

EARLY CHILDHOOD DEVELOPMENT



NATIONAL ECD PROGRAMME



DGMT
THE DG MURRAY TRUST



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Outline and structure of the report on the National Early Child Development (ECD) Programme

- The background analysis and the compilation of the National ECD Programme is a complex undertaking, as are the strategies suggested for its implementation. The reasons are:
 - Early child development is multi-dimensional and multi-sectoral services are required to promote and protect ECD.
 - The science in this field has developed extremely rapidly over the last decade.
 - In the last 15 years, more than 120 policy, programme, costing and evaluation documents on, or relevant to, ECD have been produced in South Africa; some 15 in the last two years.
- For this reason, we have designed the report as a series of “layers” of increasing detail.
- The report consists of:
 - A short, summarised report
 - A full report, which makes reference to a number of Appendices.
- The full report is preceded by Definitions of Terms and Abbreviations, and is closely referenced with Endnotes.
- The assumptions underlying our estimates of goals, coverage targets, duration and dosage of services, as well as staff and salaries have been made explicit in order to calculate human and infrastructural resource needs and costs. These can be changed and recalculated, depending on contingencies of which we are not aware.
- The report on the National ECD Programme is to be read in conjunction with the report on the ECD Policy, written by the same team.

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NATIONAL EARLY CHILDHOOD DEVELOPMENT PROGRAMME

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1.0 Definitions and Glossary of Terms

Child minder	A person who, either for gain or free of charge, takes care of up to six children in their own home. This does not include registered foster care providers, domestic workers caring for children at home, or the care of a close relative.
Early childhood development (ECD)	The composite cognitive, emotional, physical, mental, communication, social, and spiritual development of children that takes place from conception until they enter formal schooling (i.e. Grade R) or reach the age of 8 years, whichever occurs first.
Early childhood development services	Support provided to infants and young children or to the child's parent or caregiver by a government department or civil society organization with the intention to promote early childhood development.
Early childhood development programmes	A programme that provides one or a collection of services and support to a child and/or caregiver to promote early childhood development.
Early childhood care and education (ECCE)	ECCE is one component of ECD which relates specifically to the provision of daily care, education and stimulation for the cognitive, emotional and social development of children. ¹
Early childhood care and education services	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.
ECCE programmes	<p>Provide one or a collection of daily care, development, and/or education services for children. These programmes include, but are not limited to:</p> <ol style="list-style-type: none">1. Child minding of one child or several children for specific hours2. Community-based play groups operating for specific hours3. Outreach and support programmes to young children and their families at a household level4. Parenting support and education programmes5. Support for the psychosocial needs of young children and their families6. Early childhood development programmes provided at partial care facilities and child and youth care centres as contemplated in section 93(5) of the Children's Act7. Any other programme that primarily focuses on the care, development and education of children from birth to school going age and/or their families

ECD Centre	An ECD centre may offer day care as well as a preschool programme.
Early Learning Centre	A centre for the care and education of preschool children.
Family	A family is a group of persons united by the ties of marriage, blood, adoption or cohabitation, characterised by a common residence or household, interacting and communicating with one another in their respective family roles, maintaining a common culture and governed by family rules. ²
Extended family	An extended family is a multigenerational family that may or may not share the same household. It includes family members who share blood relations, relation by marriage, cohabitation and/or legal relations. ³
Developmental difficulty or difficulties	Includes conditions that place a child at risk of suboptimal development, or that cause a child to have a developmental deviance, delay, disorder or disability such as cerebral palsy or Down Syndrome.
Equity of access to ECD services	Is achieved when all children and their caregivers, not only those who can pay for services, including children with developmental difficulties have access to a Comprehensive Package of age- and developmental stage-appropriate ECD services.
Home visiting	Delivery of services at the household level to primary caregivers and young children for purposes of providing information, supporting early learning and development and promoting referrals and linkages to support services.
Inclusion	The removal of barriers to fundamental universal rights, including making physical infrastructure, information and the means of communication accessible so all can use them. ⁴
Parent	A parent is anyone responsible for the care and protection of a young child, who is stable in the child's life and who loves the child and wants to protect the child. A parent may be a biological, foster or adoptive parent or another primary caregiver such as a grandparent.
Parenting support	A broad range of programmes and intervention to support one or more aspects of parenting.
Playgroup	A group of young children, organized for play or play activities for learning (cognitive, language, motor, emotional, social). A playgroup is attended by mothers and supervised by volunteers or paid facilitators.
Preschool/Early Learning Centre	Preschool is an early childhood programme with an educational focus for children prior to statutory school going age. These are usually part day.

Toy library

A toy library provides families with access to developmentally appropriate educational play and learning materials. They may offer play and learning sessions, toy making demonstrations, individual lending and/or lending to other ECD service providers.

Vulnerable children

Children who experience compromised care-giving and or access to ECD programmes and services because of one or a combination of structural, social, economic, geographical, physical, mental, psychosocial, racial, familial or any other circumstances that are known to be predictive of, and/or associated with poor access to ECD services, and/or poor ECD outcomes. These may include, but are not limited to:⁵

1. Children living in poverty
2. Children experiencing developmental difficulties
3. Children with chronic health conditions
4. Orphaned children and other children living without their biological parents
5. Children living in rural areas
6. Children living in underserved urban informal settlements
7. Children whose caregivers suffer from mental health conditions
8. Children whose caregivers abuse substances such as alcohol and drugs

2.0 Abbreviations

ACE	Adverse Childhood Experiences
AIN-C	Integrated Community Attention to Children
ANA	Annual National Assessments
ANC	African National Congress
CAPS	Curriculum and Assessment Policy Statements
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality
CCD	Care for Child Development
CHW	Community Health Worker
CBR	Community-based rehabilitation
CBW	Community-Based Worker
CDG	Care Dependency Grant
CDW	Community Development Worker
CEMIS	Centralised Educational Management Information System
CHW	Community Health Worker
COGTA	Cooperative Governance and Traditional Affairs
CRC	Convention on the Rights of the Child
CSG	Child Support Grant
DBE	Department of Basic Education
DOH	Department of Health
DoHaD	Developmental origins of Health and Disease
DHA	Department of Home Affairs
DPME	Department of Performance Monitoring and Evaluation
DRECD	Diagnostic Review of Early Childhood Development
DSD	Department of Social Development
DWCPD	Department of Women, Children & People with Disabilities
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECDC	Early Childhood Development Centre
ECERS-R	Early Childhood Environmental Rating Scale-Revised
ECI	Early childhood intervention
ETDP SETA	Education Training and Development Practices Sector Education and Training Authority
EHS	Early Head Start
ELRU	Early Learning Resource Unit
EP	Essential Package
EPDS	Edinburgh Postnatal Depression Scale
FAS	Foetal Alcohol Syndrome
FCG	Foster Care Grant
FCS	Family Violence, Child Protection and Sexual Offences
GDP	Gross Domestic Product
HFA	height-for-age
HIV	Human Immunodeficiency Virus
HWSSETA	Health and Welfare Sector Educational Training Authority
ICDS	Integrated Child Development Service
ID number	Identity number
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illnesses
IPV	Intimate partner violence
ITERS-R	Infant and Toddler Environmental Rating Scale-Revised
JINJI	Junta Nacional de Jardines Infantiles

LMIC	Low- and/or middle-income country
M&C	Mother and Child
M&E	Monitoring and Evaluation
MM	Moderate malnutrition
MNCWHN	Maternal, Newborn, Child and Women's Health and Nutrition
MNP	Micronutrient preparations
NDP	National Development Plan
NELDS	National Early Learning Standards
NIP ECD	National Integrated Plan for Early Childhood Development
NPO	Non-profit organization
OHS	Office of Human Services
PETS	Public Expenditure Tracking Survey
PMHP	Perinatal Mental Health Project
PNP	Private and/or non-profit
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
QRS	Quality Rating System
RFP	Request for Proposal
RTO	Resource and Training Organizations
RUTF	Ready-to-use Therapeutic Foods
SALGA	South African Local Government Association
SIAS	Screening, Identification, Assessment and Support
SOCA	Sexual Offences and Community Affairs
SS	Sure Start
StatsSA	Statistics South Africa
TIMSS	Trends in International Mathematics and Science Study
TREE	Training and Resources in Early Education
WBOT	Ward-based outreach team
WHO	World Health Organization

3.0 Assignment: The Development of a National ECD Programme

The objectives of the assignment were to develop a National Early Child Development Programme, and to:

1. Outline a comprehensive ECD Programme
2. Describe a non-negotiable Essential Package (EP)

An age-appropriate approach is required that addresses the holistic needs of **children from conception to five years or the age at which the child enters Grade R**, covering the following child developmental ages:

- The first 1,000 days, comprising conception, pregnancy and delivery, and birth to two years. The package for this period should build on existing public health services and emphasise the '*what*' and '*how*' of providing adequate nutrition, care stimulation and safety at scale, starting with the most deprived children.
- Children between two and five years of age (or the age at which the child enters Grade R), building on the ECD per child subsidy and emphasising the '*what*' and '*how*' of providing adequate nutrition, care stimulation and safety at scale, starting with the most deprived children.

With respect to the Comprehensive Programme and the Essential Package, the National ECD Programme must describe:

- Specific services to fill gaps in delivery of nutrition, health protection and early learning
- Feasible delivery mechanisms that are in line with good practices nationally and internationally
- Capacity and human resources development
- Infrastructure considerations
- Roles and responsibilities of all levels of government, civil society and the private sector
- Oversight and quality assurance arrangements within a monitoring and evaluation framework that builds on existing management information systems
- Expected costs and financing for the Programme as outlined in a three-year operational plan.

The ECD Policy outlines the comprehensive programme, while the ECD Programme describes a non-negotiable Essential Package for ECD and proposes mechanisms to achieve universal access for all children to the Essential Package.

In summary, the Comprehensive Programme sets out the conditions for an enabling parental, family and community environment for young children. Sections of the South African Constitution, the Convention on the Rights of the Child (CRC), General Recommendation 7 of the CRC, the African Charter on the Rights and Welfare of the Child, and other legal instruments prescribe services to give effect to children's protected rights. These are:

- Name and nationality – birth registration services (S28 of the South Africa Constitution)
- Family and alternative care – support to families to provide family/parental care (S28)

- Health care – physical and mental health care services for infants and parents (S28)
- Food and nutrition (S28)
- Information – communication and advocacy services (S16 and 32)
- Social services, including psychosocial support, early childhood care and education and social assistance (S28 and S29)
- Education – early childhood education starting from birth in the home (S29)
- Basic services – water and sanitation services (S24 and 27)
- Housing – shelter and housing services (S26)
- Right to play, recreation and cultural activities (UNCRC, Constitution and The Children's Act) – play, recreational and cultural facilities and services.

The remainder of this report deals with the Essential Package and strategies for its implementation.

4.0 Methods Used to Develop the National ECD Programme

The assignment to develop a National ECD Programme is a complex one for several reasons. The science, policy and practice of early child development are multifaceted. There have also been many ECD-related policy and programme initiatives in South Africa since 1994, not all of which are harmonised. Some have been implemented to a degree and others barely at all. The data on implementation is incomplete.

The team who developed the ECD Policy and Programme also conducted the ECD Diagnostic Review. For that review, many documents were scrutinised, peer-reviewed local and international literature was examined, the opinions of experts and stakeholders on specific topics was sought, and three provincial consultations were held to canvas opinions on issues raised.

In developing the ECD Policy and Programme, we updated our review of South African policy documents, frameworks, and analyses, as well of international and local empirical literature, especially with respect to scaling up ECD for universal provision. We carefully analysed new policy documents and literature relevant to ECD in South Africa, again sought the views of experts on specific topics, vigorously debated options within our group, and conducted an extensive consultation process. The opinions of stakeholders elicited during the consultations are taken into account and are reflected in the document.

The consultation processes consisted of the following activities:

- **Four small group expert consultations** were held between September and December 2013 on approaches to scaling up to national coverage, media and communication, nutrition and developmental difficulties and disabilities. The documents considered and the reports from these meetings are included as **Appendix 1**.
- **Nine provincial consultations** were conducted between October and December 2013. Attached as **Appendix 2** is a consolidated provincial consultation report, together with separate reports on each of the provincial consultations. The reports detail who hosted the meeting, where it was held, who facilitated the meeting, who was invited and who attended. Also included is a document outlining principles for invitations to the provincial consultations.
- **A national consultation** was hosted by DSD on the 4th and 5th March 2014, the report on which is included as **Appendix 3**.

5.0 Starting Points

5.1 South Africa's commitment to young children

In developing a national Early Childhood Development (ECD) Policy and Programme, **South Africa is one of a growing number of countries that are taking steps to increase their investments in young children.** President Obama recently called for universal preschool in the United States, and Hillary Clinton is spearheading an initiative called 'Too Small to Fail'. The presidents of Brazil and Peru are urging greater commitment to young children and upping their financial allocations for these efforts. Cuba, Sweden, Chile and Colombia have scaled up their programmes for early child development⁶. India has made its national nutrition and child development programme an entitlement for all eligible poor families.⁷ In Southern Africa the average enrolment in preschool is 18%,⁸ whereas **South Africa has achieved near universal access to a Reception Year in a few years of determined action.**

The African Union is co-sponsoring a study of the Cost of Hunger, with pilot data indicating that early childhood stunting and its knock-on negative effects on education and diminished productivity could be costing some countries as much as 17 percent of Gross Domestic Product.⁹ A sub-group of the Sustainable Development Solutions Network has submitted arguments for the inclusion of ECD as a post-2015 development goal, a manifesto for which is also being led by United Kingdom Labour MP, Tessa Jowell. Jim Yong Kim, President of the World Bank said, in 2013, **"The lack of nutrition or stimulation in the earliest years – particularly pregnancy to age two – has lifelong negative impacts on a child's ability to learn, grow and contribute to society"**.¹⁰

The tide is rising, and South Africa is among the leads in Africa in formalising a policy, a universal programme of essential services, and budget commitments to early childhood development.¹¹ It is especially encouraging that ECD was named as an APEX priority or special focus area by the President in his 2008 State of the Nation address, and in September 2013, Cabinet approved the South Programme of Action for Early Childhood Development – Moving Ahead (2013-2018). The ANC Election Manifesto 2014 has also made early child development a top priority – in the next five years, the ANC has pledged to work towards two years of compulsory preschool education, provide about 1 million poor families with home and community services for early learning stimulation programmes, and strengthen coordination between departments responsible for ECD as well as the non-profit and private sectors.

5.2 The creation of an enabling multi-sectoral framework

As spelled out in the companion document on the National ECD Policy, **South Africa has taken a number of steps towards creating an enabling multi-sectoral and integrated framework for the advancement of the comprehensive rights of young children.**

Since 1995 numerous laws have been promulgated and policies developed which acknowledge and seek to advance the importance of early child development for South Africa.¹² These include free health care for women and young children;¹³ the introduction and expansion of the Child Support Grant;¹⁴ subsidisation of child care and early stimulation;¹⁵ and the introduction and scale up of the Reception Year for 5-year-old children.¹⁶ All these initiatives recognise ECD as an ongoing process of emotional, cognitive, sensory, spiritual, moral, physical, and social and

communication development of children from birth until the age of approximately eight years of age.¹⁷ Also, that multiple integrated services are needed to protect and promote young children's survival, health and development, and that these cut across different departments, including Health, Education, Social Development, among others.

More recently, South Africa committed to UNESCO's Education for All goals and adopted the UN General Recommendation 7: Implementing Child Rights in Early Childhood. Cabinet identified ECD as an apex priority, committing to increased access to ECD centres and human resources, and the National Integrated Plan for ECD 2005-2010 was developed, promoting provision of a wide range of support services for young children.¹⁸

Since 2010, several key processes have cemented South Africa's long-standing commitments to promoting ECD. The new Children's Act, a comprehensive child-focussed legal framework, includes a specific chapter on ECD. The 2011 White Paper 6 on Inclusive Education aims to address barriers to learning in the Foundation phase, and a 2012 draft White Paper on Families seeks to promote stable, caring family environments. Plans to transform the health care system will bring benefits for pregnant women, infants and children. Finally, the country's first National Development Plan, released in 2011, proposes extended compulsory pre-school education, nutritional interventions, and support for pregnant women.

The National Integrated Plan for Early Childhood Development (NIP ECD) 2005-2010 established a range of institutional committees tasked with facilitating coordination across departments and between the different spheres of government. It also **recognised that ECD services ought to be delivered through different programme types, not only through centres.** For this reason, the NIP ECD committed to the roll out of home, community and centre-based programmes to ensure ECD services for all children, with a special emphasis on realising the rights of children aged 0-4 years and vulnerable children, especially those in rural areas, children living in underserved areas, children with disabilities and/or children who are chronically ill.¹⁹ NGOs were recognised as partners in realisation of the national ECD plan. Partly fuelled by funding provided by the 2004 Expanded Public Works Social Sector Programme,²⁰ numerous privately owned ECD were established with operating costs met through a per-child subsidy²¹ for income eligible children.

In addition, a number of sector-specific policies and programmes have been developed to provide the relevant comprehensive ECD services to young children and their families.²² These include, as examples:

Department of Home Affairs: Children's births are required by law to be registered within 30 days of birth and numerous in-hospital and outreach programmes facilitate their registration as soon as possible after their birth. The service is provided free of charge.

Department of Health: Services include free health care for pregnant women and children under the age of six years, the Expanded Programme on Immunisation for Infants and Children (for the prevention of common childhood illnesses), the Integrated Management of Childhood Illnesses (IMCI) for the treatment of common childhood illnesses, the Prevention of Mother to Child Transmission (PMTCT) programme to prevent new HIV infection of infants, and the nutritional support, in the form of food fortification, vitamin supplementation, the provision of supplementary food for moderately malnourished children, and the promotion of beneficial feeding practices, such as breastfeeding.

Department of Social Development: Provisions include comprehensive social security, social welfare services and community development services. A number of cash transfers have been introduced to support children living in poverty and those in need of protection, including the Child Support Grant (CSG), the Care Dependency Grant (CDG) for children with severe disabilities, and the Foster Care Grant (FCG) for children in foster care. A child care and protection framework, which includes the provision of prevention and early intervention services, treatment, rehabilitation and reintegration services, and the temporary and permanent placement in alternative care of children who have been abused, neglected and or exploited. Community development services include home- and community-based care, community care forums and drop-in services, food security programmes, and the Department has increased the number of children receiving an ECD subsidy and the amount of the subsidy.

Department of Basic Education: Services and provisions for preschool children include training of ECD practitioners, paying stipends to trainees and developing and dissemination of learning materials for trainees under the Expanded Public Works Programme for ECD, as well as the universalization of a preschool year through the provision of Grade R classes at all public schools. Under the National School Nutrition Programme, children attend Grade R at a school classified as Quintile 1, 2 or 3 receive a school meal that provides at least 30 percent of the daily nutritional requirements of the child.

5.3 Recent developments

National ECD efforts accelerated from 2011 to 2013 with a number of important reports and events, including the launch of the National Development Plan in November 2011; the Diagnostic Review of Early Childhood Development in March 2012; the National ECD Conference in March 2012; the review of the ECD National Integrated Plan 2005-2010, and the South African Integrated Programme of Action for Early Child Development – Moving Ahead (2013-2018), which was approved by Cabinet on 18 September 2013.

The proposed National ECD Policy and Programme builds on these reports and decisions. Salient points from these documents that are used or referred to in the proposed ECD Programme are extracted below.

5.3.1 The National Development Plan (2011)

The National Development Plan²³ aims to write a new story for South Africa's development based on our fundamental constitutional values. Development is defined as "the process of raising continuously the capabilities of all citizens, particularly those who were previously disadvantaged" (p. 5). As stated in the introduction, a key cross-cutting theme of the plan aims to directly improve the life chances of children and youth. While housing, basic services, safety and other social benefits help to create conducive environments for children, the core areas of the plan of relevance to ECD are education, health, social protection, safety, and employment. **The plan urges investment in ECD as a key priority, pointing out that the 1,000-day window** from conception to two years is a period of heightened receptivity to environmental influences, and thus the most effective and cost-efficient time for intervention.

The plan emphasised the protection and promotion of early child development as an important aspect of combatting poverty and inequality. **These actions should build on existing child survival programmes by extending interventions in early life to include social-emotional and language-cognitive development**, and includes:

- Measures that enable women, including teenagers, to plan their pregnancies, as well as the assurance of emotional and social support to ensure a healthy pregnancy (p. 264)
- Health care to reduce maternal mortality to less than 100 per 100,000 live births (from the current level of 500), infant mortality to 20 per 1,000 live births (from 43) and under-5 mortality to less than 30 (from 104)
- The nurture of children in stable home environments where they can acquire the capacities to relate to others (p. 264). This requires, strengthening families (p. 424) and social services to deal with crime and violence, alcohol and substance abuse and other welfare needs.
- Proper nutrition, especially for children under three years of age to promote sound physical and mental development. **Given that South Africa is one of the 20 countries with the highest burden of undernutrition (one in five children), food security for these vulnerable groups must be improved, and the DOH is urged to develop a nutrition intervention for pregnant women and young children** (p. 35).
- Micronutrient deficiencies are highly prevalent – one in four women and one in three preschool children lack Vitamin A, and one in three women and young children are iron deficient. Eliminating anaemia has been shown to increase adult productivity by 5-17 percent (p. 274). Because of their importance to health and wellbeing, the Plan recommends pilots through the health system or early childhood development programmes and structures to identify effective delivery mechanism, and sets a specific target to eradicate micronutrient deficiencies among children younger than 18 months of age.
- **Support for vulnerable caregivers to ensure young children's nutrition, health and care, to be developed in pilots to identify effective delivery mechanism through the health system or early childhood development programmes and structures** (p. 279)
- **Support for stimulating home and community environments** to promote the development of 4 million children 0-3 years of age, through a range of flexible ECD services and programmes that are responsive to the needs of children and families, and support the holistic development of young children (p. 264). Services and programmes should be piloted in selected districts and expanded if proved to be successful over a period of five years. Norms and standards for the funding and management of early childhood development programmes must be developed and implemented (p. 279).
- As the most underdeveloped sector of education (p. 279), **early childhood development must be promoted through universal access to two years of preschool education** for 2 million children in the 4-5 age group for school readiness, health and nutrition (p. 279)
- **A properly qualified and professional educational workforce must be developed**, including for quality early childhood learning, through a strategy to improve qualification of ECD workers, training for new types of extension workers, and addressing conditions of service and career-pathing for ECD workers (p. 280)

- **Each household has access to a well-trained community health worker (CHW)** as part of primary health care teams to provide care, including promotive and preventive interventions to families (p. 298)
- South Africa has a comprehensive social protection system that benefits young children and their families. This currently consists of social assistance cash grants, access to free basic services for poor households (water and electricity), free or subsidised, free education in 60 percent of schools, a school nutrition programme, free health care for pregnant women and children under six years of age, and social insurance (unemployment insurance and public works programmes (p. 326). However, the plan advocates increased coherence amongst these measures to enable all South Africans to achieve a social a decent standard of living.
- Public works programmes currently reach 3-6 percent of the unemployed, and the Plan recommends expansion to an average of 30-50 percent (some 2 million people) by 2030.

To achieve impact from these measures, the NDP urges:

- **More effective policy coordination to avoid fragmentation and wasted resources.** The Plan cites the impact of children's nutrition on health, educational performance and labour market participation, and the effect of housing, water and sanitation, energy, and pollution on health (p. 341)
- Effective implementation of the social protection package which, together, go a long way to support vulnerable children and families
- **Full funding of approved NPOs that deliver agreed social services on which all provinces rely heavily.** This is recommended to replace partial subsidization by provincial departments (The Children's Bill Costing Report).²⁴
- The expansion of social welfare services and the training of more welfare professionals and community workers (p. 342)
- Social audits in response to services and provisions can increase quality, transparency and accountability and empower poor and vulnerable people (p. 347)
- **A social register of welfare and social service recipients**, such as exists in India and Brazil to harmonise coverage and protection. Identity numbers (ID numbers) could be used to merge a number of existing databases (p. 347).

5.3.2 The Diagnostic Review of Early Childhood Development (2012)

The Diagnostic Review (DRECD) was commissioned by the Department of Performance Monitoring and Evaluation (DPME) in the Presidency, in collaboration with the Inter-Governmental Steering Committee on Early Child Development. The DRECD was based on an analysis of more than 110 documents on or related to ECD in South Africa, as well as consultations with experts and stakeholders. The précis, executive summary and short DRECD report is attached as Appendix 4. The full report with the 12 detailed background papers on which the report is based is available on the DPME website at <http://www.thepresidency-dpme.gov.za/dpmewebsite/admin/Images/ProductDocuments/Full%20ECD%20Diagnostic%20Report%202%20August.pdf>. The summary is included as **Appendix 4**.

The DRECD took note of the fact that **many elements of comprehensive ECD support and services are already in place, and some are performing well**. These include early policy

thinking in line with international evidence and good practice, expressed in, for example, White Paper 5 on Early Childhood Education (2001) as well as services such as birth registration and enrolment in Grade R.

However, there is still much to be done, and the following issues were identified by the DRECD as requiring urgent attention:

- A lot is known about ECD from the many documents that have been commissioned on ECD and related topics over the last two decades. These enquiries relate to the state of ECD policy and practices and various aspects of ECD including staffing and financing. **It is time for action.**
- Despite broad, overarching policy describing early childhood development as holistic and beginning at birth, ECD is principally operationalized in a narrow way by the lead departments, Social Development and Basic Education, as centre-based preschool programmes, mainly for children 3-5 years of age.
- While services to promote early child development are being provided by the state through health and a variety of social protection mechanisms, and by the private and non-profit sectors in the form of unregistered child-minding, **these are not articulated or coordinated as part of national ECD efforts.**
- **Centre-based preschool programmes are only provided by the private and non-profit sector** and are not provided by the state as a right in the same way as health and education.
- The state supports these services by way of an **eligibility grant per child attending a registered centre. This perpetuates inherent inequality** in that children 3-5 years of age receive the benefit only if they are fortunate enough to live in an area that is served by a registered centre run by a PNP organization and if their parents can afford the user fees to bridge the gap in State funding. Only about 20 percent of the children most in need of services – children 0-4 years old from the poorest households have access to ECD or Early Learning Centres.
- Even taking a comprehensive view of current ECD provisions across departments and the for- and non-profit ECD sector, **there are gaps in current provisions.** These are most notably:
 - Apart from welfare services for serious social problems, **there is very little in place to support parents and families**, despite the fact that they constitute the most fundamental, strongest and most enduring influences on children, especially in the early years.
 - While there are services for malnutrition, **there is no programme to prevent stunting (poor linear growth or height) of children in the first two years of life.** Stunting is an expression of prolonged undernutrition that affects brain and cognitive development, and results in poor educational achievement and work productivity. It is also associated with chronic diseases in adulthood. An individual's lifelong growth trajectory is set in the first two years of life.

- **Very few children 0-2 years of age are in ECD centres, which is the only type of day care supported by government.** Most parents who need assistance, including working mothers and families with children who have disabilities, place their children in the care of home-based child minders. Child minding is currently unregulated, without training requirements, quality control or funding.

In response to the diagnosis, the DRECD recommended the following:

- **Strong and coordinated inter-sectoral vision, commitment and action through an authoritative and well-resourced agency** that can bring together all government departments, civil society, the private sector and donors to ensure comprehensive ECD services for children
- Policy provisions that **oblige all levels of government to provide, or provide for, ECD services**
- **A population-based strategy to expand ECD services** to ensure access by children and families most in need
- **A package of required ECD services** that include information provision through the media, beginning before pregnancy and continuing until children enter the formal school system
- Financing mechanisms that support a continuum of services from birth, both at home and in the community, as well as in centres and facilities
- A monitoring and evaluation framework comprising good routine data as well as evaluation to serve decisions.

5.3.3 South African Early Childhood Development Conference (March 2012)

The DSD hosted the national conference in East London, which was attended by several Ministers and Deputy Ministers from other departments. The presentations made at the conference are available on the DSD website

http://www.dsd.gov.za/index.php?option=com_docman&task=cat_view&gid=64&dir=DESC&order=date&Itemid=39&limit=10&limitstart=0

The Buffalo City Declaration, drafted at the conclusion of the conference, acknowledged that:

- ECD services are an investment in the overall well-being of children and intrinsically related to the promotion of child rights, poverty eradication, sustainable human resource development, basic education and health for all as enshrined in the South African Constitution
- **Parents are crucial to the wellbeing of a child**
- The first 1,000 days of life are fundamental to holistic development
- The lack of access to ECD services for most children, including children with special needs
- The urban bias in ECD provisioning and the inequitable distribution of services
- The declaration affirmed the role of civil society in ECD provision
- Recognised the need to improve the qualifications and conditions of service of ECD practitioners, as well as for an ECD curriculum for children 0-4 years of age.

The declaration committed the signatory Ministers to:

1. A comprehensive review and harmonisation of policy and legislation within the ECD sector moving towards universal access
2. A multi-sectoral, integrated, coordinated approach to ensure the effective provisioning of ECD services by government, non-governmental organisations, civil society and business
3. Strengthening the role of parents/caregivers, families and communities in the provisioning of ECD services
4. The inclusion of children with special needs and deliberately extending ECD services to children in rural areas
5. Adequate resourcing of ECD services, including infrastructure provisioning
6. Working towards professionalization, accreditation, improving training and promoting the Basic Conditions of Employment Act in the ECD services sector
7. Streamlining of registration processes and the standardisation of ECD services to improve the quality thereof
8. The development of a Programme of Action, in collaboration with civil society partners, with clear targets and outcomes for each of the identified focus areas.

5.3.4 Review of the National Integrated Plan for ECD 2005-2010 (2012)

The Interdepartmental Committee for ECD (consisting of departments with core ECD mandates – DSD, DBE and DOH) and the Social Sector Cluster were mandated by Cabinet in May 2004 to develop and implement the National Integrated Plan for Early Childhood Development (NIP ECD). The NIP ECD, in alignment with government's programme of poverty alleviation, was specifically designed to address the legacy of inequalities and to create greater access to quality early childhood development programmes for young children and their families by utilizing an integrated approach based on firstly, directly providing services including creating an environment for development and, secondly, leading and forging common cause across the range of social actors. One of the key challenges to be addressed by the NIP ECD is the need for coherence and synergy between various legislation, policies and plans.

The review identified **key successes of the NIP ECD as: greater awareness of ECD at all levels of government**; the establishment and functioning of the Inter-Departmental Committee; the collaboration between DBE and DSD; technical support provided by UNICEF; partnerships with civil society, and the expansion of registered sites and children in receipt of a subsidy.

As the review notes, "the model of provision of early childhood care and development continuum of intervention has mainly been met through centre-based care. Services in the area of primary levels of intervention for care and support with the family at a household level and other possible points of contact fell mainly outside of the NIP ECD".

Other areas in which the aims of the NIP ECD were not achieved include:

- **The lack of systems within government to support the implementation of the NIP ECD**; for example, inter-departmental ECD Units to operationalize the Plan were not established at national nor provincial levels

- *Ad hoc* participation of other national departments and institutions in the National Inter-Departmental Committee as a result of minimal mandates on ECD and lack of dedicated ECD capacity
- **Lack of collaboration between departments** and resource-sharing
- **Lack of effort to achieve geographical and other targeting measures** for children in poor vulnerable conditions; and the absence of ECD services to children and their families.

