South African Child Gauge 2024

Enhancing early childhood development

Wiedaad Slemming, Linda Biersteker & Lori Lake

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD
FACULTY OF HEALTH SCIENCES

CHILDREN'S INSTITUTE

The *South African Child Gauge*® is published by the Children's Institute, University of Cape Town, to monitor progress towards realising children's rights. This issue of the *South African Child Gauge* focuses attention on early childhood development, reflecting on progress since the adoption of the National Integrated Early Childhood Development Policy in 2015, and setting an agenda for 2030.

PART ONE: Children and law reform

Part one comments on recent law reform that affects children, including the National Health Insurance Act, National Identification Registration Draft Bill, Draft Regulations of the Foodstuffs Act on the labelling and advertising of food, Children's Amendment Draft Bill, Basic Education Laws Amendment Bill, Children's Amendment Act and Regulations, and Traditional Courts Act. It also reports on recent court cases on laws that affect children, including the National Health Act, Regulations of the Births and Deaths Registration Act, and the Refugees Act.

See pages 14 – 35.

PART TWO: Enhancing early childhood development

Part two draws on the science to motivate for greater investment in early childhood development (ECD). It reflects on recent trends and the current status of ECD services in South Africa and evaluates progress in implementing the National Integrated Early Childhood Development Policy. The following three chapters focus attention on how to strengthen services to enhance outcomes across three critical domains of early childhood development: health and nutrition, care and support, and early learning, followed by a chapter that explores how to achieve equity by providing extra care. The final chapters focus on how to strengthen the ECD system by establishing an enabling policy environment, strong leadership and coordination, adequate financial and human resources, and good quality data to support effective delivery on the ground.

See pages 36 – 193.

PART THREE: Children Count – The numbers

Part three updates a set of key indicators on children's socio-economic rights and provides commentary on the extent to which these rights have been realised. The indicators are a select subset taken from the website **www.childrencount.uct.ac.za**.

See pages 194 – 235.

Front cover photograph:
Quality early learning begins in the home and evolves into more structured learning programmes. Finding Thabo is an innovative game that aims to promote responsive caregiving and early stimulation of young children, using a mix of pictures and technology.

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Abbreviations

CHW	Community Health Worker
COGTA	Cooperative Governance and Traditional Affairs
CSG	Child Support Grant
DBE	Department of Basic Education
DHA	Department of Home Affairs
DHIS	District Health Information System
DoH	Department of Health
DoE	Department of Education (provincial)
DSD	Department of Social Development
ECD	Early Childhood Development
ELOM	Early Learning Outcome Measure
ELP	Early Learning Programme
EPI	Expanded Programme on Immunisation
FCG	Foster Child Grant
GHS	General Household Survey
HIV	Human Immunodeficiency Virus
IDP	Integrated Development Plan
IF	Intersectoral Forum
IMC	Inter-Ministerial Committee
IMCI	Integrated Management of Childhood Illness
LMIC	Low- and Middle-Income Countries
MCWH	Maternal Child and Women's Health
MDT	Multi-Disciplinary Team
NCDs	Non-Communicable Diseases
NCF	Nurturing Care Framework
NCF	National Curriculum Framework Birth to Four
NDP	National Development Plan
NEET	Not in Employment, Education or Training
NFNSP	National Food and Nutrition Security Plan
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NIDC	National Inter-Departmental Committee
NIECD Policy	National Integrated Early Childhood Development Policy
NQF	National Qualifications Framework
NSNP	National School Nutrition Programme
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnerships
RDP	Reconstruction and Development Plan
RTHB	Road to Health Book
SADHS	South African Demographic and Health Survey
SAM	Severe Acute Malnutrition
SANHANES	South African Health and Nutrition Examination Survey
SAPS	South African Police Service
SACE	South African Council of Educators
SAQA	South African Qualifications Authority
SASSA	South African Social Security Agency
SDGs	Sustainable Development Goals
SOCPEN	Social Grants Payment System
Stats SA	Statistics South Africa
UHC	Universal Health Coverage
UNCRC Child	United Nations Convention on the Rights of the
UNCRPD	United Nations Convention of the Rights of Persons with Disability
WHO	World Health Organization

Foreword

Prof Mark Tomlinson
Institute for Life Course Health Research, Department of Global Health, Stellenbosch University

The publication of the 2024 South African Child Gauge *(Tracking progress and enhancing early childhood development)* occurs at an opportune time. Firstly, it is a welcome follow up to the 2013 Child Gauge *(Essential services for young children)* which for the first time focused attention on the range of services and supports needed to nurture young children's development and promote their overall well-being. In other words, what needs to be in place for young children to thrive and flourish. The 2024 issue is a wonderful opportunity to assess the progress that has (or has not) been made over the past 10 years in improving the lives of young children in South Africa.

The last half century has transformed our understanding of the human brain, the remarkable capacities of infants and children, and a deep understanding of what young children need to thrive. The Lancet series[1, 2], the Nurturing Care Framework[3] and the publication of the World Health Organization Early Child Development Guidelines[4] provide everything we need to know in terms of evidence for policy, implementation and systems change. But part of what these documents show is that children in South Africa and other poor countries face a myriad number of risks and threats to their development. The COVID-19 pandemic and associated aftershocks have precipitated a substantial growth in global poverty[5] – increasing poverty by 10%, which has affected over 100 million more children. Many poorer economies are mired in debt and development gains are backtracking with increases in malnutrition and stunting[5]. Nearly 60% of children in early learning programmes in South Africa are not developmentally on track, while 81% of Grade 4 children in South Africa are unable to read for meaning.

This year also marks the convergence of a number of significant local events. It marks the fifth time South Africans have voted in a democratic election, and for the first time, the African National Congress lost its absolute majority. This has ushered in a government of national unity with all the promises and problems that coalitions such as this bring. The last few years have also seen the transfer of responsibility for improving early child development from the Department of Social Development to the Department of Basic Education. The government of national unity begins its work however with a country characterized by massive inequality, endemic poverty, an education system that is failing the vast majority of South African children, and in a world increasingly characterized by conflict and political polarization. And all of this is taking place against the backdrop of catastrophic climate breakdown.

Almost 10 years ago, together with Professor Linda Richter and colleagues, we published a report entitled 'Early Means Early' where we presented findings from interviews with policy makers, stakeholders and members of the public about the importance of the early years. We concluded that one of the major barriers to providing services to the youngest children is the tendency for people to 'age-up' – and believe that it is only during preschool that learning and other key skills are acquired –despite most respondents being cognizant of the massive brain changes taking place in the first years of life.

Unfortunately, the term 'ECD' continues to be routinely used as 'shorthand' for a developmental **process**, a developmental **outcome**, and even for a **place** (preschool). Coherent framing is essential to guide interventions and financing. One concern with the transfer of responsibility for improving early childhood development to the Department of Basic Education is the danger that efforts will be concentrated on preschool and Grade R. Yet if we continue to fail to invest earlier in the health, nutrition and care of pregnant women, infants and young children, then even the best attempts at improving later platforms are likely to achieve only partial success.

The successful publication of a WHO Guideline is an important yardstick of when a certain threshold of evidence in a field has been obtained. With the WHO ECD Guideline[4], we are in a position to state, with some confidence, that we know how to deliver and implement interventions to improve

ECD in the early years. We know what to do. What we do not know is always how to implement these in the real world. Given this, I would contend that the testing of new 'branded interventions' through RCTs is no longer required. Rather, what we need is the careful cultural and contextual adaptation of existing programmes using implementation science with close attention to the structural and social determinants of optimal child development across the life course. We also require more research to isolate the "active" ingredients of interventions[6] that would assist us in reducing the significant overlap in a saturated programming field.

Climate breakdown is a singular threat to young children, and as is the case in most crises, the poorest and most vulnerable children are suffering, and will suffer the most. Policy, implementation and research priorities need to place climate breakdown front and center to ensure appropriate programmatic and systemic change to improve the resilience of children, families and communities. Research to fully describe the unique vulnerabilities of young children to climate breakdown is also essential.

Without wishing to sound overly heretical, the widespread practice of assuming that interventions that have been shown to be effective in tightly controlled RCTs will immediately be successful when implemented within a health or education system has done a disservice to the field of improving ECD, as well as to global health more generally. Results from RCTs are often not generalizable, and expecting comprehensive long-term benefits in contexts of high adversity is a bit like "placing flour in an oven for an hour and expecting a cake"[7]. Systems change takes time and happens in small steps and requires multiple shifts in multiple systems. Evidence is critical, but my contention is that the first step to achieving system change is to acknowledge that unless we put children at the center of our policy making and our decision making, they are likely to continue to play second fiddle to the vicissitudes of politics and the unpredictable currents of social and economic development.

There has been significant global and local success in advocating for improving early childhood development. Unfortunately, however, adequate financing has not followed. We need new, sustainable financing models, that incorporate a long-term component, and because funding for young children is 'too little, too late' the youngest children must be prioritized.

In a fascinating new book (*History for Tomorrow: Inspiration from the Past for the Future of Humanity*) the philosopher Roman Krznaric looks to history for lessons to help our present. In it, he makes a subtle but important clarification. He notes, that in fact the oft cited Chinese word for crisis is not so much about crisis and opportunity, as it is about a 'change point' or 'critical juncture' where a crucial decision needs to be made about the way forward. It is clear that young children in South Africa are in crisis. But this crisis offers an opportunity to do things differently. Given the crisis and this critical juncture, now is the time to pause. To pause and to think anew. The old way of doing things is simply not working for our children. I implore you President Cyril Ramaphosa and Minister of Basic Education Siviwe Gwarube, to firstly acknowledge the crisis our children find themselves in, and to then make the critical decision to prioritise young children in your planning for the way forward. Please be brave in your decision making and put children first. Please hold close the crucial understanding that early means early. Please put young children at the center of your policy making and position your investment in young children as an investment in reducing poverty and inequality, offering (easily) the highest rate of return, and in so doing build the foundations for future economic growth and a healthy and caring society.

Our children are in crisis, but in the words of Rebecca Solnit "Hope is not a door, but a sense that there might be a door at some point, some way out of the problems of the present moment even before that way is found or followed. Hope calls for action; action is impossible without hope." The time to act for children is now.

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Reflections on early childhood development

Minister of Basic Education

The Honourable Siviwe Gwarube

It is my privilege to introduce the 2024 *South African Child Gauge*, an essential document that underscores the critical importance of integrated services for children from conception through school-going age to foster lifelong learning and success. This report arrives at a crucial moment in our nation's pursuit of universal access to high-quality and integrated early childhood development (ECD).

We recognise that early childhood development is a cornerstone of South Africa's future, shaping the foundational years crucial for children's cognitive and physical growth. Factors such as health, nutrition, nurture and stimulation significantly influence this developmental phase. When children receive adequate care during the formative early years, they embark on their educational journey with well-established foundations for personal well-being and future achievements.

Recognizing the pivotal role of early childhood development, we have prioritized it within our national agenda to enhance education quality and secure lasting prosperity for generations to come. Effective early childhood interventions are most impactful when policies and actions are intersectoral and cohesive, providing holistic support to young children and their families.

Since assuming responsibility for early childhood development in 2022, the Department of Basic Education has adopted an evidence-based approach to craft its 2030 Strategy for ECD Programmes. This strategy serves as a comprehensive blueprint aimed at achieving universal access to quality ECD programmes by 2030, with a strong emphasis on expanding access for the most vulnerable children.

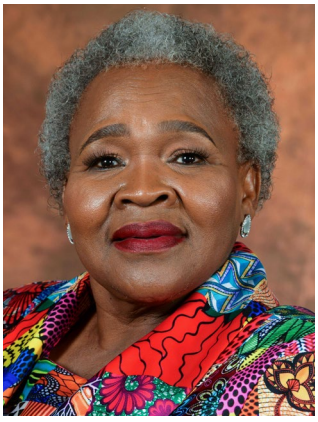
Central to our strategy is the establishment of a new Social Compact for ECD, uniting stakeholders across sectors and communities. Acknowledging that government efforts alone cannot achieve our ambitious goals, this compact seeks to harness community strengths and resources toward a shared vision of universal access to quality ECD programmes by 2030.

The 2024 *Child Gauge* embodies this vision by providing a robust, evidence-based assessment of the holistic provision of services to children. It serves as a beacon guiding our efforts to ensure every child in South Africa has the opportunity to thrive and succeed from the earliest stages of life.

I commend this report to all stakeholders committed to the well-being and future of our nation's children.

Minister of Social Development

The Honourable Nokuzola Tolashe



It is with pleasure that I introduce the 17th annual review of the *South African Child Gauge*, a valuable publication that gives a detailed account of the well-being of children in our country. As I write this piece, I am filled with optimism that my department, working in collaboration with all key partners, will continue to use this publication as a barometer as we work towards a South Africa fit for children.

The year 2024 marks 30 years of freedom and democracy in South Africa. This historic milestone requires a proper refection on how far we have come in protecting and promoting the rights of our children who have a special place in the Constitution of our country.

The *Child Gauge* provides a unique opportunity to celebrate our collective achievements in areas where we have made progress. It also requires that we consolidate our collective efforts in areas where we are lagging behind.

We launch this publication against the backdrop of an alarming increase in child malnutrition in some parts of the country. I am pleased with the measures taken to date to implement the recommendations of the South African Human Rights Commission on this matter and we will continue to do all we can to protect children from food insecurity and hunger, as we continue to strive to improve outcomes for all children to fulfill their true potential.

Working jointly with the Departments of Health and Home Affairs, we have prioritised coordinated efforts to ensure universal birth registration to facilitate access to essential services from birth. Tackling child poverty will remain central to the work of the Government of National Unity over the next five years.

The National Development Plan recognises early childhood development (ECD) as the period of human development from conception to when the child turns 6 years old. This is a cornerstone for development as it provides a firm foundation for learning and pathways to economic upliftment. The National Integrated ECD Policy seeks to maximise positive opportunities for children to get an early start in life that will provide a strong platform for the future success of our country. The establishment of the Inter-Ministerial Committee on ECD by President Ramaphosa, with Social Development as one of the key member departments, is a fundamental shift and commitment to address the needs of those children whose lives, opportunities and ambitions are constrained by poverty, unemployment and inequality. At the heart of this shift is a desire to see more investment in the early years.

Following the transfer of the ECD coordinating function to the Department of Basic Education in 2022, the role of social service professionals in relation to ECD programmes for young children and their families was redefined. The support we give on a daily basis includes support to families with young children, prevention and early intervention services as well as specific services to support families with children with disabilities and children in need of care. These services remain central to the mandate of the Department of Social Development.

The National Plan of Action for Children (2024 – 2029), which is currently undergoing national consultation processes, is instructive in what we need to do over the next five years to address some of the policy and programmatic shortcomings highlighted in the *Child Gauge*. These consultations will include engagement with many children across South Africa – enabling children and young people to have their voices heard and to raise issues that concern them.

I want to record my sincere appreciation to all who have supported and contributed their expertise to this publication. We look forward to working with all our partners to take forward the recommendations and ensure that children's rights remain at the centre of our work for this electoral term and beyond.

Minister of Health

The Honourable Dr Aaron Motsoaledi

This issue of the *South African Child Gauge* focuses on the importance of the First 1,000 days and the role of nurturing care during early childhood in promoting lifelong health, emotional and social well-being as well as improved educational outcomes. In doing so it makes a powerful case for increased investment in the well-being of young children, their mothers and their families.

Early intervention has the potential to decrease inequality and interrupt intergenerational cycles of poverty. Maternal and child nutrition during the first 1,000 days affects not only the child's growth, cognition and subsequent school attainment, but also impacts on lifelong risk of developing chronic disease.

The National Integrated Early Childhood Development Policy (NIECD Policy) recognises the interlinked nature of child growth, health and development and calls on the health sector to play an expanded role in early childhood development, in order to ensure that young children not only survive but reach their full potential. Optimising the development of young children cannot be separated from efforts to optimise the health and wellbeing of women and their families.

The *Child Gauge* provides an opportunity to reflect on what has been achieved since the NIECD Policy was approved by cabinet in 2015. It is encouraging to note that coverage of a package of essential maternal and child health services (predominantly provided by Primary Health Care facilities) has continued to increase during this period. Mothers and young children have continued to benefit from free health services, and innovative communication campaigns have increased access to information for mothers during pregnancy and the postnatal period (through MomConnect) and provided support to parents and other caregivers regarding the full scope of early childhood development (through the Side-by-Side campaign).

However, much remains to be done. Because health services for mothers and children are integrated into routine health services at community, primary health care and hospital levels, coverage and quality of these services are highly dependent on the overall coverage and functioning of the health system. Building a strong and resilient health system and ensuring that all policies and guidelines take the needs of women, children and adolescents into account are the best ways to ensure that the health sector delivers on its commitment to ensuring that mothers and children survive and thrive. A stronger health system will be able to expand the scope of services provided and place more emphasis on nutrition (especially addressing stunting and childhood obesity) and maternal mental health.

A strong and resilient health system in turn requires a more effective and equitable financing system, hence our commitment to implementation of National Health Insurance (NHI). NHI is a health financing system that pools funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. This will allow every South African to access comprehensive health-care services free of charge at the point of use at accredited clinics, GPs, other health providers and hospitals. NHI will increase access to health services for everyone, including pregnant women, mothers, children and adolescents, by ensuring that access to health services is based on need rather than ability to pay.

Community health workers (CHWs) have the potential to enhance maternal and child health and development, and there is a need to ensure that CHWs prioritise maternal and child health and nutrition services.

The delivery of a comprehensive package of care and support for young children and their families depends on the collaborative efforts of a wide range of stakeholders in both government and civil society. I therefore call on all role-players – communities, health and other care workers, policy-makers, researchers, educators – to work together so that we can ensure that all mothers and young children survive and thrive, and that no child is left behind.

Part 1

Children and Law Reform

Part one summarises and comments on recent law reform that affects children, including the:

- National Health Insurance Act
- National Identification Registration Draft Bill
- Draft regulations of the Foodstuffs Act on the labelling and advertising of food:
- Children's Amendment Draft Bill
- Basic Education Laws Amendment Bill
- Children's Amendment Act and Regulations
- Traditional Courts Act

And reports on recent court cases on laws that affect children, including on the:

- National Health Act: Free health care services for pregnant women and children under six
- Regulations of the Births and Deaths Registration Act: Adding a father's details
- Refugees Act: Expired asylum seeker visas and the abandonment rule

Quality early learning begins in the home and evolves into more structured learning programmes. Finding Thabo is an innovative game that aims to promote responsive caregiving and early stimulation of young children, using a mix of pictures and technology.

Law reform and case law affecting children 2023/24

Paula Proudlock,[i] Mbonisi Nyathi,[i] Zita Hansungule-Nefale,[ii] Tess Peacock,[iii] Lori Lake,[i] Tamryn Frank[iv] & Katie Pereira-Kotze[v]

In this chapter we summarise and comment on recent law reform and court cases that affect children. We have chosen to focus on a few notable reforms relevant to young children, and have clustered the developments according to service categories to enable readers to locate the issues most relevant to their area of interest.

Maternal and child health services

- Section 4 (3) of the National Health Act on free health care services for pregnant women and children under six years old has been interpreted by the High Court to include all women and children under six, irrespective of their nationality or documentation status.
- The National Health Insurance Act was passed by Parliament in 2023 and signed by the President in 2024 but is not yet in effect.

Birth registration, identity and nationality

- Regulation 12 (2)(c) of the Births and Deaths Registration Act has been declared unconstitutional for discriminating against children of unmarried fathers who do not have valid visas.
- Sections 22 (12) & (13) of the Refugees Act have been declared unconstitutional for deeming asylum seekers to have abandoned their refugee application if their asylum seeker visa had expired.
- The National Identification Registration Draft Bill has been published for public comment and is being prepared for tabling in Parliament.

Child nutrition

- Draft regulations of the Foodstuffs, Cosmetics and Disinfectants Act on the labelling and advertising of foodstuffs were published for comment in 2023 and are being finalised for promulgation.

Early childhood development programmes

- The Children's Amendment Draft Bill was published for comment in 2024 and is being prepared for tabling in Parliament.

Basic education

- The Basic Education Laws Amendment Bill was passed by Parliament in 2024 but is not yet signed by the President.

Family care and protection from abuse and neglect

- The Children's Amendment Act was partially put into effect in 2023 and regulations were promulgated at the same time.
- The Traditional Courts Act was signed by the President in 2023 but is not yet in effect as regulations are still being drafted.

Maternal and child health services

Section 4 (3) of the National Health Act: Pregnant women and children under six are entitled to free health care irrespective of nationality or documentation status

In *SECTION27 and Others v MEC of Gauteng Department of Health and others*,[1] the High Court interpreted the right to free healthcare for pregnant women and children under six years of age, provided by section 4 (3) of the National Health Act,[2] to include all women and children, irrespective of their nationality and documentation status. The case was brought to court by SECTION27 and three women who had been required to pay a fee at hospitals in Gauteng before being allowed access to health services for their pregnancy or their child.

The Court order declares that Gauteng policy and regulations,[vi] which excluded non-citizens and undocumented pregnant women or children under six years, or required them to pay fees prior to accessing health care services, are unlawful. To ensure that the court order would be implemented at health

i Children's Institute, University of Cape Town
ii LLD candidate, University of Pretoria
iii Equality Collective
iv School of Public Health, University of the Western Cape
v South African Medical Research Council
vi These included the Implementation Guidelines on Patient Administration and Revenue Management (2020); and General Notice 1426 in Provincial Gazette 414 of 24 November 2021, Regulations on the classification of and fees payable by patients at provincial hospitals, issued in terms of the Gauteng Hospitals Ordinance 14 of 1958.

facilities, the National Minister of Health was ordered to issue a circular to all provinces and ensure that all health facilities displayed posters which made these rights known to health facility staff and patients.

The court specified that the posters must state that:

"ALL pregnant women,
ALL women who are lactating, and
ALL children below the age of six
Are entitled to free health services at any public health establishment,
irrespective of their nationality and documentation status, unless:

- They are members or beneficiaries of medical aid schemes, or
- They have come to South Africa for the specific purpose of obtaining health care."

The High Court further ordered that the respondents appear before the court in October 2023 to provide a comprehensive report on their compliance with the order.

Compliance with the order

The respondents returned to the Court for the compliance hearing in October 2023.[3] They reported that the Policy had been amended[4] and that they had sent posters to all the provinces and all health facilities in Gauteng, and that a number of health facilities in Gauteng had displayed posters on their notice boards and in wards. They admitted there were some facilities that were not displaying the posters including the Charlotte Maxeke Hospital, Hillbrow Community Health Centre, Helen Joseph Hospital, South Rand Hospital, Kalafong Hospital and Thelle Mogoerane Hospital.

The Court gave the respondents until 6 November 2023 to fully comply with the court order. Should there be non-compliance, Judge Sutherland undertook to personally attend the relevant hospitals to monitor compliance. The respondents subsequently fully complied with the court order.

SECTION27 continues to monitor compliance with the court order and reported that it has experienced a huge drop in complaints, indicating that the Department of Health (DoH) is complying. Any non-compliance with the order can be reported to SECTION27 or the Centre for Child Law. This will enable them to continue to ensure that the court order is implemented.

National Health Insurance Act

The National Health Insurance (NHI) Act[5] has been passed by Parliament and signed by the President.[vii] It will take a few years before it can be put into effect because regulations still need to be drafted and financial laws amended. The NHI has the potential to improve child health outcomes for over 80% of the population who are currently reliant on an under-resourced public health care system.[6]

Children entitled to a broadly defined package of basic health care services

The Act explicitly provides in section 4 (3) that "[a]ll children, including children of asylum seekers and illegal foreigners, are entitled to basic health care services as provided for in section 28 (1)(c) of the Constitution". This ensures that the law is aligned with section 28 (1)(c) of the Bill of Rights which guarantees every child the right to basic health care services.

The term 'basic health care services' has never previously been defined and child health experts have been advocating for many years for legislation to define what the basic package should contain.[7] In response to submissions, Parliament agreed to add a definition of 'basic health care services'. The Act defines 'basic health care services' in section 1 as:

> *"services provided by health care service providers which are essential for maintaining good health and preventing serious health problems including preventative services, primary health care, emergency medical services, diagnostic services, treatment services and rehabilitation services".*

This broad definition extends beyond medical treatment and emergency medical care to include primary health care services such as sexual and reproductive health services, antenatal care, nutrition services and immunisation that are essential in promoting health and preventing childhood and lifelong illnesses and disability. The inclusion of rehabilitation services is a welcome addition as they are essential in helping children recover from illness or trauma, and in enhancing the functioning and participation of children with disabilities, long term conditions and developmental delays. However, it remains to be seen exactly which health care services under these categories, basic and beyond, will be included in the NHI baskets of care for children and adolescents.

Unfortunately, palliative care (for terminally ill children and children with severe health-related suffering) is not explicitly included in the definition. This omission is concerning given that palliative care is considered an essential element of the definition of health care by the World Health Organization (WHO)[8] and the United Nations Committee on the Rights of the Child.[9] Paediatric palliative care remains a weakness and a source of suffering in South Africa's health care system. Its

vii It was passed by Parliament at the end of 2023 and signed by the President in May 2024.

exclusion from the definition is likely to further marginalise these already under-resourced services.

Undocumented children and children of asylum seekers and 'illegal foreigners' are entitled to basic health care services

The Act clarifies explicitly in section 4 (3) that all children, including the children of asylum seekers and 'illegal foreigners' are entitled to basic health care services. This means that the NHI may not exclude any child from accessing basic health care services based on the immigration status or lack of documentation of their parents or themselves. This section will also protect South African children who do not have birth certificates and whose parents do not have identity documents (IDs), from exclusion.

However, other sections of the Act may pose a practical barrier to child asylum seekers, illegal foreigners, South African children without birth certificates, and South African parents without IDs: Section 4 (4) requires all users to positively identify themselves and be registered with the fund in order to access services. Undocumented parents and children will not be able to positively identify themselves as they have no documentation. They will also not be able to be registered because the registration requirements set out in section 5 provide no exceptions for adults or children unable to produce the listed documents which are limited to IDs, birth certificates or refugee identity documents. This oversight could be rectified by amending the Act to clarify how an undocumented person can register using alternative proof of identity.

Pregnant and lactating adult women who are asylum seekers or illegal foreigners are excluded

While the Act explicitly provides that children who are asylum seekers or illegal foreigners are entitled to basic health care services, section 4 (2) restricts access for adult asylum seekers and illegal foreigners to "emergency health care services" and "services for notifiable public health concerns". This is a step backwards for the rights of pregnant women who, under the National Health Act, have the right to free health care services, irrespective of their nationality or documentation status.[10] This could result in some pregnant women being denied access to antenatal and obstetric services which will not only put their health and lives at risk, but also the lives and health of their infants. Such an approach will increase the risk of birth complications, resulting in increased maternal and neonatal deaths and more infants born with disabilities and long-term health conditions. This is likely to cost the NHI more as emergency obstetrics and health care services for at-risk newborns and children with disabilities (which the NHI is legally obliged to fund) will be more costly than providing basic maternal health care services to all women.

Birth registration, identity and nationality

Court orders to enable unmarried fathers to register their children are not being implemented

In previous issues of the Child Gauge,[6, 11] we reported on the *Naki (2018)*[12] and *Centre for Child Law (2021)*[13] judgements in which the High Court and the Constitutional Court declared regulations and a section of the Births and Deaths Registration Act (BDRA)[14] to be unconstitutional because they discriminated against children born to unmarried fathers by preventing their births from being registered.

In August 2020, when opposing the Centre for Child Law's appeal in the *Naki* case, the Department of Home Affairs (DHA) told the Constitutional Court that it had started the process of amending the regulations of the BDRA to enable unmarried fathers to give notice of birth for their children.[15] However, nearly four years later, the DHA has not amended the BDRA regulations or its internal documents to guide officials on how to implement the various judgments. As a result, the judgments are generally not being implemented by local offices and the children of unmarried fathers (whether South African citizens or foreign) remain unable to be registered.[viii]

Regulation 12 (2)(c) of the Births and Deaths Registration Act declared unconstitutional

In the recent case of *UJ and Another v Minister of Home Affairs and Another*[16], the High Court has found another Regulation of the BDRA to be unconstitutional because it prohibits a father from being added to his child's birth certificate if he is not a citizen and does not have a valid visa.

Section 11 (4) of the BDRA allows for an unmarried father wishing to acknowledge himself to be the father of a child who already has a birth certificate, to apply to amend the birth certificate by including the father's details. Regulation 12 prescribes the manner in which an application ought to take place (for example the mother must be present and consent) and sub-regulation (2)(c) specifies that if the person is not a South African citizen, he must submit a valid passport and valid visa.

In the *UJ case*, the parents of the child were unmarried yet lived together as if married. The mother is a South African citizen and the father is a Bulgarian citizen. The child's birth was initially registered by the mother and did not include the father's details. When the parents attempted to add the father's details

viii Experiences of public interest law firms and academic units assisting such families, including Centre for Child Law, Children's Institute, and the Legal Resources Centre.

to the child's birth certificate at the Gqeberha Home Affairs office, the officials refused to add his details, citing the reason that the father was a non-South African citizen without a valid visa. He was informed that if he wanted to add his details, he would need to do a paternity test at his own cost and provide a court order declaring him the father. The parents launched court proceedings against the Minister and DHA, seeking an order declaring regulation 12 (2)(c) unconstitutional. They argued the regulation discriminated against their child, as well as many other children in similar situations with non-citizen fathers who do not have valid visas.[17]

The Court held that the regulation discriminated against children who were born outside of marriage and whose fathers were in South Africa illegally or were undocumented citizens of another country, and that there was no convincing justification for the discrimination.[18] The discrimination was also irrational as it disadvantaged the child (for example, it could deprive him of obtaining Bulgarian citizenship) based on something over which the child had no control[19] and there were other lawful means of addressing the father's unlawful presence in the country without having to infringe the rights of the child.[20] When interpreting section 11 (4) of the Act, the Court remarked that Parliament used the words 'any person' and therefore made no distinction between South African citizens and non-South African citizens, or between non-citizens who are legally or illegally in the country.[21] Because Parliament elected not to discriminate between children based on the citizenship or immigration status of their parents, the Minister was not authorised to restrict the application of section 11 (4) based on the father's status as he had done in Regulation 12 (2)(c).[22] The Regulation was therefore declared unconstitutional.

With multiple Regulations to the BDRA with regards to children of unmarried fathers having been declared unconstitutional or amended by the Courts over the past six years, there is a dire need for the Regulations and Application Forms to be amended by the Minister to correctly reflect the law.

Sections 22 (12) & (13) of Refugees Act declared unconstitutional

The Refugees Act[23] sets out the procedure for asylum applications and defines the standards to obtain refugee status in South Africa. The Act specifies that the applicant needs to complete an asylum application form in person at one of the Refugee Reception Offices (RRO). They will then be issued with an asylum seeker visa while the process to determine their refugee status is under way. Asylum seeker visas are valid for between six to 12 months. While the refugee status determination process is supposed to only take six months, in reality it takes many years. Asylum seekers must continue to renew their asylum seeker visas until a final decision is made. If successful, they will be issued with a refugee certificate of recognition which is valid for four years.

Refugees Amendment Act introduces the abandonment rule

In 2020, an Amendment Act introduced section 22 (12) and (13) into the Refugees Act, and the regulations were also amended.[ix] The effect of these amendments was that asylum seekers who failed to renew their visas within one month of their expiry dates were considered to have 'abandoned' their applications for refugee status ('the abandonment rule').

This new abandonment rule adversely affected many asylum seekers and their children who had been unable to keep up with the six-monthly renewals of their visas due to circumstances outside their control, such as a lack of money to travel to one of the few RROs every six months. The Scalabrini Centre launched a constitutional challenge to the automatic presumption of abandonment as it would lead to many asylum seekers and their children, who have genuine claims to refugee status, being deported back to circumstances in which they face further persecution.[24] It would also lead to many being undocumented which would restrict their access to normal life functions.[25]

Principle of individualised decision-making in all matters concerning children

The Consortium for Refugees and Migrants in South Africa (CoRMSA), admitted as a friend of the court, submitted that the provisions violated the principle that there should be individualised decision-making in all matters concerning children.[26] Children who were listed as dependents on asylum applications by their parents were at the mercy of the bureaucratic process governing their parent's claim. This meant that when a parent's claim is deemed abandoned, all their children's applications will also be automatically deemed abandoned.[27] This has led to children being exposed to the severe consequences of being undocumented for long periods of time as well as the risk of refoulment (deportation to the country from which they have fled) as a result of circumstances beyond their control.[28] CORMSA also argued that unaccompanied and separated children were particularly vulnerable and experienced great difficulty in accessing documentation, and that the abandonment rule introduced a

ix Regulation 9 and Form 3.

further barrier that made it harder for these children to legalise their stay in South Africa.[28]

Backlog of asylum applications

DHA argued that the provisions served the legitimate government purpose of addressing the backlog of inactive asylum applications by incentivising applicants to take an interest in completing their applications.[29] They also argued that the provisions were necessary to help prevent recalcitrant asylum seekers (asylum seekers who have no valid claims) from abusing the asylum system.[30] DHA informed the Constitutional Court that they had 737,315 'inactive' applications for refugee status[31] and that these 'inactive' cases disproportionately exceeded the number of active cases, creating a massive backlog and resulting in delays in finalising asylum applications. An application is considered 'inactive' if the asylum seeker's visa has expired and not been renewed in time. According to the Auditor General, it would take 68 years to clear the refugee status determination backlog – excluding any new applications.[32] Scalabrini argued that DHA failed to acknowledge and accept that the major contributing factors to the backlogs in the asylum application system lay within their own control. These factors included the respondent's decision to close RROs in certain urban areas and its lack of capacity to process asylum applications timeously.[33]

High Court declares the abandonment rule unconstitutional

These sections, and their associated regulations, were declared unconstitutional by the Western Cape High Court in 2023.[24] The court held that the provisions severely limited asylum seekers' rights to non-refoulment and deprived them of the protection of the asylum system. There was no defensible and logical connection between this limitation and the alleged purpose of reducing the backlogs in the asylum application system. And even if there was a connection, the sanction imposed on asylum seekers was grossly disproportionate to the purpose of reducing backlogs, since deported refugees could face torture or death just for being late in renewing their visas.[34]

The court held that the abandonment rule violated the fundamental rights of asylum seeker's children for the sake of alleged administrative convenience. Their basic rights to food, health and education could not be sacrificed and surrendered in this way, without individualised determination.[35]

The state was directed to amend the sections without delay[36] and the declaration of invalidity was referred to the Constitutional Court for confirmation.

Constitutional Court confirms the High Court finding

In a unanimous decision, the Constitutional Court confirmed the High Court's finding of constitutional invalidity[37] which was made retrospective to 1 January 2020, the date on which subsections 22 (12) and 22 (13) came into operation.[38]

The Court held that the sections violated a number of constitutional rights including the right to dignity, by cutting asylum seekers off from essential services needed for a dignified life such as banking, education and healthcare.[39] The asylum seekers and their children were also exposed to the constant risk of arrest, detention, and deportation, in contravention of the rights to life and personal liberty.[40]

The Court also stressed that the deemed abandonment of parents' asylum applications has drastic consequences for their children. One child had spent an entire year out of school due to their parent's visa being expired and deemed abandoned, while another could not register to write matric exams. The deemed abandonment of an asylum application disregards the constitutional recognition of children as individuals, with distinctive personalities and their own dignity, who are entitled to be heard in every matter concerning them.[41]

National Identification Registration Draft Bill

The DHA published the National Identification and Registration Draft Bill[42] for public comment in April 2023. Once passed, the Bill will repeal the Identification Act[43] which currently governs the National Population Register (NPR) and applications for IDs.

Inclusive National Identification System

The Bill gives effect to the Official Identity Management Policy[x] and seeks to provide a single, inclusive and integrated digital National Identification System (NIS) for all people who live or have lived in the country. It provides for the compilation and maintenance of a population register for citizens and permanent residents, and the creation of an identification database for certain non-South African citizens who live temporarily in the country. While the concept of a register of citizens and permanent residents is not new, the creation of an identification database for non-citizens is a new development.

Table 1: National identification system

National Identification System (NIS)	
National population register	**Identification database**
Citizens & permanent residents	Non-SA citizens who live temporarily in SA

x The final policy is not available on DHA's website. A draft of the policy prior to public comments is available at https://www.gov.za/sites/default/files/gcis_document/202101/44048gon1425.pdf

The NIS will be based on biometrics and will enable a single view of a person on either the population register or the identification database. It will also be able to interface digitally with other government and private sector identity systems.

Aims to ensure the universal registration of all vital events

The first object of the Bill is "to ensure universal registration of all vital events ... including births, marriages and deaths".[44] Universal registration of births would ensure that all children born in South Africa are able to obtain a birth certificate. However, the Bill does not have any sections aimed at addressing the reasons why many children currently do not have birth certificates.[45, 46]

Birth registration is currently provided for by the BDRA, which the Identification and Registration Bill does not propose to amend or repeal, despite the BDRA and its regulations being outdated and containing multiple sections that have been declared unconstitutional by the courts.[45] It is therefore not clear how the objective of universal birth registration will be achieved by this draft bill.

Age for first ID application to be lowered to 10 years

A significant proposed change is the lowering of the age at which a child should apply for an ID from 16 to 10 years of age.[47] The rationale is to enable biometrics to be captured earlier, curb identity theft, and ensure matriculants have a smart ID card before they write their matric examinations.[48] In addition, the previous Minister stated that this amendment will enable access to children's fingerprints to aid the fight against crime.[49]

Child applicants must be assisted by a parent or guardian

In practice, DHA requires first time ID applicants to be accompanied by their parents or guardians, although this requirement is not in the law. The bill proposes to make this practice a legal requirement by legislating that a child applying for an ID must be assisted by a "parent or guardian or any person who is duly authorised" to submit such an application on behalf of the child.[47] The Bill does not clarify what is meant by "any person who is duly authorised".

This current practice and future legislative requirement poses an inflexible barrier for many children and youth who do not have parents, legal guardians or "duly authorised" persons to assist them.[45, 46] This gap could perpetuate the growing difficulties in obtaining IDs that are being experienced by adolescents and young adults who have lost the link to their biological parents.

A rigid requirement to produce a parent or legal guardian fails to acknowledge that over four million children are not living with either of their biological parents, and many of these children are separated geographically from their biological parents.[45] The majority of their caregivers are relatives who are not legal guardians and do not have court orders placing the children in their care.[xi] The Bill therefore needs to make provision for family members to assist children in their applications for IDs if they have been orphaned or abandoned by their biological parents. For children and parents living in different provinces, the Bill needs to provide the option for the parent and child to each visit their closest DHA offices in the province where they live to do the ID application and verification processes. As DHA is a national agency, its NIS should enable such a function.

No provisions to ensure IDs can only be cancelled after following fair procedures

The Bill has been critiqued for the lack of provisions setting out procedures to verify, investigate and cancel certificates and ID cards in line with the Promotion of Administrative Justice Act (PAJA).[46] DHA was recently in the High Court defending its practice of 'blocking' IDs of people with duplicated IDs, errors on their IDs, or who are suspected of obtaining their IDs fraudulently.[50] The applicants in the case argued that the practice of blocking IDs is unconstitutional because it has no basis in law and is not done in terms of PAJA. The DHA conceded this point in its papers and in court, effectively admitting that it is acting outside of the law when blocking IDs. The Court ruled that ID blocking is unconstitutional because it does not follow fair procedure in terms of PAJA.[50] This Bill represents an opportunity to legislate a fair and transparent process for dealing with suspected ID fraud, duplicates and clerical errors.

Modernisation likely to entrench systemic exclusion unless underlying reasons for exclusions are addressed.

One of the central aims of the Bill is to create an 'inclusive' NIS. Modernisation and digitalisation are often posited as means to promote inclusivity. However, if the new system does not account for people already excluded from the current registration systems and entrenches the rigid requirements that have caused these exclusions, it will not achieve the aim of inclusion. The World Bank estimated that in 2018 there were approximately 15 million unregistered people in South Africa.[51] Since COVID-19, this number is likely to have grown significantly. DHA needs to address the underlying reasons for

xi Legal guardianship has required an application to the High Court, making it inaccessible for the majority of relatives caring for orphaned children. Since December 2023, relatives can apply for legal guardianship to the Children's Court, but this change in the law it not well known and there is no information available on government websites advising relatives on how to apply.

these exclusions if it is to realise the vision of inclusion promised in the preamble of the Bill. Introducing a new modernisation project without addressing such gaps is likely to entrench the systemic exclusion of those who are already marginalised and will compromise the completeness and accuracy of the new NIS.

Child nutrition

Draft regulations on the labelling and advertising of foodstuffs

Draft regulations to the Foodstuffs, Cosmetics and Disinfectants Act,[52] relating to the labelling and advertising of foodstuffs, were published by the National Department of Health (NDoH) for public comment in 2023.[53] Once finalised, the regulations will replace the 2010 regulations.[54]

The draft regulations propose a Nutrient Profiling Model for Foodstuffs to identify products that contain excessive amounts of nutrients of concern – including if the products exceed the cut-offs for sugar, salt and saturated fat, or contain non-sugar sweeteners. Such products will be required to carry a front-of-package warning label (FOPwL). The warning labels aim to assist consumers to make healthier decisions at a glance, which is especially important for parents selecting foods for their children. They also may not carry any health or nutrition claims and may not be marketed or advertised to children.

Figure 1: Front of pack warning labels

Alignment with global health guidance, human rights frameworks and scientific evidence

The draft regulations are a low-cost intervention and grounded in a strong scientific evidence base,[55] including the nutrient profiling model to identify unhealthy foods, the recommendation of mandatory FOPwL on unhealthy foods,[56, 57] the prohibition of health and nutrition claims on products with FOPwL and restrictions on child-directed marketing.[58]

The use of FOPwLs has been proven effective in discouraging consumption of unhealthy products,[59-61] and the labels have been tested to ensure they are easily understood in South Africa.[62-65]

The implementation of mandatory restrictions on the marketing of unhealthy foods and drinks will contribute to realising children's constitutional rights to food, nutrition, health, survival, and development. In addition, the FOPwL upholds children's rights to information (consistent with principles in the Consumer Protection Act)[66] and protection from harmful business practices (as outlined in the UNCRC's General Comment 16)[67]. The draft regulations also align with guidelines issued by the WHO which recommended mandatory, government-led regulations to protect children from the harmful impact of food marketing.[68]

Calls for restrictions to be strengthened and expanded

Submissions from health and food rights organisations have welcomed the draft regulations and called for marketing restrictions to be strengthened and expanded to cover the full range of marketing strategies used by companies to target children as consumers across both traditional and digital marketing platforms.[69-72] For example, submissions have called for the following marketing strategies to be prohibited for products carrying FOPwLs:

- the sale or advertisement of such products in schools and other child-centred settings;
- the depiction of children and adolescents on packaging, advertising or marketing materials; and
- the provision of nutrition education to the public or sponsorship of educational and scientific events by the food and beverage industry that produces such unhealthy products.

Submissions also called for restrictions on point-of-sale or location-based marketing (such as displaying sweets and chips in the checkout queues) and for the regulations to be expanded to restrict the marketing of unhealthy fast foods. A robust monitoring and enforcement mechanism will be needed to ensure compliance and implementation.[69]

Child overweight and obesity has nearly doubled since 2016, and now affects nearly one in four children under five.[73] Finalising the regulations and ensuring their effective enforcement could contribute to reversing this concerning trend. The previous draft regulations that were disseminated for comment in 2014 were never finalised due to a strong lobby against them from the food and beverage industry. Government will therefore need to withstand efforts from the food and beverage industry to delay and dilute the regulations.

Early childhood development programmes

Children's Amendment Draft Bill

In 2021, Parliament's Portfolio Committee on Social Development rejected the early childhood development (ECD) related amendments in the Children's Amendment Bill of 2020.[74] This decision came after 1,600 submissions[75] highlighted how the Bill failed to address the challenges of the ECD sector.[76]

Subsequently, the Department of Basic Education (DBE) led a Task Team, composed of government and civil society, to develop new amendments to the ECD chapter of the Children's Act.[77] This resulted in the Children's Amendment Draft Bill (2023) which was published by the DBE for public comment in May 2024.[78] The Bill is expected to be tabled in Parliament later in 2024, with further opportunities for public participation at that stage.

The draft bill reflects the shift of responsibility for ECD programmes from the Department of Social Development (DSD) to the DBE[79] and is aimed at improving the legal framework for ECD programmes under the Children's Act, while DBE works on drafting a more holistic integrated 'ECD Act'.[80]

Supporting young children and their caregivers in their early years is essential for reducing poverty and inequality and is recognised as a "fundamental and universal human right".[81] The recent steps taken by the DBE are welcomed by many in the sector who have long been advocating for an enabling legal framework to ensure universal access to inclusive, holistic and quality ECD programmes.[82]

Definition of ECD programmes

The Bill removes the concept of an 'ECD service' from section 91 of the Children's Act and re-defines 'ECD programme' expansively as "any type of programme that provides one or more forms of care, development, early learning opportunities and support to children from birth to school going age". As currently worded, this could be interpreted to mean every programme must provide all the components – care, development, early learning, *and* support. This may not be typical of some types of ECD programmes such as some parent support groups, for instance, and thus the definition should be framed in the alternative ('or' instead of 'and'). Further, the starting point of 'birth' in the proposed definition does not align with the National Curriculum Framework[83] and the National Integrated Early Childhood Development Policy[81] which define ECD interventions as starting before birth or upon conception and including maternal health services. The rationale behind the choice of birth as the starting point for the definition in this Bill should be made clear in the memorandum to the Bill.

A one-step registration process for all ECD programmes

Currently, ECD programmes must register as partial care facilities under Chapter 5 and as ECD programmes under Chapter 6 of the Children's Act. This dual registration system is burdensome and unnecessary.[84, 85] The Bill aims to create a one-step registration process by removing ECD programmes from the definition of partial care in section 76 of the Act (and removing partial care from the definition of ECD programmes in section 91 of the Act), thereby ensuring that ECD programmes no longer need to register as partial care facilities. This proposed change will provide significant relief to overburdened ECD providers, as well as regulators.

ECD programmes attended by four or more children will be required to register, comply with any conditions attached to their registration, adhere to the norms and standards published under the Act, and meet the structural safety, environmental health and other municipal requirements.[86] Currently, partial care facilities of six or more children are required to register.[87] The rationale behind changing the threshold from six to four is seemingly to ensure that more children benefit from attending regulated ECD programmes. On the other hand, there are concerns about the administrative capacity to register these additional programmes given that there are already thousands of unregistered ECD programmes caring for large numbers of children that should rather be prioritised for regulation. The streamlined registration process proposed in the Bill, combined with yet-to-be-prescribed registration requirements and norms and standards for different types of ECD programmes, could help ameliorate the administrative load.

Recognition of different types of ECD programmes

Different types of ECD programmes are recognised in the Bill, including parent support groups, play groups, child-minders, toy-libraries, mobile programmes, outreach programmes and ECD centres. The Bill proposes a new definition for ECD centre in section 91 of the Act: "An early childhood development centre means an early childhood development programme provided to more than six children from birth to school going age, on behalf of their parents or caregivers, for more than 16 hours per week." The Bill also paves the way for other types of ECD programmes to be further defined through regulations. This should enable different types of ECD programmes to be regulated differently.

If effectively resourced, this change could extend state funding to all the different types of ECD programmes and contribute towards a more systemic approach to the delivery of ECD programmes. However, the Bill does not mandate the state to effectively resource the ECD sector: the state's obligation to provide or fund, which is currently discretionary under section 93 the Act, will unfortunately remain discretionary. There are currently 1.3 million children aged 3 – 5 years not accessing any form of ECD programme,[88] yet despite this, there are no positive obligations on the state to expand access to ECD services (whether through direct state provision or funding

of programmes managed by private individuals or non-profit organisations). This makes achieving universal access highly unlikely within this proposed framework.

The proposed amendments to section 93 of the Act clarify that other departments or municipalities may provide ECD programmes, provided the programmes comply with the legislated norms and standards and other registration requirements. However, it remains unclear whether these programmes will also be required to register with the DBE. For instance, will the DoH's Side-by-Side postnatal support programme need to register with the DBE?

Simplification of registration requirements

The Bill introduces a tailored approach to simplify and streamline the registration requirements for different types of ECD programmes by amending section 94 of the Act. It does not make sense for a two-hour playgroup to have the same registration requirements as a full-day ECD centre. The Bill removes the one-size-fits all approach, which is overly burdensome.

In addition, current registration requirements are overly complex, requiring compliance with multiple national laws (Children's Act and the National Health Act) and municipal by-laws on structural safety and environmental health. This Bill cannot change the many municipal by-laws, but it innovatively aims to promote the streamlining of municipal requirements by permitting the development of a model draft by-law on ECD that municipalities can follow.

The model by-law will be consistent with the norms and standards contained in the Children's Act, adopt a developmental approach, take into account different socio-economic contexts and promote "consistent approaches by municipalities to the regulation of ECD programmes" by amending section 103 of the Children's Act.[89] Municipalities are an autonomous sphere of government and therefore cannot be legally obliged to adapt their by-laws to align with the model by-law but they can be guided to do so.[89, 90] The model by-law will therefore be a useful advocacy tool for local communities.

Potential challenges

- The National Environmental Health and Safety Norms and Standards (NEHNS) published under the National Health Act would need to be simplified and aligned with the Bill's proposed approach. Currently, ECD programmes must comply with the norms and standards under both the Children's Act, as well as the NEHNS. The overlapping, and sometimes conflicting standards, are confusing and burdensome.[84] The DoH's current review of the NEHNS is a welcome development and a real opportunity for the DBE to give input to try and ensure alignment between the two national sets of regulations.
- Since draft regulations and norms and standards have not been published with the Bill, there is no guarantee that the registration and compliance standards will be simpler than the current requirements. It is important for the draft norms and standards to be published when the Bill is tabled in Parliament to enable Parliament and the public to properly assess the impact that these norms and standards will have on the ECD sector.
- The Bill makes compliance with the structural safety, environmental health and other requirements of a municipality a requirement for all types of ECD programmes. It is suggested that this be revised and applied only to ECD centres. For example, a mobile toy-library or a home visiting programme should not have to comply with municipal by-laws on structural safety.

An enabling conditional registration framework

Forty-two percent of early learning programmes remain unregistered, and only one-third receive an ECD government subsidy.[91, 92] The Bill clarifies that if an ECD programme cannot meet all the requirements in the Children's Act, and its regulations and norms and standards, yet poses no health and safety risks to young children, they can be conditionally registered and will be eligible for funding.[93] It also allows for a framework to be published to guide conditional registration which will ensure consistency across the provinces.[94] These are positive steps that will aid the growth of regulated and funded programmes. Unfortunately, the Bill does not clarify that ECD programmes who are unable to comply with municipal standards will also qualify for conditional registration. This will limit the usefulness of conditional registration as a tool to bring more programmes into the regulated and funded pool.

Curriculum requirements

The Bill intends to ensure that ECD centres "provide structured early learning and development opportunities in line with a national curriculum framework as approved by the Minister of Basic Education".[95] The impetus behind this is seemingly to ensure that all providers caring for young children implement a learning programme. Some have raised concerns that this provision could limit some types of pedagogical approaches, such as Montessori. All providers should be required to implement a curriculum that meets the intended outcomes of the National Curriculum Framework, but the Bill should clearly permit different pedagogical approaches to achieving those outcomes.

Strategic planning, data collection and infrastructure needs of the sector

Encouragingly, the Bill strengthens and mandates strategic planning and data collection at the national, provincial and municipal levels.[96] This is vital for informed decision-making and resource allocation for the ECD sector. By enhancing data collection mechanisms, policymakers can gain deeper insights into the needs of children and caregivers, identify gaps in service delivery, and develop targeted interventions to address them effectively.

The Bill proposes amendments that require provinces to ensure the operation of sufficient ECD programmes and to prioritise "those types of early childhood development programmes" that are most urgently required.[97] The emphasis on provinces prioritising "different types" of ECD programmes strongly suggests a shift towards a more systemic approach to ECD provisioning, moving away from a purely centre-based model.

Real Reform for ECD, supported by over 200 organisations, has long called for it to be made clear that municipalities are required to build and maintain sufficient and appropriate infrastructure in terms of their 'childcare facilities' mandate under the Constitution.[89, 98] They have also called for ECD providers to receive infrastructure support, including on private land. The Bill emphasises the importance of municipalities ensuring the availability and maintenance of facilities for ECD programmes, including private and public facilities.[99] These strategies must be incorporated into municipal integrated development plans and budgets.[100] While this is a positive step, clearly laying out the obligations of municipalities in terms of their constitutional function would better ensure the sector's infrastructure requirements are appropriately supported by the state.

Inclusive ECD programmes, child protection and parent and caregiver support

The proposed amendments require the development of norms and standards that ensure support for children with disabilities,[92] promote child protection, and ensure support and information for parents and caregivers. This should hopefully create environments that are safe, nurturing, and inclusive for all children.

Conclusion

The Bill represents a significant step forward in the journey towards improving access to ECD programmes. Its amendments reflect years of advocacy aimed at promoting a more systemic approach to ECD programming and establishing an enabling and developmental regulatory framework. While celebrating these gains, it is crucial to recognise that the Bill marks just the beginning of a longer reform process. The ECD sector will need to continue to push for comprehensive legislation that not only streamlines regulations but also places positive obligations on the state to ensure universal access to ECD programmes.

Basic education

Basic Education Laws Amendment Bill

The Basic Education Laws Amendment Bill (BELA)[101] was introduced in Parliament in 2022 by the Minister of Basic Education. It proposes amendments to the South African Schools Act (SASA)[102] and the Employment of Educators Act (EEA)[103]. This piece focuses on contentious issues, raised in submissions made before the Portfolio Committee on Basic Education (the Portfolio Committee) in the National Assembly[104] as well as the Select Committee on Education (the select committee) in the National Council of Provinces (NCOP).[105]

The Portfolio Committee began the public participation process in 2022 with a call for submissions. It then held national and provincial oral hearings.[106] After deliberating, the Portfolio Committee proposed further amendments[107] and the amended Bill was passed by the National Assembly and sent to the NCOP for further deliberations. The NCOP Select Committee held public hearings,[108] finalised its proposed amendments to the Bill, and returned it to the National Assembly for concurrence, where it was again passed by the National Assembly and then sent to the President for signature in May 2024 just before the national elections. At the date of writing, it had not been signed by the President and was not yet in force.

Definition of basic education

A definition of "basic education" is inserted into section 1 of SASA to be "grade R to grade 12". The definition clarifies that basic education continues until the end of grade 12 even though a learner who has completed grade 9 is no longer subject to compulsory school attendance.[109] This is in keeping with a recent Constitutional Court judgment which clarified that despite compulsory education ending at age 15 or grade 9, this does not mean that the right to basic education does not extend to grade 12.[110]

Compulsory school-going age lowered to 6 years and Grade R

Amendments to section 3 (1) make school attendance compulsory from grade R, when a learner turns six years old, until the learner has completed grade 9 or turned 15 years old, whichever comes first. This effectively changes the grade and age at which children must start attending school, i.e., from Grade 1 to Grade R, and from seven to six years old.

Civil society submissions welcomed the move to include Grade R within DBE's responsibility for basic education and made recommendations aimed at ensuring DBE puts in place adequate resources, learning support materials and qualified teachers, including:[111]

- the need for Grade R to have a strong focus on play-based learning as it has proven to be the most effective strategy for supporting the education of young children.
- additional amendments to section 5A (2)(c) of SASA, which deals with the publishing of norms and standards on learning and teaching support material, to ensure this includes age-appropriate play material and equipment.[112]
- adequate provision for Grade R teachers in the education budget and the Post Provisioning Norms.[113]
- a phased-in approach to compulsory Grade R to allow parents enough time to make the necessary arrangements.[98]

Admission age for Grade R

Amendments to section 5 provide that the admission age for grade R is four, turning five by 30 June in the year of admission. However, schools with constrained capacity must give preference to learners subject to the compulsory age (i.e. learners turning six years old in the year of admission).

The amendments imply that despite school attendance being compulsory for children aged five and turning six in the year of admission, a parent may, subject to a few conditions, enrol a child in Grade R at a younger age (four turning five years old). Concerns were raised regarding the maturity levels of children starting Grade R at this age.

Harsher penalties for parents whose children are not attending school

Section 3 (6) has been amended to increase the penalties imposed on parents who fail to ensure their children, who are of compulsory school-going age,[xii] attend school. The duration of imprisonment has been extended from a maximum of six months to 12 months, and the Bill also makes it possible to impose both a fine and imprisonment. The DBE's rationale for these amendments is to penalise parents who refuse to take their children to school even when conditions allow them to.[114]

Submissions on the Bill generally did not support this amendment and called for doing away with criminalisation as a method to ensure children attend school. Instead, they proposed the Bill adopt a more nuanced, supportive and intervention-oriented strategy to guarantee children's school attendance. Submissions highlighted how criminalisation is contrary to the best interests of children because children of imprisoned parents/caregivers would be left without care and fines would exacerbate the difficulties faced by families living in poverty.

The Portfolio Committee opted not to make any changes, citing that imposing penalties on parents for keeping their children away from school is not a novel practice and that the new penalties have been introduced to ensure accountability. Meanwhile, the Select Committee in the NCOP made additional amendments that allow the courts to impose a sentence within their discretion as an alternative to fines and imprisonment.[115] While the NCOP's amendments offer greater judicial discretion, the fact that fines and imprisonment remain available options means punitive responses are still a concerning possibility.

Admission of undocumented learners

A definition of "required documents" has been inserted into section 1 to provide clarity in respect of the documents which must be submitted for the purpose of the admission of learners to schools.[116] This includes a birth certificate for the child and identity documents if one or both parents are SA citizens; or a birth certificate and study permit for the child, and passports and visas of the parents if both parents are foreigners. Previously these documents were only listed in the National Admission Policy and not in law or regulations.

An exception to the rule of "required documents" is included by the insertion of a new sub-section 1A in section 5, which stipulates that in cases where a learner's parent or guardian who is applying for admission has not provided any of the required documents, either concerning the learner or themselves, the learner must still be permitted to attend school. Once admitted, the school principal should advise the parent or guardian to obtain the required documents.[117] These new sub-sections are aimed at giving effect to the court order in *Centre for Child Law and others v Minister of Basic Education and others*[118] where the High Court ruled that undocumented learners may not be denied admission to schools.

However, a number of submissions pointed out that creating a legislated obligation to submit "required documents" may worsen the barriers to education for undocumented learners because the term "required" gives the impression that the documents must be provided. DBE, school officials and on-line admission portals are likely to insist on the submission of the required documents as the default, despite the law providing for exceptions.[119]

School admissions and admission policies

Section 5 of SASA has been amended to clarify the roles of School Governing Bodies (SGBs) and Heads of Department

xii Grade R to Grade 9 or age 15 years, whichever comes first.

(HODs) with regards to decisions on school admissions and admission policies.

The final decision on admitting individual learners will lie with the HoD, in consultation with the relevant SGB. With regards to admission policies; the Bill that was passed by the National Assembly for the first time in October 2023 granted SGBs the authority to set admission policies, and the HOD the power to approve the admission policies. The NCOP amended the Bill to remove the oversight role of the HOD in relation to approving admission policies. Instead, SGBs are now required to consider transformative rights-based criteria when drafting or amending their admission policies. These criteria include the best interests of the child with an emphasis on equality; if there are other accessible schools in the community for the learners concerned; the available resources of the school and the efficient and effective use of state resources; and space available at the school for learners.[120, 121]

School language policies

Section 6 has been amended to align the law with jurisprudence such as that arising from the case of *MEC for Education in Gauteng Province and Others v Governing Body of Rivonia Primary School and Others*[122] in which the court held that the power of a school to determine its language policy must be exercised in accordance with the Constitution.

The Bill that was first passed by the National Assembly in October 2023 allowed SGBs of public schools to determine language policies within the limits of the Constitution, SASA, and applicable provincial laws. The HoD had the power to approve the language policy developed by the SGB, considering the language needs of the community, the best interests of the child, and the right to equality. There was also a process of engagement between the HoD and the SGBs for any necessary amendments. The NCOP removed the oversight role of the HOD and instead directed SGBs to consider factors such as the bests interests of the children with an emphasis on equality, the changing number of learners who speak the language of learning and teaching at the public school; and the enrolment trend of the public school.

The HoD can direct a public school to adopt more than one language of instruction where practicable. This decision is to be made after certain factors are considered and engagements have been conducted with the school, the SGB, the parents, and the community within which the school is situated.

While certain stakeholders embraced these amendments, viewing them as an effort to avoid the recurrence of practices in which language and admission policies marginalised certain learners and perpetuated historical discrimination, others opposed them, arguing that they unjustly restrict or reduce the authority of SGBs and fail to foster a collaborative relationship between HoDs and SGBs.

Alcohol being sold on school premises

The tabled bill[101] proposed an amendment to section 8 of SASA to grant the HoD the authority to grant permission to SGBs to allow the possession, consumption or sale of alcohol during school activities or during other private or religious functions held on the school premises (outside of school hours).

Stakeholders, including children and young people,[123] expressed concern about allowing alcohol during school activities, fearing that it would be challenging to ensure safety at such events and that monitoring learners' access to alcohol would be difficult. Regarding alcohol at private or religious functions on school premises, there's a need for more clarity to safeguard the safety and well-being of learners. The National Assembly decided to remove these provisions from the Bill in their entirety, resulting in the Bill not dealing at all with the sale and use of alcohol on school premises.

Regulating home-schooling

Section 51 of SASA, which deals with home-schooling, has been amended to provide for the application and registration of learners to receive home education. It sets out what the HoD will look at when considering an application, the process for registering a learner for home education, and for appeal processes to the MEC when an application is denied by the HoD.

Advocates of home education[124] expressed their opposition to the proposed application and registration requirements and advocated for a mere notification process, further arguing that monitoring by the Department should only be conducted in cases of potential educational neglect. Additionally, they recommended allowing private tutoring for small groups of six or fewer children without the need for institutional registration. Lastly, they urged flexibility regarding the requirement of adherence to the Curriculum Assessment Policy Statements (CAPS). Those who supported the amendments affirmed that home-schooling should be regulated to ensure the best interests of the learners concerned.

The Portfolio Committee's deliberations about this clause and its proposed amendments saw a range of viewpoints expressed by different Committee members, both in favour of and opposed to the provisions. In the end, the clause was mostly retained in its original form.

Family care and protection from abuse and neglect

Children's Amendment Act and Regulations to solve the foster care crisis

The Children's Amendment Act[125] is primarily aimed at solving the decade-long crisis in the foster care system that occurred when the child protection system was used to provide poverty relief to relatives caring for orphaned children. Due to the high numbers of orphans in the foster care system, compared to the shortages of social workers, hundreds of thousands of foster care court orders expired because they were not reviewed and extended in time, as required by section 159 of the Children's Act. In 2010 and 2011 this resulted in the payment of over 110,000 children's foster child grants (FCG) being cancelled because the South African Social Security Agency (SASSA) is not allowed by the law regulating social grants to pay FCGs if the court order placing the child in foster care is no longer valid.[126]

In 2011, the Centre for Child Law (CCL) approached the High Court to ensure the 110,000 grants were re-instated and no more grants were cancelled. This resulted in a court ordered settlement between CCL and the Minister of Social Development that required the Minister to design and implement a comprehensive legal solution to the foster care crisis.[127] While giving the Minister time to come up with the solution, the court order protected children from losing their grants by 'deeming' all expired foster care orders to be valid. The High Court order had to be extended six times until the end of 2023 when the Children's Amendment Act and regulations were partially put into effect.

Has the Children's Amendment Act and its Regulations commenced?

In November 2023, the President announced the commencement of 10 clauses.[128] This was closely followed by the Minister publishing amendments to the Regulations to provide guidance to social service practitioners and courts on some of the changes to the Act.[129] The Department decided not to put four of the clauses into operation at this time due to the need for further consultations on the draft regulations related to these amendments.[xiii]

On 26 June 2024, after the National Elections and the inauguration of the President, the ex-Minister of Social Development gazetted regulations relating to the remaining four clauses of the Amendment Act.[130] However, in terms of section 94 of the Constitution, the ex-Minister was no longer the Minister when she signed or gazetted the regulations. Furthermore, the clauses of the Amendment Act that authorise the Minister to make these regulations have not yet been commenced by the President. Due to this legal uncertainty, we have not elaborated in detail on this second set of regulations.

A comprehensive legal solution to the foster care crisis

Some of the amendments that are in force are aimed at preventing orphaned children, who are already in the care of extended family members, from being unnecessarily placed in foster care when other options exist to recognise and support their caregiver to continue to care for them. This shift in the law is in line with the National Child Care and Protection Policy (NCCPP)[131] and the Social Assistance Amendment Act of 2020[132] which introduced the CSG Top-Up for relatives caring for orphans to replace the use of the FCG.[xiv] The NCCPP and the two amended Acts are aimed at promoting a developmental approach that strengthens and supports the extended family to care for orphaned children. They do this by recognising and respecting that the extended family is already caring for the child, acknowledging the existing family bond and psychological attachment between the family member and the child, ensuring as the first priority that the family has enough income to provide for the child's basic needs, and freeing up social worker time to assist extended families and orphaned children with prevention and early intervention programmes.

Definition of orphan

The definition of orphan has been amended to make it clear that both single and double orphans are included: "'orphan' means a child whose parent or both parents are deceased".[133] The inclusion of the two categories of orphaned children affirms that the comprehensive legal solution should cater to both groups – including 'single orphans' and not only 'double orphans'. The CSG Top-Up therefore cannot be restricted to a narrow definition of 'double orphan'.[134] This is important in the context of many maternal orphans having fathers who are unknown, not recorded on the child's birth register, or who have never been involved in the child's upbringing and

xiii The clauses that were not put into effect were 4, 5, 11 & 12 which amend sections 105, 142, 160 & 183 of the Children's Act. These amendments to s105(6) require the Department of Social Development to conduct a quality assurance process for the evaluation of child protection organisations and child protection services; the amendments to s142 authorise the Minister to draft regulations prescribing the conditions for the examination or assessment of children who have been abused, abandoned or neglected; and the criteria for the establishment and resourcing of designated childcare and protection units. The amendments to s160 (cA) authorise the Minister to make regulations prescribing the procedure, form and manner that a social service practitioner must follow when assessing, screening, investigating, referring and placing a child who is in need of care and protection. The amendments to s183 require organisations operating cluster foster care schemes to register as designated child protection organisations within two years of the amendment coming into effect, and to manage and operate a cluster foster care scheme in the prescribed manner.

xiv The CSG Top-Up is a grant of R790 (in 2024) for family members caring for orphans. It can be accessed directly from SASSA by submitting proof that the parents of the child are deceased. This proof is two death certificates or one death certificate and an affidavit attesting to a lack of knowledge about whether the other parent is dead or alive.

their whereabouts are unknown. There are also many cases of paternal orphans having mothers who have never been involved in their upbringing and whose whereabouts are unknown to the paternal family.

Clarifying when orphaned or abandoned children need state care and protection

Section 150 (1)(a) has been amended to provide clarity on when an orphaned or abandoned child should be considered by social workers and the court to be 'in need of care and protection'. An orphaned or abandoned child is now defined to be 'in need of care and protection' if the child "has no family member who is able and suitable to care for that child". This means that an orphaned or abandoned child who is already in the care of a family member, should not automatically be considered a child in need of care or protection, unless their circumstances fall under other criteria in sections 150 (1)(b) to (l). This means that:

- An orphaned or abandoned child who is found on their own (e.g. an abandoned baby) is 'in need of care and protection' and will need to be placed in alternative care, be it foster care or in a child and youth care centre.
- An orphaned child who is already in the care of a family member, is not a child 'in need of care and protection' and does not need to be placed in alternative care because they are already in family care.
- An abandoned child who is already in the care of a family member may be 'in need of care and protection' and placed in foster care if there is a likelihood that the parent who abandoned the child may re-emerge. In which case a foster placement can be made with the relative in terms of s150 (1)(g) as the child could be at risk if returned to their parent's care. However, if the parent has been gone for a very long time and their whereabouts are unknown, there is no need for a care and protection order.
- If there are allegations that the family member who is caring for the orphaned or abandoned child, is abusing or neglecting the child, then one of the other criteria listed in section 150 (1) is applicable[xv] and the child can be found to be in need of care and protection in terms of those criteria, and removed from the care of that family member. The reason for finding the child to be in need of care and protection in such an example, is not because the child has been orphaned or abandoned, but because their caregiver is abusing or neglecting him or her.

Submissions to Parliament on the amendments noted concerns around the requirement that family caregivers must be "able and suitable".[135] This could result in family members already caring for orphaned or abandoned children being assessed by social workers and the courts to determine if they are "able and suitable" before they could be supported with prevention services.[135] This could potentially delay the family's receipt of the CSG Top-Up due to the Department's lack of capacity to conduct such assessments timeously.[135]

Draft regulations gazetted for comment in 2023[136] did not elaborate on the implication of the amendment to section 150 (1)(a). Instead, they proposed a new screening and assessment process that explained to social workers how to support children in need of care and protection. They did not elaborate on how to support children who are not in need of care and protection but are in need of prevention and early intervention services such as the CSG Top-Up, or referral for such services. The draft regulations therefore continued to promote a residual approach to child welfare services, rather than the developmental and preventative approach required by the NCCPP.[137] The proposed screening and assessment process also did not explain the meaning of the new words in section 150 (1)(a) and therefore fail to provide sufficient guidance to social workers on how to change their practice.[138]

The final regulations[129] omitted the proposed screening and assessment process, but still do not explain the significance of the shift in practice required by the amendment to section 150 (1)(a). This is likely to lead to varying interpretations by social workers and magistrates which will cause injustice and inequity across the system.

Enabling family members caring for orphans to obtain guardianship orders

Many relatives are currently caring for orphaned children and they have de-facto caregiver rights in terms of section 32 of the Children's Act to make certain decisions on behalf of the child, for example consenting to medical treatment. However, there are instances when they may need a formal document to prove to a government department or third party that they have parental responsibilities and rights; for example, assisting the child to obtain their ID when they turn 16, or administering the child's inheritance. To provide relatives an accessible route to acquire parental responsibilities and rights the Amendment Act has amended sections 24 and 45 of the Act to devolve jurisdiction for guardianship to the Children's Court. Previously, only the High Court could adjudicate guardianship applications which meant that it was inaccessible to the majority of the population who cannot afford a lawyer or the transport to a High Court in a faraway city.[135] The Children's Court by comparison is at

xv For example, section 150 (1)(e), (f), (h), or (i).

magistrate court level and is accessible in most small towns and can be approached directly by a family member without the need for a lawyer.

In terms of section 29 (5) of the Children's Act, the court dealing with the guardianship application has the discretion to order that a report by a family advocate, social worker or other suitably qualified person be submitted to the court. Furthermore, the court has the discretion to appoint and order a person to investigate certain matters, and call for evidence to be given or produced. Children's Courts must be encouraged to explore the different options granted by this discretion and to call for social worker reports only when necessary, for example if there is a dispute within the extended family about the child's care arrangement.

Ensuring orphans who are already in foster care do not lose their FCGs

The Children's Court will be bound by the new section 150 (1)(a) which means they have no legal authority to extend a foster care placement of an orphan who is already in the care of a family member. Approximately 80% of all the children in foster care are orphaned children in the care of family members[126] and so approximately 200,000 children could have their FCGs stopped if a transitional clause to prevent magistrates refusing to extend their foster care placements was not included in the law.[135] The Portfolio Committee agreed to include a transitional clause, section 159 (2B), to allow magistrates to extend foster care orders of orphaned children who were placed in foster care with family members prior to 8 November 2023, despite the amendment to section 150 (1)(a).

Most of these 200,000 orphans will gradually 'age out' of the foster care system when they turn 18, or 21 if they are still in education. This ageing out of existing orphans in foster care, combined with fewer orphans coming into the foster care system, should reduce the total number of orphans in foster care over time. This in turn should reduce social worker and Children's Court high foster care caseloads, freeing up capacity and time to provide families caring for orphans with prevention services (e.g. grief counselling and parenting programmes) and to provide timeous and quality protection services to children who have been abused or neglected.

A missed opportunity to empower unmarried fathers to care for maternal orphans

Amendments to section 21 in the tabled comprehensive bill, together with the recommended additions from civil society, would have provided many unmarried fathers who are caring for maternal orphans with an option to obtain a section 21A certificate from the family advocate or a Children's Court.[135] This certificate would have provided clear confirmation of the fact that the unmarried father had parental responsibilities and rights for their child. It would have provided such fathers with a legal document that many need to assist their children to access essential and basic services. However, the Portfolio Committee failed to see the connection between section 21 and the many maternal orphans who have fathers willing and able to care for them. They decided that the amendments to section 21 should be rejected and require more consultation.[139]

Transitional regulation to replace the protection provided by the 2011 High Court order

The regulations included a transitional provision[140] which stated that "all foster care orders that may lapse after 11 November 2023 but before 30 June 2024 due to not being extended in terms of section 159 of the Children's Act, 2005 as amended, shall be deemed to be valid until 30 June 2024 or until they are extended by the children's court, whichever occurs first."

This was aimed at providing a transitional replacement for the temporary solution that had been provided by the High Court order in 2011 when it deemed all expired foster care orders to be extended while a comprehensive legal solution was being developed. The High Court's protection was due to end on 11 November 2023, yet at the end of October 2023 the Department still had a backlog of nearly 34,000 expired foster care orders[141] and these children stood to lose their FCGs.[142] The transitional regulation was aimed at providing SASSA with the legal authority to continue paying these children's grants, despite their court orders being expired.

Last minute new regulation to replace the transitional regulation

The protection provided by the transitional regulation lasted until 30 June 2024 by which time the Department planned to have eliminated the backlog and reduced the number of orphaned children coming into the foster care system so that the backlog does not continue to grow. By the end of May 2024, some progress has been made and the backlog had been reduced but there were still 18,000 expired foster care orders[143] and the children behind these orders were at risk of losing their FCGs after 30 June 2024.

On 26 June, the ex-Minister gazetted a second set of regulations[130] which included a replacement for the transitional regulation that ends on 30 June. Regulation 56H 10(5) provides that: "All foster care orders that were valid on 30 June 2024 which would have lapsed if not extended by the court shall be deemed valid after 30 June 2024 until extended by the court". This wording effectively extends the approximate 18,000 expired foster care orders (and possible also future expired

orders) indefinitely and removes the Children's Court's ability to hold social workers accountable for regularly reviewing all foster care placements. This puts children who are in need of care and protection at risk of languishing for many years in foster care with no family re-unification services or monitoring of their placement by social workers.

It is unfortunate that this regulation has been hastily inserted at the end of a decade of the Department working hard to gradually reduce the backlog and amend two laws to bring about a sustainable and accountable foster care system. The legality of this last-minute regulation is also uncertain as it was gazetted by the ex-Minister at a time when she was no longer Minister.[xvi]

Challenges preventing the comprehensive legal solution from being effectively implemented

In the absence of regulations or a directive explaining how the amendment to section 150 (1)(a) should shift their practice, social workers in the field are currently uncertain about how to provide services and support to orphaned or abandoned children in the care of family members.

Some social workers have shifted to using the CSG Top-Up as they have observed how quickly families receive the income support via the CSG Top-Up as opposed to how long it takes before the family receives the FCG. The CSG Top-Up was started in June 2022 and by the end of March 2024 it was reaching just over 67,000 orphans. Over a similar time-period (1 April 2022 to end March 2024), the total FCG numbers continued to decline and dropped by approximately 32,000 children.[144] The CSG Top-Up is therefore already demonstrating that it is more accessible for families caring for orphans than the FCG.

However, many social workers continue to recommend foster care and the FCG for orphans in the care of relatives. After two decades of using the foster care system and FCG for orphans in the care of family members, many social workers are unlikely to shift their practice unless clearly directed to do so by regulations in terms of the Children's Act and an express directive from the National Department.

Traditional Courts Act

The Traditional Courts Act[145] aims to provide a uniform legislative framework for the structure and functioning of traditional courts which are customary law dispute structures that operate in areas of the country that have traditional leadership structures. The Act has been signed by the President[xvii] but is not yet in effect due to the regulations still being drafted.[146]

This law has been the subject of much controversy, resulting in its journey, from a bill to an Act, taking more than 15 years.[xviii] Many improvements were made along the way to address some of the concerns raised. However, substantive issues remain of concern to interest groups promoting the constitutional rights of children and women.

The right to opt-out removed by the National Assembly

When tabled in 2017,[147] the Bill recognised the consensual and voluntary nature of customary law by allowing people to opt out of traditional court processes and use the civil and criminal courts if this was their preference. The right to opt-out was important for two reasons: (1) It ensured that all people living in areas under traditional authorities had the same choice to use the civil and criminal courts as people living in other areas of the country that do not have traditional authorities.[148, 149] (2) Women and children have additional protections under the criminal and civil law[xix] that are generally not practiced in traditional courts and are not provided for in the Traditional Courts Act.

Despite support for the opt-out clause from interest groups representing women, children and rural communities[150] the majority of the members of the Portfolio Committee on Justice did not support the clause on the basis that traditional law should have the same stature as common and civil law and traditional courts should have equal recognition.[151] The National Assembly therefore removed the op-out clause and the National Council of Provinces later agreed with this decision.

Persons unhappy with the decisions of a traditional court must first exhaust all traditional court system appeal procedures before they can refer the decision to the Magistrate's court.[152] They can also take the proceedings on review to the High Court, but this route will not be economically or geographically accessible for the majority of women and children in rural areas.[153]

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xvi See section 94 of the Constitution which provides that Ministers cease to be Ministers once the new President assumes office, which in this case occurred on 18 June 2024, yet the regulations were gazetted by the ex-Minister on 26 June 2024 and there is no date under her signature to provide proof that she signed them at an earlier date when she was still Minister.

xvii In September 2023

xviii The 2008 bill was withdrawn from Parliament in 2011 and the 2014 version failed to win a majority vote in the NCOP and lapsed between Parliaments. A new version was tabled in 2017. The Act emerged from Parliament 6 years later in 2023. See the following resource for a detailed explanation of the different stages of the Bill: Sonke Gender Justice "The Traditional Courts Bill, explained" https://genderjustice.org.za/card/the-traditional-courts-bill-explained/a-history-of-the-bill/

xix For example, the Criminal Procedure Act 51 of 1977 allows children to give evidence Ω intermediaries if it appears to the court that they would be exposed to undue psychological, mental or emotional stress, trauma or suffering. The Domestic Violence Amendment Act 14 of 2021 provides Magistrates' Courts with the power to grant protection orders to complainants experiencing domestic abuse.

Matters affecting children that a traditional court may hear

The Act lists what matters a traditional court may hear.[154] This includes:

- common assault,
- theft with a value below R15,000, and
- damage to property with a value below R15,000.

A traditional court may also give advice relating to customary law practices in respect of ukuThwala, initiation, and custody and guardianship of children.

If a traditional court is of the opinion that it is not competent to deal with a matter before it, or if the matter involves difficult or complex questions of law or fact that should be dealt by a Magistrate's Court, the traditional court may transfer the dispute to the Magistrate's Court.[155]

The Act does not align with Children's Act or Child Justice Act

Concerns were raised as to how the traditional courts would ensure that child offenders, victims and witnesses are afforded the protections provided by the Children's Act, Child Justice Act and Criminal Procedure Act.[118] While the Act refers to the importance of protecting the rights of vulnerable groups like children,[xx] it falls short of fully aligning with constitutional principles and legislation that uphold children's rights:

- The Act makes no mention of the need to protect the best interests of children as required by section 28 (2) of the Constitution and the Children's Act.
- In criminal and civil courts, children have the right to legal representation at state expense and the support of social workers if necessary, whereas in traditional courts, legal representation is not allowed. A party may however be assisted by a person they choose in whom they have confidence.[156]
- The civil and criminal law protect the identities of child victims, witnesses and offenders, whereas the Traditional Courts Act does not and child victims and witnesses are at risk of secondary trauma due to the public nature of the proceedings.
- The Children's Act[157] places a mandatory reporting obligation on a number of duty bearers, including traditional leaders, to report the suspected physical abuse of a child to the police, a Children's Court or the department of social development. This activates a social work investigation and a Children's Court inquiry to ensure the safety and protection of the child. It was recommended to Parliament, that cases of physical abuse of children (common assault) should not be heard by traditional courts but should be transferred to the Children's Courts.[158] However, this proposal was not supported by Parliament.
- Traditional courts may give advice relating to the customary practice of ukuThwala and customary law marriages. UkuThwala, which is a precursor to marriage, can involve sexual offences and other crimes like assault and kidnapping, as well as forced child marriages which fall under the criminal justice system. Yet the Act does not cross-refer to the mandatory reporting obligations in relation to such crimes in the Children's Act and Sexual Offences Act.
- Traditional courts are competent to give advice on "custody and guardianship" of children. This outdated terminology ignores the Children's Act, which changed the term "custody" to "care" in 2005. The Children's Act also has provisions and procedures aimed at ensuring decisions about care and guardianship are based on the best interests of the child, while no such provisions exist in the Traditional Courts Act.

Lack of meaningful participation

The finalisation of the Bill in Parliament was criticised for ignoring concerns raised by numerous stakeholders and for public participation processes occurring at short notice.[159]

One of the aims of the Act is to provide for women's participation and protection of their rights in traditional courts by requiring that traditional courts are constituted of both women and men,[160] and by recognising that women – as parties to proceedings or members of the court – should be afforded full and equal participation in proceedings.[161] However, the Act lacks guidance on how to ensure meaningful participation happens in practice in an environment where cultural and social norms tend to restrict women and children's participation and agency.[162] Commentators asked for the Act to include specific guidance on the integration of women into the courts and accountability mechanisms to ensure their meaningful and respected participation.[163]

Language of the local community

The singular use of English in the criminal and civil courts results in many women and children feeling alienated and their evidence being misinterpreted.[164] Traditional courts on the other hand are

xx Section 5 (3)(a)(ii): "(a)The Cabinet member responsible for the administration of justice must—(ii) put measures in place in order to promote and protect vulnerable persons, with particular reference to the elderly, children ..."; Section 7(3)(a)(ii): "During its proceedings, a traditional court must ensure that—(a) the rights contained in the Bill of Rights in Chapter 2 of the Constitution are observed and respected, with particular reference to the following: (ii) that vulnerable persons, with particular reference to children ... are treated in a manner that takes into account their vulnerability"; Section 11 (1)(d)(ii): "A party to any proceedings in a traditional court may, in the prescribed manner and period, take those proceedings on review to a division of the High Court having jurisdiction on any of the following grounds: (d) the provisions of section 7 (3)(a), affording— (ii) vulnerable persons treatment that takes into account their particular vulnerability".

conducted in the language of the local community and do not have to be conducted in English like the criminal and civil courts. This makes the proceedings of traditional courts more familiar and accessible than the civil and criminal courts. However, it is practice in some traditional courts that women and children need to be accompanied, represented and spoken for by a male family member. The benefits of the use of a language accessible to the affected woman or child in such a case would be negated if they are not allowed to speak for themselves.

Conclusion

The NHI Act, BELA Bill and Children's Amendment Draft Bill are aimed at advancing equality in access to health care services, basic education and early childhood development programmes. However, the status and implementation timeframes of the NHI Act and BELA Bill remain in limbo while the political parties in the newly established Government of National Unity negotiate policy positions. The much-needed reforms to the ECD chapter of the Children's Act will hopefully be tabled in Parliament in 2024 for priority attention.

An inclusive, digital and modernised National Information System is promised by the National Identification Registration Draft Bill. The underlying reasons why millions of children, youth and their parents remain excluded from birth certificates and IDs need attention or else 'modernisation' risks compounding the growing exclusion of poor and rural people; not only from documents, but also from the NHI, basic education and social protection.

Front of package warning labels on unhealthy food could assist parents and children to make healthier food choices and encourage the food and beverage industry to invest more in healthy products: A much needed intervention at a time of increasing child food poverty, stunting and obesity. Continued public support for these draft regulations could ensure they are finalised and effectively enforced.

The comprehensive legal solution required by the High Court to address the crisis in the foster care system is finally in the law after a decade of law reform. However, clear regulations, directives and training are urgently needed to address inconsistent interpretations of the new laws by social workers and Children's Courts.

The Traditional Court's Act does not ensure that traditional courts will include the protections for child victims of physical abuse that are available in the Childrens Court and criminal courts; and does not require such cases to be transferred to the Children's Court, nor give children the option to choose to have their matter heard by the Children's Court. Amendments to the Act will need to be made to deal with the contradictions between this Act and the Children's Act.

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Good nutrition is essential for health and brain development, so all children attending the Jujurha ECD centre in Nqileni Village, Eastern Cape, receive two hot meals a day.
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Part 2

Enhancing early childhood development

Investing early to build a strong foundation

- Understanding the science of early childhood development
- Monitoring the status of young children in South Africa
- Evaluating progress in policy implementation
- Ensuring mothers and young children survive and thrive
- Strengthening pathways to quality early learning
- Working together to provide nurturing care
- Achieving equity by providing extra care

Six building blocks of an effective ECD system

- An enabling policy environment
- Leadership and coordination
- Adequate funding
- Human resources for early childhood development
- Data systems for planning, monitoring and evaluation
- Effective delivery systems

Invest early to build a strong foundation for national development

Wiedaad Slemming,[i] Lizette Berry[ii] and Lori Lake[i]

The children are our future. A phrase that is so overused that it does not evoke the kind of sentiment and response that it should. However, it is an undeniable fact that the future of any society relies on its ability to care for and nurture the health and well-being of the next generation. When societies fail to provide children with strong foundations to build healthy and productive lives, it compromises the future prosperity and well-being of everyone.

Continued and enhanced investment in early childhood development is key to ensuring that South Africa supports its children's development and well-being into the future and allows them to break free from the intergenerational cycles of poverty and inequality. A rights-based approach also promotes that children are regarded as human beings with inherent value and agency who should be afforded opportunities for development and participation in society.

What is early childhood development?

To understand why it is important to invest in early childhood development (ECD), it may be useful to unpack what is meant by ECD.[1]

- **A period in the life course**

  The process of development is continuous and ongoing, but the early childhood years (from the beginning of pregnancy to the first day of school) is the period of most rapid physical growth and brain development. What happens in the early years is critical for a child's developmental trajectory and impacts their physical and mental health and well-being, educational achievement and economic participation throughout the life course, as well as that of the next generation.[2]

- **A process and an outcome**

  Development is both a process and an outcome. For young children, development is a continuous process of acquiring

Table 2: Glossary of key terms

Early childhood development	The processes by which children grow, develop and thrive – physically, mentally, emotionally, spiritually, morally and socially - from conception until the start of formal schooling.
ECD service	An ECD service is 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 a child's parent or caregiver.[5]
ECD programme	Programmes that provide one or more forms of daily care, development, early learning opportunities and support to children from birth until the year before they enter formal school- including both early learning programmes and parent support programmes.[6]
Early learning programmes	These are ECD programmes that are attended by children on a part-time or full-time basis, in a range of spaces, and which provide early learning and development opportunities. These include ECD centres, playgroups, day mothers, as well as toy libraries and mobile ECD programmes.[7]
Parent support	A broad range of programmes and interventions to support one or more aspects of parenting or to promote parents' well-being. These are provided to a parent or primary caregiver.
Primary caregiver	The person primarily responsible for the daily care and well-being of a child.
Nurturing care	An environment created by caregivers. It ensures children's good health and nutrition, protects them from threats, and gives them opportunities for early learning, through interactions that are emotionally supportive and responsive.[8]
Nurturing Care Framework	The NCF provides evidence-based guidance to help countries design policies, programmes and services that support and enable families to provide nurturing care.
Responsive caregiving	Care that is prompt, consistent, contingent, and appropriate to the child's cues, signals, behaviours and need.

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skills and abilities across the domains of motor, cognition, language, social and emotional development.

The developmental process is similar for all children, but rates at which children acquire skills may differ and is largely influenced by the interplay between their genes, physical and socio-cultural environments and experiences.

In the early years of life, children's brains develop at a speed of more than one million new neural connections per second. Such rapid brain growth and development is most pronounced during the first three years, laying the foundation for lifelong physical, cognitive, and social-emotional functioning.[3, 4] These rapid neuronal connections are made in response to the child's interactions with the environment. Thus, development is the result of the interaction between the environment and the child, with genes and experiences interacting to shape the architecture and functioning of the developing brain.

Why is it important to invest in early childhood development?

During the early childhood period, particularly from pregnancy to three years, there is heightened receptivity and plasticity of the brain which develops in response to intrinsic and extrinsic stimuli. It is during this time that supportive interventions to promote health and development may be the most beneficial, and adverse experiences and exposures may be the most harmful to children's development.[9] Supporting children's development is therefore imperative, especially for the millions of children who live in disadvantaged and vulnerable families and communities and who face multiple adversities. Early deficits are compounded and become increasingly difficult to reverse beyond early childhood.[9]

Children are much more likely to grow and develop to their full potential if they are healthy and well-nourished; protected from childhood illnesses and malnutrition, unintentional injuries, violence, abuse and neglect; and given adequate learning opportunities and have responsive caregivers. This is referred to as nurturing care.[8]

As development is multi-dimensional, sequential and interrelated, young children need a range of supports and services to nurture their overall growth and progress. Their optimal development also depends on whether they have access to comprehensive services, protected by law, including health, education, birth registration, nutrition, care and protection, access to basic services, information and participation, among others.

Figure 2: Putting Nurturing Care at the heart of the Sustainable Development Goals

Adapted from: World Health Organization. *Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential.* WHO: Geneva. 2018.

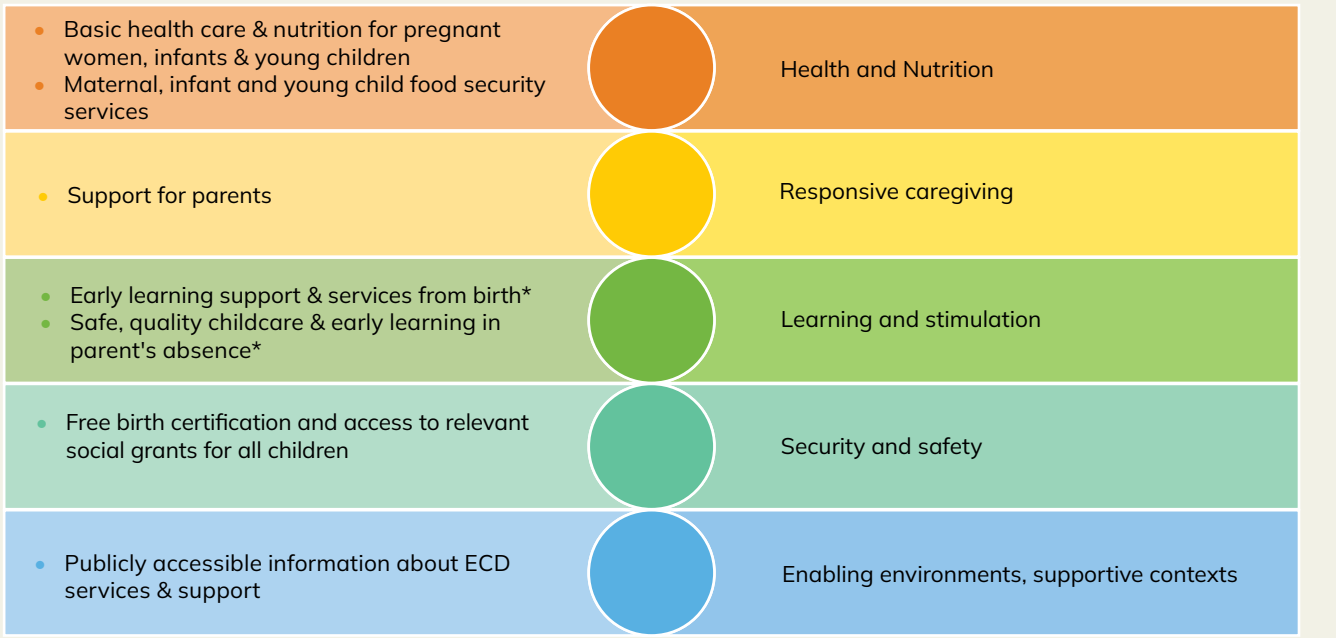
Global and national commitments

Early childhood development is recognised as a fundamental right of every child in enabling them to achieve their full growth and development potential.[10] All countries that have ratified the United Nations Convention on the Rights of the Child (CRC) are duty-bound to provide universal access to essential services for children's survival, growth and development, with a specific focus on protecting the most vulnerable children. The UN Committee on the Rights of the Child's General Comment No. 7, provides clear guidance to countries on how to fulfil these rights.

The 2030 Agenda for Sustainable Development[11] has also embraced early childhood development as central to the global transformation agenda. The Sustainable Development Goals (SDGs) outline specific commitments and targets that directly influence the services and enabling environments that young children need to grow and develop to their full potential (see Figure 2). At the same time, early childhood development is essential for attaining many of the SDG targets.

