally to the partial care provisions.

B. A strengthened role of parents/caregivers, families and communities in the provisioning of ECD service

The realisation of this objective requires that the obligations to provide and fund early childhood development programmes expressly includes an obligation to provide and fund home- and community-based services and support.

There has been little funding and provision of these programmes by the State. In moving forward, policy makers and funders will be more pro-active in the funding of these services and support programmes if the Children's Act were to expressly provide for obligatory funding and provisioning of ECD programmes defined to include a full complement of centre-, family- and community-based services.

This could be achieved through an amendment to Section 91(3) which defines an early childhood programme, to include a list of examples of home- and community-based ECD programmes.

As indicated earlier, Section 91(3) should be amended to provide that:

An early childhood development programme means a programme that provides services and support to a child or his or her caregiver to further the emotional, cognitive, sensory, spiritual, moral, physical, and social and communication development of the child.

These programmes include, but are not limited to:

(a) Parenting support and education programmes;

(b) Outreach programmes for young children and their caregivers at a household and community level;

(c) Early childhood development programmes provided at partial care facilities and child and youth care centres as contemplated in section 93(5);

(d) Any other programme that primarily focuses on the health, nutrition care, development and education of children from birth to school-going age and/or their families.

C. Local government and ECD infrastructure

Local government has an essential role to play in the realisation of the ECD conference objectives. Local governments know where the gaps are in terms of high levels of poverty and access to services. They are able to provide access to basic services for ECD programmes as well as provide ECD infrastructure and services to fill these gaps. However, they currently lack the power, mandate, capacity of funding, in terms of the Children's Act and other laws, to realise this potential.

Thus the Children's Act and the new NIP for ECD ought to be amended so as to:

1. Clarify the specific ECD roles and responsibilities of municipalities and create clear and enforceable obligations on local government (and be supported by adequate funding mechanisms) to fulfil their assigned roles.
2. Oblige a local level needs-assessment to be conducted by municipalities within the context of national ECD objectives, to assess geographical areas of need and possible services and infrastructure that can be used to fill the identified gaps.
3. Where there is a shortage, municipalities must be obliged (in collaboration with provincial DSD) to either build ECD centres in under-serviced areas, to scale up existing programmes, and/or to facilitate the use of existing community structures, such as traditional authority structures, church structures, clinics or schools, and to provide the necessary infrastructure, water and sanitation to create a safe, nurturing environment amenable to the development of young children.
4. ECD sites providing services to subsidised children should qualify for free basic water and refuse removal by local government.
5. Municipalities should be obliged to include households with pregnant women, infants and young children in their indigent policies and in the delivery of free basic services.
6. ECD sites established by NPOs that do not meet local government requirements or Children's Act norms and standards and hence cannot register and apply for subsidies, must be able to apply to the local government for support to develop their basic infrastructure and amenities to meet the requisite standards. The current policing role played by the Municipality must be transformed into a collaborative partnership to increase the number of ECD sites that are adequately equipped in under-serviced areas.