The following is a summary of the review's recommendation:

- An ECD policy should be developed which addresses critical issues for change in ECD, including **a national comprehensive package of services, institutional arrangements for inter-sectoral collaboration and integrated services, specific strategies for reaching poor and vulnerable children through geographical targeting**, and costing of universal and targeted services.
- Given the weakness of institutional arrangements, **the new ECD policy should ensure that there is clear leadership** and defined roles and responsibilities, with accountability mechanisms accompanied by monitoring and evaluation systems.
- Children living in poverty and vulnerable circumstances need to be identified by agreed criteria, age and geographical location. The means test needs to be revised as a matter of priority and the periods at which it is revised agreed. The categories of vulnerability should be defined broadly with room for local decision-making on local conditions that bring about vulnerability for children and families.
- Sufficient resources must be made available for integration and collaboration, both of which are time- and resource-intensive, especially in the initial stages. Public sector funding, specifically for integrated services, must be made available.
- Research and development must be built in to ensure that there is on-going reflection and strengthening of processes and practices. Research should accompany the implementation of all new programmes to strengthen systems.
- Monitoring and evaluation of integrated programmes are more challenging than evaluation of a single department. Systems should be designed to take into account each of the lead and non-core Department's monitoring and evaluation systems, extrapolating the strengths from each to develop an integrated M&E system.
- **A communication strategy must be developed to build public awareness** by disseminating targeted information to parents, members of communities, training providers, policy makers, all ECD service providers and the public at large.
- Civil society (NPOs, communities and parents) must be actively engaged at all levels of ECD, including planning, implementation and monitoring, decision making, and governance.
- **Training must be up-scaled** to increase the number of practitioners so as to expand access to ECD to meet national goals. The challenge of sustainable employment also needs to be addressed.

5.3.5 South African Integrated Programme of Action for Early Child Development – Moving Ahead (2013 – 2018), was approved by Cabinet on 18 September 2013

The Integrated Programme – Moving Ahead is based on the three parallel initiatives: the ECD Diagnostic Review, the review of the NIP ECD and the ECD National Conference. “One of the greatest achievements of the NIP ECD”, argues the Integrated Programme, “has been that ECD stakeholders in the country have been awakened to the discourse about the importance of integrated ECD services and both government and the ECD sector have been motivated to consider how to implement it”.

The key elements of the programme over the five year period from 2013 to 2015 include:

- **Legislation and policy framework** : The development of an ECD policy; review of all legislation, regulations, policy and municipal by-laws pertaining to ECD; development of norms and standards for differentiated ECD services, and amendment of the Children’s Act on ECD
- **Institutional arrangements, coordination and integration**: A feasibility study on inter-sectoral management and coordination to be conducted
- **Human resources, training and capacity building**: A plan for human resource development for the ECD sector; a revised National Qualifications Framework to address training and career-pathing for people working with young children; revision of ECD training programmes to align with the comprehensive package, and improved accreditation and an integration professional registration system for ECD practitioners
- **Core pack of comprehensive ECD services**: Outline a comprehensive package of ECD services for children birth to four years, specifying the roles and responsibilities of government and other stakeholders; develop mechanisms and service delivery models, ensuring government provision of obligatory services
- **ECD infrastructure**: Develop an integrated infrastructure policy for ECD, and amend and consolidate spatial norms and standards for ECD infrastructure
- **Funding and partnerships**: Conduct research on all existing funding models; develop a funding model and funding norms and standards; develop an ECD-sector funding plan; and identify and strengthen government and private donors to leverage resources for ECD services
- **Research, monitoring and evaluation**: Develop a M&E framework for ECD
- **Communication and awareness**: Develop an integrated inter-sectoral awareness raising and communication strategy; develop communication materials, and implement an advocacy and social mobilization campaign.

5.4 Time to act

A very large number of policies, frameworks, evaluations, costings and other exercises on ECD or related to ECD in South Africa have been undertaken since 1995 (see Appendix 5 – List of ECD-related documents).

Over the last two years, a number of ECD and ECD-related documents and reports have been published and several parallel initiatives within government and the for- and non-profit ECD sector are underway. While the diversity of approaches has value, the landscape is becoming

increasing difficult to traverse. Given below are close to 20 new ECD and ECD-related initiatives and/or reports which have come out in the last two years (2012-2013). This list is almost certainly not exhaustive:

- DSD White Paper on Families in South Africa (October 2012)
- DSD Integrated Parenting Framework (undated 2013)
- DSD commission to Cornerstone Economic Research to cost ECD policy based on the Integrated Programme of Action for Early Childhood Development – Moving Ahead (2013-2018)
- DSD Policy for Social Service Practitioners (January 2013)
- Draft DBE Policy Framework for Universal Access to Grade R, covering provision, teacher training, curriculum, employment of Grade R teachers, funding and M&E (August 2013)
- Draft DBE Curriculum Framework for Children Birth to Four Years of Age (August 2013)
- DWCPD National Plan of Action for Children 2012-2017
- DPSA's pilots in nine provinces, in collaboration with FHI360, to establish child care facilities in the workplace for the public services as part of its Wellness Management Policy for the Public Service (undated 2012)
- DOH National Norms and Standards Relating to Environmental Health (2013), section 1 of which deals with pre-school institutions/child care centers/Early Childhood Development Centres (ECDC)
- DOH Framework for Accelerating Community-Based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions (undated)
- The commission by DPME for a Diagnostic/Implementation Review of nutritional interventions for children under five in the identified Primary Health Care facilities and their catchment areas (2013)
- SALGA Roundtable on obligations of local government in respect of ECD (2012)
- StatsSA (2013). South Africa's young children: Their family and home environment 2012. Pretoria: Statistics South Africa
- Berry et al (2013). South African Child Gauge 2013. Stepping up national development: Prioritising essential services for young children. Cape Town: University of Cape Town, Children's Institute
- Giese et al (2011). Government funding for ECD: Can those who need it get it? Cape Town: DG Murray Trust.
- Biersteker, L. et al (2013). ETDP SETA Early Child Development 2013/14 Sector Skills Plan Update.
- Van der Heever et al (2012). Investigating the potential impact of maternity and early child support in South Africa: An options assessment. Johannesburg: Centre for Health Policy, University of the Witwatersrand.

In addition, the for-and non-profit ECD sector is taking initiatives to fill gaps created by delays and lack of coordination in implementing recommendations for the expansion of ECD services.

Examples include the publication by Ilifa Labantwana of an *Essential Package: Early Childhood Services and Support to Vulnerable Children in South Africa* in July 2013, and exploration of franchising of ECD services by Ilifa Labantwana and Brain Boosters.

A single overarching policy for young children's development is urgently needed, as is clear, decisive and authoritative leadership with respect to programmatic action across all spheres of government.

The development of a National ECD Policy and ECD Programme – and the intention to make an Essential Package of services universally available to all children – is **not business as usual. It requires bold new thinking, additional government resources and cooperation across a broad range of stakeholders, most importantly, parent and families.**

5.5 South Africa urgently needs a National ECD Programme

The ECD Diagnostic Review, and countless analyses and evaluations before and subsequent to the Review, have laid out the rationale for the implementation of a national ECD programme. As is extensively set out in the introduction to the ECD Policy, a national ECD Programme is warranted on the grounds of human rights and equity, scientific evidence and economic paybacks that make ECD a public benefit.

Inequality between and within groups of people starts with and, in turn, creates poor early development. Children who are born small, grow slower and stay smaller; they achieve less schooling and earn less as adults. The early inequalities in birth weight, growth and health in infancy, language and cognitive development, and self-esteem widen progressively with age.²⁵ These inequalities become more difficult and more costly to address the more entrenched they become, leading to diminished human development, inter-generational poverty and disadvantage.²⁶ Early childhood interventions substantially limit these adverse effects and narrow the gaps between socioeconomically advantaged and disadvantaged children, leading to improved health and productivity in adulthood. The effects are especially beneficial for the most disadvantaged children.²⁷ Moreover, early interventions increase the capacity of children for emotional control and cooperation with others, which results in greater social cohesion and civic participation, and less violence and crime.²⁸

5.5.1 Scientific evidence

Recent scientific advances in neuroscience and genetics, as well as the results of lifespan studies, permit a confident assertion that early life has a strong determining effect on a broad range of adolescent and adult outcomes. This occurs through a number of mechanisms:

- Firstly, **there is heightened receptivity to environmental influences during pregnancy and the first years of life.** Epigenesis is the process by which environmental influences affect the way genes are expressed, causing them to up- or down-regulate or turn on or off.²⁹ Some of these epigenetic modifications endure, causing changes in children's brain and behavioural development. Such epigenetic changes 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 a child's ability to deal with stress and adversity later in life. In the same way, resilience can be strengthened by exposures to positive experiences. "Put simply, the brain

adapts to the experiences it has".³⁰ Some early epigenetic changes have also been found to persist intergenerationally, affecting the health of future children.³¹

- Secondly, **child development is sequential and cumulative**. Each new stage builds on previous stages. There is no going back. If inadequate foundations are laid down in the earliest months and years of life, vulnerabilities arise that deepen and accumulate over time.

Through these processes, adversities experienced during the sensitive early developmental period become embedded in a child's biological and psychological functioning causing long term effects on health, education and productivity, and psycho-social adjustment.³² Currently, our understanding is that the period from conception to age two years, the first 1,000 days of life, are the most receptive to disadvantaging and remedial effects.³³

Early experiences affect health, education, productivity, psychosocial adjustment and mental health across the life-course:

Health

Poor growth and exposure to stress from adverse environmental events during foetal development and early infancy are associated with chronic diseases in adulthood. This occurs because the foetus and the very young child respond to information from the environment and adjust to it, resulting in epigenetic changes, as explained above. This is known as the Developmental origins of Health and Disease (DoHaD).

Apart from height and weight,³⁴ the body composition (fat and lean mass) of young children can also be affected; as can the sensitivity of hypothalamic-pituitary-adrenal metabolism which, in turn, affects appetite and physical activity. These incline the person towards overweight and obesity.³⁵ Insulin sensitivity leads to insulin resistance and diabetes in later life.³⁶ Low birth weight is related to high adult blood pressure.³⁷ Similarly, there are established associations between undernutrition and cardiovascular disease and stroke.³⁸ Patterns of early growth are also implicated in lung and immune function, bone mass, mental illness and some cancers.³⁹

Early social and psychological experiences have also been found to affect adult physical health. 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, abuse, and exposure to violence, parental mental illness and substance abuse, to be associated with a very wide range of chronic health conditions.⁴⁰

Human capital: Education and work productivity

For its development, the human brain depends on certain kinds of affectionate and stimulating human interaction. When adults are unresponsive to infants or fail to stimulate a young child, some of their neurocognitive functions don't fully develop.⁴¹

It is estimated that worldwide, more than 200 million children under five years of age 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 predicts later school entry, fewer years of schooling achieved and lower school performance, as well as lower earnings assessed in prospective longitudinal studies.⁴² Stunting, indexed by low height-for-age (more than two standard deviations below the standard) is associated with the loss of one grade of schooling.⁴³ **Stunting combined with poverty (below the third quintile for income) is associated with the loss of**

2.15 grades of schooling.⁴⁴ Studies from 51 countries show that, on average, each additional year of schooling increases wages by almost 10 percent.⁴⁵

Psycho-social adjustment and mental health

Self-esteem, good relationships with other people, and the ability to cope with challenges in early childhood.

Poor growth and exposure to high levels of stress ('toxic' stress) during foetal development and early infancy are associated with social and psychological maladjustment in adulthood, including mental illness. Exposure to stressful experiences as a young child, such as described in the ACE study, are consistently associated with a wide range of psychological and social problems of adjustment. These include work absenteeism, obesity, cigarette smoking as well as alcohol and drug abuse in adolescence and adulthood, teen pregnancy, sexual risk behaviour among women, depression and suicide risk.⁴⁶

Toxic stress is stress that goes beyond manageable levels, or is experienced in the absence of warm, protective and reassuring adult support.⁴⁷ There are several pathways between early childhood experiences and mental wellbeing in adulthood.⁴⁸

- Firstly, poor growth in early childhood affects brain development, as shown in long-term studies of children born into the 1944-1945 Dutch famine and the 1958-1961 famine in China.⁴⁹
- Secondly, stressful early childhood experiences can modify physiological and future psychological responses to stress.⁵⁰ Stress levels stay high, likened to an engine being revved for a long period of time. Stress responses also become hyper-sensitive, reacting like a hair-trigger response to signs or danger or threat.⁵¹ High baseline stress is also associated with erratic attentional and emotional responses, affecting self-regulation and behavioural control. In the absence of protective factors in childhood, such as nurturant care,⁵² toxic stress can lead to both physical and mental illness.
- A third mechanism through which early childhood experience affects lifelong personal and social adjustment is first attachment relationships.⁵³ Through these experiences, children create a mental template (an internal working model) of what they expect from future. The warmth, stability, sensitivity and responsiveness 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. This makes it difficult for them to create confident supportive relationships that are protective against stress⁵⁴ (Rutter, 1995).

Poverty is a funnel that concentrates adverse experiences in early childhood

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 low maternal education, increased maternal and family stress, maternal depression and lack of stimulation in the home.⁵⁵ Poor parents are at higher risk of being 'emotionally unavailable' to their young children because of long working hours and travel to work, stress and low morale.⁵⁶ Under these conditions, parents tend to spend less time with and talk less to their children, be less engaged in their children's activities and use physical

punishment to control young children's behaviour rather than explanation and guidance.⁵⁷ Poor parents are also less likely to support their children's schooling because of their own incomplete education and economic stresses.⁵⁸

The risks to children's emotional, cognitive and social development of living in poverty increase with the number of risk factors to which they are exposed.⁵⁹ However, even the effect of multiple stressors can be contained and their impact reduced by 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.⁶⁰

Resilience

Most children do well if they are protected and given support. Only a minority of young children exposed to poverty and other forms of adversity develop serious physical, mental and social problems. This is because many are protected or helped to recover by loving supportive people in their everyday lives.⁶¹

Long-term studies of disadvantaged children identify three types of resilience-promoting experiences. These are:

- Warm and supportive family relationships
- Stability and security at home and in the community
- Expectations, opportunities and encouragement to participate and succeed in some area of their lives.⁶²

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. This means that resilience is possible when destitution is averted, when people can take control of their own lives through, for example, income security, and when they can access health care, education and other services that they and their children need. Ann Masten speaks about the "ordinary magic" of protective and resilience-promoting factors – interested and loving parents and a functional family, being part of a community that accepts and helps each other.⁶³ These are not "interventions"; they are the product of secure and meaningful lives.

Interventions

Long-term adverse outcomes can be prevented by early intervention. Despite the susceptibility to insult of the brain and the developing mind, remarkable recovery is possible with interventions.

The earlier the intervention, the greater the benefit.⁶⁴ In the longest follow-up study in a low-income country – Guatemala – a nutritional intervention delivered in early childhood produced highly significant differences in education and adult earnings compared to controls. When followed up between 25 and 42 years of age, 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 earned on average 46 percent more than adults in the control group.⁶⁵

Importantly, it is early intervention that is critical. The education and earnings differences were found only for children who received the supplement before three years of age, and not for children who received the supplement between four and seven years of age.⁶⁶

Furthermore, the evidence indicates that **combined ‘nutrition + stimulation’ interventions are more effective** at increasing growth and cognitive development, than either nutrition or stimulation alone.⁶⁷

A review of 70 studies in 25 low- and middle-income studies showed that ECD interventions produce a small-to-medium positive effect on cognitive development.⁶⁸ Early stimulation has also been shown to have long-term effects on schooling. The children who benefit most are those who receive stimulation at home, in preschool and in the first year of formal schooling, highlighting the **importance of consistent stimulation throughout early childhood**.⁶⁹

These studies demonstrate clearly the benefits of early nutritional and psychosocial interventions for children at risk for stunting and poor development, and the critical importance of intervening when children are very young. Early childhood interventions in both resource-rich countries and low- and middle-income countries render benefits far exceeding their investment costs, and that the benefits endure well into adulthood.⁷⁰

Factors identified in research that are consistently associated with successful early child development interventions are:

- A focus on disadvantaged children
- Integration of health, nutrition, education, social and economic development (for families) in programmes
- Sufficient intensity and duration of intervention
- Beginning with children early in life, preferably in pregnancy and continuing during the preschool years
- Involving parents as partners to support children’s development
- Preserving and incorporating traditional child-rearing practices and cultural beliefs into scientifically based health and development messages
- Training, supervision and on-going management of practitioners
- Reviews have identified parent education and mass media messaging as an important avenue yet to be fully utilised in low- and middle-income countries.^{71,72}

5.5.2 Economic benefits and costs to South Africa of poor early development

Many of the economic benefits of early interventions have been described under the previous section.

The accident of birth plays a major role in defining a child’s chances in South Africa, and we cannot accept the inequity of a child being metaphorically cut off at the knees before they are even able to walk. Approximately 58 percent of children 0-4 years old live in poverty (using a poverty line of R604 per person).⁷³ The growth of more than a quarter of children in South Africa birth to three years of age is stunted.⁷⁴ Even if children catch-up in height, the impact of stunting on brain development in this critical early period may endure into adulthood.⁷⁵ On average, children who are stunted by age two go on to complete fewer years of schooling and to earn less as adults. In addition to cognitive and associated education and productivity impacts, stunted children face increased risk of negative adult health outcomes, including increased rates of diabetes and cardiovascular disease.⁷⁶ The long-term effects of stunting are passed on to the

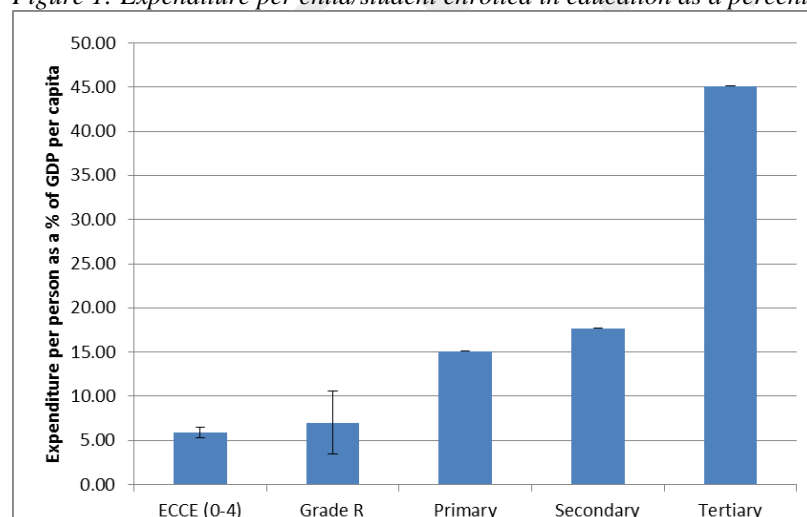
next generation because small women have babies with lower birth weight⁷⁷ who, in turn, are more likely to be stunted in infancy.⁷⁸

It is estimated that worldwide, more than 200 million children under five years of age fail to reach their full human potential as a result of unremitting poverty and undernutrition experienced during their early years. **Using the same criteria, nearly 1.5 million young children in South Africa don't reach their human potential.**

Stunting, indexed by low height-for-age (more than 2 standard deviations below the standard) is associated with the loss of one grade of schooling.^{79,80} **Stunting combined with poverty (below the third quintile for income) is associated with the loss of 2.15 grades of schooling, as demonstrated by multi-country data including from South Africa.**⁸¹

The South African government, as well as families, invest in children's education. However, with 18.5 percent of the country's budget, education does not generate the returns expected. Close to half of all children repeat a grade during their first three years of schooling, and only one in two children who enter school matriculate. The Annual National Assessments (ANA) of Grade 3 pupils found that on average only 35 percent of learners can read, ranging from a provincial low of 12 percent to 43percent.⁸² The average performance of South African school children is often rated as one of the worst in the world. For example, South Africa was placed in the bottom six of 42 countries in the Trends in International Mathematics and Science Study (TIMSS), despite administering the study to Grade 9's (most countries administer to Grade 8's).⁸³ **South Africa is not harvesting the benefits it should from its large investment in education, partly because it is not investing sufficiently in early child development.** In the ECD Diagnostic Review, we estimated that almost three times less is spent on ECCE than primary education and nine times less than tertiary education (see Figure 1).⁸⁴

Figure 1: Expenditure per child/student enrolled in education as a percentage of GDP per capita



The negative consequences of stunting have implications not only for individual children, their families and their own children in the future, but for the economy. Studies from 51 countries show that, on average, each additional year of schooling increases wages by almost 10 percent.⁸⁵ A recent study commissioned by the African Union, *The Cost of Hunger*, estimates the loss to GDP of childhood undernutrition in Ethiopia to be 17 percent and 6 percent in Uganda.⁸⁶ **If the cost of child hunger in South Africa were even at the very bottom of this range, it would represent over R70 billion lost to our GDP every year.** We have tools to reduce this cost. For

example, it has been found that receipt of the Child Support Grant early in a child's life reduced the probability of stunting.⁸⁷

Although investments in ECD will not, on their own, rectify all the troubles of the primary and secondary education system, they will better prepare children to learn and to enter formal schooling. This will increase returns on our current investments because children will stay in education and learn more. Although more research is needed, there is growing South African evidence that ECD investments can improve subsequent school performance (Gustafsson, 2010; Spaul, 2011).

In addition to costs associated with decreased schooling and lost productivity, the costs of stunting are felt in the health sector, across the lifecycle. Early adversity, including stunting, has been linked to a range of negative adult health outcomes. These include increased risk of non-communicable diseases, which contribute significantly to the burden of disease and are costly to treat.⁸⁸ The chronic nature of many non-communicable diseases places significant demands on the health care system and is rightly garnering increased attention in South Africa.

The protection and support of early childhood development generates public good. Investing in ECD leads to benefits for the child, both in the short and long term. There are, however, benefits for others beyond the child and the child's family. Benefits accrue to all other members of society as costs to them might be reduced (e.g. if the child doesn't get held back for two or three years in school because of poor learning), plus the child may contribute more to society as an adult. There is a danger that families might under-invest in ECD services if they consider only the benefits to the child and themselves. Because of this, **economic theory suggests government intervention to ensure investments at the level they should be, given the broader social (public) benefits.**

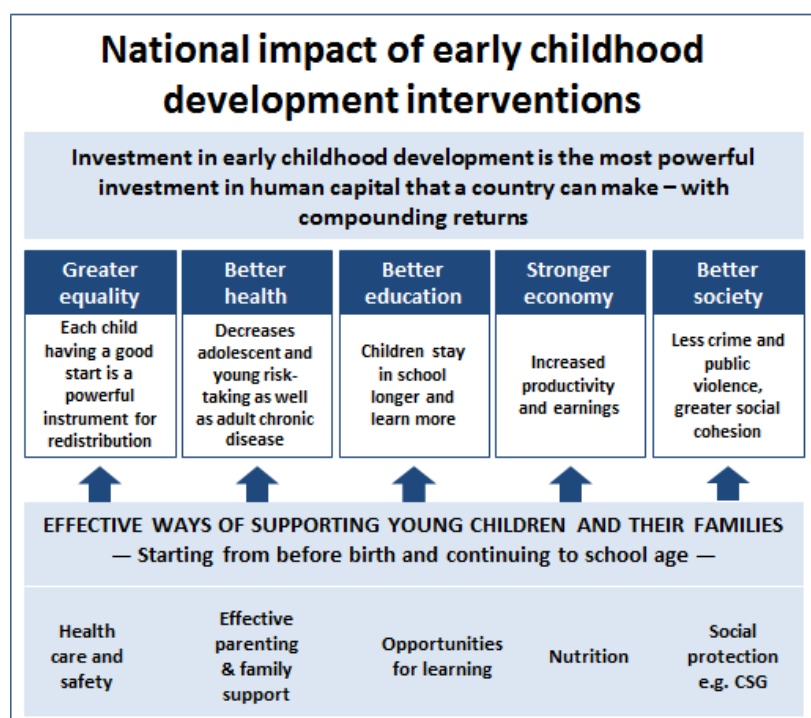
Including both the individual and the social benefits highlights the potential for extremely high returns on ECD investments. It is estimated that increasing preschool enrolment in low and middle income countries could yield a benefit-to-cost ratio of 18:1 at the upper bound. This suggests that an investment of R1 could lead to benefits of R18 over the long-term. Far more than R18 will be generated for each R1 spent, but future returns are discounted to their current value. The lower-bound benefit-to-cost ratio is still impressive at 6:1.⁸⁹ There are few investments which boast such high rates of return.⁹⁰

The public or social benefits of ECD interventions are illustrated in Figure 2.

The language of investment provides a powerful argument for supporting ECD. It does, however, miss an important element – that of protecting children's potential. At the point of conception, children have a given human potential. To improve this potential requires supporting parents before (typically long before) conception, during pregnancy and in the child's early years.

The strength of the argument in favour of supporting the massive expansion of ECD services is that it responds to all criteria for prioritization. That is, **ECD is an intervention which protects human rights, generates the greatest social return, stimulates economic growth, and decreases inequality.**

Figure 2: Science in child development, nutrition, health and economics attest to the benefits of ECD interventions



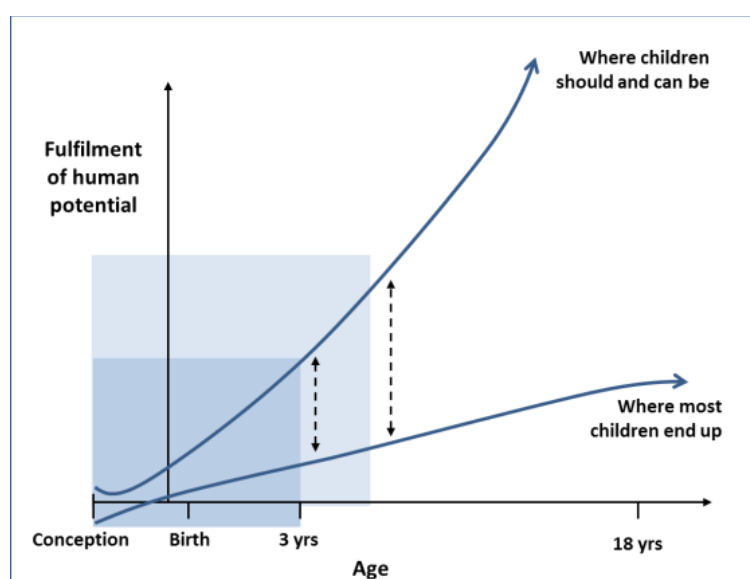
The failure to prioritize and provide effective interventions on a national-scale to support the early development of children in South Africa will likely lead to a smaller economy than is possible in the future, to poorer population health than is necessary and to greater suffering of subsequent generations than need be the case. Of similar, if not greater, importance is that failure to act now will lead to the continued denial of the human rights of the current generation of children. It is the purpose of the ECD Policy and Programme to ensure that preventing the costs of omission are treated with the same urgency as if the costs were caused by commission.

5.5.3 The goals of the National ECD Programme: Protecting and promoting early child development

A National ECD Policy and Programme is urgently needed because about 60 percent of South African children begin life at a lower level of capacity than they should, and they fall increasingly behind during the most formative period of their life.

As illustrated in Figure 3, this means that children can't take full advantage of education and

Figure 3: Gaps in the fulfilment of human potential from before birth increase along the lifecourse



they are less able to get on well with others. The net effect is educational under-achievement, high rates of personal and social problems, and poor prospects for national growth, prosperity and social stability. To address this, the goals of the National ECD Programme are to achieve:

- Individual identity and citizenship for all South African children
- Healthy babies and healthy children
- Zero-stunting and zero children who are seriously underweight as a result of insufficient food
- Parents who are empowered with knowledge, skills and the help they need to fully support their children's development
- Social protection for the families of all children who need it
- Universal availability of quality early learning opportunities and to ensure that no child is excluded
- A public informed of the importance of ECD, motivated and enabled to protect and promote early child development.

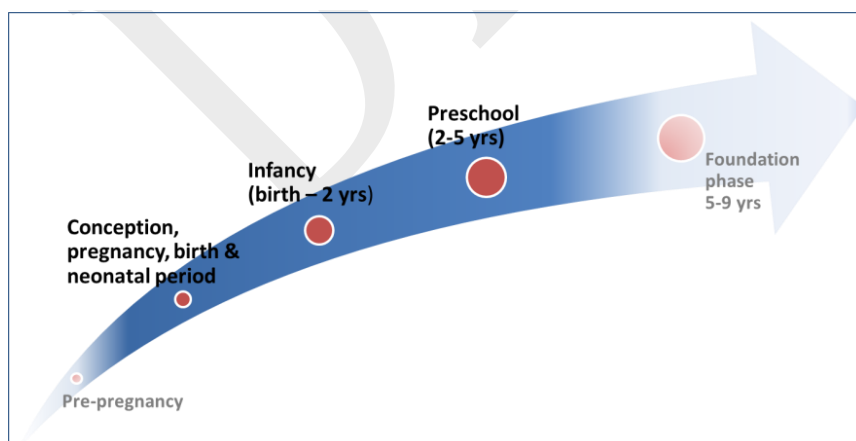
The development of a national ECD Policy and Programme is an opportunity for government to:

- Take leadership and forge alliances across society
- Give substance in a decisive way to a long history of good intentions to improve the early development of children.

5.5.4 Introduction to the Essential Package for early child development and its implementation

The National ECD Programme covers the time from conception to when the child turns five, or until the child enters the formal school system in Grade R. That is, it includes pregnancy, birth to two years, and two to age five years. As indicated in Figure 4, this period is continuous with the time before the pregnancy and with the foundation years of schooling.

Figure 4: Early childhood development: From pregnancy to age 5 years



The Essential Package for ECD, and its implementation, is approached with respect to the three time periods indicated: pregnancy, birth to two years, and two to five years.

A number of inputs are needed to promote and protect the development of young children. These include a healthy and safe pregnancy and birth, health care, good nutrition, loving care, a stable family, and opportunities to learn and exercise new skills. This means that multi-sectoral services are needed that address each of these aspects of children's early development.

From a multi-sectoral perspective, some ECD services are available in South Africa, and some of these services are performing well or are improving. Examples include aspects of maternal and child health, birth registration, social protection, and increased support for early learning centres.

However, as identified in the ECD Diagnostic Review, there are significant gaps in services and a need for stronger leadership.

The gaps in services relate to age, target groups and types of services:

- **Age:**
 - But for health, there are few services and no early learning services for children younger than two years of age. These first 1,000 days are the most important for maximising benefits and minimising impairment
- **Target groups:**
 - There are large parts of the country, both rural and urban, where there are no early learning services for young children. The poorest children in the greatest need have limited access to the fewest services.
 - There are few services to prevent or identify childhood disabilities, and children with disabilities have very little access to intervention services
- **Neglected services to be enhanced or developed:**
 - Support for child minding (of fewer than six children), which affects also the youngest age group of children birth to two years
 - Nutrition support to prevent stunting and serious under-weight
 - Social support for parents, caregivers and families
 - Public information about early child development.

Leadership is needed in the following respects:

- Government must take responsibility for ensuring that a package of essential ECD services is made available to all children 0-5 years. This includes the development, expansion, and resourcing of services, as well as monitoring implementation and ensuring quality and improvement where needed.
- Government must ensure leadership in innovation and coordination of the multi-sectoral effort needed to make available a package of essential ECD services.
- Leadership is needed to:
 - Work across government, with the private and non-profit sectors, the public, and international stakeholders, to counter fragmentation and create a united vision and understanding of young children's development and what is needed from all stakeholders working together to protect and promote early child development.

- Build a system, comprising training, human resources, infrastructure, quality control and monitoring, with sustainable financing to make an Essential Package of ECD services available to all children. **The challenge of building a system requires a longer-term perspective rather than ‘quick fixes’.**

In the following sections of the report:

- The proposed ECD Essential Package is described, as are:
- The challenges to and opportunities for rapid expansion of universal availability of the ECD Essential Package
- Human and infrastructural resource requirements
- Roles and responsibilities across government and with civil society
- Monitoring and evaluation and
- Funding and costing.