The Global Strategy for Women's, Children's and Adolescents' Health 2016 – 2030 ('Survive, Thrive and Transform')[12] further articulates this by adopting a life course approach that aims to create an enabling environment that improves physical and mental health and well-being at every age, and across generations. Similarly, global institutions such as the World Bank, UNICEF, WHO and UNESCO have made early childhood development a priority in their programmes of work.

Figure 3: Essential services in the NIECD Policy and Nurturing Care Framework



Through collective global action, the Nurturing Care Framework (NCF) was developed and launched at the 71st World Health Assembly in 2018.8 The NCF serves to build on key scientific evidence, such as the 2017 Lancet Series: Advancing Early Childhood Development: From Science to Scale,[13] and describes what young children require to survive and thrive, and the transformations needed to enable them to do so.

South Africa has a rich policy environment to support early childhood development. The Constitution[14] expressly recognises children's rights and a host of sectoral policies and plans have been developed to implement services related to these numerous rights. Similarly, the National Development Plan 2030[15] identifies early childhood development as key to realising its vision of reducing poverty and inequality through human capital development and the social and economic inclusion of historically marginalised people.

In 2015, South Africa adopted the National Integrated Early Childhood Development Policy (NIECD Policy),[6] which outlines a multi-sectoral approach to promoting the health development and well-being of young children. The Policy prioritises the provision of ECD services to vulnerable families and acknowledges that it is the responsibility of government to provide comprehensive ECD services to ensure that all children develop to their full potential.

The NIECD Policy is South Africa's principal policy governing the delivery of ECD services across a range of sectors and spheres of government. It provides for a set of essential services and supports for young children and their families (see Figure 3), and it promotes a life course approach to development targeting children from conception until the year before they attend formal schooling.

Ensuring all young children realise their potential

In other words, promoting early childhood development is so much more than preparing children for school. Sustainable investment in the provision of a basket of essential services and support is imperative to enable every young child in South Africa to realise their potential over the life course, and into the next generation.

Effective interventions to support optimal early growth and development, and to enable nurturing care, are available and backed by credible evidence. Integration of interventions into existing health, education and social service systems is also possible and affordable.[13, 16]

Adopting a life course approach and applying the principles of nurturing care from early childhood into adolescence supports the development of human capital, and promotes equity and human rights.[17] Building strong foundations in the early years and extending and enhancing development during subsequent developmental stages can propel national and sustainable development for South Africa.

Yet South Africa pays a high price, presently and into the future, by investing too little, too late, and by failing to promote, support and invest in effective ECD interventions. Children under five who are at risk of poor development are likely to experience multiple disadvantages in their lifetime, including earning about

a quarter less of average adult income per year. At country level, the loss is estimated to be nearly two times the gross domestic product spent on health.[13] Harnessing the potential of ECD interventions to ameliorate poverty and inequality, and curb complex societal challenges such as violence, gender discrimination, and child maltreatment is therefore critical for pursuing a just, equal and sustainable society.[18]

A catalyst for national development

The NIECD Policy provides evidence of how quality ECD services have positive outcomes for society by:[6]

- Enhancing the mental and physical health of children and adults, reducing maternal and under-five mortality, and preventing violence and injury, HIV, TB, and non-communicable diseases such as diabetes, cardiovascular disease and obesity as outlined in Figure 4;
- Improving school enrolment, retention and performance by enhancing early cognitive development and school readiness, and intervening early to prevent and address developmental delays and disabilities;
- Building a stronger economy as improved education outcomes drive increased employment, productivity, tax revenue and gross domestic product;
- Reducing poverty and inequality by prioritising services for children in poor households, in order to enhance care, stimulation and learning opportunities and enabling all to develop to their full potential;
- Building a safer and more inclusive society by promoting caring, nurturing relationships in the home and helping children cope with stress in ways that prevent violence and promote social cohesion.

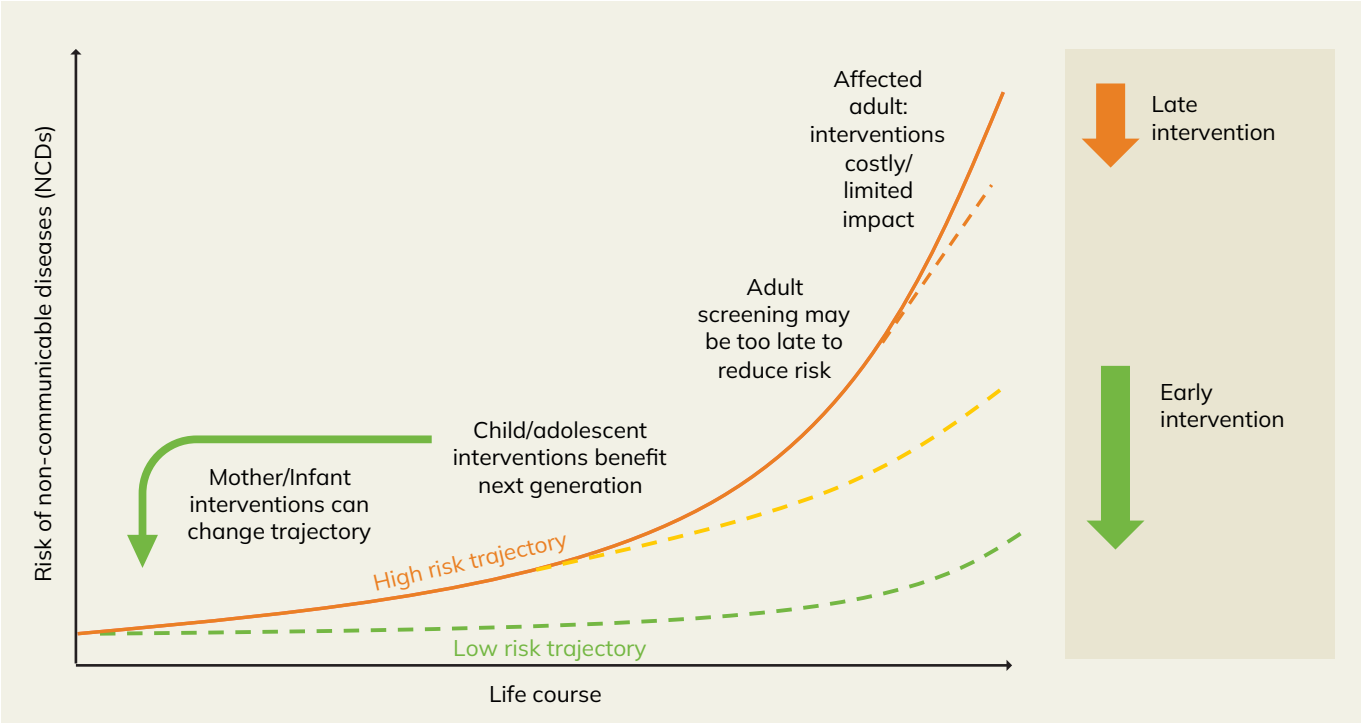
What is needed to enhance the development of young children in South Africa?

Given the strong evidence that early investments in young children can level the playing field and drive national development, this issue of the *South Africa Child Gauge* aims to provide a clear, evidence-based vision to guide policy and practice by:

- Reflecting on recent progress and current challenges;
- Identifying key priorities and opportunities to strengthen policy and practice;
- Showcasing examples of promising practice – and considering how to take these to scale

The first three chapters provide an introduction to the science of early childhood development and the policy vision that guides the delivery of services to young children and their families, followed a review of recent progress and the current status of early childhood development in South Africa.

Figure 4: Early intervention improves health outcomes across the life course



Adapted from: Hanson MA, Gluckman PD. Early developmental conditioning of later health and disease: physiology or pathophysiology? *Physiological Reviews*. 2014 Oct;94(4):1027-76.

- **Chapter 1** unpacks the science of early childhood development and describes how children's developing bodies and brain are shaped in powerful ways by their experiences. Each stage of development builds on prior growth and learning, which is why it is critical to create a healthy foundation during the first 1,000 days of life when the human brain is being built. This includes protecting children from adverse experiences and creating a nurturing environment that supports their optimal health, care, nutrition and development.
- **Chapter 2** presents a set of child-centred indicators to reflect on the current status of early childhood development services in South Africa across the domains of health, nutrition, care, protection and early learning. The chapter tracks progress in outcomes and the delivery of essential services since the introduction of the National Integrated Early Childhood Development Policy (NIECD Policy) in 2015 and reflects on the impact of the COVID-19 pandemic on young children's access to services.
- **Chapter 3** introduces the key provisions of the NIECD Policy and government's commitment to develop a publicly funded, integrated ECD system and ensure that all young children and their caregivers can access quality services. It then focuses attention on the extent to which government has succeeded in implementing five priority programmes including: support for pregnant women, new parents and children under two years of age; a national food and nutrition strategy for children under five; provision of universal early learning opportunities; inclusion and support for children with developmental delays, difficulties and disabilities; and public communication about the value of early childhood development.

The following four chapters focus on three key domains of early childhood development: health and nutrition, care and support, and early learning.

- **Chapter 4** reflects on South Africa's global and national commitments to ensure young children not only survive but thrive and reach their full potential and how this shift in the thinking has informed the design and delivery of an expanded package of health services. It reflects on progress since 2016 and identifies opportunities to enhance the coverage and quality of care.
- **Chapter 5** focuses attention on the central role of families in providing a safe, loving environment and building a strong foundation for healthy relationships and early learning. It describes how poverty and violence compromise caregivers' mental health and capacity to care for young children, and then identifies a range of strategies to promote nurturing care and strengthen support for caregivers and families of young children.
- **Chapter 6** reflects on progress in ensuring universal access to quality early learning opportunities from early stimulation in the home to more structured learning opportunities delivered through playgroups and ECD centres. It highlights how access and quality is essential to redress inequalities. It then identifies a range of strategies to enhance early learning with a strong focus on early stimulation in the home and learning through play, coupled with investments in the education and training of ECD practitioners.
- **Chapter 7** then focuses on children in need of extra care and adopts an equity lens to highlight the ways in which South African children are exposed to multiple forms of adversity – from poverty and hunger to violence and neglect. It explores how to strengthen systems and intervene early to support young children and families who are in need of extra care and improve outcomes.

The final section of the book focuses attention on how to strengthen the ECD system including the need for:

- an enabling policy environment;
- adequate financial and human resources;
- strong data systems to support population-based planning, monitoring and evaluation;
- leadership and coordination to deliver a complex package of care and support across different sectors and spheres of government; and
- effective delivery systems to ensure services reach children at the right place and at the right time.

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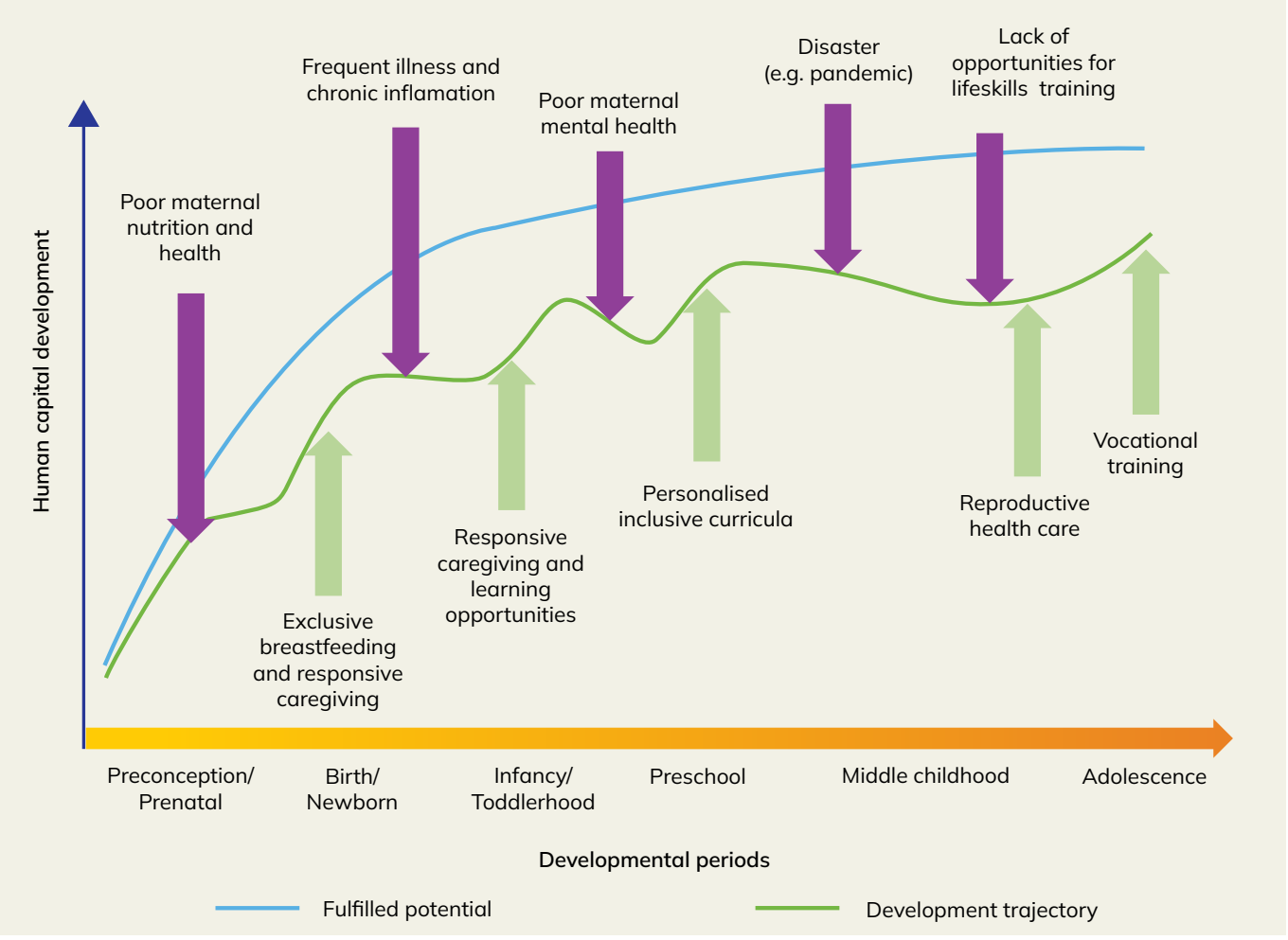
The science of early childhood development

Linda Richter,[i] Sara Naicker[ii] & Cathi Draper[iii]

The importance of early childhood is recognised historically in all cultures and, for more than a century, the development of young children has been systematically studied. While there is still much to learn, three fundamental principles are firmly established.

- The first principle is that human development is continuous across the life course. The separation of life stages, such as infancy; early, middle and late childhood; adolescence; young adulthood, mid-life and aging is somewhat arbitrary. Individuals pass through stages at different ages; stages are culturally specific and not always defined by age, but by social expectations and institutions, such as leaving education, starting work, becoming a parent and so on.
- The second principle is that development is progressive. Skills and capacities build on earlier skills and capacities – children walk before they run, babble before they say their first word, and reach for objects before they can pick them up. This is why early foundational skills are so important.

Figure 5: The effects of positive and negative experiences on developmental trajectories



Source: Black MM, Behrman JR, Daelmans B, Prado EL, Richter L, Tomlinson M, . . . Yoshikawa H. The principles of Nurturing Care promote human capital and mitigate adversities from preconception through adolescence. *BMJ Global Health.* 2021;6(4):e004436.

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- Third, our genetic and social potential is modified by our experiences, especially in the early years. For example, adverse experiences can undermine children's potential, while protective and stimulating conditions in early childhood can enhance outcomes across the life course, as shown in Figure 5 on the previous page. In all stages, the interplay of positive and negative forces can either promote or hinder development. In adverse environments, such as those experienced by the majority of young South African children, it is essential to maximise experiences that promote, protect and support their development, such as exclusive breastfeeding, responsive caregiving, safety and protection, healthy nutrition, and opportunities to learn at home and in preschool environments; in short, what is called Nurturing Care.[1]

What do we mean by human development?

The concept of human development is used in two senses which are related to one another. The first refers to the development of people and societies. From this perspective, human development is the capability of people to achieve the lives they value in addition to having rights or freedoms (that they may not be able to realise).[2] For example, some caregivers who have the right to receive a Child Support Grant may not be able to do so because they can't afford to travel to make the application, they don't understand the process, or they don't have all the required documents.

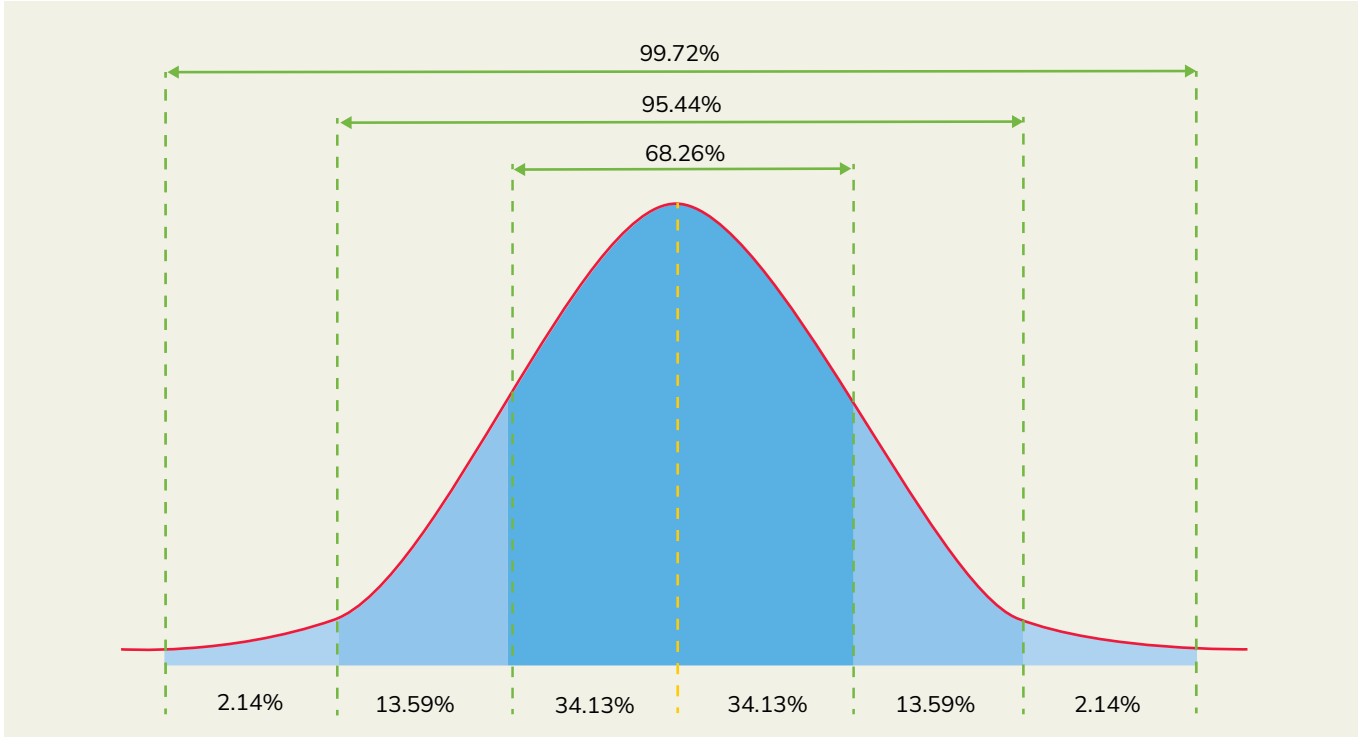
One measure of human development is the Human Development Index (HDI), based on life expectancy, education and gross national income per capita. Because this measure doesn't account for the impact of inequality on human development within countries, the index was adjusted in 2010 to reflect a more accurate measure of human development.[3] For example, in 2022 South Africa's HDI was 0.471, and we ranked 109 out of 156 countries because ours is such an unequal society.

The second conception of human development refers to the development of an individual, from conception to death. The two concepts are interdependent. For example, the development of a child in Norway is very different from that of a child in South Sudan because of differences in wealth, quality of health care and access to education between the two countries, among others. Investments in children's development in the form of health care, education and basic services, help to improve both individual human development and national human development.

How do young children's circumstances influence their growth and development?

In this chapter, we focus on different dimensions of individual human development in order to better understand how young children's circumstances influence their growth and development, the consequences this has for their lifelong health and development, and how the trajectories of young children growing up in difficult circumstances can be improved.

Figure 6: A normal distribution curve, with about 70% of people in the "average" range



From evolution to the individual

Like all living creatures, humans evolved over the last 200,000 years to become the people we are today. As a result, human beings all over the world, share many common characteristics and there are universal features of human societies, including some of the ways in which we rear our children. Likewise, because we are all born with unique genetic characteristics and live in very different circumstances, our individual and group characteristics vary, as do our childcare practices.

Universal features of children

Developmental progression

Certain characteristics are typical of human development and (barring children with specific disabilities) all young children develop motor skills, such as walking and running; cognitive capacities, such as language and basic arithmetic; social capacities such as recognising and feeling safe with familiar people, playing with other children; and personal-psychological capacities such as self-consciousness, embarrassment and pride. The ages and circumstances under which young children express these capacities vary widely, as illustrated by the examples given below of the approximate ages at which about three quarters of American children manifest particular milestones.[4]

- **Gross motor skills:** Most young children sit without support by six months, stand alone by 13 months and jump by 17 months. By three years old, a child will be able to try movements like balancing, climbing, and throwing a ball.
- **Fine motor skills:** Most young children reach for objects by five months, use their forefinger and thumb to pick up small objects by 9 – 10 months, do and undo big buttons and zips, and scribble with a crayon by three years, and copy a circle by 4 – 5 years.
- **Language development:** Most young children squeal by three months, say 'dada', 'mama' or equivalent by 11 months, say four words by 19 months, understand simple questions and commands by 2 – 3 years, and sing songs around three years.
- **Personal-social development:** Most young children smile spontaneously by six weeks, wave bye-bye or equivalent by 9 – 10 months, can put on a t-shirt by 2 – 3 years, and can brush their teeth and go to the toilet without much help by four years.

These skills are acquired at different rates, depending on children's inborn talents, and the stimulation and support that enables them to progress from simple to complex skills. Even though these skills are acquired by all children without significant impairments, the age range and competence with which they acquire them differs. The distribution of competence among populations of children follows a 'normal' distribution curve as illustrated in Figure 6 on the previous page, with most children clustered in the middle and a few children performing in the bottom and top 15%.

Accurate assessment of how a child is progressing through developmental milestones is challenging and needs to be done by a trained person to avoid parents and caregivers concluding that their child has a developmental difficulty just because they seem to be falling behind on a particular milestone. If parents are concerned about their child's development, they should seek advice from a trained professional.

Disability

Disabilities among children are seen universally, but their prevalence and the limitations they impose on an individual child, as well as the extent to which a child can be helped to compensate for those limitations, differ based on their access to effective prevention and support from both family and services.

In all parts of the world, a small – yet significant – proportion of young children do not achieve expected milestones or achieve them at a slower pace than most other children. In 2016, genetic, congenital or functional impairments, developmental difficulties or delays affected an estimated 8% of children under five years of age,[5] and nine out of 10 children with a serious congenital or inborn disorder are born in low- and middle-income countries where fewer services are available to prevent them from occurring or to assist children and their families to cope with disabilities.

Many of these disabilities can be prevented or minimised by protecting pregnant women and young children from nutritional deficiencies, toxins and injury. Maternal vaccination, adequate intake of folic acid or iodine through fortified foods, micronutrient supplementation, delivery by a trained birth attendant, post-delivery care, and protection of young children all help to prevent disabilities. Genetic testing during pregnancy and the neonatal period has advanced considerably, and screening is available in most high-resource settings.[6] However, South African public health facilities do not provide universal or targeted genetic testing during pregnancy or soon after birth.[iv] The feasibility of conducting routine newborn hearing screening has been assessed in South Africa, but implementation is challenged by lack of legislation and resources.[7]

iv Targeted screening refers to tests conducted after initial screening; for example, for Down's Syndrome or Trisomy 21 if the mother is over 40 years old.

Universal features of parenting

Intuitive parenting

Human infants are completely helpless at birth except in one special way. They have evolved to recognise and attach to other human beings and to appeal for care and protection by crying, which increases their chances of getting help and surviving. Mature human beings are also prepared by our shared biological, cultural and psychological background to respond to infants' cries for help and to react with affection to their appealing round faces and large eyes, as well as their attempts to engage us.[8] Human beings, including children, non-parents and older people, respond to babies in similar ways. They approach and touch babies gently and talk in lilting voices, often in the form of questions; for example, "how is my baby"?[9]

- This innate capacity for parenting is expressed universally by mutual gaze, changes in vocal intonation (referred to as motherese), and the ways in which we mirror or imitate infant vocalisations, gestures and actions.[10] These innate capacities are elicited and reinforced by the baby's appearance and behaviour and are designed to evolve into responsive caregiving and early learning. It is therefore critical that these complementary dispositions of parent and child to attach to one another are supported in the first hours, days and weeks after birth.[11] For this reason, the World Health Organization recommends that newborns are put to their mother's breast within the first hour of birth, and not separated from their mother so that their mutual social and biological capacities, including for breastfeeding and attachment, are activated and strengthened.[12]
- Responsive caregiving remains critical for children's development and well-being throughout the early childhood period, and continuing through adolescence.[13] As children's levels of energy and curiosity increase in the next 1,000 days,[v] caregivers (including other adults, such as grandmothers) and older siblings should be encouraged to engage in playful activities with young children. Activities that promote development of fine and gross motor skills and movement are particularly beneficial, along with those that help with language development, and the learning of early number skills, shapes and colours. As children are also developing their independence and autonomy at this age, they should be encouraged to engage in self-directed activities, and activities with other children to nurture their social and emotional skills, and they should be helped to learn how to solve problems, make decisions appropriate to their stage of development, and manage their behaviour and emotions. With all this increasing energy, curiosity and independence, establishing healthy boundaries (e.g. putting limits on screen time), and avoiding harsh methods of parenting (e.g. physical punishment) are critical for children's healthy development and well-being.

Individual and group variations

All human beings have a great deal in common, but both individual parent and child characteristics and childcare practices vary widely across contexts and cultures.

Individual characteristics

The full spectrum of individual characteristics, including height, intelligence, sociability and emotional sensitivity, for example, have their foundations in genetic configurations, but are modifiable. That is, they can be amplified or diminished by the environmental conditions in which a child grows up. Children reared in the same rural village or middle-class neighbourhood share characteristics that make them different from another village or neighbourhood. For example, in general, middle-class children do better at school than rural village children for a number of reasons. Their mothers tend to have healthier pregnancies and safer births, children tend to have good early nutrition and cognitive stimulation which prepares them well to enter school, the quality of their schooling is better, and their parents have the motivation and resources to encourage their learning and school achievements. While all the children in the middle-class neighbourhood or the rural village are different from one another, they are more similar to each other than to children in the other environment.

Childcare practices

Similarly, some elements of childcare are universal. For example, most women are capable of breastfeeding, but what is done with their colostrum varies widely across cultures. In 16th century Europe and in many traditional societies today, colostrum is discarded as 'unclean', yet this first milk has been found to boost babies' immunity and breastfeeding within the first hour of birth is strongly recommended by the World Health Organization. Co-sleeping with infants also differs across contexts, as do responses to infant crying, what parents and family try to teach infants, child-directed speech, and attitudes to children's exploration, disobedience and so on.

The differing physical, social and cultural settings in which young children are reared are called a child's 'developmental niche'[14] and the care of children within that niche patterns children's perceptions and experiences of the world. For example, whether infants are carried or transported in a

v Children aged 2 – 5 years or the preschool years.

Box 1: Changing caregiving practices in South Africa

Postnatal care

Many traditional societies, including in South Africa, prescribe a period of rest and protection for new mothers and their babies.[16] Other family members take on household tasks so that the mother and baby can recover from the birth, establish breastfeeding, and be protected from outside threats of infection and harm. With changes in family and residential arrangements, women's participation in formal labour and inadequate parental leave, many women rapidly return to work and to social activities with negative consequences for breastfeeding, their mental health, and the well-being of their baby if dedicated replacement care is not available.

Breastfeeding

While most South African women initiate breastfeeding after birth, the pressures of employment and aspirational marketing often lead to the early introduction of commercial milk formula and mixed feeding. This reduces the benefits of breastfeeding for both mothers (protection against breast and cervical cancer) and children (nutrition and immune protection).

Infant carrying

Until recently, most South African women carried their babies on their backs for much of the day. This close bodily contact helps to regulates the baby's temperature and enables the mother to 'read' her infant's state of wakefulness and well-being; the rhythm of walking is soothing for the baby, and the upright position allows the baby to see the world as the mother sees it. These elements of infant care are embodied in 'kangaroo care' which is recommended to promote the survival and development of high-risk infants, and to calm and pacify all infants. Yet infant carrying is rapidly being replaced by pushchairs and prams. These are marketed as modern and fashionable – part of the general commercialisation of childcare – but they don't have the same benefits for mother and baby as carrying, either on the mother's back or in a pouch at the front.[17]

Co-sleeping

Traditionally infants sleep with their mothers and co-sleeping has been shown to facilitate breastfeeding. Although associated with Sudden Infant Death Syndrome (SIDS) in the West, other confounding factors such as drug abuse and excessive bedding may account for this finding. Increasing numbers of Western parents are co-sleeping with their babies for reasons of comfort, attachment and breastfeeding. At the same time, though, affluent African women are beginning to put their babies to sleep in cots, and even in separate rooms.[18]

Multiple caregivers

Infants in traditional families are reared by many people in their close and extended family, and children develop strong attachment to adults and older children in addition to their mother and father. This provides young children with a supportive reservoir of close and protective relationships and relieves mothers of the sole and sometimes exhausting responsibilities of caring for a young child.[19] Increasingly though, women have babies on their own, without paternal and sometimes even family support, which increases physical and mental health risks for both the mother and child.

pushchair, affects their visual experiences, exercise, sense of security and social interactions.

Cultural practices and developmental niches are not static; they change over generations. For example, the introduction of compulsory free primary education changed many families' everyday lives, in terms of caregiving responsibilities, household duties and the value they attributed to education. Women's increasing participation in the formal labour force has also changed the environments in which children are reared, highlighting the growing importance of accessible, high-quality childcare while women work.

In addition, rapid advances in technology have also influenced caregiving practices. In previous generations, caregivers had televisions as the main source of screen-based entertainment, with computers in higher income homes. Now, smartphones are ubiquitous, tablets are increasingly affordable, and caregivers have to balance the educational value and entertainment appeal of these devices against the risks associated with excessive screen time and sedentary behaviour.[15]

From the genotype to phenotype

Although all humans are born with the same basic human genotype, there are millions of variations that are expressed to differing degrees in our phenotype, or the way we look and function.

The processes and pathways between the genetic structure and the phenotype are passed on from mother and father during conception, and how genes are expressed in an individual child, are universal. At the same time, there is infinite diversity among us. We inherit our genetic structure from our parents, and they inherit their genetic structure from their parents. But, except for identical twins, each pairing of a mother's ovum with a father's sperm makes every child unique.

The health and potential of parental sperm and ova obviously influence the health and potential of the fertilised egg which, all going well, will rapidly develop into a foetus and be born as their child nine months later. An example of the influence of parental health and well-being is the effect of age on parental reproductive cells with children born to older mothers at increased risk of Down Syndrome, and children born to older fathers at greater risk of genetic disorders than children born to younger fathers.[20] Grandparents' exposures to smoking or hormonal drugs have also been reported to affect parental sperm and ova[21] and therefore their grandchildren. These effects highlight the importance of protecting adolescent and adult health prior to conception and across generations to improve early childhood development.

Pregnancy and foetal development

Pregnancy is often divided into three-month periods known as the first, second and third trimesters. Although the foetus is only about 12cm long at the end of the third month, it is fully formed, its heartbeat can be heard and it starts to explore itself and its environment by opening and closing its fists and mouth.

During the second trimester, the foetus becomes more differentiated: hair and nails form; bones harden; hearing, sight, taste, smell and sensation become functional; and the foetus can be observed to move, suck its thumb, yawn, stretch and grimace. Its pulse rate may change and the foetus may make jerking movements or change position in response to light, sound and pain. In the third trimester, brain and body size develop rapidly, reflexes are coordinated, and the foetus can open and close its eyes, turn its head and respond to its environment, including to touch that reaches it through the mother's body.

The foetus cannot respond to threat with fight or flight. Instead, it freezes; it stops breathing and its heart rate drops. The reaction can be so strong that the foetal heart can stop working and the foetus dies. Right from the start, the foetus and young child is attuned to inputs from humans. By 24 weeks, the foetus hears (and remembers) the mother's voice, and distinguishes it from other sounds, like intestinal movements and blood flow.[22] It is these human inputs of voice, touch, smell, hearing and taste that shape which connections in the infant's brain are retained and strengthened, and which die off when not stimulated by human contact and care. This is why pregnancy and early care are so important for the development of a child's brain, including the connections which support psychological functions.

Foetal development can be derailed by a number of factors, especially teratogens, which can cause, among others, miscarriage, stillbirth, congenital abnormalities and preterm birth. Teratogens include infections (like rubella), untreated maternal disorders (like diabetes), chemicals (such as pesticides), and prescription or recreational drugs. Alcohol abuse, causing foetal alcohol spectrum disorder (FASD), is a major cause of developmental anomalies and delay in South Africa.

South Africa has the highest prevalence of FASD-related childhood disability in the world, a long-term consequence of remunerating farm workers with alcohol (through the 'dop' system). Although the practice was outlawed in 1960, alcoholism remains a problem in these areas. Heavy alcohol consumption during pregnancy can cause neuropsychological deficits. In severe cases of FASD, children have small heads with small eyes, a thin upper lip and a smooth groove between the nose and upper lip, together with stunted growth and development. Preventive approaches using self-management, motivational interviewing and support have been shown to be effective in helping heavy-drinking women reduce their alcohol consumption during pregnancy.[23]

Changes in foetal development also occur through epigenetics – or the ways in which the expression of our genetic potential is shaped by our environments.

Epigenetics

The basics of foetal development are universal, but foetal and neonatal environments affect the way genes are expressed. Epigenetics help us to adapt to optimise the fit between our genetic make-up and our environment. For example, when foetal nutrition is compromised – either through maternal undernutrition or placental insufficiency – metabolic processes may slow down to improve the foetus' chances of survival. Which organs are affected depends on which bodily cells are sensitive at that time in development; that is, which cells are undergoing differentiation, proliferation or functional maturation. For example, both the size and function of the kidneys may be affected. However, a lack of fit of our epigenetic adaptations may occur when the environment changes. For example, if a nutritionally deprived foetus is fed large amounts of energy-rich foods after birth, there is an increased likelihood of overweight or obesity because the structures and systems for storing food are enhanced.[24] This is why some low birthweight babies are more likely to suffer cardiovascular ill-health in adulthood.

These findings are evidence for the foetal and infant origins of adult disease. The trend towards overweight or obesity may continue into adolescence and adulthood with associated risks of cardiovascular and metabolic diseases like diabetes.[25]

Another example of epigenetic adaptations and their effect on later function are prenatal and early postnatal stress. Stress during this most sensitive and plastic period of life programmes the body's stress response system, by raising the baseline level of stress and increasing the individual's reactivity to stress. It is important to note, though, that health and psychosocial care during this early period can reduce physiological and psychological responses to stressful experiences among both mothers and children.[26]

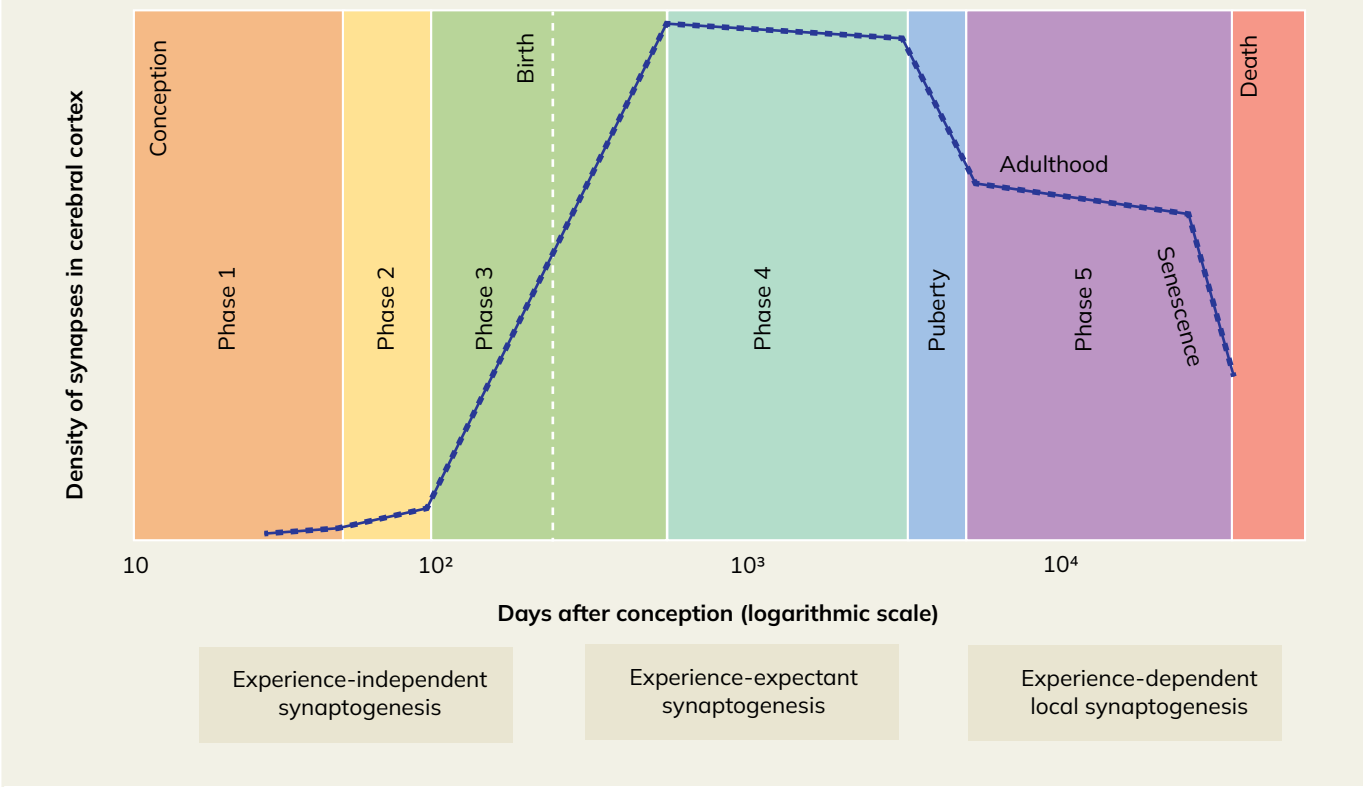
Interventions for pregnant women and new mothers include encouraging partner and family support,[27] increasing exercise and sleep, as well as relaxation procedures. Interventions to decrease the impact of toxic stress[28] on young children entail affectionate contact and reassurance, protection from stressors, and restoration of daily food, play and sleep routines.[29]

From the womb to the world

The closure of the neural tube, which happens 20 – 30 days after conception, is considered one of most important events in human life.[30] If the top end does not close, the foetus will be born anencephalic (without a cerebrum), leading to miscarriage, stillbirth or death soon after birth. If the bottom end doesn't close, the child will be born with spina bifida (paralysis of the bottom half of the body), which affects one in a 1,000 children. This can be prevented if mothers take folic acid before they fall pregnant, a supplement that also prevents anaemia. For this reason, many countries, including South Africa, have regulations to fortify staple foods such as maize meal, with a range of vitamins and minerals including folic acid and iodine. However, South Africa – like other low- and middle-income countries – have poor implementation and monitoring mechanisms, resulting in many people, including children, not benefitting from national programmes.[31]

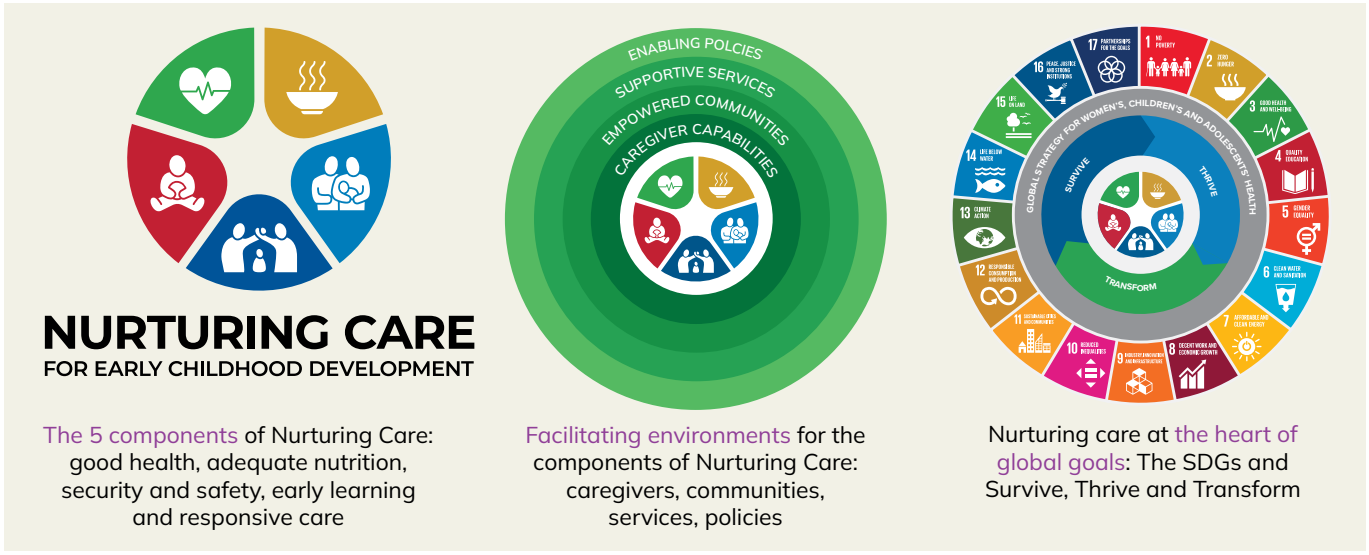
These devastating outcomes affecting initial child brain development emphasise why the period of early pregnancy is so important for children's development. Furthermore, the second semester (from 3 – 6 months of pregnancy) is the period of maximum brain growth and development, when the majority of the 100 billion neurons in the adult brain are generated. Although many surplus neurons are lost, those that are retained, are what we have for our whole life. New cerebral neurons are not generated after birth, except in the hippocampus.

Figure 7: Development of synaptic connections in the First 1,000 Days



Source: Bourgeois JP. Synaptogenesis, heterochrony and epigenesis in the mammalian neocortex. Acta Paediatrica Supplement. 1997;422:27–33.
Note: 10^2 = 100 days, 10^3 = 1,000 days (28 months) and 10^4 = 10,000 days (28 years)

Figure 8: The Nurturing Care Framework



Adapted from: World Health Organization. *Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential.* WHO: Geneva. 2018.

The first thousand days

The development of synapses (the connections between neurons) proliferate during the third trimester (between 6 – 9 months) when up to a million connections per second are formed. This period is called the 'big bang' of brain development.[32] This very rapid proliferation of connections continues after birth into the second or third year of life (see Figure 7).

This early period, from conception to the end of the second or third year – depending on an individual child's trajectory – is commonly referred to as the first thousand days of life (270 days of pregnancy, plus 365 days in each of the first two years). When we talk about early childhood development, we really mean early. While we can promote learning at four or five years of age, the potential of a child's brain is built only once, during the first 1,000 days of life.

The rapid development of synapses then levels off until puberty. Although new synapses continue to develop throughout life, development slows down during adulthood, and more rapidly as we age. Synapses are stimulated and pathways organised by sensory and emotional input from caring adults, and connections are reduced under conditions of deprivation. For this reason it is so important to ensure that women have a safe and healthy pregnancy and birth, that their mental and physical health is maintained, and their emotional connections and social conditions enable them and their families to provide their infants with nurturing care as this lays the foundation for the continued provision of nurturing care for the rest of the early childhood period (and beyond).[33]

Nurturing care

The concept of Nurturing Care was proposed in the 2016 Lancet Series *Advancing Early Childhood Development: From Science to Scale*[34] to describe the conditions under which young children survive and thrive. Infants and young children need an environment in which they receive good nutrition and health care, security and safety, opportunities to learn, and responsive caregiving. This environment is provided mainly by their family at home, with support from kin, community, services and policies which enable families to provide nurturing care to their children. The Nurturing Care Framework is at the heart of the Sustainable Development Goals and has been widely adopted by multilaterals, governments and funders.

From the human 'pouch' to autonomy

Human babies are born before they are ready to leave their mother's body. Even though their brain is about a tenth of their birth weight, babies are completely helpless and dependent at birth. However, evolution has prepared both infants and parents to negotiate this vulnerable period of development.

From birth, the infant's brain directs its sensory and motor systems specifically to other human beings. Infants preferentially orient and respond to human faces, voices, smells and touch as well as tastes to which they have been exposed *in utero*. Distress signals, especially crying, ensure parents and other adults stay close to and protect the baby. Newborns calm when conditions emulate their uterine environment, as in skin-to-skin contact – which has the added benefit of temperature regulation. They show preference for their mother's smell, voice,

and breastmilk soon after birth and they tend to mirror the facial expressions of their mothers and fathers.[35]

Together these newborn capacities 'prepare' babies for their entry into a human world and to connect with other human beings, what Colwyn Trevarthern calls "innate intersubjectivity".[36] Intersubjectivity is the conscious and unconscious interchange of thoughts and feelings between two people, which is facilitated by emotional connectivity. The emotional exchanges between mothers (primary caregivers) and their infants enable them to achieve pre-verbal intersubjectivity – emotional resonance and interpersonal understanding before the baby begins to speak. This early intersubjectivity, in the first 4 – 5 months after birth, is the platform upon which the infant is progressively inducted into the linguistic, behavioural and emotional culture of their caregivers. For example, a five-month-old baby enjoys being thrown into the air by their trusted father and a six-month-old 'understands' their caregiver's intentions when they 'tease' them in games with a climax, like 'round and round the garden'.

On their part, parents have evolved to provide what is called intuitive parenting:[37] to breastfeed infants; to be roused to respond to infant signals of distress; to closely monitor their infant's physical and psychological states; to speak slowly, repetitively and with exaggerated intonation in high-pitched tones (called motherese[38]); and to anticipate their infant's requirements and wishes.

This close nurturing environment, akin to a human 'pouch', helps the newborn adapt to life outside the womb, gradually becoming less fretful, feeding with less gastro-intestinal irritation and beginning to approximate the diurnal sleeping pattern of adults. Apart from the large size of a human newborn and the proportion of a woman's pelvis, the most important reason why babies are born early is because an enormous amount of brain development is experience-dependent, relying on physical, emotional, linguistic and cognitive input from caregivers from birth. To develop consciousness and the human faculties associated with it, the infant must be exposed to other human beings who interact affectionately with them. For example, newborns react differently when someone else touches them compared to when they touch themselves.

The first type of interaction between parents and newborns is emotional, conveyed through close bodily contact, gentle touch, gaze, soft words and imitation. Babies show delight when others imitate their vocalisations (like a cough or sneeze) and facial expressions (like yawns and coughing) and begin to imitate their caregivers in return. In the first few months of life, communication and joint attention develop between parent and child, resulting in a shared perception of the world, which is primary intersubjectivity. Between 5 – 9 months, the period of secondary intersubjectivity, their relationship expands to include topics, objects and people beyond themselves, creating triadic joint attention.[36] Caregivers and babies refer to a toy, the sound of a car, and other people and events around them. By the middle to end of the second year, children show tertiary intersubjectivity – self-recognition and embarrassment, use of possessive pronouns and claims of ownership and autonomy (saying things like 'mine!', 'Mary do it').[39] Paralleling growing intersubjectivity with others is the infant's increasing interest in, and exploration and mastery of, the environment.

Responsive caregiving and early learning

As children develop, their capacities, interests, exploration and delight in interaction with others and the environment, outline 'a curriculum for learning' to which parents respond. That is, the infant demonstrates, by sounds, words, expressions and gestures, what they are interested in and what they want to do. This is the crux of responsive caregiving and early learning – parental observation of infant behaviour, interpreting the infant's intentions, and answering or facilitating in ways that amplify their child's behaviour. Responsiveness prompts and enables the baby's exploration and learning and this 'scaffolding' of early learning enables their child to take the next steps in autonomy and skill acquisition. Parent-infant play involves the same processes, with repetition and mutual enjoyment. At the same time, parents provide limits to infant behaviour, stopping them when they approach danger and calming and gently restraining them to demonstrate how they should control their emotions, such as when they shout or hit out at others.

A child's interactions with adults and other children in the family, as well as with people in the wider community, progress along similar lines. Most children show 'stranger anxiety' around 8 – 9 months of age, which is prompted by their ability to recognise 'familiar' and 'unfamiliar' adults, and their experience of feeling safe and protected by familiar adults.[40]

Relationships with other children develop along a path described many years ago through observations of infants and children in nurseries and kindergartens.[41] Children 'play' from 3 – 6 months of age, starting with 'teasing' interactional play with parents (such as 'this little piggy went to market') to more functional play, such as rolling a ball, pushing a car, etc.

Rubin[42] categorised different types play[42] including functional play (using objects as intended), constructive play (creating or building), dramatic play (assuming roles and pretending), and games (governed by formal rules). Levels of young children's play tend to progress from being an onlooker to solitary and then parallel, associative and cooperative

play. That is, from playing alone, children progress to playing alongside other children and playing with the same objects, before being able to play *with* them. These stages of positive social play development indicate that most children are unable to benefit or enjoy group play or care until about 18 months of age. Until then, their capacities, initiatives, emotional regulation, and learning are best supported by one or more caring adults in a familiar environment, alone or with a few other infants. Social play with other children begins around 18 months with exchanging smiles, vocalisations and objects, and imitating each other's actions. Between two and three years, children enjoy a few hours of social interaction with other children in play groups and small nurseries. Children are generally ready for preschool at around 3 – 4 years of age when they are able to communicate and socialise with other children, and can engage in and learn social skills such as sharing and turn-taking through organised and free play activities. At this age, young children start to prefer to play in pairs or in small groups of three or four, a context in which friendship develops and gradually extends to more children.

In the main, young children generalise behaviours acquired in child-adult interactions when they play with their peers.[43] This means that parents need to model, teach and encourage cooperative behaviour and sharing in the family, and discourage selfish or tyrannical outbursts. If poor behavioural and emotional control is allowed or tolerated in the home, young children find it difficult to understand why it is not accepted with other children in group care and preschool settings.

From composite skills to competencies

For the baby, their most fundamental human skill is recognition, identification and learning from other human beings in warm, affectionate and devoted contexts. All other skills – sensory, motor, cognitive, linguistic and emotional skills – develop from this core capacity. Despite knowing this, our usual assessment of infant and young child development tends to focus on secondary competencies which enable the baby's drive to be human to be expressed – in walking, talking and other developmental milestones. But without fundamental emotional and communicative connections with others – children are unable to form and sustain relationships with others that are essential in enabling them to acquire complex skills through imitation, identification and cooperation.

From emotional to language expression

Babies can communicate from birth. Long periods of mutual gaze, back and forth vocalisations and gestures with parents, and mutual mirroring or imitation create both the format of language (proto-conversations) and interpersonal understanding. Cognition and language are created in the crucible of these emotional exchanges between infants and their caregivers. When assessing the health and development of children under six months of age, it is important to gauge the emotional fit, resonance and affection between them and their caregivers as this is the basis of all subsequent integrated development.

By six months of age, children babble, can follow pointing, and they delight in repetitive games. Early intersubjective understanding and trust is being established and it is common to see a child 5 – 9 months of age squealing with pleasure when they are thrown up in the air and safely caught by someone they love. By the end of the first year, children start to say words like 'mama', they can imitate social gestures like 'wave bye bye' and clap hands in concert with an adult. Language – either spoken or gestural, comprising shared understanding of meaning – becomes generative, with children adding and combining words at a rapid pace.

To acquire enhanced language, with reference to objects, people and events that are not present, either in the past or imagined (the foundation for abstract thinking), children need to be exposed to a rich language environment. Adults talking around children so they hear many different words is important, but language spoken to the child is critical to enhanced language development.[44] Child-directed language may take the form of interpreting actions ('you're playing the drum!'), asking questions ('what is this, what do we call this?' – when holding up a plate), teaching ('be careful, it's hot'), praising ('good, you're drinking from the cup'), and so on. It is also important for adults to elaborate on people, events and objects and relate them to categories beyond the here and now. For example, 'that's a red car, granny also has a red car; daddy has a blue car'; 'this ball is big, but the yellow ball is small'; 'John is here with us. Daddy's coming home tomorrow') etc. This enables the child to categorise the world, an essential cognitive capacity and helpful preparation for preschool education.

By the age of 3 – 4 years, children can usually run and jump, dress themselves in simple garments, wash their faces, know where familiar objects are and fetch them on request, know and use hundreds of words in two- to four-word sentences, tell simple stories, express their emotions and use speech in their play with other children. At this stage they are ready to participate in a supervised social group in a crèche or preschool, to learn behavioural conventions such as saying 'please' and 'thank you', and to acquire the basic elements of literacy and numeracy.

Delays and deviations

As indicated before, children develop differently at different tempos and speeds. This is expected, given the diversity of our lineage and circumstances. But a small number of children develop slower than others, and stop developing at a particular stage because of genetic, congenital or birth problems. The delays may be due to physical difficulties that affect movement, or neurological difficulties that affect learning, language and higher cognitive functions.

It is important to remember that the essence of childhood development is the same for all children, regardless of whether they experience delays or not. The Nurturing Care Framework is the basis for providing care and support for children developing well and for children experiencing difficulties and delays. Strong emotional bonds with caregivers, responsive caregiving and scaffolding help all children learn new skills. This is part of normal development, but especially critical for children facing developmental delays and difficulties. Positive emotional relationships with parents and caregivers enable these children and their parents to deal with inevitable challenges.

A small number of children also deviate socially from expected developmental phases. While all young children go through stages of learning how to share with others, make friends, control their temper and aggression, and obey rules of the home and the preschool, some children persist in 'difficult' and challenging behaviour. A good adage is that 'young children are not usually trying to be a problem, rather they are usually trying to solve a problem'. Frequently, the problems young children are trying to solve are things like feeling neglected and wanting attention, and difficulty in understanding what is expected of them when adults are inconsistent. Such children are helped by warm and consistent adult time and attention when they engage in positive behaviours, as well as encouragement and supervision to help them learn how to take turns and cooperate with other children. Harsh physical punishment, humiliation, scorn and isolation may help adults vent their frustration with a young child, but they do not help children learn. In fact, children's pain, confusion and anger disrupts their attention and learning, and may cause them to withdraw or engage in devious behaviour to avoid repeat episodes.

What are the implications for policy and practice?

This chapter outlines the basic physical and psychological structures of human development in the first few years of a child's life. It emphasises both the universality and individuality of developmental processes and outcomes, and the central role of family, peers and the community in fostering and protecting the integrity of young children's development.

The science of childhood development makes clear that the first 1,000 days of life are fundamental, as this is when the foundations for emotional, language and cognitive developments are laid down. After this time, development becomes additive and progressive, though quite dramatic transformations may occur at particular points in time in response to both physical and social changes. For example, when a younger sibling is born, when entering formal schooling and when moving house. These changes can be stressful and young children may need additional care and support to cope with these transitions.

There is a saying that 'the time to help THIS child is now, but the time to help ALL children is when or before they are conceived'. Very early childhood development, beginning at conception and influenced pre-conception, is the foundation of each child's trajectory through life. Importantly, though, this trajectory is influenced, in positive and negative ways, by experiences and events in the years after they are born, emphasising why nurturing care is so important. It also means that we cannot separate optimising the development of young children from efforts to optimise the health and well-being of women, and the health and well-being of young people who may one day become parents.

Early childhood development has been called "a powerful equalizer".[45] During this period of very rapid development, the young child's potential is highly plastic, open to influence by experiences and environmental conditions. For this reason, it provides a unique opportunity to balance the scales in a child's favour, with benefits for the rest of their life and the lives of their children. A child who is born small or sick can survive and catch up to the development of other children if provided with kangaroo care, exclusive breastfeeding and nurturing care. Similarly, a happy and stimulating playgroup or nursery can boost the learning of a child who has spent their first two years in a home where poverty strips the family of time and energy to stimulate a young child. The family's surprise, relief and pride in their child's learning and achievements may encourage them to invest more in their child's education and give the family hope for the future.

Early childhood is a once-in-a-lifetime opportunity to improve the world, child by child, family by family, and community by community. Together these individual effects add up to substantial economic benefits for countries, improve the likelihood of peace and progress, as well as the sustainability of our planet. Seemingly insignificant or trivial actions engaging with a young child – making eye contact, enjoying their discoveries, encouraging them, explaining and guiding, ensuring that they eat nutritious food and monitoring their

health – have the power to change our shared futures. Every parent, whether a president or a tea picker, has the power to give this love to a child, a gift that keeps on giving through this child's life and those that follow.

Key takeaway messages

- Human development is continuous and progressive, showing both universal, contextual and unique characteristics. Parenting and families also show both universal, contextual and unique features to support the development of young children.
- Child development and parenting are both biologically and socially determined and shaped. They are complementary processes to ensure the survival and healthy development of children and of our human species. The essential features of parenting are best facilitated and enabled rather than taught in a didactic fashion. The latter approach risks undermining parental confidence and effectiveness, both critical to responsive caregiving.
- The development of a child is governed by his or her brain development which is both experience-expectant and experience-dependent. The developing foetus and child brain has evolved to anticipate a human environment, and its development is dependent on a human environment that is loving, responsive and protective.
- The earliest phases of a child's development – during pregnancy and the first two to three years – are critical for their lifelong development and the development of their children and their grandchildren. Deficiencies and injuries during these early phases of brain development may be compensated for by later experiences and remedial care, but they can't be made up. The brain might change many times during a person's life, but it is only built once, during foetal life and early infancy.
- Despite this, advocates, programme implementers and policy makers continue to 'age up' their actions with respect to young children by concentrating almost exclusively on children in the preschool years. Unfortunately, by this time, the greatest opportunities for healthy physical growth and enriched neural connections have passed. Increased efforts will be needed to try and compensate for these lost opportunities in young children's lives.
- Science, experience and common-sense show that Nurturing Care is necessary for all children to be able to realise their human potential by laying a firm foundation for development in their early years. Safe and loving families, childcare and preschool education are all needed to foster and safeguard a young child's human potential.
- Play is an important feature of child development and of human societies. Unfortunately, many interventions tend to simplify 'play'. Encouraging parents to 'play' with their children by shaking objects in front of their babies, seriously 'dumbs down' child development, and trivialises parental responsiveness. Play and child-directed speech are important inputs to children's cognitive and emotional development, and the role of parents and families in both can be activated through sensitisation, encouragement and links to cultural values and activities.

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The status of early childhood development in South Africa: A statistical overview

Katharine Hall[i]

The National Integrated Early Childhood Development (NIECD) Policy was approved by Cabinet in December 2015[1] and covers the period from conception until the year before children enter school. It aims to transform early childhood development services by ensuring that the service package is comprehensive and equitable and that the essential components are universally available.

This chapter provides a brief overview of trends in service delivery and outcomes for early childhood development (ECD) over seven years, from the introduction of the NIECD Policy in 2016 to 2022 when the mandate for coordinating the delivery ECD services shifted from the Department of Social Development to the Department of Basic Education. This period includes the COVID-19 pandemic and lockdown, which curtailed children's access to early learning programmes and other frontline services. The lockdown period was also associated with worsening financial conditions, including rising unemployment and high food inflation. Therefore, in addition to comparing overall trend across the two outer years – 2016 and 2022 – the chapter briefly describes some of the impacts of lockdown in the intervening years. [ii]

What are the recent trends in early childhood development in South Africa?

The sections that follow present statistics on the current status and recent trends across a range of domains including the trends in the young child population, their access to basic services, and their health, nutrition, social protection, care and early learning.

Table 3: Child population, 2016 – 2022

POPULATION	2016	2022	change
Number of infants under 1	1,106,000	1,150,000	4.0%
Number of children under 6	6,997,000	6,976,000	-0.3%

Source: Statistics South Africa. *Mid-Year Population Estimates 2022 (MYPE 2022 series)*. Pretoria: Stats SA. 2022.

Child population

It is important to have accurate information on the number and whereabouts of young children so that budgets and services can be allocated appropriately. The size of the young child population has remained stable, with just under seven million children below the age of six years, making up just over 10% of the total population.[2]

What happened during lockdown?

There are signs that more babies may have been born during and soon after lockdown,[3] a possible consequence of lower access to reproductive health services especially by young women. While Statistics South Africa's population model estimated around 1.15 million infants in 2022, the estimate derived from the 2022 Population Census was over 1.3 million infants[4] (around 180,000 more than the mid-year population estimates for the same year). The 1 – 2-year-old population was also slightly larger in the Census count, exceeding the modelled population by nearly 80,000. This suggests that the number of births may have risen during lockdown and the post-lockdown period, and that the young child population may be growing faster than the population models accounted for. . There are serious concerns about the reliability of the Census results due a substantial under-count and the subsequent adjustments,[5] but if this increase is true, it will have implications for budgeting and programmes if they are to reach all young children.

Basic services

A piped water connection is used as a proxy indicator for access to adequate water. All other water sources, including public taps, water tankers, dams and rivers, are considered inadequate because of their distance from the dwelling or the possibility that water is of poor quality or erratic in its supply. The indicator is a best case scenario as it does not consider the reliability of the services or whether households have broken facilities or are unable to pay for services.

i Children's Institute, University of Cape Town
ii A more detailed analysis of early childhood indicators can be found in the Early Childhood Review 2024, which is available on the Children's Institute and Ilifa Labantwana websites.

Table 4: Access to basic services, 2016 – 2022

Indicators	2016	2022	% change 2016-22	Definition (measure/dominator)
No adequate water	33.0%	29.4%	-10.9%	Children under 6 without piped water to home (in dwelling or on site).
No adequate sanitation	28.8%	22.1%	-23.3%	Children under 6 without flush toilet or ventilated pit latrine at home (dwelling or site).

Source: Statistics South Africa: *General Household Survey 2016 – 2022*. Pretoria: Stats SA. (K Hall & N Segoneco analysis).

Adequate sanitation includes flush toilets and ventilated pit latrines that dispose of waste safely and are within or near a house. Inadequate sanitation includes pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilets at all.

There have been improvements in access to adequate water and sanitation among children under six years from 2016 to 2022. However, the coverage of adequate services remains a challenge. Nearly a third of young children do not have access to adequate water and more than a fifth of young children still do not have access to adequate sanitation. Both are essential for child health and survival.[6]

Health

An estimated three quarters of pregnant women attended at least one antenatal visit at a public health facility in 2022. Of these antenatal clients, 70% had their first visit before they were 20 weeks into their pregnancy.[7] This is a slight improvement from 2016, however, it still suggests that in 2022 only around 54% of all pregnant women had an antenatal consultation before 20 weeks.

Early antenatal visits are important for assessing the health and nutritional status of the mother, and as an opportunity for mental health screening and HIV testing. HIV prevalence amongst pregnant women shows a gradual decline (from around 31% in 2016 to 27.5% in 2022).[8] The proportion of HIV-positive pregnant women initiated on ART has remained stable at over 90% in all provinces except the Western Cape, where there has been a worrying drop in antenatal ART enrolment since 2020, with the 2022 figure as low as 63%. Paediatric HIV prevalence rates are now very low due to the success of the PMTCT programme. In 2022, only 0.4% of infants born to HIV-positive mothers were found to be HIV-positive at their 10-week PCR test, down from 1.3% in 2016.

Delivery rates in public health facilities increased from 72% in 2016 to 83% in 2022, meaning that more births were attended by skilled health personnel. There was a similar increase in postnatal follow-up within six days of birth, from 71% to 80%. In 2022, 82% of infants were fully immunised before their first birthday, up from 71% in 2016.

Nearly 90% of children under six years are reliant on the public health system, having no form of medical insurance.[9]

What happened during lockdown?

The comparisons between 2016 and 2022 obscure some of the effects of COVID-19, which impacted the health system considerably. Antenatal visits declined sharply during the hard lockdown but picked up again in 2021/22. This meant that, in addition to coping with the social and economic hardships of lockdown, women who were pregnant during 2020/21 had unusually low levels of access to antenatal care.

There was a significant increase in the in-facility maternal mortality ratio in 2020, rising from a low of 88 maternal deaths per 100,000 live births in 2019 to 120.9 in 2020 before settling back to 101.0 by 2022. Neonatal deaths in facilities also rose slightly, from 11.9 per 1000 live births in 2019, to 12.6 in 2020. Unlike the maternal mortality ratio, there was no subsequent recovery to pre-lockdown levels.

The infant and under-five mortality rates declined steadily over the decade before COVID-19 and in 2019 were calculated as 28 and 37 respectively per 1,000 live births. There was a further sharp drop in infant and under-five mortality in 2020, to 22 and 29 respectively. This was probably due to the hard lockdown in the winter months which reduced exposure to the usual seasonal infections.[10] Infant and under-five mortality rates then increased again over the next two years, reaching 30 and 40 respectively in 2022.[11] The increase in child mortality is hugely concerning as nearly a decade of progress has been lost. The reasons for rising child mortality after lockdown are unclear as StatsSA has not released Causes of Death data since 2020. Generally, the leading causes of under-five mortality (other than neonatal causes) are diarrhoea, pneumonia and other respiratory infections. This is the case despite high immunisation coverage rates.

There were widespread concerns that COVID-19 disrupted childhood immunisation programmes as resources were redirected towards the pandemic response. This was reflected in a fall in immunisation rates among infants, where the immunisation coverage at one year dropped from 83.5% in 2019

to 79.5% in 2020. The worst affected provinces were Limpopo and the Eastern and Northern Cape. Following subsequent catch-up, the immunisation coverage rate for children at one year was 82.2%. However, immunisation rates have remained below their pre-COVID levels in Limpopo, Mpumalanga, the Northern and Western Cape, and Gauteng.

Table 5: Health services, interventions and outcomes, 2016 – 2022

Indicators	2016	2022	% change 2016-22	Definition (measure / denominator)	source
Services & interventions					
Antenatal 1st visit coverage	74.9%	76.4%	2.0%	Pregnant women attending at least one antenatal visit, as a percentage of the estimated number of pregnant women.	a
Antenatal visit < 20 weeks	65.2%	70.1%	7.5%	Women who have a first visit before they are 20 weeks into pregnancy, as a proportion of all antenatal 1st visits.	a
Antenatal clients initiated on ART	95.1%	94.1%	-1.1%	Pregnant women initiated on ART, as proportion of pregnant women attending public health facilities who are diagnosed HIV-positive.	a
Delivery rate in facility	72.4%	83.3%	15.1%	Deliveries in health facilities as a proportion of expected deliveries in the population.	b
Access to postnatal care	70.5%	80.0%	13.5%	Postnatal visit within six days of birth, as percentage of births in public facilities.	a
Infants fully immunised at one year of age	70.9%	82.2%	15.9%	Proportion of all children under one year who complete their primary course of immunisation.	a
Difficult access to clinics	20.2%	20.9%	3.5%	Children under six who travel more than 30 mins to reach the usual health facility.	b
Public sector reliance – no medical aid	86.0%	87.7%	2.0%	Children under six not covered by health insurance / medical aid scheme.	b
Outcomes					
Maternal mortality in-facility ratio	111.5	101.0	-9.4%	The number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination, per 100,000 live births, where death occurs in a health facility.	a
Neonatal in-facility death rate	12.4	12.7	2.4%	Infants 0 – 28 days who died during their stay in the facility per 1,000 live births in facility.	a
Infants HIV-positive at 10 weeks	1.3%	0.4%	-69.2%	Infants born to HIV positive women with PCR positive results around 10 weeks.	a
Infant mortality rate	26	30	15.4%	Number of children less than one year who die in a year, per 1,000 live births during that year.	c
Under-five mortality rate	36	40	11.1%	The number of children under five years who die in a year, per 1,000 live births during the year.	c
Child deaths from pneumonia	2.3%	1.5%	-34.8%	Children under five who died in a health facility with pneumonia documented as main cause of death, as % of pneumonia cases in facilities.	a
Child deaths from diarrhoea	2.1%	1.8%	-14.3%	Children under five years who died in a health facility where diarrhoea was documented as the main cause of death.	a

Sources:
a. Health Systems Trust. indicators from District Health Information System. Indicators compiled from District Health Barometer, South African Health Review and online indicators at https://www.hst.org.za/healthindicators).
b. Statistics South Africa: General Household Survey 2016 – 2022. Pretoria: Stats SA. (K Hall & N Segoneco analysis).
c. Medical Research Council: Rapid Mortality Surveillance Reports. (2022 estimate not yet published, obtained from UN Inter-Agency Group for Child Mortality Estimation at https://childmortality.org/all-cause-mortality/data?refArea=ZAF&indicator=MRY0T4).

Nutrition

The share of infants born with low birth weight (under 2.5kg) has remained fairly stable at around 13%. The Northern Cape is an outlier, with nearly a fifth (18%) of infants being born with low birth weight.

The first nutritional input that children receive after birth is milk, ideally through exclusive breastfeeding up to six months. Early initiation of breastfeeding (within the first hour after birth) seems to have increased over the period, from 67% in 2016 to 89% in 2022. Conversely, exclusive breastfeeding rates for children under six months appear to have fallen substantially from 32% in 2016 to 22% in 2022. The estimates for both these indicators are derived from two different studies (the South African Demographic Health Survey (SADHS) in 2016[12] and the HSRC's National Food and Nutrition Security Survey 2021-23[13]). There are no national estimates for

Table 6: Nutrition services, interventions and outcomes, 2016 – 2022

Indicators	2016	2022	% change 2016-22	Definition (measure / denominator)	Source
Services & interventions					
Early breastfeeding initiation in first hour after birth	67.3%	89.3%	32.7%	Initiation of breastfeeding in the hour after birth, as proportion of last-born children born within two years before the survey.	a b
Exclusive breastfeeding @ 14 weeks	41.6%	44.7%	7.5%	Infants exclusively breastfed at 14 weeks as a proportion of those receiving 3rd vaccination.	c
Exclusive breastfeeding under six months	31.6%	22.2%	-29.7%	Percentage of children under six months exclusively bread-fed, as proportion of last-born children born within two years before the survey.	a b
Vitamin A coverage 12 – 59 months	50.8%	70.8%	39.4%	Proportion of children 12 – 59 months who received vitamin A dose of 200,000 units.	c
Acceptable diet 6 – 24 months	22.9%	?	?	Percentage of children aged 6 – 23 months who receive a minimum acceptable diet.	a
Outcomes					
Low birth weight	13.2%	13.2%	0.0%	Infants born with weight below 2,500g as percentage of those born in public health facilities.	c
Vitamin A deficiency under five	?	?	?	Proportion of children under five years with serum retinol concentration < 0.70 µmol/L.	
Anaemia under five	?	?	?	Proportion of children under five years with Hb <11g/dl.	
Stunting	27.4%	28.8%	5.1%	Proportion of children under five years with height-for-age below 2 standard deviations from norm.	a b
Underweight	6.0%	7.7%	28.3%	Proportion of children under five years with weight-for-age below 2 standard deviations from norm.	a b
Overweight	13.3%	22.6%	69.9%	Proportion of children under five years with weight-for-height above 2 standard deviations from norm.	a b
Severe acute malnutrition incidence	3.4	2.4	-29.4%	Children under five years newly diagnosed with severe acute malnutrition per 1,000 children under five years in the population.	c
Severe acute malnutrition deaths	8.0%	7.2%	-10.0%	Severe acute malnutrition deaths in children under five years as a proportion of severe acute malnutrition cases in health facilities.	c

Sources:

a. Department of Health, Statistics South Africa, South African Medical Research Council, ICF. *South African Demographic & Health Survey 2016: Key Indicators*. Pretoria and Rockville, Maryland: NDOH, Stats SA, SAMRC & ICF. 2017.

b. Simelane T, Mutanga SS, Hongoro C, Parker W, Mjimba V, Zuma K, . . . Marinda E. *National Food and Nutrition Security Survey: National Report.* Pretoria: Human Sciences Research Council. 2023.

c. Health Systems Trust: indicators from District Health Information System. Indicators compiled from *District Health Barometer, South African Health Review* and online indicators at https://www.hst.org.za/healthindicators).

the intervening years, and it is unclear to what extent the differences reflect real change or arise from different sampling and survey methods. This points to the need for more regular collection of nutrition data and for consistency in the data collection methods to provide comparable trends. The District Health Information System (DHIS) indicator on exclusive breastfeeding at 14 weeks is limited, in that it is based only on infants who attend clinics for their third vaccination around 14 weeks, but it circumvents the problem of comparability and given the relatively high immunisation coverage at this age, it provides a reasonable and consistent measure of reported breastfeeding practices. According to this measure, 45% of infants are exclusively breastfed at 14 weeks in 2022, slightly up from 42% in 2016; but down from 49% in the pre-lockdown year of 2019. Exclusive breastfeeding rates at 14 weeks have declined notably in the North West province, Limpopo and Mpumalanga.

There is a notable absence of reliable data on micronutrient deficiencies in children. In 2012, the SANHANES study conducted by the HSRC found that 11% of children under five years suffered from anaemia while vitamin A deficiency among this age group was as high as 44%.[14] These statistics are still widely cited as the study has not been repeated, and data collected at health services are not reported in the DHIS. Vitamin A deficiency is the leading cause of preventable blindness and can also contribute to increased risk of death due to diarrhoea and other common childhood illnesses. The recommended intervention is two doses of Vitamin A annually for children 6 – 59 months.[15] In 2022, Vitamin A coverage was 71%, representing a substantial increase from 51% in the baseline year of 2016. KwaZulu-Natal was well ahead of the other provinces in its Vitamin A supplementation programme, with a coverage rate of 91%. Only the Western Cape, Northern Cape and Limpopo had coverage rates below 60%.

Standard measures of nutritional outcomes for children are stunting, wasting, underweight and overweight in children under five years of age. These data are not routinely collected in South Africa as they require anthropometric measurements that are costly and difficult to obtain. The data table compares indicators on child anthropometry from the SADHS (2016) and the HSRC's National Food and Nutrition Security Survey (2021-23). Once again, these should be read with the caveat that the two surveys may not be directly comparable.

South Africa has persistently high stunting rates, estimated at 27% in 2016 and, according to the HSRC survey, the rate increased further to 29% around 2022. The share of children under five who were underweight was recorded as 6% in 2016, and then as 7.7% around 2022, while the prevalence of overweight in the same age group was estimated at 13% and 23% in the respective years. This suggests that worryingly large numbers of children remain under-nourished, and that there is a rapidly growing problem of over-nutrition and obesity in young children, which has immediate and long-term consequences for their health.

What happened during lockdown?

Vitamin A supplementation coverage rates for young children in South Africa plummeted from 56.6% in 2019 to 49.5% in 2020. This loss was quickly recovered with year-on-year increases across all provinces and by 2022 Vitamin A supplementation was at an all-time high.

Between 2016 and 2022, the incidence of severe acute malnutrition (SAM) cases declined from 3.4 to 2.4 per 1,000 children under five years. However, the rates had already fallen substantially in the period leading up a lockdown, reaching 1.9 per 1,000 in 2019. Even fewer cases were recorded in 2020 (1.5 per 1,000), though this may have been related to the impact of lockdown on access to public health facilities and on health-seeking behaviour. SAM incidence then rose to 2.0 in 2021 and 2.4 in 2022, suggesting that SAM in children is increasing.

Social protection

South Africa's high rates of poverty and unemployment are reflected in the child-centred indicators for young children.[16] In 2016, 29% of children under the age of six years lived in households where none of the co-resident adults were employed or self-employed, meaning that these households relied entirely on grants and/or remittances from family members living elsewhere. By 2022, the share of young children in households without employment had risen to 32%.

The Child Support Grant (CSG) is a highly effective mechanism to support children in poverty: it is well targeted to the poor because of its low means test, and because it is well-established and relatively easy to access, it has high coverage rates. Despite the small value of the grant (R530 in 2024), numerous studies have confirmed its positive impacts for children, including better nutritional and health outcomes. This is because the grant is largely spent on food.[17] It is therefore worrying that despite rising unemployment over the period, access to the CSG did not increase. Using the upper-bound poverty line as a proxy for eligibility, the share of poor children under six years receiving the CSG dropped from 94% to 85%.[iii]

iii Grant uptake numbers from South African Social Security Agency: Social Grants Statistical Reports 2016 – 2022. Pretoria: SASSA. Child poverty estimates by K Hall using Statistics South Africa's General Household Survey series.

Table 7: Social protection services, interventions and outcomes, 2016 – 2022

Indicators	2016	2022	% change 2016-22	Definition (measure / denominator)	Source
Lack of household income from employment	28.5%	32.0%	12.3%	Children under six living in households where no adult is employed.	a
Services & interventions					
Birth registration in first year	81.5%	81.4%	-0.1%	Registration of child's birth within a year of birth.	b
Access to the Child Support Grant (CSG)	60.8%	60.5%	-0.5%	Proportion of all children under six receiving the Child Support Grant.	c d
CSG uptake among poor children under six	94.1%	85.1%	-9.6%	Proportion of poor children under six receiving CSG (using upper-bound poverty line as eligible proxy).	a d
CSG uptake among poor infants under one year	73.0%	65.2%	-10.7%	Proportion of poor infants under one receiving CSG (using upper-bound poverty line as eligible proxy).	a d
Outcomes					
Young children living in poverty (below UBPL)	64.6%	71.1%	10.1%	Children under six in households with per capita income below the upper bound poverty line.	a
Young children living in food poverty	34.5%	38.5%	11.6%	Children under six in households with per capita income below the food poverty line.	a
Food insecurity	26.4%	25.7%	-2.8%	Children under six in households that reduced the diversity of foods due to lack of money.	a

Sources:
a. Statistics South Africa: *General Household Survey 2016 – 2022.* Pretoria: Stats SA. (Analysis K Hall & N Segoneco).
b. Statistics South Africa: Recorded Live Births series combined with Mid-Year Population Estimates 2022 series (Analysis K Hall).
c. Statistics South Africa. *Mid-Year Population Estimates 2022 (MYPE 2022 series).* Pretoria: Stats SA. 2022.
d. South African Social Security Agency: Social Grants statistical reports 2016-2022. Pretoria: SASSA.

Delays in uptake for infants under one year have been an ongoing concern, especially as the existing evidence suggests that dose effect is important: the grant is most impactful if it is received immediately and continuously from birth. The barriers to early uptake are mainly and consistently associated with difficulty in providing the required documentation, such as the mother or caregiver's identity document (ID) or the child's birth certificate.[18-20]

It is therefore worrying that over the review period, uptake of the CSG for infants in poor households (with per capita income below the upper-bound line) decreased from 73% to 65%. Even if these children access the CSG later, they will have missed the early benefits.

Alongside the decline in grant access the trends show rising poverty rates. The share of children under six living in households below the upper-bound poverty line rose from 65% in 2016 to 71% in 2022. The upper-bound poverty line is calculated by Stats SA as the minimum amount of money needed to meet the minimum requirements for nutritional intake and to cover other basic needs such as essential clothing and shelter.[iv] In 2022, the upper-bound poverty line was R1,417 per person per month. The food poverty line is much lower (R663 in 2022) and provides only for cost of meeting the minimum number of calories needed for survival and development. In 2016, 34.5% of children under the age of six years lived in households below this minimum line. In 2022, the percentage had increased to 38.5.

What happened during lockdown?

When hard lockdown was announced in March 2020, births could not be registered due to Department of Home Affairs (DHA) office closures. About 22,000 babies are born every week in South Africa so the backlog in birth registrations grew quickly. Even when the levels of lockdown were lowered, DHA offices only operated at partial capacity. Fear of COVID-19 infection may also have deterred new parents from taking public transport and queuing with their babies. It is likely that lower birth registration rates contributed to the decline in uptake of the CSG for infants. Trends over the time of the pandemic show serious economic impacts for young children and their families. In 2020, the number of children under six years living

iv For a discussion of the poverty lines, see Statistics South Africa. *Methodological report on rebasing of national poverty lines and development on pilot provincial poverty lines – Technical Report.* Pretoria: Stats SA. 2015.

in households without any employment income rose by over 400,000 to nearly 2.5 million (around 35% of all children in this age group). There was some recovery in the following two years as employment rates picked up gradually, but by 2022 the pre-lockdown (2019) level had still not been regained.

A spike in poverty rates (particularly food poverty) also occurred in 2020. This was partially offset by the disaster relief response. However, the relief was short-lived as the top-ups to existing grants and the additional caregiver grant for those receiving the CSG were temporary measures that ended in October 2020, while unemployment levels remained high and food prices soared over the next two years. Food poverty rates in the under-six age group have remained unusually high since lockdown, even increasing slightly between 2021 and 2022. This would not have happened if the annual increases to the CSG had kept pace with food inflation. Instead, the value of the grant has been eroded by cumulative below-inflation increases.

Around a quarter of all children under six live in households that report having reduced the range of foods that they consumed due to running out of money. Food insecurity rose through 2020 and extended into 2021, when over two million children under six years lived in households that reported reducing their dietary diversity because of poverty. The numbers then dropped again in 2022 but, like other poverty indicators, remained higher than the pre-lockdown rates. Reducing dietary diversity is a desperate measure often achieved by cutting out proteins, dairy, vegetables and fruits in favour of starches that are filling but less nutritious.

Care and learning

Of the 3.4 million children aged 0 – 2 years, around 20% were attending some kind of group care facility in 2016. Although the home environment is especially important for care and early learning in the first two years of life, many parents need to send very young children to daycare so that they can work during

Table 8: Care and learning services, interventions and outcomes, 2016 – 2022

Indicators	2016	2022	% change 2016-22	Definition (measure / denominator)	Source
Number of children 0 – 2 years	3,455,000	3,432,000	-0.7%		a
Number of children 3 – 5 years	3,541,000	3,544,00	0.1%		a
Services & interventions					
Children 0 – 2 in preschool / creche / playgroup	19.5%	16.6%	-14.9%	Children under three years who attend a creche, educare centre or home-based play group.	b
Children 0 – 2 cared for by day mother / childminder / gogo	6.6%	5.5%	-16.7%	Children under three years who are cared for by a day mother or gogo.	b
Children 0 – 2 cared for at home – no group care	74.0%	77.9%	5.3%	Children under three years who receive care at home, not attending any group care.	b
Children 3 – 5 attending early learning group programme	67.1%	68.4%	1.9%	Children between the ages 3 – 5 years attending any group early learning programme.	b
Number of ELP centres	17,846	42,420	137.7%	Total number of registered and unregistered early learning facilities.	c
% of ELP facilities registered	56.0%	40.0%	-28.6%	Proportion of early learning programmes that are fully or conditionally registered.	c
Outcomes					
4 – 5-year-olds who are developmentally on track	?	44.7%	?	Children aged 4 – 5 who are developmentally "on track" as proportion of those enrolled in ELPs.	d
Age-appropriate progress through foundation phase	86.8%	93.0%	7.1%	Children aged 10 – 11 years who have passed Grade 3.	b

Sources:
a. Statistics South Africa. *Mid-Year Population Estimates 2022 (MYPE 2022 series).* Pretoria: Stats SA. 2022.
b. Statistics South Africa: *General Household Survey 2016 – 2022.* Pretoria: Stats SA. (K Hall & N Segoneco analysis).
c. Department of Basic Education. *ECD Census 2021.* Pretoria: DBE. 2022.
d. Giese S, Dawes A, Tredoux C, Mattes F, Bridgman G, van der Berg S, Schenk J and Kotzé J (2022) Thrive by Five Index Report Revised August 2022, Innovation Edge, Cape Town.

Note: The 2016 estimates are from the 2013 ECD Audit, which was not a comprehensive census and is likely to have excluded many unregistered centres. The numbers for the two years are therefore not directly comparable.)

the day. Creches, playgroups, nursery schools and other group settings can be helpful for early development of social skills, but they are not necessarily regarded as ideal or necessary for very young children. Parent support programmes and initiatives are recommended but there is no accurate data on what is available. It is recommended that from around the age of 3 years, children attend some kind of structured group learning programme. Of the 3.5 million children aged 3 – 5, two thirds (67%) were attending an early learning programme in 2016. The attendance rate in 2022 was almost the same, although there was considerable fluctuation in the intervening years.

The ECD Census[23] counted 42,420 early learning programmes in 2021, but only 40% of these were registered and 33% received a subsidy. This means that most programmes rely entirely on fees to pay salaries and cover operating costs. A previous audit of early learning programmes in 2013[24] identified 17,846 facilities of which 56% were registered. These numbers are not directly comparable with the 2021 ECD Census as many unregistered centres were likely to have been missed in the 2013 ECD Audit. The more recent ECD Census numbers should therefore be regarded as a baseline for future monitoring.

The DBE's 2030 Strategy for ECD[25] sets the goal of universal ECD access. For early learning programmes, this requires the expansion and development of venues (new and existing infrastructure) and practitioners (additional human resources and more training). To achieve the 2030 targets an estimated 270,000 new ECD practitioners and assistants will be needed, and an estimated 115,000 new venues need to be developed.

Early learning outcomes among young children are notoriously under-researched and there are no historical estimates for comparison. The recent development of the Early Learning Outcomes Measure (ELOM) by ECD specialists provides a set of tools for assessing development across five domains: gross motor development; fine motor coordination and visual motor integration; emergent numeracy and mathematics; cognition and executive functioning; early literacy and language.[26]

The first "Thrive by Five Index" study in 2021[27] used the ELOM assessment tools to survey a nationally representative sample of children aged 50-59 months attending early learning programmes. The Thrive by Five study found that more than half of 4 – 5-year-olds attending early learning programmes were not on track for development, in that they were not able to do the tasks expected of children their age raising concerns about the quality of early learning programmes.

What happened in during lockdown?

Under-funding of early learning programmes has been a long-term and systemic challenge. On top of this, the COVID-19 pandemic and lockdown had immediate and devastating consequences for the ECD sector. ECD centres were forced to close their doors during hard lockdown. Unlike ordinary schools, most depended on monthly fees from parents for their survival, and they suffered financial losses while closed. When the programmes were allowed to resume from July 2020, they had to comply with more stringent (and costly) health and safety standards, which many could not meet. Two surveys conducted during 2020,[28] found that resource constraints were the main reason for the continued closure of early learning programmes.

Although the General Household Survey of 2020 was only conducted after the hard lockdown had lifted when ECD centres were permitted to re-open, the number of young children reported to be attending early learning programmes remained far below pre-COVID levels. Following years of improvements in attendance rates, 2019 had marked an all-time high with 74% of 3 – 5-year-olds attending early learning programmes. In late 2020 attendance rates in the same age group had dropped to 54%. Attendance rates rose to 62% in 2021 and 68% in 2022 but had still not regained the pre-COVID level.

Reflections

Despite the bold vision and clear commitments outlined in the NIECD Policy, progress has been limited and patchy since the policy came into effect. There has been progress in early initiation of early breastfeeding, in vitamin A coverage and in the growing number of ECD centres across the country. Maternal and child health services suffered setbacks during lockdown but had mostly recovered by 2022. Attendance rates at early learning programmes plummeted during lockdown. Although pre-lockdown attendance levels were regained by 2022, the longer-term consequences for the young children who missed out on early learning programmes remains to be seen. The first national study to assess learning and developmental outcomes for young children has established that far too many children are not developmentally on track. This is an important baseline for future monitoring.

Worrying trends include very high poverty rates which have not recovered since lockdown. Despite widespread access to the CSG, the persistently high rates of exclusion for infants have risen even further in recent years. Survey and administrative health data point to a rising problem of child malnutrition, and mortality rates have increased. These trends suggest serious areas of regression that compromise young children's survival and development. This calls for greater investment in the coverage and quality of ECD services to build a strong foundation for development.[29]

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Mind the policy gap: An overview of progress toward providing universal services for young children in South Africa

Lizette Berry[i] and Wiedaad Slemming[ii]

Interventions to promote early childhood development (ECD) are most effective during pregnancy and the first three years of life – as this is when the critical foundations for health, overall well-being and productivity are laid. Development begins in utero and takes place as children interact with and learn to adapt to their environment, in ways that establish the blueprints for their lifelong health and development.[1]

Young children's physical, cognitive, socio-emotional and language development are all interrelated, with progress in one domain catalysing progress in another. The impacts of interventions in early childhood will therefore be greatest when policies and interventions, from different sectors, are integrated to create environments that support young children's development and enable them to thrive.[2]

South Africa's National Development Plan (NDP), adopted in 2012, is the bedrock for national strategic planning toward 2030.[3] The Plan echoes global trends and incorporates a strong emphasis on early development, specifically recommending two years of compulsory provisioning of quality preschool education before Grade 1. While this compulsory early education proposal has received priority attention, the NDP conceptualises ECD services more broadly as a comprehensive package catering for family planning, healthy pregnancies and postnatal support; nutritional support for pregnant, breastfeeding women and young children; birth registration, social security and poverty relief; support for parenting and quality learning for young children in various settings to prepare them for formal schooling. The NDP acknowledges the role of multiple departments in delivering services to support and promote early childhood development and stipulates that the Department of Basic Education (DBE) should bear primary responsibility for the provision and monitoring of ECD services, with support from other departments.

Table 9: The primary commitments of the National Integrated Early Childhood Development Policy, 2015

Essential services	Roles and responsibilities
• Basic health care and nutrition for pregnant women, infants and young children • Maternal, infant and young child food security services	• Department of Health (DoH) has primary responsibility for health care and nutrition support. • Food security is the domain of multiple departments including the DoH, Department of Social Development (DSD), the National Development Agency, the Departments of Land Reform, Agriculture and Rural Development, and local government.
• Support for parents	• DoH has primary responsibility for parent support programmes.
• Safe, quality childcare and early learning in parent's absence* • Early learning support and services from birth*	• Multiple stakeholders have a role in providing childcare services including the DSD and local government. • The DSD has primary responsibility for the provision of early learning opportunities, in collaboration with the Department of Basic Education (DBE). • The DoH is mandated to provide play and early learning opportunities for birth to two years of age.
• Free birth certification for all children	• Department of Home Affairs.
• Publicly accessible information about ECD services and support	• Department of Communications and Digital Technologies, in collaboration with the National Inter-Departmental Committee on ECD.

* A recent function shift has resulted in the DBE assuming the primary responsibility for provision of these services.

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In response to the NDP, South Africa's first National Integrated Early Childhood Development Policy (NIECD Policy) was adopted in 2015.[4] While South Africa already had a diverse array of laws and policies that included a focus on young children, the new policy aimed to facilitate a more integrated approach to service delivery. The Policy adopts a life course approach to development and targets children from conception until the year before they attend formal schooling. It provides for a set of essential services and supports for young children and their families, aiming to strengthen and universalise these in the medium-term, and achieve provision of a more comprehensive package of services by 2030.

The Policy recognises early childhood development: (1) as a universal right for all young children, and (2) as a public good, demonstrating alignment with the scientific evidence and the global call for states to assume primary responsibility for public provision of ECD services. The South African government's sign-off on these policy statements was groundbreaking, as for the first time, the government declared responsibility for the universal, public provisioning of an essential package of services and supports for young children and their families (Table 9).

This chapter draws on the World Bank's SABER-ECD Framework to track progress in the implementation of the NIECD Policy, drawing attention to gaps and weaknesses in current services and identifying systemic factors and suggestions for high-level intervention. This includes progress made toward the achievement of the Policy goals.

What progress has been made toward achievement of the NIECD Policy goals?

The South African government has committed to the development of a publicly funded, integrated ECD system which ensures availability of ECD services to all young children and their caregivers. The NIECD Policy positioned the national Department of Social Development (DSD) as the lead department responsible for implementation of the Policy and for coordination across government actors and collaborators. To facilitate leadership and coordination, an Inter-Ministerial Committee on Early Childhood Development was constituted and supported by a national Inter-Departmental Committee.

Yet, despite these commitments and considerable civil society support, implementation of the NIECD Policy has been variable and incremental. Most of the state's efforts have focused on strengthening existing services, with limited strategic intent to lever population-level change. Extra funding for new service directions has been limited and departments have attempted to expand ECD services within their existing allocations.[5 6] While the country continues to provide robust healthcare services to enable women and young children to survive, the services needed to enable children to thrive are less developed.

More than eight years since the adoption of the NIECD Policy, two in every three preschool-aged children do not have the foundations in place to begin formal schooling, and more than half of children attending early learning programmes are not able to perform age-appropriate tasks. Inequities persist, and children in the poorest households are most affected.[7] For example, children from the poorest quintile of households are nearly three times more likely to be stunted (a sign of chronic malnutrition) than those in the richest quintile.[5] The underlying causes trace back to poor access to the fundamental supports required for healthy development – including adequate nutrition, responsive caregiving, and opportunities for early and quality learning.[2]

The section below focuses on the implementation of the five priority programmes stipulated by the NIECD Policy as necessary to shift the developmental pathways of young children in South Africa by addressing service gaps, focusing on the most vulnerable children and families, and redressing inequities.

Priority 1: Support for pregnant women, new parents and children under two years of age

The Policy assigns primary responsibility for the provision of a comprehensive package of ECD services for children 0 – 2 years to the national Department of Health (DoH) see Table 10.

This calls for a paradigm shift from the provision of vertical services focused on child survival to integrated services that promote pregnancy support and the nurturing care of young children through the health system[8] including health and nutrition, early learning, safety and security, and responsive caregiving.[9]

This expanded focus has galvanised a series of initiatives to improve the health and development of young children and pregnant women. The DoH has committed to re-engineering child health services in collaboration with partners with experience in child health, early development, and social and behaviour change communication.[8] The first step in this process was the revision and rollout of the Road to Health Book (RTHB) – the national child health record that is issued at birth for South African children. The revised RTHB and Side-by-Side Campaign[10] provide guidance to health workers on how to support and promote nurturing care at all levels of care. All child health consultations (both at primary level facilities and community health worker visits to households) should be structured around the five themes – nutrition, love, protection, health care and extra care – and health workers are expected to address each of these pillars at every contact.[8]

Table 10: Support for pregnant women, parents and children under two years

Policy goal	Scope of programme	Coverage	Equity
To enhance the ability of families to cope with and nurture vulnerable children below two years by promoting healthy pregnancy and maternal support; supporting parenting; and strengthening the holistic stimulation of infants.	A national programme for the provision of support to pregnant women, parents and infants in the first two years of life. Interventions include: 1. Maximise opportunities during maternal health visits for infant care and maternal counselling. 2. Utilise the Road to Health Book to support healthy child growth and development. 3. Provide community health worker home visits to vulnerable caregivers and infants from pregnancy to after birth. 4. Provide clinic, community groups for women and babies on selfcare and infant development. 5. Capacitate childminders to improve their knowledge on infant health, nutrition, development, and referrals. 6. Facilitate the pre-registration of pregnant women for the Child Support Grant (CSG) during the third trimester.	Universally available, subject to certain conditions such as age and definition, e.g. 'vulnerable' includes teenage mothers, those suffering from mental health or substance abuse problems, or exposed to violence.	Addresses inequities by focusing on children younger than two years; maximising clinic, group and home visits to identify extra needs and special circumstances and to monitor development; targeting vulnerable caregivers for extra services; enabling access to income support for those who are eligible.

The RTHB health promotion messages are aligned with those received by mothers and caregivers during pregnancy and the first year of life through the MomConnect mobile phone service,[11] while NurseConnect provides healthcare providers working in maternal and child health and family planning with information and advice. The Western Cape government's First 1,000 Days programme (see Case 11 on page 145) is a model of good practice for the re-orientation of services to enhance support to pregnant women and young children, including an emphasis on maternal mental health.

DSD continues to provide parenting support and is implementing a national programme,[12] but this is not specifically targeted at pregnant women or new parents of children under two years of age. The DSD has also developed a draft Maternal Support Policy to enable material support for pregnant women and improve access to the Child Support Grant (CSG) from birth.[12]

Table 11: Status of NIECD Policy priority support programme from conception to two years

Articulation of NIECD Policy provisions with existing programmes	Status of programmes	
Standard health clinic visits plus elements for pregnancy, maternal and parent support and infant development.	Standard care provided.	
	Developmentally supportive content in place for young children, but extent and quality of delivery not known and not monitored. No content for comprehensive support during pregnancy.	
Support for infant development, service referral and access through home visits for vulnerable caregivers.	Not a national, established state-led programme.	
Support for infant development, pregnancy and maternal support through clinic and community-based support groups for women, and women and babies.	Not a national, established state-led programme.	
Information available on pregnancy, maternal and parent support and infant development through public information programmes and advocacy.	National information campaigns and communication services.	
Parent support available through national parenting support programme and Road to Health Book.	Not targeted at pregnant women and new parents of infants; delivery through health services is not explicit and not monitored.	
Access to income support for pregnant women in poverty through the Maternal Support Policy.	Draft policy, not yet implemented.	
Building capacity of childminders to support infant development and stimulation.	Very limited information available. Not likely to be widely implemented.	

Good Average Poor

Coverage of programmes

There is little information available on coverage of the existing programmes. In 2021/22, 5.1 million persons were reached each week in 10 official languages by the Side-By-Side campaign radio show.[12] But it is unclear how many caregivers were reached by the campaign through other delivery platforms, including clinic visits. The RTHB should be used at each visit to engage parents, share important messages on early development and parenting, and assess and respond to individual needs. But the extent to which the developmental components are implemented and monitored is not known.

In 2020, approximately 814,000 caregivers of children under two years received MomConnect messages[13] which suggests that there are still a significant number of caregivers not reached through this service. However, postnatal and well-baby clinic visits are relatively well attended (coverage is just over 80% for immunisations under one year of age).[14]

DSD's parenting support programme is still in the process of rollout and therefore not fully implemented.

Service gaps and equity concerns

There are key gaps in the existing health service package (see Table 11). While parenting support is woven into the use of the revised RTHB, these conversations are 'light touch' and insufficient for caregivers requiring extra support.[16] The role of fathers is rarely promoted in routine maternal and child health services,[17] and access to maternal mental health services remains patchy.[18]

Quality home-visiting can reduce risks and adverse outcomes for young children.[19, 20] But home visits by community health workers and other services to support maternal selfcare and infant development are largely absent, primarily because community health workers are expected to deliver a wide range of services to households and therefore have limited time to focus on mothers and children.[21] While many non-governmental organisations have an emphasis on maternal and child health and development, these organisations lack the capacity to deliver at scale.[22]

Priority 2: National food and nutrition strategy for children under five years

All young children have a right to access nutrient-rich foods. These are critical for healthy brain development and physical growth and should be provided before and during pregnancy, and throughout early childhood. Inadequate nutrition during early childhood can result in illness, stunting, or disability.[23] The Policy therefore prioritises the development and implementation of a national, multi-sectoral food and nutrition strategy for children younger than five years of age (Table 12).

In response to the urgent need to address population-level food security and nutrition in South Africa, the National Food and Nutrition Security Plan (NFNSP) was developed in 2017.[24] It addresses food security and nutrition for pregnant women and children and prioritises scaling up high-impact nutrition interventions for women, infants and children.

Table 12: A national food and nutrition strategy for children under five years

Policy goal	Scope of strategy	Coverage	Equity
A national multi-sectoral food and nutrition strategy for children younger than five years is reviewed and strengthened. The strategy should ensure delivery of a comprehensive package of food and nutrition support and services both in the home and at community level.	The strategy targets the pre-conception to birth to four years development phases. Interventions should ensure: 1. Delivery and oversight of essential nutrition services including nutrition promotion services from pre-conception; Road to Health Book use to respond to poor growth or development. 2. Development of norms and standards, tools, and ECD practitioner training to provide nutritionally balanced food through ECD programmes. 3. Development of one national set of norms and standards for hygiene and food safety, including for ECD programmes. 4. Improved food security and access to nutritious foods in households with pregnant women, infants, and young children. 5. Improved food production and security through the promotion of and support for food gardens. 6. Improved access to environmental health services, for the promotion of infants and young children's nutritional health and development. 7. Development and implementation of a multi-sectoral food and nutrition communications and education campaign. 8. Development of an integrated nutrition information system and linking of current household profiling activities with the system.	The strategy should enable universal availability of a comprehensive package of food and nutrition support and services, subject to a focus on children from birth to four years and households with pregnant women.	Addresses inequities by strengthening delivery across the continuum of care, including ECD programmes and at household level. Improving food security, food access and environmental health services is most relevant for those in lower income quintiles.

Scope of the NFNSP in relation to pregnant women and young children

The Plan promotes improved:

1. Access to social grants from birth and strengthening of social grant systems.
2. Access, coverage and effectiveness of impactful nutrition interventions for pregnant and breastfeeding women and undernourished infants and children, and monitoring of these activities.
3. Access and coverage of breastfeeding and complementary feeding support and counselling, through community health workers and ward-based outreach teams.
4. Access and coverage of growth monitoring and promotion services and ensuring timely remedial actions.
5. Adherence to minimum nutritional standards to ensure children accessing ECD programmes receive adequate quality and quantity of nutritious foods.

The Plan also recognises the need to influence persons across the lifecycle to make informed nutrition choices through an integrated communications strategy.

Coverage of the NFNSP

The NFNSP adequately addresses the population of pregnant women and young children and seeks to expand coverage of nutrition services and support to these groups. However, the Plan fails to address nutrition in the pre-conception phase, which is an essential foundation for healthy pregnancy, and good maternal and child health and nutrition.

Policy gaps and equity concerns

While the NFNSP shows alignment with the objectives of the NIECD Policy, there is a risk that the desired focus on pregnant women and young children may get diluted in this generic policy.

The policy proposal to coordinate food and nutrition security is robust, however, there remains questions about implementation. A National Food and Nutrition Security Council chaired by the deputy president is meant to provide leadership and oversight, but this is yet to be convened and the full Plan is not yet funded.[25] As a result, nutrition interventions remain fragmented and uncoordinated across multiple departments.[5] Table 13 illustrates how current policy design and implementation are insufficient to meet the state's constitutional obligations to ensure adequate nutrition for all young children.

Priority 3: Provision of universal early learning opportunities from birth

The recent transfer of responsibilities for ECD services from the DSD to DBE has resulted in significant progress in plans to enhance the delivery of early learning programmes.

Scope of programmes

The NIECD Policy envisaged the provision of a continuum of early learning programmes (ELPs) that are attuned to the evolving needs of children and their caregivers at different stages of development (Table 14). For example, programmes to support development and learning in infants would be best delivered through health facilities and home visiting programmes. However, the primary focus has remained on

Table 13: Extent to which NIECD Policy intentions are reflected in the NFNSP

NIECD Policy provisions	Present in NFNSP
Access to social grants to improve food security and access to nutritious foods in households with pregnant women, infants, and young children.	
Delivery and oversight of essential nutrition services.	
Development of norms and standards, tools, and training for ECD practitioners to provide nutritionally balanced food through ECD programmes.	
Development and implementation of a multi-sectoral food and nutrition communications and education campaign.	
Development of one national set of norms and standards for hygiene and food safety, including for ECD programmes.	
Improved food security and food production.	
Improved access to environmental health services.	
Development of an integrated nutrition information system.	

Good Average Poor

Table 14: Provision of universal early learning opportunities from birth

Policy goal	Scope of programme	Coverage	Equity
To ensure that every child has an opportunity to access age- and stage- appropriate early learning opportunities from birth to the year before entering school.	A national programme for the provision of early learning opportunities from birth to the year before school, supported by the implementation of the National Curriculum Framework for Children from Birth to Four. Interventions include: 1. Home-visiting, health-centre programmes to build capacity of expectant parents and caregivers to stimulate early learning. 2. Early learning opportunities through child-minding services, incorporated and supported in the spectrum of early learning opportunities. 3. Community-based playgroups for mothers and children aged birth to four years for parent support; stimulating play for children. 4. Structured early learning community playgroups for children aged two to four years to foster socialisation and promote early learning. 5. Early learning programmes, mostly for three-and four-year-olds, that encourage emotional, social development and school readiness. 6. ECD programmes for six or more children for the care and development of young children through playful learning and support services. 7. Improved parental demand for early learning via public communication on the importance of early childhood development for health and human capital.	Universal availability of comprehensive, age-differentiated early learning opportunities, subject to a focus on children from birth to the year before compulsory schooling.	Addresses inequities by strengthening delivery across the continuum of care, including support to parents to offer learning opportunities at home. The inclusion of home-and-community-based programmes aims to support families with children under two years old, those unable to access centre-based learning programmes, and provid parents with a wider range of childcare and early learning service options.

early learning programmes delivered through ECD centres for 3 – 6-year-olds. ELPs are mainly provided by non-profit organisations, subsistence entrepreneurs or microenterprises, resulting in essential early learning programmes being delivered by a fragile and vulnerable sector.[26] Parent fees remain the primary source of early learning programme funding, at 69%.[27] State funding remains limited to a R17 per-child-per-day subsidy.[5] As a result, the delivery of quality and accessible ELPs is hampered by significant financial constraints, under-capacitated practitioners, and insufficient state support.[28]

Coverage of programmes

In 2021, a little over 1,6 million young children were enrolled in about 42,000 early learning programmes. About 71% of these children were aged between three and five years old; less than a quarter of enrolled children were below age three.[27] This is to be expected as children below three years are usually in the care of their parents or primary caregivers. The coverage of programmes by type is not available.

Programme gaps and equity concerns

To date, provisioning has not been driven by an age-differentiated, population-based approach. Children below three years continue to be excluded from early learning support, which should ideally be provided in partnership with their parents and caregivers. There is also limited attention to the barriers that drive inequities in access and quality, including user fees for programmes and limited, complex state funding mechanisms. The state subsidy contributes to inequities between subsidised and unsubsidised programmes as ELPs serving lower quintile communities struggle to meet the registration requirements needed to qualify for the subsidy.[27] Notably, 67% of programmes were unsubsidised in 2021[27] and dependent on user fees resulting in significant financial challenges.

Programmes receiving higher income are associated with better early learning outcomes.[29] Prioritising this financing gap and moving intentionally toward a state-led, state-funded early learning system is a critical first step in improving child outcomes.

Priority 4: Inclusion and support for children with developmental delays, difficulties[iii] and disabilities within all ECD programmes

Young children with developmental delays, difficulties and/or disabilities are recognised as historically neglected and

iii According to the NIECD Policy definition, developmental difficulties include conditions that place a child at risk of sub-optimal development, or that cause a child to have a developmental delay, disorder or disability.

Table 15: Assessment of NIECD Policy implementation via key existing early learning programmes

Articulation of NIECD Policy provisions with existing programmes	Status of programmes	
Home-visiting and health-facility-based programmes to build capacity of expectant parents, and current parents and caregivers, to offer early learning support.	Limited attention to early learning support via health facilities. Home-visiting programmes are provided by the non-state sector with limited state funding; and is not a national, established state-led programme.	
Early learning opportunities through child-minding services, which will be incorporated and supported in the early learning programme system.	Very little evidence on improvements in child-minding services is available; state support for this service is not widely available.	
Community-based early learning playgroups for mothers and children (birth to four years) to provide parenting support and a stimulating experience for children.	This playgroup programme type is not widely available; is provided by the non-state sector with limited state funding; and is not a national, established state-led programme.	
Community-based, structured early learning playgroups for children aged two to four years to foster socialisation and promote early learning.	This playgroup programme type is provided by the non-state sector with limited state funding; and is not a national, established state-led programme.	
Early learning and development programmes, particularly for three- and four-year-olds, that encourage emotional and social development and preparation for schooling.	This programme type is provided by the non-state sector with limited state funding; and is not a national, established state-led programme.	
ECD programmes for six or more children aimed at the care, early learning and development of infants and young children through play-based learning, care, and supportive services.	This programme type is provided by the non-state sector with limited state funding; and is not a national, established state-led programme.	
Increased parental demand for early learning opportunities, through public communication about the importance of early development for health and human capital.	Limited public communication programmes are in place through the state and other stakeholders. Impact on parents is not well known.	
Implementation of the South African National Curriculum Framework for Children from Birth to Four (NCF)	Several activities toward full implementation of the NCF are in progress.	

Good Average Poor

disadvantaged with poor access to services to support their specific needs.[30] Definitional issues and data challenges make it difficult to determine the numbers of children with delays and disabilities requiring support, however, one estimate suggests that about a quarter of children aged 0 – 4 years have a disability.[31] According to the 2021 Thrive by Five Index, less than half (46%) of children attending an ELP in South Africa are on track in their learning; with 28% of children falling far behind the expected standard.[32] The Countdown 2030 ECD Country Profiles, using a composite indicator of stunting and poverty, estimate that 38% of children younger than five years are at risk of poor development.[33] The NIECD Policy therefore prioritises the delivery of equitable, quality services to these children and their caregivers, to enable their development and inclusion in society. The Policy proposes that a multi-sectoral ECD guideline be developed as described in Table 16.

Scope of existing policy and programmes

In 2016, a White Paper on the Rights of Persons with Disabilities was released, which includes a focus on young children and seeks to address their needs through improved services.[34]

The White Paper provides the following directives:

1. *Ensure equitable access for children with disabilities to all ECD programmes and facilities.* This promotes accessible ECD programmes and facilities by removing participation barriers.
2. *Develop disability specific intervention and support services.* Services must focus on a range of programmes and interventions to improve independence and integration, and parent support programmes.
3. *Develop a national integrated referral and tracking system.* The system must identify, refer, register and assess children with delays and/or disabilities, and ensure access to support, treatment, social assistance and learning programmes.

The DoH has applied a more comprehensive approach to supporting early development in its re-conceptualisation of the RTHB. The book includes a focus on developmental screening, health promotion messages on how to support and promote development for caregivers, and how to support children and families requiring 'extra care'. After identification, children with a developmental delay, difficulty or disability should be routed

to the appropriate health worker for further assessment and support. Implementation of these steps requires sufficient training, adequate monitoring and support for health workers using the RTHB. Successful referral of young children with disabilities also depends on the availability of appropriate health, social service personnel and specialist services.

Coverage of existing policy and programmes, gaps and equity concerns

The White Paper adequately provides for the inclusion and delivery of appropriate services for young children with developmental difficulties and recognises the need for parent support. However, there is limited available information on the implementation of the White Paper and the use of the RTHB (see Table 17).

As identification of children with disabilities is a key priority, service providers require appropriate training. About 2,000 ECD practitioners were trained on the DBE's Screening, Identification, Assessment and Support (SIAS) Policy, indicating progress in the upskilling of practitioners to conduct identification and referral.[35]

The White Paper fails to provide for specific funding of policy interventions for children with disabilities. While the White Paper calls for the development of disability-focused budgeting mechanisms, this approach is possibly too generalised to be meaningful.[36] The Department of Women, Youth and Persons with Disabilities reported that a costing of ECD services for children with disabilities is in progress.[35] The alignment of these processes with the objectives of the NIECD Policy is unclear.

The White Paper includes provisions to build the capacity of public servants. However, it is primarily focused on disability mainstreaming and it fails to address the needs of young children with disabilities by putting in place measures to develop capacity of government stakeholders to plan, implement and coordinate, and monitor inclusive ECD programmes.

Prioritising the prevention of developmental difficulties and disabilities remains critical, by minimising risks to health and development, pre- and post-conception, as well as facilitating early identification and intervention to optimise outcomes and reduce the risk of secondary complications.[37]

Priority 5: Public communication about the value of early childhood development and ways of improving children's resourcefulness

The NIECD Policy positions a national communications and advocacy programme as critical to successfully realising its objectives. Programme success is largely dependent on the communication of key messages aimed at promoting behaviour,

Table 16: Inclusion and support for children with disabilities within all ECD programmes

Policy goal	Scope of provisions	Coverage	Equity
By 2017, a national multi-sectoral ECD guideline is developed to provide universal availability and equitable access to comprehensive, age- and stage-appropriate ECD services for all children with developmental delays and/or disabilities. *The ECD guideline will ensure quality, inclusive ECD services for all children with disabilities.* *By 2030, all young children with developmental delays and/or disabilities will have an opportunity to access comprehensive, age-appropriate, inclusive ECD services to ensure they develop to their full potential.*	The guideline targets children with developmental delays and/or disabilities. *Policy interventions should ensure:* 1. The allocation of additional, adequate public funding to ECD programmes that include children with disabilities. 2. The appropriate design of all ECD services to achieve quality outcomes for children with disabilities. 3. Norms and standards for accessible, appropriate public infrastructure to create inclusive centres for ECD service delivery. 4. Sufficient, qualified ECD practitioners to provide quality, inclusive ECD services to children with disabilities and their families. 5. Capacity development of managers in government to plan, coordinate and monitor inclusive ECD services. *ECD services should enable:* 1. The prevention of developmental delays and/or disabilities, early detection and remedial interventions. 2. Provision of community-based rehabilitation programmes and services for young children. 3. Appropriate parenting support for parents of infants and young children with disabilities. 4. Quality childcare, and inclusive early learning programmes for young children with developmental delays and/or disabilities. 5. Improved social security for caregivers of young children with disabilities for sufficient material support.	Universal availability of comprehensive, age-and-stage based services for all young children with developmental delays and/or disabilities. Parenting and income support for the parents and caregivers of young children with developmental delays and/or disabilities.	Addresses inequities by strengthening delivery across a range of ECD services required to support the development of children with developmental delays and/or disabilities. This includes targeted funding, addressing programme design to accommodate and support young children with developmental delays and/or disabilities, and building state capacity to adequately plan and deliver appropriate, quality services for this group of children. Addresses the additional needs of caregivers by providing for improved income support.

Table 17: Assessment of NIECD Policy provisions reflected in White Paper on the Rights of Persons with Disabilities

NIECD Policy provisions	Present in White Paper
Allocation of additional and adequate public funding to ECD programmes providing services for children with disabilities.	
Provide direction for the development and design of all ECD services to achieve quality outcomes for children with disabilities.	
Provide norms and standards for accessible and appropriate public infrastructure, for inclusive centres of ECD service delivery.	
Secure sufficient, qualified ECD practitioners to provide quality, inclusive ECD services to children with disabilities and their families.	
Provide for management capacity development in government.	
Promote prevention of disability and developmental delays.	
Provide for community-based rehabilitation programmes and services for young children.	
Provide for appropriate parenting support for parents of infants and young children with disabilities.	
Provide for sufficient quality childcare and inclusive early learning opportunities for all young children with developmental delays and/or disabilities.	
Provide for strengthened social security for all caregivers of young children with disabilities that provides sufficient material support.	

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attitude and practice changes among stakeholders such as parents, caregivers, practitioners, educators and government officials.

While parents, caregivers and children have a right to information, very little is currently available in terms of national communication campaigns relaying pertinent messages about early development. The NIECD Policy also highlighted the critical importance of communicating quality, evidence-based information about the science of early childhood development and its implementation to policymakers, civil society, business and trade union leaders, and the media.

Communication aimed at parents and caregivers should enable them to understand what they can do to improve their children's nutrition and health; protect their children, and engage in positive discipline and refrain from corporal punishment; understand and demand quality early learning; understand the importance of play for their child's learning and overall development; provide responsive care; access support and early intervention services for children with disabilities or additional needs; and build understanding of the roles of families in promoting early development.

The NIECD Policy also emphasises the importance of child-focused mass communication, such as using 'stories for enjoyment', to stimulate language, imagination, and young children's desire to explore and learn. It also highlights the importance of using child-focused communication platforms to provide support to parents and caregivers. For example, in South Africa, programmes such as Takalani Sesame focused on communicating with children, could also be used to strengthen support for parents and caregivers.

Scope of existing programmes

There is little evidence of a government-led, coordinated, national early childhood development communications strategy. However, individual departments have made attempts to develop explicit communication activities to raise public awareness of the importance of early childhood development, and drive demand for quality services that support nurturing care for young children.

- The DoH's Side-by-Side campaign has developed several resources to educate parents, caregivers and health workers on how to support the health, nutrition and development of young children. Such information is also meant to be communicated directly to parents and caregivers at clinic visits.
- The DBE has worked in partnership with civil society stakeholders to publicly disseminate messaging about early learning and development, e.g. the Takalani Sesame programme, and the development of specific campaigns in response to the COVID-19 crisis.
- The non-profit sector plays a significant role in the development and delivery of communications activities, some of which is publicly funded.

Table 18: Public communication about the value of early childhood development

Policy goal	Scope of provisions	Coverage	Equity
By 2024, a national multi-sectoral ECD communication strategy is developed, adequately resourced, and implemented. A coordinated national communications strategy should be implemented as part of a national branded programme.	The strategy targets all parents and caregivers, practitioners and educators, government and non-government actors with an on-going media and public communication programme. Interventions include: 1. Reinforcing the nature of the window of opportunity offered by appropriate quality interventions early in life. 2. Emphasising the crucial positive role parents and families play in the development of young children. 3. Conveying key messages to support early development, including: a. Nutrition and health care; b. Safety and protection, including alternatives to corporal punishment; c. Responsive and loving care; and d. Early learning and development.	The programme is specifically aimed at reaching the broad population of parents and caregivers, but also practitioners and educators, non-government and government stakeholders.	The programme will assist in redressing inequities, as receipt of information will likely increase parental demand, and increase the uptake of services for young children and their families.

Gaps in coverage and equity concerns and equity concerns

There is limited available information on the implementation of ECD-related communication strategies. Non-profit stakeholders are providing useful examples of public communication campaigns which could guide future planning, e.g. Grow Great's nutrition campaigns using multimedia platforms and billboards, and Ilifa Labantwana's parenting campaign using radio, a mobi site, billboards and strategic partnerships with the DoH and other stakeholders. The strength of these campaigns is the building of strategic alliances between key stakeholders, including public-private partnerships. Moving forward, it is also essential to focus on government stakeholders across the relevant departments as the targets of communication campaigns.

What are the priority areas for improved delivery of ECD services?

South Africa has made steady progress in sectors where systems and infrastructure are well-established, such as basic health care for pregnant women, mothers and young children; birth registration; and social grants. But progress has been variable for the programmes earmarked in the NIECD Policy for priority implementation. Poor cognitive development and a lack of school readiness are outcomes of poor nutrition and growth, and a lack of early stimulation and nurturing caregiver interactions, especially before the age of two years.[2] Yet, ECD services focused on the stages most critical for later development – pre-conception, pregnancy, and birth to two years – remain underdeveloped.

The early learning sector, because of its dependence on non-profit actors and micro-enterprises to deliver services, is in urgent need of greater resources to enhance access and quality improvements. Priority attention is also needed for nutrition support and food security; including fast-tracking the establishment of the National Food and Nutrition Security Council to provide leadership and drive implementation of the National Food and Nutrition Security Plan.

Delivery systems to target services for the most vulnerable children remain inadequate: children under two years, and those with developmental difficulties are under-served. Home- and community-based services require urgent attention; these modalities are also most effective for reaching marginalised populations. A comprehensive, multi-sectoral communications programme has yet to be developed and implemented and could be especially effective in reaching parents of young children at scale.

What systemic factors require priority attention?

The development of the NIECD Policy was a critical first step toward effecting universal, quality services for young children in South Africa, but robust systems are needed to support and enable implementation. Progress with service delivery to support early childhood development won't occur without proper attention to systems for implementation. South Africa has some systemic elements in place, while others need to be established or strengthened.

Elements that are critical for building a robust and coherent system[38] include:

- A legal and regulatory framework;
- Leadership and intersectoral coordination;
- ECD financing;
- Service delivery mechanisms and
- Monitoring, evaluation and quality control.

Seeking high-level political endorsement for early childhood development and ensuring its prioritisation on the political agenda, are considered essential elements of successful ECD policy.[2] While South Africa has fully acknowledged the significance of early childhood development and prioritised it in policy development, the political will to effectively translate policy into action has been lacking. This is evident in the incessant problem of ineffective high-level intersectoral coordination, the low and inequitable funding flows for the youngest children compared to older children, and the continued exclusion of young children from the poorest households.

However, the state has recently reaffirmed its commitment to early childhood development in the President's State of the Nation Addresses and through the transfer of responsibilities for ECD service provisioning from the DSD to the DBE.[6] Financial allocations to ECD services are a clear signal of a country's commitment to its young children.[38] It is therefore hoped that the new administration will clearly signal their commitment to young children in their resource allocations, to create a real and lasting difference in the lives of South Africa's youngest citizens.

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Ensuring that mothers and young children survive and thrive: The role of the health sector

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The National Integrated Early Childhood Development Policy highlights the important role of the health sector in ensuring the well-being of mothers and the optimal development of children, especially during the first 1,000 days of life (from conception until a child's second birthday). The Policy, which was approved by Cabinet in 2015, envisages an expanded role for the health sector, with the sector expected to contribute to early childhood development not only through improving the coverage and quality of existing health and nutrition services and interventions, but also through introduction of additional interventions to ensure the current and future well-being of mothers and children.[1]

The health sector has significant experience in provision of vertical, survival-focused services, and because of the overlap of risk factors for child survival and development, many of these traditional health sector interventions already contribute towards ensuring that mothers and children thrive. Nevertheless, this expanded role in promoting the well-being of mothers and nurturing care of young children, requires a paradigm shift to re-imagine and restructure health services at hospital, clinic and community levels.[2] Areas which require greater emphasis include maternal mental health, nutrition, child development and the provision of more comprehensive services for children with physical and learning disabilities.

This chapter reflects on what has changed with regards to the health and nutrition of women and children since the launch of the National Integrated Early Childhood Development Policy (NIECD Policy) in 2015. The first part of the chapter considers the policy arena with a focus on the evolution of the global policy discourse around the need to ensure that mothers and young children thrive, and how this is then reflected in global and national commitments and frameworks which inform South Africa's maternal and child health policies, strategies and interventions.

The second part of the chapter reflects on current health and nutrition outcomes, as well as recent progress in extending provision of an essential package of health and nutrition services for mothers and children. It then considers how the South African health sector has introduced new initiatives to respond to its expanded mandate and the thrive agenda.

The third part of the chapter identifies key gaps and recommends how to strengthen services to enhance the survival, health and development of mothers and young children.

What is the latest global guidance on maternal and child survival and well-being?

Over the past 10 years a number of global commitments, frameworks and guidelines have been developed that have the potential to enhance the survival and well-being of mothers and children.

The Sustainable Development Goals

The adoption of the NIECD Policy coincided with the declaration of the Sustainable Development Goals (SDGs), which define global priorities and aspirations for 2030, and provide a basis for achieving equity, prosperity and sustainable growth. As such, the SDG goals and targets aim to create an environment and services that enable young children to reach their full potential, and ensure that "no child is left behind". As a whole, the goals focus on broad socio-economic transformation[3] with an emphasis on a whole-of-society and whole-of-government approach and closer intersectoral linkages to build human capital and address the social determinants of health. This approach dovetails with evidence that approximately 50% of gains in women's and children's health in low- and middle-income countries since 1990 has resulted from progress in non-health sectors.[4]

The Global Strategy for Women's, Children's and Adolescents' Health

The importance of ensuring both survival and well-being is also reflected in the Global Strategy for Women's, Children's and Adolescents' Health 2016 – 2030,[5] which aims to provide a roadmap for achieving the SDGs related to the health of women, children and adolescents. The strategy focuses on three main

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objectives: (1) Survive: Ending preventable deaths in mothers, newborns and children; (2) Thrive: Ensuring health and well-being; and (3) Transform: Expanding enabling environments. While the survive and thrive agendas have been incorporated into health policy discourse both globally and in South Africa, less attention has been paid to the transform pillar – which includes efforts to eradicate extreme poverty, violence and discrimination, and enhance access to water, sanitation and education – within mainstream health policy discourse.

The Nurturing Care Framework

While the global health community recognises that its role in ensuring that mothers and children both survive and thrive is key to building human capital and achieving the SDGs,[6] translating this paradigm shift into the design and delivery of frontline health services requires deliberate and systematic attention and action.

The Nurturing Care Framework (NCF), which was launched at the 71st World Health Assembly in 2018, aims to assist countries in translating the vision of nurturing care into action, and re-orientating their health systems to provide a more comprehensive approach to early childhood development.[7] The framework identifies five key components that young children require to thrive: good health, adequate nutrition, to be safe and secure, to be cared for responsively and with love, and to be given opportunities to satisfy their innate capacity to learn (see Figure 9). Nurturing care is provided by parents and caregivers who, in turn, require an enabling environment of supportive policies and services.

The NCF also identifies the role of different sectors in providing nurturing care (see Box 2) and several key strategies or requirements for successful implementation. These include leadership and investment, a focus on families and communities, strengthening of services, monitoring progress, and using data to innovate.

Following the launch of the NCF, a number of documents and tools aimed at further operationalising the framework have been developed.

Figure 9: Components of nurturing care

Source: World Health Organization, United Nations Children's Fund, World Bank Group. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential.* Geneva: WHO; 2018.

Box 2: Role of the health sector in nurturing care

- Ensure women and young children have access to good-quality health and nutrition services.
- Make health and nutrition services more supportive of nurturing care.
- Increase outreach to families and children with the greatest risk of suboptimal outcomes.
- Establish specialised services for families and children with developmental difficulties and disabilities.
- Collaborate with other sectors to ensure a continuum of care.

Evidence-based guidelines

In 2020, the World Health Organization (WHO) published guidelines which provide global, evidence-informed recommendations on improving early childhood development with the objective of identifying interventions that are feasible and effective in improving developmental outcomes in young children.[8] The key recommendations (together with their associated level and strength of evidence) are shown in Table 19. For example, nutrition interventions on their own do not appear to have an impact on early childhood development. Yet, interventions that combine nutrition and responsive caregiving were found to benefit children's cognitive, language and motor development, and the impacts were greater when interventions targeted malnourished children.

Re-organising how services are delivered

As noted above, implementation of nurturing care requires significant changes to how services for mothers and young children are planned and delivered. The Nurturing Care Practice Guide aims to inspire action and serves as a basis for organising health services, health facilities, building the capacity of the health work force, and strengthening systems to meet

the needs of all children, including those with developmental delays or disabilities, chronic health conditions or living in fragile humanitarian settings.[9] The guide sets out three levels of support, depending on caregivers' and communities' needs (see Table 20).

The practice guide also describes what managers can do to prepare services and better equip service providers; and includes practical suggestions for what service providers can do as part of their ongoing contacts with families. It also provides guidance on how to adapt health and nutrition services so that they support nurturing care and strengthen caregivers' capacity to provide it.

Applying the principles of the nurturing care across the life-course

More recently, the NCF has been extended to cover preconception through adolescence (0 – 20 years).[6, 10] A package of services associated with ensuring maternal well-being is also emerging – while addressing maternal mental health is a key element of improving responsive caregiving (and therefore both maternal and infant well-being), maternal well-being also requires that women are empowered with information, and that they are treated with respect during pregnancy and especially during the intrapartum period.

Are South African mothers and young children surviving and thriving?

Mortality rates and nutrition outcomes provide a measure of the extent to which mothers and young children are surviving and thriving in South Africa.

Mortality

Maternal and child mortality rates have declined in recent decades, although these rates remain significantly higher than those of equivalent upper middle-income countries (see Table 21).[11] The Maternal Mortality Ratio increased during the COVID-19 pandemic and unpublished data suggest that the under-five mortality rate has also increased following the pandemic. It will be important to track these rates and ensure that they continue to decline.

South Africa's persistently high mortality rates are assumed to reflect high levels of inequality, with a high proportion of South Africans living below the poverty line despite the country's overall status as an upper middle-income country. The high HIV prevalence and high levels of homicide also contribute to high mortality rates.

Nutrition

Nutrition outcomes for young children also show a mixed picture. The prevalence of wasting among young children is generally low (estimated at 3.8% in 2023).[12] However, stunting which reflects chronic malnutrition remains persistently high with the most recent representative data showing 28.8% of children younger than five years to be stunted.[13] This is of particular concern given that stunting may impair children's cognitive development and ability to learn. At the same time, overweight and obesity are increasing in young children with 22.6% of children under five being affected[14] (which is four times the global prevalence of 5.6%).[15] This double burden of malnutrition places children at greater risk of growth faltering

Table 19: WHO recommendations for improving early childhood development

Recommendation		Strength of recommendation	Quality of evidence
Responsive care	• All infants and children should receive responsive care during the first three years of life. • Parents and other caregivers should be supported to provide responsive care.	Strong	Moderate (for responsive care)
Promote early learning	• All infants and children should have early learning activities with their parents and other caregivers during the first three years of life. • Parents and other caregivers should be supported to engage in early learning with their infants and children.	Strong	Moderate (for early learning)
Integrate caregiving and nutrition interventions	• Support for responsive care and early learning should be included as part of interventions for optimal nutrition of infants and young children.	Strong	Moderate
Support maternal mental health	• Psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services.	Strong	Moderate

Sources: World Health Organization. *Improving Early Childhood Development: WHO guideline*. Geneva: WHO. 2020.

Table 20: Three levels of support

Type of service	Target group	Aim
Universal interventions	All families, caregivers and children.	Should be provided through the services that families of young children use most. Should include care for caregivers.
Targeted interventions	Additional interventions for those at risk such as individuals or communities who are affected by poverty, undernutrition, adolescent pregnancy, HIV, violence, displacement and humanitarian emergencies.	Aim to reduce the damaging effects of stress and deprivation and strengthen individuals' capacity to cope.
Indicated services	Specialised services for families or children with identified needs, including: • Young children without caregivers; • Children living with depressed mothers or in violent homes; • Children with very low birthweight; • Children who have disabilities, developmental difficulties; and • Children with severe malnutrition.	Includes a range of auxiliary and specialist services such as physical, speech and occupational therapy; mental health services; chronic care and rehabilitation services.

Source: World Health Organization, United Nations Children's Fund. *Nurturing Care Practice Guide: Strengthening nurturing care through health and nutrition services.* Geneva: WHO, UNICEF. 2022.

and communicable diseases, and simultaneously puts them at risk of developing nutrition-related non-communicable diseases (NCDs) as they reach adulthood, including type 2 diabetes, hypertension, and several cancers.[16] There is therefore an urgent need to address the double burden of malnutrition, both within and outside the health sector.

What are South Africa's national commitments?

The National Development Plan 2030 calls for implementation of a comprehensive approach to early childhood development by developing and expanding existing child survival programmes with reductions in maternal, infant and child mortality as important outcomes.

The NIECD Policy builds on this foundation and lays out a multisectoral approach to promoting the health, nutrition, development and well-being of mothers and young children.[1] The Policy recognises the health sector's role in reaching pregnant mothers and young children, and assigns key responsibility for the provision of service to children 0 – 2 years to the health sector. This includes the health sector's traditional role of providing health and nutrition programmes for pregnant women, infants and children, and additional responsibilites including the provision of parenting support programmes and increasing opportunities for learning and play through health facilities and home visits by community health workers for children at risk of poor development outcomes.

While the health sector provides a well-defined package of preventive and curative services that address the leading causes of child mortality, it has not historically provided several of the services envisaged in the NIECD Policy and/or NCF at scale. There are important gaps, notably: support for parenting, prevention of stunting and overnutrition among young children, and provision of home and community-based services to those families most in need, including children with disabilities.[17]

In addition, the term 'early childhood development' is often narrowly understood as the provision of childcare and education to children aged three to five through ECD centres. Responsibility for the care of younger children (0 – 2 years) is largely assigned to families. Support from health services is primarily focused on children's health, growth and survival, with little emphasis on care, development or early learning. Health sector policy makers and frontline workers, who have historically focused on provision of routine health services, are therefore challenged to review their approaches and roles considering these broader goals.

Has there been progress in the coverage of essential health services?

While the health sector needs to expand its vision and approach to service delivery, it also needs to ensure that all pregnant mothers and young children have access to a package of essential health and nutrition services, across the continuum of care as shown in Table 22. It is encouraging to note that coverage of most of these interventions increased between 2016/17 and 2022/23, although access to HIV treatment (as measured by antiretroviral therapy coverage) and exclusive breastfeeding rates remain low.

Table 21: Maternal and child mortality rates of South Africa and other middle-income countries

Rate	Unit of measurement	South Africa	India	Brazil	Mexico	China
Maternal Mortality Ratio[1]	Deaths per 100,000 deliveries	127	103	70	59	23
Under-five Mortality Rate[2]	Deaths per 1,000 live births	33	31	8	13	7
Infant Mortality Rate[2]	Deaths per 1,000 live births	26	25	13	11	5
Neonatal Mortality Rate[2]	Deaths per 1,000 live births	11	19	14	8	3

Sources: 1: Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization. 2023.
2: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), *Levels & Trends in Child Mortality: Report 2022, Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation*, New York: UNICEF. 2023.

Increased coverage underscores the potential of the health sector to provide additional services to mothers and children. Yet, the ongoing emphasis on measuring vertical interventions (e.g. immunisation) is likely to lead healthcare workers to maintain their primary focus on 'survival' interventions. Therefore, increased attention to measuring 'thrive' interventions (e.g. early identification and response to developmental delays) is needed to facilitate the adoption of a more comprehensive approach to maternal and child health and well-being.

What new initiatives have been put in place to help mothers and young children thrive?

This section reviews progress in implementing more comprehensive approaches to mother and child well-being through several initiatives within the health sector which have specifically focused on empowering mothers and ensuring the well-being of their young children. While the initiatives described are by no means exhaustive, they include the key interventions provided at scale within the health sector.

Respectful Maternity Care

Respectful Maternity Care aims to support the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth. This includes respecting a mother's rights and choices through supportive communication, actions, and attitudes.[18] Although outcomes may not be objectively measured, respectful care as a quality component has been globally benchmarked as a key performance measure for maternal and newborn programmes with a synthesis of evidence recommending that better outcomes are anchored in maintaining standards for respectful maternity care.[19]

The Road to Health Book and the Side-by-Side campaign

The Road to Health Book (RTHB) is a widely accepted and used tool to improve child health and nutrition with more than one million of these books entering households each year, and more than 98% of caregivers of young children reporting having received a book or similar record.[13] In 2019, the National

Figure 10: The five pillars and key messages from the Road to Health Book

	**NUTRITION** Good nutrition is important for you and your child to grow healthy. It starts with breastfeeding.
	LOVE Your child learns from looking at you when you hold them close to you and love, play and talk to them.
	**PROTECTION** Your child can be protected from disease and injury by getting immunised and by playing in safe places.
	**HEALTHCARE** Your child needs help from you or a health worker when they are sick or injured.
	**EXTRA CARE** Your child may need special care or support and knowing what to do and where to go will help both of you.

Table 22: Coverage of essential maternal and child health and nutrition services

	Key indicators			Progress and achievements	Gaps/challenges/threats
	Indicator	Baseline (2016/17)	Current (2022/23 unless other stated)		
Maternal care	Proportion of women who attend antenatal care before 20 weeks[1]	65.2%	70.1%	• Significant improvements in antenatal and postnatal coverage. • Pregnant women and mothers provided with information through MomConnect (more than 4.5 million beneficiaries).	• Poor quality of care and poor healthcare workers skills continue to contribute to maternal deaths. • Focus remains on maternal survival with limited attention being paid to maternal well-being including maternal mental health.
	Proportion of mothers and newborns receiving postnatal care within six days of birth[1]	70.5%	80.0%		
Newborn care	Early neonatal mortality rate[1]	9.9 per 1,000 live births	9.6 per 1,000 live births	• Maternal, Perinatal and Newborn Policy has been developed, and guidelines are currently being finalised. • Systems for auditing of perinatal deaths (stillbirths and newborn deaths) are in place.	• Packages of care are not fully implemented. • High incidence of perinatal asphyxia due to sub-optimal maternal care. • Mortality audits are not conducted in all facilities, and/or data are not used to improve the quality of care.
Prevention and management of leading causes of child mortality (pneumonia, diarrhoea, HIV, malnutrition)	Pneumonia deaths in children under-5 years[1]	1,003	939	• Significant declines in child deaths associated with pneumonia and diarrhoea. • Integrated Management of Childhood Illness case management is institutionalised as the standard of care at PHC facilities. • Significant decline in the number of HIV-infected infants due to a successful PMTCT programme.	• A significant proportion of child deaths (up to 50% of deaths in children one month to five years) occur outside of health facilities, and these are not captured through routine data systems. • Despite reductions, HIV and poor nutrition continue to underlie many child deaths. • Despite improvements, ART coverage in children lags far behind adult coverage. • Compliance with IMCI and other guidelines, as well as impact, is difficult to monitor. • While ongoing efforts are required to address child mortality, interventions which focus on enhancing child well-being and incorporate assessment and management of other childhood illnesses (including long term health conditions) are also required.
	Pneumonia Case Fatality Rate[1]	2.0%	1.5%		
	Diarrhoea deaths in children under-5 years[1]	886	723		
	Diarrhoea Case Fatality Rate[1]	2.1%	1.7%		
	Severe Acute Malnutrition (SAM) deaths in children under-5 years[1]	1,188	836		
	Severe Acute Malnutrition (SAM) Case Fatality Rate[1]	8.0%	7.2%		
	PMTCT transmission rate[2]	3.5%	2.45%		
	ART coverage in children[2]	52.3%	60%		
Ensuring that all children are fully immunised	Fully immunised under one year of age[1]	70.1%	82.2%	• SA is self-financing spending approximately R3.5 billion per annum on childhood vaccines. • Improved coverage (remains sub-optimal). • Reduction in cases of some vaccine-preventable diseases. • Ongoing introduction of additional vaccines: rubella vaccination as well as vaccination of pregnant women against pertussis will be introduced in 2024.	• Coverage remains sub-optimal with resultant outbreaks of VPDs (e.g. measles in 2022), and risk of re-emergence of others (e.g. diphtheria, polio). • Surveillance of vaccine-preventable diseases is sub-optimal – may lead to late detection of outbreaks. • Spill-over of vaccine hesitancy associated with COVID-19 vaccination into EPI programme.
	Measles 2nd dose coverage[1]	85%	84.8%		

Optimal infant and child feeding	Vitamin A coverage (children 12 – 59 months)[1]	52.5%	70.8%	• Tshwane Declaration of 2011 signals South Africa's commitment to promote, support and protect breastfeeding. • Fortification of food successfully implemented since 2003.	• Food insecurity and hunger are not addressed in a systematic way. • Stunting rates remain stubbornly high, and the prevalence of overweight and obesity has increased dramatically. • Exclusive breastfeeding rates remain low. • Dietary diversity is poor, especially in children 12 – 24 months.
	Exclusive Breastfeeding Rate (measured at 14 weeks) [1]	41.6%	44.7%		
	Proportion of children who receive an adequate diet[3]	22.9% (2016)			

Sources:
1. District Health Information System data. Available at www.hst.org.za.
2. Thembisa Model Version 4.7 data. https://www.thembisa.org/downloads. Extracted 17th July 2024.
3. National Department of Health, Statistics South Africa, South African Medical Research Council, ICF. *South Africa Demographic and Health Survey 2016* Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF. 2019.

Notes: PHC: primary health care; EPI: Expanded programme on immunisation; IMCI: Integrated Management of Childhood Illness Strategy; PMTCT: preventing mother to child transmission of HIV+; VPD: vaccine preventable disease.

Department of Health (DoH) launched the revised RTHB which aims to provide parents and caregivers with information to support the optimal development of their child. The information is arranged around five pillars as shown in Figure 10.

The Side-by-Side Campaign aims to ensure that the messages in the RTHB reach caregivers of young children and provide them with information and support to improve nurturing care. The central message of the campaign is: "You are central to your child's nurturing, care and protection – and their lifelong health outcomes. Your health worker is there to support you".

The name "Side-by-Side" describes the supportive relationship between a child and their caregiver, as well as the relationship between healthcare workers and other practitioners who support and advise caregivers. Side-by-Side aims to convey the concept of partnership and togetherness, and speaks to the shared child-rearing journey that caregivers embark on with their children and all those who help and support them.

The Side-by-Side Campaign includes demand and supply side interventions. A recent evaluation of the campaign reported high recognition and trust among the women with young children with 87% of respondents indicating that they had changed their behaviour as a result of the RTHB messaging (unpublished report).

The Thrive-by-Five Index

The NIECD Policy envisages not only a more comprehensive approach to early childhood development within each sector, but also a more integrated approach across sectors. The Thrive-by-Five index was launched in 2021, with the aim of monitoring trends over time in the proportion of four- to five-year-old children attending early learning programmes who are on track for their age in key areas of development – including physical growth, early learning, and social-emotional functioning. The index highlights the relationship between physical growth, learning and preparation for success during formal schooling, and highlights the overlapping responsibilities of implementing departments.[20]

The National Food Security and Nutrition Plan

In 2017, the South African Presidency released South Africa's first major plan to align work on food and nutrition security across the various sectors. The National Food and Nutrition Security Plan for South Africa: 2018 – 2023[21] aimed to:

- Establish a multisectoral Food and Nutrition Security Council to oversee alignment of policies, coordination and implementation of programmes and services which address food and nutrition security.
- Establish inclusive local food value chains to support access to nutritious and affordable food.
- Expand targeted social protection measures and sustainable livelihood programmes.
- Scale up high impact nutrition interventions targeting women, infants and children (improve nutrition training and focus of community health workers and food handlers in community nutrition centres, early learning programmes, schools and community nutrition distribution centres); increase availability of micronutrient supplements, deworming tablets and fortified porridge; improve advocacy around exclusive breastfeeding; and improve the ability of early learning programmes to address nutrition issues.
- Influence people across the life cycle to make informed food and nutrition decisions through an integrated communication strategy.
- Develop a monitoring and evaluation system for food and nutrition security, including an integrated risk-management system.

However, a 2022 review of public expenditure and institutional support for early childhood development concluded that "a key

feature of the plan was the creation of a multi-sectoral Food and Nutrition Security Council to oversee the alignment of policies, legislation and programmes; coordinate implementation of services to address food and nutrition security; and draft new policies and legislation. Despite the positive policy directive, the Council was not established, and the lack of a strong coordinating agency and accountability system means that nutrition interventions remain fragmented and uncoordinated across multiple departments, rather than being addressed holistically".[22]

What are the key gaps and what can and should be done to address them?

As outlined above, progress has been made in expanding access to a package of essential services. While mothers and children continue to encounter barriers to health care, especially in underserved areas, most are able to access primary health care services. But ongoing improvements in the scope and quality of service provision will be required if South Africa is to bring its maternal and child mortality rates in line with its peers and ensure that children thrive and reach their full potential.

Important challenges remain and efforts to improve nutritional outcomes and support vulnerable families and children need to be intensified. Improved co-ordination between sectors is also required to ensure that mothers and children receive a full package of services, and that individual mothers, caregivers, families and children do not fall through the cracks.

Mobilising the health sector in support of maternal and child health well-being

Although some progress has been made in ensuring that mothers and children not only survive, but thrive, greater investment is needed to ensure that the health sector fully embraces this expanded mandate. While some elements of the NCF have been incorporated into routine services without the need for additional resources, more resources will be required if services, especially more specialised services, are to be expanded.

Advocacy at all levels has an important role to play. While the National Development Plan 2030 implicitly supports a comprehensive approach to early childhood development, the health chapter focuses more selectively on childhood mortality and future versions of the plan should adopt a more holistic approach. This would increase the visibility of the health sector's role in early childhood development and elicit greater support from politicians and senior managers within the health sector.

The Department of Basic Education also has an important role to play given its new mandate as the lead department for early childhood development. The department has a responsibility to provide leadership and co-ordination, and to ensure that the critical importance of the first 1,000 days is promoted and reinforced.

Focusing on the continuum of care

Early means early, in other words interventions aimed at ensuring that children reach their full developmental potential must start in pregnancy or even preconception. While providing a set of discrete interventions is important, better mechanisms need to be in place to provide the full continuum of care to both mothers and children especially during the first 1,000 days of life. This includes providing a seamless package of services across each level of care – from home and community-based outreach services to clinic and hospital-based care – that is tailored to meet mothers' and children's needs as they evolve across the life course, so that children and families receive the right care, at the right time, in the right place from the right service provider.

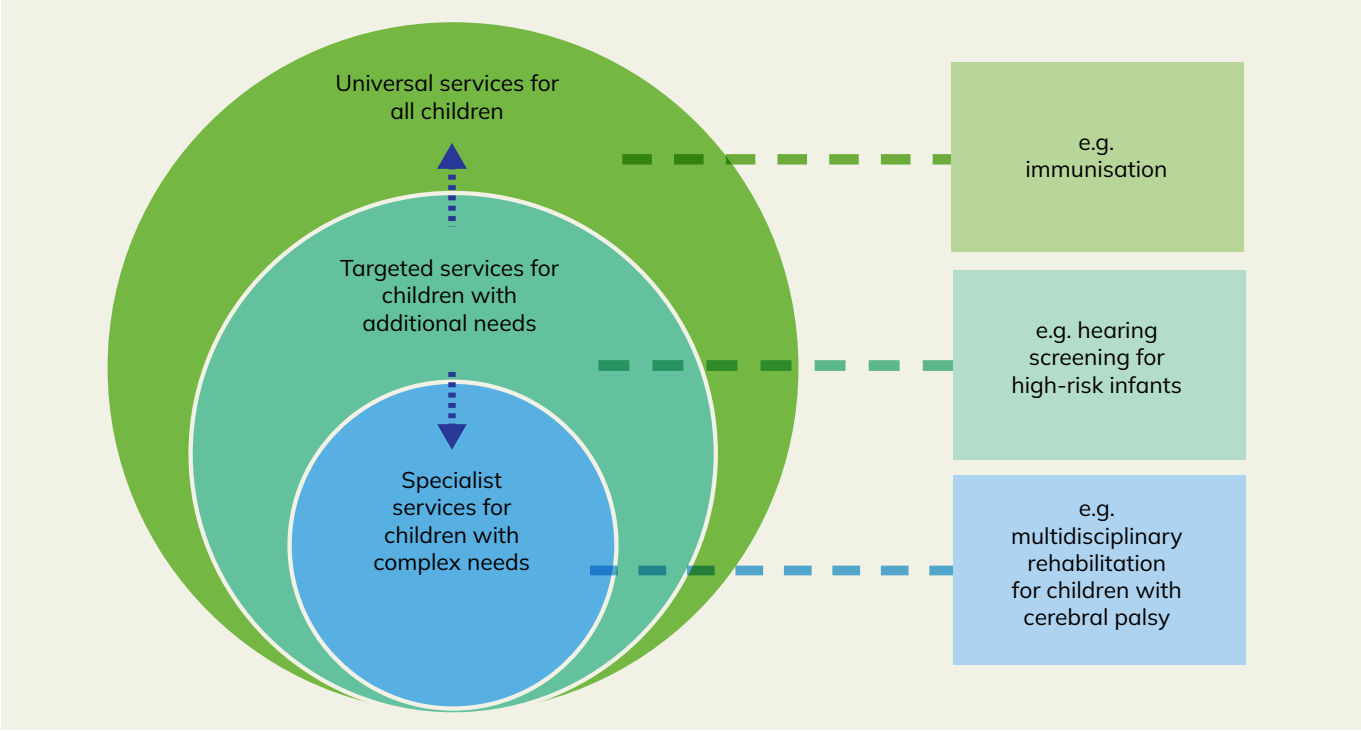
Systems need to be in place to provide socio-emotional support to all pregnant women and to identify women in need of extra care in order to support both their physical and mental health. The Side-by-Side Campaign has achieved some success in providing a comprehensive package which includes guidelines, resources and support materials across the full spectrum of care and consideration should be given to extending this approach to cover the antenatal and peripartum periods.

Better co-ordinating mechanisms (both formal and informal) need to be in place to ensure that care can be delivered across different settings and platforms by multi- and interdisciplinary teams. For example, formal procedures whereby children with developmental delays or other conditions (e.g. problems with hearing or vision) who are identified as requiring additional support are referred to and able to access such services need to be in place. Such referrals are facilitated by close working relationships between different disciplines and across sectors which are in turn facilitated by both structured co-ordination meetings and informal relationships developed over time through collaboration and common goals.

Expanding the scope of services provided

The NCF and NIECD Policy require the establishment of services for families and children with additional needs, specifically those with developmental difficulties and disabilities. Access to these services remains limited and inequitable. While some

Figure 11: Progressive universalism in child health services



Source: Slemming W, Saloojee H. Beyond survival: The role of health care in promoting ECD. In: Berry L, Dawes A, Biersteker L, Lake L, Smith C, editors. *South African Child Gauge 2013*. Cape Town: Children's Institute, UCT. 2013.

gains can be made through improved quality and more efficient delivery of services, additional resources will be required if services are to be expanded to meet the need.

An improved cross-sectoral system for the early identification of children and families requiring additional care and support must be established, with the appropriate referral and care pathways to provide the necessary interventions, management and follow-up care. Parents and those working with children in health care, early learning and social services should be capacitated to identify children and families who require this support, and to be able to initiate referral to available local services.

Promoting early childhood development through the health system requires a progressive universal[iii] approach (Figure 11) that provides targeted support for children and families whose health and development are at risk and specialist services for those with complex needs (for example, children with disabilities or long term health conditions). It is also important to recognise that children and families' needs are not fixed and that they may move back and forth between different levels of care as their circumstances change.[23] An effective system of care should therefore be responsive to changing needs, and family-centred[iv] in order to support and affirm caregivers' efforts to provide nurturing care. To date, this has not been realised within the South African health system and should be prioritised.

Implementing a comprehensive nutrition programme

As noted earlier, the package of nutrition interventions for pregnant women and young children does not adequately address the current double burden of malnutrition. The National Food Security and Nutrition Plan provides an excellent intersectoral blueprint for this but needs to be implemented as a matter of urgency and efforts to prevent and respond the double burden of child malnutrition need to be prioritised.

The health sector has a central role to play and needs to intensify its efforts. This includes promoting maternal nutrition and exclusive breastfeeding, counselling mothers on how to safely introduce complementary foods, routinely monitoring children's growth to identify and proactively support children who are growth faltering, strengthening referral systems to ensure that malnourished children and food-insecure families are fast tracked for social assistance, and providing treatment – including community-based follow-up care – for children with severe acute malnutrition.

iii The concept of progressive universalism refers to the provision of support for all along a continuum, with more support for those who need it most.

iv Policies, procedures and practices tailored to focus on the needs, beliefs, and cultural values of children and their families. This approach means working with families and recognising and building on their strengths.

These health interventions need to be coupled with broader efforts to address the rise in child poverty as nearly 40% of children now live below the food poverty line.[24] This includes the restoration of the Child Support Grant to the food poverty line so that it covers children's nutritional needs. While the *Nutrition Guidelines for ECD Centres* provide practical guidelines on how to feed babies and young children – including menus, shopping lists, food safety and how to promote healthy eating, it is essential to remove administrative barriers to the registration of early learning programmes so that more children are able to benefit from the ECD subsidy (see page 115 to find out about other measures to strengthen social assistance).

At the same time, it is important to address the commercial drivers of child malnutrition and the ways in which the marketing, sale and consumption of cheap ultra-processed foods is driving a rapid increase in overweight and obesity. Government's efforts to strengthen the regulatory framework and protect children from the marketing of foods are therefore welcome (see page 22 to find out more about Regulation R3337).

Harness CHWs and other community structures

South Africa has a large number of community health workers (CHWs) who visit households and provide services at household and community level, with a total of 46,172 CHWs as at end of March 2023.[25] Mothers and children are identified as a priority target group for this cadre, and their scope of work includes the provision of a basket of priority services for children that is fully aligned with the five pillars contained in the Road-to-Health Booklet and the Side-by-Side Campaign.

However, despite examples of effective localised programmes which have been shown to improve outcomes for mothers and children,[26, 27] the CHW programme has not been leveraged to provide services to vulnerable mothers and children at scale. Reasons for this include administrative and management issues which limit overall programme quality and efficiency, an overemphasis on provision of adult HIV and TB services, and unrealistic expectations being placed on CHWs which together limit their capacity to focus on priority interventions for children.

Addressing this situation will require leadership, advocacy and stronger articulation between MCWH managers and CHW programme managers at all levels of the health system. In addition, the training of CHWs (both preservice and in-service) needs to be fully aligned with the CHW scope of work and the package of care contained in the RTHB.

Improved intersectoral linkages at local level would also assist in ensuring that the most vulnerable children and households are identified and prioritised to receive health and other services. The Sakuma Sakhe initiative implemented in KwaZulu-Natal successfully established ward-level 'war rooms' which focus on establishing such linkages. However, this approach is yet to be adopted in other provinces.

Based on global experiences, it is questionable whether using CHWs alone will achieve the coverage required to provide home-based services at the quality, intensity and scale required to adequately support the health and wellbeing of pregnant women, mothers, and young children. Learning from countries, such as Peru, that have expanded their recruitment for home visitors across sectors (such as health, education, social services) could inform local approaches to building a sustainable home visitation programme for mothers and young children at scale in South Africa.

Expanding communication using traditional and digital communication channels

Access to information and opportunities for engagement are essential in supporting behaviour changes within the family to improve maternal and child well-being. The health sector has achieved some success, most notably, through the MomConnect Initiative which has reached more than 4.5 million pregnant women and through the Side-by-Side Campaign which has reached 3.7 million listeners during each week of its 36-week radio drama and information series. The COVID-19 pandemic underscored both the importance of public health communication, as well as the risks associated with information overload and misinformation.

Better information systems to track children's progress

While progress has been made in measuring coverage of essential services, there is a need to incorporate measures of child and maternal well-being. Furthermore, the health sector lacks an information system that tracks individual children and makes it possible to follow up children who have missed critical interventions such as immunisation – this is particularly challenging when children move within or across provinces. Likewise, mothers and children are not adequately linked which means that follow-up of infants born to mothers with HIV infection is reliant on the mother being present and disclosing this at every engagement.

While linkages and referral systems need to be established at local level, linking of different information systems – across departments – and across facilities, districts and provinces – would also make it easier to identify and support children who are at risk or who face multiple adversities.

Conclusion

The past decade has seen a shift from a focus on maternal and child survival to a more holistic approach aimed at ensuring that mothers and children not only survive, but thrive. While this shift has been incorporated into policy documents and commitments, a lot of work still needs to be done to ensure that the approach is fully integrated into the design and delivery of health services. While promising practices have been identified, attention needs to be paid to ensuring that these practices are fully institutionalised and provided at scale. This applies especially to interventions aimed at improving nutrition outcomes for young children.

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It takes more than a village: Why children need their caregivers, community and country to work together to enable nurturing care

Marguerite Marlow, Tatenda Mawoyo, Yeukai Chideya, Lungile Mdluli & Mark Tomlinson[i]

The type of care and support that children receive in their earliest years can influence the rest of their lives. For healthy development, children need a safe, secure and loving environment, with adequate nutrition, and frequent opportunities for responsive and stimulating interactions with others.[1] This type of nurturing care enables healthy neurophysiological, physical, and psychological development, and supports children's health and well-being across the life course.[2, 3]

When we think about who is responsible for providing nurturing care and support to young children, we often think first of the child's parents – particularly the child's mother. While the influence of parents is critical to support healthy child development, the provision of nurturing care is dependent on much more than individual parents and caregivers.[1] This is because the care and support that parents and caregivers can provide is influenced by a complex interplay of factors, many of which are outside their control, such as limited economic opportunities, poor infrastructure and service delivery or high levels of crime and violence. These factors, which are often interlinked and mutually reinforcing, can greatly influence caregivers' well-being, and the quality of interactions between them and their children.[4] Responses that focus on improving only the capacities of individual caregivers will not be sufficient to ensure that children receive the care they need to develop and thrive. Instead, nurturing care requires an enabling environment (see Figure 12) characterised by enabling policies, supportive services, and empowered communities, which, taken together, make nurturing care possible for parents and caregivers.[1] In this chapter, we focus on what is needed at a policy, service and community level to ensure that parents and caregivers receive the care and support *they* need to optimally care for children. To achieve this, we argue that we need to extend our focus beyond the individual parent and caregiver to the broader care economy, by actively involving government, workplaces, churches, and other community-based services in locally relevant, strength-based approaches to nurturing care.

Figure 12: Enabling environments for nurturing care

Source: World Health Organization, UNICEF, World Bank Group. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential*. Geneva: WHO. 2018.

What are South Africa's mandates and commitments?

In 2007, the first *Lancet* series on early child development (ECD) identified a lack of learning opportunities from parents and primary caregivers as a key factor contributing to the millions of children failing to achieve their developmental potential.[5] Ensuring that young children receive responsive care and opportunities for early learning has since become a prominent priority for policy makers, researchers and programme providers concerned with improving human development.[1, 2, 6]

In 2020, the World Health Organization (WHO) released guidelines to provide global, evidence-informed recommendations on improving early childhood development.[7] The guidelines recommend that parents and caregivers should be supported to provide responsive care and should

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be supported to engage in early learning interactions with their children. The guideline also recognises the importance of caregiver mental health in improving early childhood development and recommends that psychosocial interventions that support maternal mental health should be provided as part of ECD services.[7] To complement the ECD guidelines, WHO also recently released guidelines on the value of parenting interventions, recommending that evidence-based parenting programmes should be made readily accessible to all parents and caregivers of children ages 0 – 3 globally.[8] Given that children in lower- and middle-income countries (LMICs) are exposed to elevated risk of maltreatment and other risk factors, parenting interventions should also be provided to all parents and caregivers of children aged 2 – 17 years to improve parent-child relationships and prevent child maltreatment.[8] Parenting interventions offer important and effective avenues for enabling caregivers to have nurturing and supportive relationships with their children, and to reduce forms of maltreatment.[9, 10]

At a national level, the South African National Integrated Early Childhood Development Policy (NIECD Policy) recognises parenting support as a key component of a comprehensive package of ECD services for all South African children. The 2021 Revised White Paper on Families in South Africa[11] similarly promotes parenting support to strengthen family well-being, through providing wider access to parenting programmes and services, ensuring access to maternal and caregiver care, and supporting the role that both women and men play in the care and well-being of children.

Interventions to support positive parenting are mandated by the Children's Act[12] which focuses on strengthening positive relationships within families, improving the caregiving capacity of parents, and using non-violent forms of discipline. This provides the legal basis for the provision of parenting and caregiver support programmes to address these needs.[13] A core focus of the Department of Social Development is to implement programmes and strategies in support of the Children's Act.

Promotion of existing resources and knowledge is one of the national policy principles highlighted in the NIECD Policy. Through this principle, the policy aims to recognise and build on existing systems and knowledge, including beneficial indigenous and local early childhood development practices, to develop a stronger and more unified ECD system.[14] South Africa's national parenting programme is provided through the Parental/Primary Caregiver Capacity Building Training Package, which consists of 11 sessions, and aims to build on the existing experience, knowledge, and skills of caregivers.[15]

What is the status quo?

The provision of nurturing care is influenced by children's care arrangements and the capabilities and constraints of their care providers. Caring for children is a demanding task, and depends on caregivers' physical, psychological and social capacity to provide care not only for their child, but for themselves as well. In South Africa, childcare arrangements vary, and is influenced by the resources, support and programmes available to caregivers and their families.

Providers of care and factors that affect their capacity to provide care

Families and households are profoundly important to the physical, psychological, and cognitive development of children. South African families are diverse, often involving a variety of living and caretaking arrangements for children. The 2022 South African General Household Survey[16] showed that only about a third of children (33%) lived with both their parents, while nearly one in five (19.5%) lived with neither parent. A much larger percentage of children lived only with their mothers (44%) compared to children living with only their fathers (4%). Nationally, one in three families (33%) live in extended households that include grandparents or other family members. Almost two-thirds (63%) of children aged 0 – 4 years stayed home with a parent or guardian, or with another adult, while only 32% attended formal ECD facilities.

Caregiver mental health and emotional well-being are key key factors that enable caregivers to provide responsive care.[17] Female caregivers are often expected to do both caregiving and domestic work, which often results in women carrying a disproportionately high burden of care compared to male caregivers. Women, therefore, may be especially prone to poor mental health in contexts characterised by poverty, where they are often responsible for the care of young children and the upkeep of their household. Indeed, the prevalence of maternal mental illness is higher in South Africa (around 20%) compared to prevalence rates in high-income countries (10 – 15%).[18]

In addition, certain caregivers may require additional support to providing nurturing care. While father and male caregiver involvement is important for child, maternal and family well-being,[19] patriarchal norms and gendered expectations may act as barriers to men's involvement in the day-to-day care of children. However, even where fathers and male caregivers want to be involved, they are often excluded from policies, services and care activities.[20]

The availability of accessible child-care services can restrict families' decisions in terms of who can work, where they can work, and what type of work they can engage in. Many

caregivers in South Africa generate income through work in the informal economy without any formal labour and social protections. Many of these workers in informal employment are women and mothers. Balancing paid work (especially in the informal sector) with unpaid care work can be a source of mental and emotional stress in addition to the physical burden that long hours and a heavy workload puts on women.[21]

Current approaches to providing parent and caregiver support

Parenting programmes often work to improve the knowledge and practices of caregivers directly, to improve the development and well-being of the children in their care.[22] However, caregiving does not happen in a vacuum, and caregivers in South Africa face a range of challenges that may influence their caregiving capacity. For instance, research in low-resource communities in South Africa shows that parenting is influenced by the stress associated with keeping children safe in the community, often resulting in harsher parenting practices and less time spent playing with children.[23] These structural and social risks may act as key determinants of the type of care and support that families are able to provide. Yet many services and interventions seek to improve child outcomes through targeting individual caregiving "deficiencies", for example, by providing parents with information on the importance of child development and advice on what they can do differently.

For a long time, definitions of "good" parenting have been dominated by Eurocentric or Western perspectives, which often overlook the role of structural inequalities that constrain or undermine these practices. Increasingly, concerns are being raised about boldly recommending parenting styles and practices from high-income countries to parents in LMIC settings, especially where these recommendations fail to consider the many existing local strengths and traditional practices that benefit children.[24] When programmes emphasise Eurocentric parenting perspectives while overlooking local social, cultural and gender norms, it risks problematising and undermining families' existing knowledge and practices and may cause more harm than good.

One of the obstacles in using indigenous knowledge in early childhood policy-making, programming and implementation is the lack of contemporary research and documentation of local child-rearing practices, traditions, norms and beliefs.[25] Studies frequently focus on caregivers' possession of professional knowledge, such as developmental milestones and positive parenting practices,[26] while limited attention is afforded to the indigenous and experiential knowledge of caregivers that may hold value for meaningful intervention. Many development agencies are now articulating the importance of understanding local knowledge and practices and, consequently, of designing culturally appropriate interventions, such as through UNICEF's Knowledge, Attitude and Practices (KAP) studies. In South Africa, UNICEF recently conducted a study on caregiver knowledge, attitudes and practices regarding play-based learning for children from birth to six years old, with qualitative and quantitative data collected across all nine provinces in South Africa.[27] The study highlighted several key barriers faced by caregivers in providing play-based learning opportunities. Notably, the results highlighted a historical legacy of caregivers feeling inadequate and lacking confidence in supporting their children with learning, especially where caregiver education and/or income is low. Concerns about safety was a prominent challenge for parents and caregivers across South Africa, with 76% of caregivers reporting that children mainly play inside the house. Due to the increasing breakdown of social cohesion and trust in neighbours and community, children are exposed to less communal play, and no longer raised "by the community" because of safety concerns.

The UNICEF KAP study highlighted several existing beliefs and strength-based practices of parents and families that can be reinforced and built upon to strengthen responsive caregiving and play-based learning. For instance, families believe that children play and learn through daily routines, such as bath time and by being involved in household chores. This offers an important opportunity to strengthen parents' playful parenting practices as part of their daily interactions with children. Caregivers understand that children learn through copying and imitation, and the importance of modelling behaviour for children in the early years. Reinforcing the importance of modelling positive behaviours – including those that support behaviours such as identifying and expressing emotions, self-regulation, communication skills, empathy and pro-social behaviours – is a valuable avenue to enhance children's socio-emotional development. While many working parents have limited time to play with their children, older caregivers such as grandparents were frequently involved in childcare and played a significant role in children's learning, including passing on traditional play and games. Involving and supporting the wider family and older caregivers is therefore an important strategy to strengthen responsive care.

What are the key advocacy calls and recommendations?

Without enabling environments to actively support caregivers in their role, children in South Africa will not be able to thrive. It is critical for institutions such as the state, employers and community

organisations to play their part in prioritising nurturing care for children. Strengthening the care and support that children receive depends on empowering families and communities and must be done with respect for the local context, while building on the positive social norms and practices that already exist within homes and communities. Adopting a collaborative approach can help build an enabling environment that is both sensitive and responsive to caregivers' needs.

Below we provide four key recommendations for improving the care and support that children receive, along with illustrative cases from South Africa that demonstrate promising practice.

Adopt a place-based approach to nurturing care

In 2023, WHO and UNICEF released the Nurturing Care Handbook[28] to support the implementation of the Nurturing Care Framework. The handbook calls for the adoption of a "place-based" approach in order to effectively engage communities in nurturing care (as outlined in Table 23). A place-based community approach for ECD is a cross-sector effort that addresses the needs and problems of families and communities in a specific geographic area by building on strengths at the local level. This approach has been shown to benefit child well-being, particularly in terms of improving parenting practices, home learning environments, and child development outcomes.[29]

Extending the focus beyond the individual caregiver and investing in the broader care economy will require more focused attention and efforts from multiple stakeholders at different levels.[30] This is because caregiving capabilities are influenced by access to societal resources that enable families to make choices and decisions in the best interests of their children, including services such as parenting and caregiver support, quality childcare and primary health care. Increased investment and action will be needed at the household, community, service and policy level.

Table 23: Changes needed to enable a place-based approach to promoting nurturing care

From:	To:
Parent focus or child focus	Child and family well-being
Maternal involvement	Family engagement
Information	Holistic social and economic support
Isolated programmes	Connected services
Separate sectors	Multisectoral collaboration
Single-programme impact	Collective impact

Source: *The Nurturing Care Handbook: Focus on Families and Communities.*

Promote and support male caregivers' involvement in nurturing care

Mothers and female caregivers remain the focal point in interventions and services aimed at improving the care and well-being of young children. However, fathers and male caregivers also have a central role to play in nurturing care. Improving men's involvement in childcare is important to relieve the disproportionate burden of care experienced by mothers and female caregivers. Actively engaging men within existing programmes and mobilising social resources such as community and religious leadership support and peer support networks is needed to increase their involvement in care work. In addition, these solutions will need to be accompanied by a shift in mindsets through community and media campaigns that challenge entrenched cultural norms to create momentum for change.[29] Fathers Matter and MenCare+ (Case 1 and 2) highlight how programmes and services can be used to empower men and promote their involvement in nurturing care, by using different platforms such as the media and the church, as well as the public health system. These initiatives combine community empowerment and supportive services to enhance the capabilities of fathers and male caregivers.

Identify and build on existing local strengths in the community

Families and caregivers in South Africa are resilient, with many inherent strengths that sustain them in times of adversity. It is important that programming efforts harness existing assets and strengths and provide services that enhance the capabilities of caregivers to provide nurturing care. Strategies to strengthen caregiving and promote child well-being within communities should be designed to align with their best interests, leverage their strengths, and address the key challenges they face. UNICEF's KAP study [27, 33, 34] highlighted important issues that need to be addressed in order to support parents and caregivers in South Africa more effectively. First, concepts of play and learning are presented to parents and caregivers through Western terminology. To provide more effective support, programmes need to listen to and respond to parent's lived experiences, incorporate locally relevant terminology and actively promote positive indigenous and local practices. Second, advocacy is needed to ensure that programme providers speak about – and with parents – in a way that affirms their strengths and acknowledge their central role in supporting their children. Third, there are many evidence-based programmes for caregivers and parents. Rather than developing new interventions, the focus needs to be on how to implement existing programmes effectively, in the real

Case 1: Fathers Matter – Using films and faith leaders to promote father involvement.

Fathers Matter is a project of Heartlines: the Centre for Values Promotion, and uses a combination of media and community-based interventions to support and promote the active presence of fathers in children's lives. Fathers Matter harnesses the power of storytelling through six short films on fatherhood to create a national conversation about the importance of fathers in South Africa. The films were aired nationwide, supported by a broader media campaign involving radio and digital platforms.

Each film is accompanied by a discussion guide, which can be used in different contexts (such as social groups, sports clubs and churches) to create awareness of the importance of positive father involvement, and to explore and engage with the topic of fatherhood. Heartlines conducted extensive formative work involving a diverse group of fathers and men across the country, gathering personal stories and experiences to develop an in-depth understanding of what it means to be a father in South Africa. The messaging and storylines focus on creating awareness around barriers and enablers to father involvement, as well as highlighting positive examples of fatherhood. The programme has partnered with a selection of faith leaders and churches across the country to promote and discuss the films, and to create a supportive environment within the church for men and fathers to take on a positive role in the lives of their children.[31]

world, at different levels of scale. Linked to this, is the need for coordination between programme providers and community members and leaders, and for better communication and sharing between programmes.

Alongside this, there is a need to re-think what constitutes a parenting programme, and the emphasis on "training" parents or moving them through a specific curriculum. Programmes should focus on aspects of programmes and services that enable parents to feel connected to other parents, share their successes, problem solve, and receive support to cope with, and respond to, challenges. In many cases, even in the most disadvantaged communities there are families who have found ways to overcome challenges and raise healthy children.

A positive deviance model is a behavioural and social change approach acknowledging that in any context, there are individuals who – despite facing similar resource constraints or challenges as their peers – have found successful strategies to overcome problems. The Philani Mentor Mother home visiting programme (Case 3) illustrates how this approach can be used to identify, understand, and harness local solutions and protective factors to enable caregiving improvements at scale.
Community services and programmes trying to help families and children with unmet needs should direct their efforts towards strengthening natural support systems, involving relatives, friends, neighbours and community organisations, rather than trying to create new systems. For example, local faith communities and groups can play an important role in reaching and supporting the most vulnerable families and children. Given their geographic proximity, relational ties, influence, and physical resources, faith-based organisations are well positioned and equipped to play a meaningful part in enabling nurturing care for young children as illustrated by Sikunye (Case 19 on page 191).

Address structural and social barriers to nurturing care

Efforts that address the structural and social risks faced by many caregivers and families in South Africa are urgently needed to improve the quality of care and support that families are able to provide to young children. This is because structural factors such as social protection policies, economic infrastructure and access to childcare play a central role in determining the type of care that caregivers are able to provide, yet these resources are not available to all caregivers who need them.[36]
It will always be difficult for parents and families to provide nurturing care when they are struggling for survival, facing

Case 2: MenCare+ – Harnessing the public health system to engage and involve men and fathers

During pregnancy and early childhood, the public health care system often acts as a barrier that prevents the active participation of fathers in children's lives. The health system infrastructure and unwelcoming attitudes of nurses and other women, often keeps fathers away.

Sonke Gender Justice's MenCare+ programme works with communities and the public health system to engage men aged 15 – 35 as partners in maternal and child health (MCH) and sexual and reproductive health and rights (SRHR).

The initiative provides a comprehensive suite of activities aimed at individuals, communities, public service providers and organisations, including:

- Group education with young men on SRHR, gender equality and caregiving;
- Workshops with health workers on the importance of engaging and including men in SRHR and MCH services;
- Advocacy and alliance building with organisations and governments on gender transformative policies like parental leave, the prohibition of corporal punishment, and the health systems strengthening.

MenCare+ is implemented in many countries, including South Africa. It seeks to tackle harmful gendered stereotypes at multiple levels, by including individuals, families, communities and government services. The MenCare+ programme in South Africa has also initiated the "Men Disrupting the Manhood Narrative", to showcase powerful stories of men and families from different communities who exemplify real examples of men who are disrupting and rewriting the dominant narratives on fatherhood and motherhood.[32]

extreme poverty, food insecurity, and limited access to employment or livelihood support. South Africa's Child Support Grant (CSG) provides essential income support to children in poor households and aims to ensure that children receive sufficient nutrition at a critical stage of their development. It has proven successful in reducing hunger, improving nutrition and in promoting health and development in young children, but is only granted once the child is born.

Children's development starts before birth and is strongly impacted by the mother's health and well-being during pregnancy, and many women in South Africa struggle to afford the basic nutrition needed to ensure a healthy pregnancy. A policy that provides income support to vulnerable pregnant women (see Case 4) could be an effective way to improve both maternal and child outcomes, by allowing expectant mothers to cater for their nutritional needs at a time when the developing foetus requires these nutrients the most.

Employment-related care, such as leave policies, family-friendly working arrangements, maternity and parental leave benefits are equally important to enable caregivers to optimally care for and support their children. However, working caregivers in the informal sector are overlooked by most existing market-related responses and are not supported to provide the best care for their children.[38, 39] Without the security of formal employment,

Case 3: Using a positive deviance strategy to support pregnant women and mothers: The Philani Mentor Mother home visiting programme

The Philani Maternal, Child Health and Nutrition Trust's mentor mother programme[35] chooses 'positive deviants' – women who have in one way or another developed coping skills that have benefited their own and their children's health – to serve as mentor mothers. The project then recruits and trains these women to mentor and support pregnant women and new mothers in their community, with the frequency of home visits determined by the level of need of the child and their family.

While Philani staff recognised that the Mentor Mother Programme was having a positive impact on the health of the children, poverty remained a central issue to the community. Philani has tried to redress this by focusing on creating and offering education and training opportunities to mothers. Skills' training occurs at their Development Centre, where mothers are taught income-generating skills to provide opportunities for livelihood support. Through the income generation programme, it was also recognised that there was a need for a place where Philani's preschool children could play and learn in a safe environment. This was the beginning of what is now their Educare Programme. At each Philani Nutrition Centre, a space was made available specifically for the children, and the mothers took turns to care for them.

Case 4: A Maternal Support Policy to improve the well-being of vulnerable mothers and their unborn children

A draft Maternal Support Policy has been put forward by the Department of Social Development in order to provide comprehensive support to vulnerable pregnant women and mothers in South Africa.[37] The proposed introduction of a Maternal Support Grant would build on the existing CSG to reach and support children before they are born. Beyond addressing the basic economic and health needs of pregnant women, the policy also aims to phase in several complementary strategies, including assistance with childcare to enable pregnant women to remain in employment and education, and transport so that they can access key health and social services. The draft policy represents an important step towards the provision of an integrated maternity package to support women during pregnancy and into parenthood, through income support and a range of other support services including call centres and advice offices operating through schools, labour centres and the South African Social Security Agency (SASSA). The combination of maternity and early child support offers a powerful opportunity to improve the well-being of caregivers as well as the children in their care.

the majority of working mothers and caregivers are forced to choose between earning an income and providing optimal care for their children. They do not benefit from maternity leave, sick pay or the minimum wage. They are often compelled to return to work quickly after giving birth, and work long hours. They struggle to access basic health and early childhood development services as they are not at home to receive community health workers, and they lose income if they visit primary health care clinics. Supporting these working caregivers is a critical gap in South Africa, and more efforts are needed to address the needs of this vulnerable caregiving population (see Case 5).

What actions will move us forward?

Supporting parents and families to provide nurturing care will depend on the commitment and capacity of local communities and the broader political system. It requires coordination between different stakeholders, sectors and levels of government to create the enabling environment that will be needed to improve outcomes for children across the life-course.

To improve outcomes, a paradigm shift is needed from focusing on the individual parent (usually the mother) to the wider family and the broader care economy. Interventions that include the wider family and community will be important to

Case 5: Asiye eTafuleni's childcare project at Warwick Junction in Durban to support working women in the informal economy

Asiye eTafuleni (AeT) is a non-profit organization that works to achieve equitable access to sustainable livelihoods for informal workers in urban public spaces such as Warwick Junction in Durban – a major transport hub around which nine informal markets have developed. These markets sustain the livelihoods of around 8,000 informal workers, many of whom are mothers who bring their children to work with them. However, the settings in which these mothers work leave them vulnerable to environmental hazards which often compromise their well-being as well as their ability to provide nurturing care to their children. Caregivers may also be forced to stop exclusive breastfeeding and sacrifice opportunities for child bonding due to the structural limitations of their informal work environments.

AeT's current work spans a variety of projects that respond to needs and opportunities identified in close consultation with informal workers. They then collaborated with informal working mothers to co-design, pilot and implement a pop-up micro-childcare facility. 'Silindokuhle' (isiZulu for 'we hope for the best') is a small childcare facility that aims to provide a 'safer space' for the children of Warwick Junction's informally working mothers or caregivers, in close proximity to their place of work. Using a peer-to-peer/time-bank operation model, the intention was for each of the mothers who have a child attending the childcare facility to be responsible for the care of all six children for the equivalent to one day a week. However, two of the mothers offered to take on the roles of caring for the children full-time, at an affordable daily fee paid by each of the other mothers. Staying true to their participatory approach, the mothers were involved in every step of the decision-making process regarding the operating of the facility. Although two of the mothers are in charge of the facility, seven out of the group of 11 opted to complete a four-day caregiver training course through EduBabe, covering a comprehensive range of topics related to caring for babies and young children, including CPR and toy-making. This initiative demonstrates a locally responsive, structural solution designed to suit the needs of caregivers working in the informal work environment of Warwick Junction.[39]

relieve the burden of care experienced by mothers and female caregivers in particular. Strengthening the care and support that children receive must build on local solutions and the positive social norms and practices that already exist in the community. Programmes and services should use strength-based approaches that explicitly harness African perspectives and indigenous parenting practices. Importantly, policies, strategies and services need to prioritise bringing together childcare, care for women, and the economic empowerment of women in order to create an enabling environment for the provision of optimal care to young children.

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Progress and pathways towards quality early learning: From the home to structured learning programmes

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This chapter puts a spotlight on issues that drive and influence quality in early learning – from the home to structured learning programmes – and concludes with a tangible set of actions that can be taken by the sector to progress quality early learning in South Africa. The first section delves into the essence of quality early learning, beginning with critical definitions, highlighting the pivotal role of play-based approaches and child agency, emphasising inclusion, and exploring key enablers of quality. The chapter then moves on to outline a concrete set of actions for government and broader early childhood development sector. It addresses the professionalisation of practitioners delivering early learning programmes, quality assurance and support systems, and the central role that resource and training organisations should continue to play alongside government to support quality. Additionally, we examine how technology can be harnessed to scale and enhance quality in early learning.

The National Development Plan 2030[1] sets out the country's strategic plan and vision for 2030 and elevates early childhood development (ECD) as an education sector priority in order to improve the quality of education and long-term prospects of future generations. To do this, the plan provided for two years of quality and compulsory preschool enrolment before Grade 1 and a policy and programme shift to ensure that the Department of Basic Education (DBE) takes the core responsibility for the provision and monitoring of ECD. This shift became effective in April 2022. The National Integrated Early Childhood Development (NIECD) Policy,[2] ratified by Cabinet in 2015, specifies a comprehensive holistic service package for young children. This includes health, nutrition, social security and protection, parenting and family support, and early learning opportunities, which align with the global Nurturing Care Framework.[3] The Policy defines the goal for early learning as:

> *By 2030, to provide a universally available comprehensive quality age and developmental stage appropriate opportunities for learning for all children from birth until they enter formal school, which lay the foundations for optimal early learning, inclusion and the socio-emotional, physical, intellectual and language development of young children through play and other related, recognised methods for early learning, as well as safe daily care in the absence of their parents and/or primary caregivers (p 59).*[2]

Opportunities for early learning can be provided through a range of modalities including programmes that support parents to provide early learning and stimulation at home, such as parenting workshops, toy libraries and home-visiting programmes; and programmes for groups of children such as playgroups, ECD centres and preschools. Because early learning needs to be supported at home as well as in early learning programmes "recognition of and respect for parents and caregivers as primary and central to early child development" (p 51) is a fundamental principle of the NIECD Policy requiring good communication and partnership with parents.

In addition, South Africa has ratified the Sustainable Development Goals, and committed to ensuring that all boys and girls have access to quality early childhood development, care and pre-primary education by 2030 so they are ready for primary education.[4] Yet, the nationally representative Thrive by Five Index Study[5] of 5,139 children in 2021 found that only 45% of children 50 – 59 months attending early learning programmes are developmentally on track for early learning for the beginning of Grade R. A third were not emotionally ready for school and 27.5% did not show adequate social skills.

A continuum of support from home to early learning programmes is needed to get children on track. In 2020, more than 50% of children aged 0 – 4 years stayed at home with parents or guardians, while approximately 30% of 0 – 3-year-olds, and 70% of four-year-olds participated in early learning programmes.[6]

The home learning environment is a significant determinant of children's education performance – regardless of whether or not they attend a structured early learning programme. Particularly in the first three years of life, most interactions that support learning will come from the primary caregiver

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and other household members. Maternal responsiveness and cognitive stimulation in the first two years has been shown to be associated with increased cognitive scores at age five for children in low socio-economic status homes.[7]

For younger children (0 – 3 years), care at home with a primary caregiver is generally considered the best form of provision if the caregiver has adequate support and capacity to offer responsive care.[8] For those children who need care arrangements away from home, such as the services of childminders and day care centres, these need to offer age-appropriate care and play-based learning opportunities. Children between 3 – 6 years benefit from a more organised early learning experience such as a playgroup or ECD centre-based programme, provided that it is of sufficient quality to meet their learning and developmental needs. Guidance on how adults (including parents and ECD practitioners) can best facilitate child development and early learning is specified in the National Curriculum Framework for Children Birth to Four Years (NCF).[9]

Is South Africa realising the right to early learning?

The UN Committee of Economic, Social and Cultural Rights identified four elements of the right to education: which should be available, accessible, acceptable and adaptable.[10, 11] Table 24 uses this framework to assess the status of early learning provision in South Africa drawing on the best available data, including the 2021 ECD Census.

Recent data indicate that access to early learning support through parenting or group learning programmes is limited and that cost is a barrier. There are gaps in the quality of many early learning programmes with un- or under-qualified teaching staff, limited learning resources and insufficient focus on individual needs. Parents do engage in some play and early stimulation activities with their children, but few engage in activities that will support early literacy. New technologies offer strategies for addressing some of these gaps. But as it stands, the available data suggest an urgent need to address issues of quality in early learning.

What is quality and what enables it?

The goal of the NIECD Policy is that every infant and young child has access to essential, quality ECD services. Definitions of quality commonly refer to changes in children's outcomes or well-being, and the causal day-to-day experiences, relationships and interactions across the continuum of care children experience that have the most proximal influence on children's well-being or outcomes.[22]

Defining quality in structured early learning programmes

Acceptability refers to the quality of early learning programmes and the extent to which they reflect local and community values. Quality services provide for adequate nutrition, health and safety, sound administration, communication with parents, and a balanced early learning programme which provides for free and guided play and covers all the Nurturing Care Framework learning areas. In what follows we concentrate on those factors most closely associated with improved early learning and development outcomes.

There is substantial evidence, including from low- and middle-income countries, that investment in high quality provision is essential if children are to benefit from early learning programmes.[23] Early learning programmes alone cannot guarantee progress on child outcomes, they need to be implemented with quality. Quality of the classroom learning environment can be broadly divided into:

- **Structural quality**: including the physical environment, teacher qualifications, group size and practitioner-to-child ratios, access to learning materials, and provision for health and nutrition.
- **Process quality**: including classroom interactions (teacher-child and child-child), pedagogical approaches, and following a planned and holistic curriculum.

Research from both high and low- and middle-income countries indicates that process quality has a greater influence on child development than structural variables.[24-28] This refers to what children actually experience in their programme. It should include mediated teacher-child interaction that supports the learning, social and emotional needs of individual children and provides opportunities for children to interact with their peers. Language and cultural sensitivity help bridge home and school, and affirm children's identity. Warm, supportive and encouraging relationships with teachers[29] help facilitate the development of social and emotional skills and build children's confidence to explore, investigate, try new things, and learn from mistakes all of which are associated with successful school transition.[26, 30]

There is growing evidence that certain aspects of early learning programmes are more highly associated with scores on school readiness measures. These include more time in small group work,[31] and positive child-child and adult-child interactions.[32] Stronger achievement outcomes occur when teachers rely on curricula that focus on particular skill areas such as language/literacy, math and self-regulation as distinct from more general programmes.[33] Learning through play is recognised as being one of the most effective ways of delivering quality early learning programmes.[34, 35]

Table 24: The status of early learning in South Africa

Availability: *the supply of early education programmes, workforce and public funding.*
Early learning programmes
• 1.6 million children aged 3 – 5 attend 42,420 early learning programmes (ELPs).[12] • 69% of ELPS have fees as the main source of funding.[12] • 33% of ELPs receive government subsidy.[12]
Home
• No comprehensive data on enrolment in parenting support programmes. • 2023 UNICEF scoping study identified 97 organisations that offer parenting programmes (including parenting training, support groups, home visiting).[13] • Parenting programmes are concentrated in Gauteng (19), Western Cape (17) and KwaZulu-Natal (17) but at least two organisations are present in every province.
Accessibility: *provision to mitigate barriers to access and other exclusions.*
Early learning group programmes
• High socio-economic status (SES) children aged three are twice as likely to attend an ELP than low SES children.[14] • The vast majority of ELPs rely on income from parent fees which is a key determinant of early learning classroom quality[15] and child learning outcomes.[11] • In 2014, the majority of registered ECD centres did not have programmes to support children with disabilities.[16] In 2016/2017, children with disabilities accounted for .003% of the total enrolment in registered ECD centres.[17] In 2021, principals identified less than 1% of children as having possible learning barriers.[18] • 27% of ELPs had nothing in place to improve access for children with disabilities (e.g. ramps, suitable toilets, sufficient light for the visually impaired).[18]
Home
• 27% of caregivers were too busy to play with their child when they wanted to play.[19] • 43% of households reported having no children's books in the home.[19] • 71% of children (0 – 6) regularly watched TV or videos on a phone.[19]
Acceptability: *standards and quality of programmes including play-based learning and child centred learning approaches, parent understandings of the importance of ECE.*
Early learning programmes
• 52% of ELP practitioners have National Qualification Framework (NQF) qualifications and 28% attended an early learning skills programme.[12] • Only 56% of ELPs have access to age-appropriate children's books.[12] • 34% of ELPs do not have access to an outdoor playground with suitable equipment.[12] • 42% of practitioners have less than five years' experience.[15] • 60% of practitioners have a daily lesson or plan to guide the learning programme.[15]
Home
• 59% of caregivers report that a young child has been played with many times in the prior week with a strong focus on singing (65%) and active/physical play (64%) rather than cognitive activities.[19] • 36% of households report never reading books or telling stories with their child.[19]
Adaptability: *the ability of the ECE system to respond, adapt and be inclusive of the different needs of children such as children from different cultures and languages, children with disabilities, and children from difficult circumstances (abuse and neglect) and to embrace new technologies and delivery strategies to enable children's right to education.*

• Recent qualitative data suggests that most ELPs are not adaptive to individual children's needs.[20]
• New technologies have expanded opportunities to access information about early learning:
  • 127,160 ECD practitioners have completed the DBE online PLAYSA course to promote learning through play.[21]
  • There are over 6,000 active users on ECDmobi – a low-cost app developed by DBE and UNICEF to support parents and caregivers of young children to facilitate learning through play in the home.[21]

Play and opportunities for agency

Play and opportunities for children to exercise their agency are essential ingredients of quality early learning and need to be actively fostered within the home and more structured early learning programmes. "Factory" models of education, with an emphasis on didactic or rote instruction and memorisation, are still prevalent in education systems in much of the world, including early learning settings.[36]

However, play-based teaching and learning has become widely regarded as a more effective approach to early childhood education as it is more closely aligned with the developmental needs of young children. Young children thrive in a learning environment that allows them to explore and engage actively in hands-on activities, rather than sitting still for long periods and following a didactic teaching approach which frequently stifles curiosity.