6.0 The Essential Package for Early Child Development

6.1 Introduction

All young children and their families must receive a set of **services and interventions that are critical to young children's immediate and future health and wellbeing**. The Essential Package was constructed from a review of what is included in programmes internationally,⁹¹ what is currently provided in South Africa, and gaps identified in the ECD Diagnostic Review. The foundational values of South Africa, the scientific evidence, and the facilitating policy and programme environment make the following components critical to the Essential Package:

- A lifecycle approach, beginning during pregnancy, through birth to the time when a child enters the formal schooling system in Grade R, or later as might be the case with children with developmental difficulties or disabilities
- Health care for mother and child throughout pregnancy, delivery and early childhood
- Nutritional support and food security for mother and child throughout pregnancy, delivery and early childhood
- Citizenship, conferred through the child's birth registration
- Social protection to enable parents and families to provide care and protection for their young child
- Support to enable parents to deal with health, psychological and social issues that can hamper care and protection of a young child
- Developmentally appropriate opportunities for learning that are provided in the home, child minding, and in community- and centre-based programmes
- Information, education and communication (IEC) about the positive role parents can play in the development of their young child to meet their child's learning, nutritional, emotional, social and safety needs

Age Groups

The Request for Proposal (RFP) differentiates two groups of children - the first 1,000 days (conception to two years) and 2-5 years (or the age at which the child enters Grade R).

From an educational perspective, the National Early Learning Standards (NELDS) and the Draft National Curriculum Framework distinguish Babies (birth to 18 months), Toddlers (18 months to 36 months), and Young Children (3-4 years). This is also the breakdown given in the Guidelines of the Department of Social Development for ECD services and the Children's Act norms and standards.

Alternatively, the Further Education and Training Certificate: Early Childhood Development and related unit standards provide for the following breakdown: Babies (0-12 months), Toddlers (12-30 months) and Young Children (30 months-5 years). The National Development Plan highlights the needs of children up to two years of age (the first 1,000 days).

It is critical that the ECD Policy set a standard age framework for ECD in SA, using one set of categories, and that all other policies and programmes be reviewed and aligned with this framework.

For purposes of designing the Essential Package, we propose the following three categories which are compatible with the educational approach, outlined above. They are also informed by the developmental needs of children as well as the current configuration of primary service providers and sites of delivery pertinent to each age group. The age categories we propose are:

- Age Group 1: Conception, pregnancy and birth
- Age Group 2: From birth to two years (the first 1,000 days)
- Age Group 3: From two years to entry into Grade R (children who turn five in June of the year of admission) as the first foundational year in the basic education system, or later if the child shows developmental delay.

The services in the proposed Essential Package are described below and summarised in Table 1 and Table 2. They are differentiated by needed inputs to support child health and development, by age group, site of service delivery, and by responsible government department where currently provided and where new services are proposed. As indicated, services are proposed to be delivered through homes, health facilities/services, schools, early learning centres and programmes, homes, child minding services, and mass media and other forms of communication.

As indicated, the Essential Package was constructed to fulfil the essential developmental needs of young children. This required that the gaps in current services identified by the ECD Diagnostic Review be addressed. These gaps, described below, are addressed by the Essential Package and the proposed implementation strategies.

- **The critical first two years of children's lives, starting in pregnancy (the first 1,000 days).** This is a stage in development when children are especially susceptible to environmental influences, particularly variations in the quality of care and nutrition.
- Very little is in place to **support parents, other primary caregivers and families**, despite the fact that they constitute the strongest and most enduring influences on children, especially in the early years.
- **Prevention and remediation of stunting due to undernutrition as well as disability**, both of which have lifelong adverse consequences for children, their families and society.
- **Parental care and stimulation must be improved** to increase the protection and safety of young children as well as their opportunities for learning.
- Very few children 0-2 years of age are in formal early learning centres or programmes, which is the only type of day care supported by the state. Most parents who need assistance, including working mothers and families with children who have disabilities, place their young children in the care of home-based **child minders, a system without a training, registration or funding framework**.
- **The current subsidy system entrenches inequity** because children can only benefit if they are fortunate enough to live in an area that is served by a registered centre run by a for- or non-profit organization and if their parents can afford user-fees.
- **The system needs rapid expansion to meet the needs and rights of all children**, especially children whose development is threatened by poverty and disadvantage. Although the subsidy covers increasing numbers of children in an increasing number of

registered centres, only about 20 percent of 0-4-year-olds from the poorest households have access to early learning centres, and these are of variable quality.

6.2 The proposed Essential Package of ECD Services

The comprehensive programme is outlined in the ECD Policy report, and comprises the conditions for an enabling parental, family and community environment for young children. A comprehensive programme includes, amongst others, housing, water and sanitation.

The proposed ECD Essential Package consists of those services required for the normal development of children from the time of conception until they enter Grade R (or turn nine years of age in the case of children with developmental difficulties). They include:

- Citizenship, conferred through the child's birth registration
- Health care for the mother and child throughout pregnancy, delivery and early childhood
- Nutritional support for mother and child throughout pregnancy, delivery and early childhood
- Social protection to enable parents and families to provide care and protection for their young child
- Support to enable parents, to provide them with information and to help them deal with health, psychological and social issues that can hamper the care and protection of a young child
- Developmentally appropriate opportunities for learning that are provided in the home, in child minding services, and in community- and centre-based programmes
- Public information about early childhood development.

The Essential Package proposed, and the mechanisms for its implementation are:

- Based on scientific evidence of the critical inputs and supports needed by young children
- Differentiated by age group and developmental needs
- Intended to fill gaps in current services with respect to developmental stages and types of services
- Built on existing health, education and social services provided by the state as well as by the for- and non-profit sector)
- Feasibly implemented to make services universally available
- Designed to ensure equitable access.

In essence, the Essential Package comprises five categories of services addressed to three age groups as shown in Table 1.

- Age groups: Pregnancy, birth to two years, and two to five years (or age of entry into Grade R)
- Services: health care and nutrition + birth registration + social protection + parent support + opportunities for learning

Table 1: The ECD Essential Package at a glance

The Essential Package	
Age Groups	Provisions
PREGNANCY	HEALTH CARE
	NUTRITION
BIRTH TO 2 YEARS	BIRTH REGISTRATION
	SOCIAL PROTECTION
2 YEARS TO GRADE R	PARENT SUPPORT
	SOCIAL SERVICES
	OPPORTUNITIES FOR LEARNING

Table 2 shows the proposed Essential Package in more detail, by age and developmental stage, needed developmental inputs and services, and indicated government departments responsible for their delivery.

Table 2: Proposed Essential Package of services

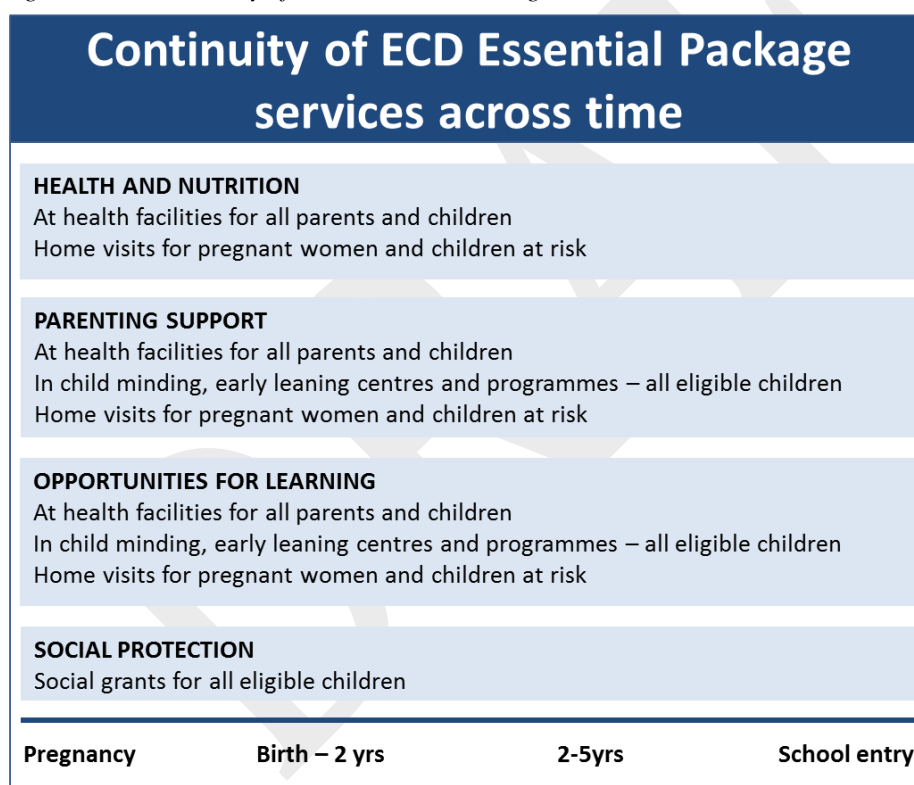
Developmental Stage/Age Group	Aspect of the Essential Package	Services	Responsible Department
PREGNANCY	Health and nutrition	> Family planning services	DOH provides
		> Antenatal care	DOH provides
		> HIV testing and PMTCT services	DOH provides
		> Micronutrient supplementation (iron, folic acid, calcium)	Enhance (DOH)
		> Self-care (rest, refraining from alcohol, cigarettes, etc.)	Not currently provided (DOH)
		> Screening, support and referral for maternal mental health, substance abuse, exposure to violence	Not currently provided (DOH)
	Parenting support	> Preparation for parenting	Not currently provided (DOH)
	Social protection	> Pre-registration for the CSG	Not currently provided (SASSA)
BIRTH TO 2 YEARS		> Well-baby care and immunization	DOH provides
		> HIV testing, treatment and care	DOH provides
		> Growth monitoring	Enhance (DOH)
		> Vitamin A supplementation	Enhance (DOH)
		> Responsive, complementary feeding	Enhance (DOH)
		> Nutrition counselling and supplementation for children showing poor growth	Enhance (DOH)

Developmental Stage/Age Group	Aspect of the Essential Package	Services	Responsible Department
		> De-worming	Enhance (DOH)
		> Screening, support and referral for maternal mental health, substance abuse, exposure to violence	Not currently provided (DOH)
		> Screening, support and referral for children with developmental delays and disabilities	Enhance (DOH)
		> Screening, support and referral for child abuse and neglect	Not currently provided (DOH)
		> Parenting support and skill building	Not currently provided (DOH)
		> Stimulation for children's learning and development in the home, in community-based programmes and in child-minding services	Home visiting – not currently provided (DOH) Child minding – not currently provided (DSD) Enhance community-based programmes (DOH/DSD)
		> Birth registration within 30 days of birth	Enhance (DHA)
		> Early access to the Child Support Grant and other social grants for which the child and family are eligible	Enhance (SASSA)
2 TO 5 YEARS	Health and nutrition	> Preventive and curative health care	DOH provides
		> HIV testing, treatment and care	DOH provides
		> De-worming	DOH provides
		> Vitamin A supplementation	Enhance (DOH)
		> Nutrition counselling and supplementation for children showing poor growth	Enhance (DOH)
		> Screening, support and referral for maternal mental health, substance abuse, exposure to violence	Not currently provided (DOH & DSD)
		> Screening, referral and support for children with developmental delays and disabilities	Enhance (DOH & DSD)
		> Screening, support and referral for child abuse and neglect	Not currently provided (DOH & DSD)

Developmental Stage/Age Group	Aspect of the Essential Package	Services	Responsible Department
	Parenting support	> Parenting support and skill building	Not currently provided (DOH & DSD)
	Opportunities for learning	> Stimulation for children's learning and development in child minding facilities, community programmes and in early learning centres	Enhance (DSD & DBE)
	Social protection	> Access to the CSG and other social grants for which the child or family are eligible	Provided (SASSA)

The continuity of the proposed services from birth to age five, for both at-risk and non-risk groups of children and families are shown in Figure 5.

Figure 5: The continuity of ECD Essential Package services across time



Underpinning the ESSENTIAL PACKAGE is ongoing media and public communication on ECD that:

- Reinforces the nature and critical window of opportunity of early child development
- Emphasises the important positive role parents play in children's development
- Conveys important messages to support early child development, including:
 - Nutrition and health care
 - Safety and protection, including alternatives to harsh punishment

- Responsive care
- Early learning.

6.3 Services in the Essential Package that are currently provided

6.3.1 Health care for pregnant women, mothers and young children

The National Department of Health has a Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition (MNCWH) in South Africa 2012-2016. The vision of this Plan is "accessible, caring, high quality health and nutrition services for women, mothers, newborns and children". In addition, South Africa has adopted the African Union Commission's Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA).

The Strategic Plan recognises that, to meet 2016 targets, "Every woman, mother and child will receive priority intervention services as part of a comprehensive service package at the community, primary health care and hospital levels." These include increased access to early antenatal care, HIV testing and antiretroviral therapy and improved intra- and post-partum care. Further a package of community-based MNCWH services by ward-based Primary Health Care (PHC) outreach teams is envisaged. The Strategic Plan is, however, less explicit about reducing some of the major risk factors for children's growth and development such as environmental pollution and hazards, smoking, and alcohol and substance misuse during pregnancy, exposure to gender-based violence and maternal mental health. Additional activities to respond to maternal under- or over-nutrition and micronutrient or trace element deficiencies are also not specifically covered (see **Appendix 7 – Health of pregnant women and young children**).

In the Essential Package, we have included the following to enhance the currently provided services:

- Strengthen the delivery of services already identified as priorities such as early antenatal booking, integrated antenatal services and community-based care
- The integration of maternal social and economic support into maternal and infant ante- and postnatal care through preparation for and pre-registration for birth certificates, identity documents and social grants
- The introduction of additional services, including:
 - Counselling on self-care and substance abuse
 - Screening and support for women at risk as a result of domestic violence and poor mental health
 - Preparation for childbirth and exclusive breastfeeding
 - Preparation for parenting and the developmental needs of young children, including learning from birth.

6.3.2 Citizenship and social protection

6.3.2.1 Birth registration

The right to a name, nationality and an identity is a fundamental right of all citizens. South Africa achieved large improvements in birth registration over the past decade, and birth

registration is near-universal, with 90 percent of births now registered within the year of birth.⁹²

However, access is skewed towards older children. While 90 percent of 0-9 year-olds had a birth certificate in 2008, 11 percent of 0-2 year-olds did not have this vital document. Rural children are also more likely to experience poor access to this service.⁹³ The Department of Home Affairs (DHA) has initiated a number of strategies to improve access to birth registration services. These include, amongst others: the establishment of new offices and mobile units, primarily in rural areas; equipping offices with 'live-capture functionality'; and integrating birth registration into services at 248 clinics and hospitals. The DHA has set the goal of extending this service to 260 health facilities by 2015. Legislative reforms now permit refugees and asylum-seekers to also register their infants.⁹⁴

Since the group of children most in need of registration services are those under two years of age, registration campaigns should in particular target new mothers, especially at the time of birth. The rate of integration of registration services at health facilities should be accelerated to facilitate increased reach of mothers at health facilities. Because mothers of young children visit health facilities fairly frequently, it is important to optimise these visits by enquiring whether caregivers have registered their children's birth, referring them to DHA officials as appropriate. Continued targeting of rural areas is likely to improve access.

6.3.2.2 Receipt of the Child Support Grant

Early access to social grants, and the CSG in particular, has been consistently associated with positive child outcomes.⁹⁵ While coverage of the CSG has incrementally increased in recent years with the majority of poor eligible children benefiting, particularly vulnerable children are not well reached. This includes children under one year of age. About 50 percent of eligible 1-year olds are not accessing the grant.⁹⁶ Infants require adequate nutrition, stimulation, access to health care and other inputs that poor caregivers often struggle to provide without economic support. Key reasons for exclusion relate to not having the prescribed documentation, a lack of time or caregivers' poor motivation to apply, as well as policy limitations. For example, teen mothers or teen caregivers cannot simultaneously access the grant for themselves and the child in their care. Take-up rates are particularly poor for teen mothers, indicating significant barriers to access for this group. Infants in urban formal and rural areas also have lower access rates.⁹⁷

The DHA's integration of birth registration facilities at health facilities is an important step to address the documentation barrier. The Social Assistance Act was also amended to allow for the use of alternative documents. Other SASSA interventions include: outreach programmes to disseminate information and reduce the distance between households and service points; CSG messaging included in various departmental programmes targeting vulnerable groups; and the Act's recognition of children heading households as eligible to apply for the CSG.⁹⁸

Despite the improved rate of early birth registration and access to birth certificates, it has not yet had an impact on the CSG take-up rate for 0-1 year-olds. Required documentation other than birth certificates may be the stumbling block, although the alternative document regulation has not made a significant improvement to CSG access.

In order to increase the number of children who receive the CSG from birth, the Essential Package includes pre-registration during pregnancy. Furthermore, legislative changes that enable teen mothers to simultaneously receive the grant for themselves and their infant would also make a difference.⁹⁹

6.3.3 Subsidies for income eligible children attending registered early learning centres

The Department of Social Development provides a per-child subsidy for income eligible children prior to Grade R age in registered non-profit ECD centres. It was initiated under the Child Care Act of 1983 to support poor children younger than five, attending registered non-profit 'places of care' to help provide for young children's basic needs¹⁰⁰. The subsidy has increased significantly from R6.07 in 2005-6 to the current subsidy of R15 per child per day of attendance. This subsidy reached 484 529 children in 2012¹⁰¹, a substantial increase from 270 000 in 2004/5,¹⁰² and constitutes most of provincial ECD spending¹⁰³. The government target for subsidised children for 2014 is 600 000.¹⁰⁴

While subsidies for poor children attending registered non-profit ECD centres increased from approximately R422 million in 2007/8¹⁰⁵ to R1.6 billion in 2013/14, and are well targeted, the funding model does not support the poorest and youngest children who mostly do not access registered centres. Barberton¹⁰⁵ estimates that there are 2.6 million children aged 0-5 years in poverty quintiles 1 and 2, but that only 19% of these were subsidised in 2012. Centre provision is skewed to older children as most infants and toddlers (<3 years) are cared for at home and in informal community care. Poor children tend to be excluded from the subsidy system because of: onerous registration requirements in terms of the Children's Act, the fact that most ECD centres charge fees as the subsidy does not cover costs and, because there aren't for- and non-profit ECD centres in many poor urban and rural areas. Even when centres are registered and eligible, it does not necessarily mean that they will receive the subsidy. The PETS study in three provinces found that over 40 percent of eligible ECD centres had to wait more than two years to receive funding after registration¹⁰⁶.

Guidelines about the use of the subsidy are not included in the Children's Act and provinces have tended to apply their own breakdowns. For example, the Western Cape specifies that 50% of the subsidy is for nutrition, 30% for salaries and 20% for equipment. Eastern Cape specifies 40% for nutrition, 40% for administration including staff stipends and 20% for stimulation programmes.¹⁰⁷ Recently, the National Minister of Social Development indicated in a press statement that the subsidy is intended to be split between nutrition at 50%, staff salaries (30%) and stimulation material and administrative costs (20%).¹⁰⁸

Provinces also apply their own means test income thresholds. In 2011, the North West threshold was R1 800 per month, while the Western Cape was R3 000 per month. Similarly, though, the subsidy is calculated and disbursed on a monthly basis, provinces use different methods to calculate the monthly payments and different maximum days. The Eastern Cape calculates the amount based on number of registered children but pays predominantly on actual attendance figures, resulting in fluctuating amounts paid to centres each month. In contrast, in the Western Cape monthly payments are based on the number of children registered at the beginning of the year, making the payments stable each month.¹⁰⁹ These inconsistencies result in unequal service delivery.

6.3.4 Other services for young children that are not included in the Essential Package

There are a range of other services for young children, not listed in the Essential Package. For example, the Department of Correctional Services provides for children younger than two years to stay with their mothers in prison; the Department of Women, Children and People with

Disabilities is mandated to coordinate and mainstream policies affecting children; and young children benefit from subsidies and other support for poor families such as free housing, electricity and water.

In the provincial consultations, a suggestion was made that the Department of Agriculture also be involved in the Essential Package through food security and livelihood support. While this is a very important input for poor families with young children, we advise that the Essential Package as formulated is universally implemented and full access for all vulnerable children is achieved. Once this is done, additional elements of the Comprehensive Programme can be added to the Essential Package. For the same reason, we have not included pre-pregnancy interventions to improve maternal health (such as delaying pregnancy, planning to have a child, nutrition and health, mental health, social support and so on) in the Essential Package, despite the fact that a woman's health and well-being is a critical determinant of pregnancy health, infant birth weight and early child development.

6.4 Gaps in Essential Package services for young children and their families

As indicated above, there are four important gaps in current provisions for young children. These are services for the youngest age group of children, nutrition and the prevention of stunting, support for parenting and expanded opportunities for learning. The imperative for expansion and the subsidy are dealt with in later sections of the report.

6.4.1 The youngest age group – the first 1,000 days

Scientific evidence points to the first 1,000 days of life, from the beginning of pregnancy to the end of the second year, as a critical period in early child development. During this time the brain and other physiological systems grow very rapidly and are highly responsive to environmental influences. Importantly, during this unique window of opportunity, neural connections that are stimulated become strengthened and expand and those that are under-used fall into disuse and are pruned. **There is no going back in development, and missed opportunities cannot easily be made up. Development is sequential, and new capacities build on those that are already established.**¹¹⁰ If learning is incomplete or inadequate, the foundation for the next developmental sequence is unstable and insecure, compounding problems as development progresses. It is thus critical to ensure that children receive the nurturance and care, nutrition and protection they need in their first 1,000 days.

The care of young children can be enhanced through the following avenues:

- Improving the health of women during pregnancy and preparing them for parenthood, including the importance of exclusive breastfeeding and the capacity of infants to learn from birth
- Improving birth and post-birth care, including to prevent developmental difficulties and disabilities
- Improving early nutrition, especially exclusive breastfeeding, complementary feeding, and the early detection and intervention for growth failure
- Supporting parents to be more nurturant and protective, and to provide their children with age-appropriate nutrition and stimulation, including by early detection and services for

young mothers, women exposed to domestic violence, HIV-positive women, and women with problems of substance use or mental health

- Supporting, regulating and monitoring child minding services and early learning programmes and centres to ensure that they provide a nurturant and protective environment for young children
- Increasing public awareness of the importance of nurturant and protective care of young children and their needs for age-appropriate nutrition and stimulation.

Interventions are thus needed at the home, family and community level, in services and programmes for child care and education, and through mass and social media. Focusing on the youngest age group, pregnancy to age two years, requires a major adjustment to the current approach to ECD by DSD and DBE. In particular, it requires the development and implementation of new services and for the role of DOH in ECD to be strengthened. During this early period, children have contact with health services several times during the first year for well-baby care and immunizations, and some contact in year two, making the health system an ideal conduit for providing many of the services in the Essential Package for this age group.

6.4.2 Nutrition and the prevention of stunting

South Africa's mothers and children have a poor nutritional profile that affects their wellbeing, their future health and their capacity to contribute to their society. More detail on nutrition and the prevention of stunting is given in **Appendix 7 – Nutrition and the prevention of stunting**.

Although about 6 percent of pregnant women are malnourished (with a body mass index <18), about one-half are overweight or obese.

Only 1.3 percent of infants are exclusively breastfed at 4-5 months, and only 39 percent of children younger than five years receive vitamin A supplementation.

A quarter of young children (0-3 years) are stunted (short) because the quantity and type of food they receive does not meet their nutritional requirements to grow optimally (to reach their genetic height potential). They are not underweight and usually have sufficient carbohydrates. What is missing from their diets is mainly minerals and vitamins (so-called micronutrients and growth nutrients such as zinc, sulphur and magnesium). They are missing because many micronutrients occur in low quantities in more affordable (e.g. maize) or highly processed foods (e.g. fast-foods). It is this form of under-nutrition which causes damage to cognitive development and results in educational deficits and low productivity in adulthood. It is also associated with higher rates of chronic disease in adulthood.

Once a child is stunted, they may catch up some height during the adolescent growth spurt but, by and large, stunted children remain shorter than their peers for the remainder of their lives. It is thus critically important to prevent stunting, to respond proactively to early signs of stunting, and to provide additional stimulation and support for children who are stunted to help avert some of the cognitive deficits that accompany stunting.

Moderate malnutrition (MM) is defined as a measurement between -3 and -2 z-scores below the median of the World Health Organization (WHO) child growth standards. This includes sub-optimal weight or height for the child's age (or weight-for-height). The exact proportion of such children in South Africa is not known, but can be estimated to be about at least **a quarter of all children under five. All of these children require some form of nutritional intervention.**

In contrast to children suffering from life-threatening severe acute malnutrition, there is no need to feed moderately malnourished children with highly fortified therapeutic foods designed to replace the family diet. Nutritional interventions for MM, and children with growth faltering (stunting) should be based on emergency food supplies when needed, improving the existing diets by nutritional counselling and, if indicated, by the provision of adapted food supplements providing nutrients that cannot be easily provided by local foods. This is the approach recommended for the Essential Package. Malnourished children are treated clinically within standard protocols of care. Obesity is a public health problem and public Information, Education and Communication (IEC) approaches are recommended to address overweight.

Stunting can be prevented in the following ways:

- Low birth weight predisposes children to stunting, so the prevention of stunting must begin during pregnancy by optimising maternal health and wellbeing to **prevent low birth weight**. The low birth weight rate (proportion of live births less than 2500 g) is high at 13 percent¹¹¹
- **Exclusive breastfeeding** prevents stunting
- **Nutritious complementary foods, frequent feeding and responsive feeding** also prevent stunting. Responsive feeding involves the active encouragement of a young child to eat the necessary quantity of nutritious food frequently, by talking to child, minimising distractions, and expressing love and care. In this way, feeding is also a unique opportunity to provide language and cognitive stimulation.¹¹²
- Maximising the health of a young child through **preventive health care and immunization** against infectious diseases; regular treatment for parasitic helminth infection (worms); and hygienic home conditions to prevent infections
- **Growth monitoring** is necessary to detect early when a child starts to deviate from the normal growth curve for their age and sex and act on the information.

When children begin to drop below the growth curve for height, action should be taken to **provide counselling, micronutrients and supplementary food**. The parents, caregivers and families of stunted children need to be helped to **provide their young child with additional stimulation** to help them catch up on any cognitive, language, motor and social delays that might be associated with their poor growth.

These interventions need to be part of a comprehensive programme to improve young children's nutrition and thus their prospects for healthier growth, better educational performance and increased adult productivity. A comprehensive programme involves:

Intensified prevention efforts through (1) improved food security via food price stabilisation, income generation and social security grants; (2) local food production systems, and (3) more effectively delivered nutritional support, and (4) more and better community-based activities that require expansion and intensification.

6.4.3 Support for parenting

A parent is anyone responsible for the care and protection of a young child, who is stable in the child's life and who loves the child and wants to protect the child. A parent may be a biological, foster or adoptive parent or another primary caregiver such as a grandparent.

Infants' sensitivity to environmental influences is embodied in their dependence on parenting. Parenting determines the nurturance (physical and emotional), sensitive teaching and guidance, as well as the protection available to a young child. In turn, the quality of parenting depends on a range of resources to which a parent has access, including socioeconomic security, social support and physical and mental health. The minute-by-minute and day-by-day interactions that parents have with their young children are vulnerable to stress and parental emotional state.¹¹³ Many poor parents struggle to get by, travel far and work long days, and many are migrant workers and do not have the social support of close family. Under these conditions, parents may unwittingly withdraw emotionally from their children, seldom speak to their children or encourage them, and respond with harsh punishment to discipline their children. Promoting and strengthening parenting is a key component of improving the care, growth, health, development and wellbeing of young children.

Providing support for parents involves the following key elements. Further details are given in **Appendix 9 - Parenting.**

- Acknowledging and affirming that in the first few years of life, **parents are the most important influence on a child's physical, social and psychological development.** Further, that all parents bar those who are overwhelmed by mental illness or substance abuse, want the best for their child and do what they can to provide for their child
- Ensuring that **parents have structural supports** such as the Child Support Grant and assistance with homelessness and other emergencies
- **Providing parents with the information they feel they need** to be able to better parent their child
- **Encouraging parents** to express love to their young child, to talk to their child about what they see and experience, to ensure their child's good health and nutrition, and to protect their young child from danger
- **Counselling parents not to punish their children harshly** by beating or hurting them. Young children learn quickly when they are praised and when they are told firmly not to do something and why they shouldn't do it. Parents need guidance and assistance to use alternative forms of socialization for young children
- **Connecting parents who lack social support** to others who share their circumstances and concerns
- Ensuring parents are **referred for more specialised help** if they or their child face particular challenges, such as disability, domestic violence, mental health problems and so on.

Support can be provided in all encounters with parents if health staff and other service personnel, such as ECD Practitioners and officials in DHA and SASSA, understand the importance of parenting. In addition, parenting support can be built into clinic and home visits, and community programmes. Mass media approaches are needed to raise awareness of the importance of parenting among the general public. There is now encouraging evidence that interventions provided by non-professionals at the community level, either through home visits or small groups for identified high risk groups, are effective for a number of family and personal challenges. Successes with these approaches have been demonstrated with, among others,

maternal and child health,¹¹⁴ maternal depression and exposure to interpersonal violence,¹¹⁵ psychological distress,¹¹⁶ parenting,¹¹⁷ and HIV positive women during pregnancy.¹¹⁸

Support for parents is also provided by **screening and referral for social problems**, including maternal mental health, substance abuse, exposure to violence and child abuse and neglect.

6.4.4 Screening, support and referral for maternal mental health, substance abuse, exposure to violence

A large number of caregivers in South Africa live in adverse conditions and experience a range of challenges that may diminish their ability to provide appropriate and responsive care, to promote early child development and to parent effectively. Adverse circumstances are related to material deprivation, low levels of education, unemployment, social isolation, mental and physical illness, and domestic violence.

In particular, caregivers in South Africa face the multiple epidemics of HIV, alcohol and substance abuse, and domestic violence, as well as poor access to basic services, educational opportunities and the formal labour market.¹¹⁹ Poverty is closely related to these factors or compounds their effects,¹²⁰ contributing to caregiver stress which may in turn impact negatively on child development. The impact and extent of these conditions is evident in the following statistics:

- South Africa has the highest documented rate of Foetal Alcohol Syndrome (FAS) in the world. Rates are as high as 41-74 per 1,000 children¹²¹
- South Africa has the highest number of estimated persons living with HIV globally, 5.8 million persons, and the prevalence rate amongst pregnant women using public health facilities was 29.5 percent in 2011¹²²
- It is estimated that South Africa will be home to 2.2 million children who have lost one or both parents by 2015, many of whom will be in the care of elderly grandparents as well as young adults¹²³
- Community-based epidemiological studies show high rates of depression amongst pregnant and postnatal women, ranging from 35-47 percent.¹²⁴

All parents require some support to cope with the demands of child-rearing, often provided by family and other community networks. Where support networks are sparse or disrupted, or caregivers' circumstances are particularly severe and render young children at risk, interventions become necessary.

South Africa has a very high rate of maternal depression, which is frequently undetected. Currently, there is no routine screening or treatment of maternal mental disorders in primary care settings in South Africa.¹²⁵ Antenatal care coverage is high but is focused on physical examination, while post-partum services concentrate on the health and development of the infant. The Department of Health is in the process of establishing primary health care outreach teams at ward level who will interface with vulnerable households, communities and health facilities in order to deliver essential health care interventions, including maternal and child health services. Early identification and referral for caregiver mental health concerns will be vital activities. While social services for vulnerable caregivers are legally mandated, service delivery is of variable quality and only a small number of vulnerable caregivers are reached.