Play is one of children's natural modes of expression and it allows them to explore, experiment, and discover the world around them in a meaningful and enjoyable manner. Much of the framing of the central role of play in children's learning and development comes from the extensive theorising of Vygotsky and Piaget, where play is recognised as crucial for children's cognitive, social, emotional, and physical development.[37, 38]

Piaget emphasized the idea that play is a primary vehicle for children to actively construct knowledge, develop cognitive abilities, and understand the world around them. He identified two main types of play: symbolic play, where children engage in pretend scenarios that foster imagination and representation; and games with rules, which promote social interaction, cooperation, and the internalisation of norms. Through play, children assimilate new information, adapt their understanding, and develop problem-solving skills. Piaget's work highlighted play as a vital component of cognitive and social development in early childhood.

Vygotsky highlights that play is a vital factor in facilitating optimal learning and development in children. Through play, children engage in self-directed challenges which maximises their learning potential. Play also fosters the development of symbolic representation and language skills, which are essential for cognitive growth. By actively participating in play, children co-construct knowledge, enhance problem-solving abilities, and cultivate self-regulation skills, contributing to holistic learning and development. Vygotsky's theory also highlights the socio-cultural aspects of learning, which is important when bridging the divide between the home and early learning environments.

Learning through play takes place when a play activity is occurring that engages the characteristics of play that are also known to lead to learning. A model proposed by Zosh,[35] summarised five characteristics of learning through play where play is meaningful, iterative, socially interactive, actively engaging and joyful. This model draws on an extensive review of research on the science of learning.[36]

Learning through play also promotes children's agency. Agency involves children's initiation and direction of activities but also incorporates an element of power – children have permission to engage and direct their own play in a learning environment. Agency is crucial in early learning as it empowers children to play an active role in their education. By fostering autonomy, choice, and decision-making, child agency promotes engagement, motivation, and a sense of ownership over learning. It cultivates independence, critical thinking, and problem-solving skills. However it should be noted that not all play necessarily promotes child agency. Practitioners and parents need to be mindful of setting up learning through play experiences that open up, rather than shut down opportunities for agency.

Supporting learning through play at home

As already emphasised, parents and primary caregivers play a central role in young children's early learning and development. As their child's first and most important teachers, they provide the conditions for a nurturing and supportive environment or conversely an environment that lacks the key features for learning to occur optimally. They play an essential role in promoting cognitive, social, emotional, and physical development through responsive interactions, meaningful communication and stimulating experiences. By engaging in activities such as play, shared picture book reading and reciprocal interactions, parents contribute to children's language acquisition, curiosity and overall readiness for learning.[39] The bond and attachment between parents and their young children create a secure base for exploration and lay the groundwork for future academic success and well-being.[40]

Consider three scenarios that characterise the caregiver-child relationship and home environment:

- **Optimal** – characterised by love, responsive caregiving,[iii] ample developmentally appropriate opportunities for learning, including play and shared attention activities such as picture book reading, serve and return interactions,[iv] and a rich home language environment.
- **Basic** – love, care, other basic needs are met, but responsive caregiving, learning opportunities, and parent/caregiver

iii Responsive caregiving = consistently and sensitively meeting a child's needs and cues in a timely manner.
iv Serve-and-return interactions = back-and-forth exchanges between a child and a caregiver that creates an interactive learning environment.

Box 3: Playful Parenting and Early Learning – examples of innovative practice in South Africa

Nicholas Dowdall[i] with inputs from Hope Worldwide SA, Takalani Sesame & Mikhulu Trust

We know from decades of research that normal, everyday parent-child interactions shape a child's life trajectory. From the earliest moments, these engagements start building neural pathways, shape social-emotional competencies through sensitive and responsive caregiving, and ultimately impact on a child's academic achievement into adolescence and beyond.

However, not all parents appreciate this central role that they play as their child's first teacher, social navigator and bedrock of emotional wellbeing. Too often parents assume that learning and education only happen in preschool, rather than being something that is cultivated first and foremost at home.

Often what is needed is a slight reframing of how parents understand the everyday interactions they have with their young children to help them recognise how play connects to the science of learning.

A sensitive and joyful parent is a crucial part of early learning. Every interaction, no matter how mundane, has a learning opportunity embedded within it. Many of the most valuable of these interactions occur in the context of play including games of hide and seek, singing and dancing, or looking at a picture book together. How we reinforce and amplify these learning opportunities is crucial. This case study highlights three different examples of playful parenting interventions from South Africa. While all are unique in their approach, they share a common orientation of building on what parents inherently know and do, with an emphasis on promoting responsive, joyful engagement.

Caregiver Learning Through Play – Hope Worldwide

The Caregiver Learning through Play (CLTP) programme is delivered through a collaborative effort between four National NGOs (HOPE Worldwide SA, Save the Children SA, Ntataise and the Early Learning Resource Unit) and is funded by the LEGO Foundation. It is a grassroots-level intervention based on the understanding that children learn best through play and that caregivers have a strong, natural care and learning disposition that can be built on. It is designed for under-resourced settings, especially where children do not have access to formal early learning opportunities.

CLTP directly educates families and caregivers on the importance of responsive care and strong caregiver-child relationships, and how they can impact on their child's cognitive, social, and emotional development through the power of play in the home environment. For example, by:

- Finding opportunities for learning through play during everyday house chores, such as sorting laundry (colour identification);
- Allowing children to help with preparing meals in a positive and fun way (e.g. helping to count and measure ingredients whilst singing a song;
- Telling children stories about themselves and their family (e.g. why you decided to name them as you did).

To date, the evidence-based curriculum – delivered through a four-session, face-to-face, group-based, facilitated approach to caregivers and young children (0 – 6 years) – has trained over 141,000 caregivers and over 5,000 ECD practitioners.

Initial assessments have shown positive results in the knowledge, attitudes and practices of caregivers around the importance of play. Specifically, there has been an increase in knowledge of play and its role in child development, more positive attitudes towards play, and an increase in play-based activities with children. Encouragingly, the programme has also shown a reduction in stress and depression levels among participating caregivers.

Play to Learn – Sesame Workshop South Africa

Play to Learn is a five-year, multi-media initiative that aims to increase capacity for learning through play among parents of ECD-age children, teachers in ECD centres, educational leaders, and social workers serving ECD-age children. Specifically, it aims to increase the capacity of these key figures in young children's lives to integrate playful learning into their everyday interactions in the home, classroom, and community centres.

The initiative is funded by the LEGO Foundation and implemented in selected districts across Gauteng, Eastern Cape, and Free State. This direct programming in communities runs in parallel with broadcasting of the Takalani Sesame TV show, which also highlights learning through play for young viewers and their families.

The intervention runs a series of 12 weekly workshops taking place in different locations across the respective

i The LEGO Foundation

provinces. Play workshops are community events that bring together caregivers and children to participate in pre-designed play activities and discover the benefits of learning through play. The workshops aim to support caregivers to experience play with their children, to learn about the benefits of play and to empower them with quick, easy, achievable tips on how to create meaningful play experiences as part of everyday life. The play workshops are facilitated by Sesame Workshop trained play facilitators.

Key messages include:

- Play helps children learn new words to help them succeed at school;
- There is no cost to play, you have everything you need;
- Play teaches sharing, caring, and respecting others.

Take-home materials, specifically textless storybooks, supported the increase in time spent by caregivers reading and telling stories with their children. WhatsApp groups were used as a bridge between facilitators and participants to drive and support the continuous implementation of playful learning at home.

From 2018 – 2023 the programme had a cumulative direct reach of 137,794 children and 5,500 caregivers, while the TV show has reached well over 4 million families.

Picture Book-Sharing – Mikhulu Trust

Mikhulu Trust (MT) is an early childhood development organisation that focuses on developing support systems for parents of young children. MT supports parents to develop nurturing and stimulating relationships with their young children by providing them with useful tools to spend quality time with their children. "Dialogic book-sharing" is one of these tools. Parents attend 4 – 8 sessions with a trained facilitator where they learn how to use wordless picture books to have engaging interactions with their children from age 10 months up to 5 years. Key messages to guide interactions include:

- Follow the interests of the child;
- Point and name what you see in the pictures;
- Ask lots of questions (what | where | why | how | who);
- Use the pictures to talk about emotions, intentions and perspectives.

Parents are encouraged to follow children's interests, ask stimulating questions and praise children's contributions during the activity. Through these skills, book-sharing fosters reciprocal, fun, interactive and engaging communication between parents and their young children.

The book-sharing programme has been evaluated in several randomised controlled trials, two of which took place in Khayelitsha, Cape Town. Through these studies, it was shown that children's cognitive and socio-emotional development benefitted immensely from this activity. Impressively, though, it was also found that parents' behaviours with their children changed – after being trained in the book-sharing programme, parents were more reciprocal in their engagements and communication, and were more responsive and sensitive to their children's needs.

Since 2018, MT has trained and supported 35 partner organisations across civil society and government to incorporate book sharing training into their programming. They have trained over 200 librarians, 650 community health workers and reached over 35,000 families with the programme.

At its core, playful parenting is about helping parents have joyful interactions with their children, but in addition to having fun, it is important to see changes in both parents' behaviours and children's outcomes, and book-sharing has been shown to positively benefit both of these. A good picture book can function as a stimulus for rich discussion – the pictures can be interpreted without the instructions or restrictions given by a written narrative. Often in shared reading, a caregiver and child will construct the story together, and then deconstruct it and reconstruct it in a different way. There are also no hard and fast rules like reading the pages in a specific order, the child is encouraged to use their agency and explore their own interests.

knowledge and awareness of child development are lacking as they see their role as providing care and not stimulating learning. However, there is no 'neutral' approach to parenting, and not engaging in certain types of interactions can have a negative impact on child development.

- **Harmful** – exposure to harsh and punitive parenting interactions, toxic stress,[v] violence (physical or verbal abuse), no stimulation (neglect), and no love. Such environments can have seriously adverse impacts on child wellbeing and development and are substantially worse than the 'basic' scenario described above.

These scenarios should help to frame what we know about caregiver-child interactions and home learning environments in South Africa at present.

v Toxic stress = prolonged and severe adversity that can negatively impact a child's brain development, emotional well-being and overall health.

Characteristics of home learning environments in South Africa

General Household Survey (GHS) data offer nationally representative insights into home learning environments. 2018 was the last time that a set of questions were administered to assess the frequency of storytelling, book reading, drawing, naming objects, counting, and discussing activities with a child within the household. The findings reveal that almost half of children younger than four years never engaged in reading books (47%) or drawing activities (43%) with a parent or caregiver, while approximately a third of children were never engaged in storytelling or just talking about things done with the child. Taken together, this paints a picture of many young children deprived of rich language experiences, which are critically important for holistic development, school readiness and future academic success.[41] It is therefore essential that South Africa resumes regular collection of nationally representative indicators on the home learning environment through existing population-level surveys like the GHS.

Some recent South African studies have sought to identify the links between the home learning environment and holistic child development outcomes using tools like the Early Learning Outcomes Measure (ELOM).[42] The Early Learning Programme Outcomes study,[43] while not nationally representative, echoed many of the concerning findings from the GHS about a lack of learning and play resources in the home and limited engagement in cognitive stimulation (shared reading, telling stories, singing) between caregivers and children. However, on a more positive note, more than 90% of caregivers reported playing, naming and counting things regularly with their children. This related to child learning outcomes on the ELOM as follows: children with greater learning resources (books and toys) at home demonstrated significantly higher performance on fine motor, cognition and executive function assessments. This positive effect stems from the presence of a greater number of books and a diverse array of toys, including store-bought, homemade, and everyday objects repurposed as toys (e.g., sticks and pans).[43]

Most recently, a larger scale study by UNICEF and the DBE,[44] revealed a mix of encouraging and concerning parenting practices. The study focussed on caregiver knowledge, attitudes and practices in relation to play-based learning in children from birth to 6-years old and included responses from 1,422 participants across South Africa's nine provinces. Considering the 2021 Progress in International Reading Literacy Study results which indicated that only 19% of Grade 4 learners could read for meaning in any language,[45] a spotlight on shared reading practices in the home revealed that 42% of households had zero access to books in the home, and while 58% had at least some books, only 32% used them regularly with their children. Encouragingly, 92% of respondents believed that it is important to play with their children, but there was limited knowledge about the link between play and optimal early learning. Parents and caregivers' attitudes suggested that they largely believe that learning happens at preschool or creche, and that teaching is the responsibility of teachers rather than parents. Also concerning, was the apparent disappearance of playing traditional/indigenous games, with only 29% of caregivers reporting playing these games with their children.

Given the critical importance of early learning experiences in the home, greater investment is needed in parenting support programmes to provide caregivers and families with the tools, knowledge, skills and support they need to create a rich and supportive learning environment in the home.

Teaching and learning through play in early learning programmes

In traditional classrooms, teachers often prioritise "known answer" or quiz questions.[46] But, in group early learning programmes it is important to carve out designated time for activities such as free play or drawing that allow children to exercise agency and encourage them to ask questions. Facilitators can help promote individual inquiry and agency through play by providing children with choices in both the activities they wish to carry out and how they wish to engage in the activities. This includes rule creation, and choice about who they want to engage with. Evidence from a nationally representative study in Columbia showed that these kinds of dimensions of process quality (opportunities for child choice, creative thinking, learning connected to prior experiences) were the strongest predictors of child development across all domains.[28]

Despite the National Curriculum Framework being anchored in a play-based pedagogical approach, the ECD Census[12] demonstrated that minimal time is allocated to free play in early learning programmes, with 54% of programmes offering less than 30 minutes for free play as part of their daily programme. In addition, there was a clear socioeconomic gradient with more affluent programmes incorporating more time for free play. While research indicates that even relatively short amounts of free play per day significantly improved children's self-regulation capacities,[47] guidelines and policies often encourage up to 2 – 3 hours of indoor free play,[48] depending on the length of the school day. Similarly, findings from the ECD Census suggested that practitioners tend to privilege their own agency or autonomy as a teacher over the agency of the

Box 4: What child capabilities are strongly associated with readiness for school?

- Executive functioning (EF) capacities underpin success in school[51] but are insufficient without exposure to academic content and skills to foster preacademic skills.[52] EF includes: holding information or instructions in mind during playroom activities; focusing on task-relevant stimuli during problem solving tasks and resisting internal or external distractions; and the cognitive flexibility to adapt and think about things in a variety of different ways.
- Early mathematics skills (such as counting, number knowledge, estimation, and measurement) are the strongest predictors of later overall academic achievement.[53-55]
- Emergent early childhood literacy skills are strong predictors of later literacy achievement and include: a large vocabulary; being capable of explanatory talk; demonstrating some letter identification before age five; understanding narrative and story; understanding writing functions; knowing nursery rhymes; and demonstrating phonological awareness.[56, 57] Vocabulary and oral language strongly predict later reading comprehension.[58-60]
- Social and emotional competence and self-regulation are important for school readiness and social success.[61-63] These include: self-awareness; self-management; social awareness; relationship skills; and responsible decision-making.[64] Prosocial behaviours enable positive peer and teacher relationships (e.g. helping, sharing, taking turns) and self-regulation skills support the inhibitory control of aggression.[61, 65]

The Thrive by Five study[5] found that 41% of 4 – 5-year-olds in South Africa were on track for cognitive and executive functioning, 55% for language and literacy skills, and 34% for numeracy and mathematics. There is a notable socio-economic gradient in learning outcomes, with a greater proportion of children from higher-income quintiles being on-track for learning outcomes. Children fared better on social and emotional functioning with 82% on track for social relations and 77% emotionally ready for school.

children in their care. This included items relating to children's choice of play and learning activities, and their ability to explore subject matter and answer questions themselves rather than being given the answers by practitioners. This pattern was consistent across all income groups. Some recent analyses from South Africa speak to the importance of practitioners providing opportunities for child choice and agency in their own learning. The positive deviance study by Data Drive 2030 found that teaching strategies (including allowing children to choose materials for engagement, levels of practitioner engagement during play, child participation, and use of open-ended questions to create opportunities for autonomy) were associated with high performance on ELOM assessments.[49] Similarly, the Deep Dive Study found that practitioner support for child agency was associated with a higher likelihood of children being on-track for early learning based on composite ELOM scores.[20] Finally, an analysis of the Thrive by Five data showed that the use of open ended play materials and teaching strategies that included free choice were associated with higher child executive function scores.[50]

Enablers of quality early learning programmes

There is growing evidence of how teacher-child interactions that enable learning in the playroom are affected by conditions at the early learning programme as a whole. Good management has been shown to affect programme quality in South African quality studies.[15, 66] Good leadership leads to financial sustainability that enables more secure working conditions and a resourced environment, oversight of the learning programme and motivated staff.[67-72] Training and education of teachers affects the quality of services and child outcomes primarily through the knowledge, skills and competencies that they can employ to guide children's learning. The main importance of staff lies in their effect on the process and content quality of early education (their ability to convey the curriculum).[73] Practitioners need to organise the programme and apply activities and strategies to facilitate the desired outcomes. A well-trained, motivated, and supported workforce is therefore key to quality implementation of the learning programme as this depends directly on practitioner knowledge, attitudes, and skills.[74, 75] This requires initial training[76] and continuing professional development (CPD) of which infield support and monitoring is a critical component[76].

As noted, the home learning and care environment has a significant impact on child development both as the first source of early learning support for children and to complement more structured early learning programmes. Good quality early learning programmes actively engage with parents/caregivers,

support their educational role, and advise on good health and nutrition practices. They also facilitate and link parents and caregivers to additional services that are of benefit to the child, such as social grants, developmental screening and health care. Figure 13 represents the pathways through which these factors influence child outcomes.

A supportive ecosystem

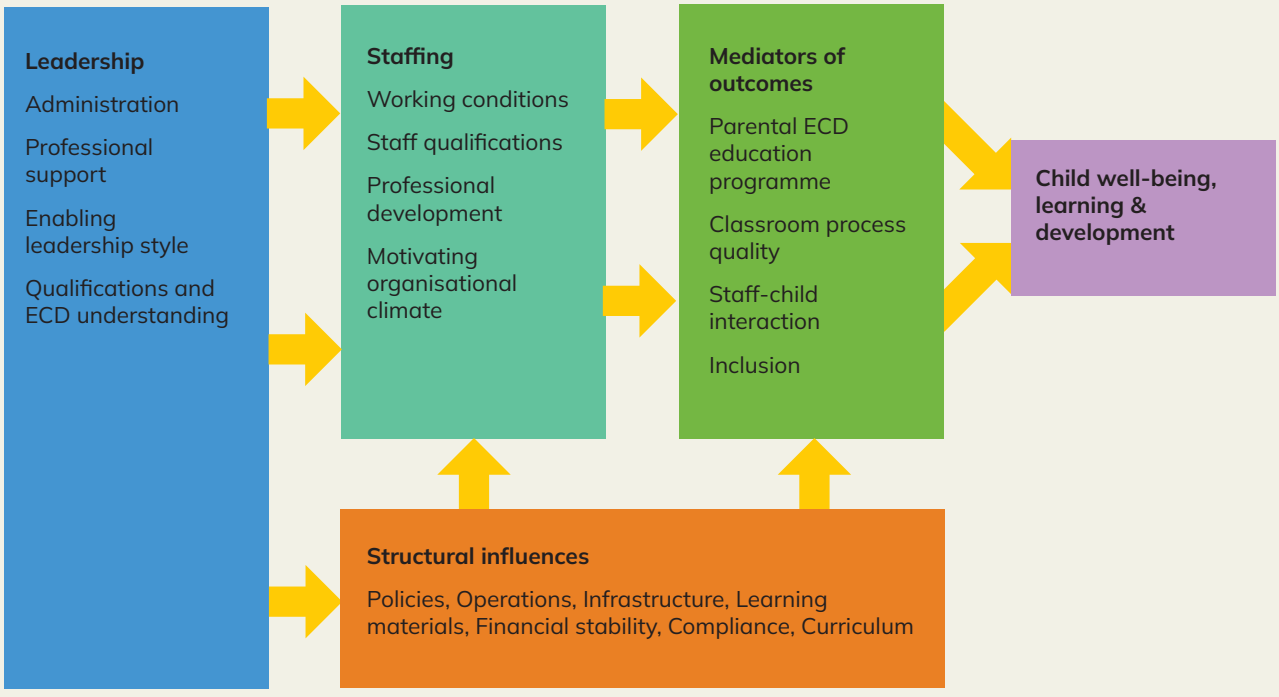
In addition, there is strong evidence that the broader supportive ecosystem can enhance the quality of early learning programmes. The DBE Deep Dive Study[20] and DataDrive 2030 Positive Deviance[vi] Initiative[49] investigated enablers of better quality programmes and outcomes, seeking levers for improvement. Both studies have identified key characteristics and practices of successful programmes and highlighted the importance of a supportive ecosystem including:

- Warm relationships between practitioners and children;
- Learning programmes allowing for free and structured play, as well as independent problem solving and adaptation to individual needs;
- Local and indigenous content integrated into the programme to support home to school transition and diversity;
- A strong focus on continuing professional development through internal support and mentoring;
- Teaching staff and principals planning together;
- Access to external workshops and courses when available;
- High performing sites engage parents and share information on learning activities;
- Strong leadership and teamwork, good administration and community linkages for external support including NGOs, government, business and ECD forums.

An inclusive approach

How early learning programmes adapt to – and accommodate – diverse needs is a critical aspect of quality programming. An inclusive approach when *"all children are actively welcomed and supported so that they can optimally participate and benefit from early learning and development opportunities... to enable them to participate on an equal level with others"*[2] is a significant and widely used indicator of quality programming.[77] While inclusion is most often associated with children with disabilities and developmental delays, it also covers the child's financial, social, and household circumstances, language, culture, and gender barriers to equal participation in early learning services.[78]

Figure 13: Predictors of group learning programmes associated with child learning outcomes



Adapted from: Douglass AL. *Leadership for Quality Early Childhood Education and Care. OECD Education Working Papers, No. 211.* Paris: OECD Publishing. 2019.

vi Positive deviance refers to children who showed exceptional development compared to their peers, despite similar circumstances.

An inclusive approach requires programming that is sensitive to diversity and that pays attention to individual children's needs rather than teaching to the level of the group.[20] Children with disabilities and developmental delays require early identification and intervention and may require individualised support. However, very few children with disabilities are enrolled in early learning programmes or receive an appropriate educational intervention. While many providers report that they accept children with mild to moderate disabilities, knowledge of how to identify disability and adequate programme support for children who are enrolled is lacking, and parents are often reluctant to enrol their children.[20, 72, 79] This is despite the fact that children with disabilities are a priority target group for ECD services specified in the NIECD Policy and the Children's Act 38 of 2005 and their enrolment in early learning services is an annual performance indicator. The Deep Dive study[20] has found that identification and referral of children with developmental delay and disability are limited. Study respondents stressed the need for DBE inclusion teams to take on a supportive and resourcing role to enable early learning providers to provide adequate identification and support.[20] Other aspects of inclusive practice involve programming that is gender responsive and supportive of different languages. DBE has developed a guide and training to gender responsive programming.[80] The extent of the language challenge was indicated in 2021 when 58.8% of early learning programmes used a language of learning and teaching the same as children's home language and a third have different home languages in the classroom.[80] Limited guidance on how to manage multilingual environments where English is the *lingua franca* makes it difficult to implement additive multilingualism, and parents often demand English language instruction as they believe it will advantage their children.

What can be done to enhance the quality of learning?

A range of interventions are needed to enhance the quality of learning at home and in more structured early learning programmes. This includes the professionalisation of early learning practitioners, strengthening quality assurance and support systems, and the central role of resource and training organisations and technology to scale up support for early learning.

Supporting professionalisation

The capacity of the teaching workforce is the most critical element in the delivery of quality early learning programmes and improving teacher competencies is an urgent priority. In 2017 the Department of Higher Education and Training finalised policy on requirements for the development of higher qualifications in early childhood care and education.[81] Since the shift in ECD function from DSD to DBE in April 2022, the DBE has shown an interest in professionalising the ECD workforce. The South African Council for Educators (SACE) has in place a set of teaching standards, and a system of CPD credit requirements which can contribute to the upskilling and continuing improvement of the workforce. However, SACE guidelines for professional teaching standards do not include the birth-to-four age group. As part of their Learning through Play initiative, the VVOB supported by DBE and the LEGO Foundation has commissioned a consortium known as the Funda Udlale Nathi (FUN) ECD professional standards team[82] to support the professionalisation of early learning practitioners by developing:

- ECD specific professional teaching standards;
- a suggested professional pathway for early learning practitioners; and
- recommended guidelines for providers on the development of early learning training programmes.[83]

The Occupational / Technical, Vocation, Education and Training qualification sub-frameworks need to align and articulate with professional qualifications frameworks in order to provide an accessible and inclusive professional learning pathway. The FUN ECD Professional Standards team has therefore adopted a systemic approach to professional development for educators of young children from birth to nine years old from preservice training to CPD, with a continuum of qualifications and different entry and exit points that will enable access and support progression along a professional learning pathway. The team will also evaluate and align SACE guidelines for providers to support flexible, quality provision.

Another promising training initiative is the development of the Higher Occupational Certificate: Early Child Development Centre Manager (National Qualification Framework Level 5). Once registered this should help principals with the leadership and management skills required to create an enabling environment for quality learning and teaching.

Quality Assurance and Support System

The NIECD Policy recognises that registration of ECD centres is not a sufficient condition to guarantee the quality of early learning programmes and therefore requires a quality assurance system to drive good child outcomes. This requires the development of an ECD quality control and improvement system including registration support, training, coaching and mentoring, monitoring, oversight and quality assurance for early learning programmes. The DBE, in partnership with Ilifa

Case 6: *Mazi Umntanakho* – A digital tool to support social emotional development and mental health

Catherine E Draper

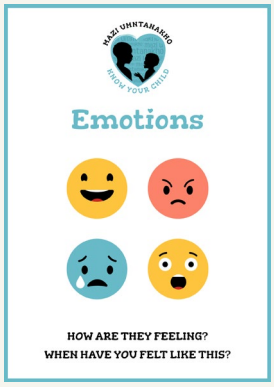
Young children in South Africa face numerous threats to their mental health, both in their home and community environments, and social emotional development remains a relatively unaddressed component of early childhood development. It is essential that investments into these aspects of children's well-being start as early as possible. Yet there is a serious lack of accessible services for children with developmental challenges. In this context, digital platforms have the potential to reach and support children in vulnerable settings.

The Mazi Umntanakho (Know your child) project aimed to respond to these challenges and brought together a multi-disciplinary team of local and technical experts from the University of the Witwatersrand, the University of California in Irvine and Riverside, and Chapman University in California to work in partnership with community-based organisations in the Western Cape and KwaZulu-Natal.

Together they designed and piloted a digital tool to help community-based workers assess the social emotional development and mental health of young children in vulnerable South African settings and to provide feedback and contextually relevant resources for caregivers of young children.

The *Mazi Umntanakho* tool is a WhatsApp chatbot. It is currently available in in English, isiXhosa, isiZulu, and Afrikaans, with plans to make it available in Sepedi, Sesotho, Setswana, Tshivenda, and Xitsonga. The chatbot guides a community-based worker through two sets of questions. Firstly, the child's caregiver is asked about the child's mental health, using adapted questions from the Strengths and Difficulties questionnaire. Secondly, questions from the social emotional subsection of the International Development and Early Learning Assessment are asked of the child. Feedback on the assessment results and some additional information are then provided in the chatbot, using a simple traffic light system: green for no concerns, orange for some concerns, and red for many concerns. Caregivers can then choose to receive resources on self-awareness, emotions, social skills, difficult behaviour, and healthy habits and routines. These resources are available in a variety of formats including pamphlets, infographics, videos, and voice notes, and caregivers can choose to receive as many resources as they would like.

Electronic versions of all resources are available on request to catherine.draper@wits.ac.za



Labantwana, has developed and consulted on a draft Quality Assurance and Support System (QASS), which is aligned with existing policy and practices, and draws on local and international quality assurance and support systems.[84] This includes draft indicators for group programmes (playgroups, ECD centres etc) at three levels (beginning, establishing, and good) and across six domains: learning programme, management and leadership, parent and community involvement, nutrition, health and safety, inclusiveness and staffing. These were based on extensive research and sector consultation. Key principles for the assessment process include self-evaluation by programme staff and a developmental approach rather than one which penalises non-compliance. The QASS proposes that government focus its resources on supporting early learning programmes not meeting the minimum level of quality provided that they meet conditional partial care registration requirements (bronze level). Further development of the system will be undertaken through a long-term testing process. Once established QASS will not only encourage early learning programmes to improve their quality,

Case 7: Finding Thabo – for Cognition, Executive Functioning, Maths and Literacy

Andrew Rudge[i]

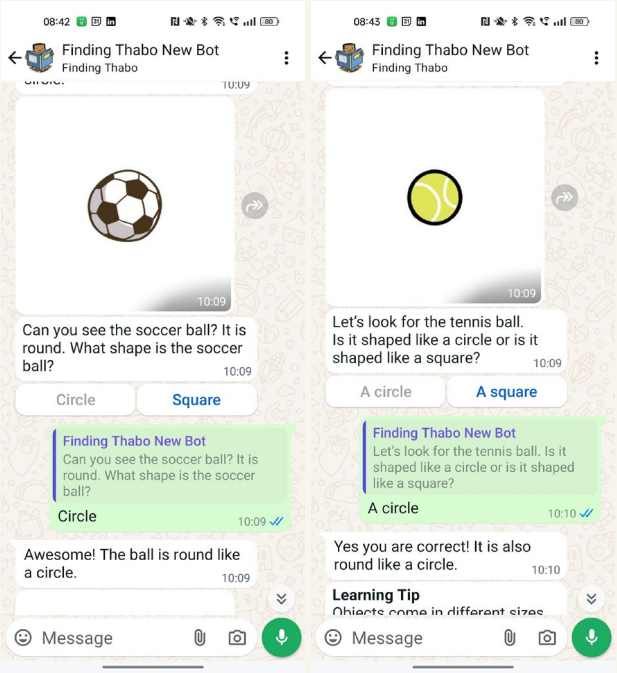
Finding Thabo is an innovative stimulation game for young children, utilising a mix of physical pictures and technology. The programme places the child at the centre of the intervention, but interestingly the child does not use the technology. Instead the child engages with a physical picture, similar to a "Where's Wally?" book, while the caregiver (parent or teacher) receives prompts and ideas via WhatsApp. This is an intentional design, seeking to improve responsive caregiving, by including the adult and empowering them to engage more effectively with the child. The result is a play-based game that provides direct stimulation of the child while encouraging behaviour change in the adult.

The programme was developed by The Reach Trust (a technology for good organisation) with input from Dr Ingrid Alhert and her team of occupational, and speech and language therapists at The Learning Initiative. The activities cover all the early learning development areas but place a special emphasis on developing executive function, literacy and mathematical skills.

Dr Alhert and her team have specifically focussed on typical learning difficulties that have been identified in studies such as the Thrive by Five report.

There are ten pictures in the series, each building on the previous picture using a scaffolding process. The core idea is to ensure that children receive high quality, play-based stimulation even in low resource settings.

Through a partnership with a leading local retailer, the pictures have been distributed to more than 100,000 children over the past three years. Over 3,000 ECD practitioners have been trained to use Finding Thabo in the classroom and in June 2023 a new app was launched to help practitioners to assess children using the Finding Thabo game.



i The Reach Trust

it will also enable parents to identify and choose a quality early learning programme.

Use of resource and training organisations for training and enrichment of parents, practitioners and programmes

Quality assessment will help identify clear areas for improvement and based on this, specific resources for training and support of the ECD programme should be recommended. Local ECD resource and training organisations (RTOs) are well placed to provide this kind of support as provincial departments lack expertise and human resource capacity. A recent survey of 79 RTOs[85] found that the that the majority of providers are focusing on curriculum-related issues (including play and literacy), management and parenting support. These are key domains identified in the draft QASS framework.

An effective model for using local RTOs to provide support has been in effect in the Western Cape where they have been engaged as service providers to support the registration of ECD programmes and services. Similarly, NGOs are providing parenting programming in all provinces at varying degrees

Case 8: Careup – Supporting Foundational Literacy

Andrew Rudge[i]

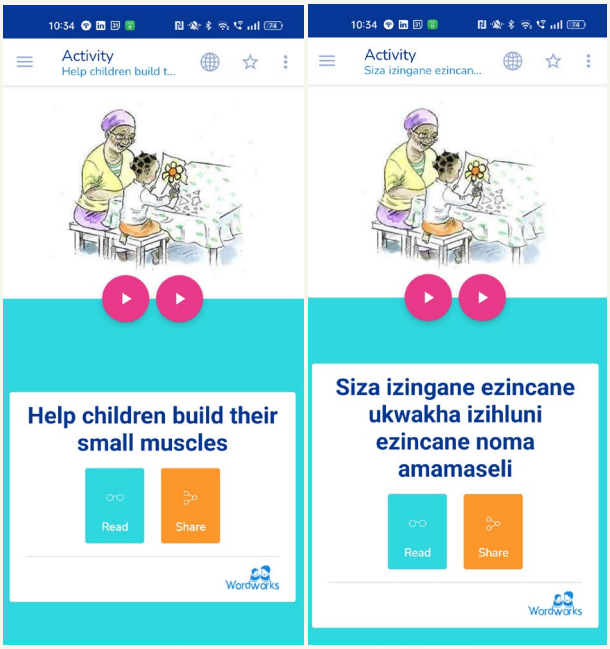
CareUp is a free parent focused application, designed to help lay literacy foundations in 3 – 5-year-olds. The app was developed with funding from Innovation Edge and the Western Cape Department of Social Development, and incorporates content from partner organisations including WordWorks, The Learning Initiative, Nal'ibali and Bookdash.

One of the key design principles was to ensure that the content is accessible to caregivers with low literacy (by using audio and images to minimise the amount of reading required) and in multiple languages (Afrikaans, English, isiXhosa and isiZulu). The user can simply toggle between languages, by pressing the world button.

Another key factor was cost of access. Once downloaded, the app runs completely offline, meaning that there is no cost to the user, and Wi-Fi hotspots were created at the parent workshops to enable them to download the app for free.

The CareUp app was independently evaluated and showed promising results in terms of engagement and retention. An unexpected finding was that ECD practitioners who used the app showed improved teaching practice. A website version is also available at https://careup.mobi/.

The website does require data to access, but is zero rated by the major cellphone networks. Since launch in 2016 the CareUp service (both app and website) has been accessed by more than 15,000 parents.



i The Reach Trust

of scale. We know that there are at least 97 organisations carrying out this essential work, but this effort would benefit substantially from some kind of central coordinating mechanism and agenda driven by government.[19] The mandate for parent support does not currently sit squarely with any single line department, but it is crucial that a department, possibly the DBE in light of the function shift, take ownership of leading, coordinating and advocating for the importance of parenting support programmes and early learning in the home.

Using technology to scale up support

Digital resources have potential to support the scale up training for quality improvement and support. There are a wide range of digital products from online training programmes to daily activity ideas. The COVID-19 pandemic pushed many organisations that had previously conducted programming in-person to pivot to digital or hybrid approaches. These include a number of digital support platforms and apps[vii] that quality support workers could deploy. For example, PlaySA is a free and zero-rated platform developed by Cotlands with the LEGO Foundation, UNICEF and DBE. It has been available since 2017. The courses are designed for anyone who implements programmes for babies and young children in South Africa (e.g. practitioners, teachers, childminders, day mothers, playgroup facilitators). PlaySA reports that they have trained over 289,000 educators across South Africa on play-based learning, 44% of whom are early learning practitioners.[21] The course sessions include videos, images, reading, tasks, evaluation and reflection activities and are registered with SACE. Other innovative examples of digital support for parents and practitioners include Care up, Finding Thabo and Mazi Umntanakho (cases 6 – 8).

There are, however, challenges with using digital resources. Most households do not have access to computers with which to access online content. While 89.4% of households exclusively use cellular phones[6] and smartphone use is increasing, costs of data remain amongst the highest in the world. So, it is important to either have the service zero-rated

vii Such as ECD Link, the Grow App, ECDMobi, ECD Connect, the Global Parenting Initiative suite of tools (ParentApp, ParentText, ParentChat), the True North Pre-School Registration Colour Guide App, the Ulwazi App, and the Impande WhatsApp Bot.

by the network providers, or to create applications that can run in offline mode. While the number of smartphones is increasing most tend to be low spec, with low processing power and small amounts of storage available. This presents a problem when trying to encourage the downloading of applications. Reaching people through apps like WhatsApp or Facebook is often more effective. More serious challenges are that targeted users may not see early education as important or find it difficult to put key messages and activities into practice. Take up of digital apps remains low.[86]

Conclusion

While the availability of early learning and parenting programmes has greatly increased in the last decade, accessibility for low-income children and those with disabilities remains a challenge requiring greater subsidisation and programme support for these priority beneficiaries. The primary challenge is to improve the acceptability or *quality* of early learning. This would entail strengthening both practitioner and parent understandings of learning through play, being more responsive to local contexts and the aspirations of parents, and providing access to appropriate training, support and teaching and learning resources. It is also clear that improving quality requires a multifaceted approach including strengthening the broader ecosystem of support for early learning programmes. Adaptability can be enhanced by focusing on new technologies, flexible systems of professional support and greater awareness of and sensitivity to children, parents' and caregivers' diverse needs in order to provide an inclusive early learning system. But this will require knowledge generation, evidence-based testing of new approaches, and resourcing.

Child learning outcomes are influenced by multiple factors in the home, community and early learning programmes, and to improve them will require a multipronged and coordinated response. Addressing the systemic changes will take time but recent South African studies[20, 49] suggest some key levers for improvement and there are promising innovations and planned initiatives which build on this foundation including:

- A greater focus on including and supporting parents in their role as primary caregivers and first teachers and in accessing support for this role;
- Professional support for teaching staff with particular focus on play, interactions and inclusion;
- Training/support for managers of early learning programmes
- Plans for a developmental and incentivising QASS;
- Continuing support to enable compliance of early learning programmes including essential financial support to ensure sustainability and workforce retention;
- Regular collection of data to track progress – at child, household, community and programme level.

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All families need some support, but some families need all the support they can get: Achieving equity by providing extra care

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Most children in South Africa are *exposed* to high levels of adversity including poverty, violence and systemic discrimination on the grounds of their race, gender, ability, age as well as the long-lasting effects of colonialism and apartheid.[1] The 2015 National Integrated Early Childhood Development Policy (NIECD Policy) identifies equity as critical concern with children living in historically underserved rural and informal settlements experiencing the highest levels of deprivation.

Additional risk factors that compromise children's development include malnutrition, maternal depression, violence and neglect. These early exposures to adversity tend to be mutually reinforcing and have a cumulative impact that serves to widen inequalities over time. It is therefore most effective – and cost effective – to intervene early in life to reduce inequalities and optimise the development of young children. Investments in early childhood development have the potential to serve as a great equaliser helping to level the playing field and improve outcomes across the life course.

This chapter identifies a range of risk factors that pose a threat to young children's development and potential strategies to address these challenges. It then examines the multiple forms of adversity experienced by children in the South African setting and considers how best to provide a system of support that is better attuned and responsive to their needs in order to ensure that no child is left behind.

What are the potential risks to children's development?

Children move back and forth along a continuum from well-being to vulnerability in response to changing circumstances over time. For example, a sudden illness such as diarrhoea has an immediate impact on children's dietary intake causing their growth to falter, but with top-up feeds, they should be able to regain the weight they lost and rebuild their immunity so that they are better able to cope with future illnesses. But many young children in South Africa are exposed to persistent challenges that have a cumulative and adverse impact across multiple domains of health and development. These are often referred to as risk factors.

In relation to child development, the term 'risk factors' refers to biological, environmental, socio-cultural and psychosocial factors that can compromise outcomes across any of the developmental domains.[2] There is significant overlap between the major risk factors that influence whether a child survives, and how a child thrives. Risk exposure often starts before birth, and early risk exposure can have lasting effects on health and development across the life course. Exposure to stunting, extreme poverty and severe psychosocial deprivation, have been shown to compromise short and long-term child health and development outcomes.[2]

A single risk factor does not necessarily lead to developmental impairments; however, children exposed to one risk factor are at increased risk of exposure to others. Risks, particularly in adverse conditions, often co-occur and persist, with multiple risks having a cumulative impact as they interact and reinforce one another. Many of the same risks that compromise child health also place children at risk of poor developmental outcomes.

Cumulative risk exposure is usually more detrimental to children as it can result in adaptive physiological and stress responses which can have long-term effects on an individuals' health and wellbeing, and their ability to cope with stress throughout the life course.

Children do not grow up in isolation, nor in vacuums. Interactions (relationships and processes) between children and their environments can support, sustain or hinder child development. Applying an ecological framework helps us to understand how interactions between factors in a child's biology, immediate family/community environment, and broader

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society steers and shapes their development over time. It also recognises the bidirectional relationship between children and their environments and illustrates the various levels at which children's development can be influenced both positively and negatively.[3]

Young children grow and thrive in environments of responsive and secure relationships with their caregivers. Children who have secure relationships with their caregivers show more controlled stress hormone responses when they are upset or experience fear. In contrast, children who have insecure relationships with their caregivers display higher stress hormone levels even when experiencing mild fear. Thus, having safe, responsive caregiving environments can serve as an important buffer or mediator against elevated stress hormone levels and responses, even among children living in adverse conditions who are particularly vulnerable to stress-system activation.

It is therefore essential to identify key risk and protective factors at each level of the socio-ecological system to ensure that children and families receive the required support and intervention to protect them from harm and optimise their health and development.

Individual

Some risks factors are intrinsic to the child. For example, preterm infants and those born low birth weight are more vulnerable to infection, undernutrition, and developmental delay. It is equally important to intervene even earlier in the antenatal period, as maternal risk factors such as teen pregnancy, obesity, diabetes and maternal depression may compromise the health and nutritional status of the developing foetus, and the mother's capacity to care for her newborn child.

Family and home

Other risks play out within the context of the home and immediate family where children's living conditions (e.g. overcrowding or poor access to water and sanitation) may increase their risk of illness, or where their nutrition is compromised due to poverty and unemployment, or where domestic violence threatens their physical and psychological safety and increases the risk of abuse and/or neglect.

Community

These household dynamics are shaped by wider political and economic forces. Persistent spatial and racial inequalities rooted in the colonial and apartheid era continue to compromise the development of children living on farms, in informal settlements and in the former homelands which are characterised by widespread poverty and unemployment, and limited access to health care, early learning programmes and child protection services. And it is children in these communities and households who are most likely to experience multiple forms of adversity, exclusion, and deprivation.

How can we counter some of these risks?

Based on the current evidence base, the 2020 WHO Guidelines on Improving Early Childhood Development,[4] recommends the following key areas to intervene.

Promote responsive care and early learning

The guideline stipulates that all children should receive responsive care during the first three years of life and that parents and other caregivers should be supported to provide responsive care. Responsive care refers to care that is prompt, consistent, contingent, and appropriate to the child's cues, signals, behaviours and needs.[4] In doing so, parents create a stable, engaged and nurturing environment in which their children will develop, learn and thrive. Responsive caregiving has been shown to improve responsive feeding, stimulation and health care seeking behaviour with benefits for both parents (parental mental health) and children (cognitive, social, and language).[5, 6]

The second guideline recommendation is that all infants and children should have opportunities for stimulation and learning from birth with their parents and other caregivers during the first three years of life; and that parents and other caregivers should be supported to engage in this early learning with their infants and children. It goes further to recommend that support for responsive care and early learning should be included as part of interventions for optimal nutrition of infants and young children.

Support maternal mental health

The final recommendation is that psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services. Maternal depressive symptoms have an adverse effect on parenting and child health and development. However, if mothers are assisted with caregiving, and their mental health is treated, children are protected.[5]

Further to these recommendations, it is important to note that children growing up in poverty are more likely to be exposed to environmental risks, household stresses and violence, in addition to receiving suboptimal healthcare, nutrition, and education. Thus, additional interventions such as social protection (e.g. financial support) have the potential to

ameliorate the effects of the multiple risks that co-occur when children live in 'poor households' or 'poverty'. (Box 5).[5, 7]

What is the situation of children in South Africa?

In 2022, just over 70% of young children lived below the upper-bound poverty line.[11,12] These children are more likely to experience multiple forms of deprivation that further compromise their health and development, including overcrowding, inadequate water and sanitation, increased risk of illness and injury, and barriers to accessing quality healthcare. Many of these risk factors are a direct result of limited access to services in poor communities where children and families are in greatest need, and this 'inverse care law'[13] further entrenches inequities across domains of health, education, protection and wellbeing. For example, in 2016, almost half of the children in lower income quintiles did not attend any educational programme.[14] These inequities have their roots in colonial and apartheid era discriminatory policies which restricted employment and educational opportunities for generations of Black South Africans, giving rise to persistent racial and spatial disparities in socioeconomic status which have proved difficult to uproot.

While the poorest children are prioritized in national policy frameworks – such as the NIECD Policy, subsidisation of ECD centres, and the pro-poor Grade R funding formula – access to quality services remains a challenge for African children living in rural areas and informal settlements. Early learning programmes in the poorest communities in South Africa are frequently characterised by overcrowding, poor infrastructure and an informal, poorly paid and under-qualified workforce.[15]

Only half of three- to four-year-olds attending an early learning programme, attend programmes of sufficient quality to improve learning – with wide disparities in enrolment and attendance across provinces, and the most disadvantaged children in rural and poorer areas.[14] Many community-based ECD programmes in rural areas and informal settlements fail to meet the registration requirements for assimilation into the national ECD system, and this prevents them from accessing government funding, further disadvantaging children from those communities.[16]

Poverty in South Africa is also notably gendered, with half of female-headed households living below the upper bound poverty line.[17] Women's disproportionate responsibility for unpaid care work in the home and in society contributes substantially to these gender inequalities by restricting their participation in income generation activities. Once again, the NIECD Policy prioritizes support for caregivers, but in practice, there is limited state investment in adequate and affordable childcare,[18] which would enable women to engage in the labour market and improve their capacity to care for and support their children's development.

Children with disabilities face additional barriers in accessing services and are more likely to experience multiple forms of deprivation. The UNICEF report – Seen, Counted, Included – describes how children are more likely to be stunted or underweight, less likely to have had their birth registered; less likely to have received basic vaccinations; more likely to have poorer access to drinking water, basic sanitation and hygiene services; less likely to receive early stimulation and responsive care, less likely to receive adequate supervision; less likely to have access to books and toys; and more likely to be exposed to violent discipline at home.[19]

Historically, social services have focused attention on 'orphaned and vulnerable children', yet orphaning rates in South Africa have declined steadily following the introduction of antiretroviral treatment, and in 2022 just under 50,000 young children (0.5%) were double orphans (who had lost both their mother and father). Most orphans remain in the care of extended family the with poorest households carrying the greatest burden of care, but they are not necessarily more at risk than other children living in poverty.

Even fewer young children (0.05%) are estimated to live in child-only households. These are often temporary arrangements and most of these children have a parent living elsewhere. While the numbers may be relatively small (under 3,000 children), these children are concentrated in the poorest households and in the absence of adult care and protection they may struggle to access services and be especially vulnerable.[20]

Strict conditions for granting nationality mean that many children are undocumented or remain without birth registration for long periods of time. Access to documentation such as birth certificates is a challenge for children of both South African and migrant parents and can compromise their access to a range of services. For example, the majority of formal ECD centres require a birth certificate for registration since centres are not able to claim government subsidies for children without birth certificates.

In addition, children and families of migrants are exposed to xenophobic violence and attacks by members of the public, and efforts by government officials to exclude foreigners from basic government services.[21]

Some measures are in place to protect children against discrimination based on nationality or documentation status. For example, the recent SECTION 27 case in the Gauteng High Court[22] has affirmed that all pregnant and lactating women and children under six are entitled to free health care regardless of their nationality or documentation status. Regulation 13 (1)

Box 5: Strengthening social protection for children and families

Social protection consists of a range of programmes aimed at supporting families in need financially or in-kind. The package includes social grants, free basic education, free health care for pregnant and breastfeeding women and children under six, free basic water and electricity and subsidised ECD facilities.

The Child Support Grant (CSG) is a proven effective mechanism in alleviating child poverty. It is well targeted at children living in the poorest households and is reaching over 13 million children and seven million caregivers, primarily women.

However, the grant amount valued at R530 in 2024 is 30% below the food poverty line (R760 in 2023) and is insufficient to meet a child's daily nutritional needs, let alone other essentials such as transport, clothing, shelter and energy. While originally set at enough money to feed a child, the value has been eroded over time because the annual increases each year have not kept pace with food price inflation.[8] This may explain why South Africa has seen a decline in child hunger following the rollout of the CSG, but little change in the high rates of child stunting. So, a strategy to address the impacts of poverty on the health, growth and development of young children would be to restore the value of the CSG to the food poverty line, and to prioritise young children under six as the first phase.

Grant beneficiaries are automatically entitled to free health care and free basic education or school fee exemptions, but these fee waivers do not cover the costs of childcare and early learning programmes. The state supports family's costs of childcare and early learning in a different way by providing a subsidy to NPO-run ECD centres that are registered. However, very few ECD centres receive the subsidy and therefore have to charge fees to survive. Those that do receive subsidies often still charge fees because the subsidy is too low to cover the basic costs of running an ECD centre (R19/child/day) and has not been increased with inflation for the past five years. The recent ECD audit showed that, among children attending ECD facilities, the poorest caregivers spent almost half the value of the CSG on ECD fees.[9]

A strategy to address this gap would be to remove barriers to registration for ECD programmes, actively support ECD programmes in poor and disadvantaged communities to register and recognise the full range of ECD programmes. Recent proposed amendments to the Children's Act aim to simplify the registration process and broaden the types of ECD programmes that qualify for funding (see p. 22). The subsidy should also be increased to ensure it covers the full operational costs of an ECD programme and enables programmes to feed children nutritious meals without having to charge fees. It is also vital to address gaps in coverage to ensure that the most vulnerable children are not excluded from social grants.

Take up of the CSG is at its lowest level during the first year of life - a time when children are most in need of nutritional support. In 2020, only 48% of eligible infants were receiving the CSG.[10] The rate of exclusion for infants in 2024 is not yet available, but there are almost 200,000 less infants accessing the CSG in 2024 than there were in 2020, and child poverty rates have risen since 2020, therefore the exclusion rate is likely to be significantly higher.

Most eligible children without birth certificates and young mothers without IDs are not receiving social grants, despite the law allowing SASSA to accept applications and pay grants to unregistered children and caregivers.

Children with disabilities and long-term health conditions – in particular very young children and those with 'invisible' disabilities – are particularly vulnerable and often encounter significant barriers in accessing the care dependency grant which is intended to contribute to the costs of caring for children with severe disabilities who need permanent care.

In addition, there is no income support for pregnant women who are unemployed, informally employed or precariously employed. Only women in formal employment have some form of income support for the maternity period. While the COVID-19 Social Relief of Distress Grant provides R370 to some unemployed pregnant women, it is too low to meet the nutritional needs of a pregnant woman, only available to those with less than R624/month in their bank accounts, and not guaranteed every month.

DSD's draft Maternal Support Policy proposes a maternal support grant starting in the second trimester of pregnancy that would provide much needed income support and reduce the risk of poor mental health and poor nutrition during pregnancy and the incidence of low birth weight babies.

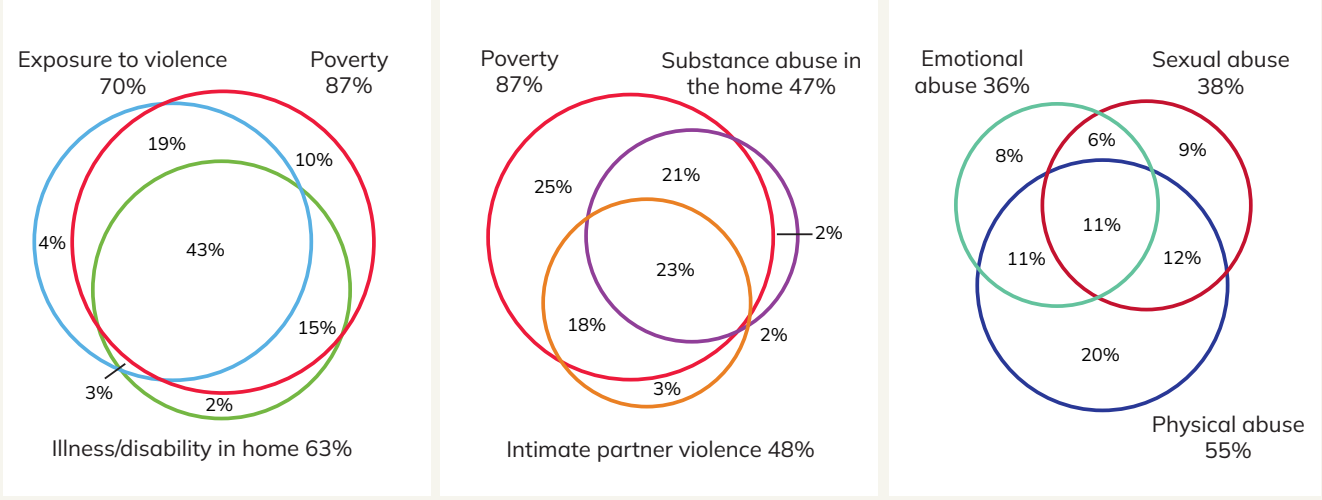
Case 9: Children exposed to concurrent adversities in the Birth to Thirty cohort study

Data from the Birth to Thirty cohort study[28] indicate that most children in Soweto were exposed to multiple concurrent adversities. For example, in Figure 14, 87% of children were reported to be living in households experiencing poverty, yet only 10% of these children experienced poverty outside of the context of violence and severe illness or disability in their homes over the same period. Nearly half the children in the cohort (43%) experienced all three adversities simultaneously.

Similarly, poverty, substance abuse and intimate partner violence often co-occurred within the same households, affecting one in four children. Only 2% of households affected by substance abuse and 3% of households affected by intimate partner violence, existed outside the context of poverty. Forms of direct abuse also tend to co-occur; across their childhoods, one in 10 children had been exposed to physical, sexual, and emotional abuse.

These three examples show how three types of abuse and adversity occur at a time. The data show that 45% of the cohort reported six or more forms of adversity across their childhood and these multiple exposures exponentially increases the likelihood that they will experience negative health and well-being across their life course.

Figure 14: Multiple, mutually reinforcing risk factors affecting children in Soweto



Source: Birth to Thirty cohort study. Analysis by Sara Naicker.

of the Social Assistance Act allows for alternative forms of identification to ensure that this doesn't compromise children's access to the Child Support Grant,[23] and the recent *Phakamisa* judgment compels government to establish an alternative, less discriminatory, means of managing admissions and resource distribution within the education system.[24]

Violence against children continues to be pervasive, with 42% of children in South Africa experiencing child abuse, violence or neglect in the Optimus national prevalence study.[25] While there is limited data on the extent to which young children are exposed to violence, a national study on child homicide found that more than three-quarters of murders of children under five took place in the context of child abuse and neglect.[26] Infants and young children are at high risk of abuse and neglect, often in their own families, because their developmental stage and dependence on those around them means they are unable to avoid – or defend themselves against – harm. Exposure to violence at an early age, particularly in the absence of responsive caregiving, can result in insecure attachment, impair brain development and impact other parts of the nervous system, negatively affecting cognitive development and resulting in poor schooling outcomes, possible conduct disorders, and a greater likelihood of engaging in risky health behaviours.[27]

Data from the Birth to Thirty cohort study (Case 9) illustrate how children in South Africa are exposed to multiple, mutually reinforcing risks that may leave them trapped in a lifelong, intergenerational cycle of poverty, violence, and ill-health. For example, early exposure to domestic violence and/or harsh physical punishment has been found to increase the risk of children becoming either victims or perpetrators of violence later in life and increases the risk that they will use harsh physical punishment to discipline their own children.[29]

Understanding how these risks co-occur can help those who care for children and families understand how to better target prevention and support efforts. For this to work effectively, a trauma-informed workforce is necessary. Comprehensive, integrated family- and community-centred approaches that cut across sectors in government and civil society are essential to addressing the multiple intersecting forms of adversity. Given the high prevalence of adversities in our context, it is critical that we find ways to deliver extra support at scale for the large proportion of children who consistently experience high levels of adversity over long periods of time.

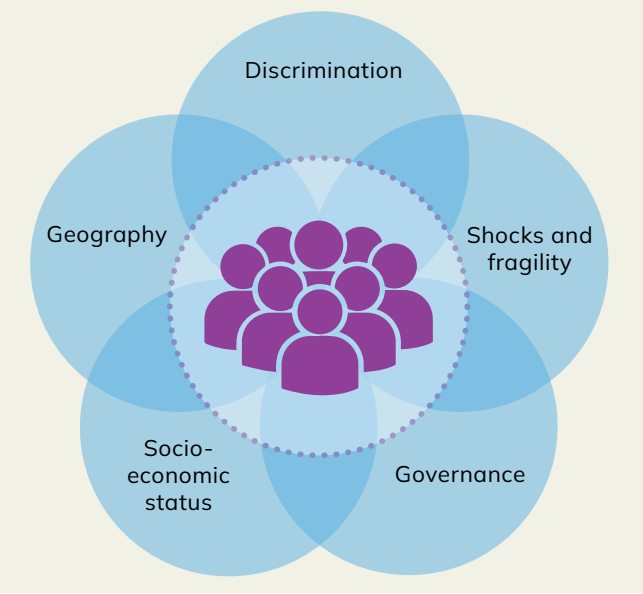
The United Nations Development Programme's discussion paper on 'leaving no-one behind' in the quest to achieve the Sustainable Development Goals, captures how these many dimensions of deprivation and exclusion intersect – with those children at the intersection of the circles in Figure 15 most likely to be deprived, excluded, silenced, and left behind. The framework highlights the ways in which income inequality is shaped by history, geography, and the play of power and discrimination on multiple grounds, and the ways in which these patterns of deprivation may be reinforced by poor governance and fragile systems or amplified during periods of shock and strain.

These shocks to the system, such as the COVID-19 pandemic, inflation and austerity, socio-political unrest, and extreme weather events driven byclimate change also intersect to form what UNICEF describes as a "polycrisis" that is intensifying these existing inequalities on a global scale in ways that leave infants and young children particularly exposed to harm.[30] Yet despite these risks, South Africa's disaster mitigation and climate change adaptation and mitigation plans tend to be centred on adult concerns and rarely contain any concrete measures to safeguard children.[31]

The 2015 NIECD Policy stipulated that Government should prioritise the development, funding and implementation of ECD programmes that target the poorest 64% of children, as these comprise the most vulnerable children as well as the group that will benefit most from ECD services.[32] This estimate was based on the proportion of children living below the upper-bound poverty line[v] at the time. The latest estimates show that this has increased further to 70% in 2022 – with nearly five million children under six years old not having their basic needs met.[11]

This places children at risk of increased developmental and learning delays and compromises nurturing care – including young children's mental and physical health, growth and nutrition, safety and protection, learning, and their caregivers' ability to provide responsive care. These in turn negatively

Figure 15: What does it mean to leave no-one behind?



Source: United Nations Development Programme. What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation. New York: UNDP. 2018.

impact individuals' short- and long-term health and well-being, educational attainment, economic potential and, ultimately, result in greater exclusion and inequity.

These high and pervasive levels of adversity mean that most children in South Africa are starting with a deficit and need a boost at baseline. Therefore, it may be more productive to move beyond targeted support for those 'at risk' and to start providing some form of extra care and support to all young children and families.

How can we provide a system of support that is responsive to the needs of all children and families?

Despite policy intentions, current efforts are largely focused on improving coverage of universal services with limited progress in the provision of indicated and targeted support for those children and families most in need. Thus, the question of how we can create a system that identifies and provides additional support to vulnerable children and families, in a way that helps level the playing field and promote more equitable outcomes, remains.

At a minimum, all families require information, encouragement when things are going well, and support when they need help to overcome specific challenges. A small proportion of children and families may require more intensive, often longer-term, sustained support – such as children with a disability or other long-term health conditions. These different

v Statistics South Africa determines the national poverty lines, and the upper-bound line represents the minimum income required to provide just enough for basic food, clothing, and other essentials.

levels of support are typically described as universal, targeted and indicated support (Figure 16).

Universal services are available for all children and their families e.g. birth registration, immunisation or deworming programmes. These services are for everyone, and provided through the platforms that young children and their families engage with the most. Services are designed to benefit all families, caregivers and children and ideally, information and resources are tailored to the child's age and developmental stage, as well as family circumstances. When there are challenges, children should be identified early through these universal services and refer caregivers for further assessment and care. These services should also provide anticipatory guidance and additional support to help families navigate times of change or heightened vulnerability, such as when mothers return to work, or when children transition to care arrangements outside the home.

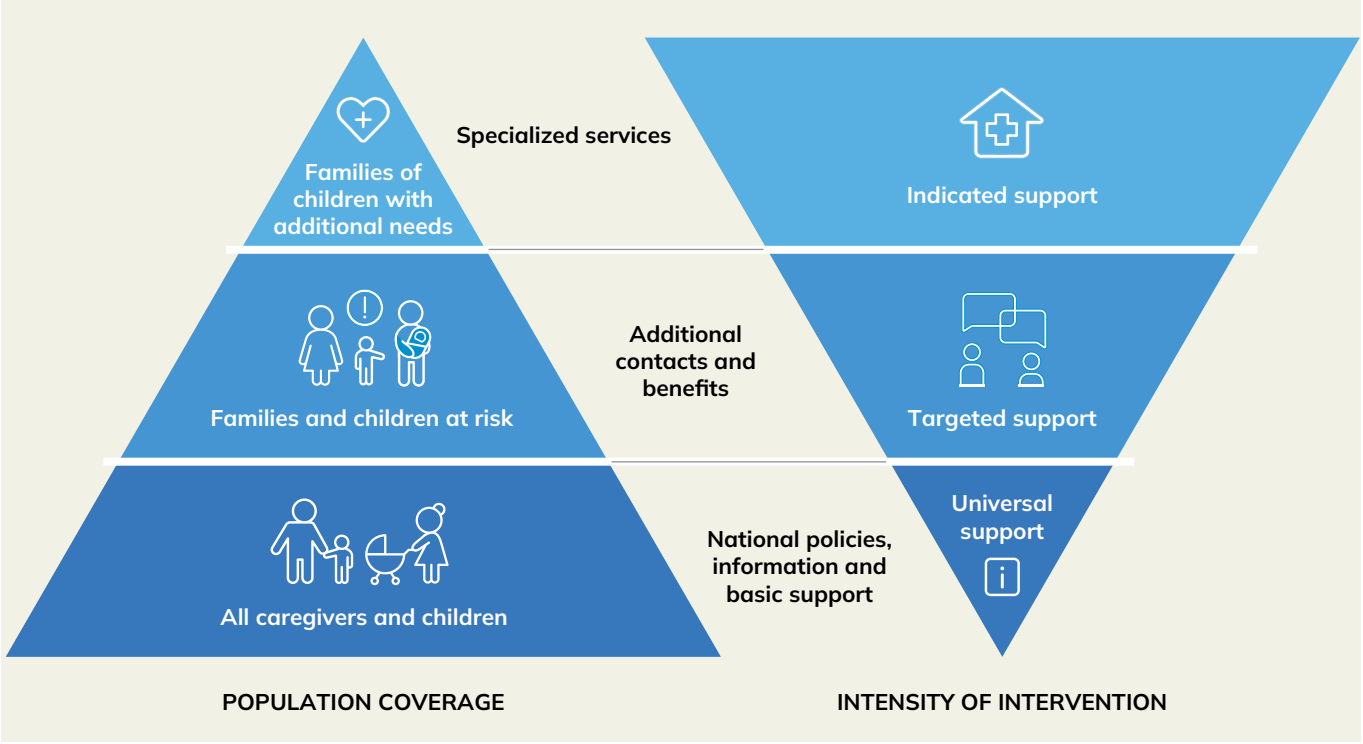
Beyond the provision of basic universal support services, children, families or entire communities may need **targeted support** when children's development is compromised, i.e. children and families deemed 'at risk'. Examples of risk factors may include children experiencing a developmental delay or disability, violence in the community or at home, or other adversities at a household or community level. In addition, the WHO Nurturing Care Handbook identifies children at risk of malnutrition, children in humanitarian settings, children affected by HIV, families living in poverty, and young mothers as groups who may benefit from targeted services. This targeted support can be provided at facility, household or community/societal levels, e.g. social grants for children living in poverty, or home visits from community health workers for premature and low birthweight infants.

Some children, and their caregivers, may need indicated support in addition to universal and targeted support. These **specialised services** are for children with more serious challenges who need higher intensity, usually more complex care and support, e.g. rehabilitation services for children with disabilities or complex long term health conditions.

Strengthening extra care and support services for children and families

The single, most sustainable, method of achieving equitable early childhood development is to effect change at a systems level – by scaling up systemic actions to promote, protect, and support early childhood development, and ensuring that the most vulnerable children and families are prioritised. The integration of ECD interventions into existing platforms for service delivery is an effective and efficient way to reach large numbers of families and children. For a start, using existing platforms to create a more integrated response and early access

Figure 16: Levels of support for children and their families



Source: World Health Organization, United Nations Children's Fund, World Bank Group. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential.* Geneva: WHO; 2018. P. 22.

Box 6: Chile Crece Contigo's suite of universal and targeted services

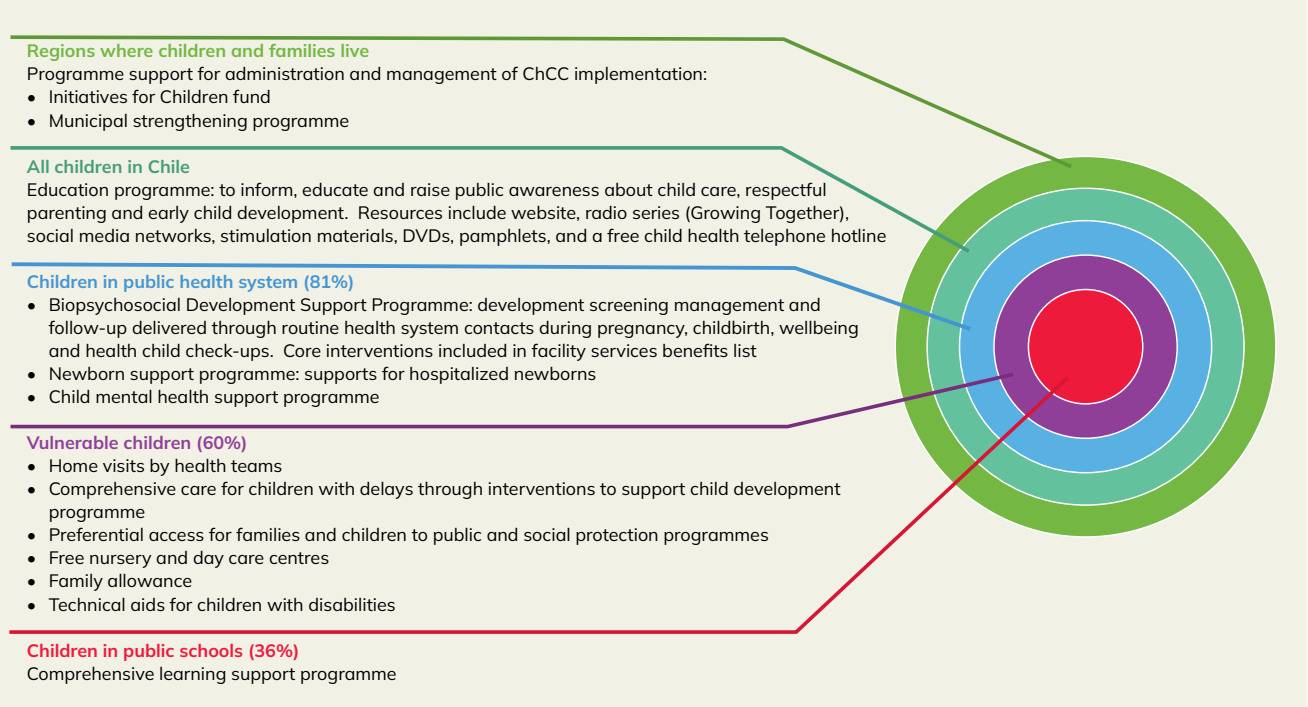
In 2006, Chile Grows with You (Chile Crece Contigo, CCC) introduced and expanded a new model of practice aimed at fostering child development through political will, evidence-informed advocacy, consensus-based policy development, and use of existing functional systems.[33, 34] Health, social care and education teams are coordinated by the municipality, and responsible for monitoring the development of children and coordinating the provision of services that are targeted to meet the needs of each child and their family.

CCC was institutionalised by law in 2009, guaranteeing consistent and increasing budget allocations, systematic collection and use of data for programme management, and coordination of health, education, and social care services.

CCC developed a range of screening tools to identify mothers and infants at risk. These are applied during routine health visits starting in the antenatal period. This includes screening for psychosocial risks in pregnant women (such as late booking (after 20 weeks), adolescent pregnancy, depression, substance use, gender-based violence, unintended pregnancy, and insufficient family support). Further screening continues after birth with a focus on identifying post-partum depression, delays in psychomotor development, safety risks in the home and infants at risk of pneumonia and malnutrition. CCC then provides a range of universal and targeted services, where:

- Universal services include education to sensitize families about infant care, respectful parenting, and stimulation.
- Universal and specialised support is offered through the public health system with a focus on newborn care, biopsychosocial development which includes a comprehensive package of care for children in vulnerable situations or with developmental delays.
- Targeted services for children from the most vulnerable 60% of the population include free early childhood education and free technical assistance for children with disabilities.
- Families and children from the most vulnerable 40% of the population are offered additional targeted services including preferential access to public programmes and services such as work placement, mental health care, prevention of domestic violence and infant abuse, and improvements in homes and living conditions, and social assistance.

Figure 17: A continuum of services from universal services to targeted support for vulnerable children and families



Adapted from: Milman HM, Castillo CA, Sansotta AT, Delpiano PV, Murray J. *Scaling up an early childhood development programme through a national multisectoral approach to social protection. Lessons from Chile Crece Contigo. BMJ.* 2018, 363(k4513).

Case 10: The Gauteng Early Child Intervention project[i]

In 2010, the rehabilitation sub-directorate of the Gauteng Department of Health established a multi-disciplinary early childhood intervention (ECI) workgroup in response to concerns over the late identification of children with developmental difficulties and disabilities and the fragmented and variable quality of services in the province. The key objectives of the workgroup are to:

- Raise the profile of ECI in the province.
- Provide provincial guidance and leadership around ECI.
- Improve coordination and standardisation of ECI service delivery at all levels of care.
- Link with partners in the field of early childhood development, education, social development, affiliate health directorates and other relevant partners to address issues with ECI service delivery.

The workgroup prioritised a few key areas to initiate change in the province, i.e. building the capacity of health professionals, providing strategic guidance on ECI, developing resources, engaging with stakeholders, and promoting service-level research and innovative approaches to ECI service delivery.

Since its inception, the workgroup has been hosting at least two workshops a year. The first workshop helps strengthen the ECI knowledge and skills of health professionals (therapists, psychologists, social workers, dietitians, podiatrists, among others) who are new to the province. The second workshop provides a platform for health professionals to share their ECI practices to promote benchmarking, shared learning and innovation. These have included a focus on workshops on child development and ECI for caregivers, educators, early learning practitioners and health care providers; workshops on making toys from waste; transdisciplinary screening and intervention services; and specialised interdisciplinary clinics for children with autistic spectrum disorders.

Regular stakeholder meetings with relevant government departments, non-profit organisations and academic partners have been used to address current gaps and challenges and to improve collaboration and the coordination of services for young children and their families.

Strategic inputs include the development of a provincial ECI policy; guidelines on "How to get started with ECI in your workplace"; integrating key ECI indicators into routine provincial data monitoring systems; and including key tenets of ECI service delivery into the provincial facility audit process.

The workgroup hosts an annual conference which attracts academics and service providers from across the country; publishes a bi-annual newsletter; and produces caregiver education materials on the development of young children for health (and other) professionals.

This investment in strategic guidance, tools and support has led to a growing interest in ECI and ECD within Gauteng and is helping to shift practice from a deficit- to strengths-based approach; place families at the centre at all levels of care; strengthen referral systems and networks; and increase the use of community resources outside the health system.

i Westwood A, Slemming W. Long term health conditions in children: Towards comprehensive care. In: Shung-King M, Lake L, Sanders D, Hendricks M, editors. *South African Child Gauge 2019*. Cape Town: Children's Institute, University of Cape Town; 2019

to support services. For example, by linking birth registration to birthing centres; ensuring CSG beneficiaries have access to free or subsidised early learning programmes (in the same way they are entitled to a fee waiver for health and education); and integrating services across various departmental systems for a comprehensive and holistic approach. While the NIECD Policy calls for an integrated approach to ECD provision, a detailed roadmap on how to achieve this practically is still absent, and a strong, capable leadership structure and funding model are yet to be established to address the equity gap.

Guiding principles

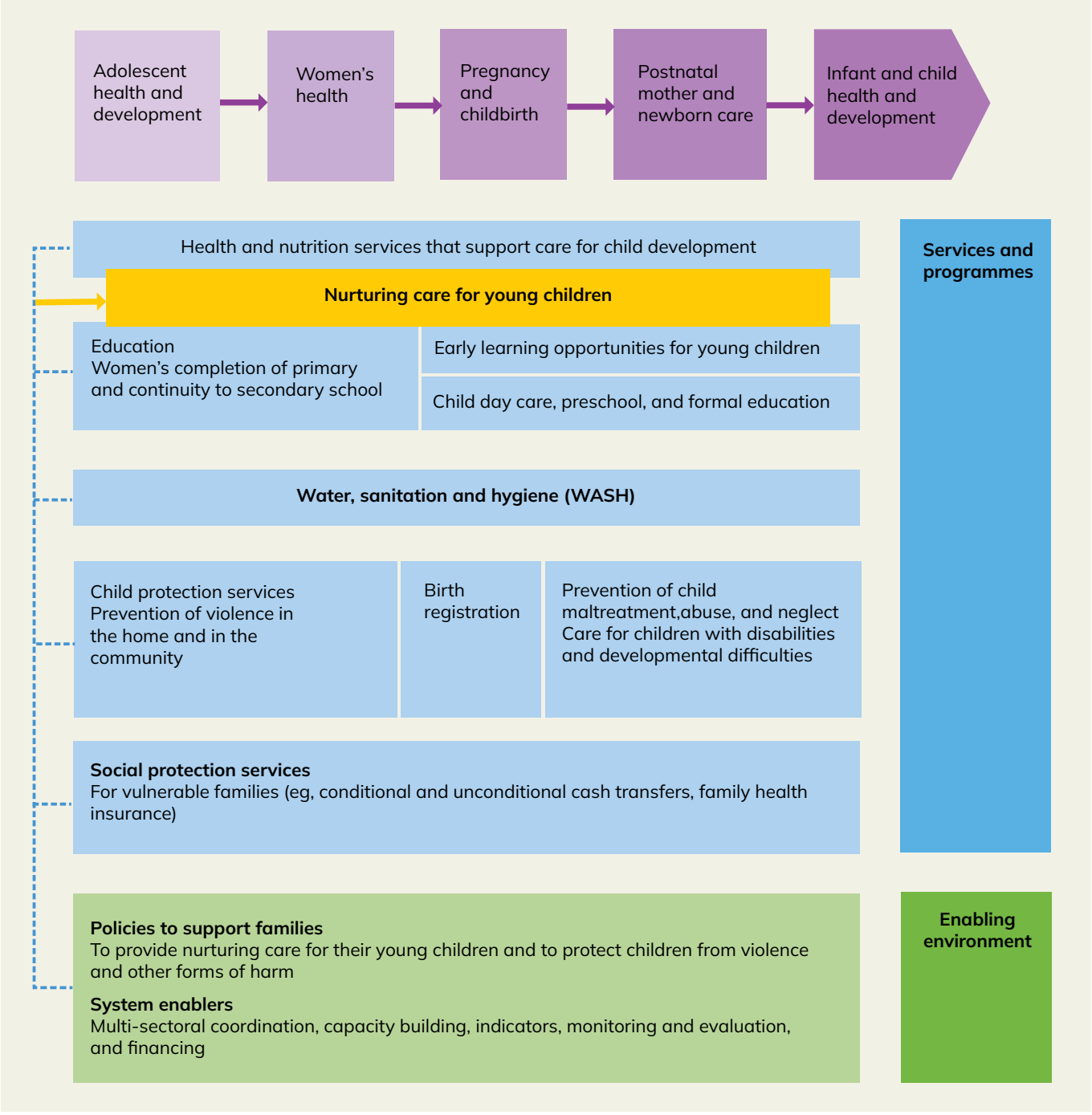
There are a set of essential guiding principles that need to underpin the design and implementation of an essential package of care and support for early childhood development to ensure that no child is left behind. In the following section, we aim to outline some of these key principles and provide some insights on how these can be implemented in practice.

Early means early

It is well-established that it is most effective and cost-effective to intervene as early as possible in the life course – to minimise risks and strengthen protective factors – starting in the antenatal period or even preconception.[7] Services must also be geared to early identification of children and families requiring additional care and support, whether for a health, psychosocial or other concern. At that point (even before a formal assessment or diagnosis), it is imperative that there

is a systemic early intervention response to prevent the initial situation from escalating or deteriorating. These early identification mechanisms and intervention responses should be embedded in existing services, such as integrating targeted interventions for children with developmental disabilities into health, early learning and social development services. These approaches include primary prevention (or actions to protect children from harm and prevent problems from arising), secondary prevention (or early identification and intervention services that detect and respond to emerging problems before they cause serious harm), and tertiary prevention efforts (or rapid response systems for children and families in a crisis or emergency situation, as well as interventions designed to soften the impact of an illness, disability or traumatic event and prevent further harm). For example, preventing violence against children could include a continuum of interventions at different

Figure 18: Framework to promote young children's development through a multisectoral approach



Source: Richter L, Daelmans B, Lombardi J, Heymann J, FL. B, Behrman JR, . . . Paper 3 Working Group and the Lancet Early Childhood Development Series Steering Committee. Investing in the foundation of sustainable development: Pathways to scale up for early childhood development. *Lancet*. 2017, 389(10064):103-118.

points in the life course including: parenting programmes with a focus on non-violent forms of discipline (primary prevention), screening for intimate partner violence during antenatal care to identify and support women at risk before the baby is born (secondary prevention), and reporting incidents of abuse and neglect to trigger a social work investigation and ensure the child's safety (tertiary prevention).

Early child intervention (ECI) services are designed to support families with young children who are at risk of or have identified developmental delays or disabilities. These services strive to provide a multisectoral, integrated and trans- or interdisciplinary response and to provide individualised care to improve child development, promote resilience and strengthen family competencies and skills to facilitate children's development. ECI services can be delivered through health clinics, early intervention, rehabilitation or community centres, homes and schools. There are longstanding local efforts to strengthen ECI services for young children in South Africa, including the Gauteng Early Child Intervention project (Case 10).

Integrated approaches across sectors

Many young children and their families are exposed to multiple forms of adversity, so it is important to adopt holistic approaches looking beyond the immediate presenting complaint to consider the interplay of different risk and protective factors. For example, there is a strong association between food insecurity, domestic violence and maternal depression,[35, 36] and maternal depression can, in turn, compromise a mother's capacity to care for their children in ways that may impact on children's health, nutritional status and early learning.[4]

Thus, we need to bring together different sectors and services to address multiple adversities. This includes strong referral systems and/or integration of services at the point of delivery to enable pregnant women, young children and families to access health care, nutrition support, social assistance, developmental and mental health screening and access to social services.[7]

For this reason, the WHO Guideline for Improving Early Childhood Development recommends integrating support for maternal mental health into early childhood health and development services. In addition, it encourages extending these interventions to expectant fathers to promote the involvement of fathers in childcare and to address other potential risk factors (such as intimate partner violence). Similarly, integrating elements of responsive care and early learning into interventions to promote the optimal nutrition of infants and young children has been found to more effective at improving ECD outcomes, than investments in nutrition alone.[4]

Family-centred and child-focused care

It is also important to recognise the central role that families play in the development of young children, and provide them with the information, resources, care and support they need to provide nurturing care for their children. Family-centred care has long been a best practice for supportive services working with families of children with developmental disabilities.[37] This approach recognises parents and caregivers (and the child) as equal partners in decision making in their child's care, honours the cultural and contextual diversity of families, and upholds the values of respect and honesty in communicating and working with families. In family-centred approaches, parents and caregivers (and children) work with and guide those supporting them as to the priorities for their care, including their specific needs, preferences and choices. These approaches take into consideration each child and family's unique circumstances and are tailored to their individual strengths and capacities.

The Road to Health Book (RTHB) and the national Side-by-Side Campaign aim to ensure that young children have access to the full range of nurturing care services at health facility and household levels. Side-by-side aims to convey the concept of partnership and togetherness and speaks to the shared child-rearing journey that caregivers embark on with their children, and all those who help and support them. The demand side of the campaign speaks to caregivers with its central message that 'You are central to your child's nurturing, care, and protection – and their lifelong health outcomes. Your health worker is there to support you.'[38]

This orientation of health services to place children and families at the centre of care, is an important paradigm shift. There is consistent evidence, across contexts, to show that parent reports of developmental concerns are generally accurate. Thus, the RTHB includes a focus on eliciting parental concerns of child development and this alone, where there are concerns, may prompt referral for further assessment. It also recognises that parents/caregivers and families are equal partners in the planning and implementation of any supportive and promotive intervention and thus these should be co-produced around their needs and priorities. In short, families should always be equal partners and at the centre of decision making around their child's care.

It is equally important to recognise that families and caregivers are often in need of extra care and support themselves. Yet support services for adults and children are often delivered in silos in ways that compromise the health and safety of children. For example, children of parents with mental illness are particularly at risk, so it is vital for adult mental health services to put protective measures in place to support

Box 7: A continuum of parenting support from universal to specialised care

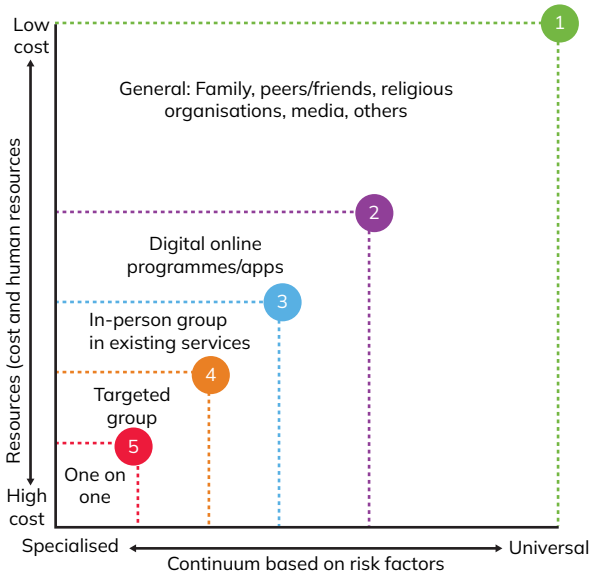
Andre Viviers[i]

Parent support exists on a continuum from the general support parents receive from families and friends to highly specialized services as illustrated in Figure 19.

1. Parents draw on the support and advice of their family, peers and religious communities, coupled with information from books, magazines and the internet on childrearing and parenting. These types of support are universal and come at low cost to parents and society (green line).
2. Online programmes and applications such as MomConnect and ECDmobi are designed to provide dedicated and developmentally appropriate support to parents of young children with a focus on child development, prevention and early intervention. But not all parents have access to these due to internet access and data costs.
3. Social services, health services or early learning programmes often run parent support groups as part of their broader package of services – for example, information sessions at clinics or ECD centres.
4. Parents who find themselves in difficult circumstances may require more dedicated time and resources in the form of a targeted support programme, such as the *National Parental/Primary Caregiver Capacity-Building Training Programme (Children Birth to Five Years).*
5. A small number of parents of young children may require individualized support and specialised services, for example, consultations with pediatricians; psychological or social work services to parents with post-natal depression; interventions by occupational therapists to support young children with developmental delays and their parents; nutrition interventions by dietitians / nutritionist in cases of malnutrition, amongst others. But the specialised staff and dedicated resources to provide these critical and often life-saving interventions is extremely limited.

It is also important to recognize that parents move back and forth along this continuum in response to changing circumstances, and how these different layers of support need to be integrated in order to enable timely referrals and continuity of care.

Figure 19: A continuum of parenting support



i UNICEF South Africa

young children when treating parents with mental illness.[39] Similarly, we need to safeguard and provide counselling for children who witness domestic violence and provide support for mothers whose own trauma may be retriggered when their child is sexually abused.[40] We must, therefore, place the family at the centre of all care and support services and programmes, ensuring that families are equipped with what they need to provide and care for their children in sustainable ways.

Strengths-based approaches to care and support

It is essential to shift away from a problem-centred approach towards more appreciative forms of enquiry, in which we look beyond the immediate risks and deficits to seek out and build on the assets that exist within the child, family and broader community. A strengths-based approach to supporting children and families is about 'how', and not 'what' support we provide. It focuses on inherent knowledge, abilities and capacities rather than deficits, or things that are 'lacking'. The approach does not seek to avoid or minimise problems, challenges or risks within the family, but to identify the assets or strengths that can be built upon and used to support the family to overcome or manage these challenges.

When the child, parents/caregivers or family are regarded as the experts in their own lives, the supportive relationship becomes about partnership and facilitation rather than solving or 'fixing'.

Inclusion and participation

It is also crucial to transform mainstream services and put in place specific supports and reasonable accommodations to enable the inclusion, participation, health and wellbeing of all children including those with disabilities and other challenges. Twin-track approaches, that promote system-level changes that enable all children to be included, along with tailored and differentiated strategies to meet the needs of individual children with specific challenges or impairments should be promoted. This includes capacity development to ensure staff working in a range of settings are able to provide appropriate care and support to children and families.

This twin-track approach is a helpful way of thinking about how the different levels of care can work together in practice, when approaching children with identified needs. Should these children be supported by mainstream (universal services available to the general population) or specialised services (targeted or indicated)? The answer is "both". Linking back to the differentiated levels of support available to children and families illustrated in Figure 16, it is important to note that universal services are also provided to children with additional needs. There is no clear distinction between children who use universal services and children who require additional support. Trained frontline workers (across sectors) should be able to recognise what type of support is required by every family and child. Thus, frontline workers will provide care for all children, and should be able to identify when children and families require specialised (targeted or indicated) services and help these families to get the support they need. This includes coordination with other service providers to ensure that children with additional needs can access all the services and support they require to promote their health and wellbeing, and enable their inclusion and participation in learning and social activities.

Providing a continuum of care

A continuum of care approach is simply having "the right person, at the right time, in the right place, providing the right care" for children and families.[41] This expression has two interpretations. First, care is necessary throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and second, there should be continuity of care between places of caregiving (including households and communities, outreach services, and clinical and other care settings for young children).[41, 42]

The objective should be to build a continuum of services that can support all families of young children, and that can identify and intervene early for those children and families who require additional support. This requires strengthening primary care services, capacitating frontline workers and caregivers, and establishing transdisciplinary and intersectoral teams to provide individualised and contextually relevant extra care for children and families.[37, 38]

It is important to take a systems approach to making such improvements. Often, we focus attention on the resources, content, and skills required to effect the envisioned changes without thinking of the broader programmatic support required to effectively expand and sustain services. For example, improvements at one level of the system may require corresponding improvements at other levels, to ensure that referral pathways and the quality and continuity of care are not compromised. Even when planning for universal support, it is important to consider children and families with additional needs and how systems can be strengthened to respond appropriately, as well as how different sectors providing nurturing care services – such as health and social services – collaborate and coordinate to provide this support for families.

An important challenge is to overcome the 'silos' that often exist between disciplines within and across sectors. To realise an effective continuum of care for children and families, intersectoral collaboration and coordination must be assured between and within government departments, as well as between government and the non-profit and private sectors. Services need to be organised around supporting the child's functioning and participation in daily life and employ place-based approaches[vi] to strengthen extra care and support for children and families who need it in their communities and close to home.

Conclusion

The case for investing in early childhood development as a strategy to dismantle inequalities in child outcomes is clear, with the potential to reap substantial developmental and economic returns for society at large.[43, 44] The nature and extent of adversity and risk that many, if not most, children in South Africa face, and their cumulative effect, undermines our efforts to promote their development. We must ensure that all children receive the essential components of nurturing care and that all families receive the support they need to nurture their children's optimal development.

Delivering this support to both young children and their caregivers, through high-quality, inclusive and equitable strategies, is the crucial pathway to reducing inequalities

vi A place-based community approach addresses the needs and problems of families and communities by building on strengths at the local level, starting from the caregivers to the relevant ECD systems around them, even to the natural environment. The geographic focus of such an approach can be a neighbourhood, municipality, district, county, province, or other sub-national area.

and leveraging early childhood development as an equalizer for all children. Achieving universal, equitable early childhood development for all children and fast-tracking those furthest behind is only possible in the South African landscape through strong partnerships between civil society, private sector and government. At the same time, parents, caregivers and communities have a crucial role to play in demanding greater investment in early childhood development.

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Building blocks of an effective early childhood development system

Part 1 of this issue of the *South African Child Gauge* unpacked the different services and interventions needed to support the health, care and stimulation of young children – including those in need of extra care.

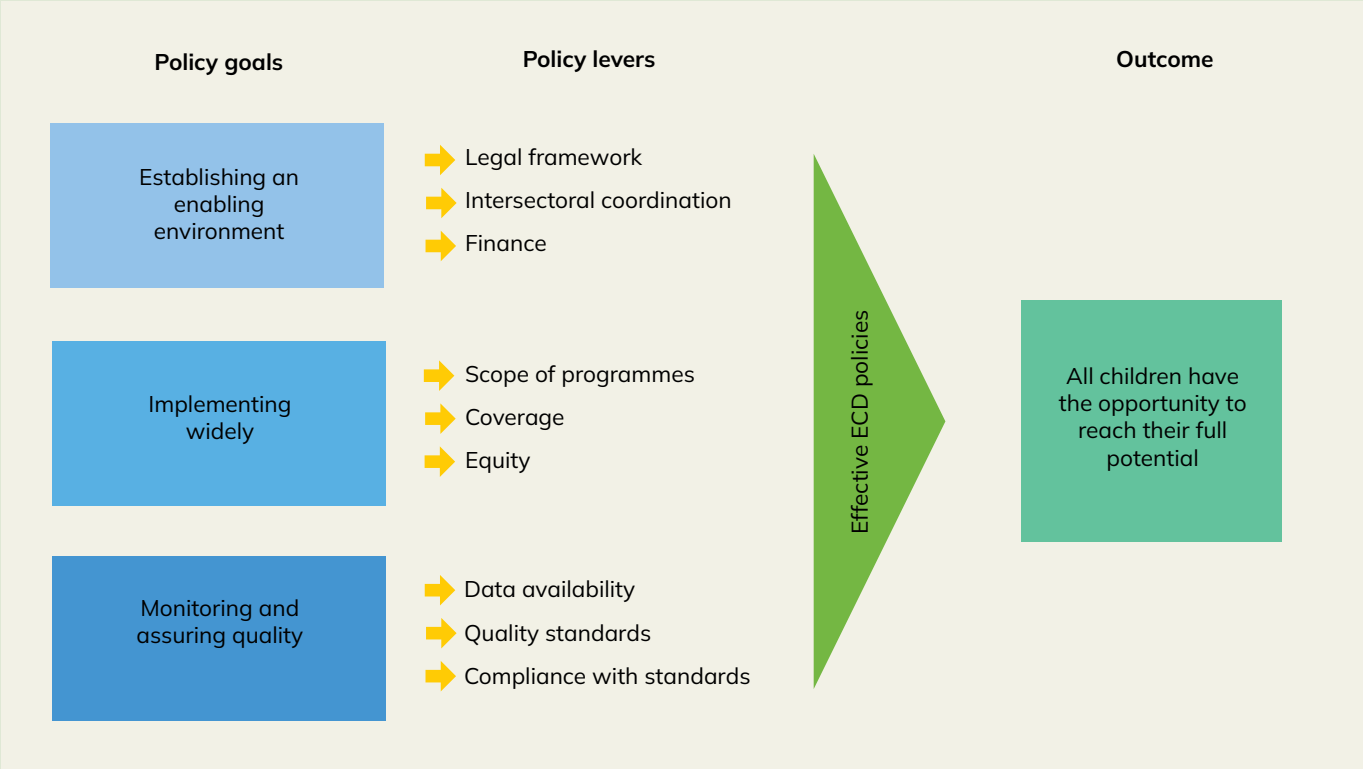
In Part 2 we turn our attention to the essential building blocks of an effective early childhood development (ECD) system. This includes clear policies, adequate financial and human resources, effective leadership and coordination, effective delivery systems, and data to support monitoring, evaluation and quality improvement to ensure that all children have the opportunity to reach their full potential. The function shift of the overall responsibility for early childhood development from the Department of Social Development to the Department of Basic Education, is an opportunity for assessing the effectiveness of the current system and making the appropriate changes.

The SABER-ECD Framework[1] was developed by the World Bank to enable policy makers to identify gaps and opportunities to strengthen the ECD system. The Framework identifies three policy goals as key to establishing an effective ECD system – including creating an enabling environment, implementing widely, and monitoring to assure quality.

The 2013 issue of the *South African Child Gauge* was developed concurrently with the National Integrated Early Childhood Development Policy (NIECD Policy), and identified the following building blocks[2] that are needed to create an ECD system that translates the policy vision into effective local services:

- An ECD policy to provide a comprehensive approach to programming and ensure the provision of an age-differentiated package of services, address governance issues, institutional arrangements and resourcing strategies.
- Effective government leadership that outlines roles and responsibilities for different sectors and spheres of government and provides clear lines of accountability. A national coordinating structure – with the ability and

Figure 20: The SABER-ECD policy goals and levers



Source: Devercelli AE, Neuman MJ. What Matters Most for Early Childhood Development: A framework paper. Washington DC: World Bank Group. 2013.

Figure 21: Core components of an effective ECD system

Adapted from: Viviers A, Biersteker L, Moruane S. Strengthening ECD service delivery: Addressing systemic challenges. In: Berry L, Biersteker L, Dawes A, Lake L, Smith C, editors. *South African Child Gauge 2013*. Cape Town: Children's Institute, University of Cape Town; 2013.

authority to oversee activities, foster collaboration, and monitor implementation against set targets.

- A resourcing strategy to ensure adequate resources for scaling up of essential services and support. This includes increased investment in human resources and training across all sectors as well as adequate funding models to support service delivery across a range of services and platforms from clinics and ECD centres to home- and community-based programmes.
- Effective local delivery including the targeting of vulnerable young children through population-based planning, and stronger integration of services at the point of service delivery.

Yet, 10 years later, a series of systemic barriers continues to retard effective delivery of ECD services as outlined in Table 25.

In the following chapters we reflect on current challenges and opportunities for systems strengthening across each of the building blocks of the early childhood development system.

Policy and planning

An effective ECD policy should provide a clear vision, legal framework and comprehensive strategy for delivering a range of services that are differentiated to meet the needs of specific age groups. Policy development, service provisioning and coordination should involve all government departments responsible for the different aspects of ECD service delivery. Such an enabling policy should establish clear norms and standards for service provision and funding, and provide for monitoring and evaluation of the quality and effectiveness of implementation. The policy chapter provides a reflection on progress and current challenges in policy and planning.

Leadership and coordination

Good governance requires the participation of all stakeholders in the planning, implementation and monitoring of services. The intersectoral nature of a comprehensive programme of support

for young children therefore requires the 'clear delineation of roles and responsibilities of different government role departments in provisioning'[3] and effective mechanisms for coordination and intersectoral collaboration.

Leadership and political will are essential to translate the vision of a comprehensive package of ECD services into practice. This includes clarifying responsibilities at every level of government, ensuring adequate resourcing and holding the multiple stakeholders accountable for delivering on their service mandates. Coordination and accountability structures need to include political as well as departmental leaders, and to be responsive to input from beneficiaries[4]. Oversight and coordination structures need to have an adequate secretariat and the authority to convene the relevant stakeholders to ensure they function efficiently. For departments where services to young children and their families crosscut many directorates or where young children benefit as part of wider community development, an ECD focal point person is essential. The leadership and coordination chapter provides an overview of status of governance across the broad suite of ECD services, while the data chapter reflects on how we can strengthen current data systems to enhance planning, monitoring and evaluation.

Finance

ECD programmes and services will only improve child wellbeing and development outcomes if services are of sufficient quality. This requires adequate funding for the staffing and operational costs of implementing the ECD service package. Resourcing needs to be sufficient to enable universal access to services from pregnancy to pre-Grade R, and prioritise support for vulnerable groups including the poor and children with disabilities to ensure equitable outcomes.

Government is accountable for mobilising the funds necessary to meet its obligations to young children. Health and social services are public services, but early learning services are provided by private operators and non-profits. Funding must be sufficient and secure so that local implementors are able to gain momentum and improve the outcomes for children and families. An adequate funding model should also provide for the waiving of fees which pose an access and quality barrier in poor communities, and cover the full range of programme modalities including parenting support and education, playgroups, childminders and centre-based early learning programmes. Alternative funding sources such as the Community Works Programme and Social Employment Fund are utilised for stipends for non-centre-based early learning programmes but do not encourage stable longer term service provision. Funding allocations are also needed to cover infrastructure and start-up costs especially in poor communities. Local government funding from the Municipal Infrastructure Grant requires a clearer mandate. The finance chapter discusses the current funding of ECD priority areas and projects the costs of service expansion.

Table 25: Systemic barriers to effective service delivery in South Africa

Policy and planning	Limited integration across policies Fragmentation and uncoordinated planning for young children Uneven quality of information systems and data A significant gap between policy and practice Limited population-based planning and geographical coverage
Good governance	Poor institutional arrangements, insufficient intersectoral collaboration, coordination and service integration Limited accountability at all levels and across sectors
Resources	Inadequate funding and inappropriate funding models Absence of coordinated multi-stakeholder funding, training and support strategy Limited, undertrained human resources Insufficient infrastructure Austerity, inflationary pressures and budget cuts
Delivery	Unequal access and quality of services within and across sectors (poor targeting mechanisms) Limited monitoring and support to ensure quality Delivery skewed towards older children and urban and centre-based services

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Human resources

Human resources for early childhood development include a diverse range of practitioners in health, education and social services among others. All these services require sufficient numbers of appropriately trained staff including frontline staff responsible for service delivery as well as management. Post provisioning for early learning staff is essential for quality improvement and sustainability, as is an adequate supply of accessible training and upgrading opportunities to support career development and professionalisation. The human resources chapter unpacks some of the successes and outstanding challenges.

Data

Tracking progress against policy goals and specific objectives is essential for improving access to and quality of ECD services. This needs reliable and regular data from all stakeholders to inform the population-based programming needed to ensure appropriate interventions for equitable and inclusive services, prioritising the most vulnerable, to track progress and service impact. The multisectoral nature of ECD service delivery requires the integration of data and data to track the effectiveness of coordination and implementation at the different levels of government. The data chapter assesses what information is available to enhance the planning, monitoring and evaluation of ECD services, highlighting gaps and proposing solutions.

Ensuring effective local delivery

To reach universal access, service delivery must be state-led, responsive and flexible to contextual priorities, and draw in a range of public, private, civil society and community stakeholders. South African civil society and the private sector are key service providers of many services for young children and delivery systems need to coordinate these and public sector efforts. Coordination of services that cover the full range of young child needs is key to effective local delivery. This can be achieved through using existing service points or practitioners as a conduit to link each child to whatever services are needed as early as possible. The critical role of local government and a variety of promising initiatives that facilitate effective delivery are featured in the chapter on local delivery systems.

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An enabling policy environment

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The National Development Plan (NDP) sets out the long-term vision for the country and envisages that children will have universal access to early childhood development (ECD) by 2030. The long-term goal of the National Integrated Early Childhood Development Policy (NIECD Policy) is in concert with the NDP's goal of universal access to early childhood development for all children, which would contribute to the NDP goals of eradicating poverty and reducing inequality. The NDP makes numerous proposals on early childhood development, among these are a focus on nutrition for pregnant women and children, and the transfer of the ECD function from the Department of Social Development (DSD) to the Department of Basic Education (DBE).[1]

A key development was the adoption of the NIECD Policy by the Cabinet in 2015.[2] The Policy covers the period from conception until children enter formal schooling. It also addresses critical gaps in order to ensure the provision of comprehensive, universally available and equitable ECD services. As such, the NIECD Policy signalled a shift away from a narrow conceptual understanding of early childhood development, as mainly school and centre-based early learning programmes (ELPs) by outlining a comprehensive package of services to support the holistic development of a young child from health and nutrition to social protection, early learning, parent support and food security.

Government recognised that the provision of ECD services does not fall neatly under one government department, sphere of government or sector. Policy and legislative coherence would be required to enable coordination and collaboration across departments and spheres of government as well as with civil society. This includes significant reform to increase access to services across the age range and improve the quality of services across the areas of health, education and social protection.

What is an enabling policy environment for early childhood development?

For children to thrive in life, an enabling environment needs to be created that ensures that the full range of quality ECD services are accessible to all families. This entails having a continuum of complementary policies that enable different role players to support communities and families' efforts to provide young children with good health, adequate nutrition, opportunities for early stimulation, responsive caregiving, and safety and security as outlined in the global Nurturing Care Framework.[3]

Creating an enabling policy environment for children begins with ensuring universal health coverage for pregnant mothers, infants and young children, and providing essential healthcare services for their health and well-being. To complement good health, integrated food security and nutrition policies are necessary to ensure adequate nutrition for pregnant mothers, infants and young children, promoting brain development and healthy growth. Social protection policies safeguard families and children from economic and social adversity and empower families to access nutrition. Labour or employment policies can support responsive caregiving by allowing caregivers time off work or providing on-site facilities to feed and care for infants. Education and childcare policies contribute to stimulating environments in which children receive early care, nutrition and stimulation while enabling caregivers to return to work. Policies around birth registration are required to unlock families' ability to access many government services. Inclusive policies are crucial for meeting the unique needs of children and families. Lastly, policies that allow for coordination of service provision at the local level could ensure that a comprehensive package of ECD services reaches children in the most vulnerable circumstances.

What laws and policies are currently in place?

The basic right to a comprehensive package of ECD services for all children has its foundation in the Constitution of the Republic of South Africa. Section 28 of the Constitution, in the Bill of Rights, declares that "every child has the right (a) to a name and a nationality from birth; (b) to family care, or parental care, or appropriate alternative care, when removed from the family environment; (c) to basic nutrition, shelter, basic health care services, and social services; (d) to be protected from maltreatment, neglect, abuse or degradation".[4] Section 29 (1)(a) of the Constitution further declares that "everyone has a right to a basic education". Read together, it is safe to

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say that children in South Africa should have access to quality health services, early learning, basic nutrition, shelter, care and protection.

Since 1994, the legislative and policy framework and plans have been developed to enable the realisation of these rights. Table 26 below highlights the legislation, policies and plans that have been introduced since 1994 to regulate the provision of a comprehensive package of services for young children. Together these govern the many different dimensions of early childhood development. An example of this is the regulatory framework for ECD programmes in chapters five and six of the Children's Act (No 38 of 2005) and the associated regulations, norms and standards. These provisions also intersect with other laws which fall under the responsibility of various government departments.

The NIECD Policy establishes the government's responsibility to provide comprehensive ECD services in South Africa. Its goal is to transform service delivery by addressing gaps and ensuring universal and equitable access. The Policy defines a range of services necessary to fulfil the constitutional rights of young children, including:

- free birth registration;
- parenting and family support;
- essential health care for pregnant women and children;
- food and nutritional support for pregnant women and children;
- social protection;
- protection from abuse and neglect;
- psychosocial services for pregnant women, children and mothers;
- early childcare and early learning;
- information on the value of early childhood development and how these services may be accessed;
- subsidised and affordable water, sanitation and energy services;
- access to safe housing; and
- access to play, recreational and cultural amenities.[2]

It also has a strong emphasis on early identification and intervention for children with disabilities and developmental delays, demonstrating government's commitment to inclusivity and upholding all children's rights to early childhood development.

The Policy's comprehensive and integrated approach has the potential to serve as a foundation to align other policies and create a coherent policy environment that enables the delivery of comprehensive services to families and children. While many of the programmes were already in place, the NIECD Policy presented an opportunity to reframe and reform the delivery of comprehensive and integrated services for children at the local level. Yet despite this clear policy intent, the dominant narrative continues to focus on ELPs, and while there has been some progress in terms of increasing access to services, it has been far too slow.

Yet, policy and legislative developments to date have taken place quite disparately across different government departments and political administrations, with no overall strategic vision to ensure that the different laws and policies are coherent and complement each other. This is partly due to early childhood development being narrowly understood as centre-based early learning programmes, and partly due to the way in which government departments tend to operate in silos.

Primary legislation (e.g. Acts) and secondary legislation (e.g. regulations) governing early childhood development frequently overlap, causing unnecessary complications and contradictions. For example, health and safety in ECD programmes is currently regulated by different government departments and spheres of government. The norms and standards of the Children's Act (No. 38 of 2005) specify health and safety norms and standards for partial care facilities (including ECD centres). In addition, ECD centres must comply with local by-laws that incorporate the National Environmental Health Norms and Standards which fall under the National Health Act (No. 60 of 2003). This means that under the current system, ECD centres are effectively assessed twice for health and safety compliance – first by an environmental health practitioner from local government, and then by a provincial education official. The draft Children's Amendment Bill of 2023 therefore aims to address these tensions and streamline the registration process for ECD programmes.

In addition, it is important to consider whether the health and safety norms and standards are appropriate in a developing country such as South Africa, as many centres in rural and informal settlements struggle to comply. It may therefore be more appropriate to set a minimum safety threshold that would enhance access to quality early learning and childcare, and to then drive further improvements through a quality assurance process, provided this does not compromise children's safety.

What is working well and what needs to change to create a more enabling environment?

There have been three key successes in developing an enabling policy framework for early childhood development over the past 15 years:

Table 26: Legislation, policies and plans for early childhood development in South Africa

		Components of Nurturing Care Framework				
		Early learning	Nutrition	Health	Responsive caregiving	Safety & protection
Legislation	Constitution of the Republic of South Africa No. 108 of 1996	x	x	x	x	x
	Births and Deaths Registration Act No. 52 of 1992		x	x	x	x
	National Health Act No. 60 of 2003		x	x		
	National Health Insurance Act No. 20 of 2023		x	x		
	Social Assistance Act No.13 of 2004		x	x	x	x
	South African Social Security Agency Act No. 9 of 2004		x	x	x	x
	Unemployment Insurance Fund Act No. 63 of 2001				x	x
	South African Schools Act No. 84 of 1996	x				
	Basic Education Laws Amendment Bill [B2D-2022]	x			x	
	Domestic Violence Act No. 116 of 1998					x
	Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007					x
	Children's Act No. 38 of 2005	x	x		x	x
	Children's Amendment Draft Bill 2023	x			x	x
Policies	White Paper on Education and Training (1995)	x				
	White Paper on a New Housing Policy and Strategy for South Africa (1995)					x
	White Paper on Social Welfare (1997)					x
	White Paper for the Transformation of the Health System in South Africa (1997)		x	x		
	White Paper 5 on Early Childhood Development (2001)	x			x	
	White Paper 6 on Inclusive Education (2001)	x				
	Free Basic Water Policy (2000) and Free Basic Water Implementation Strategy (2001)					x
	White Paper on Basic Household Sanitation (2001)					x
	National Integrated Early Learning and Development Standards (2009)	x				
	Revised White Paper on Families in South Africa (2021)				x	
	The South African National Curriculum Framework for Children from Birth to Four (2014)	x				
	Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams (2017)		x	x		
	Maternal, Perinatal and Neonatal Health Policy (2021)		x	x		
Plans	National Plan of Action for Children in South Africa 4 [2019 – 2024]	x	x	x	x	x
	National Food and Nutrition Security Plan for South Africa 2018 – 2023		x			
	National Integrated Plan for Early Childhood Development 2005 – 2010	x	x	x	x	x
	National Development Plan (2012)	x	x	x	x	x
	Maternal, Newborn, Child and Women's Health and Nutrition Strategic Plan (2012)		x	x		
	2030 Strategy on ECD Programmes (2024)	x			x	

A clear vision

The first success has been the clear vision and broad definition set out for early childhood development in the NDP and the progress made to achieve these goals. The NIECD Policy gave effect to this broad definition of early childhood development by introducing a comprehensive package of services and in 2022 the overarching responsibility for the national integrated early childhood development programme and policy shifted from the DSD to the DBE.

In addition, universal access to two years of preschool education could be achieved in the medium-term as proposed in the NDP. Access to Grade R has been above 95% over the past 10 years and the Basic Education Laws Amendment Bill will make Grade R compulsory; while roughly two-thirds of the age group one year below Grade R are already accessing some form of early learning programme.[5]

The standardisation of guidelines, norms and standards for ECD programmes is also achievable, thanks to the work of the Presidency's Red Tape Reduction Team who are revising the National Environmental Health Norms and Standards and drafting model local government by-laws for ECD programmes, and recent amendments to the Children's Act which aim to streamline the registration of ECD programmes (see page 22).

A comprehensive and integrated policy

The second success has been the introduction of the NIECD Policy in 2015. Although ambitious in its vision, the Policy defined the comprehensive package of services required to ensure the holistic development of children and allocated the responsibility for delivering the various services to specific government departments. The Policy, therefore, has the potential to provide a framework to enhance coherence across different policies and pieces of legislation that pertain to ECD services.

One example of this is the clarification of the role of local government in "municipal planning and spatial development, including providing and regulating land used for childcare facilities and safe and adequate play and recreation facilities".[2] The role of local government in the provision of childcare facilities is included in Schedule 4 Part B of the Constitution, however, since "childcare facilities" are undefined, there is arguably an overlap between this definition and the definitions of "partial care" and "ECD programmes" in the Children's Act. The Policy, therefore, provides a platform from which the Children's Act can be amended to clarify the definition of "childcare facilities" and the role of local government.

A strategy to enhance the delivery of community-based health services

The final success has been the introduction of the Wards Based Primary Health Care Outreach Teams Policy Framework and Strategy in 2018 which provides a framework for improved implementation of the Community Health Worker (CHW) Programme. CHWs play a critical role in providing primary health care and information on early childhood development to pregnant mothers, new mothers and children. CHWs are therefore one of the main mechanisms through which the government can provide children and families with a comprehensive package of services during the first 1,000 days of a child's life. The policy aims to bring health care closer to families and communities and envisages strengthening intersectoral collaboration at the community level with a specific focus on rural and under-served areas. If implemented well, working in synergy with the maternal and child health services provided by primary health care clinics, the policy and strategy could enhance maternal and child health and nutrition outcomes, and enable children to thrive.

Which challenges remain?

Since the adoption of the NIECD Policy, progress has been sluggish. The National Planning Commission's Review of the NDP[6] attributes the slow progress to poor leadership within and across the departments of DSD, DBE, and Health. This is supported by the Bureau of Economic Research's 2020 Assessment Report,[7] which showed no increase in the proportion of four-year-olds attending early learning programmes between 2012 and 2019.

To address these challenges, the DBE should draw lessons from other successful policy interventions. Lund, in her reflection on the implementation of the Child Support Grant (CSG), states that poor implementation of policy intent often results from a lack of necessary technical and administrative capacity.[8] The initial success of the CSG implementation was largely due to the fact that there was an implementation machinery in place across the provinces which paid the state maintenance grant to those who qualified. Furthermore, according to Lund, the Minister and Director General of the Department of Welfare (now the DSD) provided political will, institutional support, and administrative or technical assistance.[8] While the design and delivery of ECD services is more complex, these factors remain pertinent.

Key policy questions that need to be addressed in order to enhance early learning outcomes, include efforts to increase the value of the ECD subsidy and ensure that it reaches the majority of children under-five (who currently do not benefit from the

subsidy). These efforts to enhance access need to be coupled with interventions to improve the quality of programmes.

The ECD conditional grant was introduced in 2017/18 to improve the maintenance of infrastructure and increase the number of children benefitting from the ECD subsidy. This resulted in an injection of an additional R1,8 billion into ELPs between 2017/18 and 2021/22. However, the South African Public Expenditure and Institutional Review showed that the proportion of children who accessed ELPs did not increase during the period from 2014 to 2019.[9] This is of concern as it may point to provinces deciding to reduce the amount they allocate from the provincial equitable share to ECD. This is likely to deepen inequalities in access to ELPs as families in poor communities cannot afford to pay fees.[9]

The National DBE should therefore ensure that its attempts to increase access and quality of ECD services are backed up by increased budget allocations through the provincial equitable share in addition to the ECD conditional grant. Provincial DBEs and Treasuries should guard against ECD budgets being re-distributed to other service areas. While all services within the provincial equitable share are being squeezed due to austerity measures being implemented, children's services should be protected.

It was also explicitly stated in the Concluding Observations of the UN Committee on the Rights of the Child that children's rights and access to services should not be adversely affected by budget cuts.[10]

Another key challenge that remains is DBE's leadership role in the ECD sector. The DBE 2030 Strategy for ECD clarifies the department's role in respect of its mandate to deliver ELPs, but does not address its broader leadership role sufficiently.[2]

What are the potential solutions?

The ECD function shift has brought new momentum to the ECD sector and allowed for three changes to strengthen the implementation of the NIECD Policy.

An update of the NIECD Policy

The first is the opportunity to update the NIECD Policy to reflect recent developments in the ECD sector, such as the ECD function shift. The update is also an opportunity to strengthen the implementation of the NIECD Policy's vision of enhancing access and quality of ECD services. While DBE has historically focused on centre-based ELPs, the DBE should broaden its approach and develop an overarching strategy to increase access and improve the quality of all ECD services across the life course – from health and nutrition to care, protection and development. While the DBE is the lead department for ECD, the Presidency should play a support role as envisaged in the NIECD Policy. Each department has its mandate, however there are overlaps in service provision, such as parent support, that require collaboration between departments. It is also the responsibility of the lead department to engage with other departments to identify systemic challenges and develop consensus on solutions.

The DBE is conducting an implementation evaluation of the NIECD Policy to ensure the update of the Policy is evidence-based. The DBE should also involve other departments fully in this process, as anecdotal evidence suggests that the DSD fell short in doing so during the initial development of the NIECD Policy. This process of improving the Policy should also be used to develop a common vision for the well-being of children, which all different roleplayers are invested in. The 2012 ECD Diagnostic Review acknowledged existing ECD programmes but highlighted notable gaps in caregiver and parent support. The DBE should build upon these findings.[11]

The Children's Amendment Bill

The second potential for improvement in the regulatory framework governing early childhood development is the draft Children's Amendment Bill of 2023 which aims to streamline the registration requirements for ECD programmes. It introduces a differentiated approach to regulating different kinds of ECD programmes (such as ECD centres, playgroups and home-visiting programmes), and provides for the collection of administrative data in ECD programmes and the funding of ECD programmes.

The Bill further intends to clarify the roles and responsibilities of the different spheres of government, especially the role of local government in the provision of ECD facilities and implementation of health and safety standards. These measures are intended to enhance access and quality, and the Minister of Basic Education should therefore prioritise the processing of the Bill in the legislative programme of the seventh Parliament.

The possibility of an ECD Act

The DBE acknowledges the necessity for extensive legislative reform in order to realise the comprehensive package of services outlined in the NIECD Policy. The DBE is therefore conducting a scoping study to determine whether existing legislation should be further enhanced or if a new ECD statute aligned with the NIECD Policy's vision is needed. The scoping study aims to initiate dialogue among government departments and the ECD sector in order to create a more collaborative and enabling environment for integrated ECD delivery.

Conclusion

The NIECD Policy in South Africa provides a coherent and complementary framework to guide the development of policies and legislation across government departments and spheres of government. Through the ongoing review process led by the DBE, there is an opportunity for departments responsible for ECD services to improve services that fall within their mandate and take full ownership of their responsibilities outlined in the Policy, leading to more effective implementation and improved child well-being.

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Strengthening the system: Leadership and coordination

Mastoera Sadan[i]

The National Integrated Early Childhood Development Policy (NIECD Policy), adopted by Cabinet in 2015, clearly outlines the roles and functions of government departments and other stakeholders in the ECD system as well as the leadership and coordination structures needed to implement the Policy across all three spheres (national, provincial and local).[1] We have had a clear roadmap since 2015 – so why has there been such slow translation of the Policy into implementation?

In this chapter we will examine progress made in strengthening leadership and coordination of an integrated early childhood development (ECD) system (that includes health, social protection and early learning). It reflects on recent developments, the policy vision, challenges encountered to date, and opportunities to strengthen leadership and coordination following the recent shift in the leadership function to the Department of Basic Education.[ii]

History and recent developments

The NIECD Policy is closely aligned with the Children's Act of 2005, which called for the development of a "comprehensive national strategy aimed at securing a properly resourced, coordinated and managed early childhood development system".[1 (p. 31)]

This was followed by the National Development Plan (NDP) which outlines government's commitment to provide universal access to early childhood development by 2030. This includes equitable access to age-appropriate, responsive, timely and quality services close to where children live.[2] But since the adoption of the NDP in 2012 there has been limited progress.

The approval of the NIECD Policy by Cabinet in 2015 was a significant milestone and many in the ECD sector, government officials and those in civil society thought it was a turning point in the delivery of a package of ECD services. However, nine years later there has been limited progress, and the Bureau for Economic Research[3] indicates that there was no increase in access to early learning programmes for 0 – 4-year-olds between 2012 and 2019.

Capacity at all levels of government remains weak and unevenly distributed, with competing departmental mandates and a tendency to work in silos further hampering service delivery within and across departments. So, what is needed to get things to work for children in all communities? What further reform is required? How do we get leadership and guidance from national government with support from provinces to support delivery on the ground – at local government level?

These challenges are not new. Institutional arrangements were identified as a key challenge impeding the delivery of ECD services in the 2012 ECD Diagnostic Review[4] and in the NDP, which proposed shifting the ECD function from the Department of Social Development (DSD) to the Department of Basic Education (DBE) in order to strengthen the education component as well the leadership and coordination of an integrated ECD system[2].

In April 2022 the ECD function shifted with DBE taking over the role of lead department from the DSD, at both national and provincial level, and the responsibility for providing the vision and strategic direction for the sector as a whole. This shift in function, provides an opportunity to strengthen leadership and reinvigorate coordinating structures within and across different spheres of government, and between the public and private sector.

Recently there has been some significant developments. In March 2024, the DBE published South Africa's 2030 Strategy for Early Childhood Development Programmes: Every Child Matters.[5] In April 2024, the ECD IMC held its first meeting since the function was transferred to DBE, and in May 2024, the DBE published the draft Children's Amendment Bill 2023[6] for public comment. It is important that this law reform process is finalised as it will strengthen strategic planning and data collection. An evaluation of the NIECD Policy has also been completed and notes the lack of coordination between the three spheres of government and calls for their legislative and institutional mandates to be clarified.[7]

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What is the policy vision?

Chapter 7 of the NIECD Policy is titled "Leadership and coordination of the national integrated early childhood development system". This title is apt in that coordination requires leadership. Coordination of the ECD system is essential as the responsibility for the delivery of ECD services is not limited to one department.[1] The different components of the comprehensive ECD programme are a concurrent national and provincial competence in terms of Schedule 4 of the Constitution. Hence, the responsibility for planning, coordination and implementation falls within the mandate of national, provincial and local government.[1] The policy also provides for intergovernmental relations to ensure planning across the spheres of government and mechanisms for the involvement of the non-governmental sector.

Chapter 7 of the NIECD Policy establishes the government's responsibility to lead and coordinate the delivery of ECD services in the country. However, it remains unclear how coordination is best understood and managed in the early learning sector where government is not the sole or primary provider of services.

Leadership

The NIECD Policy states that "leadership is essential to develop and sustain a common national vision for early childhood development",[1 (p. 84)] and that to realise the Policy vision, there must be both political and bureaucratic leadership.

The Policy states that the Inter-Ministerial Committee (IMC) supported by the National Inter-Departmental Committee (NIDC) is mandated and required to provide political leadership in realising the development of the vision, aim and objectives of the NIECD Policy. This includes, amongst others, providing technical support in programme development, monitoring services and overseeing quality improvement.

Coordination

The NIECD Policy defines coordination as the exchange of information and alignment of activities in order to work synergistically towards a common objective. The Policy views coordination not an end in itself, but rather as a means to strengthen:

- Leadership in order to develop and sustain a common vision for early childhood development;
- Planning, monitoring and evaluation to track progress and enhance service delivery and child outcomes; and
- Accountability for the realisation of the NIECD Policy vision, goals and objectives.

The ultimate goal of coordination is to support the delivery of integrated ECD services on the ground – where integration is defined as "the effective coordination of policies, laws and programmes across and within sectors to ensure that young children and their families receive access to comprehensive early childhood development services and support in combinations to ensure their optimal development".[1 (p. 13)] For example, where health services identify children whose growth is faltering and refer them to SASSA so that they are able to access the Child Support Grant. But while the word integration is foregrounded in the title of the Policy and is clearly seen as fundamental to delivering comprehensive ECD services, this has been challenging to translate into practice.

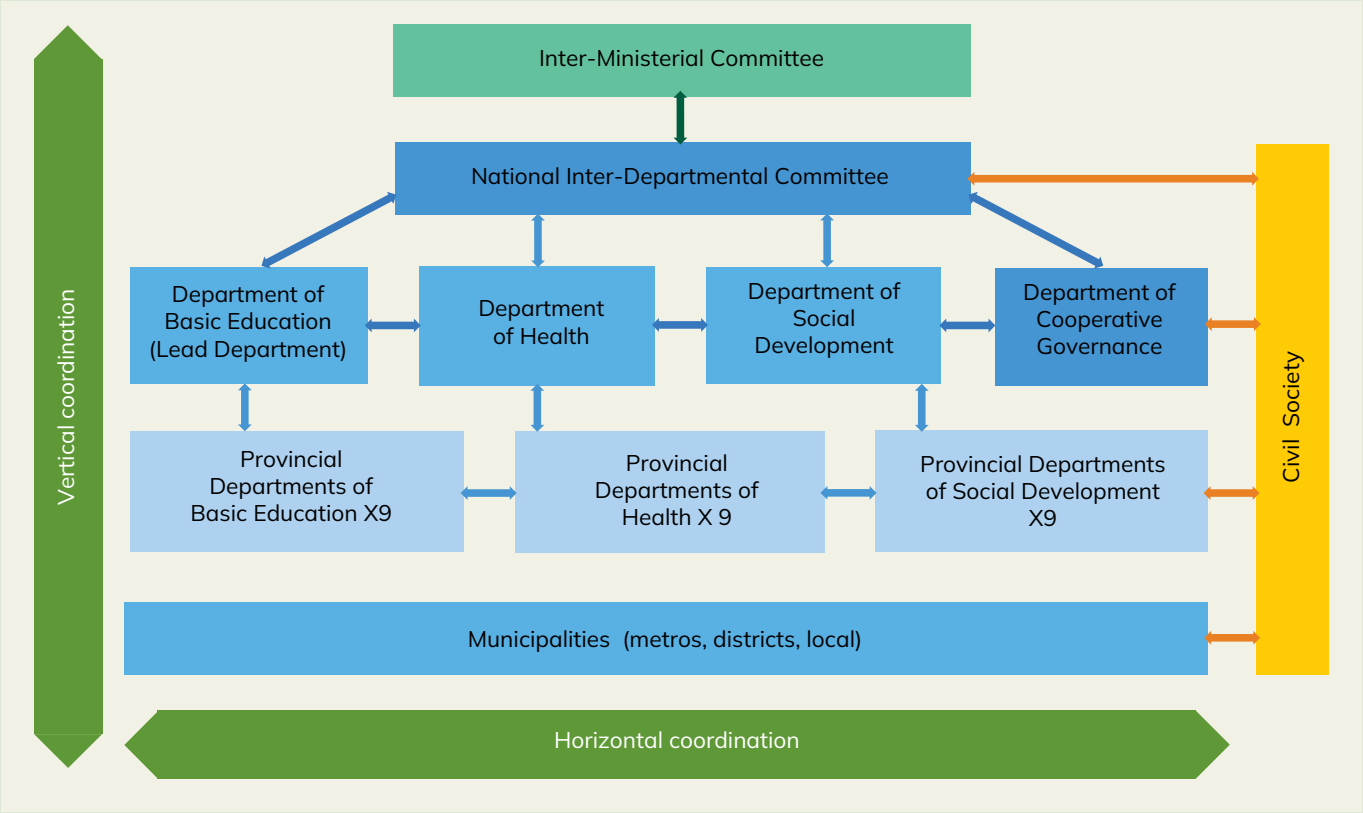
There are a wide range of both public and private role players in the ECD sector. Key departments include the departments of Basic Education, Health, and Social Development. The Department of Cooperative Governance and Traditional Affairs also has an important oversight role and a further 15 departments play a role in fostering early childhood development. While maternal and child health services are largely provided directly by government, early learning services are primarily offered by private providers in a market-led system, with limited government oversight and funding through the registration and subsidy system. Key civil society stakeholders include NGOs, NPOs, donors and the business sector as well as individuals who own early learning centres.

Coordination therefore has to be undertaken internally – within government departments; horizontally – across different government departments such as Health, Education and Social Development; vertically – across the different spheres of national, provincial and local government; and between government and civil society.

The Policy therefore provides for the establishment of coordination mechanisms at a political and bureaucratic level as well as across the different spheres of government, and between government and civil society. This includes the Inter-Ministerial Committee (IMC) on Early Childhood Development, supported by the National Inter-Departmental Committee (IDC) for Early Childhood Development, which should be replicated at provincial level; and an Intersectoral Forum (IF) which includes representatives from civil society to enable seamless planning and implementation at national, provincial and local government level.

Figure 22 illustrates the institutional arrangements to facilitate coordination within and across national, provincial and local spheres of government and with civil society.

Figure 22: Institutional arrangements and coordination mechanisms



What have been the challenges to date?

Since the adoption of the NIECD Policy in 2015 there has been very little translation of the policy reform prescripts into programme development. The NDP Review[8] ascribes this to limited capacity and poor leadership in the DSD who were responsible for the ECD function until March 2022.

The IMC

The Policy proposed that at national level the IMC, led by the Minister of the lead department, should meet four times a year to provide strategic direction. The NIECD Policy envisaged that the Presidency would support the ECD IMC to reinforce the national importance of early childhood development.[1] Ideally the IMC should demonstrate political will and commit the time, energy and human and financial resources needed to realise government's commitment to early childhood development as a national priority. A functioning IMC would strengthen policy direction in the system,[9] across spheres of national, provincial and local government i.e. vertical coordination and across departments i.e. horizontal level coordination within a sphere of government. However, the IMC had not been functional for some time, even prior to the function shift from DSD to DBE. Subsequent to the function shift in April 2022, it took some time for the Minister of Basic Education to constitute the IMC. In a significant development the ECD IMC met in April 2024, however this was just before the end of the sixth Administration. Nonetheless, this development should be welcomed as it provides a springboard for the seventh Administration.

The NIDC

The National Inter-Departmental Committee (NIDC) was envisaged as body that would to provide technical support to the IMC and drive implementation. The Policy identifies twelve core departments and an even larger group of departments as co-opted members. The NIDC is meeting regularly, however it has been reduced to a quarterly meeting of mostly junior level officials from a large number of departments. This cumbersome structure is not viewed as an effective coordination structure,[9] as it has failed to provide strategic direction for the sector. Key departments did not attend on a regular basis or were represented by relatively junior officials who did not have any decision-making power. Furthermore, a series of sub-committees were set up to deal with functions that were strategic in nature, for example developing data systems, which should ideally have been undertaken by the lead department, rather than being outsourced to a sub-committee. Another limitation of the NIDC is that it largely focuses on the challenges in the early learning sector, rather than it's broader ECD mandate.

Planning has remained department specific with no real attempt to coordinate planning across sectors, although there have been improvements since DBE assumed responsibility for ECD, for example an ECD Census in 2021. This Census 2021 provides both the Departments of Health and Social Development with the number and spread of ECD early learning centres to plan for the provision of health services and child protection services.

Intersectoral Forum

The NIECD Policy states that the South African Intersectoral Forum (IF) should be established to serve as a national platform through which the government and the non-government sector could engage. The IF consists of a range of NGOs, NPOs and donors, and has met regularly and is viewed as somewhat more effective than the NIDC.[9] The IF has provided technical support from NGOs and donors including research, for example, the ECD Census undertaken in 2021,[10] and operational support for the Vangasali Campaign[iii]. The forum brings together a broad range of civil society and donor organisations with different objectives, a concern has been raised that the forum is too large and that this hinders substantive engagement and that it mainly focuses on early learning programmes.[9] It may be useful to explore different mechanisms for different interest groups to facilitate substantial engagement. In addition, the IF has largely focused on centre-based early learning programmes, as the civil society representatives largely come from this sector. Greater effort should therefore be made to strengthen engagement with civil society partners in the health and child protection sectors to ensure that the IF addresses the full spectrum of ECD services.

Provincial Level Coordination

Provincial government is responsible for the delivery of key components of ECD services including basic education, health and social services. At provincial level the NIECD Policy envisaged that the Premiers would play the role of "reinforcing early childhood development as a provincial priority, ensuring sufficient resources, and inter-departmental commitment and collaboration".[1 (p. 86)] The NIECD Policy prescribes that a structure similar to that of the NIDC be established at provincial level. Given that the national coordination structures have not been functioning optimally, it has been difficult for good practices to filter down to provincial level.[9] There has been limited implementation of these structures across the provinces. To date only the Western Cape and KwaZulu-Natal have set up provincial coordination structures.[9]

Local Government

The local government level is responsible for amongst others the provision of basic services including water and sanitation; health care services; the development of policies and laws governing childcare facilities and the provision of land and regulation of land use.[1] These functions are crucial for ensuring child well-being across the different facets of early childhood development, for example health and early learning. The World Bank Group's 2023 review of public expenditure and institutional structures for coordinating, managing, monitoring and delivering ECD services in South Africa notes that "there appears to be weak coordination and collaboration between national level and local municipalities".[9 (p. 127)]

From coordination to integrated service delivery

Integrated service delivery has proven to be very difficult in practice, largely because there hasn't been a clear strategy that articulates how integration of services could work. Coordination mechanisms which should drive the strategy have not been functioning optimally which raises questions around political will and government's commitment to deliver ECD services. Yet even with optimal coordination, there would be a number of significant factors militating against integrated service delivery: including sector fragmentation, the significant role of non-state actors with different lines of accountability, systemic under-funding, and the inadequacy of the overarching legislative scheme.

What are the challenges and opportunities moving forward??

A change of leadership

In April 2022 the ECD function shift from DSD to DBE came into effect, this was initially proposed in the NDP[2] and subsequently announced in the State of Nation Address in 2019.[11, 12] While the function shift cannot address all the challenges faced in the ECD sector, it does present both opportunities and risks. As the lead department, there is the risk that the DBE could focus narrowly on their component of the ECD system i.e. centre-based early learning programmes. Ideally DBE should use this as an opportunity to adopt a broader view of early childhood development and lead on the strategic vision, goals and objectives needed to implement the NIECD Policy and reform the ECD system. This includes working with the Department of Health to improve the quality of services in the first 1,000 days of children's lives, as the evidence shows that investing early in life has the most impact across the life course (see page 44). The DBE has the capacity to reform the registration and subsidy systems for early learning programmes, and has

iii The Vangasali Campaign, run in collaboration with the Nelson Mandela Foundation, aimed to increase the number of registered ECD centres.

Case 11: Transforming ECD services at local level – PPT's experience in eThekwini Municipality

Mark Misselhorn[i]

Project Preparation Trust (PPT) is a non-profit organisation established in 1993 to assist with pro-poor change and transformation in South Africa. Amongst other focus areas, PPT has been working collaboratively with stakeholders at a metro, provincial and national level since 2013 to develop a scalable and programmatic ECD response model.

This collaborative effort has culminated in the development of a ground-breaking ECD Strategy for eThekwini Municipality, the first of its kind in South Africa. The Strategy was developed in close cooperation with multiple municipal, provincial and national departments (including those dealing with Basic Education, Social Development, Health, and Cooperative Governance), the South Africa Local Government Association (SALGA), and various civil society formations. Much can be learned from this experience to help other municipalities in South Africa.

Initiating programmatic collaboration in eThekwini

PPT's efforts to develop a programmatic ECD response model achieved traction in eThekwini Municipality largely due to its long-standing relationship of mutual trust and cooperation with the Municipality across a range of sectors including human settlements, infrastructure and informal settlement upgrading.

The presence of large numbers of vulnerable children in informal settlements and peri-urban communities was jointly identified as a key issue more than a decade ago. Most official data sets do not adequately cover informal settlements which can be challenging to survey. In these areas, most children are being cared for in poorly built, unsafe, under-resourced and mainly un-registered 'crèches' or informal daycare. Others are left at home with friends and relatives and can often be seen roaming unattended during the day.

Municipal support has been key to the strong progress made and was obtained at the outset via two Council Resolutions in 2017 and 2018 which prioritised the development of a programmatic ECD response. The resolutions mandated the Human Settlements and Safer Cities Units to play an initiating role, and established a Memorandum of Agreement with PPT to undertake initial work including surveys to obtain data, and infrastructure assessments and improvement plans with a view to improving existing facilities to acceptable standards.

The ECD collaboration was initiated via eThekwini's Human Settlement's Unit, with whom PPT was already working closely given its central role in the planning of more functional human settlements and the critical importance of ECD as an essential service in low income communities.

Field surveys to gather data

The initiative commenced with field surveys of ECD centres in informal settlements, townships and peri-urban communities, most of which were informal and unregistered falling outside the current system of state oversight and support. The data gathered was invaluable in better understanding the characteristics and prevalence of ECD services in these under-serviced communities. 657 ECD centres providing for 24,796 children were surveyed between 2015 and 2019 to establish the number and ages of children, ECD and NPO registration status, physical

i PPT

infrastructure, and the governance and capacity of centres. The survey found that: most informal ECD centres have the potential to provide acceptable education and care if they receive state assistance; poor infrastructure is a major challenge, posing health and safety threats to children and preventing partial care registration with government; most centres are unregistered for partial care and not receiving state assistance including ECD operational grants. In addition, regulatory flexibility is required in respect of formal zoning and building plans (noting that there are no approved planning layouts, land use schemes or approved building plans in informal settlements and rural communities).

A programmatic response model

A programmatic ECD response model was collaboratively developed in 2015/16 and included the following key elements: ECD data gathering and sharing; infrastructure improvements for under-resourced centres; support to achieve partial care registration; population-based planning; and multi-stakeholder coordination.

The initial phases of work were undertaken in collaboration with diverse stakeholders including the national and provincial departments of Social Development, Basic Education, and Cooperative Governance, the University of KwaZulu Natal, Training and Resources in Early Childhood Development (TREE), Ilifa Labantwana, and the Hollard Foundation amongst others. Key municipal departments, including those dealing with Human Settlements, Health, Development Planning, Safer Cities and Community Participation, were involved throughout. Funding was provided by eThekwini Municipality, the European Union via the Department of Planning Monitoring and Evaluation's Programme to Support Pro-poor Policy Development (PSPPD) and the DG Murray Trust / Ilifa Labantwana.

A municipal-level, multi-stakeholder ECD Steering Committee was established in 2015. Representation has expanded over time including alignment with the District Development Model and One Plan for eThekwini in 2021.

ECD Categorisation and prioritisation framework

A key component of the ECD response model was the development of a framework to categorise ECD centres, based on their infrastructure, registration status, institutional capacity and potential. Centres with the greatest potential for infrastructure assistance, investment and improvement were prioritised in order to unlock registration and access to ECD operational grants. Additional criteria included centres with 20 or more children and those which had been operating for at least five ten years.

eThekwini ECD Strategy

eThekwini's ground-breaking ECD Strategy is the outcome of more than six years of collaborative work, and is significant because, for the first time, it sets out a programmatic, multi-stakeholder and integrated ECD approach which is evidence-based and can optimise ECD outcomes amidst constrained resources. It can also serve as a resource to assist other municipalities who may want to develop ECD Strategies of their own. Key strategic thrusts include:

1. **Effective, programmatic ECD coordination, planning and budgeting**, including: quarterly meetings of the ECD Steering Committee; assignment of dedicated personnel to perform municipal-level ECD functions; establishment of annual ECD project pipelines and MTEF budgets.
2. **Improved infrastructure for ECD facilities**, including: improvements of existing centres with potential as the top priority; affordable new builds where required using affordable national standard designs; defining clear eligibility requirements for infrastructure support; availing under-utilised municipal buildings for ECD; prioritising ongoing operating and maintenance sustainability.
3. **Expanded capacity to deliver acceptable quality ECD services**, including: determining an optimal mix of ECD service types (e.g. ECD centres versus playgroups); training and skills development for ECD service providers; mentoring and support for child minders (home carers); evaluating the potential to support private operators in under-serviced communities; evaluating the potential for playgroups, toy libraries and safe outdoor play parks.
4. **Streamlined registration of ECD facilities, playgroups and childminders**, including regular infrastructure assessments; compliance inspections by municipal environmental health practitioners and registration inspections of ECD centres and child minders by the KZN Department of Basic Education and the municipality.
5. **Enabling regulatory flexibility**, including establishing an enabling ECD bylaw and more flexible land use arrangements (e.g. simplified land use application processes); relaxing land use conditions (e.g. parking requirements); help desk services; addressing building plan barriers; waiving or reducing rates and tariffs.
6. **Improved health, food and nutrition**, including regular visits by KZN Department of Health for health advice, monitoring of child health, immunisation etc.; training

of ECD practitioners / childminders / mothers to screen children for malnutrition; food supplementation; nutritional training and guidance relating to food safety, hygiene and communicable diseases.

7. **Improved ECD data, data management and data co-ordination**, including facilitating access to the national online ECD Registration Management Tool; collecting, capturing and analysing ECD and infrastructure data; collecting and reporting on provincial ECD indicators.
8. **Adequate ECD funding (capital and operational)**, including engaging with the Department of Basic Education and National Treasury regarding possible funding for the maintenance of ECD facilities owned by the Municipality and more adequate provision of capital funding for ECD infrastructure improvements.

Key achievements in eThekwini

Overall strong progress has been made since 2015 including:

- Multi-stakeholder ECD collaboration and cooperation including the metro-level ECD Steering Committee which has been running since 2015;
- A comprehensive field survey of 657 ECD centres serving 24,796 children in underserviced communities;
- Identification, categorisation and prioritisation of ECD centres for investment;
- Assessment of infrastructure and development of improvement plans;
- Establishment of an ECD infrastructure support and improvement framework with initial funding allocations;
- Accredited training for 160 ECD practitioners facilitated by the eThekwini Municipal Academy;
- Simplified and more affordable municipal land use processes to facilitate ECD partial care registration (e.g. neighbours consent instead of rezoning);
- Population-based services modelling by the Municipality to identify and prioritise the most-underserviced areas for long-term strategic planning;
- A situational analysis of demand and supply of ECD services;
- Development of eThekwini ECD Strategy and draft ECD Sector Plan, and integration of ECD into eThekwini's One Plan from 2021.

Cross cutting barriers to scaling up ECD

Several key barriers continue to constrain the scaling up of ECD services in a programmatic manner:

- Insufficient consensus across the spheres of government (hence the need for municipal-level ECD strategies and plans which enjoy multi-stakeholder buy-in);
- Insufficient priority given to early childhood development (despite national policy-level recognition);
- Funding constraints and fiscal limitations (not only for ECD operating grants but also for infrastructure improvements and local-level coordination);
- Statutory and regulatory inflexibility (e.g. making it difficult if not impossible for less-formal ECD centres to comply with land-use and building regulations);
- Difficulties in responding in working effectively with informality (rather than attempting to eradicate it);
- Inadequate ECD planning and coordination (including a lack of local-level integrated plans and strategies);
- Poor infrastructure (including buildings and basic services such as water, sanitation and electricity);
- A lack of capacity to respond to ECD at local level (which necessitates better coordination and cooperation and the assignment of additional personnel);
- No coordinating structure for ECD at municipal level (in eThekwini the absence of a suitable Unit or Department with the required capacity and resources to take the lead, has delayed the adoption of the ECD Strategy and implementation of upscaled ECD responses).

Implications and lessons for municipal collaboration

Municipal-level ECD collaboration is inherently challenging but it is possible for ECD support organisations to play a valuable role at municipal level in promoting cooperation and meaningful change. It is however important that they establish a relationship of trust and cooperation with all three spheres of government and are prepared to sustain their support over time as patience and endurance are required.

Significant trade-offs and compromises will inevitably be required if change at scale is to be achieved, so it is also beneficial to adopt a programmatic mind-set and to identify those interventions and responses which are most necessary, cost effective and potentially scalable.

Perhaps most challenging, is the need for all stakeholders to adopt new approaches and move outside of their historical comfort zones. This includes a willingness to work with and not against informality in its many facets, including the statutory and regulatory flexibility this unavoidably entails. Achieving meaningful ECD improvements can only be realised if we are prepared to work in ways which are more incremental, flexible, evidence-based and partnership-orientated.

particular strengths in developing and managing data systems. However, it must be noted that the government is operating in a fiscally-constrained environment.

The DBE should also revive the moribund coordination structures as set out in the NIECD Policy. Currently the NIDC meets quarterly, but the DBE has not made any significant changes to the way in which it operates. The Intersectoral Forum has continued to meet quarterly and collaborates reasonably well with the DBE but as noted earlier – it needs to expand its focus beyond early learning programmes.

Challenges with regard to capacity and technical expertise remain, even though this was highlighted in the NDP Review.[8] This was not adequately addressed in the function shift as a limited number of posts were transferred from DSD to DBE at both national and provincial level, and this has an impact both in operational terms as well as the on the capacity required to undertake coordination tasks. Furthermore, there also seems to have been inadequate planning by DBE, for example, a director-level post has not been filled for the past two years).[9] The transfer of posts and officials from DSD to DBE also raises the matter of different work cultures in the respective departments, and the 2023 Public Expenditure and Institutional Review proposed that the DBE should develop a comprehensive and intentional change management process to address this.

Currently the DBE is undertaking a review of the NIECD Policy. This presents an opportunity for the DBE in consultation with other government departments and stakeholders to enhance the functioning of the coordination structures. For example, the DBE has re-established the IMC and could potentially strengthen support from the Presidency by inviting the DPME Minister in Presidency to play a more active role in leading the IMC.

The challenge of coordination

Coordination of functions across government departments is a challenge for governments across the world,[13] hence this is not a challenge that is unique to South Africa. While the NIECD Policy has outlined the roles and functions of the key departments, the role of DBE as lead department is crucial to provide strategic leadership and direction for the ECD sector. This includes building and steering the coordination structures to work effectively towards a common goal, in this instance towards universal availability of – and equitable access to – quality early childhood development services[1] including health, nutrition, care, protection and early learning.

Schedule 4 of the Constitution assigns roles and responsibilities to the three spheres of government. Ideally mechanisms to address intergovernmental relations should work effectively, with cooperation as the basis for achieving national development goals. However, in practice, setting up, leading and managing coordination structures is both complicated and complex. Complicated, as it involves both vertical coordination (across different spheres of government – national, provincial and local government) and horizontal coordination (across departments at provincial level, at municipality level and with civil society), as well as coordination with civil society organisations. This has been a particular challenge in the early learning component of ECD. It is also complex as it operates in a complex web of systems, such as data, human resources and budgets as well as a network of contested and competing relationships within and across government departments and between government and civil society, multilateral and donor organisations.

Coordination is a function of strategic management and requires human resources with the requisite expertise and high-level skills to build relationships, manage conflict and negotiate solutions.

Nationally, the coordination structures for ECD are in a relatively weak state, either not functional or when functional, not very effective. While the President has mentioned early childhood development in his State of Nation Address over the last few years, there has been insufficient follow-through. It would seem that there is a lack of political will to translate the NIECD Policy into practice and to drive the building of an effective ECD system across government departments. The NIECD Policy clarifies the roles and functions of each government department. Within government departments, Deputy Director Generals (DDGs) would have ECD as part of their job function. Given that the IMC has met and a committee of Directors General has been set up to provide technical support to the IMC, we should see some progress in the seventh Administration.

The National Planning Commission has published an ECD Advisory[14] which deals with coordination challenges in the ECD sector. It spells out in great detail the different institutional mechanisms proposed in the NIECD Policy and shows how convoluted the coordination structures are for the delivery of ECD services. While the Advisory raises the vexing matter of child hunger, it largely focuses on the early learning component of ECD. Furthermore, the Advisory shows the complicated structures that are set out in the NIECD Policy and highlights the ambiguity created by local government legislation which has a negative impact on implementation, as there isn't consensus on roles and functions.[9]

The Advisory makes practical proposals with regard to coordination between provincial and local government and notes that ECD issues should be raised through existing

structures such as the intergovernmental forum that exists in different forms across the provinces. While some attention has been given to coordination at national level, both across government departments and with civil society organisations, few resources and attention have been provided at the provincial and local government level. The Constitution assumes cooperative intergovernmental relations across the spheres of national, provincial and local government, but in practice this has been quite challenging.

Coordination at provincial and local government level

Some provinces such as the Western Cape, KwaZulu-Natal, Eastern Cape and Gauteng have some level of functionality and some structures exist, however there is a question of whether these operate optimally[9, 15].While the NIECD Policy envisages that provinces would replicate the NICD, some provinces have opted to combine the provincial interdepartmental committee with the provincial intersectoral form.[16]

An often-neglected element of coordination is intra-departmental coordination. An example of good practice at provincial level is the First Thousand Days (FTD) transversal project implemented by the Western Cape Provincial government (see case 12). This FTD project was adopted as an apex priority in the Provincial Strategic Plan (2019 – 2024) which indicates high level political support. Furthermore, operational governance structures were set up to support the integration of services. This is a good example of what is possible when there is political support and capacity to implement ECD policies and programmes at provincial level.

The District Development Model

Government also introduced the District Development Model (DDM) in 2019, which aims to support the vertical integration of plans across the three spheres of national, provincial and local government. The DDM is meant to break down silos in terms of planning, budgeting and implementation at the district and metro level[9] in order to develop a plan that cuts across the three spheres. However, the DDM is unlikely to succeed when overlaid on a weak and dysfunctional local government sphere. Moreover, metros tend to have more capacity than districts and rural municipalities both in terms of government resources and services delivered by civil society organisations, which could further entrench inequalities.

There has been some success at building coordinating structures at local government level. The eThekwini Metro has been working with an organisation, the Project Preparation Trust (PPT) for a number of years (see Case 11). PPT has been assisting municipalities to develop an ECD infrastructure support model, focusing on informal settlements. PPT has established multi-stakeholder committees in every municipality in which it has worked, providing support to guide the development of ECD strategies, infrastructure and municipal plans. The Project Steering Committees (PSC) typically include a range of municipal departments such as environmental health as well as the provincial departments of Basic Education, Social Development and Health. The PSCs then undertake a range of functions including planning, and communication both within and between municipal departments, and engagements with national and provincial departments.

Civil society structures

Civil society organisations contribute substantially to the ECD sector at a variety of levels. Donor organisations and their donor intermediaries, such as Ilifa Labantwana, and multilaterals, like UNICEF, provide material or systemic support at national, provincial and local level. Donor networks such as the National Association of Social Change Entities in Education (NASCEE) and Independent Philanthropy South Africa (IPASA) work together to ensure a coordinated approach to funding ECD initiatives. Real Reform for ECD is a broad-based advocacy movement focusing on regulatory reform. In addition, there are in excess of 140 not-for-profit ECD Resource and Training Agencies which provide non-centre-based programmes, and practitioner training and capacity building. Many of these are members of national structures such as the National ECD Alliance (NECDA) and the Ntataise Network which support them, develop materials and advocate with government and donors on their behalf. The ECD Census noted in excess of 40,000 early learning programmes that constitute the largest stakeholder in civil society. These include for-profit microenterprises and NPOs. Local ECD Forums play a significant coordination role[iv] and act as a conduit for consultation, information sharing, capacity building and sharing of resources. The South African Congress for ECD advocates on behalf of ECD workers, provides skills programmes and has a provident fund and funeral policy scheme for ECD staff.

Building capacity

Additional human resource capacity with the requisite skills sets – both expertise as well as strategic management and relationship building skills – is required to provide strategic leadership (stewardship) and to manage coordination. Coordination goes beyond the administrative function of scheduling a meeting, it requires the provision of strategic direction and the building of relationships through building

iv Deep Dive study – 80% of respondents were part of an ECD Forum

a 'guiding coalition' across different departments.[16] There is important work that must be undertaken between monthly or quarterly meetings.

Coordination structures work when the different government departments work towards a common goal and barriers between government departments and professions are broken

Case 12: Strengthening services and support in the First 1,000 Days: An apex priority in the Western Cape

Hilary Goeiman & Nicolette Henney[i]

The Western Cape province has recognised the first 1,000 days (FTD) of life as a provincial priority and that investment in the health and wellness of pregnant women and infants is essential to enable children to thrive and reach their full potential.

The FTD was officially launched February 2016 as a transversal project and became an apex priority in the provincial strategic plan (2019 – 2024). Internally the Department of Health identified FTD as a priority in the life course and started to integrate the key building blocks in services and in the Western Cape Government strategic and Health annual performance plans. A situation analysis and intersectoral theory of change were developed to identify gaps and inform planning processes.

The GROW, LOVE and PLAY icons were developed to depict the key building blocks of the project and this branding is prominent in all communication materials. The project has also evolved in response to the emergence of new national and international policy, strategy and evidence and is closely aligned with the Nurturing Care Framework.

Operational governance structures were established to support the integration of health services, intersectoral collaboration and communication. The executive committee oversees the project – monitoring progress, identifying and responding to challenges, managing internal and external stakeholders and ensuring their participation throughout the implementation process. The exco then feeds back to management in the Department of Health and Wellness and through the provincial transversal management system.

FTD interventions are now integrated into health services at all levels of care including the delivery of facility- and community-based services; the training, support and mentoring of staff; drawing on lessons learned to drive quality improvement and systems strengthening. Partnership and collaboration with stakeholders have been a key component moving the initiative forward across the whole of government and whole of society.

Key deliverables include:

- A baseline survey to identify the predictors and drivers of stunting in the Western Cape
- Integration of risk screening tools into routine services
- A pilot of the Blanket Project[ii] to enhance parent and infant relationships
- Integration of book-sharing parent-caregiver package
- Geographically targeted interventions to address nutrition challenges and support ECD
- Monitoring and evaluation by applying an FTD lens when reviewing data across sectors
- Sensitisation of colleagues across a range of government departments to obtain buy-in, foster collaboration and facilitate the integration of the FTD agenda.

Key ingredients for success

- **Political will** is essential in driving the implementation of new initiatives and securing collective buy-in from key stakeholders.
- **Leadership** is needed to transform the environment, ensure sustainability (articulating goals and objectives) and facilitate adaptation (developing realistic action plans within available resources) while maintaining and improving service delivery.
- **Robust governance structures** are essential for project management, clear decision-making, effective risk management, efficient resource allocation, stakeholder engagement, compliance and accountability, alignment with organizational goals, transparency, reporting and continuous improvement to achieve the desired outcomes.
- The development of new initiatives is a **dynamic process** which requires agility, flexibility, adaptation and innovation.
- **Integration** is essential for optimal use of resources and sustainability.
- **Investing in relationships** is critical to develop a shared vision and foster collaboration.

i Western Cape Department of Health and Wellness
ii For more information, see: https://ilifalabantwana.co.za/project/ibhayi-lengane/

down.[16] But the current system disincentivises working across departments, as individual departments are only responsible for their respective mandates and the indicators and targets in their departmental Annual Performance Plans (APPs), which has largely resulted in a culture which is compliance driven and risk averse. For example, officials will set indicators and targets where they have control, rather than set an indicator which requires collaboration with another department, as there is a risk that the collaborating department does not undertake what they had committed to and there is a risk that targets will not be met. This results in a tick-box exercise rather than a cooperative and collaborative culture where working towards achieving a common objective is central.

The current manner in which planning is undertaken and budgets allocated does not support intersectoral coordination and collaboration. For example, APPs are department specific and there is no mechanism to undertake cross-departmental or cross-sectoral planning. Coordinating planning and budgeting across sectors is a challenge across countries. To address this challenge Chile, through its 'Chile Crece Contigo' (Chile Grows with You) has built incentives into the ECD system, where the national government has allocated funds, similar to South Africa's conditional grant mechanism, for the position of a coordinator at the local level,[17] based on the understanding that the coordination role requires dedicated capacity.

In South Africa, we may want to think about a support structure at the national level that will provide technical and organisational development support to build coordination structures at provincial level, especially where these are weak or do not exist. This should also be replicated at local level, but we may want to think about doing this in both a phased and differentiated manner as there are some structures already in place in some metros.

Coordination structures can also be used as an opportunity to showcase work of a specific department and to build a common understanding of different roles and functions and how different contributions can best complement one another.

What are the conclusions and recommendations?

The recent changes in institutional arrangements are a step in the right direction. In addition to the operational responsibility for early learning programmes, the DBE also has the responsibility for leading the broader ECD system within government. This needs to be undertaken in partnership with the Department of Health which remains responsible for the delivery of maternal and child health services and the Department of Social Development which remains responsible for child protection services as well as engaging with other relevant departments.

- The new Minister of Education should be given some time to get a sense of what the priorities are in early childhood development. She then needs to work with the Presidency to set up the next meeting of the IMC and set out the key priorities of the IMC in the seventh administration. It is further proposed that the DPME Minister in the Presidency should play a more active role in supporting the IMC, as outlined in the NIECD Policy.
- The evaluation of the NIECD Policy has been completed and it points to a disjointed approach to early childhood development across sectors and spheres of government. Hopefully this review process has built ownership of the Policy within DBE and coordination structures will be revisited to improve effectiveness. In revising the structures for improved coordination, the matters of intergovernmental coordination across the spheres (vertical coordination) should be prioritised.[1]
- The NIDC structure requires some changes to become more effective, for example, introducing an NIDC Executive Committee, comprised of senior level government officials from each of the three key departments, Basic Education, Social Development and Health,[9] which meets monthly. These senior-level officials should focus on strategic issues and have the authority make key decisions or be close enough to the executive management of the department they represent so that they can enable reforms in the ECD system. This is where political will can play a constructive role, given the demands on the time of senior government officials. A second tier NICD which includes high level representatives of the other relevant government departments should meet bi-monthly or quarterly.
- There is also room for improvement in the functioning of the IF, as it has a lot more potential than has been realised. In particular, civil society partners in the health and the child protection sectors should be included. Also, given the different interests and needs of the varied stakeholders, it may be an opportune time to revisit the role and structure of the IF and its related powers and functions, by establishing a separate donor forum.
- An ongoing challenge has been the capacity required to manage the coordination function at all levels of government and coordination with civil society. As part of the DBE strategy, the resources required for this function should be identified and costed. This may be an area where the government can partner with civil society, and donors and the private sector could play a role.
- With regard to integrated services provision this should be long-term goal and is worth striving towards over time.

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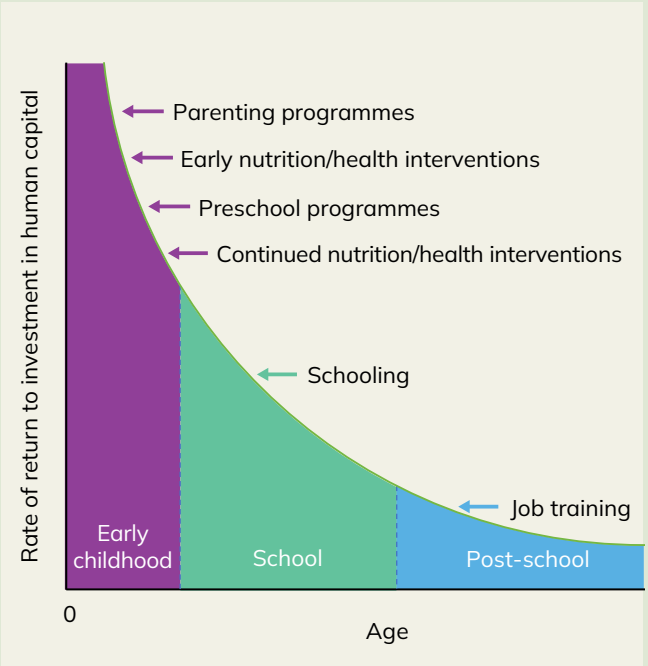
Strengthening the system: Early childhood development finance

Jesal Kika-Mistry,[i] Laura Droomer,[ii] Zaheera Mohamed[ii] & Engenas Senona[iii]

Investment in early childhood development (ECD) is one of the most powerful opportunities available to reduce structural inequalities in South Africa. A large body of evidence suggests that high-quality ECD programmes are needed to improve the skills of young children, particularly the most disadvantaged.[1-3] A study analysing the cost and impact of scaling 10 nutrition interventions in South Africa for a cohort of children born in 2021, estimates that every USD1 invested in early nutrition has the potential to yield USD18 in productivity return.[4] Investment in early childhood development also has the potential to reduce gender inequality by enabling women on the social and economic margins to access the labour market. First, directly by being a large employer of women in the care economy;[5] and second, through indirect and induced job creation. Recent estimates in South Africa suggest that every USD1 invested in accessible childcare services could generate USD7 in increased economic activity for previously unemployed caregivers.[6]

Figure 23: Rates of return to investing in human capital at different ages



Source: Dulvy EN, Devercelli AE, Van der Berg S, Gustafsson M, Pettersson GG, Kika-Mistry J, Beaton-Day F. *South Africa Public Expenditure and Institutional Review for Early Childhood Development (ECD PEIR)*. Washington DC: World Bank Group. 2023. Adapted from Heckman and Masterov.[7]

What is the status of funding for early childhood development in South Africa?

Several interventions are considered essential for a child's healthy growth and development, starting from pregnancy through to the transition into primary school.[8] These interventions can be grouped by sector and age/stage (Figure 23).[9] Recognising the importance of the first 1,000 days has resulted in a simultaneous improvement in child survival rates in South Africa.[10] However, young children still fail to reach their full potential, evidenced by high levels of stunting and poor learning outcomes.[10-12] Ensuring that young children not only survive, but also thrive, requires a focus on these key outcomes.

Budget allocations for early childhood development are largely located in three core national and provincial departments, i.e. health, education and social development.[13] Allocations to early childhood development interventions within these sectors are mainly through the equitable share. There are a range of policies that highlight the importance of different investments in early childhood development, however, in the mix of competing priorities, provincial governments often choose not to adequately allocate equitable share funding to early childhood development interventions. In theory, provinces have high levels of autonomy over these funds, but this is limited in practice due to the distribution of salaries across different cadres of personnel, which reflects the extent to which different services related to early childhood development are being funded.[14] Another major source of funding for early childhood development are conditional grants which are earmarked for a particular purpose. The ECD conditional grant was introduced to leverage change in the way that ECD subsidies are structured and managed, and encourage investment in ECD infrastructure as a national priority.

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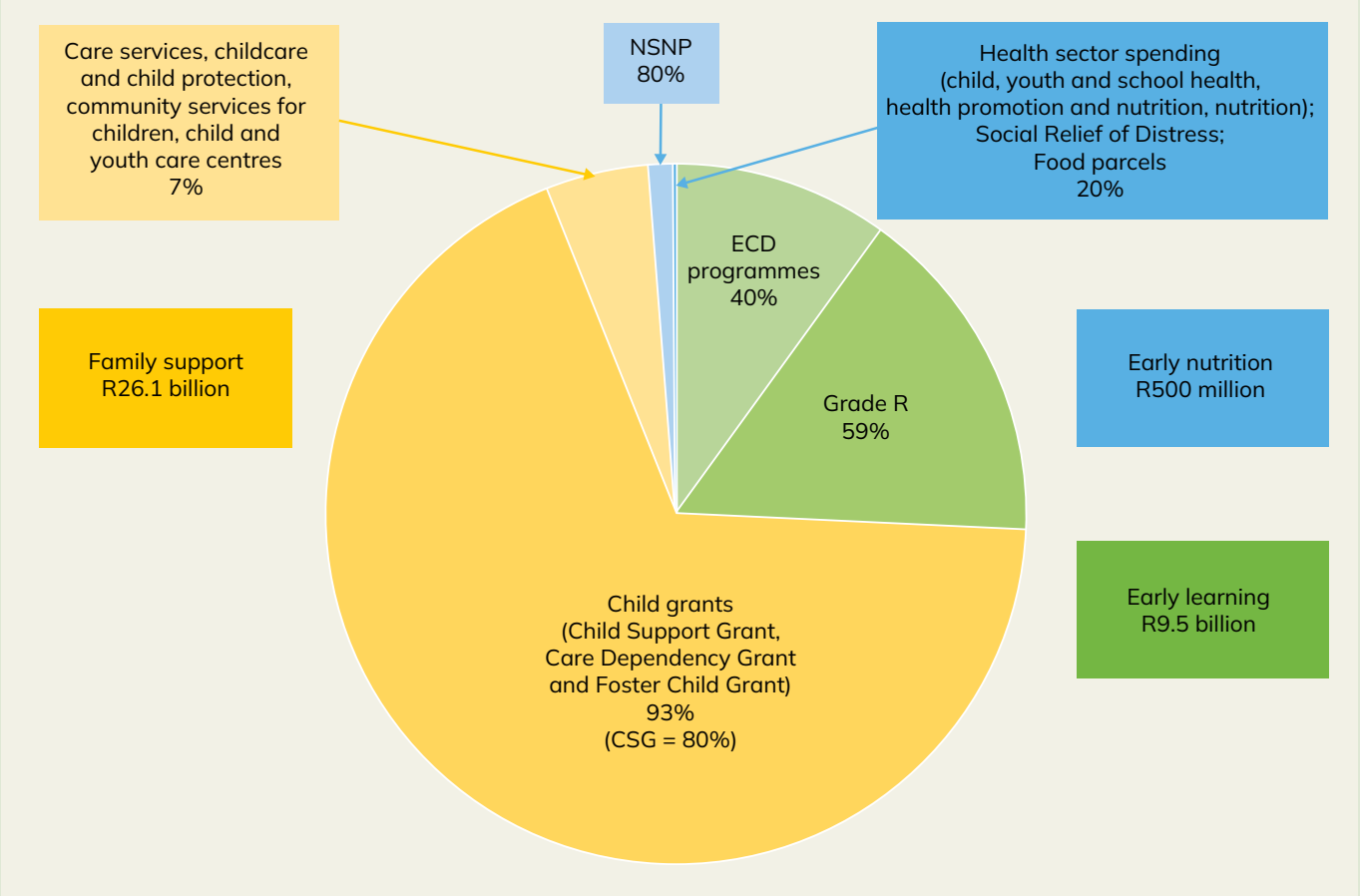
There are data limitations which restrict how the status of early childhood development funding can be analysed, even across core departments. Expenditure on maternal and child health services which fall under health in the above conceptual framework, are not recorded in South Africa's national Basic Accounting System or the Estimates of Provincial Revenue and Expenditure in a way that makes it possible to track spending on health and nutrition interventions during pregnancy and early childhood.[9]

Table 27: Critical interventions for early childhood development

<table>
<tr><th>Sector/Department</th><th>Sphere of government</th><th>Pregnancy</th><th>Birth</th><th>6 months</th><th>12 months</th><th>24 months</th><th>36 months</th><th>48 months</th><th>60 months</th><th>72 months</th></tr>
<tr><td rowspan="10">Health</td><td rowspan="10">Provincial government</td><td>Antenatal care visits</td><td colspan="4">Immunisation</td><td colspan="5"></td></tr>
<tr><td>Attended delivery</td><td colspan="2"></td><td colspan="7">Deworming</td></tr>
<tr><td colspan="10">Access to family planning and sexual reproductive health (including youth-friendly services)</td></tr>
<tr><td colspan="10">Access to healthcare</td></tr>
<tr><td colspan="10">Prevention and treatment of parental depression</td></tr>
<tr><td rowspan="2">Counselling on adequate diet for pregnant females</td><td rowspan="2">Exclusive breastfeeding</td><td rowspan="2">Complementary feeding</td><td colspan="7">Adequate, nutritious and safe diet</td></tr>
<tr><td colspan="7">Therapeutic zinc supplementation for diarrhoea</td></tr>
<tr><td>Iron-folic acid supplementation for pregnant females</td><td colspan="9">Prevention and treatment of acute child malnutrition</td></tr>
<tr><td colspan="10">Micronutrient supplementation and fortification</td></tr>
<tr><td rowspan="3">Water and Sanitation</td><td rowspan="3">Local government</td><td colspan="10">Access to safe water</td></tr>
<tr><td colspan="10">Adequate sanitation</td></tr>
<tr><td colspan="10">Hygiene / handwashing</td></tr>
<tr><td rowspan="4">Education</td><td rowspan="4">Provincial government</td><td colspan="10">Maternal education</td></tr>
<tr><td colspan="10">Caregiver education about early stimulation, growth and development</td></tr>
<tr><td colspan="5"></td><td colspan="3">Centre-based early learning programmes</td><td colspan="2">Grade R</td></tr>
<tr><td colspan="4"></td><td colspan="6">Childcare (if necessary)</td></tr>
<tr><td rowspan="3">Social Development</td><td rowspan="3">National and provincial government</td><td colspan="10">Child protection</td></tr>
<tr><td colspan="10">Childcare</td></tr>
<tr><td colspan="10">Social assistance transfer programmes</td></tr>
<tr><td>Home Affairs</td><td>National government</td><td colspan="2"></td><td>Birth registration</td><td colspan="6"></td></tr>
<tr><td>Employment and Labour</td><td>National government</td><td colspan="10">Parental leave</td></tr>
</table>

Source: Dulvy EN, Devercelli AE, Van der Berg S, Gustafsson M, Pettersson GG, Kika-Mistry J, Beaton-Day F. *South Africa Public Expenditure and Institutional Review for Early Childhood Development (ECD PEIR).* Washington DC: World Bank Group. 2023. Reproduced from Denboba A, Elder L, Lombardi J, Rawlings LB, Sayre R, Wodon Q. *Stepping up early childhood development: Investing in young children for high returns.* 2014. Adapted to the South African context.
Note: Some caregiver education and support interventions are in the health sector.

Figure 24: Spending on early childhood development, 2021/22



Source: Dulvy EN, Devercelli AE, Van der Berg S, Gustafsson M, Pettersson GG, Kika-Mistry J, Beaton-Day F. *South Africa Public Expenditure and Institutional Review for Early Childhood Development (ECD PEIR.)* Washington DC: World Bank Group. 2023.

Given these data limitations, expenditure on interventions for children aged 0 – 5[iv] that can be analysed are grouped into three buckets:

- early learning programmes (ECD centres and Grade R);
- family support (social assistance transfer programmes targeted to children; caregiver education about early stimulation, growth and development; childcare and child protection services); and
- early nutrition (complementary feeding; adequate, nutritious and safe diet; and micronutrient supplementation and fortification).[v]

Overall, early childhood development is grossly underfunded. In 2021/22, only R36.1 billion was spent on early learning, early nutrition and family support interventions to improve early learning and reduce malnutrition for children aged 0 – 5 years, as illustrated in Figure 24.[9] This is equivalent to 1.7% of national expenditure and 0.6% of GDP.[vi] The South African government spent over R26 billion on family support interventions, mainly on the Child Support Grant (CSG) for children aged 0 – 5; around R9.5 billion on early learning interventions, of which 59% was spent on Grade R in primary schools; and only R500 million on early nutrition interventions, of which 80% was spent on the National School Nutrition Programme (NSNP) for children aged 5 – 6 in Grade R in public primary schools.

Across the identified interventions that contribute to improved early learning and reduced malnutrition, and for which expenditure data is available, it is important to ask the following:

- Is public expenditure adequate to achieve desired outcomes?
- Is public expenditure on services to promote child development equitable?
- Is public expenditure efficient when considering allocations between different child development needs?

iv Pre-primary interventions for older children (aged 5 – 6) are included to capture the transition from centre-based early learning programmes to primary school. Nutrition services provided at the pre-primary level are also covered.
v Expenditure analysis for early nutrition interventions cannot be restricted to the age group of focus since the available financial data is not disaggregated by age. Interventions included are those most likely to cover young children.
vi Other estimates by Ilifa Labantwana and Kago Ya Bana come to roughly 5% of national expenditure and 1.5% of GDP.

Spending on early learning

More is spent on older children in Grade R

The government tends to spend more on older children in Grade R in public primary schools compared to younger children in early learning programmes (ELPs). About 59% of early learning expenditure is on Grade R, with the remaining 40% being spent on the ECD subsidy for poorer children in registered early learning programmes. This is the case even though Grade R in public primary schools accounts for approximately half the number of all children enrolled in ELPs. The difference in expenditure is driven by the relatively low value of the ECD subsidy in ELPs (where government spent R4,488 per child per year in 2021/22) compared to its expenditure on Grade R learners (valued at R7,307 per year in 2021/22). In addition, only 40% of the 42,420 ELPs identified in the 2021 ECD Census are fully or conditionally registered, and only 32.5% received the subsidy.[15]

Early learning programmes do not benefit from the NSNP, so the ECD subsidy also needs to subsidise the costs of nutrition support for younger children. In addition, ELPs require more specialised infrastructure, class sizes are smaller, and staff salaries are far lower than those for staff working in Grade R in public primary schools – in ways that further deepen inequalities in expenditure across the two groups.

The ECD subsidy amount is inadequate

The National Integrated Early Childhood Development Policy (NIECD Policy) states that the purpose of the ECD subsidy is to ensure that costs do not prevent the poorest children from accessing quality services. The current subsidy amount of R17 per child per day (for 264 days per year)[vii] is not sufficient to cover the cost of a minimum level of quality provision. Recent estimates using the 2021 Baseline Assessment finds that the cost of provisioning in an ELP is approximately R91 for ELPs that are compliant with norms and standards.[26] As a result, the costs of provisioning (for both subsidised and unsubsidised programmes) are often passed on to families in the form of fees, with roughly 80% of children attending ELPs being charged fees.[16] Private fees pose a major barrier for poor households and ELPs servicing these poor households bear the triple burden of trying to get government subsidies, charging lower fees and providing fee exemptions for children in poor households.[17] This means that the poorest children are often the least able to access subsidised services, undermining the overall purpose of the subsidy. This also stands in contrast to quintile 1 to 3 schools, where the poorest children do not pay fees.

The value of the subsidy has been eroded by inflation

Figure 25 on page 152 shows how the value of the ECD subsidy has been severely eroded by inflation over the past 16 years. It shows that the value of the subsidy in real terms (in the absence of inflationary increases) is R13.59, compared to the R29.44 it would have been, had it been increased on an annual basis with inflation (plus 1%)[viii] since 2008.

Insufficient budget to reach all children eligible for subsidy

Analysis of the Estimates of Provincial Revenue and Expenditure shows that the budget for subsidies in 2022 was around R2.73 billion, suggesting a reach of around 607,220 children.[ix] This represents less than 45% of the estimated 1.4 million CSG beneficiaries currently accessing ELPs.[18] In addition, some provinces report that there is insufficient budget to reach all children who are eligible for the subsidy. In these instances, provinces often end up 'rationing' the subsidy, with some covering a certain proportion of eligible children, some reducing the daily rate or funding fewer days. These concerns are compounded by inefficiencies and inequities in the registration process,[x] and challenges in applying for, and using the ECD subsidy. The removal of the requirement for ELPs to register as non-profit organisations to receive the subsidy is progressive,[19] but other barriers to registration still need to be addressed. See commentary on the draft Children's Amendment Act on page 22.

Spending on early nutrition

Expenditure on nutrition interventions favour older children

Stunting can have a profound impact on long-term health, development, and productivity. The National Food and Nutrition Security Survey reports that 28.8% of children under the age of five were stunted.[20] While malnutrition among young children is widespread, expenditure on nutrition interventions favours older children. Most of the nutrition spending is directed to children in Grade R in public primary schools through the NSNP, which does not benefit younger children who have not yet entered formal schooling,[9] even though remediation for stunting is most effective for the youngest children. While 40% of the ECD subsidy is intended to cover nutrition, the subsidy's

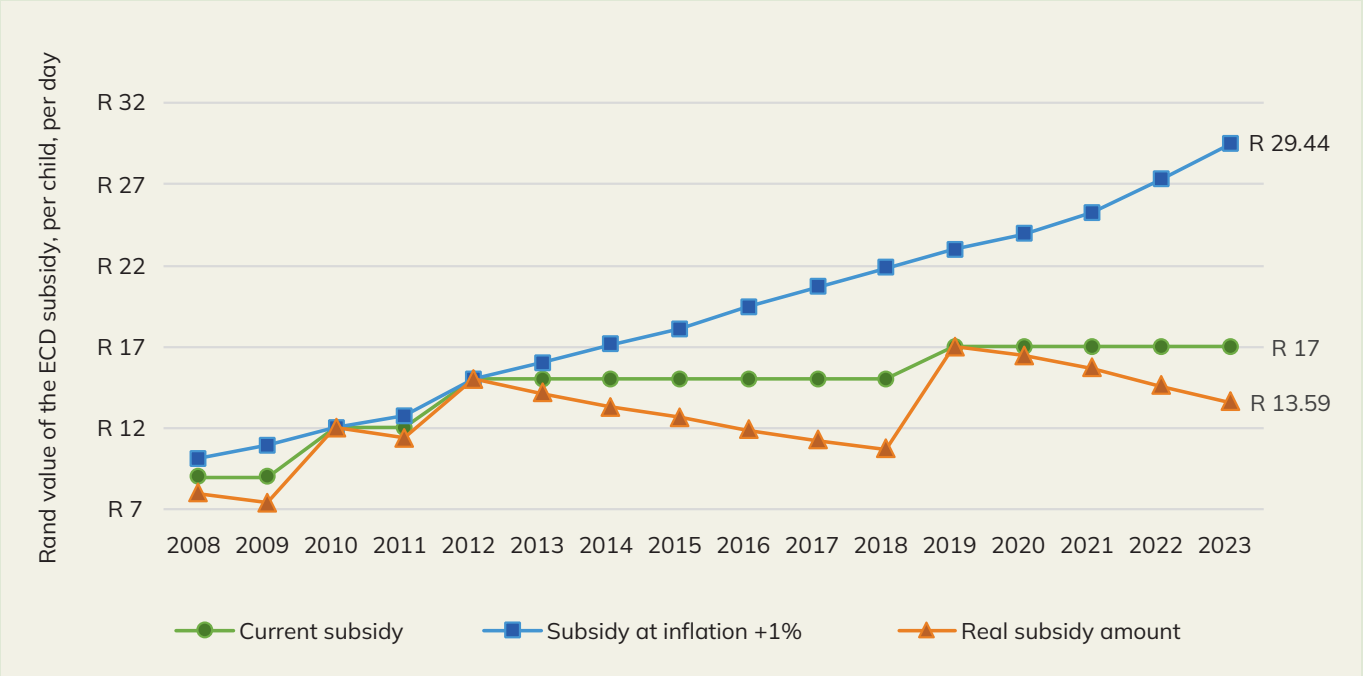
vii For children whose parents/caregivers fall below the Child Support Grant (CSG) income threshold.

viii The Consumer Price Index (CPI) is used for the inflation rate. An additional 1% is added to this rate as a minimum based on the assumption that CPI in itself does not accurately capture the actual inflation on the inputs that the subsidy should pay for. Currently, the recommended split of the subsidy is 40% for food, 40% for salaries and 20% for other items, including learning and teaching materials. The additional 1% is, therefore, a proxy/placeholder for the difference between CPI and the actual inflation in the inputs that the subsidy should buy.

ix This could be more if there were subsidies for non-centre-based programmes (R6 per child per session), but these are extremely limited.

x These include onerous regulatory frameworks, coupled with insurmountable costs to start up a programme that meets the regulatory requirements, especially for programmes in the poorest communities.

Figure 25: Impact of inflation on the real value of ECD subsidy, 2008 – 2023



Source: Brooks LE, Kotzé J, Almeleh C, Senona E. Assessing the policy options for the public provisioning of early childhood development programmes. *South African Journal on Human Rights*. 2022;38(3–4):240–260.

limited reach and low value mean that it is does not provide comprehensive nutrition support for children in ELPs.

Delays in the initial uptake of the CSG

Coverage of the CSG is overall high and well-targeted to poor households. However, there are delays in the initial uptake of the grant (for children aged 0 – 12 months), which restricts families' ability to provide adequate nutrition during the critical first year of a child's life. While 85% of poor children under six years received the CSG in 2022, only 65% of infants living below the upper-bound poverty life benefited from this essential income support.[21]

CSG is inadequate to cover the basic per child food cost

The amount of the CSG is inadequate to cover the basic cost of feeding a child, and, in 2024, the CSG amount of R530 was equivalent to only 70% of the food poverty line (valued at R760 in 2023 after accounting for inflation). This implies that households cannot rely on the CSG to meet their young children's basic nutritional needs, even if they were to spend it all on food, let alone the costs of other essentials, such as rent, electricity, transport etc.

What can be done to enhance adequacy, equity and efficiency of spending?

The migration of the responsibility for early childhood development from the Department of Social Development (DSD) to the Department of Basic Education (DBE) presents a window of opportunity for the government of South Africa to redefine and re-imagine effective financing practices for early childhood development. Recommendations are provided for financing the overall early childhood development system, including specific recommendations to improve early learning and reduce malnutrition. Policymakers need to make decisions about the appropriate sequencing of interventions, depending on their relative importance in improving early childhood development outcomes, supporting evidence, the benefits to families and caregivers, and barriers to roll-out such as capacity and financial constraints.[4]

Overall recommendations:

Increase government funding for ECD services

A substantial increase in government funding is required to improve the delivery of comprehensive ECD services and to improve child development outcomes. Interventions with expected high rates of return should be introduced in order of priority, as affordable, and targeted to support the most vulnerable children, families and ELPs.

Over the last decade, continuous austerity measures has significantly reduced spending on public services, particularly for healthcare, basic education and social services.[22] This has resulted in implications for the value the CSG, children's access to health care services, closure of NPOs providing child

protection services, and an ECD subsidy that has not increased with inflation for years.[23] Prioritising social sector spending is, therefore, essential to prevent the erosion of children's rights, development, and overall well-being.

Considerations for a new funding model

While it may be ideal from an administrative point of view to have a single funding model, the reality is that to date, the government has underfunded early childhood development and that any single proposed funding model at this stage, is unlikely to leverage the strengths and resources of multiple stakeholders (or funding sources) available, thereby limiting the overall impact on children.

To this end, a variety of funding models could be considered. Public funding for early childhood development should account for most of the funding, given its ability to reach scale, address inequalities, ensure sustainability, and being subject to greater scrutiny and accountability. Public funding can come from different spheres of government (national, provincial, or local) and within the general funding model, government could choose from a variety of funding and provisioning modalities. While primary funding responsibility should be public, other funding sources could be leveraged, including private funding through foundations, corporations, or individuals; social impact bonds; philanthropic funding or public-private partnerships.

Holistic planning, budgeting and implementation

Overall, the lack of a holistic approach to budgeting for early childhood development across key departments and interventions results in inadequate funding amounts and disparate funding flows, particularly in areas that span across more than one sector.

This requires strengthened coordination and leadership; regular dialogue across relevant departments to ensure that ECD outcomes are being achieved collectively; and for the respective departments to be held accountable for delivering essential programmes. The Annual Performance Plans and Annual Reports of the respective national and provincial departments should clearly articulate the linkages between expenditure, programme implementation and outcomes.[9]

In terms of accountability related to children's health, the United Nations Convention of the Rights of the Child (UNCRC) recommends that investment in children should be visible in state budgets through a detailed compilation of resources allocated and expended.[24] These budgets and expenditure should be further disaggregated for monitoring and analysis of spending on maternal and child health interventions, which may become possible through the National Health Insurance (NHI) baskets of care.

Reducing malnutrition

Provide maternal income support

The government should provide income support to poor pregnant women in their second or third trimester by extending the CSG into pregnancy. This income support would then automatically convert into the CSG when the child is born. A secondary benefit would, therefore, be an increase in uptake of the CSG among 0 – 12-month-old children.

Raise the amount of the CSG to cover basic food costs

Nutrition has a critical impact on child development outcomes and has one of the highest expected rates of return on investment. The value of the CSG should therefore be restored to the food poverty line in order to cover the costs of feeding a child.

Provide nutrition support for young children in ELPs

The government should provide nutrition support to the poorest young children attending ELPs, irrespective of the registration status of those ELPs. A mechanism separate to the ECD subsidy could be introduced to ensure nutrition support reaches all children attending ELPs. For example, more mature ELPs could receive fund transfers directly and procure and prepare food on site, while less developed ELPs could be supported by the NSNP suppliers, logistics, school kitchens and monitoring systems. The feasibility of this approach in the ECD sector should be explored.

Double-discounting ten best buys

Another proposal that is being debated proposes that if food manufacturers and retailers agreed to waive the mark-ups on one product label of ten best-buy foods (that are low cost and highly nutritious)[25] and government matched this discount on proof of the discount sales, the combined discount could be passed on to consumers, enabling them to affordably access nutritious food.[xi]

If the entire CSG value of R530 were spent on the discounted basket of foods (assuming a combined 30% discount),[xii] it would just about meet the child's minimum daily nutritional requirements and the government could be deemed to have almost met that part of its constitutional obligation in ensuring

xi Eggs, speckled beans, pilchards, fortified maize and rice, milk powder, soya mince, peanut butter, lentil soup mix and amasi (sour milk).
xii Assuming a 15% discount from retailers matched by government.

that every child has the right to basic nutrition. In addition, for eligible non-recipients of the CSG and children of foreign nationals, this approach would ensure some protection against the risks of hunger and acute malnutrition.

Improving early learning

Increase the value of the ECD subsidy

Increases in the value of the ECD subsidy should be linked to inflation to ensure that it retains its value from year to year. The value of the subsidy should also be increased to a level which is able to ensure an acceptable level of quality service provision[xiii]. Using data from 2021, this was estimated to be R91 per child per day.[26]

Increase access to the ECD subsidy

This can be achieved through the following:

- The 2024 Children's Amendment Bill aims to streamline two onerous registration processes (for partial care facilities and early childhood development programmes) and aims to enhance coordination between national, provincial and local government to streamline health and safety regulations and bylaws.
- National government should explore extending the ECD conditional grant (infrastructure) to provide inclusive start-up and growth support to ELPs to ensure the subsidy benefits the poorest children. For example, by providing more infrastructure grants to independent providers of ELPs. One of the key reasons that programmes remain unregistered is that they often do not meet infrastructure norms and standards.
- Government should consider collaborating with strategic implementing partners (such as resource and training organisations) in order to achieve universal access to ELPs more cost efficiently. For example, these partners could be contracted to interact with ELPs on the government's behalf in order to help providers meet registration requirements and access the subsidy, and monitor outcomes.
- Provincial governments should allocate sufficient funds to provide subsidies for all children attending ELPs who meet the eligibility criteria.

However, increasing access will also require an increase in the workforce and in the required infrastructure. The expansion of the system should, therefore, be phased and targeted to prioritise the most disadvantaged children and communities.

xiii An acceptable level of quality provision is defined as meeting four-fifths of norms and standards in the Children's Act related to structural quality.