A few non-profit organisations are implementing programmes to support vulnerable caregivers and offer general counselling. Support programmes are primarily delivered through home-visits or group-based activities conducted by non-professional practitioners. The Philani Mentor Mother programme, for example, addresses a range of risk factors including maternal and child health, the early mother-infant relationship and maternal mental health. The programme has been shown to benefit caregivers significantly, improving health promoting behaviours and reducing risky behaviours such as alcohol consumption.¹²⁶

A recent systematic review¹²⁷ of psychosocial interventions delivered by non-mental health specialists (including lay persons and community health workers) for preventing and treating common perinatal mental disorders in middle-income countries concluded they were effective and reduced mental health symptoms. Some characteristics associated with effective interventions are:

- Psychological rather than health promotion interventions showed greater effects
- Benefits were greater when delivered during pregnancy and post-natally rather than during pregnancy only
- Both group and individual interventions were associated with improvements in symptoms
- Multiple contacts or sessions events are required. The Sobambisana evaluation found that visits every two weeks over 12 months to vulnerable caregivers improved their coping abilities.

While public health services do not offer routine mental health screening, an initiative has been developed in the Western Cape, known as the Perinatal Mental Health Project (PMHP) for the integration of maternal mental health screening and support services into existing antenatal care services at four maternity units.¹²⁸ This service offers a specialist approach to mental health conditions.

Screening for mental health conditions peri-natally is an important first step toward providing effective mental health care. The Edinburgh Postnatal Depression Scale (EPDS) is widely used to screen for depression during the perinatal period. A self-report 10-item instrument, it has been used in multiple languages and in rural and urban settings in South Africa. Shortened versions of the instrument (3- and 5-item versions have been tested in rural contexts. The shortened versions showed sensitivity and reliability, coupled with the brevity, they could be used for widespread community screening.¹²⁹

Key recommendations from the available literature to improve access to support services for parents and caregivers are:

- **Improve screening, support and referral for maternal mental health conditions, substance use and exposure to violence during pregnancy and post-natally.** This could be done through the provision of appropriate counselling, inclusion in community support groups, individual home visiting, and referral of especially vulnerable caregivers through community health workers and other cadres of community-based practitioners to more specialised services at primary health facilities.
- **Make referrals to social services** and appropriate community organisations where violence and abuse is detected; similarly referrals for support and treatment in the event of substance abuse and dependency.

6.4.5 Women's exposure to domestic violence

Domestic violence, which includes psychological, physically and/or sexually abusive acts, is a common phenomenon in South Africa, with gender-based and intimate partner violence (IPV) considered the most common form of domestic violence. With a prevalence rate of 8.8 per 100,000 among women aged 14 years and older, South Africa has the highest known rate in the world.¹³⁰ Findings from a 10-country study¹³¹ (several of which are LMIC countries) show that the effects of IPV are wide-reaching, affecting both physical and mental health. In South Africa, studies have similarly found that women who have experienced IPV have a much higher prevalence of depression, post-traumatic stress disorder, binge drinking and suicidal tendencies.¹³² A range of forms of gender-based violence are associated with mental health problems, including non-partner rape, emotional abuse, sexual and physical IPV.¹³³ Alcohol use is found to be closely intertwined with violent acts, for both the victim and perpetrator.¹³⁴

Critically, there is evidence linking IPV with negative child development outcomes.¹³⁵ The quality of care, interaction between caregivers and their children, and stimulation in the home environment, significantly affects early development.¹³⁶ In addition to the impact of poor physical health, depression and other mood-related conditions may impair a caregiver's ability to engage emotionally and develop a meaningful attachment with an infant or young child.¹³⁷ Currently, there is no routine screening or treatment of maternal mental health conditions in primary health care settings in South Africa.¹³⁸

The prevention of crime, especially violence against women and children is high on the agenda of government and civil society alike. National activism and advocacy campaigns are frequent activities, and special programmes have been instituted to counter gender-based violence, such as the annual *16 Days of Activism Campaign on No Violence against Women and Children*. The criminal justice system has special procedures in place to assist women experiencing domestic violence, including protection orders to help safeguard women from known perpetrators. The National Prosecuting Authority's Sexual Offences and Community Affairs Unit (SOCA) has established about 50 Thuthuzela Care Centres country-wide¹³⁹, one-stop facilities for victims of sexual violence where integrated services can be accessed that offer the victim support and counselling, and engage the victim with the prosecution process.¹⁴⁰ SOCA's main focus is to address victimisation of women and children, especially gender-based violence.

Police services have specialised units to respond appropriately to matters of domestic violence and child protection, known as the Family Violence, Child Protection and Sexual Offences (FCS) units at individual police stations. Additionally, about 900 victim-friendly facilities have been established at police stations to enable safe and secure environments when victims provide statements.¹⁴¹

Shelters for abused and destitute women and other social welfare responses are available. However, the service response does not match the need, and across the board, services are considered to be insufficient, with limited resources and variable quality. Services are also not distributed evenly across the country.

The Essential Package of services and support for young children provides a useful opportunity to offer care and support to abused and at-risk caregivers. Contact time with caregivers through the health, education and social development systems should be maximised and attention also given to assessing the care and protection needs of caregivers. Wherever possible, referrals for appropriate support and intervention must be made.

6.4.6 Screening, support and referral for child abuse and neglect

While it is difficult to determine the extent of child abuse and neglect in South Africa, largely due to variations in definitions, community perceptions, and ineffective monitoring and reporting systems, child abuse and neglect is considered to be widespread.¹⁴² Sexual abuse is understood to be the single largest category of abuse against children.¹⁴³

A recent study¹⁴⁴ on child homicide in 2009 found that over a third of deaths due to child abuse and neglect were the result of infant abandonment. Almost 75 percent of cases attributed to abuse and neglect concerned children under five years of age, the majority of whom were girls. The most common perpetrators of this abuse were mothers. These findings point to risk factors associated with maternal well-being, undetected mental health issues, possible substance abuse, and lack of social support.

While death is the worst outcome of child abuse and neglect, young children who experience abuse and neglect are subject to multiple psychological, emotional and sometimes physical insults that can leave a lasting effect on their growth, development and behaviour. Scientific evidence shows that deprivation and neglect, when defined as the significant absence or disruption of caregiver responsiveness, can result in cognitive delays, executive functioning impairments and inappropriate stress responses in young children.¹⁴⁵ Long-term effects discernible in adulthood as a consequence of childhood sexual and physical abuse include a range of physical and mental disorders,¹⁴⁶ as well as increased sexual risk behaviour that could render people vulnerable to HIV infection.¹⁴⁷

South Africa has a number of laws, policies and programmes promoting the rights of children and their protection from abuse and neglect, but systems and resources are limited and largely ineffectual in responding appropriately in terms of prevention, identification and treatment.¹⁴⁸ The Department of Social Development has established protocols for the reporting of abuse and neglect, investigative procedures to verify abuse and neglect and to ensure the safety of at-risk children, and provision for psychosocial services to affected children. A lack of human resources is the major barrier to ensuring a responsive and efficient system, particularly for social welfare services. Costing of the Children's Act estimated that some 16,000 social workers would be required by 2010 for children's social services, at the lowest level of implementation.¹⁴⁹ The current number of registered social workers is about 11,500, with fewer than half of these estimated to be working in the public service.¹⁵⁰ Training initiatives are in place to increase the capacity of social service professionals, and DSD is developing a Risk Assessment Tool for social workers to enable appropriate risk assessment of vulnerable children. The DSD has also initiated a Child Protection Surveillance Survey to determine the incidence of child abuse and neglect and to establish regular surveillance mechanisms. Fieldwork for this project began in 2013. The NPO sector is extensively involved in service provision with community volunteers rendering services to vulnerable families and affected children.¹⁵¹

Long-term solutions must address the systemic social problems that underlie child abuse, as well as strengthen services to affected children and families. Prevention strategies are key, and must be based on an understanding of the interaction of risk factors at the individual, family, community and societal levels.¹⁵²

Activities critical to preventing child abuse and neglect are:

- **Information, education and communication strategies** to strengthen norms against harsh punishment

- The **scale-up of parenting programmes**
- Providing additional support to **assist vulnerable caregivers**, including mothers with substance abuse and mental health problems, and women subjected to domestic violence¹⁵³
- Such services should **promote the strengthening of family relationships** and non-violent forms of conflict resolution.¹⁵⁴

There are a number of issues in the identification of child abuse and neglect, and improving services to respond to affected children:

- Identifying risk and protective factors for children and families likely to be at risk of exposure to violence, abuse and neglect is an important diagnostic step. The DSD's Risk Assessment Tool may be useful for individual assessments, although it is likely to be resource-intensive and it may not be feasible to implement an individual screening process at a national level.¹⁵⁵
- Training and awareness-raising amongst practitioners providing services to young children is crucial, particularly awareness of unexplained injuries and as well as duties to, and procedures for reporting suspected abuse and neglect.
- The efficiency of current systems must be improved, particularly the response time for the provision of psychosocial support to affected children. Availability of these services can be drastically improved by recognising and deploying social service practitioners – other than social workers – who with the appropriate training, can competently provide psychosocial support to affected children and families. This approach was adopted with South Africa's commitment to a developmental approach to social welfare; however, progress in this regard has been very slow.¹⁵⁶

6.4.7 Prevention of and support for children with developmental difficulties

There is an absence of data on the prevalence of child disability. Using Census 2001 data,¹⁵⁷ 436,123 children, or 2.5 percent of the total child population (i.e. under 18 years of age), were reported to have some form of serious disability. Taking into account population growth over the last decade and assuming disability prevalence has remained constant, this implies that there are some 474,000 children living with severe disabilities in South Africa today, about a quarter of whom are younger than five years of age.¹⁵⁸ In addition, many more children may have mild to moderate disabilities. Children in rural areas were more likely to be reported to have some form of serious disability (2.7 percent) than children in urban areas (2.3 percent).¹⁵⁹

An estimated 40 percent of disabilities affecting children are due to preventable causes, i.e. birth asphyxia, infections etc.¹⁶⁰ Available data on the number of children in early childhood development (ECD) facilities is not consistently disaggregated by disability status. Analysis of the profile of CDG beneficiaries found that only 24 percent of children aged 0-6 years who were recipients of the CDG attend a crèche or child-minding group.¹⁶¹ At the end of March 2013, 120,000 children were receiving the Care Dependency Grant, valued at R1,260 per month.¹⁶²

Despite an array of policies and strategies aimed at improving access to services and guiding service planning and implementation, there is a disproportionate lack of concrete laws and programmes obliging any specific government department or agency to budget for or to ensure provision of services to children with developmental difficulties and disabilities.¹⁶³ This results in services that are fragmented and often marginalised due to a lack of funding and subject to

competing priorities.^{164,165} More detailed information is given in **Appendix 9 – Developmental difficulties and disabilities**.

The major barriers and challenges are:

- Currently no specific disability policy focuses on young children, particularly addressing inclusion in ECD
- Inadequate alignment of policies to strategic and implementation plans of national and provincial government Departments
- Government departments still work in silos and services are not coordinated and integrated, where feasible. At a local level, some efforts have been made to promote early development among young children with disabilities. With no additional financial or human resource investment, most districts in Gauteng have implemented targeted ECI programmes.¹⁶⁶

Three issues merit special consideration: prevention, education and inclusion:

Prevention

Primary prevention of developmental difficulties and disabilities is integral to child survival and child health, and strengthening existing antenatal, obstetric and postnatal care would improve preventive efforts.

Secondary prevention, to avert cumulative disability, involves screening and detection of developmental difficulties and disability in children within the primary health care (PHC) setting, often during immunisation visits. The new Road-to-Health booklet provides an opportunity for early detection and referral. It includes a simple monitoring chart that clinic staff can use to track children's progress in relation to developmental milestones (see also **Appendix 10**).

With respect to tertiary prevention or support, the World Health Organisation has recommended the use of a counselling approach where there are no integrated, readily available and accessible early intervention services.¹⁶⁷ This builds on the Integrated Management of Childhood Illness (IMCI) counselling process, by including a Care for Child Development (CCD) module. Incorporation of this module into the national IMCI strategy is currently under consideration by the National Department of Health.

Education

Efforts to implement a standardised assessment protocol in South Africa's education system are ongoing. In 2008, the Department of Education launched the National Strategy on Screening, Identification, Assessment and Support (SIAS). It serves as an assessment tool that assists educators in determining the nature of a child's disability in terms of educational support needs. Training of educators in the use of the SIAS assessment tool started in 2007, and to date over 28,000 educators have been trained.¹⁶⁸ There is currently no SIAS equivalent available for children accessing early care and education settings. There is no information available on whether children in Grade R which are attached to primary schools benefit from SIAS.

School health services are considered an essential element of "Primary health care re-engineering" (as part of the National Health Insurance plan) that must be delivered to every school in the country, targeting all children attending learning sites, including children with special needs. Initial assessment of learners is at school entry, which is mainly Grade 1, although

children in Grade R facilities attached to schools may also benefit from these assessments. No equivalent national screening programme exists for younger children.

Inclusion

There is no policy guidance for the promotion of inclusion in ECD services and programmes, which cuts across sectors. For example, the development of systemic support structures, an inclusive ECCE curriculum, practitioner skills development and training, funding to support inclusion etc.¹⁶¹ Many of the young children with disabilities who have some access to early learning programmes are cared for in informal community settings or care centres, with individuals (such as mothers of disabled children) running stimulation programmes.

Community-based rehabilitation (CBR) has been identified as a key strategy for addressing the needs of children with disabilities, and thereby promoting inclusion, in low and middle income countries.¹⁶⁹ CBR programmes have been implemented in South Africa for many years and have shown benefits. Currently, there is no comprehensive national strategy on community-based rehabilitation, and CBR programmes have dwindled due to difficulties with training, employment and retention of CBR workers.

The Care Dependency Grant (CDG) is potentially a positive tool for reaching large numbers of children with disabilities and their families and providing income support. Research indicates that the CDG has a significant and positive impact on children and households that are recipients.¹⁷⁰ However, coverage is a problem because, to date, assessments to determine eligibility have been based primarily on determination of the severity of the health condition or impairment, without in-depth assessment of activity limitations, participation restrictions and/or environmental factors that may result in severe disability for the child or their family. In 2008^{171,172} there were calls to review the assessment process for access to the CDG based on a pilot study. There has subsequently been some consultation processes but the status of the progress is not known.

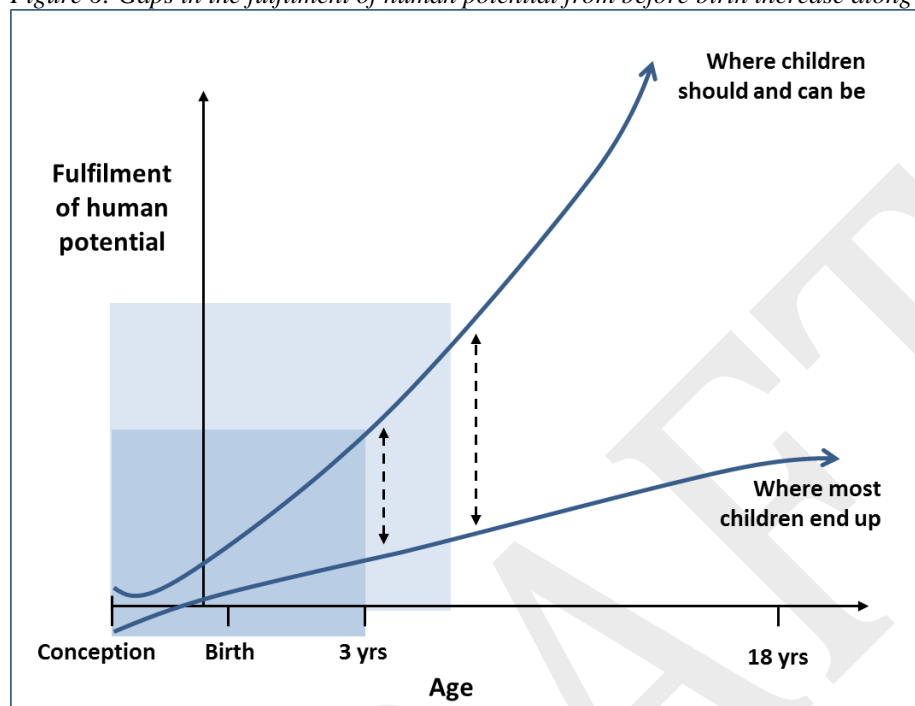
6.4.8 Opportunities for learning

All people have a unique capacity to learn, and this is what makes human beings so adaptable. Learning begins *in utero* at a biological level, for example, in terms of epigenetic changes in response to environmental challenges or altered stress responsiveness as a result of toxic stress in infancy. But language, cognitive, and emotional learning also begin before birth and brain circuitry develops very rapidly in the first two years of life.

The learning of very young children occurs in response to the people who care for them. For example, there is a very large word gap between children whose parents talk to them and children whose parents don't talk to their children; there is also a gap between parents who talk to their young child about the things the child is interested in, and parents who don't follow the attention of their child.¹⁷³ Children learn self-esteem from the way they are shown affection and valued. Most importantly, children "learn how to learn" from their experiences with parents and other intimate caregivers. Children who are encouraged to explore, who are helped to solve problems, whose questions are answered and who are encouraged to ask questions, and who are praised for their small achievements, learn to enjoy learning, and develop the confidence to try to solve problems on their own. They also ask adults for assistance when they need it. Children who enjoy these opportunities for learning in the first two years of life have a solid basis for structured learning in a group in preschool and later formal schooling.¹⁷⁴

The slope of the life-long learning curve is largely determined in the first few years of life as these basic scaffolds for learning are put into place. The fundamental problem for education in South Africa is that a large number of children do not have the scaffolds necessary to fulfil their learning trajectory. As time goes by, they fall further and further behind, as illustrated in Figure 6.

Figure 6: Gaps in the fulfilment of human potential from before birth increase along the life course



This is illustrated in the results of the Annual National Assessments, which demonstrate that the achievement gap widens as children grow older. The roots of both literacy and numeracy lie in early adult-infant communication, which promotes listening and attentiveness, understanding and speaking ability.¹⁷⁵ Yet, for most children, these building blocks are not in place by the time they reach school.¹⁷⁶

To date, the approach to early learning in South Africa has been to extend educational opportunities downwards to Grade R and now, as proposed by the National Development Plan, to a pre-Grade R year). While two preschool years are important, a programme for 0-3-year-olds and their parents must be developed at the same time. The two reasons for this are:

- **The learning skills children need to benefit from preschool experience develop from birth**
- Without improving these early learning experiences with parents and in the home, the anticipated benefits of extending the preschool programme to two years will be significantly diluted.

Recognition of this is shown in the efforts of DBE and DSD to develop the *content* of programmes for 0-4 year olds. This is being done through the National Early Learning and Development Standards for Children 0-4 years, the National Curriculum Framework for Children 0-4 years currently under review, and the DSD's Parental/Primary Caregiver Capacity Building Training.

A number of approaches are needed to improve early learning, starting from pregnancy (see **Appendix 11 – Opportunities for early learning**):

- There must be a continuum of services to support early learning, starting with parenting support, awareness raising and education during pregnancy and extending through Grade R into school.

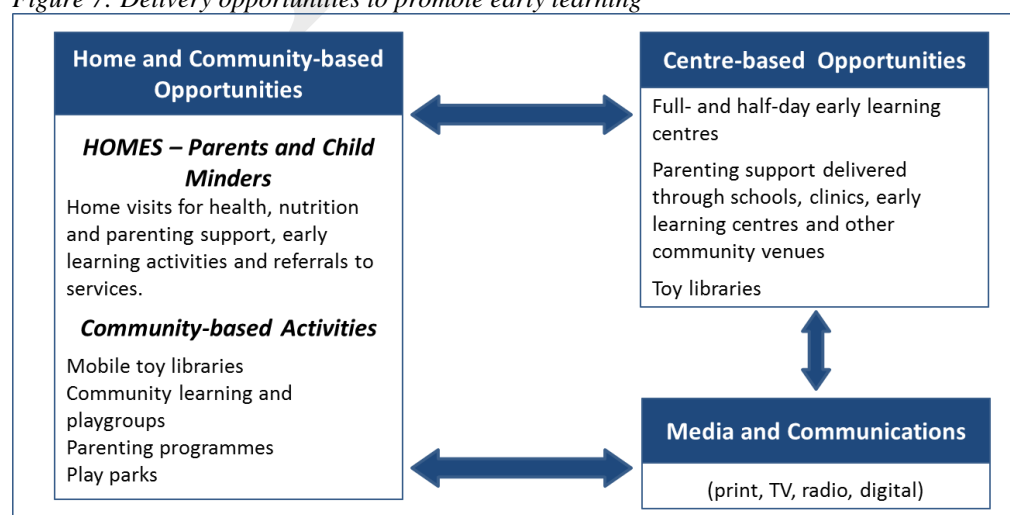
Parents must know that they don't need specialised knowledge or bought toys to teach their young child. Their child learns from parents' loving behaviours that they are worthwhile and that they are valued and cared for; they learn about objects and events from what parents show and tell the child; they learn language and numbers from how parents talk about ordinary things; they learn about reading from pictures they're shown, the descriptions they're given and looking at print while parents read out loud to them, and children learn self-control and respect for other people by the way parents behave, how parents explain to children what is wrong and how children are expected to behave.

- A mass communication strategy is needed to enable parents to play an effective role in their children's learning, and to promote parents' talking, telling stories, singing and reading to young children from birth. Everyone who comes into contact with a newborn baby, a 6-month-old, an 18-month-old or any young needs to know that the child is rapidly learning about the world, other people, and themselves every moment of the day. Young children learn by watching, hearing, feeling, smelling and tasting, they learn by imitating actions of the adults who care for them, and they learn from the way adults respond to their communication and behaviour.
- A system of programme support must be developed that includes all aspects of children's development and learning. In particular, there is a need to stimulate concepts and skills that are the foundations of reading, writing and maths.¹⁷⁷
- Systems to improve practitioner training, in-service development and support, quality management and provision of early learning and training support materials in early learning centre- and community-based programmes.

6.4.8.1 Providing early learning opportunities in the home, community and early learning centres

Support for early learning must begin as early as possible and any strategy to do so needs to use multiple opportunities to access both parents and young children. Figure 7 summarises promising strategies for facilitating early learning opportunities in different settings.

Figure 7: Delivery opportunities to promote early learning¹⁷⁸



Early Learning in the home: Support for parents and child minders

For children birth to two, parents and other primary carers are the most important facilitators learning. Currently the majority of this age group are cared for at home. Approximately 30 percent of women with children of this age engage in some economic activity; many of their children would be in the care of relatives and domestic workers in the child's home. Ununknown proportion are in the care of paid child minders who care for fewer than six children in the child minder's home.

There is almost no provision of programmes to support early learning at home or in child minding. For this group, it is important to create awareness of the importance of the caregiver's role and provide encouragement and guidance for supporting children's growth and development.¹⁷⁹

Parent and parent-child group have the benefit of social support for carers as well as providing information, service links and early learning activities for young children. Groups may include a toy making session, information about child development and/or a programme of learning and play activities. The opportunity to engage with concept toys and books, scissors, drawing and painting through these programmes gives children helpful experience in preparation for the school environment later on.

Home visiting is a useful delivery strategy for reaching out to vulnerable caregivers who are less likely to attend group sessions. Research indicates the following characteristics of home visiting and other parent/child programmes are associated with better outcomes:¹⁸⁰

- Interventions that involve direct activities with the child and training with the parent, plus joint activity with both
- Parental participation needs to be active, engaged and regular, normally over extended periods.
- The relationship between participant and programme staff needs to be stable, warm, supportive and uncritical. When parents/caregivers feel valued and supported as people in relation to their own needs as well as a focus on child development and parenting information.

Home visiting and parent/child groups should be extended to support child minders who care for small groups of young children in their home. This would be a relatively simple way to upgrade a widespread form of child care and add an early learning component to what is often purely custodial care. Child minders also require support and information about caring for other people's children for pay, including meeting norms and standards, administration, relations with parents, reporting on child progress, emergency arrangements, and so on.

Early Learning in centre- or community-based group programmes

From two years on child benefit from facilitated interaction with same-aged peers, and from 2-3 years children benefit from structured learning experiences in small groups that prepare them for formal schooling. In group learning experiences children acquire social and sensorimotor skills as well as emerging language and maths capacities. These learning experiences are less prescribed than formal instruction.¹⁸¹ Learning programmes for children that include partnership with parents have been shown to have the best outcomes.¹⁸² Learning programmes are effective in promoting cognitive and language outcomes when they are of sufficient quality.

Group programmes can be offered in the form of playgroups, or more formal part- or full-day centre programmes. Community-based learning or play groups or part- or full- day centre programmes are ways of providing group experiences. In the short term, mobile learning and play groups are a way of reaching children in areas without facilities. Toy and book libraries play an important role in providing for a varied range of materials for use in learning and play groups and in early learning centres.

The curriculum for this age group is based on the NELDS which specifies desired outcomes but is too general on its own to guide the programme. The lack of an approved curriculum for this age group has been identified as one of the reasons for the poor quality of much centre-based provision.¹⁸³ The draft Curriculum Framework 0-4 years, when finalised, is intended to provide greater direction. It is important to ensure that the 0-4 curriculum links clearly to the Curriculum and Assessment Policy Statements (CAPS) curriculum for Grade R to allow for progression and smooth transition.

7.0 Rapid expansion of the ECD Essential Package to ensure universal availability and equitable access

There are many examples of small scale intervention programmes and pilots showing the benefits of early interventions, including in low and middle income countries.¹⁸⁴ The majority of these programmes were designed as efficacy trials; that is, to test an idea, such as whether a particular intervention “worked”. For example, does preschool attendance improve educational achievement;¹⁸⁵ or does home visiting improve child health and development and maternal life choices among teenage mothers.¹⁸⁶ Undoubtedly, most of these studies, including those in low and middle income countries, have produced greater or lesser positive results.¹⁸⁷ However, they are generally very small scale and very resource intensive. The key difference between an efficacy trial and a national or state-wide programme is that the latter is conceived, from the start, as population-based. That is, its intention is to achieve equity by providing services for all eligible children even if it is not able to do so from the very start.

The programme structure and systems for delivering the Essential Package must achieve universal coverage with measurable impact on children’s growth, health and development. A good place to start is by trying to learn from the structure and delivery systems used in programmes across the world that are population-based, have achieved scale with some indication of success, and have proved to be sustainable. Examples of these programmes are given below (see **Appendix 11 – Learning from international experiences of going to scale**).

7.1 Population-based international programmes at scale

The Integrated Child Development Service (ICDS), inspired by Head Start in the United States, was started in India in 1975 to improve the health, nutrition and development of preschool children by improving the capacities of mothers. It is now the largest child nutrition and development programme in the world, reaching some 8 million pregnant women and 39 million children under six years of age. The main services provided are growth monitoring and supplementary nutrition; encouragement for immunization, health check-ups and preschool enrolment; nutrition education; and early stimulation for learning.¹⁸⁸

Early Head Start in the United States, and later Early Head Start, emanated from the sentiments of the War on Poverty expressed in Lyndon B. Johnson’s 1964 State of the Nation address. The program was designed to help break the cycle of poverty, providing preschool children of low-income families with a comprehensive program to help meet their emotional, social, health, nutritional and psychological needs. Early Head Start (EHS) grew out of Head Start in 1994 as a two-generation program to provide services for preschool children and their families. Within eight years of starting, by 2002, EHS was serving 55,000 children in 664 communities. Despite doubling that number to more than 120,000 in 2010, Early Head Start only reaches about 4 percent of eligible poor children.¹⁸⁹ EHS operates as a quasi-franchise in that eligible agencies apply for financial assistance for a period of five years to conduct, administer and evaluate a program focused on low-income children, targeted as locally agreed, and that meets the basic tenets of the programme.

Sure Start in the United Kingdom (SS) was initiated in 1998 by the Labour Government as part of its Comprehensive Spending Review, including also Wales, Scotland and Northern

Ireland. It is similar in some ways to Head Start USA and Head Start Australia. SS was launched to be large scale and to target geographic areas of disadvantage. It was intended to “join up government” and “join up thinking”. The foundational principles were “to give every child the best possible start in life”, by improving child care, early learning, health and family support, especially through outreach activities and community development. Initially, and for about 10 years, SS was centrally funded, but then responsibility was transferred to local authorities with the intention of establishing a SS centre in every community (3,500 centres by 2010). The reach of SS is impressive – 94 percent of families take up their entitlement of up to 15 hours per week of free nursery education for 3-4-year-olds.¹⁹⁰

ECD Programmes in Latin America. Many pilot ECD programs have been developed in Latin America during the past 35 years. Programmes continue to proliferate and several are at national scale: Chile (Educational Foundation for the Integrated Development of the Child; Colombia (Families in Action), Honduras (Integrated Community Attention to Children (AIN-C) and its Project for Nutrition and Social Protection), and Mexico (*Oportunidades*)¹⁹¹

Chile: Junta Nacional de Jardines Infantiles (JUNJI) is a public-sector preschool program that began in 1970. JUNJI has successfully gone to scale and continues to expand its coverage. It serves urban, peri-urban, rural and indigenous families living in poverty and focuses on serving at-risk children and those with developmental delays. With a combined strategy of parent education, child-centered early education, and support for working women, JUNJI’s services include parent education and support, early stimulation, nutrition services, child assessments, early childhood intervention (ECI) services for children with delays and disabilities, crèches and preschool education, transition to primary school, and community participation.¹⁹²

Colombia: Families in Action. Founded in 1999, Programa Families in Action is a conditional cash transfer programme located in Colombia’s Directorate of Presidential Programs within the Presidential Agency for Social Action and International Cooperation. It was developed by the National Department of Planning in collaboration with the World Bank, and it is based on the Mexican CCT program *Oportunidades*. A pilot project was first conducted in 22 municipalities to field-test the program design, then it was scaled up to cover more municipalities until now it is close to achieving national-level coverage. The programme is based on a demonstrably effective psychosocial stimulation programme.¹⁹³ Families in Action targets pregnant women and mothers with young children younger than seven years¹⁹⁴.

Expansion of Grade R in South Africa. The substantial roll out of Grade R in South Africa provides pointers for scale up of services for younger children. Between 2001 and 2012 the number of children in Grade R classes in public and independent schools grew from some 240,000 children to nearly 768,000.¹⁹⁵ The clear policy intention that Grade R would be the first year of compulsory schooling as early as 1995 was a major political driver for scale-up and illustrates the importance of policy. This was followed by the Education White Paper 5: Early Childhood Education (2001) and Norms and Standards for Grade R funding in 2012. Scale up was facilitated by the relative simplicity of the intervention, being situated in the education system with funding, infrastructure and staffing, as well as age-related universal provision so that there was no complexity in terms of targeting (though funding formulae positively discriminate for poor children). Access to Grade R classes has been very successfully scaled up with very high enrolment rates in the poor rural provinces of the Eastern Cape, Limpopo and KwaZulu-Natal, illustrating the fact that it responds to family need and demands, as well as the benefits of building on existing service systems. However quality remains a major challenge,

with staff largely underqualified, infrastructure is often unsuitable and materials lacking.¹⁹⁶ There are a number of current initiatives to remedy this,¹⁹⁷ but the key lesson is to address quality at the same time as scale up.

7.1.1 Characteristics of international programs at scale

7.1.1.1 Programs in high-income countries

A review of 10 large scale (national or state-wide) programmes in the United States, Canada, Australia and the UK shows that they have common foundational, implementation and service features that can serve as a model for the South African programme.¹⁹⁸

Foundational features include: political commitment to the welfare of children, social quality, poverty eradication and/or social inclusion; a comprehensive approach to children and families (“whole-of-government”; “joined-up-thinking”; the “whole child”); foundation for statute; responsibility accorded to a senior lead government department or agency, working in collaboration with other departments as well as civil society organizations; and state funding, together with private sector contributions.

Implementation features include: communication and participation; outsourcing and/or franchising of local service delivery; locally responsive programming; and quality standards set by government.

Service features include: local programme content informed by, amongst others, parents and families; mass communication, parenting support, financial assistance, health, nutrition, child care, and preschool preparation; parent and family involvement is central, and programs offer both universal preventive services to strengthen parenting and early childhood development, as well as targeted intervention services for vulnerable and at-risk children and families.

7.1.1.2 Programs in Latin America

Many of the characteristics of scaled up programs in high-income countries are shared by scaled up programs in low- and middle-income countries. However, the 2009 review by Vargas-Barón of 10 national programs in Latin America offers some insights of particular relevance to South Africa’s efforts to provide a package of essential ECD services to all children.

- Cultural relevance. Abundant field experience in many world regions has shown that ECD and parent education programs will fail if they are not culturally competent and do not fit local patterns of childrearing and care. Participants rapidly sense if program contents do not meet their cultural expectations and do not fit their cultural values and cognitive domains. They “vote with their feet” and rapidly leave such programs (p. 21). To develop educational programs well, program curricula, materials, teaching/learning methods and media need to be prepared, field-tested, revised, produced and applied flexibly.
- Training systems are essential. Training needs to include both pre-service and frequent continuous in-service training combined with supervision, monitoring and evaluation.
- Program development processes are critical - including baseline studies and situation analyses are conducted to ensure the program meets child and family demands and needs and is well targeted; objectives are clear and appropriate; organizational structures, roles and responsibilities are well defined; program delivery system is well structured and effective at all levels; program leadership is clearly established and well linked with other entities; internal coordination system is strong; personnel structure is developed with roles

and responsibilities specified; process for selecting families/children is well developed and functional; geographic coverage plan is keyed to program objectives; personnel training system (pre- and in-service) is well developed and functional; efforts have been made to ensure the program is culturally competent, flexibly fits the local culture and meets local needs; educational contents, materials, methods and media are selected or designed and field-tested and can be produced and distributed at scale; supervisory system is well elaborated and effective; evaluation and monitoring system is designed and field-tested; financial and accounting system is sound; program feedback and revision system is developed and used for program improvement and growth over time; communication system with program participants, communities and nation is designed and implemented.

- Community participation includes community authorities and organizations that help the program establish itself and provide program services; help to provide educational activities; members are selected by the community to be trained as mother educators, monitors, promoters, or community representatives who provide direct services to children and families; community members help to identify potential participants and conduct outreach activities; community members conduct program advocacy activities to support local services; community members conduct program oversight (evaluation, social accountability, oversight) and communities donate program service sites and help to maintain them.
- Approaches to achieving sustainability involve the following strategies: achieving child and family outcomes that meet parents' goals and needs; having policy support and a legal basis for the program; attaining strong community involvement and support; providing good program management at all levels; obtaining stable and secure funding.

Recommendations from the review of Latin American scaled up programs:

- **Begin with prenatal to age three**
- **Target vulnerable groups** e.g. children living in poverty and in rural communities
- **Conduct mapping exercises for program development** to ensure that targeted participants actually access and utilize services
- **Ensure programs are child-centered and family-focused**
- **Employ all modalities** appropriate to achieve stated results. Both home visiting and group sessions should be used.
- **Ensure children are screened and assessed** as needed. Significantly more attention should be given to developing low-cost, effective systems of combined nutritional, health and developmental screening, assessments, tracking and follow-up services, especially for vulnerable children and high-risk parents.
- **Provide ECI services.** ECD services that serve children with developmental delays, malnutrition or disabilities should provide more intensive, individualized, content-rich, family-focused and continuous services to help vulnerable children achieve their full potential.
- Include **community and parent participation** in programs

- **Establish well-articulated personnel structures.** Use professionals at national, regional and municipal levels who are experienced in providing technical support, supervision and training workshops for local service providers. They are essential for expanding services and improving program quality.
- **Design sustainable volunteer systems.** To become sustainable, it appears that volunteer systems require strong community organization, many incentives, and frequent in-service training and technical support to guide them over time. Volunteer turnover remains a critical issue in all places using volunteers as mother educators, community educators or child caregivers. Consideration should be given to providing basic fees to such volunteers to enable them to support their own families while assisting others.
- **Use existing agency structures and coordination systems** to the extent possible. If ECD programs decide to use existing coordination systems, then structural roles, responsibilities and coordination activities should be clearly designated. However, to provide fully integrated ECD services at the local level, several large-scale programs found it necessary to develop new national, regional, municipal and community structures.

Develop bottom-up and horizontal as well as top-down coordination systems. Vertical and horizontal coordination processes and contents should be developed at all levels: national, regional, municipal and local. Horizontal coordination is particularly important for sharing innovations widely and rapidly.

- **Develop culturally competent programs.** Programs should seek to build on and derive key components from positive cultural traditions and practices regarding child rearing, especially including the preparation of outreach systems, curricula, educational and training manuals, materials and methods.
- **Prepare a plan for scaling up the program.** Unless the program is a part of a large preexisting system into which it can develop its services, it will require at least two to three years to pilot its initial services. Geographic and population coverage should be expanded slowly and cautiously, with attention given to consolidating core systems and building institutional capacity for growth.
- **Prepare all components needed for scaling up the program.** For a program to go to scale and be replicated in communities throughout a nation, it should plan, field-test, revise and produce all essential program components.
- **Design, field-test and continuously upgrade pre- and in-service training systems.** To go to scale, programs should develop training systems and program management manuals such as specialized manuals for home visits, assessments and screening, group sessions, child care and preschool education, evaluation and monitoring, program administration, and financial management. These training systems should be flexible and should feature continuous internal evaluation and revision in response to changing community and program needs.
- **Maintain a spirit of innovation and openness to change.** To achieve sustainability, ECD programs should purposefully foster continuous innovation and guided change for improvement through activities such as developing and modifying educational contents, materials and methods; conducting internal monitoring and evaluation and external evaluations; utilizing participatory processes that include program participants; providing continuous training and upgrading of personnel at all levels; revising management,

regulations and standards to meet evolving needs at all levels; and collaborating with and conducting horizontal coordination and in and inter-site exchanges nationally and internationally.

These recommendations from long experience in Latin America **provide a blueprint for a 2-3 year preparatory period for the development of the Essential Package roll-out in South Africa**, starting with design and ensuring sufficient pilot work prior to full national implementation.

7.2 Strategies for the expansion of services

Universal availability involves strategies for expansion that achieve the primary purpose, **to provide essential support for the early development of all South African children**, ensuring that poor and vulnerable children have equitable access to all elements of the Essential Package

Chosen strategies must acknowledge the following challenges:

- The current severely uneven distribution of services for young children
- The need to develop new services for the EP
- The imperative for rapid development and expansion of services into under-serviced communities and for under-served children
- Options for joining up services among government department and between government and the for- and non-profit sectors.

7.2.1 The uneven distribution of services for young children in South Africa

There are some 5.3 million children under five years of age in South Africa, close to a million at in each yearly age group.¹⁹⁹ Of these, some 65 percent live in poverty as determined by the fact that they qualify for the Child Support Grant.²⁰⁰ While it is the goal for all children to have access to the Essential Package, it is critical that the implementation strategy reaches, in particular, poor children, children who live at a distance from current services and marginalised groups such as parents and children with disabilities and developmental difficulties.

The current Department of Social Development provision for ECD is to provide subsidies for children younger than 5, whose parents are income-eligible, attending a registered early learning centre run by a non-profit organization. According to the 2001 ECD audit, the vast majority of these centres also levy fees. This means that current ECD provision in South Africa is highly inequitable, and the consequences of this inequitable provision contribute further to social inequality.

The inequitable provision occurs because:

- Very few children younger than three years of age attend an early learning centre, and it is critical to ensure protection, nutrition, care and opportunities for learning for children from birth onwards, especially during the first two years of life.
- All early learning centres and programmes are built, owned, rented and/or run by for- or non-profit organizations. The centres are required to meet local government standards and be registered as a non-profit organization and as a partial care facility with the national

DSD before they can receive a per child subsidy. Thus children attending better provisioned centres or centres with better infrastructure are benefiting from the subsidy.

- The majority of registered non-profit centres and services charge fees for attending children, the children whose families cannot afford fees do not benefit from the subsidy.
- Registered for- and non-profit centres and services cluster in urban areas. This means that many children in rural areas do not have access to safe child care and opportunities for learning.

There has been a significant increase in the number of subsidies for children over the last six years, and the ECD Diagnostic Review estimated that, under the current ECD provisions, some 467,000 children receive income means-tested subsidies in about 18,826 registered centres. But the youngest children (0-3 years of age), children living beyond the catchment area of a centre or programme, and children in families that cannot afford fees do not benefit from the current government subsidy provision. In fact, the ECD Diagnostic Review estimated that 80 percent of children 0-4 years in the poorest 40 percent of households have no access to any form of out-of-home care, including early learning centres and programmes.

This means that the expansion of services to young children, to children living beyond the catchment area of a centre or programme, and children whose families cannot afford fees is a priority for making an Essential Package of services available to all children.

7.2.2 The need to develop new services

Currently, the delivery of different aspects of ECD is split between different departments, as indicated in the Integrated Programme of Action for ECD: Moving ahead (2013-2018), is shown in Table 3.

Table 3: Departmental responsibilities for services in support of early childhood development

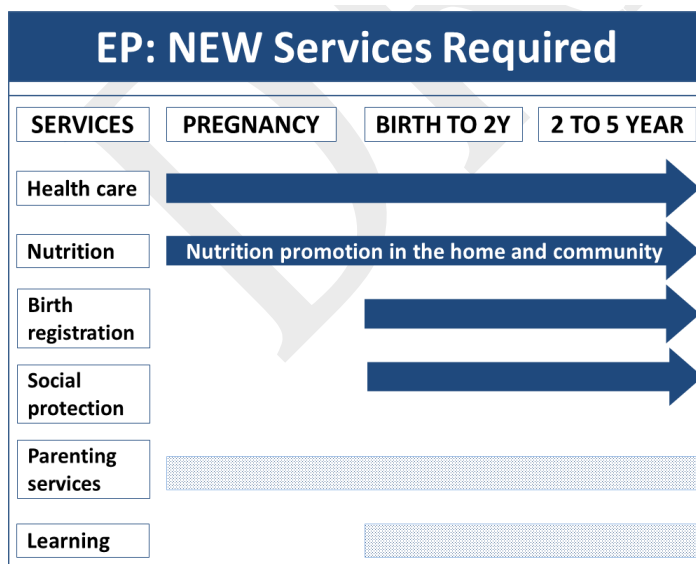
Department	Responsibilities
Department of Social Development (DSD)	<ul style="list-style-type: none"> • Lead the implementation of the National Integrated Plan for ECD • Registration and inspection of partial care facilities • Registration and inspection of ECD programmes • The Child Support Grant administered by SASSA
Department of Education (DBE)	<ul style="list-style-type: none"> • Implementation of White Paper 5 that informs ECD201 services • The curriculum for ECD pertaining to Grade R • The curriculum for ECD pertaining to children birth to 4 years of age • Development of training and stimulation materials • Training of ECD practitioners and payment of stipends to trainees • Grade R
Department of Health (DOH)	<ul style="list-style-type: none"> • Implementation and compliance of all health-related legislative mandates • Promotive and preventive health services for pregnant women and young children, including: • Immunization and growth monitoring (Road to Health booklet) • Integrated national nutrition programme • Integrated Management of Childhood Illness (IMCI) • Prevention of mother-to-child transmission of HIV (PMTCT)

Department	Responsibilities
Department of Cooperative Governance and Traditional Affairs (COGTA)	<ul style="list-style-type: none"> • Provision of child care facilities (Schedule 4 of the SA Constitution, p 149) • Implementation of by-laws regulating day care facilities and child-minding • Issuing of health certificates pertaining to child care facilities
Department of Women, Children and People with Disabilities	<ul style="list-style-type: none"> • Promoting the realization of the rights of all children across all sectors, including children with disabilities • Monitoring and evaluating progress towards realising children's rights
Department of Home Affairs	<ul style="list-style-type: none"> • Provision of identify documents, marriage, birth and death certificates
Department of Correctional Services	<ul style="list-style-type: none"> • Register mother and child units in prisons as partial care facilities • Register ECD programmes in mother and child units in prisons

The Department of Public Service and Administration (DPSA) is omitted from this list. If DPSA takes to scale its current plans to provide subsidised child care for all government employees, it will become a major player in the ECD arena.

Figure 8 shows the gaps which require new services. Health care is provided across the age band from pregnancy to early childhood, as is nutrition support though it must be considerably expanded and strengthened. Birth registration and social protection are provided from birth. Parenting support and opportunities for learning are new services to be developed and provisioned by government.

Figure 8: New services required for the Essential Package



There is infrastructure and systems for the expansion of health care, nutrition support, birth registration and social protection, and moves are afoot to achieve greater coverage and quality of services in these areas, including for potential expansion of social protection into pregnancy through a maternity grant.²⁰² There is also a framework for nutrition promotion in the home and community through the DOH *The DOH Framework for Accelerating Community-Based Maternal, Neonatal, Child and Women's Health and Nutrition Interventions*. **There is some, though not near extensive enough, provision of opportunities for learning** through for- and non-profit centres and programmes.

However, parenting support, starting in pregnancy and continuing until children turn five, and opportunities for learning for children from birth are **new services without systemic infrastructure, including facilities, professional and non-professional staff, government salary allocation or a clear departmental home**. These services fall between DSD and DBE. For example, in 2013 DSD drafted an Integrated Parenting Framework and DBE a Curriculum Framework for Children Birth to Four Years of Age. However, it is not clear how these two frameworks relate to one another, and neither has a feasible implementation plan for universalization.

7.2.3 The imperative for rapid development and expansion of services

The health services and the traditional ECD sector – child minding and early learning centres – are the natural starting points from which to rapidly develop and expand parenting support and opportunities for learning for pregnant women and their young children.

Table 4 shows estimates of the number of children 0-4.5 years (eligible age to enter Grade R), by age band, currently covered by some service, and the estimated needs for different kinds of services, either by location (health service, early learning centre, home and/or community) or by estimated risk. The numbers are based on the assumption that 65 percent of women and children (those income eligible to receive the Child Support Grant²⁰³) are the most vulnerable and the group for whom the State is obliged to provide services.

Table 4: Children by age group to be covered by the Essential Package

AGE GROUP	ESTIMATED ANNUAL NUMBER	ALREADY COVERED	TO BE COVERED
Pregnancy	900,000	97% attend antenatal services	<p><i>Home visits for pregnant women who do not attend or have poor attendance at antenatal clinics (unknown overlap)</i></p> <ul style="list-style-type: none"> • HIV-positive women (29% or 261,000) • mothers with mental health problems (+30% or 300,000)²⁰⁴ • mothers facing domestic violence (+33% or 330,000)²⁰⁵ • teen mothers (15-19 years) (12% or 108,000) • mothers with substance abuse problems (8% Foetal Alcohol Syndrome or 72,000)²⁰⁶

AGE GROUP	ESTIMATED ANNUAL NUMBER	ALREADY COVERED	TO BE COVERED
Birth - 1 year	1 million	93% at home with caregiver 7% in child minding or crèche	604,500 to be reached by home or community programmes 45,500 children • assuming 6 children = 7,600 child minders
1 - 2 years	1 million	72% at home with caregiver 28% in child minding or crèche	468,000 to be reached by home or community programmes 182,000 children • assuming 6 children = 30,000 child minders
2 – 3.5 years	1.5 million	43% at home with caregiver 57% in child minding or centre	419,000 by home and community programmes 556,000 in centres • assuming 25 children = 22,230 centres
3.5 – 4.5 years	1 million	Numbers as above ECD services indicated, but age eligible for proposed additional preschool year – pre-Grade R	280,000 by home and community programmes 370,000 in centres • assuming 25 children = 14,820 centres
4.5 years	Age eligible for Grade R	-	Policy for comment: universalization of Grade R

Figures from Stats SA, 2012, unless otherwise indicated

At risk categories among children 0-4 years: teen mother (12%), children living in urban informal areas (10%), children living with neither parent (20%)

As indicated earlier, **the so-called ECD sector is composed entirely of private and not-for-profit services.** At the moment, there is no national system for coordination towards expansion; in fact, the sector suffers from fragmentation and competitiveness. Further ECD provision in centres is limited. There are an estimated 37,000 early learning centres serving the 65 percent poorest children and families (see Table 4 above), of which only about 19,000 are registered with DSD.

The gap in subsidisation and services is huge. The current formalised “ECD system” accommodates between only 1-1.5 million of the 5.3 million children younger than five years of age (24 percent), an unknown proportion of which would not be eligible for free State services.

This makes it imperative to rapidly expand resources to provide the Essential Package to all children, beginning in pregnancy.

Close to 8,000 early learning centres or crèches must be brought into the State subsidy system. More than 1 million of the poorest children between birth and two years of age, and their families, must be reached by home- and community-based mother and child support services; and 700,000 of the poorest children two years and older need to be brought into formalised centre- or community-based early learning programmes.

7.2.4 The current distribution of services for young children

In order to understand the current topography of service provision, we provide below maps of available services for young children. In Figure 9 and Figure 10 we indicate social welfare offices across the country (n=240) from information supplied to us by DSD in August-September 2013. The information for some provinces is clearly incomplete; for example, for Western and Northern Cape. For this reason, we also provide an illustrative map for one province, KwaZulu-Natal, for which we believe we have fairly reliable data (Figure 9)

We then add ECD Resource and Training Organizations (RTO) (n=115).²⁰⁷ An RTO is a not-for-profit organization that, usually in addition to direct service provision, also offers training and in-service support to smaller community-based organizations, centres and ECD programmes (examples include Training and Resources in Early Education (TREE), Early Learning Resource Unit (ELRU), Ntataise and Flying Children). RTOs who wish to offer SAQA accredited qualification and standards have to be registered as training providers, meeting the requirements of the relevant quality assurance body (mostly, ETDP SETA and HWSSETA). Most RTOs also offer non-accredited training on different topics, including basic ECD skills.

Figure 10: National map of Social Welfare offices and RTOs (information not complete)

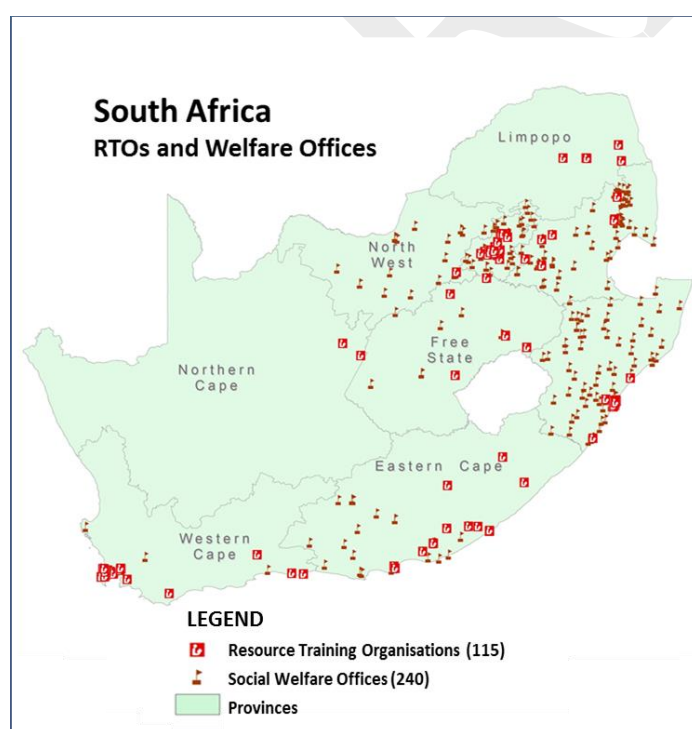
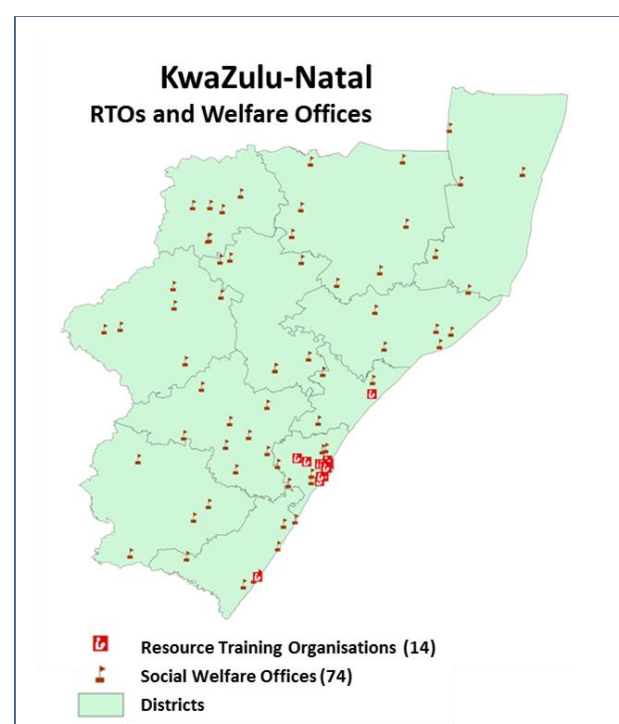


Figure 9: Map of Social Welfare offices and RTOs in KwaZulu-Natal



Despite the incomplete nature of the data, it is clear that the potential to use social welfare offices and RTOs as resources for expansion of ECD services is limited. Neither has been located with population coverage of services in mind. Building up the sector from this base will be a significant challenge. For example, despite an intensive clinic building programme by the DOH since 1994, only 1,600 clinics have been built or upgraded in 20 years.²⁰⁸ At capacity levels of approximately 25 children per centre 14,000 centres or facilities will need to be established to accommodate half of the poorest 2-4.5-year-olds currently not served by ECD centres (350,000 children, see Table 4 above).

However, services could be very rapidly expanded if they are built on, or reach out from, the established physical and managerial infrastructure of health and education. There are $\pm 20,000$ primary and combined schools in South Africa, of which about 16,634 have a Grade R class, and there are 3,236 fixed site health clinics. Figure 11 and Figure 12 show clinics and schools with Grade R (national and then for one province, KwaZulu-Natal). These maps illustrate the extensive reach of the combined infrastructure of services that could be used to reach young children and their families.

Figure 12: Social Welfare offices, RTOs, primary schools with Grade R and clinics in KwaZulu-Natal

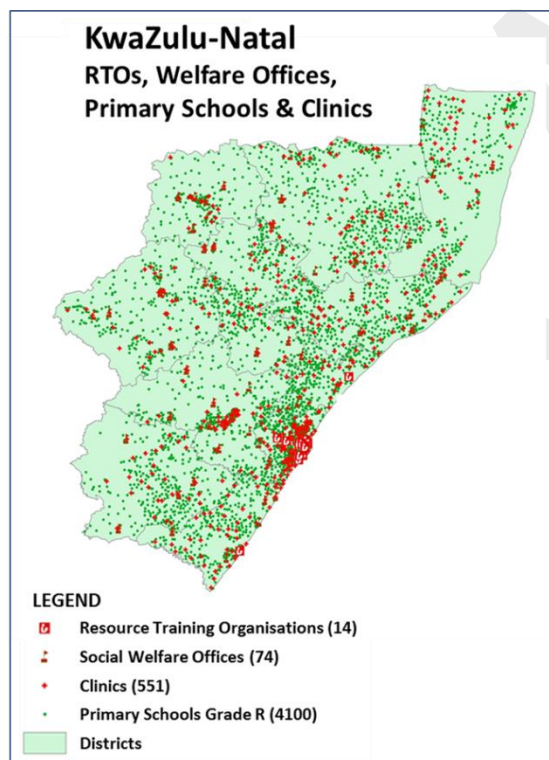
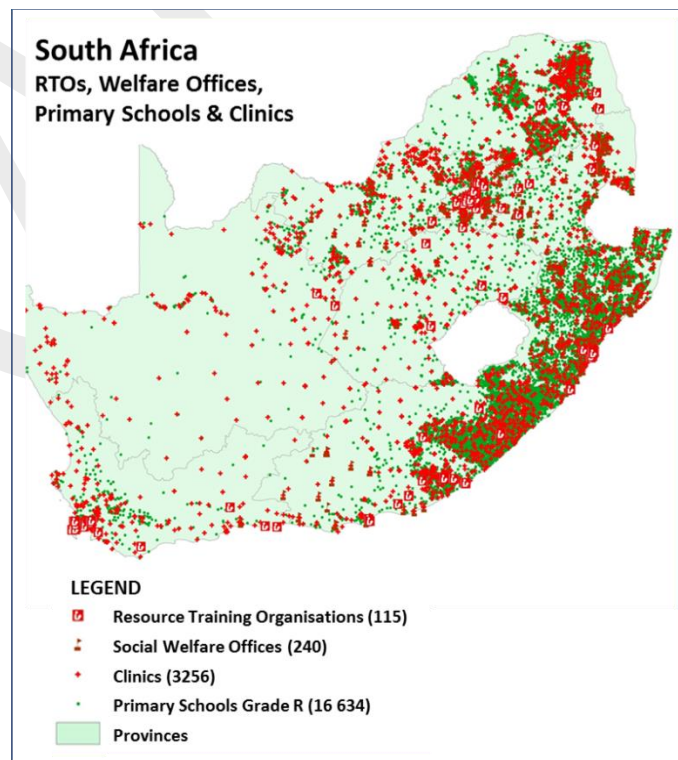


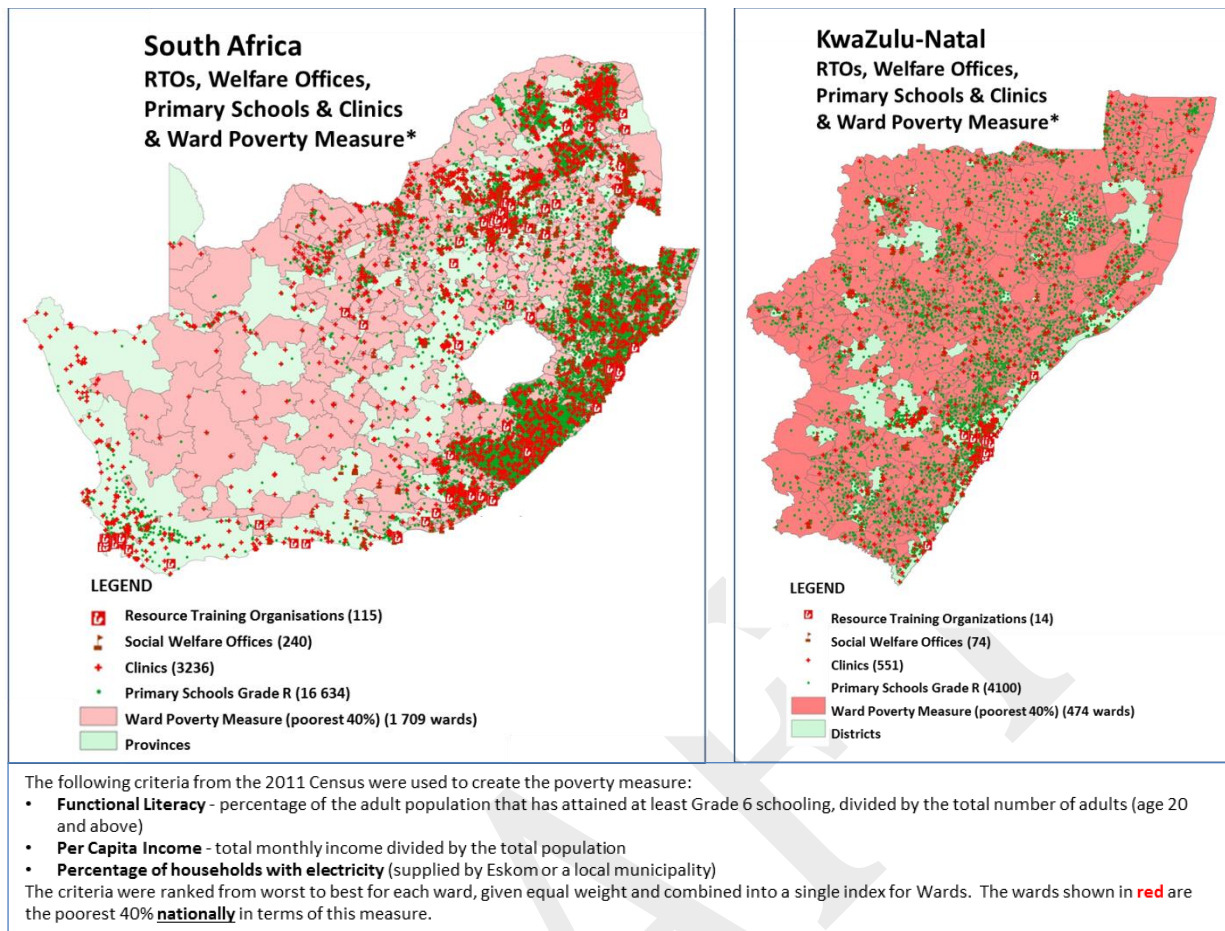
Figure 11: Social Welfare offices, RTOs, primary schools with Grade R and clinics in South Africa



In Figure 13 and Figure 14 the potential infrastructural resources for expansion of ECD shown above, are overlaid on a composite measure of poverty made up from Census 2011 ward data on functional literacy and household income (first national and then for KwaZulu-Natal). The wards shown in pink are the poorest.