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Building the capacity of the early childhood development workforce to deliver quality and responsive services

André Viviers,[i] Neil McKerrow[ii] and Nkele Yvonne Lechaba[iii]

The delivery of an integrated package of services and support to young children and their families is dependent on the expertise of a diverse array of professionals and practitioners working both within and outside of government. Most of these essential services are rendered within the basic education, health and social welfare systems at national and provincial level. While each sector is clearly differentiated with its specific mandate, opportunities and challenges, it is also important to consider points of integration and collaboration across disciplines and sectors in order to support young children's holistic development.[1]

There are two major challenges that arise from current policy and practice discourse that need to be addressed in order to build an effective early childhood development workforce:

- On the one hand the workforce responsible for delivering quality services from pregnancy to school-going age needs to be comprehensive and cut across a range of sectors, yet there is a risk that attempts to be inclusive may cause a dilution in focus;
- On the other hand, the predominant focus on early learning has the potential to compromise the delivery of a broader package of care and support.[2]

Both of these challenges stem from the principle that the early years provide a unique window of opportunity to enhance human development by providing a comprehensive range of services to young children and their families.[1] Yet the continued

Figure 26: A multi-sectoral workforce for early childhood development

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iii South African Council for Educators (SACE)

romanticisation of an integrated rather than a harmonised approach to service delivery has its limitations. Notwithstanding decades of policy attempts to facilitate integrated service delivery by government at national, provincial and local spheres this has not proven feasible and sustainable at scale and a more harmonised approach to service delivery to young children and their families may provide for a more sustained and coordinated approach.

Who are the human resources for early childhood development?

Supporting young children's optimal health, care, nutrition, protection and early learning requires a multi-sectoral workforce that includes specific cadres within the basic education, health and social welfare sectors, as illustrated in Figure 26.

While most human resources in the basic education, health and social welfare sectors are responsible for delivery of services, it is equally important to ensure that adequate human resources are in place to create an enabling environment. This includes human resources for: policy, administration and coordination; management and supervision; and education and training, as these are key determinants of the quality of services and child outcomes.[3, 4]

How have policies evolved to strengthen human resources for early childhood development over the past three decades?

The evolution of policies related to services to young children since the advent of democracy coincided with the recognition of the need to develop appropriately qualified human resources, in order to transform South African society from the devasting effects of the apartheid system, and to ensure that young children and their families are afforded their human rights as safeguarded in the Constitution of the Republic of South Africa, 1996.

The policy intent to develop the human resource capacity to render a variety of services to young children was well established in the early years of democracy.[5-8] Yet, by 2013 persistent challenges were apparent across all three sectors.[9-11] While the human resource policy provisions in the health and social development sectors have remained relatively unchanged over the past 15 years, there have been significant policy changes aimed at strengthening the early learning and development workforce. This includes the goals set out in the National Integrated Early Childhood Development Policy (NIECD Policy),[3] the requirement for a stronger pedagogical approach to early learning in the National Curriculum Framework for Children from Birth to Four (NCF),[12] and the inclusion of young children with disabilities as outlined the White Paper on the Rights of Persons with Disabilities.[13]

The National Integrated ECD Policy outlines a comprehensive suite of early childhood development services and aims to "develop appropriate cadres of early childhood development (ECD) practitioners, in sufficient numbers and with sufficient skills" to support the implementation of the policy. This included health promoters and community health workers (CHWs), ECD practitioners, child minders, toy librarians, community-based rehabilitation workforce and health care practitioners to support children with disabilities and their families , and with a primary focus on the education and training of those working in early learning and development programmes, and the direct supervision of CHWs and ECD practitioners. Yet the policy is silent about the wider cadre of human resources in the health care and social development sectors, and the proposed qualifications[iv] for ECD educators and practitioners.[1] However, the subsequent approval of the Policy on Minimum Requirements for Programmes Leading to Qualifications in Higher Education for Early Childhood Development Educators,[14] provided the impetus to improve the qualifications of those responsible for implementing early learning programmes.

The shift in leadership and coordination of early childhood development from the Department of Social Development to the Department of Basic Education in 2022[15] provides an opportunity to strengthen the workforce for early learning programmes but has no impact on the other cadres of the ECD workforce. However, in the short- and medium-term, it may provide an opportunity to review policy and programmes across all three sectors in order to enhance collaboration with health and social development.

The following section will identify challenges and opportunities to strengthen human resources for early childhood development by examining the mandates, staffing, education and training, and career pathways in each of the three sectors: early learning, health and social development.

What are the opportunities to strengthen human resources for early learning and development?

A good start

The 1995 White Paper on Education and Training set the democratic government's agenda for education in the country[5] and gave effect to the Reconstruction and Development Programme's (RDP)[16] vision that early learning programmes should be an integral part of a future education and training

iv National Qualification Framework (NQF) level 4 and 5 qualifications equivalent to a matric and a higher education certificate.

Case 13: The search for a professional home: ECD practitioners and 30 years of promises

André Viviers,[i] *Rex Molefe*[ii] *and Ruby Motaung*[iii]

Professional recognition for any profession coincides with three interrelated areas of regulation. These are *prescribed qualifications* (the minimum qualification needed to be registered (licensed) to practice); registration (the legal requirement to be registered with a regulatory body before a person may practice); and *minimum standards of conduct* (the required conduct and ethical practice that a registered professional must adhere to and the sanctions for non-adherence).[17]

Professional recognition plays an important role in the agency of the person practicing the profession as well as the locating them within a system that supports their career development, conditions of service and required proficiency recognised by peers. This coincides with professional accountability and support for continued professional development.

The commitment to develop a professional workforce to provide early learning and development programmes under new democratic dispensation emerged 30 years ago in the Reconstruction and Development Programme (RDP)[16] which called for training, upgrading and the setting of national standards. This commitment was reflected in the White Paper on Education and Training (1995)[5] which recognized that teachers in early learning programmes require specialised knowledge and skills, while the Interim Policy for Early Childhood Development (1996)[18] explicitly called for the professional registration of ECD practitioners/educators and that they be registered with the South African Council of Educators (SACE). The latter commitment is also reflected in the Education White Paper 5 on Early Childhood Education (2001)[6] and the Children's Act 38 of 2005 which require those providing early learning programmes to have the required skills and training. Again, the Diagnostic Review of the ECD Sector (2012)[10] reminded the country nearly 20 years after the RDP that standardisation of the training, qualifications and remuneration of those providing early learning need should to be prioritised which led to the National Development Plan[11] stating that government needs to invest in training ECD practitioners, upgrading their qualifications and developing clear career paths. The latter was articulated in more detail in the National Integrated Early Childhood Development Policy (2015)[1] nearly ten years ago, while the Policy on Minimum Requirements for Programmes Leading to Qualifications in Higher Education for Early Childhood Development Educators (2017)[14] followed with clear commitment on the qualifications required for educators and practitioners teaching in early learning programmes. The main objective being the development of a cadre of educators and practitioners who are capable of delivering quality early learning programmes

In 2004, SACE started to register Grade R educators in both public and independent schools, providing a professional home for ECD educators and practitioners, which was later followed with the opportunity for ECD practitioners who completed ECD Level 4 or Level 5 qualification to register, subject to certain conditions (conditional registration that opened an opportunity to follow the qualification trajectory for full recognition).[19] Between 2017 to 2023 a total of 136,296 ECD practitioners completed the P.L.A.Y. free online in-service training[20] that is accredited with SACE for continuing professional teacher development (CPTD) points. The significance of this is that more ECD practitioners completed a CPTD accredited course, than the 119,773 Grade 1 to 3 educators who required CPTD points over the same period, despite there being no regulatory benefit or requirement for them to do so.

The early learning workforce is ready for professional recognition through regulation, and the immediate ask is for the accelerated implementation of 30 years of commitments and promises.

i UNICEF South Africa.
ii Motheo Training Institute Trust and National Early Childhood Development Alliance (NECDA)
iii TREE (Training and Resources in Early Education)

system and that the Ministry of Education needs to improve access to all levels of education, including early childhood development. In particular, the White Paper indicated that a specific pedagogical approach is required for the early learning and development of young children from birth until they enter school; and that their early learning needs to be "entrusted to teachers who have specialised training in the educational needs of this age group". The latter echoes the vision of the RDP[16] which indicated that "the democratic government also bears the ultimate responsibility for training, upgrading and setting national standards" for those who provide early learning, i.e., ECD educators and practitioners.

Lost opportunity and new opportunities

But this vision of the Ministry of (Basic) Education being responsible for early learning programmes and the training, professionalisation and recognition of ECD practitioners as part of the education workforce did not unfold as intended during the 1990s. The National Development Plan (NDP) reaffirmed these earlier commitments by proposing to shift responsibility for the ECD function from the Department of Social Development to the Department of Basic Education, and by calling on the country to invest in the training ECD practitioners, upgrading their qualifications and developing clear career paths.[11]

The achievement of the goals set out in the NDP and Sustainable Development Goals to improve early learning and development outcomes for young children is directly dependent on the capacity of the workforce to provide quality and age-appropriate ECD programmes,[3, 21, 22] and these national and global commitments provide further impetus to ensure the systematic and resourced implementation of the NIECD Policy, and the Policy on Minimum Requirements for Programmes Leading to Qualifications in Higher Education for Early Childhood Development Educators[14] as well as the professionalisation of those providing early learning and development programmes.

Early learning educators and practitioners

According to the 2021 ECD Census, the majority of staff providing early learning and development programmes, work in the non-governmental sector, with a total of 165,059 ECD practitioners and educators (with an average ratio of 3.9 "teaching staff" per ECD programme).[27] Nearly half (48%) of ECD practitioners have no appropriate qualification in early learning and development, while 42% have a Level 4 or 5 qualification (with the overwhelming majority having a Level 4 qualification), and a further 10% having an NQF Level 6 to 9 qualification.[27] This indicates that an overwhelming majority of ECD practitioners do not have the required knowledge and skills to implement quality early learning and development programmes and improve early learning outcomes for children. In 2013, 30% of ECD practitioners had an ECD qualification and 55% had no formal ECD qualification.[28] In other words, there has been no significant change since 2012 when the *ECD Diagnostic Review* expressed concern about the limited capacity of ECD practitioners, educators and administrators to implement quality early learning and development programmes as required in policies and curricula.[9-11]

Qualifications

Unlike other professionals working with children in their early years, there is no official professional recognition of ECD practitioners nor any requirement for them to register with a professional body in order to be employed by an early learning programme. Although the Children's Act 38 of 2005 in its Regulations and Norms and Standards provides for some basic requirements, these are seemingly not adhered to, nor used to regulate those who provide early learning programmes to young children, other than (in some instances) the provisions of the Child Protection Register which prohibit people convicted of child abuse and neglect from working with children.[29]

The lack of professional recognition coupled with a lack of minimum requirements for qualifications, supervision and career paths has an impact on the agency of ECD educators and practitioners as there is little incentive for them to invest in further qualifications and skills development, and when individuals do improve their qualifications, they are more likely to seek opportunities outside of the early learning sector, for example in Grade R and/or primary schools. In addition, early learning programmes are largely dependent on parent fees, donors and government subsidies for their income, which makes it almost impossible for ECD practitioners to earn a reasonable wage in line with their qualifications, especially in poorer communities. In the relatively large not-for-profit sector, government's financial support through the ECD subsidies is not sufficient to support the development of a more professional and qualified workforce, and simply perpetuates the cycle of underqualified ECD practitioners remaining in jobs with low wages and with very little opportunity or incentive for progression within the sector.

Education and training of ECD practitioners are offered by approximately 169 registered training providers (resource and training organisations (RTOs) and TVET Colleges, excluding private providers),[30, 31] though not all of these are currently offering qualifications. A concern is that the majority of current registrations are for the legacy Education, Training and Development Practices Sector Education and Training Authority (ETDP SETA) ECD qualifications and DHET Educare qualifications, phasing out at present and relatively few providers are registered for the Quality Council for Trades and Occupations ECD related occupational qualifications.[31] Degree level programmes are mainly provided by universities as part of their education of Foundation Phase educators where the primary emphasis is on schools rather than ECD programmes.

The Policy on Minimum Requirements for Programmes Leading to Qualifications in Higher Education for Early Childhood Development Educators provides an opportunity to improve the qualifications of people working in early learning programmes.[14] However, the successful implementation of this policy is directly dependant on the sector's ability to afford

Case 14: The story of Grade R and why public provision of an early learning workforce is important for young children from birth to five years

André Viviers[i] *& Marie-Louise Samuels*[ii]

The Grade R was initiated between 2002 and 2005, with South Africa being the first country in sub-Saharan Africa to legislate, fund and implement one year of free early childhood education under the auspices of the Ministry of Basic Education. Before the formal initiation of Grade R, less than 40% of five-year-old children were enrolled in an early learning programme,[21] and by 2022 this had risen sharply to 95%.[22] Similarly, the number of children in this age group enrolled in Grade R classes has doubled since 2011 with 96% of public primary schools offering Grade R in 2022[22] and employing more than 20,000 Grade R educators[23].

To understand the importance of the Grade R story for our early learning workforce we first need to go back as far as 2001 when the *Nationwide Audit of ECD Provisioning In South Africa* found that only 17% of the sites providing early childhood education to children aged 0 – 7-years-old were attached to a school, while the remainder were community- or home-based. More than 70% of children aged 5 – 7 were in either a community based or home-based site in 2001, while only 6,828 of practitioners (13%) were in school-based employment.[24] Secondly, we need to look at the Statistics South Africa General Household Survey data that shows that over a 15-year period the percentage of 0 – 4-year-olds attending a "Grade R, preschool, nursery school, crèche, educare centre" showed a relatively low increase from 29.9% in 2009[25] to 33.6% in 2023.[26]

If one merges the aforementioned data then one understands how the story of Grade R is a success story not only for young children's early learning opportunities, but also how political will ensured universal access in a planned manner.[21] If a single driving force for this success story needs to be identified, it would be a fundamental decision and commitment to shift from community-based and private provision for about 70% of children aged 5 – 7 in 2001, to more than 95% children in this age group being reached through public provision in 2024. This also resulted in a significant expansion and recognition of the early learning workforce teaching Grade R in terms of salaries, conditions of employment in the public service, professional recognition, career paths and being embedded as part of the wider basic education workforce.

The story of Grade R shows us what it possible, and that the early learning workforce as well as the children may benefit from the public provision of early learning programmes for children from birth to age four as part of the country's basic education system.

i UNICEF South Africa
ii Retired Director: ECD, Department of Basic Education

to employ and retain better qualified staff. This will require a deliberate, well-resourced and well-planned reform of the early learning and development sector within the context of the basic education system as envisaged in the NDP (Chapter 9).

Professional career paths

The professional career structure for ECD educators and practitioners provides for two categories of staff: professionally qualified educators who are in possession of either a degree or diploma; and ECD practitioners with NQF Level 4 and Level 5 qualifications. These ECD practitioners are currently registered with the SACE with a condition attached to their registration status binding them to teaching only in the early learning programmes.[32] Introducing a requirement for all people teaching in early learning programmes to be professionally registered with SACE (a licence to practice similar to all other educators in the country) will not only be a positive step in the professional recognition of the ECD workforce, but will also create a regulatory system in terms of: the prescribed qualifications; minimum standards for the conduct and practice of ECD practitioners in line with a clearly defined Code of Ethics; and requirements for continuing professional development (SACE accredited).[33] The work of the *Funda Udlale Nathi* (FUN) ECD professional standards team to support the professionalisation of early learning practitioners (see page 105) needs to be taken forward and adapted by SACE as the regulatory authority responsible for the professional standards for ECD educators and practitioners.[34] Currently, SACE is registering ECD practitioners qualified with an ECD Higher Certificate (NQF Level 4) or higher qualification. From 2021 to 2023 a total of 13,032 ECD practitioners were registered with SACE.

Improving the early learning outcomes of South Africa's children will require concerted investment in the education and training of ECD educators and practitioners to ensure they are qualified to deliver quality early learning programmes, instead of continuing investing in piecemeal interventions.[35] It is evident

that the latter has not been effective over the past 30 years since democracy, though it needs to be acknowledged that there has been an increase in the lower-level qualifications (NQF level 4 and 5).[27]

Part of the basic education system

The shift of early learning programmes for 5 – 6-year-olds to the Department of Basic Education through the establishment of Grade R in 2001, coincided with the establishment of new funding norms and requirements for employment in order to achieve the required early learning outcomes as outlined in the Curriculum Assessment Policy Statements (CAPS). This process contributed significantly to the professionalisation of Grade R educators, with the improved funding norms enhancing the salaries, retention, career paths and service conditions of Grade R educators.

The 2022 function shift is not only an administrative shift, but it also provides an important impetus to incorporate early learning as part of the broader basic education system, as envisioned in the NDP. This integration will require a careful planning to ensure a seamless career path for educators within a single system, while also ensuring the advancement of the early learning workforce by improving their qualifications, agency and employment conditions. This will require a well-resourced intervention to advance the professional qualifications of those already employed and those entering the sector, and must coincide with a system-wide reform process to ensure the well-resourced public, private and non-governmental provision of quality early learning programmes within the basic education system.[36] The Government of South Africa's commitments 12 and 13 in 2022 as part of the National Statement of Commitment in preparation for the Transforming Education Summit, provides important national impetus towards ensuring that the early learning workforce has the required knowledge, skills and qualifications to provide quality and inclusive ECD programmes, and that priority be given to the professional recognition and professionalisation of the education workforce in early childhood development, including the requirement to be registered with the SACE.[37]

What are the opportunities to strengthen the workforce for young children and their families within the health system? [v]

The health system plays a central role in young children's health, survival and development starting early in the antenatal period and continuing until the start of formal schooling. It is also often the first point of contact with young children and their families that then enables referrals to a range of other support services.

A bold vision

The past 10 years have seen a paradigm shift in the design of child health care services – from a narrow focus on child survival to the delivery of a more comprehensive package of care to ensure that children not only survive but thrive. This bold vision implies that care needs to be both comprehensive (encompassing promotive, preventative, curative, palliative and rehabilitative care) and holistic (to address the physical, mental, emotional, social and spiritual needs of child, mother and family).

Most of the non-clinical elements of holistic care are already embraced in models of palliative care and the global Nurturing Care Framework (NCF) which includes a focus on "good health, adequate nutrition, safety and security, responsive caregiving and opportunities for learning".[38] The NCF underpins the redesign of South Africa's Road to Health Book and Side-by-Side Campaign, and has been progressively adopted within the health sector to expand the package of care and support, and to strengthen the in-service training of health care professionals working with young children and their families.[39, 40]

The momentum with which the health sector has embraced the Nurturing Care Framework to deepen health professionals' knowledge and capacity to support early childhood development will contribute to achieving essential child health outcomes in line with the country's national, continental and global commitments. Sustaining this momentum amidst budget cuts, will depend on the efforts of champions (either individuals, organisations or provincial departments), and needs greater political commitment at both a national and provincial level.

Critical shortages

The *Human Resources for Health Strategy 2030* South Africa pointed to critical shortages of paediatricians, doctors, nurses and allied professionals, and persistent inequalities between public and private health care and across provinces. It also called for "significant additional investments in the health workforce .... to improve health service access, quality and equity"[41] by 2025, including an additional 97,000 health workers. This was prior to the recent austerity cuts that have led to the freezing of more posts.

The HRH strategy does not address what human resources are needed to build a workforce for child health. This is symptomatic of a broader challenge within the public health

v This analysis draws on the *2019 South African Child Gauge* which included a chapter on building the workforce for a child- and family-centred health service.

system which aims to deliver care to the entire population and where children tend to be a secondary focus. The child health workforce is regularly redeployed to address emerging crises such as the COVID-19 pandemic or to strengthen programmes such as HIV/AIDS and TB, raising concerns that children's access to health care will be further compromised by additional austerity cuts.

The primary cadres of health workers providing direct services to families and young children include medical practitioners (doctors), nurses, midwives and community health workers. They are accompanied by a range of allied health professionals including nutritionists and dietitians who support children's optimal growth and nutrition, and occupational therapists, physiotherapists, speech therapists and psychologists who provide screening and support for children with developmental delays, disabilities and long term health conditions. So, to what extent are there sufficient human resources in place to enhance children's health, survival and development?

Community health workers

Community health workers (CHWs) have the potential to enhance child health outcomes by improving the uptake of breastfeeding and vaccination, and reducing child morbidity and mortality.[42] In 2011, Ward-based Primary Health Care Outreach Teams were established to support the re-engineering of primary health care, with teams of CHWs providing a range of home and community-based services to bring health care closer to the home, including antenatal and postnatal care and routine promotive and preventive child health programmes..

The 2018 *Policy Framework and Strategy for Ward-based Primary Health Care Outreach Teams*[43] aimed to build on this foundation by improving CHWs working conditions and integration within the public health care system. It envisaged that each outreach team (comprising 6 – 10 CHWs led by an enrolled nurse) should serve 1,500 households or 6,000 people, and proposed a phased approach to scaling up access by prioritising poor communities.

As the end of March 2023, there were a total of 46,172 CHWs in the country.[44] This is less than half of the required number (96,030) estimated in an investment case undertaken for the Department of Health in 2018.[45] While their scope of practice includes a focus on maternal, neonatal and child health care, most of their time is focused on HIV, TB and adult non-communicable diseases, with less than 15% of their time dedicated to maternal and child health.[46]

In addition, there are concerns about the capacity of CHWs and their low levels of education. There is no clear requirement set out in policy or law with regards to their education and training, and regulation by the Health Professions Council of South Africa. Yet the expectations of what interventions CHWs are to deliver continue to increase. It is therefore unlikely that CHWs will be able to deliver parenting support programmes at scale as proposed in South Africa's 2030 Strategy for ECD Programmes.

The role of CHWs within the health sector requires greater recognition and investment as well as increased numbers so that there is a greater ratio of CHWs to population. A more appropriate ratio will enable greater prioritisation of maternal, infant and child health and nutrition within the broader basket of community-based health services. Coinciding with the aforementioned is a formal recognition of the community health workers by government through employment, at a decent wage, within the public sector.

Nurses

Nurses form the backbone of the health system and are primarily responsible for the provision of child health services in clinics and district hospitals. Yet the training of professional, general and auxiliary nurses does not have a specific focus on child health – other than professional nurses who are introduced to midwifery and neonatal care.

While the majority of pregnant women and young children access primary health care services such as antenatal care, immunisation and growth monitoring that are delivered through clinics and community health centres, some are in need of more specialised care for acute or long term health conditions.

Paediatric specialist and advanced specialist nurses have more specialised postgraduate training and have the clinical expertise to manage the complex care needs of children with acute and/or long term health conditions. Yet their numbers are extremely limited and their deployment is concentrated at higher levels of care.[47]

Paediatric specialist nurses also have the potential to play a central role in enhancing the quality of care at primary health care clinics and district hospitals[48] given that most doctors, nurses and CHWs working within the district health system have had limited education and training on neonatal and child health.

Doctors

Very few district hospitals have specialised paediatric staff, with most doctors sharing responsibility and rotating across a wide range of clinical services including paediatric and neonatal wards. This means all doctors in the district health system need to be competent to care for children and neonates, yet most doctors have had limited exposure to child health and

the district health system during their medical degrees.[47] While in-service training plays a critical role in building their capacity to deliver priority programmes such as the management of sick and small newborns, or children with severe acute malnutrition, the medical curriculum also needs to be revised to include a greater emphasis on child health services at district level. In addition, it would be helpful to limit rotation of staff in paediatric and neonatal wards to enhance continuity and quality of care.

Allied health professionals

Allied health professional play a critical role in the early identification and support of children with developmental delays and disabilities and their families, yet few districts have a full multidisciplinary team of physiotherapists, speech therapists, occupational therapists, psychologists and social workers capable of meeting their complex care needs. Efforts to develop a cadre of community-based rehabilitation workers and/or peer supporters have the potential to expand access to care by providing practical and psychosocial support to children and families at community level.[47]

Leadership and coordination

Given these systemic challenges, strong leadership for maternal and child health services is needed at provincial, district and facility level – to coordinate services, provide mentoring and support, monitor and evaluate programmes, drive quality improvement and systems strengthening, and ensure that maternal and child health is prioritised within the broader basket of care. This should include the appointment of provincial paediatricians, as recommended by the National Perinatal Morbidity and Mortality Committee (NaPeMMCo) and Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC),[49, 50] paediatric outreach programmes from regional hospitals to support lower levels of care, and district specialists capable of driving intersectoral collaboration to enhance child health, nutrition and development within their catchment area.

Given the current economic climate in the country, additional funding for health services is highly unlikely. It is therefore imperative to ensure that the child health workforce is protected from austerity cuts,[51] and that the current staff working with children are reorientated and their role expanded beyond basic preventative and curative care to deliver true holistic care. This shift is especially feasible in in-patient settings where bed utilisation rates across the country were 60.7% in 2022,[52] as this may free up capacity and allow existing staff to more fully support children's comprehensive and holistic care.

What are the priorities for social service professionals?

Social service professionals, i.e., social workers, child and youth care workers and community development workers, provide services to young children and their families within the wider social development mandate to address the rights of vulnerable individuals, groups and communities.[53] The latter include young children, and these services are rendered by the Department of Social Development (DSD) as well as civil society organisations employing social service professionals.[54] In 2022 the role of social service professionals in relation to ECD programmes[vi] for young children and their families was significantly redefined following the function shift,[15] particularly at a policy implementation and administrative level. However, the social services for young children that includes support to families with young children with disabilities, prevention and early interventions services as well as specific services where families and young children are at risk, remain central to the mandate of the Department of Social Development and rendered by social service professionals as directed by the Children's Act 38 of 2005, NIECD Policy, Revised White Paper on Families in South Africa, and White Paper on the Rights of Persons with Disabilities, amongst others.

Services to young children within the social development sector are rendered as either dedicated or generic services by social workers, social auxiliary workers, child and youth care workers and auxiliary child and youth care workers within the public and non-governmental sector. According to the South African Council of Social Service Professions (SACSSP),[55] the regulatory authority for the registration of social service professionals, there were 38,173 social workers, 12,343 social auxiliary workers, 159 child and youth care workers and 7,964 auxiliary child and youth care workers in the country on 31 March 2021.

Young children remain a core mandate

The Minister of Social Development emphasised in her 2024 Budget Vote Speech[54] the central role of families within the social development sector, while confirming that priority service delivery by social service professionals within the government and civil society sectors needs to focus on addressing determinants related vulnerability as well as those who are vulnerable. Thus, affirming the important role of social service professionals in rendering services, including service for young children and their families, aimed prevention and support such as through poverty alleviation programmes, skills development,

vi The Children's Act 38 of 2005 defines an early childhood development programme as "a programme structured within an early childhood development service to provide learning and support appropriate to the child's developmental age and stage", and corresponds to early learning or similar programmes that form part of the basic education system as outlined by Chapter 9 of the NDP.

Case 15: Responding to the rights of young children in child protection system

André Viviers[i] & Nicolette van der Walt[ii]

Social workers render a wide array of social services of which child protection services is one of the better known and publicly scrutinised services. Working with children requires specialised knowledge to engage with the complex interplay of human development, while navigating family and societal dynamics and diversity in language, culture and socio-economic context. Social workers rendering child protection services to young children under six years also must take into account the social, emotional, language and physical development, and evolving capacities of young children.

An interview with Lerato,* a social worker with 12 years' experience working in the inner-city of Johannesburg, responding to and investigating cases of child abuse, provides some valuable insights.

> *I started to work in child protection fresh out of university. In the first two years, I realised that my biggest challenge was to provide professional services when very young children are victims of abuse. At the best of times, it is difficult for young children to articulate what happened to them and to understand why you must take certain actions, even if you are well versed in their mother tongue. I found that my knowledge of human development and general understanding of young children's developmental milestones only took me to a point, and then I need to have more in-depth knowledge to support, communicate and most of all serve in the best interest of young children.*
>
> *I realised that I need a different and more concrete approach, without compromising my professional investigation and be cautious not to traumatise young children further. I continuously seek advice and attended courses at organisations like the Teddy Bear Clinic and Childline in Gauteng for my professional development.*
>
> *Today, after 12 years in the field, I am more confident in my practice, but with young children it is every time critical to be aware of their varying capacity and how they are making meaning of the trauma to ensure that they receive the best service from us.*
>
> *I think all social service professionals working in the child protection system need to be required to receive capacity development on how to support and respond to young children who are victims of abuse as part of their continuous professional development. Not only to improve our knowledge and skills, but also to protect the rights of young children.*
>
> *Lastly, one aspect that we often forget is the impact of working with young children who are victims of abuse on one as a professional as well as a personal level, and the importance of professional support to combat vicarious trauma.*

Lerato's reflections highlight the importance of training and support for social service professionals in safety and risk assessment as well as their need for in-depth knowledge of all the forms of child-maltreatment, particularly when it concerns young children and their families. This includes the need for a trauma-informed approach, especially regarding developmental trauma and adverse childhood experiences, and how these unfold in the early years.

i UNICEF South Africa
ii ACVV
* Not her real name as a footer

support to parents, care and support to young children with disabilities and their families, and child protection services, among others.

A central mandate of social service professionals, and in particular social workers and to some extent child and youth care workers, is to develop and implement programmes for families with (young) children to strengthen their capacity and self-reliance through prevention programmes; and to families where (young) children have been identified as vulnerable or at risk of harm as prescribed in sections 143 and 144 of the Children's Act. These parenting support programmes require social service professionals to assess where such programmes may benefit parents and their young children, and to develop and implement such programmes either as individual or group programmes. The NIECD Policy confirms the role of social service professionals in supporting parents with young children, and the National Parental/Primary Caregiver Capacity-Building Training Programme (Children Birth to Five

Years) is a national resource used for the purpose of prevention and early intervention.[56]

Social workers in particular play an important role in providing care and support to young children with disabilities and their families, which include early identification, referral to services, direct support to parents/caregivers, and the management and/or oversight of care facilities and programmes for young children with severe disabilities. Notwithstanding the Children's Act 38 that explicitly provides for services to children with disabilities, including partial care facilities for children with disabilities or chronic illnesses[57] which is amplified in the White Paper on the Rights of Persons with Disabilities,[13] accessible social services remain a challenge.[58] and there is a specific call towards those providing social services to young children with moderate and severe disabilities needing special care. In addition, the recent Concluding Observations of the United Nations Committee on the Rights of the Child, call for greater investment in building the capacity of professionals to work with and support parents of children with disabilities.[59]

Social workers in particular are also at the forefront in providing statutory and therapeutic interventions for young children who are victims of abuse and neglect or witnesses of domestic violence (children's court procedures, services to children and families, and family reunification), adoption services, and services to children in alternative care (foster care and residential care) amongst others. These services for young children require expert knowledge and skills on young child development and how best to engage with young children as part of child protection services. Most child and youth care workers and auxiliary child and youth care workers largely work in residential care programmes (child and youth care centres where young children are placed in alternative care) while some work in community-based programmes such as Isibindi and the DSD's multi-disciplinary RISIHA programme (a community-based prevention and early intervention programme).[vii]

Not-for-profit sector

The challenges in the funding of the not-for-profit sector rendering services to children by provincial DSD's were prominent in the media in 2023/2024 and have an impact on the retention of qualified and experienced social service professionals working with young children and their families in the social development sector. Not only does it contribute to uncertainty and instability for those rendering social services to vulnerable young children, whether prevention, early intervention or statutory, but also impacts on their ability to render quality services and meet the demand for services. Thus, rendering meeting of professional standards extremely difficult with high caseloads, poorer quality in services due to mismatch between demand and personnel available, while compromising the rights of young children and their families.[60]

More specialised training

The education and training of social service professionals as well as their professional regulation in terms of the Social Service Professions Act 110 of 1978 is well established compared to that of the early learning sector, although there are still prominent systemic challenges in the child and youth care work profession.[61] However, the education and training of social service professionals tends to be focussed on generic professional practice, with only basic input on child development and how to work with young children in the undergraduate programme for social workers and child and youth care workers, and even less on the qualifications for social auxiliary work and auxiliary child and youth care work.[62] Other than postgraduate degrees in play therapy for social workers, there are no formal qualifications specialising in work with young children whether in general or within the child protection system. Working with children younger than five years requires social service professionals to have more in-depth profession-specific proficiency, that goes beyond the general child development theories covered in undergraduate developmental psychology, to ensure they are equipped to intervene and support young children in difficult circumstances including child protection.

What are the implications for policy and practice?

The safeguarding and fulfilment of the rights of children to their early childhood development is directly related to the competency (required minimum knowledge and skills) of the human resources who are responsible for providing quality services, and in particular those working in the early learning (basic education), health and social development sectors. Evidently such competency differs between professionals as defined in their respective scopes of work, but at the core remains the requirement to be able to provide a service that meets the expected minimum requirements that will achieve the required outcomes for young children as envisaged in law and policy.

vii The Department of Social Development's RISIHA (resilience in Xitsonga) programme is a community based prevention, early intervention and care and support programme for orphaned and vulnerable children where a range of social service professionals from government and NGOs, in particular social workers and child and youth care workers, provide direct services and referral for services in line with the Core Package of Services (child care and protection, psychosocial support, HIV and AIDS, health promotion, food and nutrition, economic strengthening, as well as educational support for orphaned and vulnerable children).

Early childhood development services, not dissimilar to services for older children and adults in general, require service-type specific interventions, with a clear understanding of the wider range of services needed and/or provided in the interest of holistic development. This is only achievable when each sector is clear about the scope of practice of those working within the sector, while understanding and embracing the contributions of those in other sectors. While collaboration and coordination have improved over the past four decades, there remains significant room for approvement in line with the provisions of the NIECD Policy, which needs to be rekindled by the Department of Basic Education as newly designated lead for the wider ECD sector.

Young children and their families are the *single user* of multiple services starting already during pregnancy and often shaped around specific needs. This provides both an opportunity and a challenge for those working in different sectors with this age-group, which include the balance between a profession's scope of practice and the comprehensive, often complex, service needs of young children and their families. The responsibility of education, health and social service professionals is to ensure that the young children and their parents experience a harmonised and coordinated approach within and across different services, including appropriate and responsive referrals and follow up care – to ensure children and families don't fall through the cracks.

This calls for a breaking down of the silos between sectors and disciplines, to ensure that the education and training of these professionals include sufficient understanding of the scope of practice of other professionals providing services to the same *single user*. This should coincide with a commitment and understanding to lead on this at national, provincial, district and practice levels.

Young children and their families have the right to expect quality and timely services from the basic education, health and social development sectors delivered by sufficient numbers of competent and well-qualified staff. This requires the state, as duty-bearer, to:

- fulfil its commitments in policy and plans to strengthen the ECD workforce as a priority;
- make available the resources needed to address the gaps and challenges;
- ensure that all members of the ECD workforce have the required competency to meet the constitutional and legal obligations towards young children; and
- ensure that all who work with young children and their families are held accountable for upholding their professional code of ethics.

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Early childhood development data systems[i]

Colin Almeleh,[ii] Katherine Hall,[iii] Sonja Giese,[iv] Nicholas Dowdall[v] & Janeli Kotze[vi]

Good quality data are vital for planning, programme implementation, monitoring and accountability. But the significant efforts and costs of collecting data are only worthwhile if the data are used effectively.

South Africa has invested in improved monitoring and reporting systems over the past two decades especially in those sectors where there are significant amounts of public funding e.g. social protection, health and basic education. South Africa has also demonstrated its ability to rapidly develop and deliver administrative information systems, and to do this at scale, as was demonstrated by the development and implementation of the COVID-19 Electronic Vaccination Data System. While progress is being made in the early childhood development (ECD) sector to improve information

Table 28: Key components of an ECD information ecosystem

Type of data	Method of data collection	Example use cases
Population monitoring		
Censuses	• National Census • Early Childhood Development Census	Provides information on children's demographics, socio-economic conditions, trends, disparities, and inequalities, and supporting evidence-based policymaking, planning, research and advocacy, and international comparisons.
Population-level surveys	• General Household Survey • Demographic and Health Survey • Thrive by Five Index • National Income Dynamics Survey	Facilitate more regular sample-based data collection that usually focus on specific domains. Can help planners determine trends in between less frequent censuses and do relational analysis.
Administrative data	• District Health Information System • Social Pensions Data System • South Africa Schools Administration and Management System • Early Childhood Administration and Reporting System	Provide a more 'real-time' monitoring perspective that enables decision-making at various levels, e.g. from national level right down to that of an individual school or clinic. They should enable administrators to perform their duties effectively and while enabling system-wide resource allocation and planning.
Population registers	• National Register for Sex Offenders • Child Protection Register	Risk assessment and screening for individuals applying to work with children.
Implementation monitoring		
Monitoring specific programmes	• Three Interlinked Electronic Register (TIER.NET)	Monitors specific programmes such as access and use of antiretrovirals for children and pregnant women. TIER.NET is linked into the DHIS.
Monitoring individual children's development		
Developmental monitoring and screening	• Road to Health Book	Patient-held record to monitor developmental milestones from birth to six years old. Enables immunisation tracking, early detection of developmental delays or disorders, referrals for further intervention. Should ideally be linked into routine information systems.

i This chapter draws heavily from the South African Early Childhood Review series, particularly the 2024 edition. Source: Hall K, Almeleh C, Giese S, Mphaphuli E, Slemming W, Mathys R, Droomer L, Proudlock P, Kotze J, Sadan M. *South African Early Childhood Review 2024*. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana
ii Ilifa Labantwana
iii Children's Institute, University of Cape Town
iv DataDrive2030
v Lego Foundation
vi Department of Basic Education

systems, it lags significantly behind the health, education and social security sectors, especially in the areas of early learning, disability, caregiver support and child protection.

This chapter assesses the ECD information landscape in the context of South Africa's international and domestic commitments, and the Nurturing Care Framework. While not exhaustive, it aims to highlight important missing indicators, data sources and systems – particularly the lack of a child-level information system that tracks children across all services and departments and over time. The chapter focuses mainly on population-level data rather than data arising from research studies. Finally, the chapter reflects on the major progress that has been made to build an information ecosystem for early learning.

What kind of data is needed to improve ECD service delivery and child outcomes?

There are a range of data sources that are considered essential to the design of an information system that can enable population-level planning, monitoring and measurement, and when taken together will allow countries to assess progress towards ensuring all young children are developmentally on track. There are also a range of data users. While government and funders are often thought of as the primary data users and consumers, those designing and delivering services need data that are accessible, understandable and actionable. While not exhaustive, Table 28 describes some of the various components of the ECD information ecosystem, their data collection methods and use cases.

What are South Africa's international reporting commitments?

Table 28 describes the spectrum of data sources that strengthen South Africa's ability to monitor and improve service delivery for young children and their families, and that track progress towards South Africa's domestic and international goals. These commitments include, among others: the Sustainable Development Goals (SDGs); the African Union Agenda 2063; the United Nations (UN) Convention on the Rights of the Child, and the UN Convention on the Rights of Persons with Disabilities as outlined in Table 29. These commitments help to frame the country's ECD policies, programmes, and interventions, and reporting on these allows for cross-country comparison and accountability from an international perspective.

How can we build a monitoring and evaluation system for ECD in South Africa?

Previous chapters in this *Child Gauge* have described challenges in assessing the extent to which children are receiving essential services and achieving desired developmental milestones. Previous authors have also reflected on the implementation of the National Integrated Early Childhood Development Policy (NIECD Policy), highlighting the complex service delivery landscape where multiple departments and levels of government are responsible for various components of the comprehensive package of essential ECD services. Despite the NIECD Policy being approved by Cabinet in 2015, a final monitoring and evaluation framework for the policy has

Table 29: International data commitments

Commitment	Reporting and data commitments	Sample indicators
UN Convention on the Rights of the Child[1]	Periodic reporting (five-year cycles) on a broad range of indicators to assess the well-being of children and their rights.	• Under-five mortality rate • Percentage of children living below the national poverty line • Access to social protection
UN Convention on the Rights of Persons with Disabilities[2]	Periodic reporting (four-year cycles) on legislative measures, policies and programmatic activities to promote and protect the rights of persons with disabilities.	• Percentage of learners with disabilities enrolled in mainstream school • Percentage of public buildings that are accessible
Sustainable Development Goals 2030[3]	Voluntary national reviews every two to four years. Reporting includes a wide range of ECD relevant indicators across nutrition, safety and security, education and health.	• Stunting prevalence in children 0 – 59 months • Maternal mortality ratio • Percentage of children (36 – 59 months) receiving at least one year of a pre-primary education programme • Percentage of children aged 24 – 59 months who are developmentally on track in health, learning and psychosocial well-being
African Union Agenda 2063[4]	Agenda 2063 has seven aspirations, reported on bi-annually, each with high-level goals, targets and indicators. Many relate to early childhood development, and are aligned with the SDGs.	• Percentage of population with access to safe drinking water • Neonatal mortality rate

Note: This list of international commitments relevant to early childhood development is not exhaustive.

never been published. It is unclear how progress is assessed, especially by the various coordination and leadership structures established by the NIECD Policy, such as the ECD Inter-Ministerial Committee, ECD Inter-Departmental Committee, and ECD Inter-Sectoral Forum.

What indicators and data sources are already in place?

The development of a robust monitoring and evaluation framework for the NIECD Policy is only one of a number of frameworks that need to be in place to ensure a robust ECD information ecosystem – that responds to the imperatives of planning, resourcing, programme monitoring, measurement and accountability. This should include measures to assess the delivery of services and the well-being of children and their caregivers across different sectors and domains, and enable government to report on its international commitments. In the absence of an official framework for analysing early childhood development, the Nurturing Care Framework is a useful organising framework to assess and benchmark whether core indicators of early childhood development in South Africa are available and of good quality.

Table 30 lists a comprehensive set of data sources available in South Africa that are currently or can be used to monitor early childhood development as it is conceptualised across the various domains of the Nurturing Care Framework. For example, the ECD Baseline Audit includes data on nutrition, health and early learning, but not on safety and security and responsive caregiving. It can be argued that this extensive list of data sources for early childhood development are very close to being sufficient to meet South Africa's international reporting commitments as illustrated by South Africa's ECD Country Profile in Figure 27. A similar picture exists in terms of domestic reporting commitments.

How can the ECD data ecosystem be further strengthened?

The section below describes the current data sources on different domains of child development with a view to identifying the missing data elements and sources required to provide a comprehensive picture of early childhood development in South Africa. It also identifies new data collection systems that need to be put in place and changes to existing sources and systems in order to improve service delivery and accountability.

A cross-cutting issue is that child identification numbers are not consistently used across all government administrative systems. This makes it impossible to track children across the essential package of services offered by the departments of health, basic education, social development and others. It is also impossible to monitor children's progress and ensure that they are receiving the necessary support.

Information on children under six years old and their caregivers in South Africa

Nationally representative data from the National Census and General Household Survey (GHS)[vii] are the bedrock of population-level data collection in South Africa. These two data sources provide the most relevant information on the general living conditions of households and children e.g. population figures, household and caregiving characteristics, household income and employment, hunger, etc. While the Census is only conducted every 10 years, it provides the most reliable estimates of the young child population across the country, which enables planning and appropriate budgeting for services. The GHS is arguably the most important annual source of information on living conditions, and it allows progress to be measured year-on-year. However, the GHS does not allow for analysis at district level and below. The National Income Dynamics Study (NIDS) is another critical tool for informing policy development and evidence-based decision-making for child and family well-being in South Africa. The panel study, run on a bi-annual basis since 2008, collects comprehensive data on income, health, education, employment and other socio-economic indicators, providing valuable insights into the factors that impact child and family well-being.

At an international level, there have been several developments to address the lack of standardised, nationally representative and internationally comparable data on early childhood development. The UNICEF-initiated Multiple Indicator Cluster Survey (MICS) has proved a valuable tool for collecting data on the well-being of women and children in over 100 countries. But South Africa has elected not to conduct the MICS survey. This means that the country does not have a full set of internationally comparable indicators focused on the well-being of women and children. This makes it difficult to track South Africa's progress towards the SDGs and to benchmark and compare South Africa with other countries.

Maternal and child health information

South Africa has a comprehensive District Health Information System (DHIS) that provides aggregated routine (monthly) and primary care data from the public sector clinics and

vii The GHS is a nationwide survey administered by Statistics South Africa to collect data on the socio-economic characteristics of households. The survey is conducted through face-to-face interviews with randomly selected households, where a representative from the household acts as the respondent, providing information on behalf of the household members.

Figure 27: South Africa ECD Country Profile – Countdown to 2030

EARLY CHILDHOOD DEVELOPMENT 2023 updates

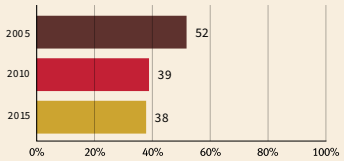
South Africa

Countdown to 2030
Women's, Children's & Adolescents' Health

Demographics	
Population	59,893,886
Annual births	1,155,858
Children under 5	5,818,687 (10%)
Under-five mortality	33/1,000

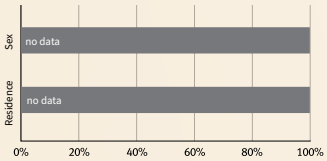
Threats to Early Childhood Development	
Maternal mortality	127/100,000
Low birthweight	17%
Child poverty	no data
Violent discipline	no data
Adolescent birth rate	41/1,000
Preterm births	8%
Under-five stunting	23%
Inadequate supervision	no data

Young children at risk of poor development



At risk in 2005, 2010 and 2015, using a composite indicator of under-five stunting or poverty

Risk by sex and residence

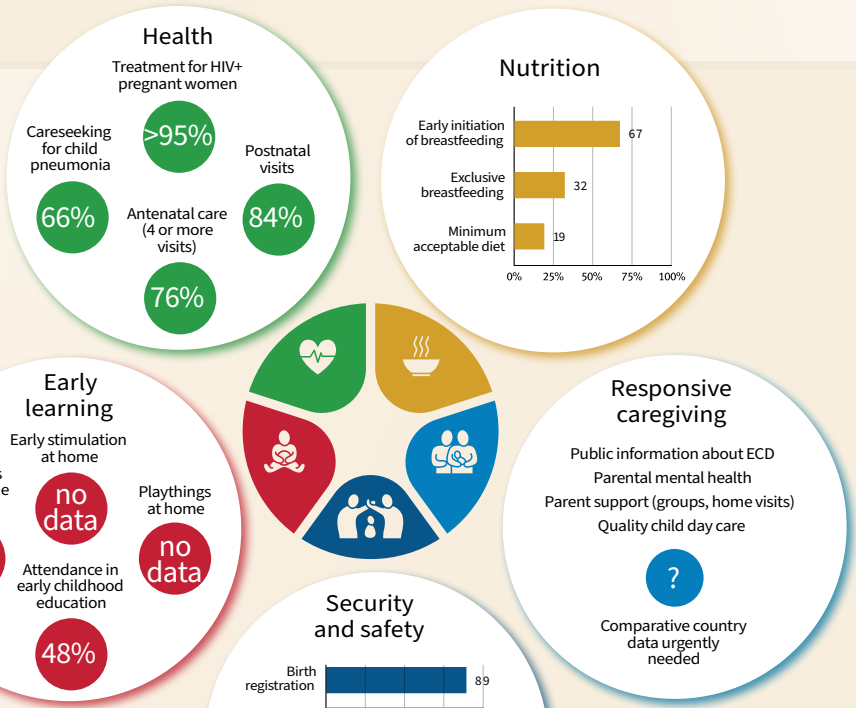


Children with functional difficulty: no data

Children developmentally on-track: no data

Support and services for early childhood development:

Nurturing care



Parents and caregivers need a facilitating environment of laws, policies, services and community support to assist them in providing their young children with nurturing care.

Facilitating environments

Policies				
3	Officially adopted national multisectoral ECD policy			
<20%	20-39%	40-59%	60-79%	≥80%
Child and family social protection				
None	<14	14 – <18	18 – <26	≥26
Maternity leave (weeks)				
None	<14	14 – <18	18 – <26	≥26
Paternity leave (weeks)				
Not	Slightly	Moderately	Substantially	
International Code of Marketing of Breastmilk Substitutes (alignment)				

International conventions	
3	Convention on the Rights of the Child
3	Convention on the Rights of Persons with Disabilities
3	CRC Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography
3	Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption

DETAILED COUNTRY DATA SOURCES AND FOOTNOTES CAN BE FOUND IN THE MASTER DATABASE AT NURTURING-CARE.ORG

Source: Nurturing Care for Early Childhood Development. *Country Profiles for Early Childhood Development: South Africa:* 2023. Accessed: 28 June 2024. Available from: https://nurturing-care.org/south-africa-2021/.

district hospitals. The DHIS tracks data related to antenatal care, postnatal care, immunisation, vitamin A and deworming, among other maternal and child health indicators. The annual publication of the District Health Barometer by the Health Systems Trust demonstrates the depth and breadth of the indicators captured by the DHIS and the ways in which having this information allows for detailed analysis to support decision making by the Department of Health (DoH) and others. However, there are some areas where DHIS is lacking:

- The DHIS does not collect and track data at the individual level except for the TIER.NET system which collects information on individuals on antiretroviral treatment.
- Data on maternal mental health is limited despite the increasing evidence of its impact on maternal and child health and development outcomes.
- Quality of care data are important but difficult to collect.
- There are no routine data collected on children with disabilities or developmental delays. Data on the numbers of children screened for disabilities and developmental delays and referred for higher levels of care or specialised services is limited. The Child Functioning Module, developed by the Washington Group/UNICEF, could be used at a population level to provide a proxy indicator of disability among children aged 2 – 4 years and 5 – 17 years.
- One of the ultimate goals of the provision of health services is to reduce mortality. The DHIS data collects information on in-facility mortality rates and case fatality rates. However, this is not generalisable, partly because many young child deaths occur outside health facilities.
- Infant and under-five mortality rates are drawn from the Rapid Mortality Surveillance Report using data from the National Population Register. These rates cannot be disaggregated to a provincial or district level.
- Child deaths in hospitals are audited by the Child Health Problem Identification Programme to identify modifiable causes of death and drive quality improvement. The Child

Table 30: Sources of data for early childhood development in South Africa, mapped against the Nurturing Care Framework

	Last year	Frequency	Lowest level	N	H	EL	SS	RC
National Population Census – Statistics South Africa	2022	10-yearly	Ward	x	x	x	x	x
General Household Survey – Statistics South Africa	2022	Annual	Province	x	x	x	x	X
Governance, Public Safety and Justice Survey – Statistics South Africa	2022/3	Periodic	Province				x	x
National HIV and Syphilis Prevalence Survey – Statistics South Africa	2013	Annual	Province		x			
District Health Information System – Department of Health	2023	Routine	District	x	x			
South Africa Demographic and Health Survey – Statistics South Africa	2016	Periodic	Province	x	x			
Rapid Mortality Surveillance Report – Medical Research Council	2020	Annual	National		x			
South African National Health & Nutrition Examination Survey (SANHANES-1)	2012	Periodic	Province	x	x			
Social Grants Payment System (SOCPEN) – South African Social Security Agency	2023	Routine	Province				x	
South African National Nutrition and Food Security Survey – HSRC	2023	Periodic	Province	x	x		x	
Trends in International Mathematics and Science Study (TIMMS)	2015	4-yearly	National			x		
Thrive by Five – Department of Basic Education and DataDrive2030	2021	3-yearly	National	x		x		
ECD Census – Department of Basic Education	2021	Periodic	Municipal			x		
ECD Audit Baseline – Department of Basic Education	2021	Once off	Province	x	x	x		
Community Survey – Statistics South Africa	2016	Periodic	Municipal	x	x	x	x	x
Progress in International Reading and Literacy Study (PIRLS)	2023	5-yearly	National			x		
Three Interlinked Electronic Register (TIER.NET)	2023	Routine	Individual		x			
National Income Dynamics Survey (NIDS) and NIDS-CRAM	2021	Periodic		x	x	x	x	x

Note: Drawing on the Nurturing Care Framework: N = nutrition; H = health; RC = responsive caregiving; SS = safety and security; EL = early learning.

Death Review Project provides a similar analysis of out-of-hospital deaths, but is limited to the Western Cape.

Nutrition information

Accessing up-to-date information on child nutrition in South Africa remains challenging despite its importance from a human rights and an early childhood development perspective. Data from annual surveys such as the GHS allow for analysis of trends in child hunger over time. Tracking trends in under- and over-nutrition is more challenging and resource intensive. For example, stunting data are not routinely collected through the DHIS, and the stunting data collected by nutrition surveys are not always disaggregated by age despite studies showing that stunting rates are higher among younger children.[5]

A number of nationally representative surveys over the past 15 years have included anthropometric measures (e.g. weight-for-age, and height-for-age). The South African Health and Nutrition Examination Survey (SANHANES)[6] and the Demographic and Health Survey (SADHS)[7] include anthropometric measures together with questions about dietary intake (e.g. breast- and complementary feeding). SANHANES was last conducted in 2012 and the report published in 2015, and there have only been two SADHS surveys in the past 20 years (2003 and 2016). The most recent nationally representative study to measure the prevalence of stunting is the National Food and Nutrition Security Survey (NFNSS) conducted between 2021 and 2023 by the Human Sciences Research Council (HSRC) and commissioned by the Department of Agriculture, Land Reform and Rural Development.[8] While all of these studies are necessary, and most importantly point to high levels of malnutrition in South Africa, it is difficult to monitor trends over time and evaluate the impacts of policies and programmes designed to improve food security and nutrition. This is because these surveys do not use comparable methodologies and sampling strategies, are often not nationally representative, do not have large enough sample sizes or are not repeated regularly.

Information on responsive caregiving

South Africa tracks a range of indicators on adult co-residence and a limited number on caregiving practices (i.e. attending to the needs of, and providing assistance, care and love to a child) through national household surveys. Between 2017 and 2019, the GHS collected useful information on caregiving practices such as frequency of book sharing and singing with children. These caregiving questions in the GHS were stopped during COVID-19 and it is unclear whether they will be reintroduced in the future. However, there is limited information on the services that are provided to caregivers, nor is there a standard set of indicators on which policy and programmes can draw to design and monitor services. Publications such as the *South African Early Childhood Review* compile indicators for which there is available data, but these are inadequate to properly gauge the ways in which parents are supported.[10]

Key challenges relating to caregiving support data include:

- There is a lack of data on the provision of support, information, and advice to pregnant women and mothers. Information on the quality of antenatal and postnatal services can only be drawn from the periodic DHS where indicators include specific antenatal services.
- There are no routinely collected national data on maternal mental health challenges and screening (including screening for domestic and intimate partner violence, and alcohol and substance abuse).
- There is partial data on the availability of parent support programmes, their identified target groups, reach, and parenting outcomes. While not widespread or necessarily exhaustive, recent efforts to collect data on parent support programmes, include a study commissioned by UNICEF and the Department of Basic Education (DBE), that gathered

Box 8: Recent research partnerships between government, academia and civil society that are updating the knowledge base on malnutrition

- The DBE's Thrive by Five Index,[9] collected anthropometric data (height-for-age) from 5,129 children aged 50 – 59 months attending early learning programmes
- The National Dietary Intake Survey 2022 is primarily focused on adults, but includes children attending schools and ECD programmes
- Grow Great, a national zero-stunting initiative, has conducted community nutrition surveys in all nine provinces in particularly high-risk districts
- The DG Murray Trust partnered with the Western Cape Department of Health to conduct a provincial-level comprehensive anthropometric malnutrition profile
- The HSRC and Department of Agriculture, Land Reform and Rural Development conducted the nationally representative National Food and Nutrition Security Survey between 2021 and 2023.

information from 97 organisations offering various types of parent support programmes.[11]

- Support for primary caregivers is often narrowly conceptualised as face-to-face parenting training programmes. Parent support provided by the DoH is not included in government reporting. These programmes include: the community health worker programme, clinic-based breastfeeding counselling, or the Side-by-Side communication campaign. These are all part of a broader constellation of support for caregivers, yet are missed opportunities for reporting.

Safety and security information

SOCPEN is the data system used by the South Africa State Security Agency (SASSA) and the Department of Social Development (DSD) to run their comprehensive system of social grants. This legacy system from the 1980s is remarkable as it has the capability and functionality to administer the six major grants and interact with a number of other government systems. In some respects, SOCPEN sets the example of what a functional management information system in South Africa could be like. The system manages the application and distribution of around 20 million social grants on a monthly basis and integrates with other government information systems e.g. the National Population Register. During COVID-19, SOCPEN was also linked to the Learner Unit Record Information and Tracking System (LURITS) and the National Student Financial Aid Scheme (NSFAS) to ensure that all eligible learners from low-income households could access additional government support. There are a number of critical areas in the social protection service portfolio on which we have limited information. For example:

- Routine national data on the prevalence of child abuse and neglect is needed. Stats SA has recently launched "Child Series Volume 1 – Children Exposed to Maltreatment", which uses the GHS and Governance, Public Safety and Justice Survey data to produce a population-level analysis of child maltreatment in South Africa.[12] While the surveys are critical to monitoring and measurement, routine data that directly supports service delivery needs to come from cases reported to the police and social services. Good systems need to be in place to ensure that reporting is encouraged, and that cases are accurately recorded and maintained in local offices and properly compiled at provincial and national level. Reporting systems also need to move beyond a criminal justice approach of tracking cases and prosecution, and include the monitoring of social services to help children heal.[13]
- Good administrative data on the delivery of responsive child protection services and psychosocial support for children is needed. Government needs to track child protection cases that are brought before the court within 90 days (as

Box 9: Data on disability and developmental delays

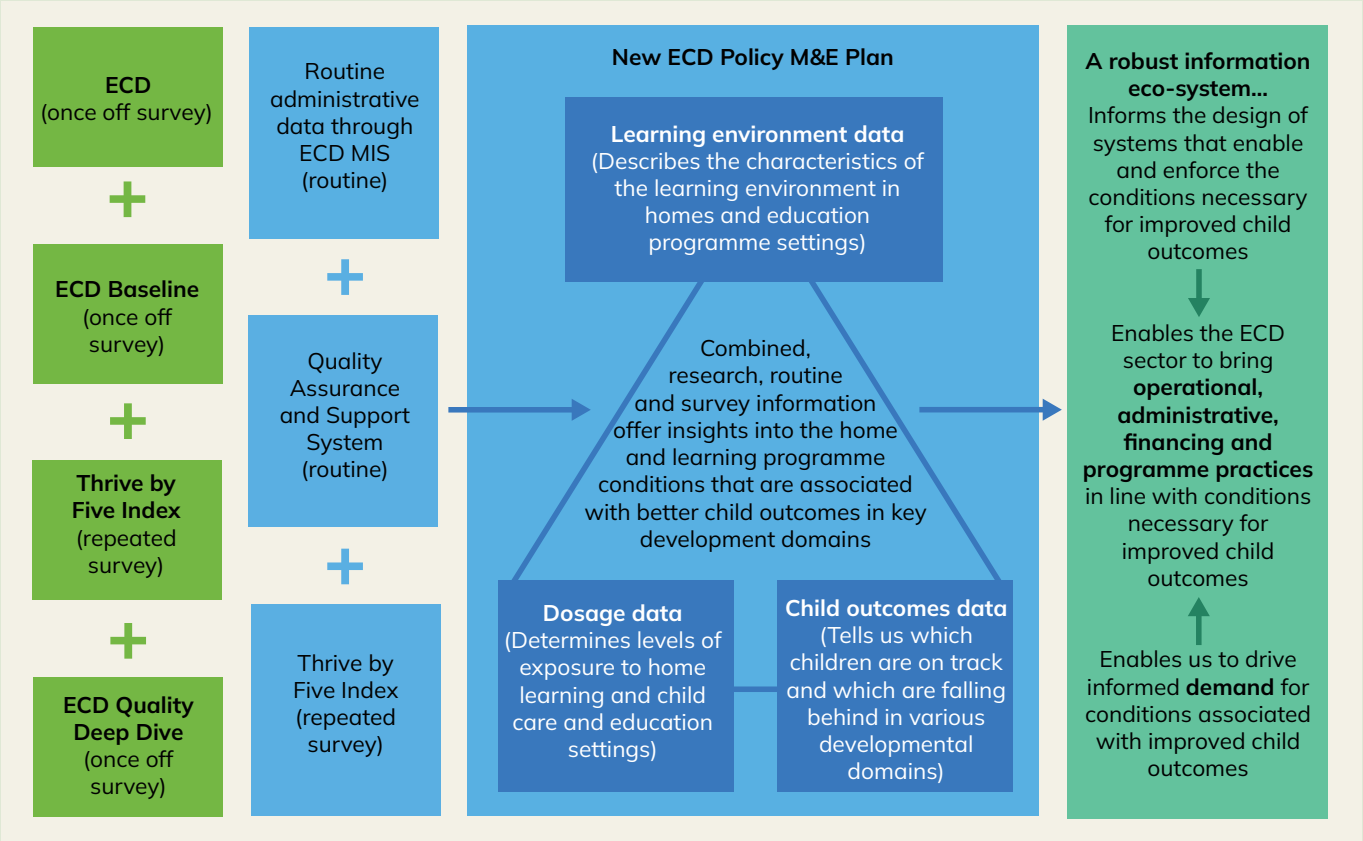
As with many other components of early childhood development, data on disability and developmental delays do not fit neatly in a specific component. Rather, the Nurturing Care Framework emphasises the cross-cutting inclusion of children with disabilities and/or developmental delays across the five key components: good health, adequate nutrition, responsive caregiving, opportunities for early learning, and security and safety.

South Africa does not have a nationally accepted tool for measuring the prevalence of disability among young children. The last dedicated National Disability Prevalence Survey was conducted in 1999, and more recently, modules of disability questions have been included in the National Census, the Community Survey, and certain General Household Surveys. It is argued that existing measures cannot be used reliably to determine prevalence of child disability particularly in children younger than five as evidenced by their exclusion from the analysis in key reports.[viii]

The Road to Health Book includes a section that aims to help identify children at risk of disability and developmental delays but this data is not routinely collected in an administrative system and remains within the book itself. Another source of data on severe disability for children under the age of 18 can be drawn from the Care Dependency Grant administered by SASSA. Certain screening systems for identifying disability in school-age children have been introduced through the public education system in conjunction with the Department of Health, including assessments of hearing, speech and gross motor function. Similar efforts are yet to be rolled out to younger children in early learning programmes

viii Statistics South Africa. (2014). *Census 2011: Profile of persons with disabilities in South Africa. (Report no. 03-01-59.)* Pretoria: Stats SA. Department of Social Development (DSD), Department of Women, Children and People with Disabilities (DWCPD) and UNICEF. (2012). *Children with Disabilities in South Africa: A situation analysis: 2001-2011*. Pretoria: DSD/DWCPD/UNICEF.

Figure 28: Early learning information ecosystem



Adapted from: Giese S, Dawes A, Tredoux C, Mattes F, Bridgman G, van der Berg S, . . . Kotzé J. *Thrive by Five Index Report Revised August 2022*. Cape Town: Innovation Edge. 2022. [www.thrivebyfive.co.za]

stipulated in the Children's Act) by linking the administrative data systems of DSD and the Department of Justice and Constitutional Development.

Early childhood care and education information

South Africa does not yet have an implemented national administrative data system for early learning programmes that can collect aggregate programme and learner level data in the same way as the DBE's SA-SAMS and LURITS systems. While government regularly reports on the number of registered and funded early learning programmes and children (nationally and provincially), the accuracy of this data is uncertain because data collection is paper-based and reporting done manually, without clear data standards and protocols in place. Administrative data through the paper-based system are also limited to registered early learning programmes that account for less than half of all early learning programmes.[14] The number and proportion of children accessing early learning programmes at a population-level is generally drawn from the GHS. The *South African Child Gauge, the South African Early Childhood Review* and the Statistics South Africa Education Series are publications that use the GHS in this way.[13]

In order to address some of these data gaps, the government embarked on a series census-type surveys of the ECD sector in 2001, 2013 and 2021. The latest iteration of the ECD Census in 2021 identified 42,420 early learning programmes (see Box 10). On each occasion, the government has intended the survey to form the basis of a routine administrative information system for early learning programmes. An interim administrative system, known as the Registration Management Tool, was built for the Department of Social Development in 2021 and transferred to the DBE following the function shift. However, its use is not yet widespread and routine across all provinces. The end result is that government has not been able to take a population-based approach to the monitoring, planning and delivery of early learning programmes, or to overcome the challenges of paper-based data collection and manual reporting.

Since taking over the early childhood development function, the DBE has made significant efforts to build the early learning information ecosystem. There are a range of social partners supporting the DBE with these initiatives, enabling South Africa to respond to its international reporting obligations and improve its planning, service delivery and policy development domestically. Two major initiatives are worth highlighting:

Box 10: Major developments in the ECD information ecosystem[16]

Prior to 2021, key ECD publications such as the *Child Gauge* and the *South African Early Childhood Review* reported a dearth of data on early learning. The situation has improved with several new initiatives spearheaded by the DBE to address data gaps.

The ECD Census: The DBE commissioned an ECD Census to enable better oversight, support and resource allocation.[14] It was the largest effort to date to map the early learning landscape in South Africa. The census sought to document every early learning programme (registered and unregistered) across the country. Data were collected between August 2021 and February 2022 and included information on location, operations, income sources, learning resources, registration status, child enrolments, staffing, teaching practices and infrastructure at 42,420 sites nationally. Around 1.6 million children were enrolled at the surveyed sites, with a lower number of 1.1 million in attendance on the day of the survey.

The Thrive by Five Index: Building on the development of the Early Learning Outcomes Measure (ELOM) by DataDrive2030, the Thrive by Five Index[17] is the first in a series of population-based surveys planned to take place every three years. The Index will monitor the proportion of children aged 50 – 59 months who are on track for their age in three key areas of development: early learning, physical growth and socio-emotional functioning. Between September and November 2021, the index assessed ±5,100 children between the ages of 50 – 59 months, enrolled in 1,247 early learning programmes across nine provinces. A shortcoming of the Index was that it only assessed children enrolled in early learning programmes, and the next round in 2024 will include non-enrolled children.

The Early Learning Programme Baseline Assessment:[18] The baseline assessment was undertaken alongside the Thrive by Five Index. Principal and practitioner interviews were conducted in 545 of the 1,247 early learning programmes that participated in Thrive by Five. Trained assessors also observed and rated the quality of the learning environment and practitioner-child interactions in each of these sites.

The ECD Deep Dive Study: DBE and The LEGO Foundation initiated the Deep Dive Study[19] to complement the ECD Census and Thrive by Five Index and enhance understanding of how early learning programmes were implementing the curriculum. The mixed methods study included significant qualitative and observational work in 50 early learning programmes and seven more in-depth case studies, and examined the implementation of the National Curriculum Framework, play-based learning, the inclusion of children with disabilities, parent engagement, and the services supporting early learning programmes to deliver quality programming.

1) the Thrive by Five Index; and 2) the Early Childhood Administration and Reporting Systems (*eCares*)

The introduction of the Thrive by Five Index, by the DBE and DataDrive2030,represents a significant step forward in terms of assessing population-level outcomes at the end of the preschool phase to assess school preparedness among other critical developmental outcomes (see Box 10). The Early Learning Outcomes Measure (ELOM)[15] used in the Thrive by Five Index also enables South Africa to report on Sustainable Development Goal 4.2, defined as the proportion of children under five years of age who are developmentally on track in health, learning and psychosocial well-being, by sex.

Unfortunately, the findings from the Thrive by Five Index have not yet been included in the South Africa ECD Country Profile despite South Africa having developed a local validated measure officially accepted by the DBE. The likely reason for this exclusion is because the ELOM measure is not directly comparable to the UNICEF-led Early Childhood Development Index 2030 (ECDI2030)[viii] which has been recommended globally as the tool to measure developmental outcomes among young children for the purposes of SDG monitoring and reporting.

Neither the ELOM nor the ECDI2030 were designed to measure development outcomes for children under three years old. To fill this gap, the World Health Organization launched the Global Scales for Early Development (GSED) in 2023 to provide an internationally validated tool to assess young children during this critical period of development. It is unclear whether the GSED will be adopted by South Africa.

The second major initiative led by the DBE and their social partners is the design and roll out of the Early Childhood

viii The ECDI2030 captures the achievement of key developmental milestones by children between the ages 24 – 59 months. The module can be integrated into existing national data collection efforts (such as the DHS) and can be disaggregated by key demographics and subnational areas.

Administration and Reporting System (*eCares*). *eCares*, a partnership between the DBE and Ilifa Labantwana, and funded by the Lego Foundation, is being designed to collect routine information on: the registration status of early learning programmes; child enrolment and attendance; funding; human resources; infrastructure needs; and programme quality. The *eCares* initiative, to be rolled out from 2024 to 2027, will address one of the most important gaps in the early learning information landscape, by establishing an administrative data system to support population-based planning and accountability.

Where to from here?

South Africa is capable of meeting its domestic and international reporting requirements for early childhood development, particularly when guided by the priority indicators of the Nurturing Care Framework. This chapter has outlined various shortcomings in the current ECD information ecosystem. It has also highlighted several promising initiatives between the government and social partners to address data gaps. It has shown areas where better information can lead to improved service quality, and those areas that increase South Africa's ability to properly plan, resource, monitor and scale its efforts to reach the goals set out in the National Development Plan and the NIECD Policy.

To build on these efforts, we argue for the following five priorities:

- Develop an ECD Outcomes Framework to unify the various strands of data on early childhood development. The ECD Outcomes Framework should inform the next Medium-Term Strategic Framework. The government should also accelerate plans to publish a clear and pragmatic monitoring and evaluation framework for the NIECD Policy. One outcome of a new monitoring and evaluation framework could be an 'ECD Dashboard' like that used in the Nurturing Care Framework Country Profiles but tailored to South Africa's specific needs and context. The dashboard, which would include the priority set of indicators known to be drivers of child development outcomes from across the essential package, would enable assessment of the implementation of the Policy and would support leadership and coordination in the relevant government structures at national and provincial levels. If the dashboard was publicly accessible, it could also be used by civil society, communities and caregivers themselves to hold government accountable as they are the most invested in ensuring that their children receive the best start in life.
- Establish the Thrive by Five Index as a routine outcomes survey conducted every three years to assess progress towards improving quality of early learning programmes with sufficient time between surveys to make improvements to service delivery and to measure whether these improvements are effective. The Index should be elevated to a priority indicator in the Medium-Term Strategic Framework.
- Accelerate the build and roll-out of the Early Childhood Administration and Reporting System (*eCares*) and the transition from paper record keeping to a digital architecture. While there are very real digital gaps at the population-level, connectivity and access to digital tools should not be an impediment for government officials and their workplaces. The development of *eCares* should be accompanied by a change management approach wherein relevant government officials are supported to make the shift from paper to digital, and financial resources are invested in the tools of trade to enable these officials to adopt new digital administrative and quality assurance processes.
- Leverage existing data collection efforts and systems to improve information on disability, early learning, nutrition and the home learning environment. In the case of data on disability, the Child Functioning Module could be used at population level to provide a proxy indicator of disability amongst children aged 2 – 4 years. In addition, the GHS questions on home stimulation should be reintroduced by Stats SA to regularly monitor and track improvements in the home learning environment.
- Work towards child-level data collection using unique identifiers and to improve integration and interoperability between the various government administration systems to allow for tracking children across services and over time.

Prioritising these five areas will substantially strengthen ECD data systems in South Africa. By transitioning to a digital early learning management information system, conducting regular population-level child assessments, improving what data is collected on children, standardising the ways in which data is collected, and tracking children across services – South Africa will lay a foundation for making measurable progress to achieve its early childhood development ambitions.

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Delivery systems: What is needed to strengthen delivery on the ground?

Linda Biersteker[i] *& Lori Lake*[ii]

South Africa has outlined a bold vision to guide its investment in early childhood development. The National Integrated Early Childhood Development Policy (NIECD Policy)[1] details government's commitment to provide a comprehensive package of care and support to enable all young to children to thrive – with a strong equity focus – prioritising the most vulnerable children to ensure no-one is left behind.

While earlier chapters have highlighted opportunities to strengthen leadership and coordination, financing, human resources and the use of data for planning, monitoring and evaluation, this chapter considers how to strengthen delivery systems in order to close the policy-implementation gap and ensure all young children are able to access all the components of the NIECD Policy service package.

What are the design challenges?

Designing an effective delivery system is challenging as it needs to consider how to ensure that a complex package of care and support reaches young children and their families in the right dose, in the right place and at the right time in order to respond to their changing needs at each stage of development.

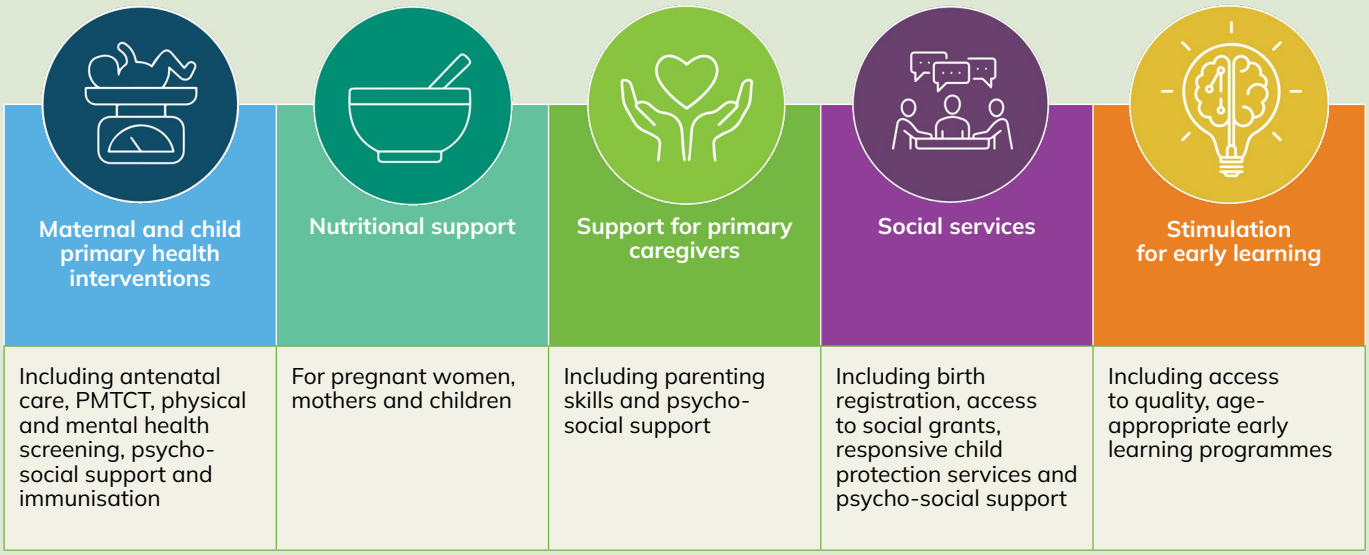
What: An integrated package of care and support

The science of early childhood development highlights how children's health, nutrition, care, protection and early stimulation are interdependent – and how responsive caregiving within the family is essential for good nutrition, health care and early learning.[2, 3]

This integrated approach was given effect in the South African setting in 2015 by the NIECD Policy which defines the roles and responsibilities of different sectors in delivering a comprehensive package of care and support for young children and families – from health care and nutrition to social protection, parent support programmes and opportunities for early learning.

Effective delivery of this complex package of care and support therefore depends on the collaborative efforts of a wide range of stakeholders in both government and civil society to ensure

Figure 29: Core elements of the essential package of ECD services



Source: Hall K, Sambu W, Almeleh C, Mabaso K, Giese S, Proudlock P. *South African Early Childhood Review 2019.* Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana. 2019.

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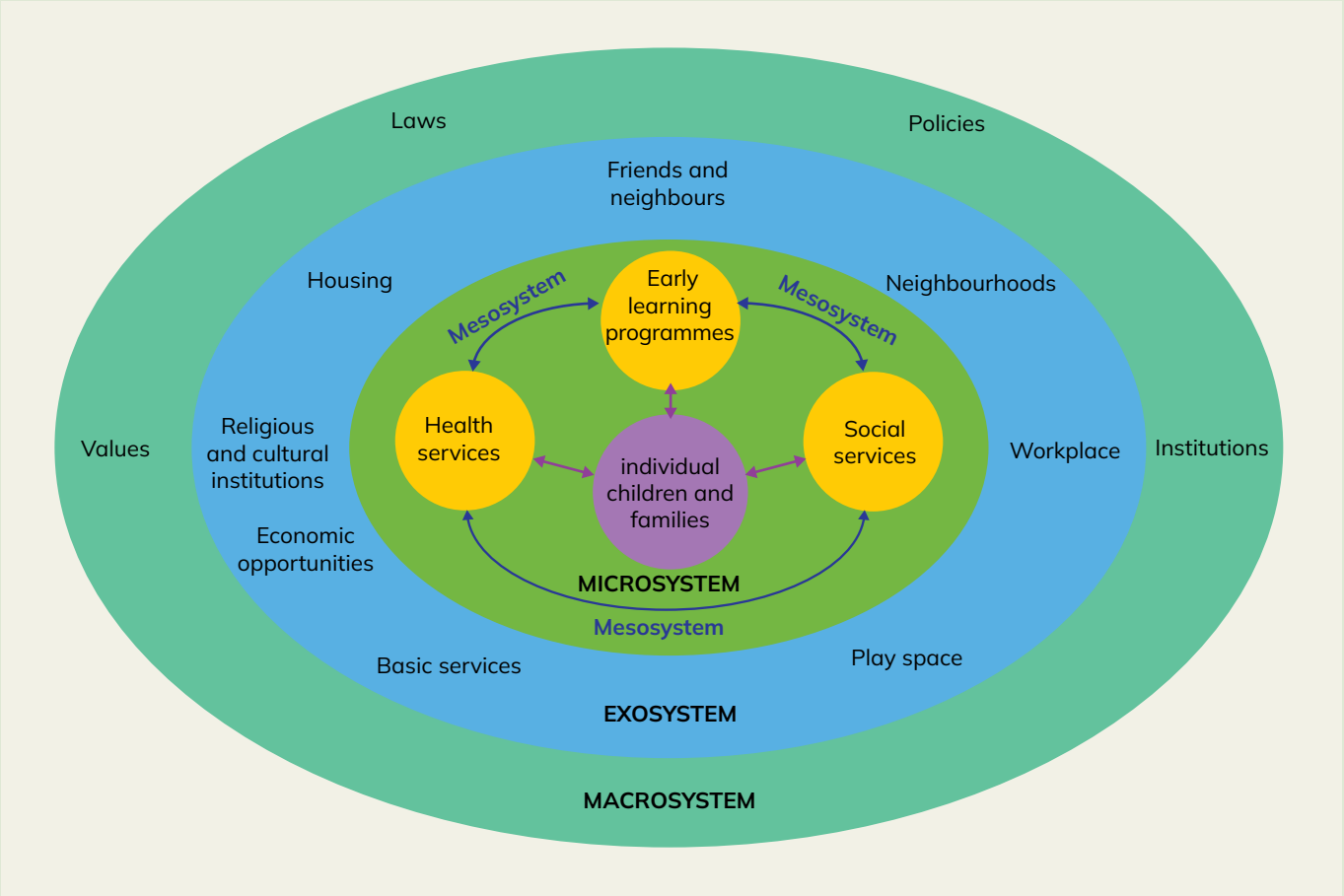
Figure 30: An ecosystem of services and support



Adapted from: Woodhead M, Feathersone I, Bolton LL, Robertson P. *Early Childhood Development: Delivering Inter-sectoral Policies, Programmes and Services in Low-resource Settings.* Oxford: Health & Education Advice & Resource Team (HEART). 2014.

that children and families are able access each element of the ECD package in the right place and at the right time.

When: Attuned and responsive to children's evolving needs

Early childhood is recognised as a sensitive period of development, when the rapidly developing body and brain are acutely sensitive to young children's experiences of care and/or adversity. It is therefore vital that this integrated package of services is carefully tailored and attuned to the evolving capabilities of young children – starting early in the antenatal period as outlined in Figure 31. This includes a strong emphasis on anticipatory guidance and responsive services to support families and caregivers, promote nurturing care, and intervene as early as possible to protect children from harm. This adds a further layer of complexity, as the respective roles, responsibilities and contributions of different stakeholders shift in response to children's changing needs.

Where: Drawing on a range of delivery platforms

An effective delivery system also needs to identify the best possible platforms for reaching mothers and children – bearing in mind that this is likely to change at different stages of the life course. Solid coverage of antenatal care, in-facility births and immunisation for infants makes health services an ideal point of contact for reaching mothers and children during the first 1,000 days of life, but utilisation of health services then declines with an increase in access to early learning programmes providing a more solid point of contact for older children and their caregivers with 68% of children 3 – 5-years-old attending some form of early learning programme[iii] in 2022.[4]

But less than one in five children under three attend a group early learning programme.[4] This raises questions around how best to reach younger children and their caregivers to provide early stimulation, responsive caregiving and positive discipline at a time when children are starting to ask questions, explore their environments and become more independent.

iii This figure includes children in Grade R classes which are part of the formal schooling system and have a high uptake.

Given these challenges, it is important to remember that most care and stimulation of infants and young children takes place within the home and family. So, in addition to strengthening and scaling up the provision of facility-based health, childcare and early learning programmes, we need to explore other potential strategies for reaching out and supporting caregivers and families of young children and strengthening their capacity to provide nurturing care. This includes the use of community health workers, family and community motivators and toy libraries to bring services close to home (see case 18); the use of mainstream and social media and technology (see Cases 6 – 8); and programmes delivered by employers and faith-based organisations (see case 19).

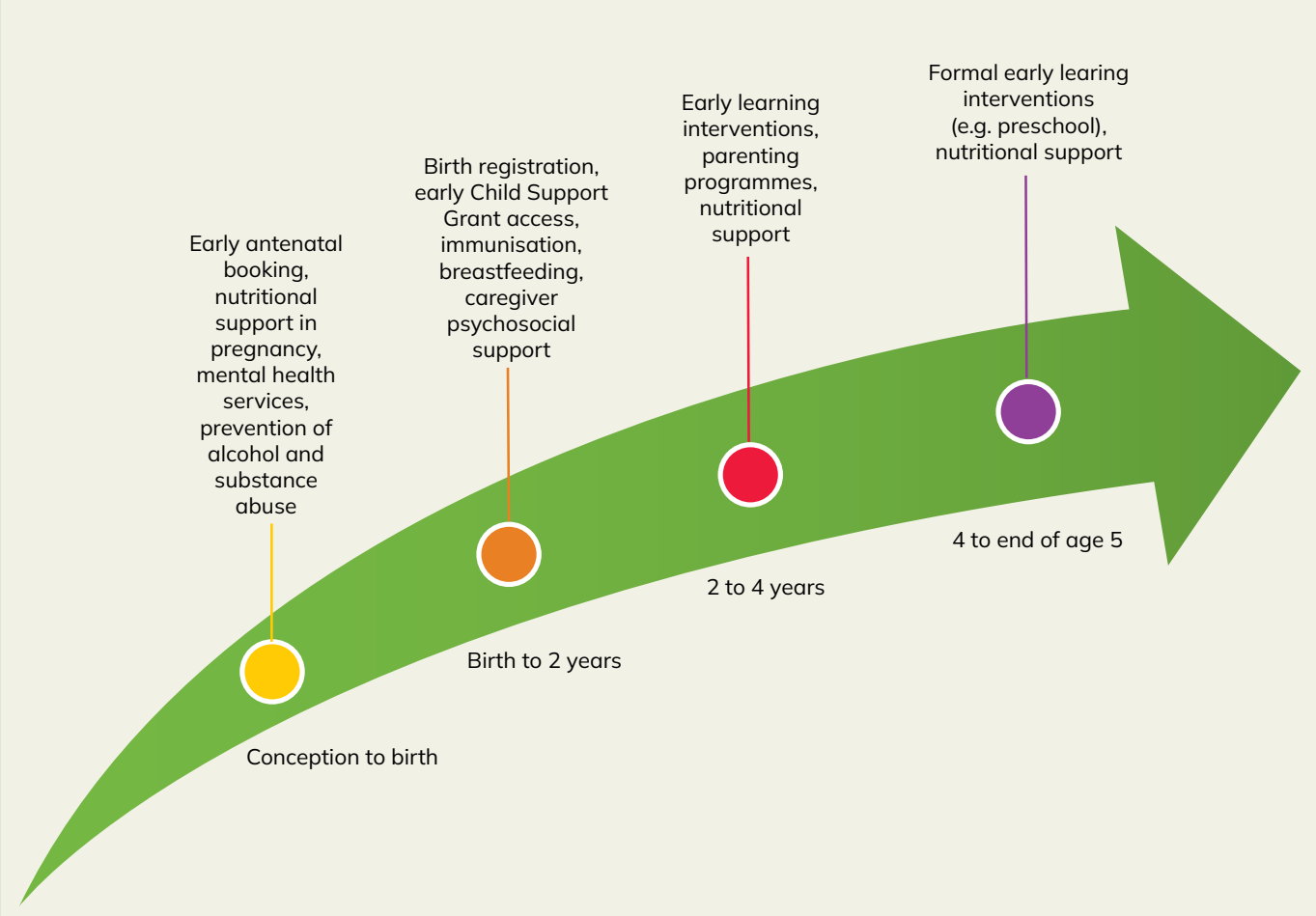
What principles and practices have the potential to enhance delivery?

In this section we reflect on a range of initiatives to enhance the delivery of ECD services and share some of the key principles and practices that enable effective delivery on the ground. This includes efforts to build on existing services and strengths, adopting a multi-modal approach, establishing public-private partnerships, integrating services at the point of delivery, using home visits to expand reach, strengthen community participation and engagement and building the capacity of local government.

Build on existing services and strengths

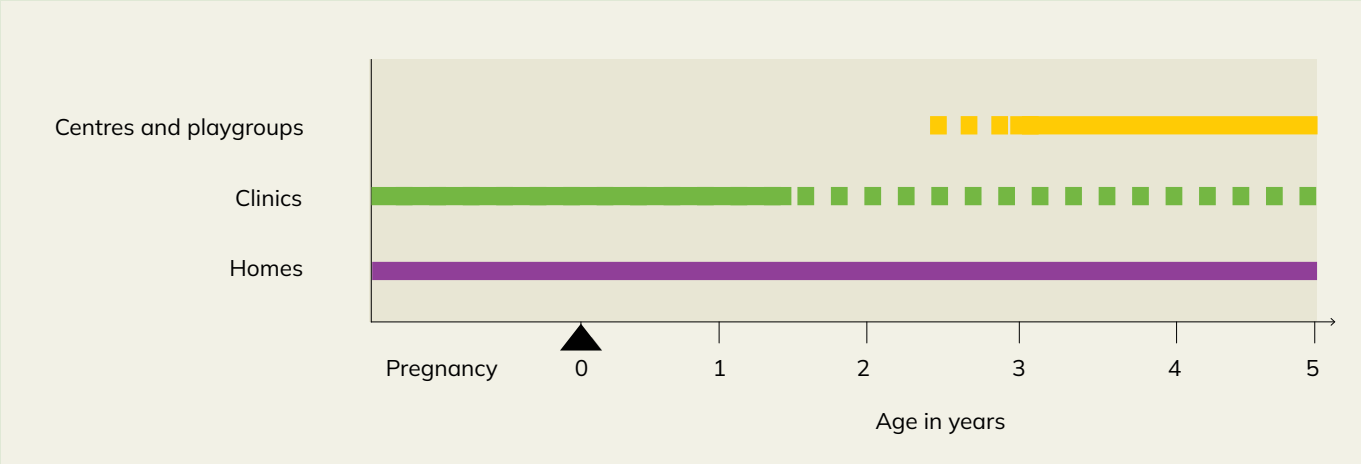
One potential strategy is to build on and strengthen existing services. For example, in 2015, the NIECD Policy identified Health as the lead department responsible for the first 1,000 days of life. This expanded mandate promoted a shift from a narrow focus on child survival to optimal development and has transformed the design and delivery of health care services for pregnant women and youth children in South Africa. An expanded package of care and support now includes a greater emphasis on mental health, responsive caregiving, nutrition, and early stimulation supported by the re-design of the Road to Health Book. The shift from a survive to a thrive agenda has also transformed the ways in which services are delivered, for example through the Side-by-Side Campaign

Figure 31: A developmentally appropriate package of care



Source: Ilifa Labantwana. *The Essential Package: Early Childhood Services and Support to Vulnerable Children in South Africa.* Cape Town: Ilifa Labantwana. 2013.

Figure 32: Age-appropriate platforms for service delivery



and reorientation of health workers to ensure that they affirm and work in partnership with families to support health, care and nutrition in the home. Home visits by community health workers complement facility-based services and mothers and children in need of extra care are referred to social workers or allied health professionals for more specialised care and support. Facility- and home-based care are reinforced by a series of targeted health promotion messages using a range of communication channels including MomConnect and the Side-by-Side[iv] Campaign to increase caregivers' understanding of what they can do to support their child's optimal development, as well as their ability to recognise the danger signs and know when to seek medical care.

This series of innovations highlight how it is possible with strong leadership and technical support to drive change and transformation within a single government department, but even here there are gaps and limitations. For example, it is unclear how much Community Health Workers prioritise maternal and child health support in amid competing priorities.[5]

Adopt a multimodal approach

While health care services for pregnant women and young children are nearly universal, and delivered primarily by the Department of Health, the pivotal role of non-state actors in the design, delivery and financing of early learning programmes makes efforts to strengthen the reach and quality of early learning and parenting programmes considerably more complex and challenging.

The Department of Basic Education's 2030 Strategy for Early Childhood Development Programmes[6] recognises this complex landscape, and its new ECD Service Delivery Model (see Figure 34) allows for a range of programme modalities in order to respond to the different and changing circumstances of families and communities. This includes:

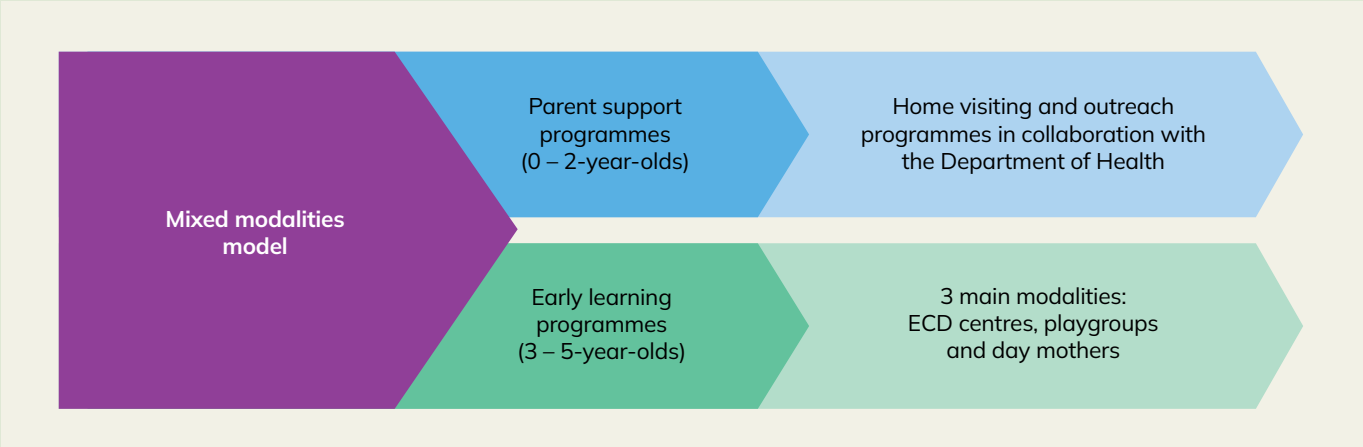
- parent support programmes for caregivers of younger children (0 – 2 years) delivered in collaboration with the Department of Health through home visits and outreach programmes, and
- early learning programmes for older children (3 – 5 years) offered through a mix of ECD centres, playgroups and day mothers – with an intention to expand access to younger children whose parents are in need of childcare.

The Department of Basic Education (DBE) then identifies a number of mechanisms to expand access, improve quality, and strengthen the integration of services, including an emphasis on the following for universal coverage:

- Population-based planning to identify and prioritise those communities with the lowest access to early learning programmes – especially those in townships, informal settlements and rural areas to ensure more equitable access.
- Public-private partnerships to mobilise support and leverage expertise and additional resources from business and donor community to scale up the provision of both infrastructure and services.
- Public communication to encourage parents and caregivers to access ECD programmes, and to strengthen knowledge and skills.

iv The National Department of Health's MomConnect initiative is a free, cellphone-based communication campaign integrated into maternal and child health services that sends targeted health promotion messages to women from pregnancy until their babies are one year. It is accompanied by the Side-by-Side Campaign which includes a range of materials to build the capacity of families to provide nurturing care and encourage health workers to work side-by-side with families to affirm and support their central role in the care of young children.

Figure 33: A mixed modalities approach to implementing the National Curriculum Framework



Source: Department of Basic Education. *South Africa's 2030 Strategy for Early Childhood Development Programmes. Every child matters.* Pretoria: DBE. 2024.