Figure 13: Potential ECD infrastructure by a ward poverty index, national (incomplete data)

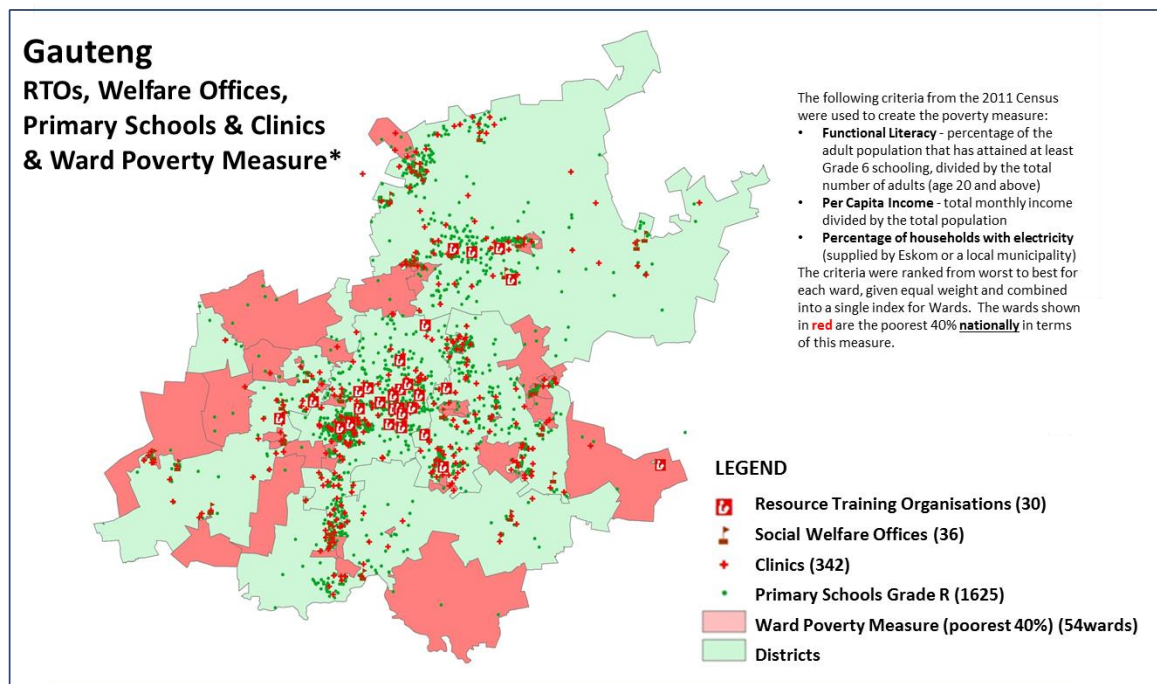
Figure 14: Potential ECD infrastructure by a ward poverty index in KwaZulu-Natal



A number of conclusions can be drawn from the mapped data:

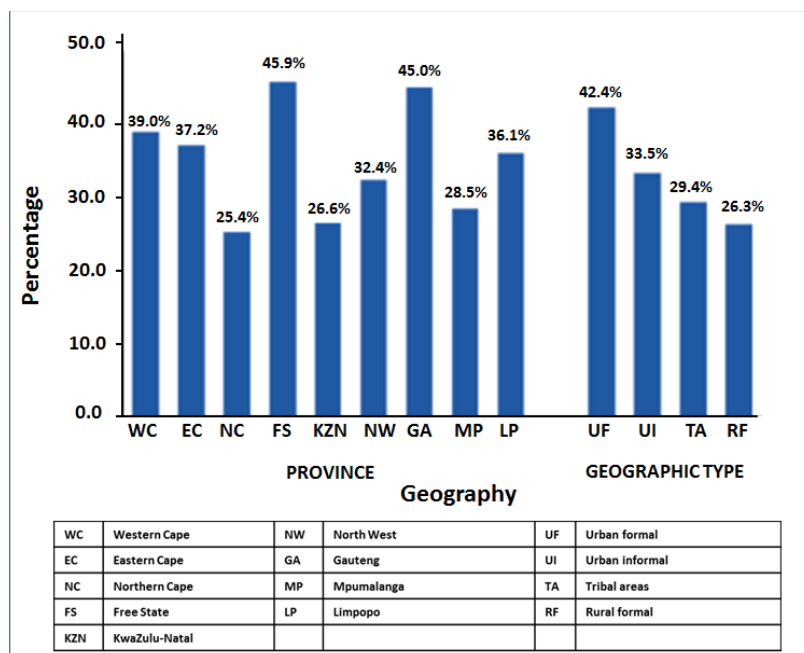
- The expansion of services outwards from Social Welfare offices and RTOs is only feasible in urban areas and, even in these areas, will be insufficient to meet the needs of the numbers of the poorest children not yet receiving parenting services or services to promote early learning.
- Primary schools already providing Grade R and clinics expand significantly the infrastructural possibilities for facility-based, outreach, home- and community-based ECD services for young children and their families.
- Even if primary schools and clinics were used as hubs for facility-based or outreach services, it will still be necessary to establish services *de novo*, most notably illustrated, at least by available data, in Northern and Eastern Cape. This is probably true also in pockets of what appear to be relatively well provisioned areas. This is well demonstrated by the data we were able to source for Gauteng, see Figure 15.

Figure 15: Potential ECD infrastructure by a ward poverty index in Gauteng



The distribution of children 0-4 years of age attending some form of out-of-home care, as reported in StatsSA's 2012 publication, *South Africa's Youngest Children*, is shown in Figure 16 below. As can be seen, the Northern Cape, KwaZulu-Natal and Mpumalanga have the lowest number of children in out-of-home care, as do rural areas.

Figure 16: Distribution of children in out-of-home care*, by province and rural-urban status



* The questions in the GHS do not allow for the disaggregation of attendance at an early learning centre from child minding or other form of out-of-home care

7.2.5 Options for expanding the gap in ECD services (parenting and opportunities for learning) in under-served areas

There are at least two options for expanding ECD provision into under-served areas, and several combinations of them. The first is the establishment of new centres and programmes, and the second is maximising the scope of some existing services. These two approaches are briefly described below.

7.2.5.1 The establishment of new centres and programmes

New centres and programmes could be established using one or a combination of approaches:

- NPOs could be given financial incentives to establish new infrastructure and programmes in under-served areas with contracts for service provision.
- Government could allocate, rent or build new centre infrastructure, an option which is discussed in more detail under infrastructure.
- The above option could include the use of existing primary school and health facilities to provide the gap in services in the Essential Package, staffed by government.
 - The use of primary schools for the provision of ECD could be conceived and developed as part of the proposed plan to add a second year of preschool, a pre-Grade R. According to this proposal, children turning four in the year (i.e. 3.5 years old) would be eligible for admission. Where feasible, in some areas this could be done through partnerships between non-profit organizations and government. If community-based Grade R, comprising about 15 percent of Grade R provision, continued with the sliding scale subsidy in place,²⁰⁹ this model could be extended to the proposed pre-Grade R year. This strategy would likely have the same strong uptake as occurred with Grade R, and would enable all poor children to access free State-provided early learning programmes offered in public schools from the age of 3.5.
 - Screening for parental and social problems, and support for families would still have to be addressed as part of the Essential Package, and it is conceivable that this could be done through outreach activities from Early Learning Centres and from Pre-Grade R facilities.

7.2.5.2 Maximizing the scope of existing services e.g. Care for Child Development in health services for mothers and children

DoH has responsibility for health care for young children. In South Africa, as in all low- and middle-income countries, the State health sector has the greatest interface with young children (under two years of age) and their families, with the highest possibility of potentially reaching all poor children. As advocated by the World Health Organization (WHO), “The health sector is well placed to influence a range of both proximal and distal factors that affect child development, such as the quality of interaction between the parent and the child; the opportunity for early stimulation; the home and community environment; and the national policy on early childhood care. The health sector works through several mechanisms, including primary healthcare services, home visiting services, and other community activities and services, all of which are important in improving learning and development in the child”.²¹⁰ In South Africa, young children are brought to a health centre, on average 4-5 times in the first year for well-baby care and immunizations. These contacts are an invaluable and unrepeatable

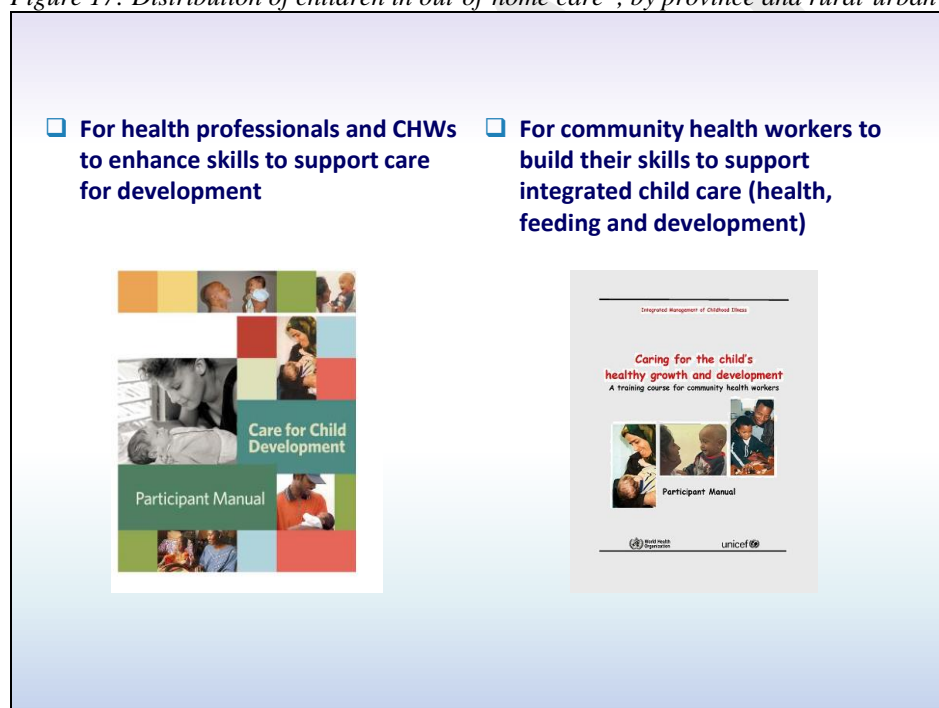
opportunity to engage families in protecting and promoting the development of their young children.

WHO and UNICEF developed a package of support for caregivers and for encouraging learning among children from birth that can be delivered in clinics and community settings, called Care for Child Development (CCD).

Care for Child Development (CCD) was developed by WHO and UNICEF as part of the Integrated Management of Childhood Illness (IMCI) Strategy.²¹¹ CCD involves counselling parents on how to promote young children's development, using counselling cards with age-specific messages and demonstrations of activities. Counselling sessions last between 5-10 minutes and can be repeated every time a mother attends the health centre for a sick or well child visit.²¹² South Africa was the site of the first pilot evaluation of CCD in 2001, which was very positively rated by nurse participants.²¹³ Evaluations in Turkey,²¹⁴ China and three central Asian countries showed benefits for children's development. The CCD intervention and all supporting materials can be found on the WHO website at http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/index.html (see Figure 17).

DOH could train nurses and community health workers to deliver the Care for Child Development package as part of all routine visits.

Figure 17: Distribution of children in out-of-home care, by province and rural-urban status*



7.3 Government coordination and coordination with the private and non-profit sectors

Current coverage by services in the Essential Package is variable, both for specific components and within components. Some examples are given below:

- In 2008, 87 percent of births were registered; however, in 2011/2012, only half of all births (51%) were registered within 30 days of birth as required under the Births and Deaths Registration Act (51 of 1992 as amended).²¹⁵
- 89 percent of 1-year-olds are fully immunised but, as yet, only 30 percent of mothers and babies receive postnatal care within one week of delivery.²¹⁶
- 44 percent of the parents or primary caregivers of children younger than one year of age are receiving the Child Support Grant, below the anticipated eligibility for the CSG of around 60-65 percent.²¹⁷
- An updated audit is in process, but an increased number of early learning centres are registered and receiving a State subsidy for income eligible children - in the region of 20,000, receiving subsidies for nearly half a million children.²¹⁸ However, this is nowhere near the scale needed to reach the 3 million poor children younger than five years of age whose early learning is not being subsidised.²¹⁹

Health, education, social protection and birth registration are state provided for all children, that is, they are universal services. Some aspects of the Essential Package are mandatory by law (birth registration) and some require eligibility (the Child Support Grant and the ECD subsidy). Others, like health care are offered to everyone, but parents can choose not to avail themselves of the service; for example, immunization depends on government stimulating uptake among parents. Those families who can afford to pay for services may choose to use private health and education, but training, practice accreditation and quality standards in both sectors are State regulated. Social services are intended to be universally available to all who need or want to use them, although the coverage is very limited.

7.3.1 Private and non-profit provision of child care, opportunities for learning and parent support

In contrast, child care and opportunities for early learning are provided entirely by the for- and non-profit sectors. Parenting support for families with young children is provided by a small number of non-profit and faith organizations. The Department of Public Service and Administration is currently piloting the provision of child care for government employees in nine sites under its Wellness Management Policy. All other paid child care is provided by private and not-for-profit child minders caring for fewer than six children in their own homes. This activity has no prescribed training, practice, or quality standards and receives no support from the State. In response to this situation, in 2008 UNICEF and DSD drafted a Child Minding Policy, but it seems not to have been completed.²²⁰

Opportunities for early learning in centres or programmes are also provided entirely by the for- and non-profit sectors, but with some regulation and support from government. The Children's Act governs the regulation of early childhood facilities but not the payment of subsidies to early childhood facilities.

Registration of an early learning centre or crèche for the purpose of receiving a subsidy requires the centre first be registered as a place of partial care under the Children's Act. The application to DSD requires the submission of a weekly menu and daily programme, a building plan or hand drawn sketch, a copy of the constitution, a service or business plan, the financial report from the prior year, a copy of the contract or lease with the owner and a clearance certificate regarding sex offenders. Lastly, the centre must successfully meet the structural and health requirements of the local authority upon inspection.

The State provides these privately owned registered centres with a subsidy based on a per child amount for children who come from a family with an income below a certain level. The subsidy provision is confusing in several respects, in addition to the fact that it does not serve the equity agenda of South Africa:

- **The income threshold is not aligned with other poverty-targeted provisions and services**, such as eligibility for the Child Support Grant or the quintile system used for classifying schools that are exempted from fees and receive school feeding. Provinces are also applying their own means test income thresholds. For example, in 2011, the North West threshold was R1,800 per month, while the Western Cape was R3,000 per month.
- The Children's Act and its Regulations **do not outline what the subsidy is aimed to achieve nor is there clarity on what it should be spent**. No written document has been provided by national DSD specifying how the subsidy should be allocated and in what proportions.²²¹ In June 2013, the social work policy manager in the ECD Directorate, national Department of Social Development²²² noted that the formulae is prescribed as: nutrition, 50 percent; staffing, 25 percent and other costs, 25 percent. In October 2013 the National Minister of Social Development indicated in a press statement that the subsidy is intended to be split between nutrition at 50 percent, staff salaries 30 percent and stimulation material and administrative costs (20 percent).²²³
- In the absence of national guidance, provincial Departments of Social Development prescribe their own formulae to outline what the subsidy is allocated for, and in what proportions. For example, the Western Cape specifies that 50 percent of the subsidy is for nutrition, 30 percent for salaries and 20 percent for equipment. Eastern Cape specifies 40 percent for nutrition, 40 percent for administration including staff stipends and 20 percent for stimulation programmes.²¹⁴
- The average amount per child in 2009/2010 was R11-R12 per day for 264 days a year, equal to R2,901-R3,168 per child per year, again varying by province.
- Despite success in increasing the amount and the number of recipients of the subsidy, the model itself has come under severe criticism. **The dual process of registration is unnecessarily bureaucratic and burdensome**, delaying registration of thousands of centres; the norms and standards prejudice facilities in poor rural areas; monthly claims have to be submitted and payments are late.²²⁴
- However, the ECD Diagnostic Review drew attention to a much more systemic problem – that the subsidy as designed, rather than helping poor families, in fact supported better off children and families who lived in the vicinity of a for- or non-profit owned and run centre and who could afford to pay the user fees that are levied by the vast majority of facilities. It is urgent that the subsidy system is revised in favour of a funding formula that supports the

universal availability of the Essential Package for all children, ensuring that the most vulnerable children have equitable access to the package.

That said, what is the role of the current model of subsidised privately-owned centres to provide universal child care and opportunities for learning for children zero to four in South Africa?

7.3.2 Government provision of services

As indicated in the Integrated Programme of Action for ECD: Moving ahead (2013-2018), shown in Table 3, **there is some confusion between the roles of the Departments of Social Development and Basic Education with respect to the provision of ECD services beyond those provided by the Department of Health.**

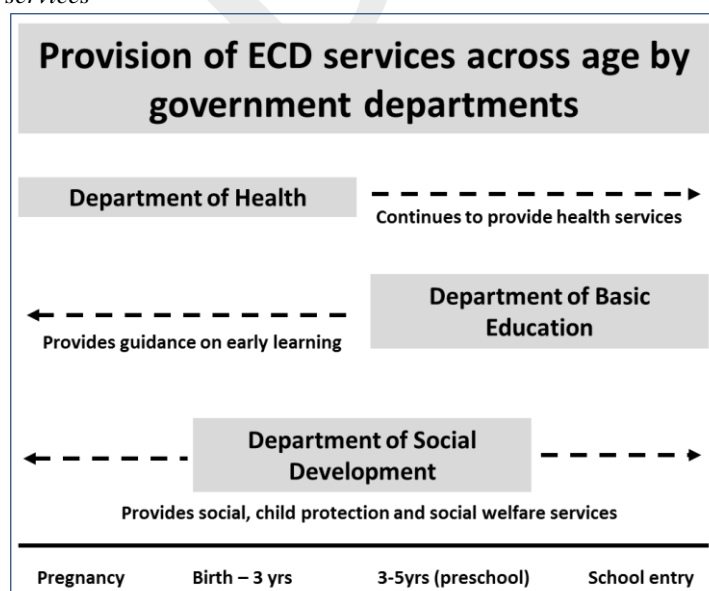
The Department of Social Development leads the implementation of the National Integrated Plan for ECD, registers and inspects partial care facilities, registers and inspects ECD programmes, and provides budget for the Child Support Grant administered by SASSA.

The Department of Basic Education is responsible for the implementation of White Paper 5 that informs ECD²²⁵ services, the curriculum for ECD pertaining to children birth to four years of age (as well as Grade R), development of training and stimulation materials, and training of ECD practitioners and payment of stipends to trainees.

The split of responsibilities between departments is principally by care (DSD) and education (DBE). In Social Development, ECD services are framed as a welfare provision.

In most countries, the provision of comprehensive ECD services is split between the Departments of Health and the Department of Education. In this configuration, Health takes responsibility for the early years when families have intense contact with health facilities and services, and Education takes responsibility for preschool education in continuity with the foundation phase of schooling. This arrangement predominates in low and middle income countries because of the critical role of preventive and curative health services in promoting and protecting early child health, growth and development. Departments of Social Welfare (with various names) supplement the broadly categorised work of the Departments of Health and Education with social protection, child protection and social welfare services,²²⁶ as indicated in Figure 18.

Figure 18: Illustrative government department cooperation in the provision of an Essential Package of ECD services



In the configuration displayed in Figure 18, or some variation of it, government departments would have the following mandates:

Department of Health has responsibility for health and nutrition for pregnant women and young children, with the most extensive and frequent contact with young children (4-5 visits per annum in the first year of life).²²⁷ Using programs such as Care for Child Development, the DOH also incorporates early learning and parent support into preventive and promotive health care for young children.

Department of Basic Education takes responsibility for expansion towards universal access to early learning for children 3-5 years by providing an additional preschool year, as recommended in the National Development Plan and in the ANC Election Manifesto.²²⁸ DBE would provide free Grade RR in public schools and a subsidy on a sliding scale for Grade RR provided in community centres in the same way as is now done with respect to Grade R.

The advantages of DBE offering Grade RR are:

- DBE already has extensive responsibilities for the preschool group,²²⁹ including to develop, evaluate and maintain an accreditation system for providers and trainers; develop and maintain policy concerning curricula, programmes, qualifications and assessment for Early Childhood Development; and render support to qualifications and quality assurance authorities concerning Early Childhood Development.
- Despite concerns about quality,²³⁰ DBE has achieved close to universal access to Grade R in five years, especially in the most disadvantaged areas.²³¹ This demonstrates the State's capacity to rapidly expand access to early learning, including for children in marginalised areas, if services for 3- and 4-year-olds are made part of the foundation phase of the basic education system. Grade R is offered at schools and in community sites. There are challenges occasioned by community site provision of Grade R, but there is, in principle, no reason why a pre-grade R year and Grade R cannot continue to be provided in community sites for those families who wish to exercise the option of private or non-profit provision.
- Policy prescribes that all scholars must be within 3km of a transport pick up point.²³² The extensive distribution of primary schools throughout the country (see Figure 11) means that early learning facilities could be made available to all children through the public schooling system within 5-10 years, in addition to community sites for those families who chose these. This is a very compelling option considering the alternatives, which all require establishing new infrastructure from scratch in those areas not currently served by the current private and non-profit system (which uses non-governmental infrastructure entirely).

It should be noted that concern has been expressed about the freedom afforded to children to learn through play and other activities that are less structured than formal instruction in some of the current preschool environments attached to primary schools.²³³ But this is more a concern about poor quality in public schools than an, in principle, objection to the model. Many elite South African schools include up to three years of preschool. Concerns also emanate from vested interests created through the establishment of physical infrastructure, staff training and employment, and materials by private and non-profit early learning centres and providers.

Department of Social Development supplements the services of Health for 0-2-year-old children and supports early learning and parenting programmes for families with children younger than

pre-school age (<3.5 years of age). It would also provide oversight of child minding services for children too young to enter an early learning centre or programme (<2 years of age). This would extend important service and oversight to the youngest age group, agreed to need concerted attention. In addition, DSD provides new home-, centre- and community-based services for early learning, parent support and the protection of children and families (parenting support and screening and referral). DSD also supplements DOH's responsibility to screen mothers for mental ill-health, substance use and exposure to violence; to screen for developmental difficulties and childhood disabilities, and to manage, treat and support children who are abused and/or neglected.

DSD might render these services by one or a combination of strategies: developing a workforce of ECD Practitioners, analogous to or including what is being done with Isibindi (whose target is 10 000 community child care workers);²³⁴ by combining with or supplementing other cadres of community workers (such as Mother and Child Community Health Workers, or assistant Community Development Practitioners), and/or by outsourcing these services to competent civil society organizations. There has been some suggestion that ECD Practitioners would perform differentiated tasks and would need differential training. However, any specialization must be justified in the face of increasing complexity of training, supervision, management and regulation.

What also needs to be considered in this approach is the basis for State subsidization. A more equitable approach is for DSD to continue to subsidise early learning centres on the same basis as is currently the case (per-child for the provision of an programme as per registration requirements) with some adjustment, and extend the per-child subsidy to community-based early learning programmes and child minding services that meet specified criteria.

Other departments have clearly specified roles; for example, Department of Public Works funds the Expanded Public Works Programme which supports training and stipends for young people working in Early Child Development; the Department of Home Affairs registers births; the Department of Correctional Services provides ECD support for children of incarcerated mothers, and so on.

Splitting responsibility between departments in whatever way needs coordination and, as is indicated later, an ECD Agency seems the optimal choice for overall governance.

7.3.3 Interaction between the state and the current for- and non-profit infrastructure and provision of ECD services

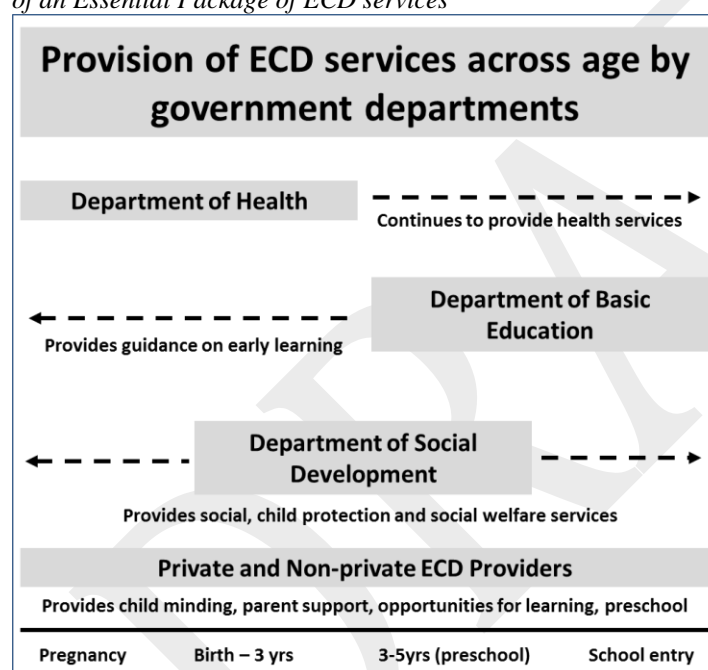
ECD services in the Essential Package should be free and State-provided for children in poor families whose parents cannot afford to pay for services (about 65 percent of all children). Under the current system, the State is providing subsidies for close to 500,000 children from income-eligible families attending registered early centres, at a cost of some R2b a year (R15 per day for 500,000 children for 250 days a year).

However, most young children are cared for at home, and receive no ECD services. About 35 percent of 0-2-year olds (\pm 230,000) and about 57 percent of 2-4.5-year olds (close to 1 million children) spend some time of their day in out-of-home care – in an unknown but very large number of unsubsidised and unregulated child minding services, and in approximately 37,000 early learning centres.

In respect of early learning provision, the State currently supports private (as opposed to public) provision on a sliding scale. This parallels South Africa's support for private (independent) education on a sliding scale.²³⁵ And, given the urgency to expand services and to improve their quality, this subsidisation should continue in respect of children in the year prior to pre-grade R and in Grade R. In our view, the subsidy should also be expanded to include child minding services that comply with requirements to provide or to ensure the provision of social services in the Essential Package, as well as children attending accredited community-based early learning programmes.

Given the central role of the private and non-profit sector in providing child minding, parent support and opportunities for early learning, the State must incorporate the expertise, experience, capacity, physical and managerial infrastructure and service provision of this sector into plans to universalise the availability of an Essential Package of services. The funding model for the Essential Package must take this into account. Figure 19 shows the current role of the PNP sector in service provision in relation to the core government departments.

Figure 19: Illustrative cooperation between government, and the private and non-profit sectors in the provision of an Essential Package of ECD services



7.4 Planning processes needed to up scale the Essential Package

Government must immediately begin the 2-3 year process of preparing for national scale up of the Essential Package, learning from national programmes in other parts of the world. This involves preparation for all components required to make the Essential Package universally available, amongst others, multi-sectoral buy-in, training programmes, personnel requirements, roles and responsibilities, culturally relevant materials, funding and accountability systems, and pilot testing.

As provinces, districts, municipalities and wards have different resources and capabilities for the ECD Essential Package, a one-size fits all approach is not recommended. **Pilot tests and demonstration sites should be set up under varying conditions to explore options for delivery of the Essential Package under different conditions.**

8.0 Prioritization

The ECD Essential Package is to be made universally available to all children. However, given that there are substantial gaps in provision, implementation should must prioritise the following services, target groups and geographical areas. While these points have been made earlier in the report, they are repeated here for emphasis.

- **Nutrition support**
- **Pregnancy and children up to 2 years of age, as this is the period of life most susceptible to optimisation and damage**
- **The primary and secondary prevention of disabilities and developmental difficulties**
- **The poorest 60 percent of children as these comprise the most vulnerable children, as well as the group who will benefit most from the Essential Package**
- **Areas without services, especially rural areas and informal urban areas, as the vulnerability of young children is compounded by the absence of services to moderate the effects of risk.**

8.1 Nutrition support

The pillars of nutrition support for children under five years of age are:

- Promotion and support of exclusive breastfeeding, starting before birth and sustained for six months
- Counselling to support appropriate and responsive complementary feeding, including to prevent overweight
- Growth monitoring, early identification of growth faltering and referral for investigation and follow-up for all children aged 0-2 years of age
- Food supplementation – both of micronutrients and basic foodstuffs for pregnant women and children who fail to thrive for reasons of poverty and associated social problems – made available through clinics, non-government organisations and social service centres.

8.2 Pregnancy and infancy (birth to 2 years)

Support can be provided to pregnant women and infants by:

- Maximising opportunities during antenatal and post-natal clinic visits for well-baby care and immunization to provide support messages regarding self-care and infant health, growth and learning
- Providing supportive home visits to vulnerable mothers and families during pregnancy and for 6-9 months after birth. Vulnerable mothers include teenage mothers and mothers with problems regarding mental health, substance use and/or domestic violence.
- Conducting clinic- and community-based support groups for women and women + babies that address self-care and infant health, growth and learning.

To fulfil these functions, we propose a ‘specialised’ Mother and Child Community Health Worker. Further discussion about Mother and Child Community Workers is given under the **Human Resources** section of the report.

8.3 Universally available opportunities for learning for children from birth to reach especially the poorest 60% of children and children in under-served areas

This can be achieved through the following strategies:

- In clinics during pregnancy and postnatal care: Sensitising pregnant women to the hunger for learning that her child has from birth and throughout their early years, using tools such as the WHO/UNICEF Care for Child Development Package
- In child-minding for children 0-2 years: Sensitising and training child minders about the importance of early learning through responsive care, language stimulation, structured activities, etc., also using simple tools and materials
- Community-based play-and-learning groups for mothers and children 0-2 years
- Community- and centre-based learning programmes for children 2-5 years
- A Pre-Grade R programme, phased in over five years, in collaboration with community-based early learning centres where available, and in primary schools with Grade R where community facilities are not available
- Increasing parental demand for early learning opportunities for their children through public communication about the importance of early child development for health and human capital across the life course.

8.4 Primary and secondary prevention of childhood disabilities

Most childhood disabilities result from complications of pregnancy and delivery, as well as injuries sustained in early childhood. Pregnancy and birth complications can be reduced by improving the quality of antenatal and delivery care, and many childhood injuries can be prevented through effective public safety information and product packaging and control (e.g. of poisons, paraffin, etc.).

Secondary prevention is important because, without timeous screening, support and referral, genetic abnormalities, injuries resulting from pregnancy and birth complications and accidents can result in disabilities that seriously hamper a child being able to realise their human potential. Lack of access to early childhood development services further disadvantages young children with disabilities and their families and contributes to the difficulties they face.

In addition to addressing these challenges, policy and legislative changes are needed to support:

- The development of an inclusive ECD disability policy
- The development of a national strategy for community-based rehabilitation of children with disabilities and developmental difficulties
- The Care Dependency Grant must be made accessible to the family of every eligible child with a moderate to severe disability.

8.5 Public communication

Public communication about the importance of promoting and protecting early childhood development will help to:

- Garner support for the National ECD Programme among government and civil society, especially parents and families
- Reinforce the importance of parenting and the early learning environment provided in the home
- Emphasise the strong effect that simply talking and singing more to young children and reading to them will have on children's language and cognitive development
- Improve nutrition and children's eating habits in the home
- Promote norms against physical punishment and provide information about alternative forms of limit-setting
- Value traditional practices that protect children and promote their development
- Increase home and community safety to protect young children.

9.0 Human resources for the provision of the services in the Essential Package

9.1 Current human resources for ECD

Both the Departments of Health and Basic Education have established human and infrastructural resources for the delivery of universal services. But this is not the case for the Department of Social Development with respect to the delivery of the services included in the Essential Package – parent support and opportunities for learning. Other services in the EP – screening, support and referral for children with developmental difficulties and disabilities and women with substance abuse or mental health problems, and women experiencing domestic violence – are included in the scope of work of the social service professions that fall under DSD. However, the reach of the services is far from readily available and there is an acknowledged critical shortage of staff at the national, provincial and local levels.²³⁶

The DOH has primary, secondary and tertiary facilities with staff at various ranks with a range of qualifications deployed from national to provincial to district to local levels. Health services are universally supplied, either fixed or mobile. There are no user fees at government facilities for pregnant women, children younger than six years of age, people with disabilities and the elderly. Quality of provision is variable.

DOH is extending its workforce through systematic expansion of Community Health Workers (CHWs) as part of the global trend towards task shifting or task sharing.²³⁷ There are currently about 72,000 CHWs who are directly or indirectly employed, or whose employment is funded, by the DOH. However there is not a great deal of consistency in the education and training of the existing workers in terms of knowledge, skills and competence.

The DBE has pre-primary, primary and secondary school facilities with staff at various ranks with a range of qualifications deployed from national to provincial to district to local levels. Primary education is universally available. The majority of primary schools have a Grade R class. There are no school fees for children living in the poorest three quintile areas, and school meals are supplied to these schools. Quality of provision is variable.

DBE is extending its workforce through universalisation of Grade R. Currently there are about 22,000 Grade R practitioners serving about 80 percent of children who are age eligible for Grade R. At a ratio of 1:30, an additional 7,000 practitioners are needed for universal availability. The Draft Policy Framework for Universal Access to Grade R becomes compulsory by 2019. In addition, the 360 credit Diploma in Grade R will become the minimum qualification, and a B Ed degree is the preferred qualification. This will be difficult to achieve because of the large proportion of under-qualified Grade R teachers already in the system. As many as 70 percent may need upgrading to the Diploma. Expansion of training capacity for Grade R will have a knock-on depletion effect on training for pre-Grade R programmes.

In 2010, the DPSA employed 3,100 Community Development Workers (CDWs), based at the ward level.²³⁸ Their focus areas include food security, ECD, HIV and AIDS, and Social Protection. They are intended to identify children who are not in ECD programmes and link them to grants, services and DSD subsidised early learning centres. They are also intended to link centres to registration and quality assurance processes. CDWs are thinly spread, at one per municipal

ward. Nonetheless, many CDWs play a valuable role for young children, and increases in the number of CDWs would be an important resource for ECD expansion.

The DSD employs provincial, district and local staff who provide services for a wide range of social groups facing difficulties, including children, youth, women, substance abusers, victims and perpetrators of violence, the elderly, probation services. Among social service practitioners listed in the 2013 policy, numbers of each are hard to come by:

- Social Workers, including Auxiliary Social Workers and Student Social Workers. The numbers working with children are estimated to be: 6,499 Social Workers (4,726 employed by government, 1,773 by the non-governmental sector) and 4,014 Auxiliary Social Workers (2,434 in government and 1,580 in non-governmental agencies).²³⁹ With over 5 million children under five years of age, there are roughly 572 children per Social Worker or Auxiliary Social Worker.
- Community Development Practitioners, and included in this category are: Social Workers in fields of specialization Community Development, and Assistant Community Development Practitioners. Given the wide scope of their duties and relatively small numbers, their role in ECD could be enabling, even if limited.
- Child and Youth Care Workers, and included in this category are: Auxiliary Child and Youth Care Workers, students and learners in Child and Youth Care Work, of which there are an estimated 2,603 (1,532 in government and 1,071 in non-governmental posts).²⁴⁰ As the work of this category has changed, from care of children in institutions, to the provision of community-based care, they are a category which may align with the services to be provided in the Essential Package. Currently, there are just over 1,000 Isibindi workers working with children in the ECD age range, but the programme is not yet near capacity.²⁴¹
- Youth Development, and included in this category are Youth Workers.
- Community Based Personal Care Workers, Aged and Disabled carers and Special Care Workers. Qualifications among these social service practitioners vary from Levels 7 and 8 (professional Social Worker, professional Child and Youth Care Worker, Community Development Practitioners) to Levels 3 and 4 (auxiliary Social Worker, auxiliary Child and youth Care Worker and Assistant Community Development Worker).

9.1.1 Early Childhood Development Practitioners.

Although there is no recent data on numbers, ECD practitioners are listed in the 2013 Social Services Practitioner Policy as the largest group of social development service providers. According to provincial departments surveyed in August 2012 for the ETDP Sector Skills Plan Update, there were **36,552 practitioners working with children in registered ECD centres**. An unknown, but presumably large number are working in unregistered centres or as community-based child minders.

An ECD practitioner is described as promoting and facilitating the optimum care, development and education of young children from birth to school going age, through a holistic approach to the well-being and development of young children. An ECD service is described as a service that intends to promote the development of children from birth to school-going age, which is provided regularly by a person who is not the child's parent or care-giver. ECD services can include home-based, community-based and centre-based interventions.

9.1.2 ECD qualifications

While the Children's Act refers to the National Certificate in ECD Levels 1 to 6, the requirement does not fit into the DHET nomenclature, and no Level 6 existed at the time of writing of the Social Service Practitioner Policy (2013). The provision for a qualification starting at Level 1, which is being phased out, enables many currently employed ECD Practitioners to enter the qualifications process at the low end. In addition, the Quality Council for Trades and Occupations has scoped a Level 1 Child Care Worker qualification as an entry for a wide range of workers, including playgroup supervisors, child minders, crèche and pre-school assistants. The majority of current ECD Practitioners have sufficient general education for an NQF Level 4 or 5 qualification.²⁴²

The following are the current SAQA-accredited ECD qualifications:²⁴³

- Level 1: GETC Adult Basic Education and Training with an ECD specialisation (ID 71751)
- Level 4: Further Education and Training Certificate in ECD
- Level 5: Higher Certificate (120 credits)
- Level 5: Diploma (240 credits)
- The National Certificate Vocational (NCV) with an ECD specialization phased in by some Further Education and Training Colleges from 2007. This is intended as an entry to the Level 5 as it is an orientation rather than an occupational qualification.
- A 360 credit Diploma in Grade R at Level 6.

In addition, the Department of Higher Education and Training is developing a policy on appropriate professional qualifications for those working with children younger than five years of age.

The following ECD qualifications with specialisation are registered with SAQA. The qualifications apply to practitioners working with primary caregivers/parents, and to practitioners promoting a community development approach to ECD.

- National Certificate Community Development (Level 3)
- Further Education and Training Certificate: Community Development (Level 4)
- National Certificate Community Development (Level 5).

A useful entry point for previously untrained practitioners working in home, community and centre settings is a skills programme including the following registered unit standards:

- NQF Level: Maintain records and give reports about babies, toddlers and young children (244261)
- NQF Level 1: Prepare an environment for babies, toddlers and young children (244263)
- NQF Level 2: Care for babies, toddlers and young children (244255)
- NQF Level 2: Interact with babies, toddlers and young children (244262)
- NQF Level 2: Demonstrate basic understanding of child development (244258).

Qualifications, content and level must be aligned with the requirements of the National ECD Programme, including both elements of the Essential Package and different service delivery

strategies. This will require input into the new qualifications being developed by the ETDP SETA under the Quality Council for Trades and Occupations. These include the Child Care Worker qualification (Level 1) discussed above, and the Level 4 ECD Certificate. The new Level 4 should be a generic qualification for ECD work, including those who work in formal facilities, community learning and play groups, child minding, and mother-child support groups. The elective component could include specialisation options for those workers focused on younger children (birth to two years) and those who work with children two years and older in group settings.

9.1.3 Career paths for ECD practitioners

The Social Service Practitioner Policy highlights confusion in the roles and responsibilities between the Departments of Social Development and Basic Education with respect to the career paths for ECD Practitioners. While the “career path for ECD practitioners is located within the education sector” “They attain “professional status by becoming ‘educators’, yet an educational qualification is not a prerequisite to work as an ECD practitioner within the social development sector” (p. 57). “At the time of writing, the debate on whether this field of service falls within the field of education or social services in terms of the career path of practitioners had not been resolved. The important issue is that one of the departments must take responsibility to lead the qualification mandate, or a memorandum of agreement be entered into to ensure joint responsibility”.

Just as there is no clarity in social services regarding ECD practitioner career paths, there is not registration with the South African Council of Educators for ECD practitioners working in services for children younger than Grade R. Despite the qualifications available, there is no career path framework providing for clear progression linked to qualifications. The Integrated Plan for ECD 2013-2018 indicates that DBE is the lead department to facilitate establishment of a Board to regulate the sector, and the timeline for completion is 2015.

In addition to resolving career-pathing and professional status, poor working conditions for ECD practitioners of all kinds, the lack of sustainable jobs, and limited opportunities for progression all need to be addressed in order to enable take-up of higher-level qualifications and the retention of trained ECD Practitioners in the sector.²⁴⁴

9.1.4 Training supply and demand

There is no recent national data on the qualifications of practitioners working with children younger than five years of age, but studies suggest that between a quarter and a half of all existing ECD centre managers and large numbers of ECD Practitioners have no ECD qualifications. There is also a need for upgrading the skills of those practitioners who have received initial training, as well as training new practitioners for an expanding sector.²⁴⁵ In addition, orientation is required for Community Development Workers, Community health Workers, Isibindi workers, and others reaching into homes and communities where they encounter young children, as well as for oversight personnel.

Current training supply and funding is totally inadequate for a scaled up ECD system. Furthermore, it is unevenly spread with an urban bias, as well as skewed towards higher level qualifications. Until recently, most ECD qualifications training was by the for- and non-profit sector. Policy now directs that learnerships are offered by public Further Education and Training (FET) providers, though they sometimes outsource to the for- and non-profit sector.

In 2012 there were 21 FET colleges offering occupational ECD qualifications (Level 4 and 5, mostly), and 11 offering the National Certificate/Diploma programmes (Educare). A large number, 186, for- and non-profit providers were accredited to offer ECD qualifications.²⁴⁶ A 2012 study of ECD for- and non-profit organizations offering training indicates that only 16 (of 47 accredited to offer Levels 4 and 5) had delivered learnerships between 2010 and 2012. Rather, the bulk of the training offered by these organizations was not accredited. The training offered was partly in response to the need for skills courses of different kinds, but mostly because the major portion of funds for qualifications training during this period came from limited donor funds and fees – not public funding.²⁴⁷

As a consequence, existing training capacity is not being utilised effectively, and brokering of partnerships between public and for- and non-profit providers is an important part of any strategy to increase training. In addition, fewer Higher Education Institutions offer ECD qualifications with a focus on pre-Grade R services, and this is an urgent area for development.

A further concern is that training does not necessarily improve service quality.²⁴⁸ While there may be many reasons for this finding, including lack of resources and low practitioner motivation, uneven quality training is a factor.²⁴⁹ There is a need for research to inform the development of training curricula and programmes. To assess the effectiveness of different formats for delivering training, including costs, and whether the current system for quality assurance of training provision is valid, reliable and practical.

9.2 Human resources needed to implement the Essential Package

Several types of personnel are needed to make a package of essential services universally available for early child development. As indicated, some services in the proposed Essential Package are already provided and the human resources, including the systems for training, management, and supervision are in place; for example, the majority of the proposed health and nutrition services, birth registration and social grants.

Some of these existing services need to be strengthened in terms of access and quality; for example, access to early learning centres and programmes, and the quality of nutrition support provided in clinics. New or expanded services need to be supplemented and/or developed. These include the human resources required to deliver the services and the supervisory structures, training and capacity development necessary to manage the services and ensure their quality. Amongst others, leadership and management are needed at the national level, including in the proposed ECD Agency, in the collaborating national government departments, and in provincial offices. Service provision must be supported by cascading management and supervision at the district and sub-district levels.

The services in the Essential Package, as proposed, are provided by three main categories of staff, apart from assistants, cleaners, cooks and other personnel needed to maintain services at quality. These are Mother and Child Community Health Workers, Child Minders and ECD Practitioners. Mother and Child Community Health Workers and Child Minders work principally with children aged 0-2 years and their families, especially their mothers, both individually and in groups. ECD Practitioners work principally with children aged 2-5 years of age in groups in centres and community-based programmes.

9.2.1 Mother and Child Community Health Workers

Pregnant women and children up to two years of age have more contact with the health system than with any other service. It thus makes sense to root ECD services for pregnant women and children younger than two years in the health sector. The services to be delivered include expanded aspects of health and nutrition (screening for maternal mental ill health, substance use and exposure to violence, as well as nutrition counselling), parenting support and opportunities for learning.

To provide services for pregnant women and children younger than two years, we propose the development of an ECD-specific Mother and Child (M&C) Community Health Worker, who functions within the 5,482 primary health care (PHC) outreach teams in rural areas, informal urban settlements and in townships (see **Appendix 13**). The ward-based PHC outreach team is the cornerstone of community-based PHC services, which encompass activities in communities, households and educational institutions (schools and ECD centres), and referral networks with community based providers. A PHC outreach team comprises of one professional nurse and six Community Health Workers. Health promotion practitioners as well as environmental health practitioners will be added to the team over time.

The PHC re-engineering model includes CHWs for the first time as part of the formal structure of the health service. Each CHW is allocated an average of 270 households. This threshold is indicative and depends on density, geography as well as burden of disease. The role of the CHW relevant to the delivery of ECD services include:

- Conduct screening
- Promote key family practices to support child and family health and wellbeing
- Maternal and child health promotion and information provision
- Referral to health and other services
- Facilitate early birth and death registration
- Facilitate access to social grants (child care, disability, old age) and other social services (OVC, substance abuse)
- Supportive counselling.

The minimum entry requirements are: functional literacy, accredited NQF level 1-4 training, relevant experience, resides in the area they will be serving, prepared to undergo orientation and training and sign a performance agreement, and meet basic competence requirements.

There is an existing pool of about 72,000 CHWs that are either directly or indirectly employed, or whose employment is funded, by the DOH. However, there is little consistency in the education and training of these workers in terms of knowledge, skills and competence.

Supervision of CHWs is by a professional nurse.

New CHWs are being appointed on one-year contracts. Budget provision for CHWs has been at the provincial level, although provinces have employed differing mechanisms to create these posts. For example, KZN and North West province have put all CHWs on the Persal system as “extra employees”. CHWs are paid between R800 and R2,200 a month.

A criticism of the CHW plan is their excessively high case load (1 for 270 households). As yet, there is no evidence yet of any influence of the current cadre of CHWs on MCH, and there is no

description either about how CHWs are fulfilling their MCH roles. Based on current realities, there is sufficient reason to be concerned about the contribution CHWs can make to MCH in the next three to five years. This has led to the recommendation that a special cadre of ECD M&C workers be developed to cope with the likely deficiency in both the short and longer term.

The establishment of this new cadre of M&C CHWs workers is likely to have the same logistical, training, human resource and other difficulties experienced with CHWs. But the smaller numbers, more focussed role, and (possibly) more established budgets, all portend towards a more successful immediate outcome.

Decisions about how best to integrate the function of general and M&C CHWs will need further discussion, but it is easy to see how their overlapping and complementary roles could best be aligned for optimal outcomes for high risk mothers and children.

In the model we have proposed, M&C CHWs would:

- Conduct supportive groups for pregnant women, both at the health facility and in the community in response to need
- Undertake two home visits to high risk pregnant women. High risk being defined as mothers younger than 19 years, HIV-positive mothers, mothers with mental health or substance use problems, and mothers exposed to domestic violence.
- Conduct mother-baby support and early learning groups for women with children younger than 2 years, both at the health facility and in the community. All mothers will be encouraged to attend these groups. The per-child subsidy is to be made available for these activities for the equivalent of 8 hours a week.
- Undertake two-weekly home visits to at risk mothers for six months post-birth, and up to nine months for especially vulnerable mothers.²⁵⁰

While the staffing needed to achieve universal availability is much higher, we estimate that 18,000 M&C CHWs are needed to conduct these activities for the 65 percent poorest pregnant women and children, with an 80 percent coverage. Because the necessary expertise cannot be assumed to exist in the PHC team, about 250 special purpose supervisors are needed to maintain the quality of the specific mother and young child activities proposed in the Essential Package.

9.2.2 Child Minders

An estimated 26% percent of children younger than two years of age are in out-of-home care, in centres and/or in the care of child minders. Child Minders are non-relatives who take care for up to six children in their own home, whether for free or for payment.

The Children's Act does not require child minders to register but local authority environmental health norms and standards must be met. In countries where child minding is a major form of childcare it tends to fall to local authorities to register and regulate child minding and they may provide some training. Child Minder Associations often take on training and support roles, examples being the National Child Minding Association in England and Wales, Family Day Care Australia and the National Association for Family Child Care in the United States which also offers an accreditation scheme. In South Africa there were large associations in Soweto and Alexandra in the past.

Such associations could potentially act as an accreditation and subsidy conduit. Another option that has been piloted in Cape Town has involved satellite child minders linked to ECD centres for support and subsidy purposes.

The first two years comprise a critical period in a child's health, growth and development, and good quality but affordable early child care is a fundamental enabler of women's participation in the workforce. Child Minding is also an economic opportunity for women who want to work from home and are interested in young children. For these reasons, the Essential Package includes Child Minders as an important set of service providers, especially for children younger than two years of age and especially for the provision of early learning opportunities.

In 2008 UNICEF initiated a process to develop a policy and guidelines for Child Minders, and these need to be revitalised and updated. An urgent effort needs to be made to train and accredit Child Minders, and to put in place a system of support and supervision. This is a responsibility of the Department of Social Development.

In the Essential Package, we recommend that children younger than two years of age in the care of accredited Child Minders (or centres) who are income eligible be subsidised to receive early learning opportunities for eight hours a week. The subsidy is justified by the fact that the State is taking responsibility to ensure the health, growth, development and early learning of the poorest 65 percent of children. At this stage, though, the State is not subsidising child care. Parents are obliged to pay for the remaining hours if their child is in half- or full-day child minding.

We recommend that all child minding for children younger than two years, whether in a centre or a child minder's home, or of children income eligible or not, is supervised under the aegis of DSD. This will require some 700 supervisors and probably more because child minding of young children is probably more extensive than estimated from available information.

9.2.3 ECD Practitioners

There are an estimate 37,000 ECD Practitioners in South Africa, almost all employed in early learning centres by the for- and non-profit sectors; a few are in community-based programmes. In the proposed model, the intention is to make the Essential Package universally available and paid for by the State for the poorest 65 percent of children. This means that salaries for posts and per-child subsidies need to be made available to these children through both centre- and community-based programmes.

ECD Practitioners will undertake the following activities (see also **Appendix 13 – Human resources for early learning programmes**):

- Conduct early learning playgroups with children 2-5 in community programmes
- Run early learning programmes in centres
- Run toy and book libraries to resource community- and centre-based programmes for early learning.

From a training supply perspective, the staffing need for universal availability is in the region of 100,000 ECD Practitioners. From the point of view of State support, we propose that salary provision be made for 27,000 full-time equivalent (FTE) practitioners. That is, 54,000 practitioners who are State subsidised to provide 20 hours a week of early learning experiences for the 65 percent poorest children, assuming 80 percent coverage.

Provision is also made for a per-child subsidy for all income eligible children in registered early learning centres and programmes.

We estimate that approximately 4,300 supervisors and in the region of 160 sub-district coordinators are needed to manage, support and oversee these services at the required level of quality.

9.2.4 Managerial staff

The staffing estimates given above do not include national or provincial management staff. This includes staff in the proposed ECD Agency, managers of the national ECD programme in the collaborating national departments and managers at the provincial level.

The cost implications of the staffing proposals made here are dealt with in Section 13.

10.0 Infrastructural considerations

Two types of infrastructure are required to make the Essential Package universally available:

- Physical infrastructure and services to deliver components of the Essential Package
- Physical infrastructure and services for mentorship, supervision, management and oversight of the services delivered.

In the short- to medium-term, priority services must not be delayed while infrastructure is planned and commissioned. The Essential Package must start to be rolled out immediately through existing infrastructure – health and education facilities, municipal and traditional affairs buildings, the premises of non-profit organizations, amongst others.

While building new infrastructure needs to be planned for the medium- to longer-term, the delivery of the Essential Package should not be delayed until special purpose buildings are constructed. Lessons from the clinic building programme by the DOH are that new infrastructure takes longer to establish than anticipated. Despite strong commitment and a dedicated programme, only 1 500 new clinics were built in the 20-year period post 1994. It will take considerably longer to meet the unmet need for new infrastructure for the number of early learning centres required.

10.1 Infrastructure for service delivery

10.1.1 Current situation

Both service and management infrastructure exists for the delivery of health, education, birth registration and social security payments. These services are generally accessible to all South Africans, and the services of both sectors contribute significantly to the wellbeing of children. These systems must be maximally used to deliver the Essential Package. Their expansion (e.g. in scaling up services for anti-retroviral treatment, the provision for Grade R and increased birth registration) also provides valuable learning opportunities for ECD.

The weakest infrastructural component is in providing safe and conducive spaces for early learning. Some municipalities (especially the metros) provide and maintain buildings as early learning centres. However, these are insufficient to meet the need. The vast majority of children are accommodated in homes (child minding), privately run centres or facilities managed by non-government organisations.

We do not have a current picture of the state of ECD facilities. The most recent nationwide data is now a decade old, and will be updated once the data from the National ECD Audit that is currently underway is completed. 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 Table 5 summarises the findings of the PETS study insofar as they relate to community and unregistered ECD facilities.

Table 5: State of physical infrastructure for ECD in three provinces, 2008

Variable	Registered community facility	Unregistered community facility
Meets the norm of 1 toilet per 20 children	63%	57%
Electricity in the last month	79%	73%
Water-borne sanitation system in place (other than pit latrines or bucket system)	65%	62%
Secure fencing around facility	88%	84%
Building in very good, good or fair condition	89%	23%

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

At present, child minders (caring for six or less children in their home) do not need to be registered and there is no information about the general state of infrastructure and facilities for children in child minding. The National Income Dynamics Survey (2008)²⁵¹ found that 26 percent of 0-3 year olds and 15 percent of 3-4 year olds are in child minding, which implies that a significant proportion of children are accommodated in unmonitored premises.

While children do not need elaborate infrastructure for play and outdoor activities, their learning experience is enhanced by equipment such as swings, jungle gyms and toys. The PETS survey of three provinces in 2008 presents a bleak picture, with fewer than half of facilities having basic play equipment.

Although the current system of registration is intended to benefit the poorest children, infrastructural quality standards imposed by municipalities often act to exclude those who need State subsidization most. A few municipalities have recognized this contradiction, and accepted that different infrastructural standards need to be applied in formal and informal settlements. This approach is strongly endorsed.

10.1.2 Principles for infrastructural provision

The State should have a systematic programme of infrastructural development for early childhood development, based on the following principles:

- Provision should be made for the mix of service delivery platforms required for early childhood development, including centre-based and community-based activities such as toy libraries and learning playgroups.
- Provision of transport vehicles for the effective management of services and distribution of learning and training resource materials is critical to the success of community- and centre-based programmes.
- Equipment (for outdoor play) and materials for Community-based Essential Package services, such as *Opportunities for learning* and *Parent support*, should be included as part of the State provision for ECD.
- Municipalities should develop infrastructure in poorly resourced areas, drawing on municipal infrastructural grants.

- Municipalities could contract with non-profit service providers of early learning programmes, and should make such facilities available rent-free, and provide water and electricity (capped, to prevent abuse) at no cost to the provider.
- The State should not be responsible for capital costs of infrastructure at private facilities, but should provide that part of the per capita subsidy may be used for routine maintenance of private infrastructure used for service provision.
- Infrastructural considerations are important for safety and shelter, but infrastructural standards should be applied in the best interests of the child, taking into account living circumstances and the other environmental hazards were the child not in a facility.
- Whether the pre-Grade R infrastructure is predominantly school- or community-based should depend on the specific circumstances of each community (taking into account travelling distances, child safety, parental convenience and other relevant considerations).
- The development of the national programme to make the Essential Package universally available should not be held up until sufficient dedicated ECD infrastructure is available. Given the need for rapid scale-up, the infrastructural requirements for ECD will need to be flexible, making use of existing State and community facilities, while a more systematic municipal infrastructural programme is being rolled out.

10.1.3 Flexible and opportunistic approach to infrastructure for ECD services

State facilities:

- Essential Package services can be delivered to pregnant women and to children birth to two years of age through health services, and by using health facilities as the base for home visiting and group activities provided by the Mother & Child Community Health Workers.
- *Support for parenting* and community-based *Opportunities for learning* can be offered from Grade R facilities for children two to five years and their families in those areas without for- and non-profit ECD centres and programmes.
- Ultimately, schools providing Grade R can be extended to provide a further preschool year, a pre-Grade R, together with capacitated early learning centres.
- Provincial Departments of Social Development have built approximately 18 One-Stop Development (Thusong) Centres which are earmarked for, amongst other things, ECD activities and related services.
- Both local government and traditional affairs have buildings and grounds (e.g. community halls and libraries) that can be made available on a part-time basis for Early Learning Centres and/or for Essential Package activities.

Private (non- and for-profit) sector facilities:

This infrastructure must also be maximally used to deliver services, for example:

- Existing Early Learning Centres can be used to deliver *Support for parenting* and community-based *Opportunities for learning* for children two to five years and their families.

- Child-minders use their homes and these can also be used to deliver *Support for parenting* and community-based *Opportunities for learning* for children from birth to two years of age and their families.
- Many faith-based organizations make their facilities available to ECD programmes.
- The private sector is also likely to be able to make some buildings and/or spaces available for Essential Package activities, either through Corporate Responsibility initiatives, or efforts to provide care and early learning facilities for the young children of their staff.

10.1.4 Process of infrastructure development

New built Early Learning Centres should be established by government in under-served areas, building on successful community-based efforts to provide components of the Essential Package to young children. For example, when community groups, a toy library or a mobile ECD programme have taken off, ECD practitioners have been trained, and demand created in the community.

A planning process to establish new Early Learning Centres, preceded by community programmes, should begin immediately and must prioritise the poorest and most-underserved areas. This needs to be done in collaboration with the for- and non-profit ECD community, the private sector, donors, and local government, traditional authorities, communities and parents.

10.2 Physical infrastructure for management

There is very little management infrastructure for ECD outside of Health and Basic Education.

- Depending on the province, the Department of Social Development has ECD Coordinators based at provincial and district level, as well as Family Coordinators.
- Some municipalities house ECD coordinators employed by them or by DSD.
- There are close to 100 Resource & Training Organisations, of varying size, with training and management capacity.
- In addition, many other well-established non-government organisations manage and provide a range of ECD services.

A major task for Social Development over the next 2-3 years is to establish management structures at the district, and sub-district levels to manage, oversee and coordinate the delivery of the Essential Package services.

These management structures include staff trained and tasked to coordinate, manage and oversee service delivery, including ensuring the provision of materials to government-run or -supported Early Learning Centres and programmes to support children's early learning.

As Mother & Child Workers will be a specialised category of community health worker, they will need to be based within the health service infrastructure, together with their supervisors.

Management support for community- and centre- based early learning programmes will need to be located at sub-district level, either within the service points of the Department of Social Development, or accommodated in municipalities or willing non-government organisations.

11.0 Roles and responsibilities

Roles and responsibilities for the National ECD Programme are fully described in the National ECD Policy. Main points are included here for completeness of the Programme report.

11.1 Government responsibility

As laid out in the ECD Policy, government is responsible for the Essential Package, in particular for:

- The universal availability of all components of the Essential Package, some of which are already universally available, with human and infrastructural resources to provide the services
- Ensuring that *all* children have equal access to Essential Package services and that the services meet the quality standards laid down by government
- Funding the Essential Package at the national, provincial and local level.

Delivery of the Essential Package requires mechanisms to ensure cooperation amongst several government departments, effective at the national, provincial, district, municipal and ward levels.

To make the Essential Package universally available, government must draw and build on, and collaborate with the relatively well-developed for- and non-profit ECD community. This must be underpinned by explicit expectations, secure contracting and performance requirements.

To fund the rapid expansion of the Essential Package, government must:

- Motivate for start-up funds and a larger allocation of the budget to the multi-sectoral provision of the national ECD programme
- Draw donors and the private sector into the vision for universal availability of the Essential Package
- Ensure that provincial allocations are protected and that funds are effectively spent on Essential Package services at the district, municipal and ward levels.

11.2 Leadership – An ECD Agency

A non-sectoral ECD Agency should be established urgently to begin the process of development of the national programme to make the Essential Package universally available. As is done in some countries that have successfully scaled up ECD, the Agency should be established by statute at the highest authority, reporting to the Office of the President. There must be ECD Agency representation at the provincial level in the office of the Premier.

The Agency should be adequately resourced with reporting lines to the Social Cluster in Cabinet. It should have a Board or other mechanism to represent the main stakeholders in ECD, including collaborating government departments and civil society. It must be staffed and financed to meet its mandate.

The Agency shall serve as a technical support and coordinating structure, and will not be responsible for delivering services. Service delivery remains the responsibility of the departments providing substantial components of the Essential Package: Health, Social

Development, Basic Education, SASSA, Department of Home Affairs, and COGTA (and other relevant departments).

11.3 Responsibility of the ECD Agency

The Agency should be responsible for the following:

1. The preparatory processes needed to develop the national roll-out of the Essential Package

Lessons from other countries, particularly countries in Latin America that are successfully scaling up ECD, **indicate that a national programme is only likely to succeed and be sustained if it is carefully prepared.** In some countries, this process has taken 2-3 years. However, countless ECD programmes in many countries have failed, largely attributable to hasty attempts at scale up in which required components are not in place or are poorly developed.

Amongst the processes to be prepared are:

- Strong leadership, policy support and public support for the national ECD programme
 - Articulated personnel structures, training needs and supply
 - Targeting and scale up strategies
 - Quality control and monitoring strategies
 - Media and communications strategies
 - Community and parent participation.
2. Communicating the vision, policies and strategies of the ECD programme and the Essential Package to government departments at all levels, the public, donors and implementing partners
 3. Working with participating government departments to plan human, financial and other resources, training and capacity for service delivery, monitoring and reporting and to ensure collaboration
 4. Harmonising policy and regulations affecting young children across departments to ensure there is clarity in roles and responsibilities for delivering the Essential Package
 5. Designing and developing support programmes that strengthen service delivery with respect to critical priorities, including those described below.

11.4 Development of a national programme implemented by the National ECD Agency

International experience is that well-defined, high-profile, integrated programmes (often specifically branded) create the necessary traction for early childhood development, and have been able to improved nutrition, social, educational and cognitive outcomes. Examples include Cuba's *Educa a Tu Hijo* (Educate your Child) programme,²⁵² Mexico's *Oportunidades*²⁵³ and the United Kingdom's *SureStart*²⁵⁴ programme. See **Appendix 15** for models for coordination of multi-sectoral ECD services.

The agency will develop and support implementation of those elements of a national programme that strengthen and enhance the current scope of ECD, focusing on neglected activities and those likely to give highest returns. These areas of programmatic should focus on the national priorities identified, including:

- ***Family- and home-based support***, for pregnant women and children younger than two years of age
- ***A systematic national nutrition strategy*** for children younger than five years aimed at eliminating stunting and moderate-to-severe underweight over the medium term
- Universal availability of developmentally appropriate ***early learning opportunities*** for children from birth to entry into Grade R (as described in the section on Early Learning)
- ***Inclusion and support for children with developmental difficulties and disabilities***
- ***Public information*** about the value of ECD and ways of improving the foundation for children's future wellbeing.

An outline of what the agency structure might look like at national and provincial levels is included as **Appendix 16 – Options for ECD Agency structure.**

12.0 Monitoring and evaluation

ECD programmes only work if they are well designed and well-executed through quality management procedures. Monitoring is the ongoing collection of output, outcome, coverage and quality data, while evaluation involves the assessment of impacts. Evaluation refers to procedures to determine how well the services and the system are performing, and with what effect on intended beneficiaries.

Currently, there is no integrated national information system describing and tracking trends in the lives of young children in South Africa, and the adequacy of the national response to their needs.

12.1 Monitoring

12.1.1 Objectives of monitoring

Monitoring of the implementation of the Essential Package of ECD should serve three purposes, namely to:

- Assess the access and level of participation of children in ECD services
- Assess the adequacy, efficiency and quality of local service provision
- Support planning for adequate resourcing of the district in order to meet the targets of coverage and quality of services.

12.1.2 Principles of monitoring

The approach to monitoring will be to:

- Keep the system simple, using existing departmental and other databases where possible
- Identify sentinel measures that can be used to track progress over time, drawn from across Government departments
- Work towards the tracking of individual children across Government systems that link birth registration with utilisation of health and social services, and participation in early learning programmes and entry into Grade R and schooling
- Simplify systems of administrative compliance and reporting to increase time available for practitioner-child interaction.

12.1.3 Monitoring domains

A standard log frame prescribes the collection of data on inputs (resources and services provided), outputs (e.g. numbers reached) and outcomes (benefits to children and families).

Service inputs and outputs

Monitoring data must be collected on the delivery of the Essential Package at a number of levels, domains, components, resources, quality control, and expenditure

Essentially, a monitoring system must be able to provide information on:

- **Whether a child is receiving** all Essential Package services, who is providing them, where are they being provided, in what dose and duration, and whether the child is benefitting from the services in terms of health, growth and development
- **How services are delivered**, including the numbers and work load of the staff, their performance quality, supervision received, materials available, and so on. Data on these elements must be collected at each level of service provision – clinic, centre, community programme, and child minding service.
- **How the system is functioning** as expressed in the numbers of early learning centres and community programmes, toy libraries, child minders, services meeting norms and standards, ECD Practitioners and MCHCWs, Essential Package Coordinators, staff qualifications, training capacity and trainees.
- **What funding is received**, allocated and spent.