The strategy highlights DBE's leadership role in creating an enabling environment by introducing regulatory reforms to reduce red tape, setting norms and standards, monitoring programme outcomes to drive quality improvement, developing an infrastructure and workforce strategy to scale-up the provision of ECD services.

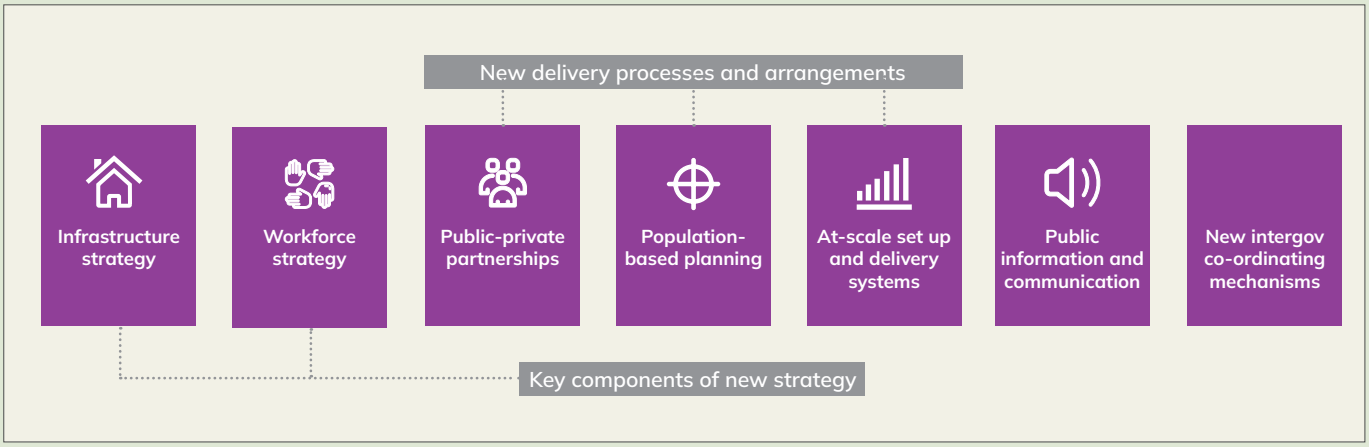
While the new strategy aims to address numerous gaps in delivery, much will have to be put in place before it can impact at any scale. Strategy milestones involve developing of plans and frameworks for the key components as well as piloting of elements such as public private partnerships (PPP), district coordination mechanisms, a quality assurance and support system and major legal reform towards an ECD Act. A large focus for 2024 is on a registration drive to identify and conditionally register early learning programmes which focus on 3 – 5-year-olds while parenting support remains extremely limited.

Establish public-private partnerships

The National ECD 2030 Strategy recognises and promotes the establishment of public-private partnerships to mobilise resources and build capacity for ECD at the local level. For example, Kago Ya Bana's groundbreaking partnerships with the Gauteng Department of Social Development and municipalities of Midvaal, Lesedi and the City of Johannesburg, and SmartStart have proved effective in scaling up ECD services by activating local government's commitment to young children, identifying blockages, streamlining administrative systems and actively supporting day mothers and playgroups to meet the registration requirements.[7]

The work of Project Preparation Trust (PPT) in eThekwini (case 11 on page 140) and the Leave No Young Child Behind Partnership led by the DO MORE Foundation in the Nkomazi district in rural Mpumalanga (Case 16) illustrate some of the key elements that contribute to successful partnerships:

Figure 34: Mechanisms to delivery quality, affordable and equitable ECD programmes



Source: Department of Basic Education. *South Africa's 2030 Strategy for Early Childhood Development Programmes. Every child matters.* Pretoria: DBE. 2024.

Case 16: DO MORE uses collective impact model for effective ECD delivery in Nkomazi, Mpumalanga

Jessica Ronaassen[i]

The DO MORE Foundation (DMF) founded by RCL Foods serves as a strong backbone organisation that aims to leverage the power of business and build partnerships to support local initiatives to enhance young children's access to services in targeted communities through its Everyone Gets to Play (EGTP) model.

Lessons from the field

EGTP grew from the experience of the Leave No Young Child Behind (LNYCB) Partnership in the Nkomazi district, northeast Mpumalanga. While significant cross-border migration from Mozambique and eSwatini makes it difficult to obtain accurate data on the well-being of young children, it is estimated that less than four in ten children aged 3 to 5 are enrolled in early learning programmes. The district also faces pressing health challenges related to inadequate immunisation, water, and sanitation.

In 2015, a local business, RCL Foods, established LNYCB to respond to these challenges by providing a comprehensive suite of services including: food security and nutrition, parent and caregiver support, early learning through play Infrastructure and services, maternal and child health, child safety and protection, enterprise development, capacity building and leadership development.

How is the partnership structured?

Coordination of LNYCB partnership is led by a **provincial steering committee** which includes representatives from the core ECD departments – Social Development, Education and Health – and RCL foods represented by DMF. The work of the steering committee is governed by a Memorandum of Understanding (MoU) and they have worked together to develop a common vision, business plan and monitoring and evaluation framework based on departmental mandates in the NIECD Policy.

A **technical committee** comprising of local stakeholders and implementers meets monthly. The committee includes district staff from Education, Health, Social Development, Home Affairs, Cooperative Governance and Traditional Affairs (COGTA), Social Security Agency (SASSA), LIMA Rural Development Foundation (an implementing agent for the Community Works Programme (CWP), the National Development Agency, Ntataise Lowveld, local ECD non-governmental organisations, Grow Great and the DMF who co-convene the meetings with a district official from Education. On the ground implementation receives additional support from LIMA – a community development intermediary supervised by DMF – who are responsible for management, coordination and stakeholder mobilisation. Other stakeholders and donors are drawn in to support capacity building and resourcing.

How has this partnership enhanced service delivery?

The LNYCB partnership has facilitated information sharing between different sectors, deepened partners' understanding of the national policy, clarified roles, reduced duplication and streamlined efforts. It has also succeeded in leveraging additional human and financial resources through private sector partnerships and the CWP as illustrated in Table 31.

Table 31 The LNYCB strategic areas and key programme inputs to May 2019

Strategic area	Leave No Young Child Behind (LNYCB) partnership inputs
Collaborative partnership working together, to achieve agreed objectives in line with common vision and monitoring and evaluation framework	• MOU signed by DSD, DoH, DoE and RCL foods (represented by the DMF). • A provincial LNYCB steering committee with business plan and monitoring and evaluation framework. • An inclusive local LNYCB technical committee meets monthly to report on developments for young children. • Lima Rural Development Foundation provides on the ground management, coordination and stakeholder mobilisation for the LNYCB. • Variety of other stakeholders drawn in to provide expertise, inform programme strategy and leverage additional resources.
Maternal health services	• Flourish antenatal classes offered by Grow Great • Training of clinic staff and CHWs

i DO MORE Foundation

Strategic area	Leave No Young Child Behind (LNYCB) partnership inputs
Child health services – every child reaches his/her potential in terms of health, growth and development	• Training for health professionals and CHWs on integrated management of childhood illnesses,, the Road to Health Book and Side-by-Side Campaign. • Vitamin A and deworming at ECD centres by DoH. • Champions for Children CHWs trained by Grow Great on growth monitoring and support for breastfeeding mothers and young child nutrition. • Children at risk of hunger identified and provided with monthly food parcels by SASSA and DSD. Catch-up immunisation campaigns and community jamborees on early childhood health and nutrition. • Food gardens established at 14 ECD centres. • Daily nutritious snack provided by RCL Foods to all playgroup children.
Parent support and early stimulation in the first 1000 days through home visiting	• Planning with DoH for CHWs to provide support to pregnant women and families of babies and toddlers. • Possible home visiting support programmes investigated. • Meetings with COGTA about potential CWP stipends for CHWs during first 1,000 days.
Parental and caregiver support	• 45 CWP workers trained by DSD are facilitating DSD Parenting Programme for parents/caregivers of young children and being paid CWP stipends. • Weekly ECD 'LovePlayTalk' radio broadcast on Nkomazi FM for pregnant women and caregivers or teachers of young children on a wide variety of topics. • Monthly press articles for parents of young children in local newspapers.
Prevention and early intervention services for protection of young children	• Increased referrals for birth certificates and social grants with support from DSD and SASSA. • Referral task team set up to pilot an integrated child-centred referral process and tools with ECD programmes. • Comprehensive Resource Directory of services for pregnant women and young children compiled. • 27 ECD centre managers trained on identification and referral for child protection. • Most ECD centres have submitted national Child Protection Register screening applications for staff. • Some training on protection of and inclusion of children with disabilities.
Stimulation for early learning	• 2017 ECD programme baseline assessment informed quality improvement plans and follow up 18 months later showed improved classroom quality scores. • Training on ECD programme quality for DSD and DoE district officials responsible for monitoring and supporting quality ECD programme implementation. • Toy kits for each ECD centre, and membership of the Ntataise Lowveld Toy Library funded by the Sugar Industry Trust Fund for Education (SITFE). • Kits of siSwati children's books for each centre provided by Biblionef. • Teaching and learning support materials provided to registered ECD centres by Mpumalanga DoE. • Partial Care Registration support offered by DSD – with more facilities conditionally or fully registered. • DSD subsidies for children in 19 centres and nine playgroups • Training offered by Mpumalanga DoE on National Curriculum Framework, Riverview Preparatory School quarterly workshops on making equipment from waste, Ntataise playgroup training. • Accredited ECD practitioner skills development training, and ECD enrichment programme for ECD practitioners funded by SITFE. • LNYCB Young Child Forum established for all stakeholders working with or for young children and their families to share information and build capacity. • Follow up quality study of ECD programmes to track improvements and identify further gaps in October 2018.
Infrastructure and services – safe, child friendly spaces and facilities	• First aid training and kits distributed to ECD centres. • Emergency fire training and fire extinguishers distributed to ECD centres. • Ehlanzeni Environmental Health Officer has audited health and safety requirements of all ECD centres. • Infrastructure included in centre development plans. • Minor infrastructure improvements such as provision of stoves, a freezer, roof repairs, shade structures, a pit latrine and fencing for eligible community-owned ECD centres funded by SITFE. • Outdoor play equipment including climbing frames, slides and swings constructed at 24 ECD centres. • Nkomazi Local Municipality provided JoJo tanks for some ECD centres.

Source: Biersteker L, Mabaso Z. *Leave No Young Child Behind: Towards implementation of the ECD service package of the National Integrated ECD Policy in Wards 16 and 19, Nkomazi district*. Westville: DO MORE Foundation. 2019.

What makes it work[18]

The MoU with departments provided a clear mandate and the common plan and monitoring and evaluation framework helped hold partners accountable. Joint leadership by the private sector and DSD facilitated the process, and the DMF and LIMA played a pivotal role in driving coordination, communication and implementation at community level.

Initial trust building was a challenge as were the different operational requirements of civil society and government departments, but strong communication, planning based on needs identified by participating departments, and the benefits leveraged for the area's young children helped to resolve these tensions. Achieving municipal buy-in has remained a slow process and a challenge.

The intervention confirms the efficiency and benefits of coordinated service delivery and the value-add of public private partnerships. It provides significant pointers as to what is needed to enable integration. This included a strong and respected backbone organisation to drive and sustain coordination, the allocation of time and resources for coordination (which was mandated by the departmental MoU), the leveraging of expertise and resources across different sectors to deliver on a common plan. The role of monitoring and evaluation data to inform planning and implementation was also highlighted.

Is it possible to take the model to scale?

The DMF has drawn on its experience in Nkomazi to expand delivery and guide the planning and implementation of basket of ECD services and support in other communities (including Pongola, Hammarsdale, Randfontein, Rustenburg, Molteno, Worcester and Bushbuckridge). The DMF continues to assume the crucial role of a backbone organisation and facilitate private and public partnerships to achieve a multiplier effect. It also takes into careful consideration contextual factors such as local priorities, buy-in and support, governance and leadership, access to services, and the unique geographic context of each community. This affects the composition of local partnerships which are also fluid as each intervention develops. For example, in peri urban Hammarsdale a local forum was created including stakeholders from the local municipality, government departments, big businesses, ward councillors and community leaders which then prioritised addressing unemployment, hunger and poverty, while in Rustenberg and Nkomazi, non-centre-based models have been developed to extend the reach of early learning services.

To find out more about the collective impact model for young children: https://domore.org.za

1. A memorandum of understanding is essential in establishing a common vision, generating buy-in, clarifying roles and responsibilities and providing government and civil society stakeholders with a clear mandate, and sense of common purpose.
2. An effective coordinating structure coupled with a strong backbone organisation to facilitate open and continuous communication and collaboration across different sectors and to drive implementation.
3. A local survey to identify the characteristics and distribution of young children and ECD services provides a clear evidence base to guide population-based planning in a way that builds on existing strengths, addresses gaps and prioritises those most in need.
4. A shared planning and monitoring and evaluation framework to guide implementation, track progress and ensure accountability.

These elements are similar to those identified in the Collective Impact Model – an emerging approach used to address community health and other social sector challenges in a collaborative manner by breaking down silos and integrating and aligning the efforts of actors from a range of sectors to achieve a common goal.[8, 9]

Yet challenges remain. For example, despite PPT's success in establishing a metro-level ECD steering committee, providing training, simplifying land-use planning and developing an eThekwini ECD strategy and sector plan, this still hasn't been formally adopted or funded by the municipality. So, political will and resourcing are key constraints even in an urban setting.

King argues that "collaboration always takes place in a context, and its features will be shaped by the dynamics and players in this context. To understand the dynamics of any particular collaborative project, it is useful to map out the who, why and how of collaboration in the context of practical delivery aspects of that programme".[10] For example, the DO MORE Foundation is an initiative of the food giant RCL Foods, and their work in Nkomazi (Case 16) provides a sense of what is possible with strong coordination and commitment at a local level. But such models are possible partly due to the presence of invested partners with resources to champion these issues

and this raises questions about the extent to which it is possible to scale up this model and adapt it to meet the needs of children and families in other settings.

The Foundation is currently drawing on lessons learnt in Nkomazi to guide the establishment of PPPs in another 15 communities through their Everybody Gets to Play Model. This may prove an effective strategy in districts close to businesses, but it is less clear how to extend private investment and technical support beyond the areas from which the company work force is recruited to reach children and families in more remote communities who are most in need.

Integrate services at the point of delivery

PPPs provide one potential strategy for strengthening intersectoral collaboration and service integration on the ground. The Insaka programme in Zambia offers an alternative model that enables existing local services to be delivered more easily and to more beneficiaries, in an integrated way, through establishing community-based ECD hubs (see case 17). Each hub provides spaces that can be used for early stimulation and play-based learning, the delivery of health care services, parent counselling, adult literacy and community meetings, as well as access to clean water, a cooking area and food garden. This kind of multipurpose ECD centre has the potential to enable a more efficient and seamless approach to service delivery. It brings service providers together in ways that strengthen communication and referral pathways, and alleviate the burden on families who no longer have to travel from one service point to another.

The NIECD Policy calls for all services to be integrated into, and delivered across, the full continuum of care settings from the home to centre-based programmes,[1] yet this degree of service integration is rare in the South African setting. There have been some efforts to adopt a more integrated approach within the health system, for example, by establishing Home Affairs offices at maternity and obstetric units to facilitate early birth registration, introducing parenting and book-sharing programmes to promote early stimulation at primary health care facilities, and reaching out to provide health and nutrition services to children attending early learning programmes.

At the very least, it is helpful to establish a directory of services, and local forums to foster healthy working relationship between different service providers and strengthen systems for referrals and tracking of follow up at community level.

Use home visits to expand reach

Home visiting programmes provide an alternative to centre and facility-based models of care – and are explicitly prioritised

Figure 35: Multipurpose community ECD hub

in the NIECD Policy.[1] For example, community health workers (CHWs) have the potential to play a critical role in improving child survival and development by reaching out to caregivers and children who live far from health care facilities or who are in need of additional support.[11 12] Yet, CHWs spend most of their time focused on the care of adults with HIV, TB and non-communicable diseases, with less than 15% of their time dedicated to pregnant women and young children.[5]

Given these constraints, it is highly unlikely that CHWs will be able to drive the delivery of parenting programmes (as proposed by DBE in the National ECD Strategy 2030) in addition to their current workload.

The Foundation for Community Work offers a more focused approach by training local family and community motivators who visit homes to promote the stimulation and care of young children – including those living on farms who are unable to attend ECD centres (see case 18). Their Family in Focus programme has worked closely with ward councillors to establish local teams of home visitors in over 20 rural and peri-urban communities in the Western Cape – with each community project forging strong links with a range of community structures and networks – including community kitchens and feeding programmes – in order to strengthen referrals and improve services for families and young children.

Strengthen participation and community engagement

The NIECD Policy calls for a focus on families and their communities and an approach that builds on local strengths

Case 17: Insaka Zambia – A community-based integrated ECD programme model

Zewelanji Serpell[i]

Insaka[ii] [19] takes an integrated approach to the provision of care to pregnant mothers and children 0 – 8 years of age. The model draws on UNICEF's Care for Child Development package to train health and other frontline workers, to help parents and caregivers provide responsive and good care to young children. The health system functions as the primary delivery platform because of its wide reach and capacity to reach families and its mandate to serve the youngest children, however, systems across multiple sectors including agriculture, education, social welfare, water and sanitation, and child protection are leveraged to deliver a holistic ECD programme. Communities in participating villages are supported to set up a structure on land allocated by the traditional leader. Sometimes this is a covered area, other times it is a set of small buildings where services can converge and community learning and sharing takes place.

These community-based integrated ECD hubs bring multiple services to the community: frontline workers provide health outreach services, and trained community-based volunteers engage children in early learning and play, and provide workshops for parents and caregivers on health, nutrition, sanitation, hygiene, child protection and income generating activities such as gardening and food processing.

The minimum package at each ECD hub includes:

- Early stimulation room for children 0 – 3 years and their caregivers.
- Learning through play classroom and playground for children 3 – 6 years.
- Health office outreach services, including growth monitoring and immunisation.
- Multipurpose area for parenting counselling, adult literacy classes and community meetings
- Cooking area and garden for nutrition promotion – cooking demonstrations, use of locally available nutritious food stuffs and a community-developed garden.
- Access to clean and safe water as well as programming to promote good sanitation and hygiene practises.

A community-nominated centre management committee, with equal representation of women and men, manages the hub with support from various subcommittees, traditional leaders, local government and the district health and education offices, and community welfare assistance committees. In addition, a cadre of community-based volunteers trained in the Care for Child Development package, support parents through coaching and training sessions delivered at the hub and home visits. These volunteers are trained and supervised by staff at nearby health facilities and schools. A midline evaluation in three districts[20] found that it was regarded by families, caregivers, communities as acceptable and appropriate. Knowledge and awareness of the importance of early childhood development had increased and stakeholders could see the benefits of the programme for their young children.

Factors supporting and hampering implementation

Insaka is not reinventing new services but simply establishing a place where existing services are delivered more easily, to more beneficiaries, and often simultaneously so communities implicitly understand that ensuring optimal child development involves many different dimensions.

- The presence of UNICEF and NGO partners ensured the programme stayed on track.
- Quarterly reviews and planning meetings by district multisectoral teams improved coordination.
- Community involvement including leadership facilitated engagement and programme ownership.
- ECD programmes in the area created a favourable climate for the introduction of integrated hubs as ECD activities were familiar.
- Introducing a feeding programme in one community helped increase programme uptake.
- Distances in some rural catchment areas made it hard for volunteers to reach households on foot, and parents and caregivers to access services and support.
- Many of the trained volunteers involved in programme delivery of the programme had no specialised training and this limited the care and guidance they could provide.
- The lack of incentives for volunteers who were offering different programme activities, led to some dropout and threatened ongoing sustainability.

Despite these resource constraints, the Insaka model provides an excellent example of how to engage key stakeholders and integrate services to provide a universal package of support for young children and families.

i UNICEF Zambia
ii Insaka means a space in the community where community members gather, dialogue and share knowledge.

Case 18: Shifting paradigms – from private to community ownership of early childhood development

Riedewhaan Allie[i]

The Foundation for Community Work (FCW) efforts to support the early learning and development needs of children initially focused on helping communities acquire land from local authorities and build preschools. Yet by the early 1980s it was clear that the preschool building programme was not a sustainable model in poor communities as community organisations did not have the means or the capacity to maintain the facilities and programmes.

A paradigm shift

This led to a paradigm shift at FCW from investing money in buildings, to investing in developing the capacity of people in poor communities to better serve the needs of young children. This included the Family in Focus programme which support families, parents and caregivers to provide a caring, safe and stimulating home environment for young children through a series of home visits.

The FIF programme aims to:

- increase access to ECD services and programmes for young children and their caregivers
- increase awareness around the importance of ECD
- encourage caregivers and families to become active participants in the early childhood education, development, and stimulation of their children
- empower local communities to take ownership of the FIF programme
- provide employment opportunities for local home visitors.[21]

Each community project employs 10 – 20 home visitors who support between 300 – 500 families and their children, with just over 250 home visitors reaching out to nearly 9,000 families in 20 peri-urban and rural communities across the Western Cape. The organisation's ability to grow the home visiting programme was as a direct result of various government initiatives to create employment and skills development opportunities for young school leavers and unemployed people which enabled FCW to sustain its complement of home visitors despite many exiting the programme to find better employment opportunities.

Working with local government and municipalities

Introducing the FIF programme in new areas required meetings with municipal officials and councillors. While we were looking to recruit for home visitors to be trained, councillors saw the opportunity to make good on their promises to assist families. In many communities, councillors played a pivotal role in anchoring the local community consultative process and facilitating community buy-in for the home visiting programme. Strong linkages are forged with local stakeholders including ECD practitioners, the local ECD and community policing forums, ward councillors, civic members, and social workers. In rural communities, representatives from the farmers associations are also invited to extend access to families living on farms.[21, 22]

Although the projects aim to support early stimulation and care, home visitors also raise challenges through community police forums, neighbourhood watches, residents and ratepayer's associations to ensure that communities became safer for families and children. Home visitors also serve as the eyes and ears of other health and social service professionals – reminding caregivers to follow-up on vaccinations and identifying suspected incidents of abuse.

In many of these communities, teams of home visitors have become involved in a range of community structures and networks in order to improve services to families and children. Access to community kitchens and feeding programmes are increasingly benefitting more young children, and home visitors have been invited by councillors to assist with parenting programmes at feeding centres.

Working with ward councillors and committees to deepen their understanding of young children's entitlements is essential. But local municipalities still have a long way to go before fully embracing their responsibilities to young children. The small contributions through grant-in-aid funding or discretionary budgets of councils that offer ECD equipment or toolkits for preschools are not enough to make a difference. Only when ECD is recognised as a public good and is incorporated as an essential element of local Integrated Development Plans, will sufficient resources be allocated to help children access their constitutional rights.

In 2023, FCW facilitated an ECD indaba for the Cape Wineland District to deepen the municipality's understanding of its responsibilities as outlined in the NIECD Policy, Constitution, Municipal Systems Act and Children's Act. This culminated in a commitment to include ECD partners in local government processes to ensure young children's needs are prioritised in the local Integrated Development Plan.

i Foundation for Community Work

in the home, neighbourhood and community. Similarly, the Nurturing Care Framework Handbook (that offers global guidance on how to strengthen early childhood development programmes) advocates for the adoption of a place-based approach that builds on local strengths in the neighbourhood and community to support families and children.[13] It argues that "creating an enabling environment for nurturing care cannot happen from the top down", [13)] it needs to be built from the ground up and community engagement is critical from the start. This includes efforts to listen to families, involve them in decision-making and mobilise the resources needed to support them; using the media to create demand for services, and encouraging communities to demand good quality care and hold service providers accountable.

Similarly, the Nuts and Bolts evaluation of the Smart Start programme in the USA,[14] argues that disjointed, onerous and 'hard-to-negotiate' bureaucracies place unnecessary burden on families and undermine their access to the very support systems on which they depend in ways that may deepen inequities. Instead, it motivates for the inclusion of families and service providers in decision-making processes in order to better understand what works for them and ensure that policies and practices are more attuned and responsive to local needs.

The Safe Inclusive Participative Pedagogy (SIPP) research project in Vrygrond, Western Cape (Case 20) aimed to strengthen safety, participation and inclusion in early learning programmes. Researchers drew on a number of different strategies to engage with parents, young children and community members, working in partnership with community stakeholders to develop a series of concrete action plans to address local challenges. This case highlights the benefits of adopting a more inclusive approach to policy formulation to ensure that policies are flexible enough to embrace the lived realities of actors on the ground.

It is at local level where change happens most significantly and "designing inclusive local structures that purposefully connect and collaborate with state infrastructure is a key strategy for advancing equity".[14] Through such interactions and negotiations, policy can be effectively implemented, with buy in from those on the ground. Engaging with stakeholders provides a reality check allowing "avoiding obstacles and changing course if some measures do not align with local needs".[15] Yet, there is general agreement among South African ECD stakeholders that local level stakeholders and beneficiaries have little influence on the policy process, either formulation at national level or local implementation, despite the policy intention "to build on the foundation provided by existing systems and knowledge".[1]

Build the capacity of local government

Challenges, particularly with registration of ECD facilities and the limited role of local government in other supports for early childhood development, are well documented.[16] While municipalities offer a number of services that benefit young children (water, sanitation, parks) they do not often support ECD programmes beyond zoning and environmental health and safety. ECD support is not well understood and is also often referred to as an unfunded mandate. The 2030 ECD Strategy notes that municipal cooperation and buy-in is needed to reduce red tape.[6] The National Planning Committee's ECD Advisory[17] highlights several potential reforms to facilitate coordination between provincial education departments and districts, clarify municipal responsibilities and enable better funding and other supports to ECD providers. These include efforts to utilise existing coordination structures rather than creating an additional administrative burden. Key recommendations include:

- The provincial head of early childhood development reporting on the implementation of the strategy to the Premier and provincial Inter-Governmental Forum;
- The MEC responsible for early childhood development working through the MEC for Cooperative Governance and Traditional Affairs (COGTA) to streamline communication with municipalities utilising existing coordination structures;
- Establishing a specific line of accountability in COGTA for its role in overseeing and supporting local government ECD functions and facility development;
- Developing working relationships between education districts and municipalities which may be supported by aligning their boundaries.

The Integrated Development Plan (IDP) is the primary development instrument for municipalities and should explicitly promote municipal support for the provision of infrastructure and sites for ECD facilities. To this end the NPC Advisory proposes: Developing an ECD strategy guideline for municipalities on how to include early childhood development in the development of the IDP including engaging stakeholder participation in its consultative processes, clarifying legal and procedural responsibilities and promoting a developmental role for ECD, as broadly defined.

Infrastructure development is an essential requirement for expanding access to ECD programmes and national departments responsible for early childhood development should engage the Joint Reporting Forum for Local Government (chaired by Treasury and COGTA) to include an ECD target for local government planning.

Similarly, the Children's Amendment Bill of 2023 proposes reforms to address the challenges. These include requiring municipalities to develop a municipal ECD strategy and integrate this into their municipal IDP and annual budget. It also proposes that the Minister of Local Government in collaboration with the ministers of health and basic education develop a draft by-law to promote consistency in the regulation of ECD programmes and that takes into account all socioeconomic contexts. However, municipalities can set their own standards and advocacy would be needed to ensure the take up of such a by-law.

While many concrete solutions have been put forward for streamlining the regulatory framework and clarifying local government roles, implementation will depend on buy-in, budgetary flexibility and the capacity of provincial education departments, COGTA and municipalities.

Conclusion

While finance, infrastructure, human resources, monitoring and evaluation, and public communication are all essential building blocks of an effective ECD system, it requires strong leadership and political will to champion the needs of young children and build a thriving ECD sector in communities across South Africa. In particular we need to nurture local champions who can breathe life into the system and make it work.

Creating an enabling environment for early childhood development cannot only happen from the top down, it must also be built from the ground up. This includes building on existing strengths, fostering collaboration between different sectors and spheres of government, building partnerships with civil society and the private sector, and putting children and families at the centre of our efforts so that our services are attuned and responsive to their needs.

Case 19: The role of the church in supporting parents with young children

Richard Lundie[i]

The First Thousand Days (conception to two years) is a once-in-a-lifetime opportunity to nurture brain development and enable children to thrive. So, how can we intentionally support families of young children and what is the role of the local church in the first 1,000 days of a child's life? This research question was posed by Common Good, a faith-based, non-profit organisation in 2017. After a year of engaging 194 church leaders, practitioners and parents, the results were clear: the church is already equipped and well-positioned to have a profound impact on children's well-being and development.

- Churches have the inherent capacity to build community, journey with people and ensure that parents are not isolated and able to seek support. Local churches can use their existing strengths to care for families in unique ways. They understand their community's unique strengths, risks and opportunities.
- They are already involved in caring for people. It is natural, normal, and even expected, that families are visited. This can be leveraged to provide more intentional, targeted support for families in the stage of the first 1,000 days.
- Collectively, they have incredible reach: with an estimated 43,000 churches in South Africa.
- They have congregants who have skills, networks and time that can be directed towards families with young children. This incredible social capital can be harnessed.
- They are familiar with recruiting volunteers for various purposes. This brings sustainability to their support for families.
- They have a trusted voice: health information and encouragement to adopt new caregiving behaviours can be shared and received in the context of a supportive relationship.

Sikunye has identified six areas of church life that can be used to support, strengthen and encourage families. They provide free workshops for church leaders to support them in how to make their church a "First Thousand Days Friendly" church and to discern next best steps.[ii] They provide training so that church leaders and members know how to conduct home visits, establish supportive relationships, share key information and skills, build up caregivers' confidence, and when to refer families to service providers for more targeted support. In addition, they host coaching and check-in sessions to create opportunities for church leaders to learn from, encourage and pray for each other.

Regardless of their size, denominational practice or cultural heritage, faith communities are well positioned and equipped to play a meaningful role in enabling young children and families to thrive. This includes deploying volunteers in powerful ways to provide practical, emotional and spiritual support to families during this important life stage.

i Sikunye
ii These services are available online through Zoom live events, a five-day flexible WhatsApp learning journey and information on their website.

Case 20: Key principles for successful local policy implementation: Lessons from research on early learning in a vulnerable community

Marsha Orgill,[i] Linda Biersteker,[ii] Leigh Morrison,[iii] & Malibongwe Gwele1[i]

The Safe Inclusive Participatory Pedagogy (SIPP) Project provided an opportunity to explore the experiences of local stakeholders and learn from them about which aspects of ECD policy and implementation work and which do not.[iv]

The SIPP international research partnership aimed to identify and develop safe, inclusive, and participative pedagogies that can be implemented and sustained in under resourced contexts. The study critically considered how these concepts were understood and applied in Vrygrond, Cape Town, as one of a series of case studies, given that local contexts always influence the implementation of government guidelines and policies.

Vrygrond is a densely populated area with formal and informal dwellings, and a diverse population of some 42,000 Coloured, isiXhosa and foreign nationals. It is a vibrant area with a taxi rank, informal traders and small businesses, but there is high unemployment and poverty and social challenges such as crime, domestic violence and substance abuse. There are 35 ECD centres but about two thirds of young children in the area do not have access to organised ECD programmes of any kind.

Adopting participatory approaches

The research intentionally took a participatory approach. This includes the recognition that (1) community members are knowledge holders, and that this knowledge is embodied in their lived experiences (2) community members are equal agents in developing action plans that drive community development and (3) bringing people together strengthens relationships across all stakeholders. Participatory approaches make it possible to bring various forms of knowledge together and bridge the gap between learning, knowledge and practice through a process of co-creation.

1. The researchers sought to build a relationship with a credible community partner before the project started, and True North, the leading ECD resource and training organisation in Vrygrond helped facilitate partnerships with other key stakeholders, in the community.
2. True North facilitated setting up a community advisory board (CAB) made up of service organisations working with families and young children in the community, members of the ECD Forum and a representative of the Vrygrond Community Trust. The CAB guided the research and stakeholder engagements, helping to identify questions and stakeholders for discussion.
3. Interviews and focus groups were conducted with parents, children, ECD principals, practitioners and members of service organisations to ensure a range of voices were heard in the process of learning about and generating key ideas to promote safety, inclusion and participation of children and parents. Conversations about the key concepts were supported by mapping, visualisations and in the case of the children the use of stimulus pictures, drawing and persona doll stories.
4. Findings from these discussions were shared with the CAB and the development of a community ECD action plan was facilitated.

Key findings

These engagements helped to surface a range of concerns around safety, inclusion and participation:

- **Safety:** Child safety was a concern for all. Children were only safe when accompanied by adults, kept at home, or at ECD centres. ECD staff emphasised both physical safety precautions as well as making sure children felt emotionally safe. Children explained that their homes and ECD centres were safe spaces and parents and ECD practitioners were sources of comfort and protection.
- **Inclusion**: There were insufficient ECD services in the area and fees were a major barrier. Poor children, children from homes with substance abuse and children with disabilities were less likely to attend. ECD staff helped children feel included by learning different languages, addressing exclusion and bullying and allowing leeway for parents who could not pay. But felt that they provided inadequate support for children with disabilities with staff lacking confidence and feeling overwhelmed because of staff shortages and insufficient training and support.
- **Participation:** Child participation in decision making was not a parent priority, due to cultural norms and

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also because providing for basic needs such as safety, nutrition and access to education was seen as more urgent. Practitioners often directed all the learning activities, believing that children learn by instruction. This limited children's opportunities to play and make choices. Parents felt powerless due to limited opportunities to exercise their own agency within the community; this in turn restricted their ability to promote child participation.

ECD stakeholders valued having the space to engage and reflect on their needs and challenges, identify assets in the community, and transform knowledge gained from the research into a plan of action. This included plans to:

- Encourage parents' active participation in ECD centre activities and their child's development, by finding creative ways to share key messages at parent meetings, and by inviting parents to fun activities such as celebrations to make them feel more welcome and included in ECD centre activities;
- Reach children who are not attending early learning programmes by offering basic support and information to parents at clinics and through faith-based organisations;
- Develop an ECD community hub to share information, build capacity of practioners, and support parents.

An example of an activity that has already come about as a direct result of creating this space for engagement, was the identification of two safe places for children to play (at the community centre and the community library), and the first has already been transformed into a play area where ECD centres can now book play time sessions for children.

In conclusion, working in participatory ways enables the co-creation of ideas and actions that value and leverage local knowledge in order to design and implement policies that are fit for purpose.

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Part 3

Children Count – the numbers

Part three presents a set of key indicators and disaggregates data to make visible inequalities in children's health, education, nutrition, living conditions and access to services. The indicators track progress in the following domains:

- Demography of South Africa's children
- Income poverty, unemployment and social grants
- Child health and nutrition
- Education
- Housing
- Basic services

A full set of indicators and detailed commentaries are available on www.childrencount.uct.ac.za

The Side-by-Side Campaign encourages health workers to work in partnership with caregivers and families to enhance nurturing care and responsive caregiving within children's homes and children's services.

Introducing Children Count

South Africa's commitment to the realisation of socio-economic rights is contained in the Constitution, the highest law of the land, which includes provisions to ensure that no person should be without the basic necessities of life. These are specified in the Bill of Rights, particularly section 26 (access to adequate housing); section 27 (health care, sufficient food, water and social security); section 28 (the special rights of children) and section 29 (education).

Children are specifically mentioned and are also included under the general rights: every child has the right to basic nutrition, shelter, basic health care services and social services. These form part of what are collectively known as socio-economic rights. While these rights are guaranteed by the Constitution, the question is: *how well is South Africa doing in realising these rights for all children?* To answer this question requires monitoring the situation the situation of children, which means there is a need for regular information that is specifically about them.

A rights-based approach

Children Count was established in 2005 to monitor progress for children and is an ongoing data and advocacy project of the Children's Institute, updated every year. It provides statistical information that can be used to inform the design and targeting of policies, programmes and interventions, and as a tool for tracking progress in the realisation of children's rights.

Child-centred data

Any monitoring project needs regular and reliable data, and South Africa is fortunate to have a reasonably good supply. There is an array of administrative data sets, and the national statistics body, Statistics South Africa (or Stats SA), undertakes regular national population surveys that provide useful information on a range of issues. Most reports about the social and economic situation of people living in South Africa do not focus on children, but rather count all individuals or households. This is the standard way for statistics bodies to present national data but is of limited use for those interested in understanding the situation of children.

'Child-centred' data does not only mean the use of data about children specifically. It also means using national population or household data and analysing it at the level of the child. This is important because the numbers can differ enormously depending on the unit of analysis. For example, national statistics describe the unemployment rate, but only a child-centred analysis can tell how many children live in households where no adult is employed. National statistics show the share of households without adequate sanitation, but when a child-centred analysis is used, the share is significantly higher.

Counting South Africa's children

Children Count presents child-centred data on many of the areas covered under socio-economic rights. As new data become available with the release of national surveys and other data sources, it is possible to track changes in the conditions of children and their access to services over time. This year, national survey data are presented for each year from 2002 to 2022, and many of the indicators in this issue compare the situation of children over this 21-year period.

The main household survey used as a data source for *Children Count* is the General Household Survey (GHS), a large nationally representative survey that Stats SA runs every year. We analyse the raw data to derive statistical estimates for the *Children Count* indicators. Usually, the survey is undertaken through face-to-face interviews at people's homes and fieldwork runs throughout the year. In 2020, data collection was stopped abruptly in March due to COVID-19 and the consequent lockdown.

In 2020 and 2021 the survey was conducted telephonically with a smaller sample of just under 30,000 individuals in 9,000 households, and some of the questions usually analysed for *Children Count* were excluded – notably the time taken to get to school and to health facilities. The GHS returned to its full face-to-face sample in 2022.

The tables on the following pages give basic information about children's demographics, care arrangements, income poverty and social security, education, health and nutritional status, housing and basic services. Each table is accompanied by commentary that provides context and gives a brief interpretation of the data. The data are presented for all children in South Africa and, where possible, by province.

The indicators in this *South African Child Gauge* are a sub-set of the *Children Count* indicators. The project's website contains the full range of indicators and more detailed interactive data, as well as links to websites and useful documents. It can be accessed at www.childrencount.uct.ac.za.

Confidence intervals

Sample surveys are subject to error. The percentages simply reflect the mid-point of a possible range, but the true values could fall anywhere between the upper and lower bounds. The confidence intervals indicate the reliability of the estimate at the 95% level. This means that, if independent samples were repeatedly taken from the same population, we would expect the estimate to lie between upper and lower bounds of the confidence interval 95% of the time.

It is important to look at the confidence intervals when assessing whether apparent differences between provinces or subgroups are real: the wider the confidence interval, the more uncertain the estimate. Where confidence intervals overlap for different subpopulations or time periods, it is not possible to claim that there is a real difference in the estimates, even if the mid-point percentages differ. In the accompanying bar graphs, the confidence intervals are represented by vertical lines at the top of each bar (I).

Data sources and citations

Children Count uses a few data sources. Most of the indicators are analysed by our team using data from the General Household Survey conducted by Stats SA, while some draw on administrative databases used by government departments (Health, Education, and Social Development) to record and monitor the services they deliver.

Most of the indicators presented were developed specifically for this project. Data sources are carefully considered before inclusion, and the technical notes, strengths and limitations of each are outlined on the project website.

Here are examples of how to reference *Children Count* data correctly:

When referencing from the *Demography* section in this publication, for example:

> Hall K (2024) Demography of South Africa's children. In: Slemming W, Biersteker L & Lake L (eds) *South African Child Gauge 2024*. Cape Town: Children's Institute, University of Cape Town.

When referencing from the Housing and Services online section, for example:

> Hall K (2024) Housing and Services – Access to adequate water. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 20 May 2024: www.childrencount.uct.ac.za

Each domain is introduced below, and key findings are highlighted.

Demography of South Africa's children

(pages 196 – 200)

This domain provides child population figures and gives a profile of South Africa's children and their care arrangements, including children's co-residence with biological parents. There were 21 million children in South Africa in 2022 and 20% of children do not live with either of their biological parents. This does not necessarily mean that they are orphaned: 80% of children who do not have any co-resident parent do have a living mother, and 88% of children without any co-resident parents have at least one parent who is alive but living elsewhere.

Income poverty, unemployment and social grants

(pages 201 – 209)

Child poverty rates increased during lockdown and then levelled off in 2021, before increasing again in most provinces in 2022. with 70% of children living below the upper-bound poverty line. Social assistance grants are therefore an important source of income for caregivers to meet children's basic needs and to protect children and their households from income shocks. In March 2022, just over 13 million children received the Child Support Grant (a slight drop from the previous year); 253,000 children received the Foster Child Grant (a substantial and consistent decline in numbers over the past decade), and there has been a gradual but consistent increase in access to the Care Dependency Grant with about 168,000 child beneficiaries in 2022.

Child health and nutrition

(pages 210 – 217)

In 2022 over 2.5 million children (12%) lived in households where children are reported to experience hunger; 20% of children lived far from the primary health care facility they normally use, and 82.2% of infants were fully immunised in their first year of life. While long-term trends indicate that infant and under-five mortality rates peaked in 2003, preliminary estimates by the Medical Research Council suggest that infant and under-five mortality rates rose sharply in 2021 and 2022, climbing to 30 and 40 deaths per 1,000 live births respectively.

Children's access to education

(pages 218 – 225)

South Africa has made significant strides in improving access to education with a reported attendance rate of 98% in 2022. The effect of COVID-19 and lockdown on early learning was dramatic: causing a rapid reversal of the gains made over nearly two decades. Attendance rates rose again after 2020, and by 2022 the pre-lockdown attendance rate had been regained, with 91% of 5 – 6-year-olds reported to be attending early learning programmes. However, attendance rates do not necessarily translate into improved educational outcomes or progress through school. In 2022, a third of young people aged 15 – 24 (34%) were not in employment, education or training, indicating that South Africa has failed to make any progress toward the Sustainable Development Goal target of substantially reducing the proportion of youth not in employment, education or training by 2030.

Children's access to housing

(pages 226 – 229)

This domain presents data on children living in rural or urban areas, and in adequate housing. The latest available data show that, in 2022, 57% of children were living in urban areas, and 85% of children lived in formal housing. In 2022, 1.6 million children (8% of the child population in South Africa) lived in informal housing – in backyard shacks or informal settlements, and 3.5 million children lived in overcrowded households.

Children's access to basic services

(pages 230 – 233)

Without water and sanitation, children face substantial health risks that also compromise their nutritional status. In 2022, 72% of children had piped drinking water at home, and 79% had an adequate toilet on site – an improvement from 46% in 2002.

Demography of South Africa's children

Katharine Hall (Children's Institute, University of Cape Town)

The United Nations (UN) General Guidelines for Periodic Reports on the Convention on the Rights of the Child, paragraph 7, says that reports made by states should be accompanied by "detailed statistical information ... Quantitative information should indicate variations between various areas of the country ... and between groups of children ...".[1]

The child population in South Africa

In 2022, South Africa's total population was estimated at 62 million people,[2] of whom nearly 21 million were children under 18 years. Children make up 34% of the total population.

The distribution of children across provinces is slightly different to that of adults, with a greater share of children living in provinces with large rural populations. Together, KwaZulu-Natal, the Eastern Cape and Limpopo accommodate 45% of all children in South Africa, compared with 37% of adults. Gauteng, the smallest province in terms of physical size, has overtaken KwaZulu-Natal to become the province with the largest child population: 22% of all children in the country live in Gauteng. Gauteng also has the largest share of the adult population (28%) and the largest share of households. The child population of Gauteng has grown by 57% since 2002, making it the fastest growing province.

There have also been striking changes in other provincial child populations since 2002. The number of children living in the Eastern Cape has decreased substantially (by 14%) while the number of children living in the Western Cape has risen by 32%. The North West has also seen a substantial increase of 27% in the child population since 2002. A rise in the child population is partly the result of population movement (for example, when children are part of migrant households or move to join existing urban households), and partly the result of natural population growth (new births within the province).

We can look at inequality by dividing all households into five equal groups or income quintiles, based on total income to the household (including earnings and social grants) and dividing that by the number of household members, with quintile 1 being the poorest 20% of households, quintile 2 being the next poorest and so on. Quintile 5 consists of the richest 20%, although there is substantial inequality even within this upper quintile group. Children are concentrated in poorer households, with 64% of children living in the poorest 40% of households (the poorest two quintiles), compared with 45% of adults.

The gender split is equal for children: 50% male and 50% female. In terms of the apartheid-era racial categories, 86% of children are African, 8% are Coloured, 4% White and 2% Indian.

These population estimates are based on the General Household Survey (GHS), which is conducted annually by Statistics South Africa. The GHS usually collects data on about 20,000 households and over 70,000 individuals, though in 2020 and 2021 the survey was conducted telephonically with a smaller sample of just under 30,000 individuals in 9,000 households. The GHS returned to its full face-to-face sample in 2022. The population numbers derived from the survey are weighted to the mid-year population estimates using weights provided by Statistics South Africa. Using previously weighted data (the 2014 population model), it appeared that the child population had remained fairly stable, with a marginal

Table 1a: Distribution of households, adults and children in South Africa, by province, 2022

PROVINCE	HOUSEHOLDS		ADULTS		CHILDREN		
	N	%	N	%	N	%	% change 2002 - 2022
Eastern Cape	1,742,000	10%	4,009,000	10%	2,530,000	12%	-14%
Free State	975,000	5%	1,965,000	5%	1035,000	5%	4%
Gauteng	5,587,000	30%	11,645,000	28%	4,621,000	22%	57%
KwaZulu-Natal	3,200,000	17%	7,470,000	19%	4,352,000	21%	5%
Limpopo	1,729,000	9%	3,651,000	9%	2,516,000	12%	4%
Mpumalanga	1,445,000	8%	3,089,000	8%	1,769,000	8%	16%
North West	1,349,000	7%	2,726,000	7%	1,480,000	7%	27%
Northern Cape	371,000	2%	856,000	2%	438,000	2%	10%
Western Cape	2,079,000	11%	5,106,000	12%	2,125,000	10%	32%
South Africa	18,477,000	100%	40,517,000	100%	20,867,000	100%	15%

Source: Statistics South Africa (2023) *General Household Survey 2022*. Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

reduction of 0.2% in the population size between 2002 and 2015. However, there was considerable uncertainty around the official population estimates, particularly in the younger age groups.[3] In 2017, Statistics South Africa updated the model and recalibrated the mid-year population estimates all the way back to 2002,[4] and subsequently released the data with new weights. The same population model was used to weight the data from 2018 onwards. Based on the revised weights it appears that the child population has grown by 15%, increasing from 18.1 million in 2002 to 20.9 million in 2022.

Children living with their biological parents

Many children in South Africa do not live consistently in the same household as their biological parents. This is an established feature of childhoods in South Africa, and international studies have shown that the country is unique in the extent that parents are absent from children's daily lives.[5, 6] Parental absence is related to many factors, including apartheid-era controls on population movement, labour migration, poverty, housing and educational opportunities, low marriage and cohabitation rates, as well as customary care arrangements.[7-11] It is common for relatives to play a substantial role in child-rearing. Many children experience a sequence of different caregivers, are raised without fathers, or live in different households to their biological siblings.

Parental absence does not necessarily mean parental abandonment. Many parents continue to support and see their children regularly even if they have to live elsewhere.[12-14]

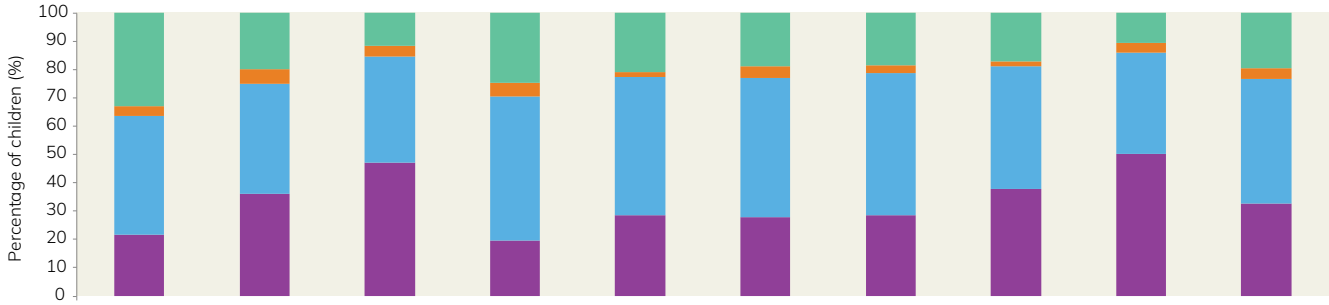
Virtually all children live with at least one adult, and 89% of children live in households where there are two or more co-resident adults. This indicator tracks co-residence between children and their biological parents specifically. Although many children live with just one of their biological parents (usually the mother), this does not mean that the mother is a "single parent" as she is not necessarily the only adult caregiver in the household. In most cases, there are other adult household members such as aunts, uncles and grandparents who may contribute to the care of children.

The share of children living with both parents decreased gradually from 39% in 2002 to 34% in 2010 and remained stable at around 34% for the next 10 years. In 2022, 33% of children had both their biological parents living in the same household. Forty-four percent of all children (9.2 million children) live with their mothers but not with their fathers. Only 4% of children live in households where their fathers are present and their mothers absent. Twenty percent do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: 80% of children who do not have any co-resident parent do have a living mother, and 88% of children without any co-resident parents have at least one parent who is alive but living elsewhere.

There is substantial provincial variation within these patterns. In the Western Cape and Gauteng, the share of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (50% and 47%, respectively). Similarly, the number of children living with neither parent is relatively low in these two provinces (11% in both cases). In contrast, a third of children (33%) in the Eastern Cape live with neither parent. These patterns have been fairly consistent from 2002 to 2020.

Children in the poorest 20% of households are least likely to live with both parents: only 17% of the poorest children have both parents living with them, compared with 73% of children in the wealthiest 20% of households.

Figure 1a: Children living with their biological parents, by province, 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Both parents	21,6%	36,1%	47,0%	19,8%	28,5%	27,8%	28,7%	37,8%	50,3%	32,7%
	546,000	374,000	2,171,000	861,000	718,000	492,000	424,000	166,000	1,068,000	6,819,000
Mother only	42,2%	39,0%	37,5%	50,6%	48,8%	49,3%	50,1%	43,2%	35,6%	44,1%
	1,068,000	404,000	1,732,000	2,201,000	1,228,000	872,000	742,000	189,000	757,000	9,192,000
Father only	3,4%	4,9%	4,1%	4,8%	1,9%	3,9%	2,7%	1,8%	3,6%	3,7%
	85,000	51,000	191,000	211,000	48,000	69,000	40,000	8,000	77,000	779,000
Neither parent	32,8%	20,0%	11,4%	24,8%	20,8%	19,0%	18,6%	17,2%	10,5%	19,5%
	831,000	207,000	528,000	1,079,000	523,000	335,000	275,000	75,000	223,000	4,077,000

Source: Statistics South Africa (2023) *General Household Survey* 2022. Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Less than 30% of African children live with both their parents, while over 80% of Indian and White children reside with both biological parents. More than one in five of all African children do not live with either parent and a further 47% live with their mothers but not their fathers. These figures are striking for the way in which they suggest the limited presence of biological fathers in the home lives of large numbers of children. Younger children are more likely than older children to have co-resident mothers, while older children are more likely to be living with neither parent. While 13% of children aged 0 – 5 years (907,000) live with neither parent, this increases to 25% (1.7 million) of children aged 12 – 17 years.

Orphaned children

An orphan is defined as a child under the age of 18 years whose mother, father or both biological parents have died (including those whose living status is reported as unknown, but excluding those whose living status is unspecified). For the purpose of this indicator, orphans are defined in three mutually exclusive categories:

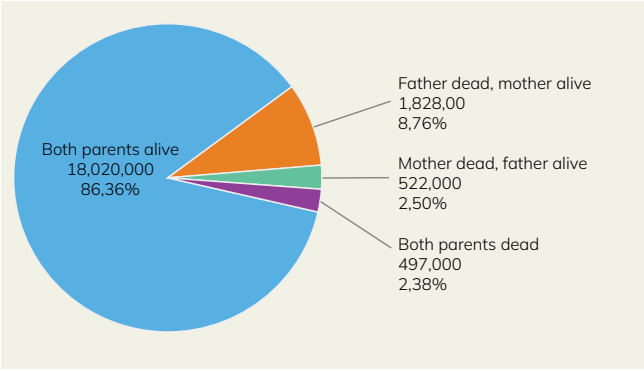
- A maternal orphan is a child whose mother has died but whose father is alive.
- A paternal orphan is a child whose father has died but whose mother is alive.
- A double orphan is a child whose mother and father have both died.

The total number of orphans is the sum of maternal, paternal and double orphans.

In 2022, there were 2.8 million orphaned children in South Africa. This includes children without a living biological mother, or father or both parents, and is equivalent to 14% of all children in South Africa. The majority (64%) of all orphans in South Africa are paternal orphans (with deceased fathers and living mothers).

The total number of orphans increased by over a million between 2002 and 2009, after which the trend was reversed. By 2017, orphan numbers had fallen to below 2002 levels. This was largely the result of improved access to antiretrovirals. Contrary to expectations, the number of orphaned children did not increase significantly during the COVID-19 pandemic in 2020 and 2021, and in 2022 the orphaning rates in all categories (maternal, paternal and double orphans) are lower than they were in 2019. This may be because COVID-19 related deaths were most prevalent among older people, while prime-age adults with children were less vulnerable.

Figure 1b: Orphan status of children in South Africa, 2022



Source: Statistics South Africa (2023) *General Household Survey 2022*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Orphan status is not necessarily an indicator of the quality of care that children receive. It is important to disaggregate the total orphan figures because the death of one parent may have different implications for children than the death of both parents. In particular, it seems that children who are maternally orphaned are at risk of poorer outcomes than paternal orphans – for example, in relation to education.[15]

In 2022, 3% of all children in South Africa were maternal orphans with living fathers, 9% were paternal orphans with living mothers, and a further 2% were recorded as double orphans. In total, 5% of children in South Africa (1 million children) did not have a living biological mother and 11% (2.3 million) did not have a living biological father. The numbers of paternal orphans are high because of the relatively high mortality rates among men in South Africa, as well as a greater probability that the vital status, and perhaps even the identity, of a child's father is unknown. Around 300,000 children have fathers whose vital status is reported to be "unknown", compared with fewer than 40,000 children whose mothers' status is unknown.

The number and share of children who are double orphans more than doubled between 2002 and 2009, from 361,000 to 886,000 after which the rates fell again. In 2018, there were 471,000 children who had lost both their parents, but the numbers rose again to over 580,000 in 2019, with a further slight increase to 620,000 in 2020. Subsequently, the rate of double orphaning dropped back to around 540,000 in 2021 and dipped below 500,000 in 2022.

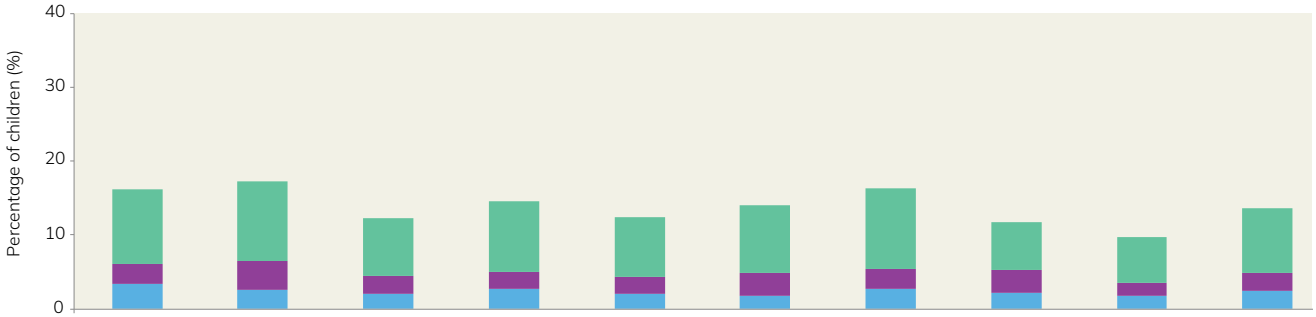
There is some variation across provinces. The Eastern Cape, for example, has historically reported relatively high rates of orphaning, reflecting a situation where rural households of origin carry a large burden of care for orphaned children. In terms of orphan numbers, double orphans are concentrated mostly in three provinces: KwaZulu-Natal (accounts for 24% of double orphans), Gauteng (20%) and the Eastern Cape (17%). Together these three provinces are home to 61% of all double orphans.

KwaZulu-Natal has the largest child population and the highest orphan numbers, with 634,000 children (15% of children in that province) recorded as orphans who have lost a mother, a father or both parents. Orphaning rates in the Eastern Cape (16%) are even higher, although the number of children orphaned is lower (408,000 because the child population is smaller). In 2020, Gauteng emerged as the province with the second highest and quickest growing orphaning numbers, where 13% of children (566,000) were single or double orphans. Orphaning rates in that province remained stable in 2021 and 2022. The lowest orphaning rates are in the Western Cape, where 10% of children are maternal, paternal or double orphans.

The poorest households carry the greatest burden of care for orphans. Nearly 40% of all orphans are resident in the poorest 20% of households.

The likelihood of orphaning increases as a child gets older. Across all age groups, the main form of orphaning is paternal orphaning, which increases from 4% among children under six years of age, to 14% among children aged 12 – 17 years. While less than 1% of children under six years are maternal orphans, the maternal orphaning rate increases to 4% in children aged 12 – 17 years.

Figure 1c: Number and percentage of orphans, by province, 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Double orphan	3,4%	2,6%	2,1%	2,8%	2,0%	1,7%	2,7%	2,2%	1,8%	2,4%
	85,000	27,000	97,000	120,000	51,000	30,000	40,000	10,000	37,000	497,000
Maternal orphan	2,8%	3,9%	2,4%	2,3%	2,3%	3,1%	2,6%	3,1%	1,8%	2,5%
	70,000	40,000	109,000	99,000	58,000	55,000	39,000	14,000	39,000	522,000
Paternal orphan	10,0%	10,8%	7,8%	9,5%	8,1%	9,1%	11,0%	6,4%	6,2%	8,8%
	253,000	112,000	360,000	415,000	204,000	161,000	163,000	28,000	131,000	1,828,000

Source: Statistics South Africa (2023) *General Household Survey 2022*. Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Child-only households

A child-only household is defined as a household in which all members are younger than 18 years. These households are also commonly referred to as "child-headed households", although this definition differs from the one contained in the Children's Act. The Children's Act definition of a child-headed household includes households where there are adults who may be too sick or too old to effectively head the household and a child over 16 years bears this responsibility.

While orphaning undoubtedly places a large burden on families, there is little evidence to suggest that their capacity to care for orphans has been saturated, as commentators feared in the past. Rather than seeing increasing numbers of orphaned children living on their own, the vast majority of orphans live with adult family members.

In 2022 there were about 44,000 children living in child-only households. This equates to 0.2% of all children. Because this household form is very rare, the confidence intervals are quite wide and the true number may lie within a margin of 15,000 around either side of the estimated number.

While children living in child-only households are very rare relative to those residing in households with adults, the number of children living in this extreme situation is of concern as the children may be particularly vulnerable.

Importantly, however, there has been no increase in the share of children living in child-only households in the period 2002 – 2022. If anything, the number has dropped, and there has been a statistically significant drop in Limpopo and the Eastern Cape provinces. Predictions of rapidly increasing numbers of child-headed households as a result of HIV were unrealised, and similarly there seems to be no sign of a spike in child-headed households due to the COVID-19 pandemic.

In line with previous studies that examined the circumstances of children in child-headed households in South Africa,[16] the data suggest that most children in child-only households are not orphans: 74% have a living mother and 89% have at least one living parent. These findings suggest that social processes other than mortality may play important roles in the formation of these households. For example, leaving teenage boys to look after a rural homestead while parents migrate to work may be a livelihood strategy for the household.

While it is not ideal for any child to live without an adult resident, it is positive that over half of all children living in child-only households are aged 15 years and above, and nearly a quarter are 17 years old. Children can work legally from the age of 15, and from 16 they can obtain an identity document and receive grants on behalf of younger children. Only 16% of children in child-headed households are under 10 years of age.

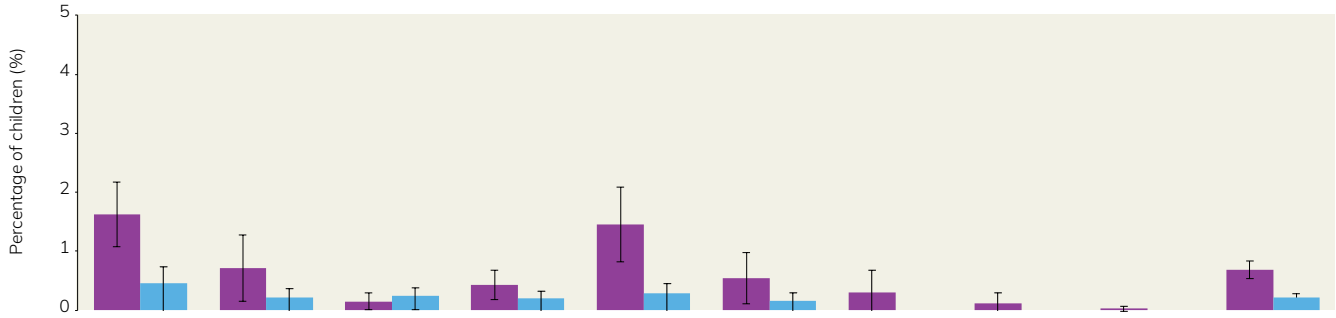
Research suggests that child-only households are frequently temporary arrangements, and often exist just for a short period, for example while adult migrant workers are away, or for easy access to school during term time, or after the death of an adult and prior to other arrangements being made to care for the

children (such as other adults moving in or the children moving to live with other relatives).[17]

Relative to children in mixed-generation households, child-only households are vulnerable in a number of ways. Child-only households are predominantly clustered in the poorest households; three out of four children living in child-only households are in the poorest 20% of households. In addition to the absence of adult members who may provide care and security, they are at risk of living in poorer conditions, with poor access to services, less (and less reliable) income, and low levels of access to social grants.

There has been very little robust data on child-headed households in South Africa to date. The figures should be treated with caution as the number of child-only households forms just a very small sub-sample of the *General Household Survey*. In 2022, only 73 children (unweighted) were identified as being in child-headed households, out of a sample of nearly 23,000 children.

Figure 1d: Children living in child-only households, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	1,6%	0,7%	0,1%	0,4%	1,5%	0,5%	0,3%	0,1%	0,0%	0,7%
	47,000	7,000	4,000	18,000	35,000	8,000	4,000	0	0	125,000
2022	0,5%	0,2%	0,3%	0,2%	0,3%	0,2%	0,0%	0,0%	0,0%	0,2%
	12,000	2,000	12 000	9,000	7,000	3,000	0	0	0	44,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

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Income poverty, unemployment and social grants

Katharine Hall (Children's Institute, University of Cape Town)

The Constitution of South Africa, section 27 (1)(c), says that "everyone has the right to have access to … social security, including, if they are unable to support themselves and their dependants, appropriate social assistance".[1]

The UN Convention on the Rights of the Child, article 27, states that every child has the right "to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" and obliges the state "in case of need" to "provide material assistance". Article 26 guarantees "every child the right to benefit from social security".[2]

Children living in income poverty

This indicator shows the number and share of children living in households that are income-poor. Because money is needed to access a range of goods and services, income poverty is often closely related to poor health and nutrition, reduced access to education and early learning programmes, and physical living environments that compromise health and personal safety.

International law and the Constitution recognise the link between income and the realisation of basic human rights and acknowledge that children have the right to social assistance (social grants) when families cannot meet children's basic needs. Income poverty measures are therefore important for determining how many people need social assistance, and for evaluating the state's progress in realising the right to social assistance.

No poverty line is perfect. Using a single income measure tells us nothing about how resources are distributed between family members, or how money is spent. But this measure does give some indication of how many children are living in households with severely constrained resources.

The poverty threshold used is the Statistics South Africa (Stats SA) 'upper bound' poverty line that was set at R779 per person per month in 2011 prices. The poverty lines increase with inflation and in 2023 the real value of the upper bound line was R1,558.[3] Per capita income is calculated by adding all reported earnings for household members older than 15 years, adding the value of social grants received by anyone in the household, and dividing the total household income by the number of household members.

Stats SA publishes two other poverty lines:

- A 'lower bound' poverty line is calculated by adding to the food poverty line the average expenditure on essential non-food items by households whose food expenditure is below but close to the food poverty line. The value of the lower bound poverty line in 2011 prices was R501 per person per month (R1,058 in 2023 prices). *Those living below this line would not be able to pay for the minimum non-food expenses or would be sacrificing their basic nutrition to pay for non-food expenses.*
- A 'food' poverty line is based on the cost of the minimum nutritional requirement of 2,100 kilocalories per person per day, without any allowance for other basic necessities. The value of the food poverty line in 2011 prices was R335 per person per month (R760 in 2023 values). *Anyone living below this line will be malnourished and their health and survival may be at risk.*

We use the upper bound poverty line as our main indicator for tracking child poverty, as this is linked to the minimum requirement for basic nutrition and other basic needs such as clothing and shelter. In other words, the upper bound line is the only poverty line that meets the minimum requirement for children's basic needs.

South Africa has very high rates of child poverty and, although poverty rates have reduced substantially over the last two decades, a large number of children remain in poverty. In 2019, 56% of children (11.2 million) lived below the upper bound poverty line and 33% were below the food poverty line. Income poverty rates had fallen substantially since 2003, when 78% of children (14.1 million) were defined as 'poor' at the upper bound threshold and 53% were below the food poverty line. The reduction in the child poverty headcount over this period was mainly the result of a massive expansion in the reach of the Child Support Grant (CSG).

Child poverty rates increased in the lockdown year of 2020, with the upper-bound poverty rate rising by seven percentage points to 63%, and the child food poverty rate rising by six percentage points to 39%. Average poverty rates levelled off in 2021, although they did not decline. Poverty rates then increased again in most provinces in 2022. Across all the poverty measures, poverty rates were higher in 2022 than they were in the pre-lockdown year of 2019. In terms of population numbers, this translates as an additional 1.3 million children below the food poverty line, and an additional 3.4 million children below the upper-bound poverty line, compared with 2019. Given that the child population has grown over the past two decades, there were more children living in poverty in 2022 than there had been in 2003.

There are substantial differences in poverty rates across the provinces. Using the upper bound poverty line, nearly 80% of children in the Eastern Cape, KwaZulu-Natal, Limpopo, North West and Mpumalanga are poor. Gauteng and the Western

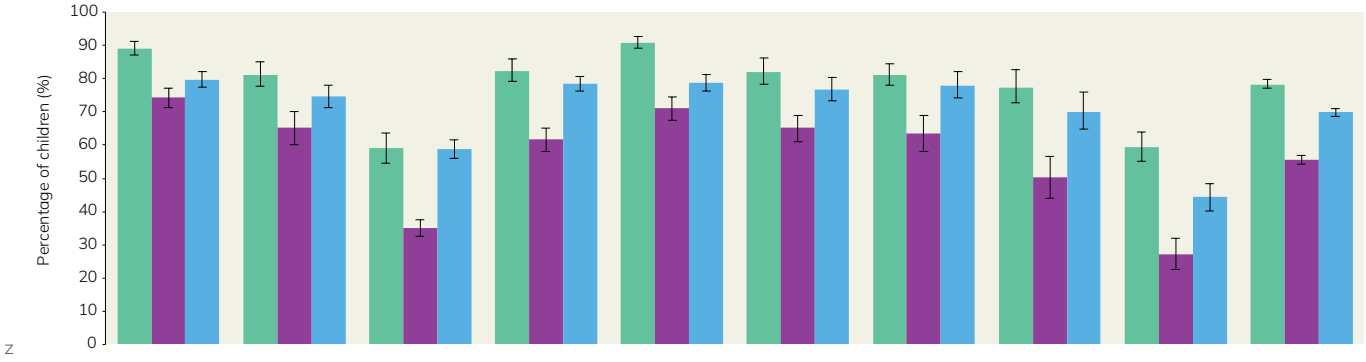
Cape have the lowest child poverty rates, although there was a substantial increase in poverty in these provinces – from 35% in 2019 to 59% in 2022 in Gauteng, and from 27% to 44% in the Western Cape. Child poverty remains most prominent in the rural areas of the former homelands, where 87% of children were below the poverty line in 2022. However, poverty rates have also risen sharply among urban children, with the upper-bound poverty rate in urban areas standing at 60% in 2022 (up from 41% in 2019), and the food poverty rate at 28% (up from 21%).

There are glaring racial disparities in income poverty: 75% of African children lived in households below the upper bound poverty line in 2022 (up from 61% in 2019). Although poverty rates among Coloured children are consistently lower than for African children, the increase in poverty was even more pronounced in the Coloured population over the period, with upper bound poverty rates rising from 33% in 2019 to 49% in 2022. There are no significant differences in child poverty levels across gender or between different age groups in the child population. Using Stats SA's lower bound poverty line (which only provides for basic essentials if people make food sacrifices), 53% of children (11.1 million) were poor in 2022 (up from 44% in 2019), and 38% (7.9 million children) were below the food poverty line, meaning that they were not getting enough nutrition.

The Sustainable Development Goals (SDGs) replaced the Millennium Development Goals in 2015 and set a global agenda for development by 2030. Target 1.1 is to eradicate extreme poverty using the international poverty line of $1.90 per person per day (equivalent to R403 per person per month in 2022, using the International Monetary Fund purchasing power parity conversion).[4] This poverty line is extremely low – below survival level – and is not appropriate for South Africa. No child should be below it. In 2003, 52% of children (9.3 million) lived below the equivalent of the SDG poverty line. By 2019, this had decreased to 22% (4.3 million), but in 2020 the ultra-low 'SDG poverty rate' spiked to 28% before settling back to 21% (4.4 million children) in 2022.

Figure 2a: Children living in income poverty, by province, 2003, 2019 & 2022

(Upper bound poverty line: Households with monthly per capita income less than R1,558, in 2023 Rands)



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2003	89,0%	81,1%	59,1%	82,3%	90,8%	82,0%	81,1%	77,4%	59,4%	78,3%
	2,544,000	813,000	1,759,000	3,349,000	2,165,000	1,237,000	941,000	302,000	961,000	14,070,000
2019	74,3%	65,3%	35,0%	61,7%	71,1%	65,1%	63,6%	50,4%	27,1%	55,6%
	1,902,000	662,000	1,514,000	2,593,000	1,724,000	1,095,000	905,000	216,000	544,000	11,156,000
2022	79,8%	74,6%	58,8%	78,5%	78,7%	76,7%	78,0%	70,0%	44,4%	69,9%
	2,018,000	772,000	2,717,000	3,415,000	1,981,000	1,357,000	1,155,000	307,000	943,000	14,578,000

Source: Statistics South Africa (2003; 2020; 2023) *General Household Survey 2002; General Household Survey 2019; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Impact of disaster relief grants and grant top-ups on child poverty

The poverty rates presented above are based on reported income and the normal grant amounts – in other words, it reflects poverty rates in the absence of disaster relief.

There was a sharp rise in unemployment in the lockdown with three million jobs lost between February and April 2020. Two million of those who lost employment were women.[5] This had a direct effect on child poverty, especially as children in South Africa are more likely to be co-resident with women than with men.

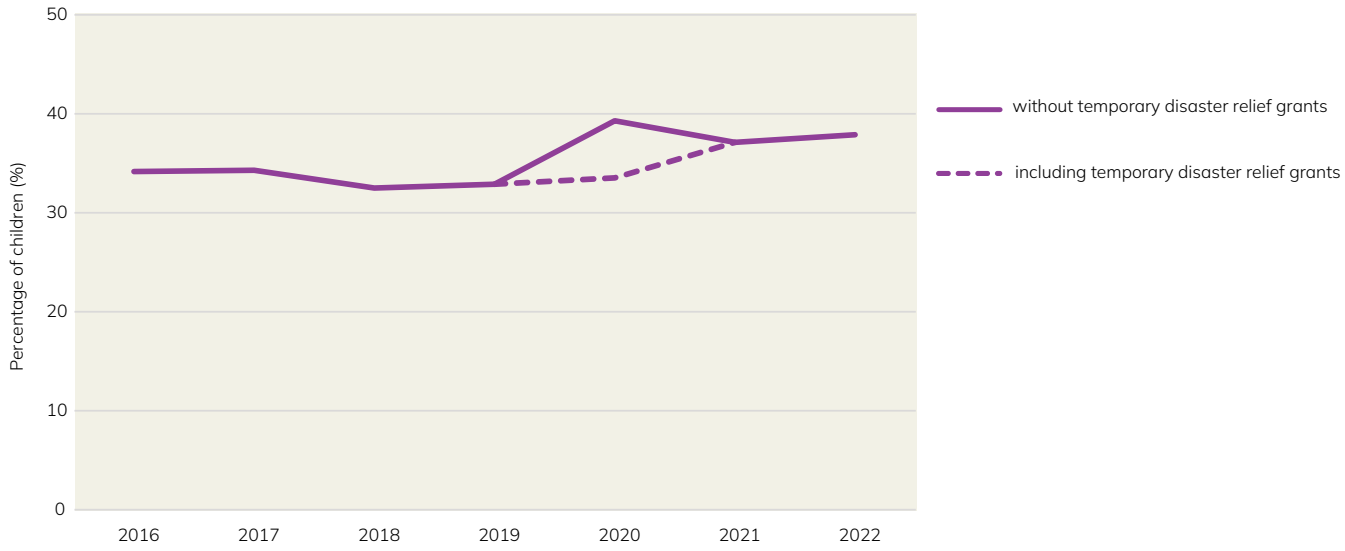
The South African government introduced disaster relief grants and top-ups to existing grants, starting in May 2020 and ending in October. Only the newly introduced R350 COVID-19 Social Relief of Distress grant for unemployed adults (SRD) continued into 2021 and beyond.

The General Household Survey, on which the analysis for this indicator is based, took place telephonically between September and December 2020. The survey therefore spans two months when grant top-ups were in place, and two months after they had been terminated. For this reason, the child poverty rates for 2020 have been estimated in two ways:

- First, the poverty rates are calculated in a scenario without the disaster relief grants and top-ups (i.e., including existing

Figure 2b: Child food poverty and impact of COVID-19 disaster relief, 2016 – 2022

(Food poverty line: Households with monthly per capita income less than R760, in 2023 rands)



Source: Statistics South Africa (2017 – 2023) *General Household Survey 2016 – 2022*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

grants but excluding disaster relief) as presented above; and

- Second, the poverty rates are calculated in a scenario that includes the R250 top-ups to existing grants, the temporary caregiver grant (R500 per month per caregiver who receives a CSG for one or more children) and the R350 COVID-19 SRD. The CSG received a top-up for only one month, in May 2020, and this has not been included in the poverty calculations as it was a once-off top-up that preceded the survey.

The disaster relief grants and top-ups had a small impact on child poverty at the upper bound poverty line, reducing the poverty rate from 63% (without disaster relief) to 60% (including disaster relief). The impact of disaster relief was more pronounced at the food poverty line: during the months where grant top-ups and the caregiver grant were active, the food poverty rate for children would have decreased from 39% (8 million children) to 34% (6.9 million children).

As shown in the trend graph below, the disaster relief grants and top-ups had a strong protective effect, counteracting rising poverty in the context of lockdown. This protective effect would have ended when the top-ups and caregiver grant were withdrawn.

Children living in households without an employed adult

This indicator measures unemployment from a children's perspective and gives the number and proportion of children who live in households where no adults are employed in either the formal or informal sector. It therefore shows the proportion of children living in 'unemployed' households where it is unlikely that any household members derive income from labour or income-generating activities.

Unemployment in South Africa continues to be a serious problem, and the situation worsened during lockdown. In the second quarter of 2020, the expanded unemployment rate breached the 40% mark for the first time since the Quarterly Labour Force Survey was introduced in 2008, and it remained above 40% for the rest of the year.[6]

Although there was some clawback of jobs, in the last quarter of 2020 Stats SA still recorded a net decrease of 1.4 million (8.5%) in total employment numbers, compared with the same period the previous year. By the end of 2020, 39% of men and 46.3% of women in the labour force were unemployed.[7]

The official national unemployment rate was 29.1% in the fourth quarter of 2019 and 32.5% in the fourth quarter of 2020.[8] In the fourth quarter of 2021 it had risen to 35.3%, and then dropped slightly to 32.7% in the fourth quarter of 2022. This official rate is based on a narrow definition of unemployment that includes only those adults who are defined as economically active (i.e. they are not studying or retired or voluntarily staying at home) and who had actively looked but failed to find work in the four weeks preceding the survey.

An expanded definition of unemployment, which includes 'discouraged work-seekers' who were unemployed but not actively looking for work in the month preceding the survey, gives a higher, and more accurate, indication of unemployment. The expanded unemployment rate (which includes those who are not actively looking for work) was 38.7% in the fourth quarter of 2019 and 42.6% a year later at the end of 2020. It rose further, reaching 46.2% in 2021 and then settled back to 42.6% in the last quarter of 2022.

Gender differences in employment rates are relevant for children, as it is mainly women who provide for children's care and material needs. Unemployment rates are consistently higher for women than for men. At the end of 2019, 42.4% of women were unemployed by the expanded definition (compared with 35.5% of men) and this increased to 44.5% for

women at the end of 2022 (compared with 38.1% of men).[8] Of the 12.5 million women who were available and willing to work, 5.6 million could not find work or had given up trying to do so.

Apart from providing regular income, an employed adult may bring other benefits to the household, including health insurance, unemployment insurance and parental leave that can contribute to children's health, development and education. The definition of 'employment' is derived from the Quarterly Labour Force Survey and includes regular or irregular work for wages or salary, as well as various forms of self-employment, including unpaid work in a family business.

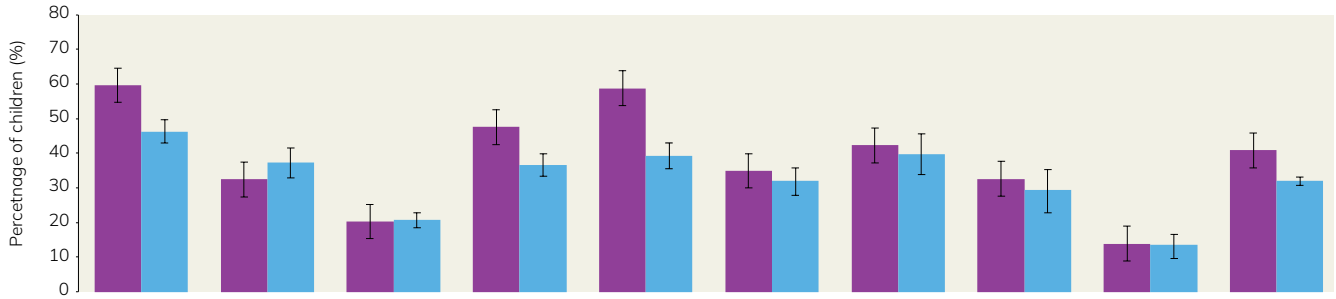
In 2019, before lockdown, 70% of children in South Africa lived in households with at least one working adult. The other 30% lived in households where no adults were working. The number of children living in workless households had decreased by 1.4 million since 2003, when 41% of children lived in households where there was no employment. But by late 2020, the share of children in workless households had increased again to 36% (7.3 million). By 2022, despite slight declines in adult unemployment, the 2019 levels had still not been regained. Nearly 6.7 million children (32%) lived in households where no adults were earning income from employment.

This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. In 2022, nearly 50% of children in the Eastern Cape lived in households without any employed adults, and nearly 40% of those in North West, KwaZulu-Natal, Limpopo and the Free State were in workless households. These provinces are home to large numbers of children and also have relatively high rates of child poverty. In contrast, Gauteng and the Western Cape have the lowest poverty rates, and the lowest unemployment rates, although the effects of job loss were also evident in these provinces in 2020. In the Western Cape, 22% of children lived in households where nobody was working in 2020 (up from 12% in 2019), and in Gauteng the rate was 23% in 2020 (up from 14% in 2019). By 2022 the Western Cape rates had dropped again to 13% but the Gauteng rate remained persistently high at 21%.

Racial inequalities are striking: 35% of African children had no working adult at home in 2022, while 19% of Coloured children and less than 4% of Indian and White children lived in these circumstances. There are no significant differences in child-centred unemployment measures when comparing girls and boys or different age groups. In the rural former homelands, 48% of children lived in workless households in 2022, while the rate was 22% among children in urban areas.

Income inequality is clearly associated with unemployment. Over 70% of children in the poorest income quintile live in households where no adults are employed.

Figure 2c: Children living in households without an employed adult, by province, 2003 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	59,7%	32,4%	20,3%	47,6%	58,7%	34,9%	42,2%	32,6%	13,9%	40,8%
	1,706,000	325,000	603,000	1,935,000	1,400,000	527,000	490,000	127,000	225,000	7,338,000
2022	46,3%	37,3%	20,8%	36,7%	39,3%	31,9%	39,8%	29,4%	13,5%	32,0%
	1,171,000	386,000	959,000	1,596,000	990,000	565,000	589,000	129,000	287,000	6,670,000

Source: Statistics South Africa (2004; 2023) *General Household Survey 2003; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

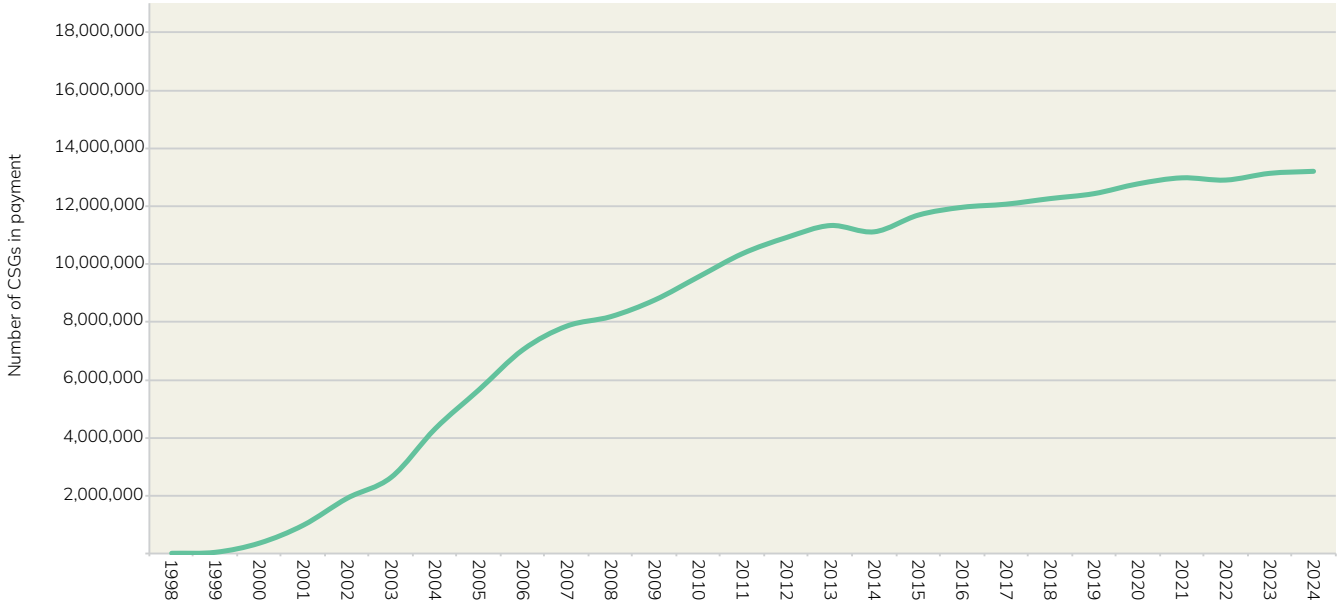
Children receiving the Child Support Grant

This indicator shows the number of children receiving the Child Support Grant (CSG), as reported by the South African Social Security Agency (SASSA) which disburses social grants on behalf of the Department of Social Development.

The right to social assistance is designed to ensure that people living in poverty can meet basic subsistence needs. Government is obliged to support children directly when their parents or caregivers are too poor to do so. Income support for poor children is provided through the CSG, which is an unconditional cash grant paid to the caregivers of eligible children.

Introduced in 1998 with an initial value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. The grant amount was originally linked to the minimum cost of feeding and clothing a child. Its monthly value is increased slightly each year, more or less keeping pace with headline inflation although it has fallen behind food inflation. As a result, the value of the CSG has been eroded

Figure 2d: Children receiving the Child Support Grant, 1998 – 2024



Sources: 1998 – 2007: National Treasury Intergovernmental Fiscal Reviews. 2008 – 2024: South African Social Security Agency SOCPEN monthly statistical reports.

relative to the food poverty line, and the CSG no longer covers the cost of providing for a child's minimum nutritional needs.

At the end of March 2023, a monthly CSG of R480 was paid to just over 13 million children aged 0 – 17 years. The value of the CSG increased to R500 per month from the beginning of April 2023, and to R510 from October 2023. From April 2024, the value of the CSG was R530 per month.

Because the CSG is targeted to poor children, a simple means test is used to determine eligibility. The income threshold is set at 10 times the amount of the grant. This means that every time the grant is increased, the means test also increases. From April 2024, the income threshold was R5,300 per month for a single caregiver and double that if the caregiver is married (R10,600 per month for the joint income of the caregiver and spouse).

Initially the CSG was only available for children younger than seven years. From 2003 it was gradually extended to older children up to the age of 14. Since January 2012, eligible children can receive the grant until they turn 18. Take-up of the CSG increased dramatically over the first 15 years, after which the numbers started levelling off.

A slight dip in grant access in 2014 was probably the result of the introduction of a biometric system which led to the identification and suspension of grants to beneficiaries who were not verified biometrically. Most of them were reinstated the following year, although without back-pay. From 2014, the numbers increased again gradually, only tapering off in 2021 and 2022.

In March 2022, fewer CSGs were in payment than in March the previous year – the number of CSGs had decreased by nearly 80,000, from 13 million in 2021. Although the overall numbers have picked up again subsequently, it is worrying that the number of infants (under one year of age) receiving the CSG has continued to fall each year, while at the same time poverty rates have risen. In March 2020, just before lockdown, 658,000 infants were receiving the CSG. This number dropped by over 100,000 to 550,000 in March 2021. The substantial drop between 2020 and 2021 was almost certainly the result of delays in birth registration and grant applications in the context of lockdown. Although birth registration rates recovered after 2021, the number of infants receiving the CSG continued to fall – to 543,000 in 2022 then to 509,000 in 2023 and to 468,645 in 2024. This has reversed improvements in uptake by caregivers of infants by 10 years, taking us back to 2014 levels. It is not clear what is causing the further decline in CSG access for infants. Possible reasons

Table 2a: Children receiving the Child Support Grant, by province and age group, 2024

Province	Number of child beneficiaries at end March 2024			
	0 – 5 years	6 – 11 years	12 – 17 years	TOTAL
Eastern Cape	614,091	660,416	681,611	1,956,118
Free State	222,726	239,559	247,038	709,323
Gauteng	637,591	720,601	688,020	2,046,212
KwaZulu-Natal	989,991	1,012,185	1005,231	3,007,407
Limpopo	691,891	686,133	624,500	2,002,524
Mpumalanga	415,821	406,742	384,288	1,206,851
North West	303,454	312,722	301,217	917,393
Northern Cape	112,256	116,633	107,457	336,346
Western Cape	283,856	374,526	378,168	1,036,550
South Africa	4,271,677	4,529,517	4,417,530	13,218,724

Source: South African Social Security Agency (2024) Twelfth Statistical Report: Social Assistance: Period April 2023 – March 2024. Pretoria: SASSA.

may include staff shortages, the introduction of rotating days for grant applications, and the impacts of load-shedding on the systems at SASSA offices.

There is substantial evidence that social grants, including the CSG, are being spent on food, education and basic goods and services. The evidence shows that the CSG not only helps to alleviate income poverty and realise children's right to social assistance, but is also associated with improved nutritional, health and education outcomes, especially if the grant is accessed soon after birth and received continuously.[9-18]

Given the positive and cumulative effects of the grant, it is important that caregivers can access it for their children as early as possible. One of the main concerns is the slow take-up by caregivers of young children. An analysis of exclusions from the CSG found that exclusion rates for eligible infants were as high as 43% in 2014. The total rate of exclusion for all ages was estimated at 17.5% (more than 1.8 million children).[19] A subsequent analysis found that infant exclusion rates dropped to 35% in 2017 – 2019, but increased again to 48% in 2020.[20] Exclusion rates are consistently found to be highest in the Western Cape and Gauteng. Barriers to take-up include confusion about eligibility requirements and the means test in particular; lack of documentation (mainly identity books or birth certificates, and proof of school enrolment, although the latter is not an eligibility requirement); and problems of institutional access (including the time and cost of reaching SASSA offices, long queues and lack of baby-friendly facilities).

Children receiving the Foster Child Grant

This indicator shows the number of children who are accessing the Foster Child Grant (FCG) in South Africa, as recorded in SASSA's administrative data.

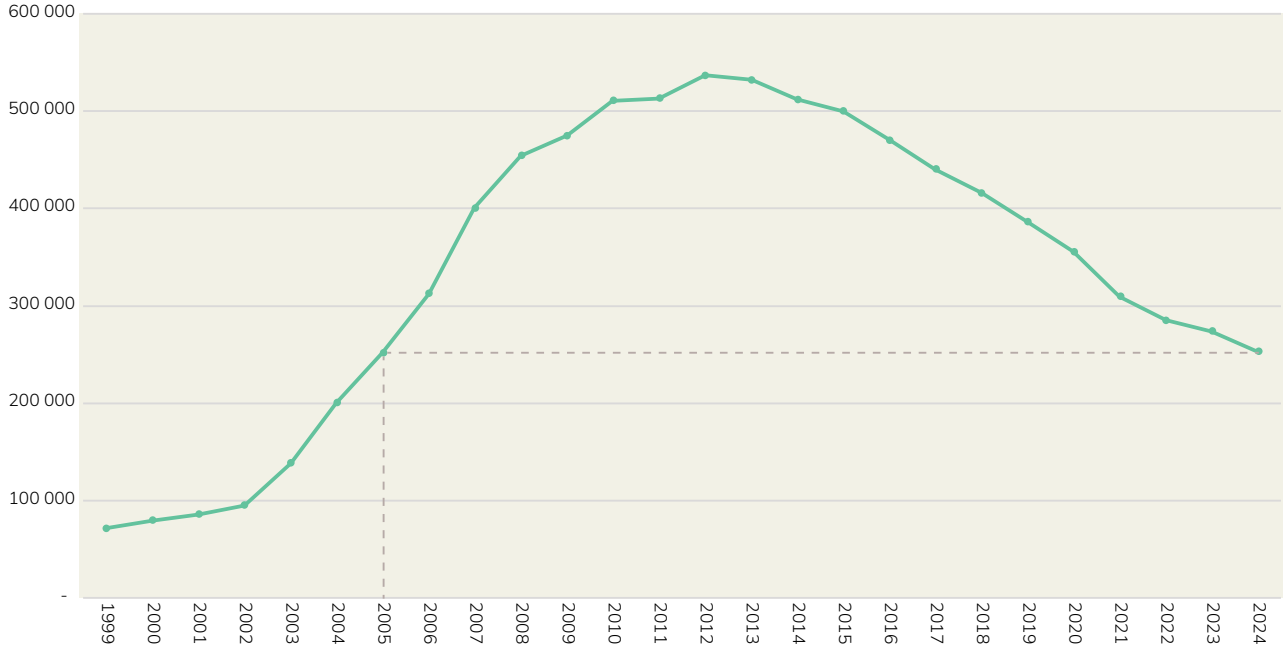
The FCG is available to foster parents who have a child placed in their care by an order of the court. Foster care was designed for children who are placed with another family because they are in need of care and protection due to abuse, neglect or abandonment. Unlike the CSG, the FCG is not means-tested but is automatically paid to the foster parents of children who have been placed in their care. The monthly value of the grant was R1,120 in April 2023, and R1,180 from April 2024.

The absence of a means test and the relatively large value of the grant compared to the CSG is justified on the basis that the child is a ward of the state because a court has placed them in alternative care, and the state is therefore directly responsible for ensuring that all the child's needs are provided for.

The number of children in foster care remained stable at around 50,000 nationally for many years when foster care was used primarily for children who were in need of care and protection or were awaiting adoption. However, from 2003, as HIV-related orphan rates rose sharply, the Department of Social Development and its social workers started encouraging family members to apply for foster care placements. They particularly encouraged grandmothers who were caring for orphaned children to apply for foster care placements because the value of the FCG was nearly three times that of the CSG.