Table 6 illustrates possible key input and output indicators for service provision at district planning level and below.

Table 6: Illustrative indicators for monitoring ECD programmes at district level and below (inputs and outputs)

FUNCTION	CHILD DATA	SERVICE MODE DATA	HUMAN RESOURCES	IMPLEMENTERS	FINANCE
District planning and management	<ul style="list-style-type: none"> • No. of children by age in the district • % participating in ECD programmes (by mode) • % receiving per capita subsidy • % attendance/enrolled by facility, ward, district 	<ul style="list-style-type: none"> • No. of programmes by type • Degree to which facilities meet norms & standards for conditional & full registration • Infrastructure data (facilities, vehicles, information & communication) 	<ul style="list-style-type: none"> • Skills/qualifications & continuing education database • Ratio of community workers and practitioners per 100 children 	<ul style="list-style-type: none"> • Mapping of all ECD services and capacity in the district • No. of applications for registration (conditional/ full) • No. registered (conditional/ full) • Status of funding 	<ul style="list-style-type: none"> • Budget • Expenditure
Local programme management	<ul style="list-style-type: none"> • No. of children by age in each ward • % participating in ECD programmes (by mode) • % of children receiving per capita subsidy (by programme type) 	<ul style="list-style-type: none"> • Assessment of progress with quality improvement (baseline, annual review of adherence to norms and standards) 	<ul style="list-style-type: none"> • Number of community workers • Number of ECD practitioners in early learning centres • Number of playgroup practitioners for 2-4.5 year olds • Number of ECD co-ordinators 	<ul style="list-style-type: none"> • Name • NPO registration • ECD programme/centre registration (full/conditional) • Key contact details • Bank account details 	<ul style="list-style-type: none"> • Budget • Expenditure • Requisitions • Payment

FUNCTION	CHILD DATA	SERVICE MODE DATA	HUMAN RESOURCES	IMPLEMENTERS	FINANCE
Child participation	<ul style="list-style-type: none"> • Enrolled in ECD programme • Attendance recorded (daily or sessionally) • Six monthly weight & height of each child • Utilisation of child protection services • (Ultimately, tracking of individual children through health) 	<ul style="list-style-type: none"> • Norms & standards of provision of modes of delivery (measured as part of quality improvement process) • Number of completed Form 22s (for notification of child abuse and neglect for inclusion in Part A of the Child Protection Register) received at a DSD service point for investigation over six-month period. Time between receipt of a report (Form 22) and completion of report of the investigation (in days. A completed report must be on the case file. 			
Citizenship, child recognition and social protection	<ul style="list-style-type: none"> • Identity number • (Or unique identifier for non-citizens and for unregistered children) 				

12.1.4 Sentinel outcome indicators across departments

Key indicators from across from Government departments will be developed to monitor the outcomes of the Essential Package at district (planning level) and above (Table 7).

Table 7: Key indicators from across from Government departments

POPULATION DATA	Statistics South Africa
Population & demographics	Census data
Household data	Census & community surveys
HEALTH & NUTRITION	Department of Health
Antenatal care	<ul style="list-style-type: none"> • No. of pregnant women who attend first antenatal visit before 20 weeks gestation • Indicators of Prevention of Mother-to-Child Transmission of HIV

Perinatal care	<ul style="list-style-type: none"> • No. of live births • % low birth weight (<2.5 kg) • Indicators of PMTCT • Perinatal mortality rate (< 7 days old)
Neonatal care	<ul style="list-style-type: none"> • Neonatal mortality rate (< 28 days) • Percent of mothers who receive a postnatal home visit within a week of delivery • Percent of children exclusively breastfed at 6 months
Screening for disability & developmental delay, and management	<ul style="list-style-type: none"> • No. of children screened at 0-6 weeks, 9 months and 12 months as per protocol • % of eligible children < 5 years with diagnosed developmental difficulties who are receiving rehabilitation services
Management of failure to thrive	<ul style="list-style-type: none"> • No. of children who fail to thrive (do not gain weight or continue losing weight) • No. of children failing to thrive (<24 mo.) who are screened for TB • No. of children referred for food support
Prevention and management of childhood illness	<ul style="list-style-type: none"> • % of HIV-exposed children who sero-convert (PCR) by 6 weeks and 18 weeks • % of HIV positive children on ART • Incidence of diarrhoeal disease and respiratory diagnosed at health facilities
CITIZENSHIP & SOCIAL SERVICES	
Birth registration	Percentage of children registered within 30 days of birth
Access to Child Support Grant	<ul style="list-style-type: none"> • Percentage of children < 12 months and < 5 years who receive the Child Support Grant • Number of eligible children who receive the Care Dependency Grant
EARLY LEARNING	
Service quality measures	Simple metrics should be devised to measure quality in home-visiting, learn-playgroups, child-minding facilities and early learning centres. These measures should draw on existing scales e.g. BradleyHOME, BriefCope, ECERS, etc.)
Grade 3, 6 & 9 annual national assessments	Long-term monitoring of changes in home language and mathematics achievement at school

12.1.5 Development of an integrated monitoring system

Service level monitoring

Child data

The starting point for monitoring ECD services is the child, and ultimately, **each child should be able to be uniquely identified** to track his/her access to birth registration and social

security, participation in early learning programmes, referral for failure to thrive or for psycho-social counselling and support. This system should be linked to the Centralised Educational Management Information System (CEMIS) to track progression of children to Grade R and into school.

A system of unique child identifiers will facilitate the extension of per capita subsidisation of participation of children across all modes of delivery (home-visiting, children's playgroups and ECD centres). It will enable each child to be linked to a specific service, and to individual service providers and implementing organisations.

In addition, the height and weight of children will be monitored by the service provider at regular intervals, depending on child age and adequacy of the child's growth.

Service data

As part of the process of continuing quality management, each service mode should have specific quality criteria related to adequacy of personnel, health and safety, provision of learning and training support material, and minimal infrastructure requirements). Monitoring should take the form of baseline assessment and review following a process of training and support.

Local programme management

Local programme management must be informed by continuing assessment of adequacy, quality and efficiency of service provision:

- *Adequacy of provision* - local programme managers should be able to assess population coverage of services, and whether resource provision (including human resources) is sufficient to meet coverage targets.
- *Quality* – based on the synthesis of local data, programme managers should have a real-time picture of the quality of provision of services (as measured in terms of mode-specific norms and standards). This will enable them to put in place processes of training and quality improvement, especially in services that are conditionally registered.
- *Continuing quality improvement* – the good use of monitoring data for quality managements is central to the services outlined in the Essential Package. A shift must be made away from administrative control to an ongoing programme of self-assessment, in-service support and incentivised external accreditation (see **Appendix 17 – Quality Improvement**). Simple metrics need to be used to measure quality in supportive home visits and early learning services and, practitioners must be trained in the collection and use of data for quality improvement. Regular quality assessment must be done by supervisors and sampled quality moderation by sub-district ECD coordinators. Incentives, including study opportunities, should be considered.
- *Efficiency* – programme managers should have a clear sense of the 'pipeline' of registration applications (achieved through recording applications at critical steps in the process and analysing progress through the system).

District planning and management

The data from municipalities in the District will be collated to monitor the same factors (adequacy of provision, quality, quality improvement and efficiency). These data will be combined with service data from other departments and population survey data to provide the basis for motivating for public funding, mobilising district resources, developing strategies for

inter-departmental collaboration (when required) and implementing a human resource development plan for ECD in the District.

- Integration of data across departments would happen at district level
- Integration of data across providers of different service modes monitored directly by the agency would happen at local programme level
- Integration of child-specific data at local level (using identity numbers or proxy identifiers for non-citizens) is ideal and would be developed over time.

The synthesis of these data will then inform provincial and national planning (see proposed information flow in **Appendix 18 – Information flow of monitoring data**).

Pilot sites and demonstration projects, together with monitoring systems must be carefully assessed during the planning process. Pilot testing must include:

- Data collection instruments at the child and service level
- Aggregation and the decision tools needed to use and feedback data at each level collected
- Support, supervision and re-training to respond to weaknesses in data collection and use
- Participation and incentives needed to sustain data collection for good quality monitoring.

12.2 Evaluation

Evaluation is both ongoing and intermittent:

- *Ongoing*: indicators of success (access, coverage, service quality) are made available by good quality monitoring data
- *Intermittent* evaluations need to be designed to assess both impact of components of the Essential Package (such as nutrition support) and the Essential Package as a whole.

12.2.1 Objectives of evaluation

The objectives of the evaluation are to assess the:

- Effectiveness and impact of the national ECD programme and its components
- Cost-effectiveness of the different interventions being implemented (e.g. with respect to early learning opportunities)
- Quality and efficiency of service provision and management
- Staff morale, understanding and efficacy
- Public perception, understanding and demand for ECD services.

12.2.2 Principles of evaluation

Evaluation must be planned at the start of the roll out of the Essential Package, by collecting baseline data and by enrolling cohorts of children in several sites who can be followed up over time.

User surveys, that is, the perspectives of families and communities on the services provided, should be conducted to periodically assess the acceptability, penetration and demand for Essential Package services.

International experience suggests that between 5 and 10 percent of national investment in ECD should be devoted to evaluation research, monitoring, statistical reporting, and feedback systems.

12.2.3 Development of the system of evaluation

The National ECD Agency will be responsible for developing a system of evaluation that is practicable and cost-effective, including:

Effectiveness:

- Assessment of child outcomes (physical growth and wellness, social and emotional self-regulation, cognitive development and foundation phase school achievement)
- Assessment of parental efficacy, coping and hygiene in home-visiting and parenting programmes.

Cost-effectiveness:

- Costing of programme elements related to child and parenting outcomes.

Quality & efficiency of service provision:

- Tracking of self- and external assessments of early learning opportunities and other services in the Essential Package through a standardised quality gauge.

Staff morale, understanding and efficacy:

- Periodic surveys and human-resource specific dimensions of the quality gauge.

Public perception, understanding and demand for ECD services:

- Formative research (e.g. focus groups) and periodic surveys (face-to-face, telephonic or electronic)

The ECD Agency must stimulate research to benefit the national ECD programme through the science, technology and higher education systems. This can be done by advertising research topics that are of value to improving the national ECD programme, by requesting that science and technology funds are assigned to research that benefits the national ECD programme, and so on.

Both monitoring and evaluation data should be included in the public information campaign to build and maintain support for the national ECD Programme.

13.0 Funding and costing

Government funding is essential if the Essential Package of services is to be made universally available, especially to reach low income families who cannot afford user fees. We propose that eligibility to receive government provided and government subsidised services be simplified, and aligned to eligibility for the Child Support Grant. We also propose that funds for staffing be allocated to the ECD Programme.

Around the world, countries have utilized a variety of mechanisms to finance the provision of ECD services. There is no agreement on what mechanism is best, largely because of the importance of context. In reviewing effective financing, Valerio and Garcia argue that, in preference to recommending a mechanism, what is needed is to evaluate proposed mechanisms to ensure that, in a given context, the mechanism enables equity in access, has administrative simplicity and is sustainable.²⁵⁵

At this stage of the development of the national ECD Programme and the roll out of the Essential Package, it is more useful to give an indication of funding needed and range of potential costs, by units, rather than detailed implementation budgets.

13.1 Funding model

We propose the following funding model to make the Essential Package universally available:

1. Funds are currently allocated to SASSA, and the Departments of Home Affairs, Health, Basic Education, Social Development and others for functions and services that support the development of young children, including those proposed in the Essential Package.
2. In addition, Treasury allocates additional funds to:
 - The national departments of Health, Social Development and Basic Education to cover national level management and support functions of new services in the Essential Package
 - The ECD Agency for the planning process in preparation for the roll out of the Essential Package, as well as for Agency staff and ongoing support and monitoring functions, and the development and administration of a national media campaign
 - Provinces, which funds are ring-fenced and allocated to Health, Basic Education, Social Development, and COGTA for:
 - Cost of departmental management and supervision of the Essential Package services
 - Cost of training the necessary work-force
 - Cost of infrastructure development (ring-fenced grants to municipalities through COGTA and/or maximal use of existing municipal infrastructure funds)
 - Cost of programme implementation.

13.2 Costs

Programme implementation costs include:

- Services in the Essential Package for pregnant women and children from birth to two years through budget increases for the Department of Health for the new category of Mother and Child CHWs
- Any extension of schooling (Pre-Grade R) paid through budget increases to DBE
- Staffing allocations and subsidies for centre- and community-based parent and child learning groups paid through the DSD
- Subsidies for early learning activities conducted in registered centre or community programmes, and child minding paid through DSD.

13.2.1 Staffing and subsidies

Calculation of centre, community-based learning group and child minding staffing and subsidies costs are broken down into staffing and per-child subsidy. The costing assumptions are given in **Appendix 19 – Costing assumptions.**

- Staffing:
 - Staff posts are allocated on an *ECD Practitioner: Child* ratio, funds for which are paid to staff appointed to DSD at the provincial or district level or allocated to non-profit organizations through sub-contracting.

- Fixed per-child subsidy

This is paid for all income eligible children for all models of delivery – centre- or community-based learning groups, and child minding.

- Children 0-2 years of age subsidised to make use of learning groups for eight hours a week for 48 weeks a year in any mode of delivery provided it is accredited
- Children 2-5 years of age subsidised for 20 hours per week (four hours per day per child, five days a week) for 48 weeks a year in either centre- or community-based learning programmes. Additional time in the programme or centre for child care is expected to be covered by user fees.

13.2.2 Approximate costs

A full costing of the ECD Policy and Programme will be conducted after the National Consultation. However, it is possible to provide an indication of the resource requirements to inform discussions based on the assumption that the State pays for services for the 65 percent poorest children and families; i.e. those eligible to receive a Child Support Grant. The main resource requirements are:

- **Subsidy payments: R6.8 billion per annum**

Assuming a subsidy at the current rate of R15 per day per child, calculated on a subsidised 8 or 20 hours per week for income eligible children 0-2 or 2-5 in any registered programme (centre, community or child minding), R9.2 billion per annum is needed to support

programme, food and other costs associated with early learning programmes for the poorest 65 percent of children and families in South Africa, assuming 80 percent coverage.

- **Staffing: R2.6 billion per annum**

Pregnant women and children up to two years of age: Home visiting for at risk antenatal clinic attendees and vulnerable mothers and children, as well as mother support groups and mother-child learning and play groups will require approximately 19,000 Community Health Workers trained in ECD services. This equates to R565 million if these M&C CHWs are paid at the same rate as CHWs (R30,000pa), which is likely to be too low for a quality service. Supervision, materials and transport are likely to add close to 50 percent to the salary bill. An estimated R810 million per annum is thus needed for state provision of these services to the 65 percent poorest children and families in South Africa, assuming 80 percent coverage.

The largest staffing requirement arises as a result of support for posts in centre- and community-based learning programmes for children 2-5 years. This requires approximately 65,000 ECD practitioners subsidised by the State for 20 hours per week (32,500 FTE). At an average salary of R48 000pa, the salary bill is in the region of R1.6 billion, plus an additional 35 percent for close supervision and support, excluding sub-district, district and provincial management. This equals R2 billion per annum to provide these services to the 65 percent poorest children and families in South Africa, assuming 80 percent coverage.

Child minder supervision will also require staff. Given current levels of child minder uptake for children 0-2 years, this would require over 1,040 supervisors with transport and other expenses at a total cost of approximately R104 million.

The costs in the next 3-5 years will depend on coverage targets. The totals mentioned here would be reached once coverage reaches 80 percent of the poorest 65 percent of children and families.

13.2.3 Total direct programme implementation cost:

The costs of subsidies and staff are likely to be the major cost components of the programme. The combined staffing (including supervision) and subsidy costs are estimated to be R10 billion per annum.

Costs not included in the staffing and subsidy estimate are, amongst others:

- The National ECD Agency start up and maintenance
- Monitoring and evaluation
- Ongoing media and communications campaigns
- Management structures within Departments to oversee the programmes
- Training to ensure availability of appropriately qualified staff
- Infrastructure development
- Materials for ECD home visitors
- Micronutrients and direct food support for children 0-2 years who need it.

These will be included in the final costing. But a ballpark estimate is R6 billion, totalling R16 billion per annum for all costs.

The cost estimates are based on assumed efficiency in the system. This assumption is justified by the high level of supervision suggested. However, it should be noted that the salaries used in the calculations may not lead to the development of a professional workforce capable of this level of efficiency. The appropriate salary structure, therefore, requires careful consideration. Salaries represent 30 percent of the costs included.

The costs are based on a subsidy of R15 per child for 8 or 20 hours a week. The costing study to be conducted after the national consultation will consider the adequacy of this amount. The costing estimate is highly sensitive to this assumption as the subsidy represents 70 percent of the costs currently estimated – this proportion will obviously fall when management structures and other costs are added.

At this stage the total cost estimate is not divided into new and existing budget allocations. This will be included in the final costing. However, it is worth noting that the DSD already allocates over R1.2 billion to subsidies and other ECD related expenditures.

The total cost must be met when the programme has reached target levels. In the next 3-5 years the budget allocations necessary will be smaller, as scale up takes time.

14.0 Immediate next steps

Interest in ECD all over the world is increasing; so too in SA the impetus is growing. But without leadership, danger of uncoordinated efforts, fragmentation.

Agency

International experience in high, middle and low income countries provides a blueprint for a 2-3 year preparatory period for the development of the Essential Package roll-out in South Africa, starting with design and ensuring sufficient pilot work prior to full national implementation.

No clear policy or programmatic direction, and different approaches may well work in different provinces. Set up 4-5 district-wide pilots to run over 2-3 years while setting up agency and creating demand.

- Establish the ECD Agency, and use the opportunity to launch a high-profile, well-designed communication strategy to inform government departments, the public and parents about the importance of early child development, why the State is committing to developing a national programme, and how it is envisaged to be done.
- As its first task, the ECD Agency must produce a plan for the development processes needed to roll out the Essential Package, including negotiations with the key departments.
- SASSA should immediately pre-register eligible pregnant women for the Child Support Grant. The CSG has been shown to have its greatest benefits when received early, but uptake is lowest in the first year of life and lowest amongst vulnerable teen mothers.
- DSD should immediately address the following issues:
 - Registration and subsidization:
 - Simplify the processes for determining the income eligibility of children and use eligibility for the CSG as the eligibility criterion to receive an ECD subsidy
 - Simplify the processes for registration of early learning centres as partial care centres and for subsidization
 - Provide funding for all eligible children in facilities that are already registered
 - Require provincial departments to make full use of the conditional registration provision in the Children's Act by identifying unregistered centres that can be conditionally registered for a year and to support them to undertake improvements towards registration.
- Child minding:
 - Revitalise discussions on policy, training, accreditation and quality control processes for child minding.
- Training:
 - In collaboration with DOH, DBE, Further Education and Training Colleges, Quality Councils and other stakeholders, bring clarity and standardisation to the training of ECD Practitioners.

15.0 Endnotes

¹ 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). UNICEF uses ECCD (early childhood care and development. 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

² DSD. 2012. Green Paper on Families

³ DSD. 2012. Green Paper on Families

⁴ UNICEF (2007). Children with Disabilities: Ending Discrimination and Promoting Participation, Development and Inclusion. UNICEF (2013). State of the World's Children 2013: Children with Disabilities. New York: United Nations Children's Fund.

⁵ UN Committee on the Rights of the Child, 2006, General recommendation 7; UNICEF (2012). Inequities in Early Childhood Development. What the data say: Evidence from the Multiple Indicator Cluster Surveys.

⁶ Yáñez, L. (2013). Learning from birth. Early Childhood Matters, 120, 5-6.

⁷ Gupta, A. et al (2013). Integrated Child Development Services (CDS) Scheme: A journey of 37 years. Indian Journal of Community Health, 25, 77-81.

⁸ UNESCO (2014). Education for all 2013-2014. Teaching and learning: Achieving quality for all. Paris: United Nations Educational, Scientific and Cultural Organization.

⁹ The Social and Economic Impact of Child Undernutrition in Egypt, Ethiopia, Swaziland and Uganda", prepared within the framework of the Memorandum of Understanding between the UN Economic Commission for Africa (ECA) and the World Food Programme (WFP): "The Cost of Hunger in Africa: The Economic and Social Impact of Child Undernutrition" (2013).

¹⁰ Lombardi, J. & Sayre, R. (2013). Providing a path to early success: Securing the foundation for learning. Early Childhood Matters, 120, 7-12.

¹¹ Of countries in Eastern and Southern Africa on which UNICEF has data up to 2011, only 4 besides South Africa have EDC policies (Angola, Botswana, Kenya and Malawi); of these, most are only very partially implemented (e.g. in 7 out of 28 districts in Malawi), with very little budget from central government (e.g. 0.3% of the budget spent by Ministry of Education on ECD

¹² These include but are not limited to the White Paper on Education (1995), the Interim Policy for Early Childhood Development (1996), the National Programme of Action for Children in South Africa (1996), the White Paper for Social Welfare (1997), the White Paper on Early Childhood Development (2001), the National Integrated Plan for Early Childhood Development 2005 – 2010, and the Children's Act No. 38 of 2005.

¹³ Reconstruction and Development Programme, 1994.

¹⁴ Welfare Law Amendment Act, 1998

¹⁵ White Paper for Social Welfare, 1997

¹⁶ White Paper on Education and Training, 1995

¹⁷ The different policy documents adopt different definitions and cut-off ages for ECD. For example, the National Integrated Plan for Early Childhood Development 2005 – 2010 and other policies define ECD as up to the age of nine years, whereas the Children's Act NO 38 of 2005 defines ECD as ending when children reach school-going age.

^{18 18} Biersteker L (2010) Scaling-up early childhood development in South Africa. Introducing a reception year (Grade R) for children aged five years as the first year of schooling. Working paper 17. Washington, DC: Wolfensohn Center for Development, Brookings.

¹⁹ The National Integrated Plan for Early Childhood Development 2005-2013; The Children's Act No 38 of 2005

²⁰ The Expanded Public Works Programme (EPWP) was introduced in 2004 as a five-year programme, extended in 2009 for another 5 years as EPWP II. The EPWP Social Sector programme focuses on two areas - ECD and home-and-community-based care (HCBC). The ECD EPWP encompasses three components: increasing the number of registered ECD centres; increasing the number of children subsidised by DSDs; and increasing the training of ECD practitioners, with a focus on provision for children aged 0-4 years.

²¹ The subsidy was introduced in terms of regulation 38 of the Child Care Act of 1983. The subsidy averages R15 a day, for 171 days a year in the Eastern Cape to 264 in the Western Cape. There is also programme funding for non-profit organisations (NPOs) in respect of ECD programmes, mostly non-centre based. Provinces have discretion on how to split the subsidies for different purposes. In the Western Cape, 50% of the subsidy is specified for nutrition, 30% for salaries and 20% for equipment. The Eastern Cape specifies a 40-40-20 split in respect of nutrition, administration including stipends, and stimulation programmes.

²² Martin, P. (2011). Government funded programmes and services for vulnerable children in South Africa. Cape Town: HSRC Press.

²³ National Planning Commission (2011). National Development Plan: Vision for 2030. Pretoria: The Presidency, South Africa

²⁴ Budlender, D. & Proudlock, P. (2011). Funding the Children's Act: Assessing the adequacy of the 2011/12 budgets of the provincial departments of social development. Cape Town: The Children's Institute.

²⁵ Walker, S. et al (2011). Inequality in childhood: Risk and protective factors for early childhood development. *The Lancet*, 378, 1325-1338.

²⁶ Heckman, J. (2013). Giving kids a fair chance. Cambridge, Mass: MIT Press; Alderman, H. (Ed). No small matter: The human impact of poverty, shocks, and human capital investment in early childhood. Washington, DC: The World Bank.

²⁷ Engle, P. et al (2011). Strategies for reducing inequalities and improving developmental outcomes for young children in low and middle income countries. *The Lancet*, 378, 1339-1359; Black, M. & Dewey, K. (2014 in press). Promoting equity through integrated early child development and nutrition interventions. *Proceedings of the New York Academy of Sciences*.

²⁸ Moffit, T. et al (2011). A gradient of childhood self-control predicts health, wealth and public safety. *Proceedings of the National Academy of Science*, 108, 2693-2698; Wessels, I. et al (2013). Preventing violence: Evaluating outcomes of parenting programmes. Geneva: World Health Organization.

²⁹ Meaney, M. (2010). Epigenetics and the biological definition of gene x environmental interactions. *Child Development*, 81, 41-79.

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- ³⁰ National Scientific Council on the Developing Child (2010). Early experiences can alter gene expression and affect long-term development. Working Paper No 10, p 2. <http://developingchild.net>.
- ³¹ Champagne, F. (2010). Epigenetic influences of social experiences across the lifespan. *Developmental Psychobiology*, 52, 1-13; Kuzawa, C. & Thayer, Z. (2011). Timescales of human adaptation: The role of epigenetic processes. *Future Medicine*, 3, 221-234
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¹⁵⁷ Disability among children under the age of 5 years was not measured in Census 2011

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¹⁷⁷ The PETS survey found that over a third of facilities did not show the required evidence of pre-writing and pre-maths activities (Van den Berg et al, 2010). Further, many ECD centres still teach in rote fashion, and do little to promote creativity, thinking and exploration

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¹⁹⁵ *EMIS, Annual Survey*

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¹⁹⁷ DBE (2013) Draft Policy Framework on Universal Access to Grade R; Government Notice No 617. Government Gazette 15 August 2013, 36752

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²⁰⁶ South Africa is considered to have the highest incidence of Foetal Alcohol Syndrome in the world, with a prevalence of 68-89 per 1000 in certain areas (8%). (May, P. et al (2008). The epidemiology of fetal alcohol syndrome and partial FAS in a South African community. *Drug and Alcohol Dependence*, 88, 259–71. May, P. et al; (2000). Epidemiology of fetal alcohol syndrome in a South African community in the Western Cape Province. *American Journal of Public Health*, 90, 1905–12. Viljoen, D. (2005). Fetal alcohol syndrome epidemiology in a South African community: A second study of a very high prevalence area. *Journal of Studies on Alcohol*, 66, 593–604).

²⁰⁷ Information provided by Ilifa labatwana and Linda Biersteker

²⁰⁸ <http://www.southafrica.info/about/health/health.htm#UuS9T10aLIU>

²⁰⁹ ECD centres are categorised in the same quintiles as the public schools closest to them. The subsidy ranges from R5 per child per day for Quintile 5 to R17 per day for Quintile 1 schools serving the poorest communities, paid in respect of 200 school days per annum (between R1 000 and R3 400 per child per annum).

²¹⁰ Sigurdson, C. et al (2013). Health for learning: The Care for Child Development Package. *Early Childhood Matters*, 12, 23-27.

²¹¹ WHO/UNICEF (2012). Care for Child Development: Improving the care for young children. Geneva: World Health Organization.

²¹² WHO/UNICEF (2012). Care for Child Development Technical Note. Geneva: World Health Organization.

²¹³ Chopra, M. (2001). Chopra M. Assessment of participants on the care for development IMCI training course. Geneva: World Health Organization (unpublished report)

²¹⁴ Engle, P. (2011). Care for Development in three Central Asian countries: Report of process evaluations in Tajikistan, Kyrgyzstan and Kazakhstan. Geneva: UNICEF Regional Office; Ertem, I. et al (2006). Promoting child development at sick-child visits: A controlled trial. *Pediatrics*, 118,e 124; Jin, X. et al (2007). Care for Development: Interventions in rural China: A prospective follow-up study. *Journal of Developmental and Behavioral Pediatrics*, 26, 213-218.

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²¹⁶ DWCPD (2013). South Africa's initial country report on The African Charter on the Rights and Welfare of the Child. Pretoria: Department of Women, Children and People with Disabilities

²¹⁷ StatsSA (2013) South Africa's young children, their family and home environment. Pretoria: Statistics South Africa

²¹⁸ Richter, L. et al (2012). Diagnostic Review of Early Childhood Development. Pretoria: Department of Performance Monitoring and Evaluation, The Presidency

²¹⁹ StatsSA (2013) South Africa's young children, their family and home environment. Pretoria: Statistics South Africa

²²⁰ Desmond, S. (2008). Child minding services: Towards policy and practice. UNICEF Knowledge Building Seminar Nation Building from the Start. Pretoria: United Nations Children's Fund

²²¹ Linda Biersteker, Head of Research, Early Learning Resource Unit. Personal communication, August 2013.

²²² Personal correspondence with social work policy manager in the ECD Directorate, National Department of Social Development, June 2013

²²³ National Department of Social Development, October 2013. Children the focus of Ministerial visit, Media Statement. Available at: www.dsd.gov.za

²²⁴ Giese et al (2011). Government funding for ECD: Can those who need it get it. Cape Town: DG Murray Trust.

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²²⁶ Vargas-Barón, E. (2013). Building and strengthening national systems for early childhood development. In Rebello Britto, P., Engle, P. & Super, C. (Eds), Handbook of early childhood development research and its impact on global policy. New York: Oxford University Press.

²²⁷ Health Systems Trust (2013). District Health Barometer 2011-2013.

²²⁸ National Development Plan

²²⁹ www.education.gov.za/TheDBE/DBEStructure/GET/EarlyChildhoodDevelopment/tabid/96/Default.aspx

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²³¹ Department of Basic Education (2013). Universal Access to Grade R: Policy Framework (p. 4). "In 2009, the President indicated that the realisation of universal access to Grade R will be extended to 2014. There has been a steady increase in participation in Grade R from 15% of the age population in 1999 to 70% in 2010 in schools. This excludes coverage in community-based sites. According to the Action Plan to 2014, the target is to increase the percentage of children who have access to formal Grade R programmes to 80% by 2014 and 100% by 2019. Currently, the number of primary schools offering grade R has increased from 13,964 in 2008 to 15,096 in 2009. The goal is to have all primary schools with Grade 1 classes offering Grade R by 2014"

²³² Final Draft National Scholar Transport Policy (2009), p34.

²³³ Children and play, method of teaching in Grade R attached to school

²³⁴ Isibindi 10 000 workers

²³⁵ The 2000 National Norms and Standards for the Funding of Schools regulates state subsidies. Each provincial department ranks independent schools from the highest to the lowest fees they charge. Schools with the lowest fees receive 60% of the average per learner expenditure of the province. Schools with fees that are more than 2.5 times the provincial average per capital expenditure on a learner in a public school receive no subsidy.

²³⁶ Department of Social Development (2013). Policy for social service practitioners. Pretoria.

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- ²⁴² Biersteker, L. & Picken, P. (2013). ETDP SETA Sector Skills Plan ECD Update 2013-2014. Johannesburg: ETDP SETA.
- ²⁴³ Department of Social Development (2013). Policy for social service practitioners. Pretoria. Section 5.1.5.
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- ²⁴⁷ Biersteker, L. & Picken, P. (2013). Report on a survey of non-profit organizations providing training for ECD programmes and services (birth to four years). Cape Town: Ilifa Labantwana.
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- ²⁴⁹ Government of SA (2012). National Integrated Plan for Early Childhood Development *Tshwaragano Ka Bana* Programme 2005-2010 Review Report.
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- ²⁵¹ Southern Africa Labour and Development Research Unit. National Income Dynamics Study 2008, Wave 1 [dataset]. Version 5.2. Cape Town: Southern Africa Labour and Development Research Unit [producer], 2009. Cape Town
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