Over the next decade, the FCG was increasingly used to provide poverty alleviation for orphaned children in kinship care. The appropriateness and effectiveness of this approach was questioned as far back as 2003, particularly because many children live with grandparents, aunts or other relatives anyway, whether or not their parents are alive. In 2022, for example, four million children – a fifth of the child population – did not live with either of their parents. Of these, 97% lived with

Figure 2e: Children receiving the Foster Child Grant, 1999 – 2024



Sources: 1999 – 2007: National Treasury Intergovernmental Fiscal Reviews. 2008 – 2024: South African Social Security Agency monthly statistical reports

relatives, mainly in households that included a grandparent. Less than one third were orphans. Nevertheless, with over half a million double orphans living with relatives, there were concerns that increasing demand for foster care placements would overwhelm the child protection system, which was not designed or resourced to process such large numbers.[21 22]

By 2010, more than 500,000 FCGs were in payment and the foster care system was struggling to keep pace with the numbers due to the strict checks and balances required by law. These included initial investigations and reports by social workers, newspaper adverts, court-ordered placements, and additional two-yearly social worker reviews and court-ordered extensions of placements. SASSA is not allowed to pay the FCG without a valid court order or extension order, and it stopped paying more than 110,000 FCGs between April 2009 and March 2011 because of backlogs in the extensions of court orders.[23-25]

In 2011, a High Court-ordered settlement stipulated that the foster care court orders that had expired – or that were going to expire in the following two years – must be deemed to have been extended until 8 June 2013. This effectively placed a moratorium on the lapsing of these FCGs. As a temporary solution, social workers could extend orders administratively (without having to go to court) until December 2014, by which date a comprehensive legal solution should have been found to prevent qualifying families from losing their grants in future.[26] No legal policy solution had been developed by the 2014 cut-off date. The Department of Social Development sought (and received) an urgent High Court order extending the date to the end of 2017, which was then extended until the end of November 2019, then to November 2020, then November 2022, and finally to November 2023.

Two laws needed to be amended to enable a comprehensive legal solution. This process took over a decade to be completed. An amendment to the Social Assistance Act was passed by Parliament in 2020 to provide for a new CSG Top-Up (instead of the FCG) for orphaned children living with relatives.

The CSG Top-Up is more easily accessible than the FCG because the caregiver can apply directly at SASSA without first having to go through a social worker investigation and court placement. It also gives access to a grant that, although lower than the FCG, is close to the food poverty line – enough to cover the basic food needs for a child. Importantly, it is not at risk of being stopped every two years. The CSG Top-Up is set at one-and-a-half times the value of the CSG, so that for example when the CSG is R500 per month, the CSG with top-up is R750. Implementation of the top-up started in mid-2022. By March 2023 there were 37,000 children receiving the top-up, and by February 2024 the number had increased to 65,000.[27] Although uptake of the CSG Top-Up has been substantial, it has not been fast enough to offset the declining numbers of FCGs, and it is likely that many more orphans are excluded from these higher value grant amounts.

The Children's Act also needed to be amended to clarify that orphaned children in the care of relatives should be referred to the CSG Top-Up, and that only those who are in need of supervised care and protection should be placed in foster care. After much debate, the Children's Amendment Bill was finally passed by Parliament and signed by the President at the end of 2022.[28] Regulations were published in the government gazette and the Amendment Act came into effect a year later in December 2023. It clarifies that an orphaned child who is in the care of family members is not a child in need of state care and protection simply due to being orphaned. This means that all new cases of orphans in the care of relatives should go directly to SASSA to apply for the CSG Top-Up and do not need to go via social workers or the courts to access an adequate grant. Orphans in the care of relatives who were already in foster care and receiving the FCG in December 2023 are exempted from the effect of this change and should remain on the FCG until they turn 18 (or 21 if still in education). The Amendment Act also devolves jurisdiction for guardianship orders to the Children's Court (previously only accessible at the High Court) to make it easier for relatives caring for orphans to secure parental responsibilities and rights orders.

Since its height in 2012, when nearly 540,000 FCGs were paid each month, the number of FCGs has declined year-on-year. At the end of 2014, 300,000 court orders had expired, representing more than 60% of all foster care placements.[29] Those grants remained in payment only because the High Court order mentioned above prevented them from lapsing. In March 2024, 253,000 FCGs were paid to caregivers of children in foster care, a 53% reduction since 2012. The most dramatic drop has been in KwaZulu-Natal, where the number of FCGs fell by 70%, from 142,000 to 42,000. Over the same period, the number of children receiving FCGs fell by 62% in the Free State and was more than halved in the Eastern Cape, Mpumalanga and North West.

The rapid decline over the past decade cannot be attributed to the introduction of the comprehensive legal solution described above, as it was only partially in place by mid-2022 and fully in place from December 2023. Rather, declining numbers were due to lower rates of foster care placement and enrolment onto the grant, along with an increase in the numbers of grants

Table 2b: Children receiving the Foster Child Grant, by province, 2012 & 2024

Province	2012	2024	Difference	% difference
Eastern Cape	116,826	54,799	-62,027	-53%
Free State	43,311	16,374	-26,937	-62%
Gauteng	56,451	33,962	-22,489	-40%
KwaZulu-Natal	142,114	42,120	-99,994	-70%
Limpopo	56,066	31,648	-24,418	-44%
Mpumalanga	32,886	14,387	-18,499	-56%
North West	45,634	19,880	-25,754	-56%
Northern Cape	14,456	8,392	-6,064	-42%
Western Cape	29,003	31,697	2,694	9%
South Africa	536,747	253,259	-283,488	-53%
FCG amount	R 770	R 1 180		

Source: South African Social Security Agency (2012; 2024) social grant statistics.

terminating at the end of each year when children turn 18. This is because the beneficiaries of the FCG are still mainly orphans, who are typically older children.

In 2022, only 14% of FCGs went to children who were not orphaned, while approximately 5% went to paternal orphans, 11% to maternal orphans and 69% to double orphans.[30] The Western Cape is the only province that has not experienced a drop in the number of FCGs, probably because it is also the only province where foster care is used mainly for its original purpose, rather than to supplement grant income for orphans living with relatives. Rural provinces have tended to bear the main burden of caring for orphans so, for example, many children who are orphaned in the Western Cape may be sent to live with families in Eastern Cape.

It is not possible to calculate a take-up rate for the FCG as there is no accurate record of how many children are eligible for placement in foster care because they are abused or neglected and in need of care and protection. Until the Children's Amendment Act was put into effect in December 2023, the majority of orphans in the care of relatives were legally eligible to be placed in foster care and receive the FCG,[i] but only a small portion of these children were accessing it.

The introduction of the CSG Top-Up in June 2022 has helped reverse this trend with 67,000 orphans accessing the CSG Top-Up by March 2024. More attention needs to be paid to promoting awareness about the availability of the CSG Top-Up among the public and government personnel at SASSA, the Department of Social Development, and the Children's Court.

Children receiving the Care Dependency Grant

This indicator shows the number of children who are accessing the Care Dependency Grant (CDG) in South Africa, as recorded in the SOCPEN administrative data system of the SASSA.

The CDG is a non-contributory monthly cash transfer to caregivers of children with disabilities who require permanent care or support services. It excludes those children who are cared for in state institutions because the purpose of the grant is to cover the additional costs (including opportunity costs) that the parent or caregiver might incur as a result of the child's disability. The child needs to undergo a medical assessment to determine eligibility and the parent must pass an income or 'means' test.

Although the CDG targets children with disabilities, children with chronic illnesses are eligible for the grant once the illness becomes disabling, for example, children who are very sick with AIDS-related illnesses. Children with disabilities and chronic illnesses need substantial care and attention, and parents may need to stay at home or employ a caregiver to tend to the child. Children with health conditions may need medication, equipment or to attend hospital often. These extra costs can put strain on families that are already struggling to make ends meet. Poverty and chronic health conditions are therefore strongly related.

It is not possible to calculate a take-up rate for the CDG because there are no reliable data on the number of children with disabilities or who are chronically ill, and in need of permanent care or support services. At the end of March 2024, nearly 168,000 children were receiving the CDG, and from the beginning of April 2024, the grant was valued at R2,180 per month.

The provincial distribution of CDGs is fairly consistent with the distribution of children. The provinces with the largest numbers of children – KwaZulu-Natal, Gauteng, the Eastern Cape and Limpopo – receive the largest share of CDGs, though the number of CDG recipients has also increased in the Western Cape. There has been a gradual but consistent increase in access to the CDG each year since 1998, when only 8,000 CDGs were disbursed.

Table 2c: Children receiving the Care Dependency Grant, by province, 2012 & 2024

Province	2012	2024	Difference	% difference
Eastern Cape	18,235	24,625	6,390	35%
Free State	5,419	9,834	4,415	81%
Gauteng	14,170	24,057	9,887	70%
KwaZulu-Natal	34,969	41,144	6,175	18%
Limpopo	11,318	18,440	7,122	63%
Mpumalanga	7,950	12,685	4,735	60%
North West	8,736	10,967	2,231	26%
Northern Cape	4,236	6,102	1,866	44%
Western Cape	9,960	17,912	7,952	80%
South Africa	114,993	167,790	50,773	44%
CDG amount	R 1 200	R 2 180		

Source: South African Social Security Agency (2012; 2024) social grant statistics.

i In terms of section 150 (1)(a) of the Children's Act No 38 of 2005.

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Child health and nutrition

Katharine Hall (Children's Institute, University of Cape Town)

Section 27 of the Constitution of South Africa provides that everyone has the right to have access to health care services. In addition, section 28(1)(c) gives children "the right to basic nutrition and basic health care services".[1]

Article 14 (1) of the African Charter on the Rights and Welfare of the Child states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health", ", and article 14 (2)(c) states that State Parties shall take measures "to ensure the provision of adequate nutrition...".[2]

Article 24 of the UN Convention on the Rights of a Child says that state parties should recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". It obliges the state to take measures "to diminish infant and child mortality" and "to combat disease and malnutrition".[3]

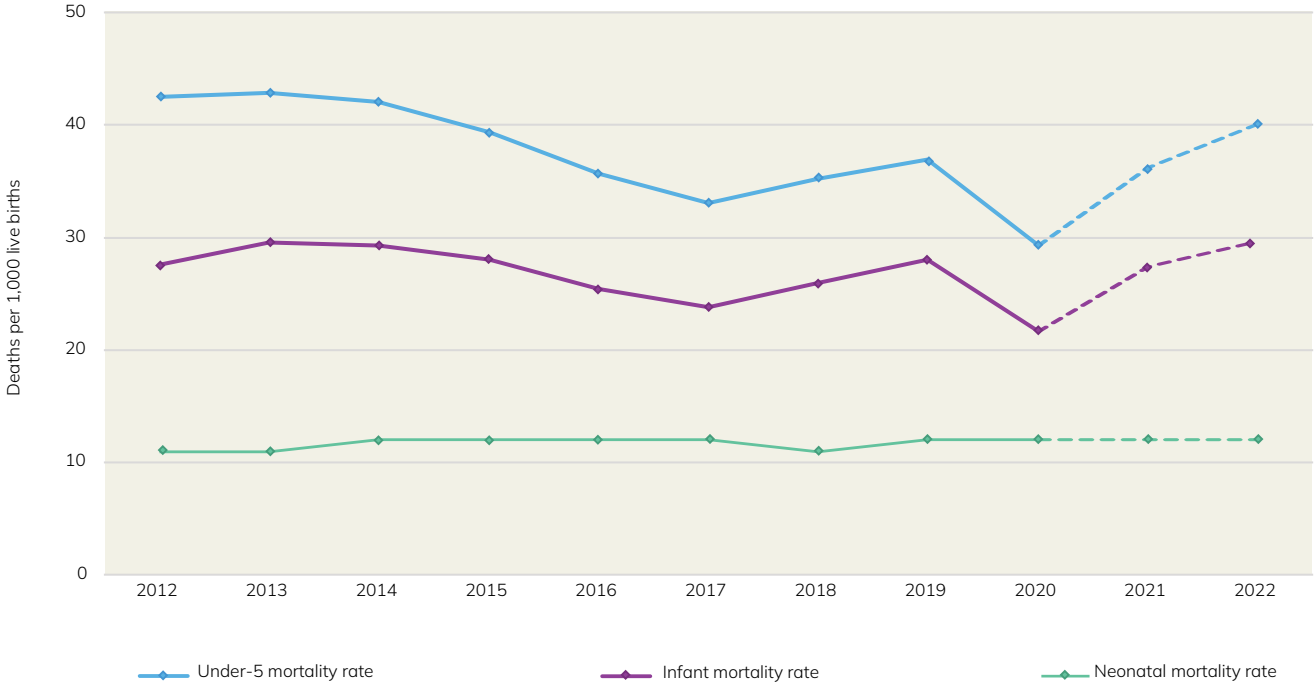
Infant, under-five and neonatal mortality

Nadine Nannan (Burden of Disease Research Unit, Medical Research Council)

The infant and under-five mortality rates are key indicators of heath and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and refers to the number of babies under 12 months who die in a year per 1,000 live births during the same year. Similarly, the under-five mortality rate (U5MR) is defined as the probability of a child dying between birth and their fifth birthday. The U5MR refers to the number of

Figure 3a: Child mortality rates, 2012 – 2022



Sources: 2015-2019 mortality rates from Dorrington RE, Bradshaw D, Laubscher R & Nannan, N (2021) *Rapid Mortality Surveillance Report 2019-2020*. Cape Town: South African Medical Research Council.
2012-2014 and 2021-2022 mortality rates derived from the same Medical Research Council Rapid Mortality Surveillance project published by the UN Inter-agency Group for Child Mortality Estimation and available at https://childmortality.org/all-cause-mortality/data?refArea=ZAF&indicator=MRY0T4. Note that the 2021 and 2022 RMS estimates are preliminary and have not yet been published by the MRC.

children under five years old who die in a year per 1,000 live births in the same year.

This information is ideally obtained from vital registration systems. However, as in many middle- and lower-income countries, the under-reporting of births and deaths renders the South African system inadequate for monitoring purposes. South Africa is therefore reliant on alternative methods, such as survey and census data, to measure child mortality. Despite several surveys which should have provided information to monitor progress, the lack of reliable data since 2000 led to considerable uncertainty around the level of childhood mortality for a prolonged period. However, the second South Africa National Burden of Disease Study has produced national and provincial infant and under-five mortality trends from 1997 up until 2012.[4]

An alternative approach to monitoring age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs.[5] These data have been corrected for known biases. In other words, the trends shown in Figure 3a are based on nationally representative numbers. The RMS reports vital registration data adjusted for under-reporting which allows for the evaluation of annual trends.

Long-term trends show that the IMR peaked in 2003 when it was 54 per 1,000 and decreased to 27 per 1,000 in 2019 with a further decrease to 21 in 2020. During the same period the U5MR decreased from 81 per 1,000 in 2003 to 36 per 1,000 in 2019 and 28 in 2020.[6]

With reference to the substantial drop in infant and under-5 mortality in 2020, the authors of the Rapid Mortality Surveillance Report note that "the lack of seasonal increases in the numbers of registered deaths suggest that the winter increases in respiratory syncytial virus (RSV) and other pneumonias as well as seasonal outbreaks of diarrhoea were absent in 2020."[7] This was possibly due to the effects of lockdown with "unusually low" monthly deaths in April and May 2020, and "no seasonal trend in the following [winter] months".[8] In other words, while the hard lockdown of 2020 was devastating for the economy and society in many ways, an unexpected benefit was that the restrictions on socialising and travel may have protected young children from infectious diseases that contribute to high mortality rates.

Preliminary estimates by the MRC suggest that infant mortality rates rose sharply in 2021 and 2022, with a corresponding increase in under-5 mortality. The estimated IMR for 2022 was 30 deaths per 1,000 live births, while the U5MR reached 40. The reasons for rising child mortality after lockdown are unclear as there have been long delays in the release of Causes of Death data by StatsSA. It is partly due to this delay that the MRC has not formally published its child mortality estimates since 2020, although the estimates have been shared with the United Nations Inter-Agency Group for Child Mortality Estimation and incorporated into the UN models. Generally, the leading causes of under-five mortality (other than neonatal causes) are diarrhoea, pneumonia and other respiratory infections, while malnutrition is often an underlying cause of death in young children.

The neonatal mortality rate (NMR) is the probability of dying within the first 28 days of life per 1,000 live births. The NMR has remained stable, at around 12 deaths per 1,000 live births. Estimates of the NMR were derived from vital registration data (i.e., registered deaths and births without adjustment for incompleteness) up to 2013, and from 2013 onwards the estimates were derived directly from neonatal deaths and live births recorded in the Department of Health's District Health Information System (DHIS). The NMR estimates therefore exclude deaths that occur in private sector health facilities or at home.

The DHIS also records the in-facility neonatal death rate – i.e. the number of infants aged 0-27 days who died during their stay in the facility, per 1,000 live births in public health facilities. The recorded rates were also around 12 in the years leading up to COVID-19 but increased slightly to 13 per 1,000 live births in 2021 and 2022. [9]

Children living in households where there is reported child hunger

This indicator shows the number and proportion of children living in households where children are reported to go hungry 'sometimes', 'often' or 'always' because there isn't enough food.

Child hunger is emotive and subjective, and this is likely to undermine the reliability of estimates on the extent and frequency of reported hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to monitor trends from year to year.

In 2022, 12% of children in South Africa (nearly 2.6 million) lived in households that reported child hunger. Nearly a third of these children (31%) were from KwaZulu-Natal. Reported child hunger rates in 2022 were 18 percentage points lower than they were in 2002 when 30% of children (5.5 million) lived in households that reported child hunger. The largest declines have been in the Eastern Cape, Limpopo, Mpumalanga and KwaZulu-Natal. One of the main contributors to the long-term decline is the expansion of the Child Support Grant which steadily increased its coverage, reaching nearly 13 million children in 2020.[10]

Another possible contributor to declining child hunger is the National School Nutrition Programme (NSNP), which reaches over nine million learners in approximately 20,000 schools.[11] However, the NSNP only operates during term-time and does not include children who are too young to attend school.

Analysis of child hunger rates within provinces shows that child hunger rates in 2022 are highest in the Northern Cape (where 24% of children were in households that reported child hunger) and North West (19%), followed by KwaZulu-Natal (18%) and Western Cape (16%). The Western Cape is also the only province where child hunger rates have not reduced in the past two decades. Given population growth, the estimated number of children reported to be hungry in that province has increased from 275,000 in 2002 to 340,000 in 2022.

The lowest reported hunger rates were in Limpopo (4%). Despite high poverty rates, Limpopo has always reported child hunger rates below the national average, perhaps because of its highly fertile and productive land in rural areas where most

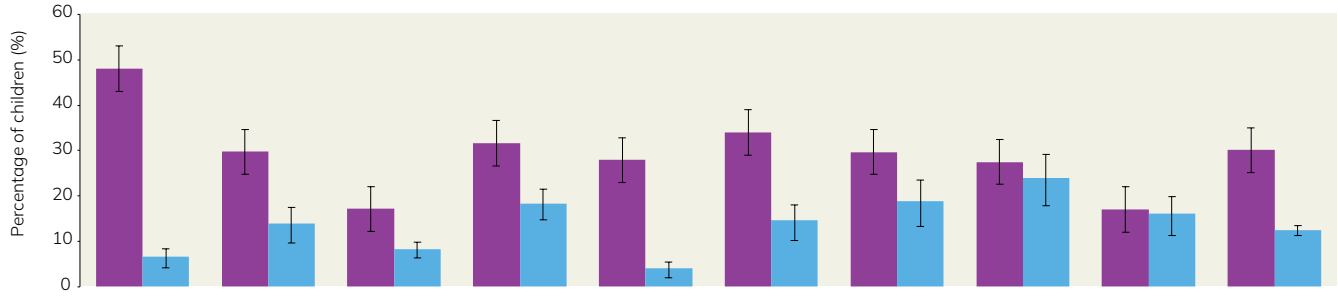
of the population lives. However, there is no clear explanation for the dramatic decline in reported hunger in the Eastern Cape. Over the period 2002 – 2022, reported child hunger rates in that province fell from 48% (higher than any other province) to 7% (the second lowest), despite the fact that the Eastern Cape has the highest poverty rates in the country, with nearly half of children living below the food poverty line.

There are no differences in reported child hunger across gender or age groups. However, as with many other indicators, child hunger is high racialised: 13% of African children and 11% of Coloured children live in households that reported child hunger, compared with less than 4% of Indian and almost no White children. Differences are even more pronounced across income quintiles. While 20% of children living in the poorest 20% of households experienced hunger, less than 1% of children in quintile 5 (the richest 20%) lived in households where child hunger was reported. Of all those who did report child hunger, over half were in the poorest income quintile. For many years, reported hunger rates were higher in the rural former homelands than in urban areas, but the difference has reduced over time and in 2022 there was no significant difference between the area types. Food insecurity is prevalent in both urban and rural areas.

Children who suffer from hunger are at risk of various forms of malnutrition, including wasting, stunting, overweight and micronutrient deficiencies. The 2016 Demographic and Health Survey recorded the stunting rate among children under 5 years at 27% - a figure that has remained persistently high since the 1990s and indicates high rates of chronic undernutrition. The more recent National Food and Nutrition Security Survey conducted by the Human Sciences Research Council between 2021 and 2023 found similarly high levels of malnutrition, with the under-5 stunting estimate at 29% nationally.[12] This suggests that chronic malnutrition has remained persistently high, and even worsened in the last decade.

It must be recognised that child hunger is a subjective indicator and does not capture other important aspects of food security such as dietary diversity and consumption of nutrient-rich foods, both of which are important for children's healthy growth especially in early childhood. Children living in households that do not report hunger may still not have access to sufficient nutritious food be at risk of malnutrition. In 2022, for example, around 80% of children who lived in households with incomes below the food poverty line were not reported to have suffered hunger. Food poverty is an indicator that households lack the financial resources needed to meet minimum dietary requirements for children and other household members.[13] Other measures of food insecurity also suggest a more serious challenge than the subjective hunger indicator. For example, in 2022, 20% of children lived in households that reported running out of food due to lack of money, while 25% lived in households that had been forced to cut the range of foods they could afford to buy.[14]

Figure 3b: Children living in households with reported child hunger, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	48%	30%	17%	32%	28%	34%	30%	27%	17%	30%
	1,407,000	297,000	503,000	1,314,000	675,000	518,000	346,000	109,000	275,000	5,455,000
2022	7%	14%	8%	18%	4%	15%	19%	24%	16%	12%
	165,000	145,000	382,000	798,000	102,000	257,000	280,000	105,000	340,000	2,581,000

Source: Statistics South Africa (2003; 2023*) General Household Survey 2002; General Household Survey 2022.* Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Children living far from their health facility

This indicator reflects the distance from a child's household to the health facility they normally attend. Distance is measured as the length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is regarded as 'far' if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

A review of international evidence suggests that universal access to key preventive and treatment interventions could avert up to two-thirds of under-five deaths in developing countries.[15] Preventative measures include the promotion of breast and complementary feeding, micronutrient supplements (vitamin A and zinc), immunisation, and the prevention of mother-to-child transmission of HIV, amongst others. Curative interventions provided through the government's Integrated Management of Childhood Illness strategy include oral rehydration, infant resuscitation and dispensing of medication.

According to the UN Committee on Economic, Social and Cultural Rights, primary health care should be available (in sufficient supply), accessible (easily reached and affordable), acceptable and of good quality.[16] In 1996, primary level care was made free to everyone in South Africa, but the availability and physical accessibility of health care services remain a problem, particularly for people living in remote areas.

Physical inaccessibility poses particular challenges when it comes to health services because the people who need these services are often unwell or injured or need to be carried because they are too young, too old or too weak to walk. Physical inaccessibility can be related to distance, transport options and costs, or road infrastructure. Physical distance and poor roads also make it difficult for mobile clinics and emergency services to reach outlying areas. Within South Africa, the extent to which patients use health care services is influenced by the distance to the health service provider: those who live further from their nearest health facility are less likely to use the facility. This 'distance decay' is found even in the uptake of services that are required for all children, including immunisation and maintaining the Road-to-Health Book.[17]

In 2022, 20% of South Africa's children lived far from the primary health care facility they normally use. Analyses from previous surveys shows that over 90% of children live in households where members attended the health facility closest to their home. The main reasons for attending a more remote health service relate to perceptions of service quality; a preference for private health services (36%), and other specific quality complaints including long waiting times (19%); the unavailability of medication (8%) and rude or uncaring staff (4%). Cost considerations also inform choices, and 12% of households that did not use their nearest facility chose to travel further in order to access cheaper medical care or free government health services.[18] Unfortunately these questions were dropped from the GHS in 2022. In total, over 4 million children travel more than 30 minutes to reach their usual health care service provider. This is a significant improvement since 2002, when 36% (or 6.6 million children) lived far from their nearest health facility. Improvements in the accessibility of health services are probably related both to the roll-out of additional facilities since 2002, and to increased urbanisation and greater population density in the areas around existing health infrastructure. While it is easier to deliver services in areas of greater population density, it may lead to greater pressure on health facilities if their capacity is not increased alongside a growing client population.

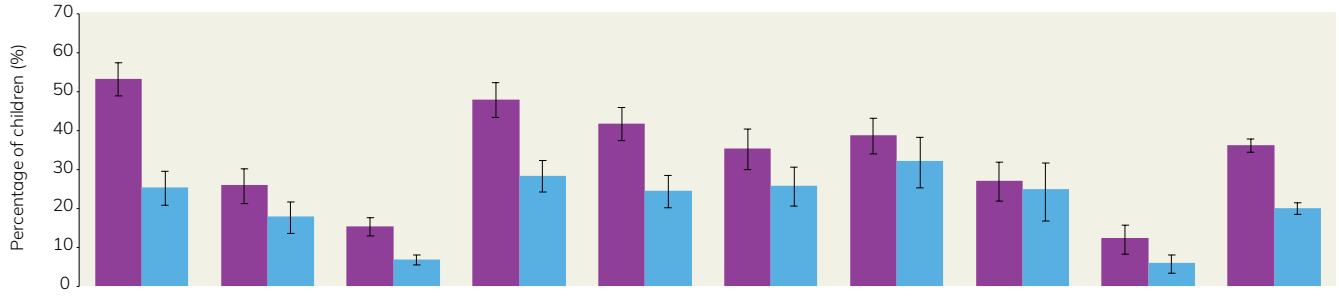
It is encouraging that the greatest improvements in health facility accessibility have been made in provinces which performed worst in 2002: the Eastern Cape (where the share of children with poor access to health facilities dropped from 53% in 2002 to 25% in 2022), KwaZulu-Natal (down from 48% to 28%), and Limpopo (from 42% to 25%). Provinces with the highest rates of access are the largely metropolitan provinces of the Western Cape and Gauteng, where only 6–7% of children live more than 30 minutes from their usual health care service.

Over twenty percent of African children travel far to reach their usual health care facility, compared with between 6 and 10% of Coloured, Indian and White children. Racial inequalities are amplified by access to transport: if in need of medical attention, 94% of White children would be transported to their health facility in a private car, compared with only 13% of African children. Only 3% of the poorest children (quintile 1) travel to their health facility in a private car, while 58% walk.

Poor children bear the greatest burden of disease, due to undernutrition and poorer living conditions and access to services (water and sanitation). Yet health facilities are least accessible to the poor. More than a quarter of children (28%) in the poorest 20% of households travel far to access health care, compared with 7% of children in the richest quintile.

There are no significant differences in patterns of access to health facilities when comparing children of different sex and age groups.

Figure 3c: Children living far from their health facility, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	53%	26%	15%	48%	42%	35%	39%	27%	12%	36%
	1,559,000	259,000	453,000	1,988,000	1,010,000	538,000	451,000	108,000	199,000	6,568,000
2022	25%	18%	7%	28%	25%	26%	32%	25%	6%	20%
	644,000	186,000	317,000	1,239,000	617,000	458,000	477,000	110,000	129,000	4,174,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Immunisation coverage of children

This indicator shows the percentage of children younger than one year who are fully immunised. 'Full immunisation' refers to children having received all the required doses of vaccines given in the first year of life. The primary course of immunisation in the first year includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles vaccination (usually at 9 months).

Immunisation is one of the most effective preventative health care interventions to prevent serious illnesses and death in young children. It entails giving injections or drops to young children that protect them against potentially life-threatening illnesses such as tuberculosis, polio, hepatitis and measles. South Africa has an up-to-date immunisation programme, in keeping with world standards. The Expanded Programme on Immunisation (EPI) in South Africa was last updated in 2015.

The revised EPI schedule for public health facilities providing services to children in the first year of life includes immunisation at birth, and then at 6 weeks, 10 weeks, 14 weeks and 9 months.[19] Thus, by the time of their first birthday, all babies should have visited a health facility at least four times after birth for immunisation services, and these immunisations should be recorded in the child's Road-to-Health Book.

Immunisation coverage serves as a good indicator of the extent to which young children access primary health care services. Immunisation coverage is also a proxy for the extent to which children access other health services, as the immunisation schedule provides a point of contact for identifying other health problems and for scheduling preventative child health interventions. Examples of these are the vitamin A supplementation programme, developmental screening, and prophylaxis for babies born to HIV-positive mothers.

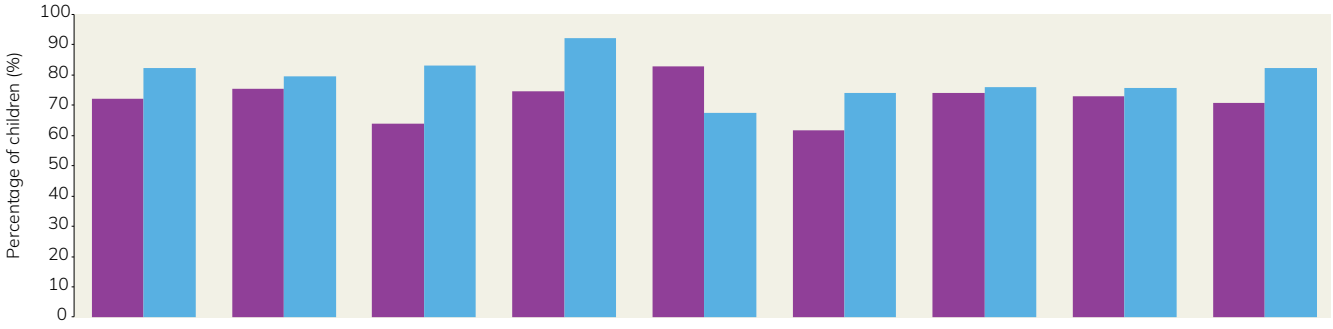
Immunisation rates are tracked in the District Health Information System and are calculated as the number of children who have received complete immunisation divided by the child population within that district. The percentages obtained in this way may be influenced by population movement in health seeking behaviour – for example, if children from one district or province are taken to a health facility in a neighbouring district or province.

The immunisation rates are also affected by national (and district-level) estimates of population size.

The 2015 immunisation rate, as reported in the 2016 District Health Barometer, reflected high levels of immunisation for infants under a year, at 89.2%,[20] but the population model for the country had under-estimated the number of children. Statistics South Africa subsequently revised its population model and released a new series of mid-year population estimates[21] and the 2015 immunisation rate was revised downwards to 79.5%. The 2016 rate dropped to 71% after retrospective adjustment to the revised population estimates. The lower immunisation rate for that year was attributed to a global shortage of Hexavalent vaccine.[19] In 2017 the immunisation rate picked up to 77%, increasing further to 82% in 2018 and 83.5% in 2019. In 2020, the immunisation rate dropped to 79.5% nationally as a result of lockdown, and as low as 61% in Limpopo. These fluctuations illustrate how the immunisation programme, which generally has high levels of compliance, is highly sensitive to disruptions in vaccine supply (as in 2016) or service delivery (as in 2020).

Immunisation rates improved again to 85.5% in 2021, dropping back slightly to 82.2% in 2022. This increase in the year following the hard lockdown, followed by a slight decline the next year, occurred across all provinces and might have been the result of a catch-up in delayed infant immunisations. When comparing the baseline immunisation rates in 2015 with those in 2022, the overall rates are quite similar despite some volatility in the intervening years.[i] The average rate for the country was slightly higher in 2022 (82%) than in 2015 (79%).

Figure 3d: Immunisation coverage of babies younger than one year, by province, 2015 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	72%	75%	64%	75%	83%	63%	62%	74%	73%	71%
2022	82%	80%	83%	92%	68%	89%	74%	76%	76%	82%

Source: Health Systems Trust (2024) "District Health Barometer" data file (derived from Department of Health's District Health Information System – DHIS). Available at www.hst.org.za.

i The immunisation rates in the District Health Barometer have not been adjusted to the revised population model before 2015, and so it is not possible to determine historical trends in immunisation uptake before 2015.

Underlying the overall increase between 2015 and 2022 are some quite contrasting patterns across provinces. Immunisation rates over the period increased substantially in KwaZulu-Natal and, to a lesser extent, in the Eastern Cape, Free State and Mpumalanga. At the same time, immunisation rates dropped in Limpopo, the Northern and Western Cape and Gauteng.

The highest immunisation rates for 2022 were in KwaZulu-Natal (92%) and Mpumalanga (89%), while the lowest rates were in Limpopo (68%), North West (74%), and the Northern and Western Cape (both 76%).

Effective immunisation requires high levels of coverage to achieve a certain level of immunity within the broader community. This is known as 'herd immunity' and it means that, if immunisation coverage has reached a high enough level, even the most vulnerable who have not been immunised in that community will be protected – including young children and those with low immunity.

Even though immunisation is freely available, and the goal is for it to be universal, it is voluntary and there is growing evidence that some parents choose not to immunise their children. A "worldwide increase in vaccine hesitancy and refusal" has been described as a threat to the public health achievements in controlling and preventing infectious diseases.[22] At a country level, vaccine sentiment and voluntary compliance is inversely correlated with socio-economic status (i.e. compliance is lower in wealthy countries than in poorer ones).[22]

The completion rates for 'basic immunisation' in the South African Demographic and Health Survey of 2016 were substantially lower than those recorded in the District Health Information System for the same year (at 61%, compared with 77%). The reason for this discrepancy is not clear, but it is important to note that compliance was highest in the poorest wealth quintile (66%) while the richest quintile was lower, at 60%.[23] This suggests an inverse correlation between socio-economic status and immunisation in South Africa.

HIV prevalence in pregnant women

The HIV status of pregnant women is vitally important for children, and HIV continues to be a contributor to both maternal and child mortality. An inquiry into reported maternal deaths between 2012 and 2013 found that of the 87% of women who died and whose HIV status was known, 65% were HIV-positive.[24] This number dropped subsequently, to 40.5% in 2021, although HIV status was not known for another 12% of mothers who died.[25] HIV-negative deaths outnumbered HIV-positive deaths – a switch from what was found in the pre-lockdown years of 2017-19.

Of all children who died in hospital between 2012 and 2013, only 35% were known to be HIV-negative. Twenty-two percent were HIV-exposed, and a further 18% were HIV infected. The HIV status of the remaining 14% of children was not known.[26] Subsequent data on the causes of death in children suggest that HIV-related deaths among children continued to be under-recorded on death notifications, as the rates were very low considering the extent of the epidemic.[27] Delays in the release of "causes of death" data by Statistics South Africa have meant that these data have not been analysed since 2016.

The HIV prevalence amongst pregnant women is the proportion of pregnant women (aged 15 – 49 years) who are HIV positive. The majority of children who are HIV positive have been infected through mother-to-child transmission. Therefore the prevalence of HIV amongst infants and young children is largely influenced by the HIV prevalence of pregnant women and interventions to prevent mother-to-child transmission (PMTCT).

The PMTCT programme had a notoriously slow start in South Africa, with only an estimated 7% of pregnant women receiving HIV counselling and testing in 2001/02. Following legal action by the Treatment Action Campaign, the Department of Health was ordered to make PMTCT services available to all pregnant women, and testing rates increased rapidly in subsequent years. Since 2009 HIV testing has been almost universal.[28] An evaluation of the PMTCT programme showed that transmission rates had declined to as low as 2.6% by 2013.[29] Data on paediatric prevalence from the District Health Information System show further and substantial declines in paediatric infections suggesting ongoing effectiveness of the PMTCT programme. The percentage of eligible infants (those known to be exposed to HIV) who tested positive in a PCR test at around 10 weeks after birth dropped from 1.3% in 2016 to 0.4% in 2022.[30]

HIV prevalence in pregnant women is measured in the National HIV and Syphilis Prevalence Survey which targets pregnant women aged 15 – 49 years who attend a public health facility. The most recent publicly available estimate, for 2022, is a prevalence rate of 27.5%. HIV prevalence rates increased rapidly from 1% in 1990 when the first antenatal prevalence survey was conducted, to 25% by 2000 and 30% in 2005. The prevalence rate remained at around this level until 2019, after which it dropped slightly.[31]

Results are reported in five-year age bands. For many years, HIV-prevalence rates were consistently highest amongst women in their 30s (reaching a prevalence rate of 43% in 2013) followed by those in their late 20s & 40s. Since 2014, prevalence rates among women under 35 years have declined, while those among older women have increased. In 2022, the highest HIV prevalence rates among ante-natal attendees were in the 40 – 44-year age group.

HIV prevalence rates have remained comparatively low amongst youth (15 – 24 years) and have continued to decline steadily. In 2022, the prevalence rate among 20 – 24-year-old pregnant women was 16.4% (down from 24.2% in 2012), while prevalence among 15 – 19-year-olds was 7.6% (down from 12.7% a decade earlier).

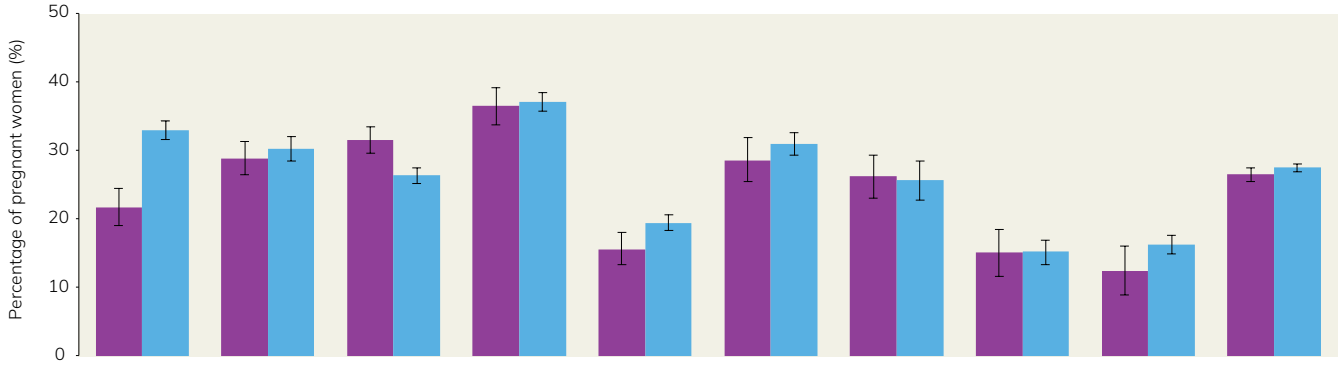
There are substantial provincial differences in HIV prevalence. KwaZulu-Natal has consistently had the highest antenatal HIV rates, with prevalence in excess of 36% since 2000 and over 40% between 2013 and 2019. In contrast, the Western Cape has had relatively low prevalence, although the rate increased by ten percentage points to 19% over the 14-

year period after 2000 before dropping back to 16% in 2022. Other provinces with relatively low HIV prevalence are the Northern Cape and Limpopo, with HIV-prevalence levels at 15% and 19% respectively in 2022.

These inter-provincial differences are partly a reflection of differences in HIV prevalence between different racial and cultural groups. For example, male circumcision is believed to be a major factor explaining inter-regional differences in HIV prevalence within Africa.[32, 33] Other factors such as differences in urbanisation, migration, socio-economic status and access to HIV-prevention and treatment services could also explain some of the differences in HIV prevalence between provinces.

Although HIV testing is almost universal in public health facilities, the antenatal prevalence survey does not include pregnant women who attend private health facilities, or women who deliver at public health facilities without having made a booking visit. Women with higher socio-economic status (proxied by post-secondary levels of education) and those seeking antenatal care in the private health sector have historically had a relatively low prevalence of HIV.[34] Thus the surveys, which are conducted only in public health facilities, are likely to over-estimate HIV prevalence in pregnant women generally.

Figure 3e: HIV prevalence in pregnant women attending public antenatal clinics, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	21,7%	28,8%	31,6%	36,5%	15,6%	28,6%	26,2%	15,1%	12,4%	26,5%
2022	32,9%	30,3%	26,4%	37,1%	19,4%	30,9%	25,7%	15,2%	16,3%	27,5%

Source: National Department of Health: Antenatal HIV Sentinel Surveys 2002 and 2022. Pretoria: DOH.

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Children's access to education

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Section 29 (1)(a) of the South African Constitution states that "everyone has the right to a basic education", and section 29 (1)(b) says that "everyone has the right to further education", and that the state must make such education "progressively available and accessible".[1]

Article 11 (3)(a) of the African Charter on the Rights and Welfare of the Child says "States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realization of this right and shall in particular ... provide free and compulsory basic education".[2]

Article 28 of the United Nations Convention on the Rights of the Child recognises "the right of the child to education" and also obliges the state to "make primary education compulsory and available free to all".[3]

Children attending an educational institution

This indicator shows the number and percentage of children aged 7 – 17 who are reported to be attending a school or educational facility. It is different from "enrolment rate", which reflects the number of children enrolled in educational institutions, as reported by schools to the national Department of Basic Education (DBE) early in the school year.

Education is a transformative socio-economic right that provides the foundation for lifelong learning and economic opportunity. All children have a right to basic education, which the Constitutional Court has ruled extends to Grade 12.[4]

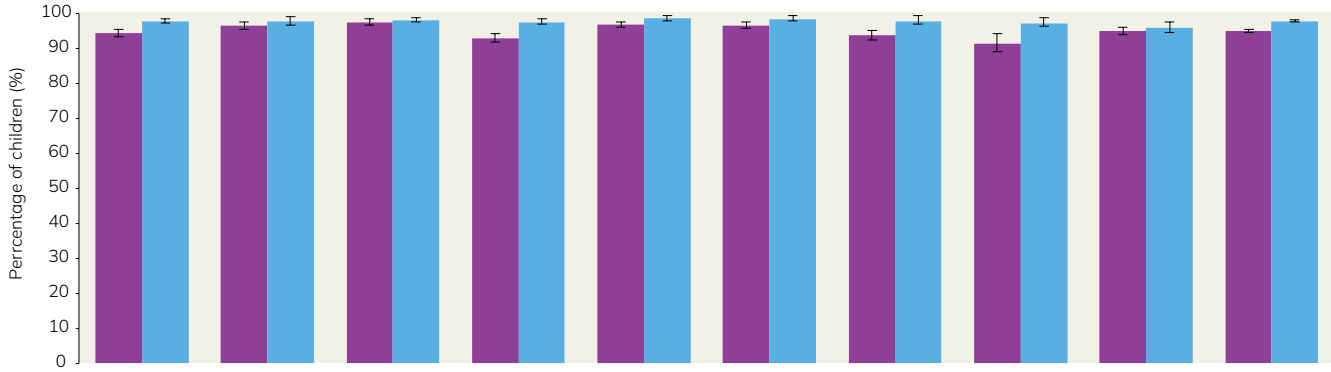
Basic education is compulsory from Grade 1 (the year in which a child turns seven). Once the Basic Education Laws Amendment (BELA) Bill comes into effect, Grade R will also become compulsory. The compulsory stage ends on completion of Grade 9 or when the child turns 15. After this, children may leave school, but the state has a responsibility to provide basic education up the end of Grade 12 for those who want to complete school.

South Africa has high levels of school enrolment and attendance. Among children of school-going age (7 – 17 years), the vast majority are reported to attend some form of educational facility. There was a small but significant increase from 2002 when the reported attendance rate was 95%, to 2018 when reported attendance rates were 98%. The overall increase was mainly due to the growth in reported attendance rates for African and Coloured children, and in 2018, for the first time since this indicator was tracked, there were no significant differences in attendance rates across race groups.

All schools were closed between March and June 2020, due to COVID-19 and lockdown. From June, schools partially re-opened, but only for specific grades. Schools re-opened for all grades from late August 2020, but even then, they operated at reduced capacity with rotational timetabling of classes.

Stats SA ran its 2020 General Household Survey (GHS) later than usual, from September to December. The survey included the usual question about whether household members were

Figure 4a: School-age children (7 – 17-year-olds) attending an educational institution, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	94,2%	96,3%	97,4%	92,9%	96,6%	96,4%	93,6%	91,2%	94,8%	95,0%
	1,811,000	603,000	1,763,000	2,470,000	1,525,000	917,000	671,000	221,000	944,000	10,926,000
2022	97,7%	97,6%	98,1%	97,4%	98,5%	98,4%	97,8%	97,2%	95,7%	97,7%
	1,575,000	623,000	2,732,000	2,657,000	1,509,000	1038,000	870,000	247,000	1,243,000	12,494,000

Source: Statistics South Africa (2003, 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

attending an educational institution but did not ask whether they were attending every day. Thus, reported attendance rates do not reflect the regularity of attendance, even at a time when it is known that learners were unlikely to be attending every day. Reported attendance rates in the last quarter of 2020 were at a similarly high level as previous years, with just a small decrease of one percentage point from 2019, to 97%. Wave 3 of the NIDS-CRAM survey, conducted in November 2020, asked whether children had attended school at any time in the last seven days. The overall estimate was 98%, a similar attendance rate to that reported in GHS. Attendance rates earlier in the year had been much lower, and varied substantially by grade, ranging from 88% for Grade 12 learners to as low as 11% for Grade 9 learners.[5] This was due to the staggered re-opening of grades and prioritisation of those approaching the end of the primary or secondary school.

Reported attended rates remained at 98% in 2021 and 2022. Of the 12.8 million children aged 7-17 years in 2022, 12.5 million were reported to attend school (98%), while 300,000 were not attending. The lowest attendance rates were in the Western Cape (95.7%).

Overall attendance rates tend to mask dropout among older children. Analysis of attendance among discrete age groups shows that although there is a slight drop in reported attendance among children beyond the compulsory schooling phase, attendance still remains in the mid-90s for children aged 16 and 17. It is only at age 18 that there is a substantial drop: to around 84% for males and 82% for females who have not completed Grade 12. Differences in reported school attendance rates between boys and girls are not statistically significant.

The GHS asks about reasons for non-attendance for those who are not attending an educational institution. The main reasons for non-attendance can be divided into three main categories: system failures (including exclusions and quality problems); financial barriers; and illness or disability. Together, these account for nearly two thirds of non-attendance.

Of the school-age children who were not attending any school in 2022, 8% were "unable to perform at school", 7% left because "education is useless or not interesting" while 5% dropped out because they failed their exams and 4% were not accepted for enrolment. These reasons signal failures in the education system and account for nearly a quarter of all reported non-attendance.

The second main barrier to education is financial or accessibility constraints. These include the cost of schooling (the reason given for 13% of children not attending schools in 2022) and difficulties in reaching school (4% were not attending because the school is too far). Six percent of those not attending were too busy due to work or domestic responsibilities, suggesting that for some families the opportunity cost of education is a barrier.

Disability is also an important reason, accounting for 11% of non-attendance in 2022 and again pointing to a failure in the education system to accommodate children with disabilities. Illness accounted for an additional 5% of the non-attendance rate. Pregnancy accounts for 2% of all non-attendance, and 7% of non-attendance amongst teenage girls who are not attending school.[6-8]

Although the costs of education are cited as a barrier to attendance, the overall attendance rate for children in the lower income quintiles is not significantly lower than those in the wealthier quintiles.

Attendance rates alone do not capture the regularity of children's school attendance or their progress through school. Research has shown that children from more disadvantaged backgrounds – with limited economic resources, lower levels of parental education, or who have lost their mother – are more prone to dropping out or progressing more slowly than their more advantaged peers. Racial inequalities in school advancement remain strong.[9-11] Similarly, school attendance rates tell us nothing about the quality of teaching and learning.[12] Inequalities in learning outcomes are explored through standardised tests such as those used in the international SAQMEC,[13] TIMMS and PIRLS[14] studies. The DBE's Annual National Assessments[15] have been discontinued.

Access to early learning programmes

This indicator shows the number and percentage of children aged 5 – 6 who are reported to be attending an early learning programme (ELP) or school – in other words, those attending out-of-home group care and learning facilities including ECD centres, pre-Grade R, Grade R or Grade 1 in ordinary schools. While all these facilities provide care and stimulation for early learning for young children, the emphasis on providing learning opportunities through structured learning programmes differs by facility type.

Educational inequalities are strongly associated with socio-economic (and therefore also racial) inequalities in South Africa.[11, 16] These inequalities are evident from the early years, even before entry into primary school.[17] They are exacerbated by an unequal schooling system,[18, 19] and are difficult to reverse. But early inequalities can be reduced through pre-school exposure to developmentally appropriate activities and programmes that stimulate cognitive development.[20, 21] Evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age.[22] Provided that they are of good quality, early learning programmes are an important mechanism to interrupt the cycle of inequality by reducing socio-economic differences in learning potential between children before they enter the foundation phase of schooling.

The National Development Plan (NDP) priorities, cited in the DBE's 2030 ECD Strategy,[23] include universal access to two years of early childhood development programmes. The DBE funds and monitors thousands of private and community-based ELPs in addition to the school-based Grade R classes. The NDP proposes the introduction of a second year of pre-school education, and that both years be made universally accessible to children.[24] It therefore makes sense to monitor enrolment in learning programmes for children in the 5 – 6-year age group.

According to the DBE's administrative data, 768,000 learners were attending Grade R at ordinary schools in early 2022, of

whom 94% were in public (government) schools. Of the 24,000 learners attending pre-Grade R at ordinary schools, just over half (56%) were enrolled in independent schools, while 44% of pre-Grade R learners were at public (government) schools.[25] These would include some private ECD centres which are registered as schools, but would exclude many other independent and unregistered facilities. Government schools are therefore already providing the large bulk of education services for children in Grade R, but not for pre-Grade R.

In 2019, 93% of children (nearly 2.2 million) in the pre-school age group (5 – 6-year-olds) were reported to be attending some kind of educational facility, mostly in Grade R or Grade 1. This was double the 2002 level, signifying substantial gains in access to ELPs over the years. Unlike many other child indicators, this measure of ECD access is not associated with significant inequalities across provinces.

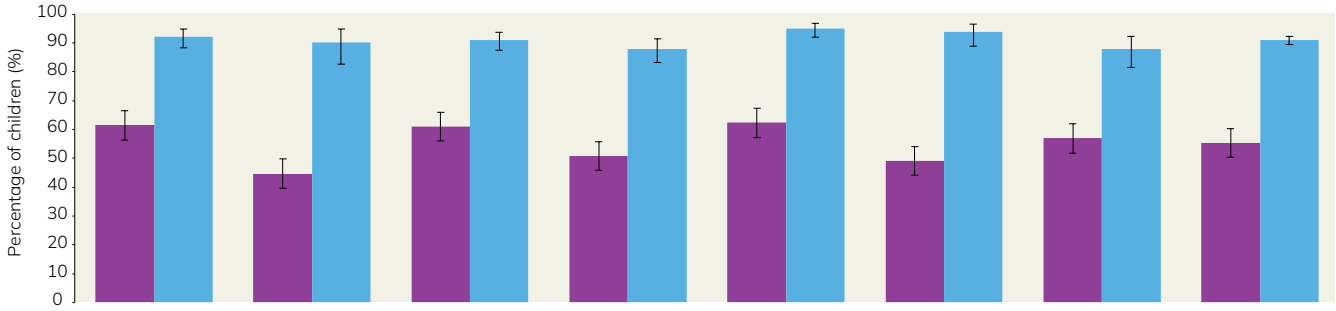
Similar patterns were found in analyses of the 2007 Community Survey and the 2008 National Income Dynamics Study, which also did not find strong provincial disparities.[26] Given the inequalities in South Africa, it was also pleasing to see that as access to education increased among 5 – 6-year-olds, the inequalities across races and income quintiles reduced.

The effect of COVID-19 and lockdown on early learning was dramatic: the year 2020 saw a rapid reversal of the gains made over nearly two decades in early learning access for 5 – 6-year-olds. Young children could not attend ELPs during lockdown because of the closure of schools and ECD centres.

Attendance rates rose again after 2020, and by 2022 the pre-lockdown attendance rate had been regained, with 91% of 5 – 6-year-olds reported to be attending learning programmes. The inequalities across income quintiles and races had also reduced.

This indicator tells us nothing about the quality of care and education that young children receive at educational facilities or the resources available at those facilities. Attendance provides a unique opportunity because almost all children in an age cohort can be reached at a particularly important developmental stage; but this is a lost opportunity if the service is of poor quality.

Figure 4b: Children aged 5 – 6 years attending school or ECD facility, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	61,4%	44,7%	61,0%	50,8%	62,2%	49,1%	49,1%	34,7%	56,9%	55,2%
	194,000	49,000	188,000	220,000	158,000	80,000	63,000	16,000	97,000	1,064,000
2022	92,0%	90,3%	91,1%	87,8%	94,9%	93,7%	92,3%	86,1%	87,9%	90,8%
	237,000	106,000	477,000	405,000	258,000	194,000	145,000	46,000	186,000	2,055,000

Source: Statistics South Africa (2002; 2023) *General Household Survey 2002, 2022;* Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.
Note: Prior to 2009, enrolment in crèches, playgroups and ECD centres would have been under-reported as the survey only asked about attendance at "educational institutions". More specific questions about ECD facilities were introduced from the 2009 survey onwards and are likely to have resulted in higher reporting of attendance rates (for a more detailed technical explanation, see www.childrencount.uct.ac.za).

Children living far from school

This indicator monitors the share of school-going children who have to travel far to get to school. Distance is measured as the length of time travelled to reach school. The school the child attends is defined as "far" if a child has to travel more than 30 minutes to reach it, irrespective of mode of transport. Children aged 7 – 13 are defined as primary school age, and children aged 14 – 17 are defined as secondary school age.

Access to schools and other educational facilities is a necessary condition for achieving the right to education. A school's location and distance from home can pose a barrier to education. Access to schools is also hampered by poor roads, transport that is unavailable or unaffordable, and danger along the way. Risks may be different for young children, for girls and boys, and are likely to be greater when children travel alone.

For children who do not have schools near to their homes, the cost, risk and effort of getting to school can influence decisions about regular attendance, as well as participation in extramural activities and after-school events. Those who travel long distances to reach school may wake very early and risk arriving late or physically exhausted, which may affect their ability to learn. Walking long distances to school may also lead to learners being excluded from class or make it difficult to attend school regularly.

Questions about distance and means of travel to school were not asked in the 2020 or 2021 GHS as the number of questions was reduced during lockdown. Of the 12.5 million

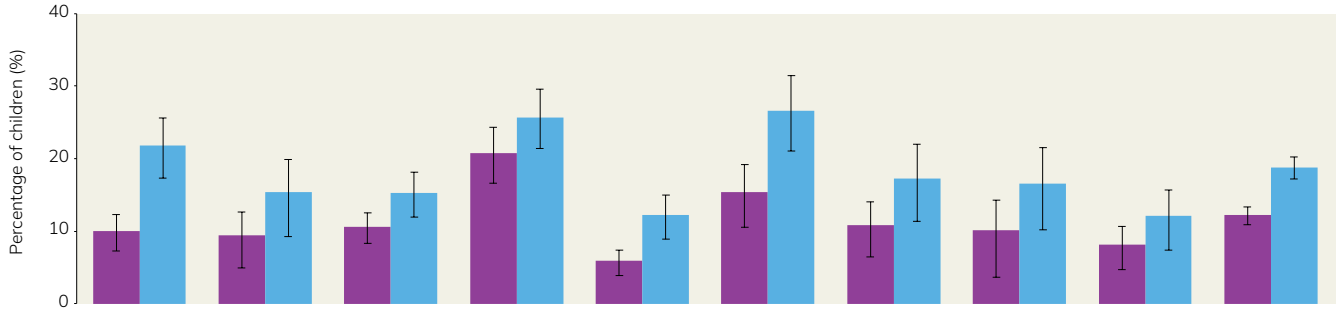
children who were attending school in 2022, over 8 million (65%) walked to school, while 12% travelled in vehicles hired by a group of parents, 9% travelled in private cars and 7% used public transport (bus, minibus, taxi or train). Only 4% used school transport. The vast majority of White learners (78%) were driven to school in private or hired cars, compared with only 18% of African children. And while 69% of African children walk to school, only 7% of White children do so. These figures illustrate pronounced disparity in child mobility and means of access to school.

Assuming that schools primarily serve the children living in communities around them, the ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school. This analysis is no longer possible due to question changes in the GHS. Instead, the indicator shows the number and percentage of children who travel far (more than 30 minutes) to reach the actual school that they attend, even if it is not the closest school.

Overall, the vast majority (86%) of the 12.5 million children who attended school in 2022 travelled less than 30 minutes to reach school. Children of secondary school age are more likely than primary school learners to travel far to reach school. In 2022 there were 8.3 million children of primary school age (7 – 13 years) in South Africa. A million of these children (12%) travel more than 30 minutes to and from school every day. In KwaZulu-Natal, this percentage is significantly higher than the national average, at 21%. Of the 4.5 million children of secondary school age (14 – 17 years), 19% travel more than 30 minutes to reach school, and again it is children in KwaZulu-Natal who are most likely to travel far (26%). The majority of these children live in rural areas: 19% of secondary school age children in the former homelands and 25% living on farms travel far to school, compared to 11% of children living in urban areas.

Physical access to school remains a problem for many children in South Africa, particularly those living in more remote areas where public transport to schools is lacking or inadequate and where households are unable to afford private transport for children to get to school. There were 24,871 schools in South Africa in 2022, of which 22,589 were public and 2,282 independent.[25] Nearly 4,000 government schools have closed since 2002 as the DBE consolidates smaller schools and closes state-funded farm schools. While the concentration of more children into fewer schools may be an advantage from a school management perspective, it may mean that children in remote areas have more difficulty in accessing school. Over the same period, the number of independent schools in the country has almost doubled, from 1,158 to 2,282.[27]

Figure 4c: School-age children living far from school, by province, 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Primary	10,0%	9,4%	10,6%	20,7%	5,9%	15,4%	10,8%	10,1%	8,1%	12,2%
	109,000	39,000	186,000	363,000	60,000	106,000	63,000	16,000	68,000	1,009,000
Secondary	21,7%	15,3%	15,3%	25,7%	12,3%	26,6%	17,3%	16,6%	12,1%	18,8%
	113,000	35,000	157,000	251,000	63,000	97,000	53,000	16,000	57,000	845,000

Source: Statistics South Africa (2023) *General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

Children's progress through school

School attendance rates are very high during the compulsory schooling phase (Grades 1 – 9). However, attendance tells us little about the quality of education that children receive, or their progress through the education system.

Previous systemic evaluations by the DBE have recorded very low pass rates in numeracy and literacy among both Grade 3 and Grade 6 learners,[28] and internationally comparative studies have repeatedly found South Africa's performance to be poor even when compared with other countries in the region. Both the 2016 and 2021 international PIRLS studies, which assessed literacy among Grade 4 learners, found that four out of five Grade 4 children in South Africa could not read for meaning in any language.[29, 30] In the international TIMMS study, which assessed numeracy among Grade 5 learners, South Africa was placed second last out of 49 countries. Three out of five learners could not do basic arithmetic calculations like addition and subtraction.[31] Despite measures to address the inherited inequities in the education system through revisions to the legislative and policy frameworks and the school funding norms, continued disparities in the quality of education offered by schools reinforce existing socio-economic inequalities, limiting the

future work opportunities and life chances of children who are born into poor households.[19, 32, 33]

High rates of grade repetition have been recorded in numerous studies. An analysis of grade promotion, repetition and dropout using administrative data showed that in 2019, 12% of Grade 1 learners were not promoted to the next year and repeated the grade. In the same year 9% of Grade 2s and 7% of Grade 3s repeated their grade. Repetition rates are much higher in the senior phase, where 17% of Grade 8s and 14% of Grade 9s repeated the year.[34] Progression rates were considerably higher in 2020, perhaps because the criteria for grade promotion were relaxed in light of extensive disruption of the teaching programme during lockdown. For those who are not properly evaluated at foundation and intermediate phase, automatic promotion may lead to higher rates of repetition and dropout in the upper grades and affect matric pass rates down the line.

A study of children's progress at school, using 2008 data from the National Income Dynamics Study, found that only about 44% of young adults (age 21 – 29) had matriculated, and of these less than half had matriculated "on time".[35] In 2016, only 51% of young people aged 20 – 24 had completed a matric or matric equivalent.[36] In South Africa, the labour market returns to education only start kicking in on successful completion of matric, not before. However, it is important to monitor progress and grade repetition in the earlier grades as slow progress at school is a strong determinant of school dropout.[7]

The South African schooling system is divided into three-year phases: the "foundation phase" (Grades 1 to 3), the intermediate phase (Grades 4 to 6), the senior phase (Grades 7 to 9) and the further education and training phase (Grades 10 to 12). Assuming that children are enrolled in primary school at the prescribed age (by the year in which they turn seven) and assuming that they do not repeat a grade or drop out of school, they would be expected to have completed the foundation phase (Grade 3) by the year that they turn nine, and the general education phase (Grade 9) by the year they turn 15.

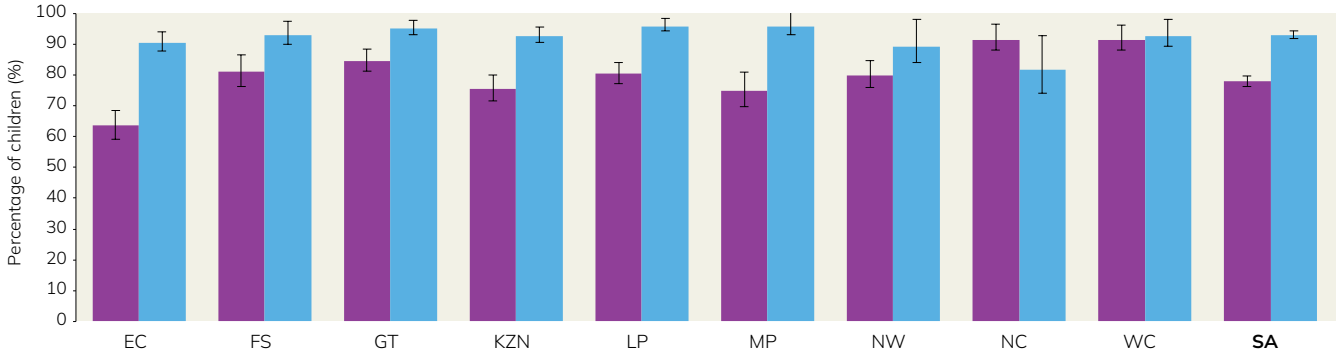
This indicator allows a little more leeway and therefore provides a generous estimate of school progress: it measures the number and percentage of children aged 10 and 11 who have completed a minimum of Grade 3, and the percentage of those aged 16 and 17 who have completed a minimum of Grade 9. In other words, it allows for the older cohort in each group to have repeated one grade.

In 2022, 93% of children aged 10 and 11 were reported to have completed Grade 3, up from 78% in 2002. An improvement in progress through the foundation phase was evident across most provinces, with significant advances in the Eastern Cape (from 64% in 2002 to 90% in 2022), Mpumalanga (75% to 96%), Limpopo (80% to 96%) and KwaZulu-Natal (75% to 93%). These improvements have narrowed the gap between provinces, although it is uncertain to what extent this reflects real improvements in education or arises from stricter rules limiting the number of grades that can be repeated in a school phase.

As would be expected, the rate of progression through the entire general education and training band (up to Grade 9) is lower, as there is more time for children to have repeated or dropped out by the end of Grade 9. Three quarters of children aged 16 – 17 years had completed Grade 9 in 2022, while one quarter had not attained this level of schooling. This represents an overall improvement of almost 20 percentage points over the two decades from 50% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase with Gauteng having the highest rate of Grade 9 progression (85%), followed by the Western Cape (75%). Progress was poorest in the Northern Cape, North West, Free State and Eastern Cape, where less than 70% of children had completed Grade 9 by the expected age.

As found in other analyses of progress through school,[11, 16, 37] educational attainment (measured by progress through school) varies along socio-economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression

Figure 4d: Children age 10 – 11 years who passed Grade 3, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	SA
2002	63,7%	81,0%	84,5%	75,4%	80,5%	74,8%	79,9%	91,5%	91,3%	77,9%
	215,000	94,000	272,000	374,000	223,000	136,000	108,000	46,000	169,000	1,637,000
2022	90,4%	92,8%	94,9%	92,6%	95,8%	95,6%	89,3%	81,6%	92,5%	93,0%
	291,000	117,000	434,000	418,000	288,000	165,000	143,000	31,000	226,000	2,113,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

have remained consistent and even widened over the years: girls are more likely than boys to progress through school at the expected rate and the difference becomes more pronounced in the higher grades. In 2022, the gender difference in grade progression for Grade 3 learners was not significant (94% for girls versus 92% for boys). But in the same year, 82% of 16 – 17-year-old girls had completed Grade 9, compared with only 67% of boys in the same age cohort. These findings are consistent with previous analyses of different data sources.[7, 38]

There are significant differences in grade completion across income quintiles, especially amongst children who have completed Grade 9: in 2022, 67% of 16 – 17-year-olds in the poorest 20% of households had completed Grade 9, compared to 92% of those in the richest 20% of households.

The most striking improvements in grade progression, at both Grade 3 and Grade 9 level, occurred through the years between 2002 and 2010. The rate of improvement has slowed and in some years remained stable since then.Of course, grade progression and grade repetition are not easy to interpret. Prior to Grade 12, the promotion of a child to the next grade is based mainly on assessment by teachers, and the measure may be confounded by the teacher's competence to assess the performance of the child, as well as pressure on teachers and/or schools to promote children through the system. Analyses of the determinants of school progress and dropout point to a range of factors, many of which are interrelated: there is huge variation in the quality of education offered by schools.

These differences largely reflect the historic organisation of schools into racially defined and inequitably resourced education departments. Household-level characteristics and family background also account for some of the variation in grade progression. For example, the level of education achieved by a child's mother explains some of the difference in whether children are enrolled at an appropriate age and whether they go on to complete matric successfully.[35] This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

Youth not in employment, education or training (NEETs)

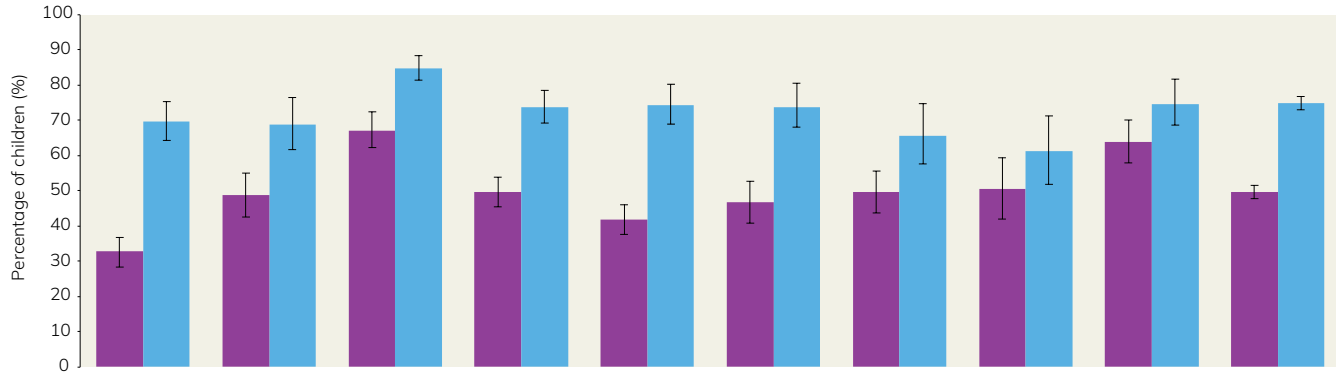
"NEETs" is a term used to describe young people who are "not in employment, education or training". The definition used here includes youth aged 15 – 24 who are not attending any educational institution and who are not employed or self-employed.[39]

Widespread concerns about the large numbers of youth in this situation centre on two main issues: the perpetuation of poverty and inequality, including intergenerational poverty; and the possible implications of a large "idle" youth population for risk behaviour, social cohesion and the safety of communities.

Little is known about what NEETs do with their time. Young people who are neither learning nor engaged in income-generating activities may nevertheless be "productive" within their households, for example by helping to maintain the home or looking after children and others in need of care. However, in the absence of income, NEETs remain dependent on the earnings of other household members, and on grants that are directed to children and the elderly. The Old Age Pension in particular has been found to support job-seeking activities for young people[40] and this unenvisaged expenditure of the grant could be addressed by extending social security to unemployed youth.[41]

The large number of NEETs in South Africa is linked to underlying problems in the education system and the labour market. Young people in South Africa have very high participation rates in education, including at secondary level. Enrolment rates for Grades 11 and 12 have increased in recent years and more young people attain Grade 12 (and at an earlier age).[42] But there is still a sharp drop-off in enrolment numbers after Grade 10

Figure 4e: Children age 16 – 17 who passed Grade 9, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	32,7%	48,9%	67,1%	49,6%	41,9%	46,8%	49,7%	50,7%	63,8%	49,6%
	113,000	55,000	225,000	238,000	122,000	80,000	64,000	21,000	120,000	1,037,000
2022	69,5%	68,7%	84,6%	73,6%	74,2%	73,8%	65,7%	61,1%	74,6%	74,8%
	167,000	71,000	432,000	342,000	182,000	124,000	105,000	31,000	178,000	1,632,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

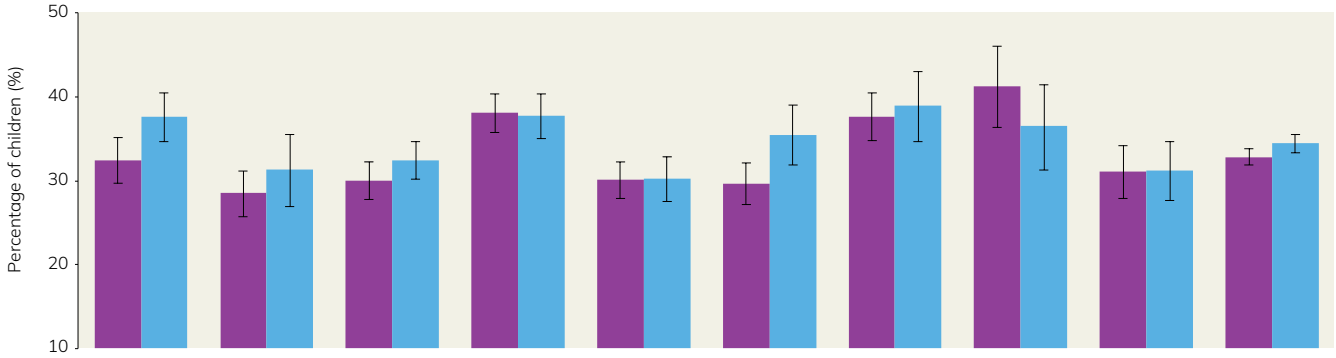
and only about half of young people in their early twenties have successfully completed Grade 12.[36, 42] This reduces prospects for further study or employment.[43] Low quality and incomplete education represent what are termed the "supply-side" drivers of youth unemployment, where young people do not have the appropriate skills or work-related capabilities to be employable or to set up successful enterprises of their own, and so struggle to make the transition from education to work.[44, 45] The "demand-side" driver relates to a shortage of jobs or self-employment opportunities for those who are available to work.

In 2022, there were 9.9 million young people aged 15 – 24 in South Africa. Of these, 34% (3.4 million) were neither working nor enrolled in any education institution such as a school, university or college. The number of young people nationally who are not in education, training or employment has remained remarkably consistent over the last decade, but has increased since the beginning of democracy when only two million NEETs were recorded in 1996.[46] South Africa has made no progress towards what is now an explicit target of the Sustainable Development Goals, namely to substantially reduce the proportion of youth not in employment, education or training by 2030.[47] If anything, the number of NEETs has increased marginally.

The NEET rates are quite consistent across the provinces. This is hard to interpret without further information. Limpopo, for example, is a very poor and largely rural province where one might expect high rates of unemployment. It is possible that the slightly lower-than-average percentage of NEETs in that province is partly the result of young people migrating to cities in Gauteng or other provinces in search of work. It is also possible that young people who are not employed in the labour market may nevertheless be employed in small-scale agriculture if their household has access to land, and this could also help to smooth the provincial and spatial inequalities that are characteristic of many other indicators.

There is enormous variation within the broad youth group of 15 – 24 years. Only 5% of children aged 15 – 17 are classified as NEET because the majority are attending school. Within the 18 – 20 age band, 38% are NEETs, and more than half (57%) of those in the 21 – 24 age band are NEETs. While education attendance rates are fairly even for males and females, the gender disparity among NEETs is significant. Thirty-six percent of young women are not in employment, education or training – compared with 32% of young men.

Figure 4f: Youth (15 – 24 years) not in employment, education or training (NEETs), by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	32,4%	28,5%	30,0%	38,1%	30,1%	29,7%	37,6%	41,3%	31,1%	32,8%
	436,000	150,000	568,000	783,000	338,000	213,000	229,000	76,000	294,000	3,086,000
2022	37,6%	31,4%	32,5%	37,7%	30,2%	35,5%	38,9%	36,5%	31,3%	34,4%
	382,000	147,000	832,000	758,000	307,000	294,000	274,000	77,000	342,000	3,413,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

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Children's access to housing

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Section 26 of the Constitution of South Africa provides that "everyone has the right to have access to adequate housing", and section 28(1)(c) gives children "the right to ... shelter".[1]

Article 27 of the United Nations (UN) Convention on the Rights of the Child states that "every child has the right to a standard of living adequate for his/her development" and obliges the state "in cases of need" to "provide material assistance and support programmes, particularly with regard to ... housing".[2]

Children living in urban and rural areas

This indicator describes the number and share of children living in urban and rural areas in South Africa.

Location is one of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights.[3] Residential areas should ideally be situated close to work opportunities, clinics, police stations, schools and child-care facilities. In a country with a large rural population, this means that services and facilities need to be well distributed, even in areas that are not densely populated. In South Africa, service provision and resources in rural areas lag far behind urban areas.

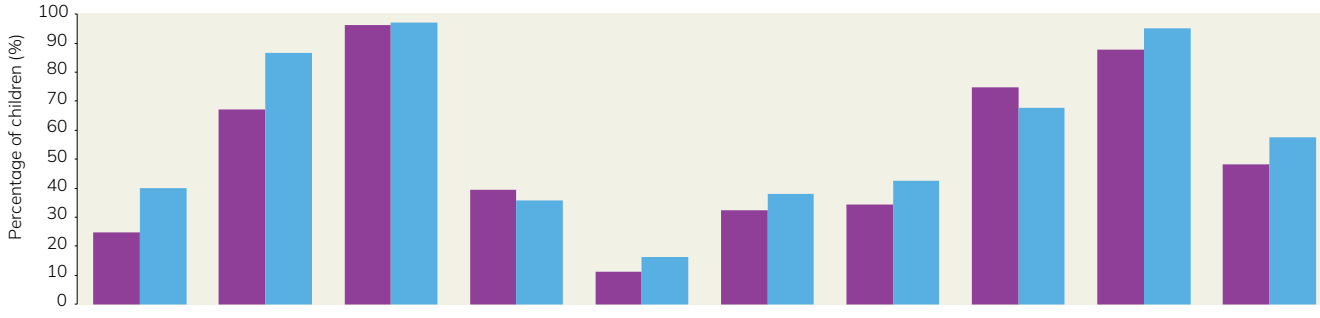
In 2022, 57% of children lived in urban areas while 43% were in rural households. Looking back over two decades, there is a clear shift in the distribution of children towards urban areas: In 2002, 48% of children were in urban households, and this increased gradually to 57% by 2017, after which it remained stable. The urban child population has grown by 3.2 million, from 8.7 million children in 2002 to 12 million in 2022. Children are consistently less urbanised than adults: In 2022, 68% of the adult population was urban, compared with 57% of children.

There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the legacy of apartheid's spatial arrangements where women, children and older people in particular were relegated to the former homelands. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to over 70% of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.8 million (64%) of its child population being classified as rural. The least urbanised province is Limpopo, where only 16% of children live in urban areas. Proportionately more children (39%) live in the former homelands, compared with adults (28%). Almost all of children living in the former homeland areas are African.

Children living in Gauteng and the Western Cape are almost entirely urban (97% and 95% respectively). The urban child population in Gauteng alone has grown by over 1.6 million since 2002 and the urban child population in the Western Cape has grown by over 600,000. These increases are partly the result of urban births, and also partly the result of within-province movement and migration from other provinces. Other provinces that have experienced a marked growth in the urban share of the child population are the Eastern Cape, Free State and North West. KwaZulu-Natal, in contrast, has seen a slight reduction in its urban child population.

Rural areas, particularly the former homelands, have poorer populations. In 2022, six out of every ten children in the poorest income quintile lived in rural areas and this had been a consistent

Figure 5a: Children living in urban areas, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	24,6%	67,2%	96,1%	39,5%	11,1%	32,5%	34,3%	74,8%	87,7%	48,2%
	721,000	672,000	2,825,000	1,641,000	270,000	494,000	399,000	298,000	1,411,000	8,730,000
2022	40,1%	86,7%	97,1%	35,9%	16,4%	38,2%	42,6%	67,7%	95,1%	57,5%
	1015,000	897,000	4,487,000	1,563,000	412,000	675,000	631,000	297,000	2,021,000	11,998,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall & Neo Segoneco, Children's Institute, UCT.

trend over the previous decade. Within the poorest part of the population, it is mainly rural households that care for children – even though many of these children may have parents who live and work in urban areas. The inequalities also remain strongly racialised. Over 90% of White, Coloured and Indian children are urban, compared with 52% of African children.

Children living in formal, informal and traditional housing

This indicator shows the number and share of children living in formal, informal and traditional housing. For this indicator, "formal" housing is considered a proxy for adequate housing and consists of: dwellings or brick structures on separate stands; flats or apartments; town/cluster/semi-detached houses; units in retirement villages; rooms or flatlets on larger properties provided they are built with sturdy materials. "Informal" housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards built of iron, wood or other non-durable materials; and caravans or tents. "Traditional" housing is defined as a "traditional dwelling/hut/structure made of traditional materials" in a rural area.

Children's right to adequate housing means that they should not have to live in informal dwellings. One of the seven elements of adequate housing identified by the UN Committee on Economic, Social and Cultural Rights is that it must be "habitable".[3] To be habitable, houses should have enough space to prevent overcrowding, and should be built in a way that ensures physical safety and protection from the weather.

Formal brick houses that meet the state's standards for quality housing could be considered "habitable housing", whereas informal dwellings such as shacks in informal settlements and backyards would not be considered habitable or adequate. Informal housing in backyards and informal settlements make up the bulk of the housing backlog in South Africa. "Traditional" housing in rural areas cannot necessarily be assumed to be inadequate. Some traditional dwellings are more habitable than formal dwellings in low-cost housing developments – they can be more spacious and better insulated, for example.

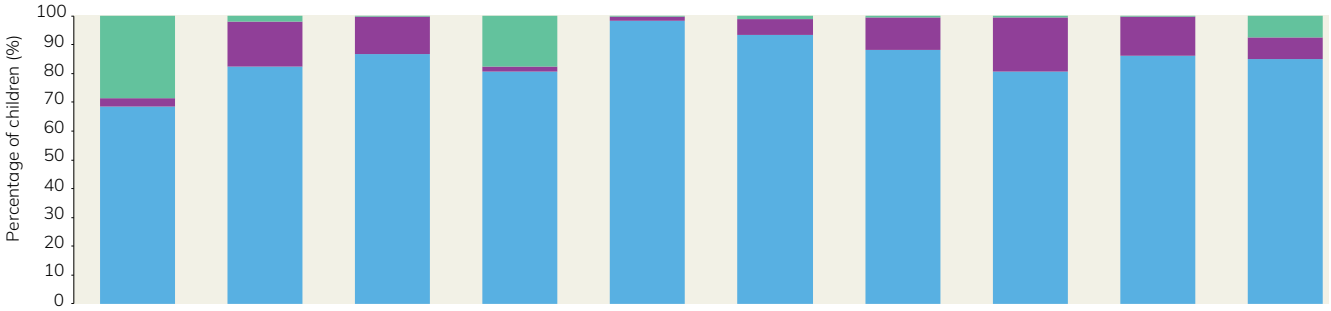
Access to services is another element of "adequate housing". Children living in formal areas are more likely to have services on site than those living in informal or traditional dwellings. They are also more likely to live closer to facilities like schools, libraries, clinics and hospitals than those living in informal settlements or rural areas. Children living in informal settlements may be more exposed to hazards such as shack fires and paraffin poisoning.

The environmental hazards associated with informal housing are exacerbated for very young children. The distribution of children in informal dwellings is slightly skewed towards younger children: four out of 10 children who live in informal housing are pre-school age.

In 2022, 1.6 million children (8% of children in South Africa) lived in informal housing – backyard shacks or informal settlements. The number of children in informal housing has declined gradually from 2.3 million (13%) in 2002. The provinces with the highest shares of informally-housed children are the Western Cape, Gauteng, Northern Cape and Free State. The Eastern Cape, KwaZulu-Natal and Limpopo have the lowest shares of children in informal housing. Most children in Limpopo live in formal housing, while Eastern Cape has a relatively large share of its child population living in traditional dwellings (29%).

The distribution of children in formal, informal and traditional housing has remained fairly constant since 2002. But racial inequalities persist. Virtually all White children lived in formal housing in 2022, compared with 83% of African children. Access to formal housing increases with income. Nearly 100% percent of children in the wealthiest 20% of households live in formal dwellings, compared with 78% of children in the poorest quintile.

Figure 5b: Children living in formal, informal and traditional housing, by province, 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
Formal	68,6%	82,4%	86,7%	80,6%	98,4%	93,3%	88,3%	80,8%	86,1%	84,9%
	1,736,000	853,000	4,007,000	3,506,000	2,475,000	1,651,000	1,307,000	354,000	1,830,000	17,719,000
Informal	2,9%	15,6%	13,3%	2,0%	1,4%	5,5%	11,4%	18,8%	13,8%	7,7%
	73,000	161,000	613,000	87,000	34,000	97,000	168,000	82,000	293,000	1,608,000
Traditional	28,5%	2,0%	0,1%	17,4%	0,3%	1,1%	0,4%	0,4%	0,1%	7,4%
	722,000	20,000	2 000	759,000	7,000	20,000	6,000	2,000	1 000	1,540,000

Source: Statistics South Africa (2023) *General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall & Neo Segoneco, Children's Institute, UCT.

Children living in overcrowded households

Children are defined as living in overcrowded dwellings when there is a ratio of more than two people per room (excluding bathrooms but including kitchen and living room). Thus, a dwelling with two bedrooms, a kitchen and sitting room would be counted as overcrowded if there were more than eight household members.

The UN Committee on Economic, Social and Cultural Rights defines "habitability" as one of the criteria for adequate housing.[3] Overcrowding is a problem because it can undermine children's needs and rights. For instance, it is difficult for school children to do homework if other household members want to sleep or watch television. Children's right to privacy can be infringed if they do not have space to wash or change in private. The right to health can be infringed as communicable diseases spread more easily in overcrowded conditions, and young children are particularly susceptible to the spread of disease. Overcrowding also places children at greater risk of sexual abuse, especially where boys and girls have to share beds, or children have to share beds with adults.

Overcrowding makes it difficult to target services and programmes to households effectively – for instance, urban households are entitled to six kilolitres of free water, but this household-level allocation discriminates against overcrowded households because it does not take account of household size.

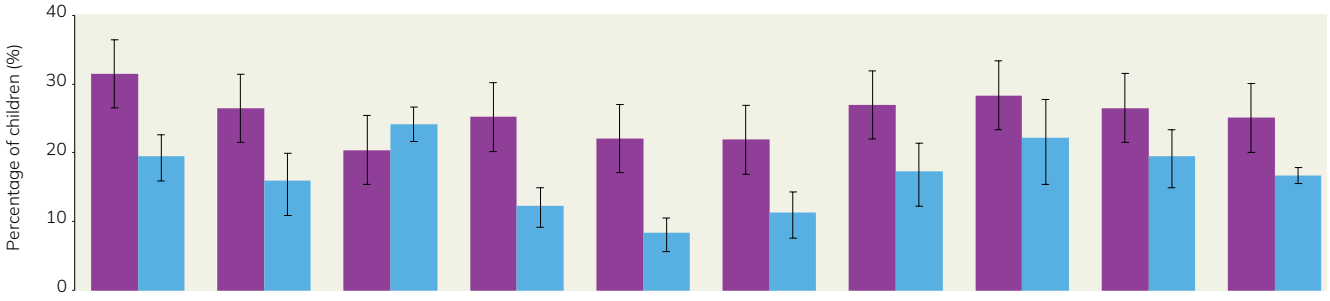
In 2022, 3.5 million children lived in overcrowded households. This represents 17% of the child population – much higher than the share of adults living in crowded conditions (9%).

Overcrowding is associated with housing type: 48% of children who stay in informal dwellings also live in overcrowded conditions, compared with 24% of children in traditional dwellings and 13% of children in formal housing. Young children are slightly more likely than older children to live in overcrowded conditions. Twenty percent of children below six years live in crowded households, compared to 14% of children over 12 years.

There is a strong racial bias in children's housing conditions. While 18% of African and 17% of Coloured children live in crowded conditions, less than 1% of White children live in overcrowded households. Children in the poorest 20% of households are more likely to be living in overcrowded conditions (24%) than children in the richest 20% of households (2%).

The average household size has decreased from 4.5 at the time of the 1996 population census, to around 3.5 in 2022.[4] The reduction in average household size during the 1990s and early 2000s was linked to the rapid provision of small subsidy houses that could not accommodate extended families.[5, 6] It has also been linked to adult urban migration coupled with continuing constraints on family co-migration and declining marriage and cohabitation rates between men and women.[7] In recent years, an important contributor to declining average household size has been the fairly rapid growth in single-person households where adults live alone.[8-10] In 2022 there were 18 million households in South Africa, double the number recorded in 1996.[4] Of these 18 million households 25% (around 4.6 million) were households where one person lived alone.[11, 12] Households in which children live are larger than the national average, although they have also declined in size over time. The mean household size for adult-only households in 2022 was 1.7 while the mean household size for households that included children was 4.6.

Figure 5c: Children living in overcrowded households, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	31,5%	26,5%	20,4%	25,2%	22,1%	21,9%	26,9%	28,3%	26,5%	25,1%
	922,000	264,000	599,000	1,046,000	534,000	333,000	314,000	113,000	427,000	4,551,000
2022	19,5%	15,9%	24,2%	12,3%	8,4%	11,4%	17,3%	22,2%	19,5%	16,7%
	493,000	165,000	1118,000	537,000	212,000	201,000	256,000	97,000	414,000	3,492,000

Source: Statistics South Africa (2003; 2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA.
Analysis by Katharine Hall & Neo Segoneco, Children's Institute, UCT.

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Children's access to services

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Section 27 (1)(b) of the Constitution of South Africa provides that "everyone has the right to have access to ... sufficient ... water" and section 24 (a) states that "everyone has the right to an environment that is not harmful to their health or well-being".[1]

Article 14 (2)(c) of the African Charter on the Rights and Welfare of the Child obliges the state to "ensure the provision of ... safe drinking water".[2]

Article 24 (1)(c) of the United Nations (UN) Convention on the Rights of the Child says that state parties should "recognise the right of the child to the enjoyment of the highest attainable standard of health" and to this end should "take appropriate measures to combat disease and malnutrition ..., including the provision of clean drinking-water".[3]

Children's access to basic water

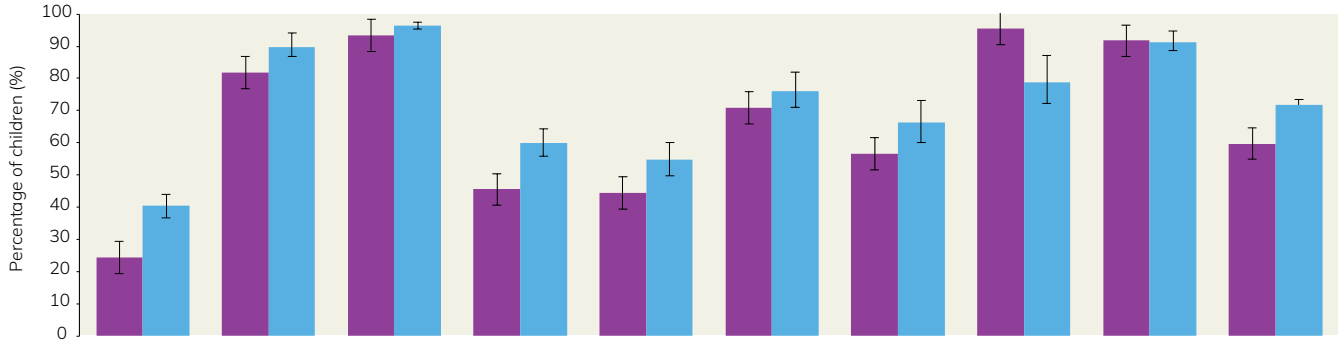
This indicator shows the number and percentage of children who have access to piped drinking water at home – either inside the dwelling or on site. Piped water is used as a proxy for access to adequate water. All other water sources, including public taps, water tankers, dams and rivers, are considered inadequate because of their distance from the dwelling or the possibility that the water is of poor quality. The indicator does not show whether the water supply is reliable, or if households have broken facilities or have had their service restricted because of an inability to pay. It is therefore likely to be an over-estimation of children's access to adequate water.

Clean water is essential for human survival. The World Health Organization defined "reasonable access" to water as being a minimum of 20 litres per person per day.[4] The 20-litre minimum is linked to the estimated average consumption when people rely on communal facilities and need to carry their own water for drinking, cooking and the most basic personal hygiene. It does not allow for bathing, showering, washing clothes or any domestic cleaning.[5] The water needs to be supplied close to home, as households that travel long distances to collect water often struggle to meet their basic daily quota. This can compromise children's health and hygiene.

The Sustainable Development Goals (target 6.1) call for universal and equitable access to safe and affordable drinking water. This is defined as a safely managed drinking water service from an improved water source located on the premises.

Young children are particularly vulnerable to diseases associated with poor water quality. Gastro-intestinal infections with associated diarrhoea and dehydration are a significant contributor to the high child mortality rate in South Africa,[6] and intermittent outbreaks of cholera in some provinces pose a serious threat to children. Lack of access to adequate water is closely related to poor sanitation and hygiene. In addition, children may be responsible for fetching

Figure 6a: Children living in households with water on site, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	24,4%	81,7%	93,5%	45,5%	44,5%	70,8%	56,5%	95,6%	91,7%	59,8%
	716,000	817,000	2,747,000	1,888,000	1,077,000	1,077,000	658,000	380,000	1,476,000	10,836,000
2022	40,4%	89,9%	96,3%	59,9%	54,9%	76,0%	66,2%	78,7%	91,3%	71,9%
	1,022,000	930,000	4,450,000	2,606,000	1,381,000	1,344,000	980,000	345,000	1,939,000	14,999,000

Source: Statistics South Africa (2003; 2023) General Household Survey 2002; General Household Survey 2022. Pretoria: Stats SA.
Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

and carrying water to their homes from communal taps, or rivers and streams. Carrying water is a physical burden that can lead to back problems or injury from falls. It can also reduce time spent on education and other activities and can place children at personal risk.[7] This child-centred indicator of adequate water is therefore limited to a safe water source on site (either inside the house or in the yard of the household where the child lives).

The share of children with piped water at home increased by 10 percentage points, from 60% in 2002 to 70% nationally in 2017, representing an increase of three million children with a piped water connection at home. The biggest improvements over this period were in the Eastern Cape (from 24% to 40%) and KwaZulu-Natal (from 46% to 60%).

The trend has since levelled off, suggesting that a ceiling effect has been reached. In 2022, 72% of children were living in households with piped water, while over a quarter (5.9 million children) depended on water connections that were off-site or did not meet the adequacy standard of providing a safe, reliable supply. Adults are more likely than children to live in households with adequate water access (79% of adults compared with only 72% of children). This is because, compared with the adult population, children are over-represented in rural households located in areas without bulk service infrastructure.

Over 90% of children living in urban areas have water on site, compared with 43% of children in the rural former homelands and 48% of children living on farms. While most children (78%) living in formal dwellings have access to an adequate water supply on-site, this decreases to 59% for children living in informal dwellings. Only 14% of children living in traditional dwellings have water available on the property. The vast majority of children living in the former homelands and in traditional dwellings are African, so there is also pronounced racial inequality in access to water. In 2022, two thirds (68%) of African children had water on site, while levels of piped water access for all other population groups exceeded 95%. There are no significant differences in access to water across age groups.

Provincial differences are striking. Around nine out of ten children in Gauteng (96%), the Western Cape (91%) and the Free State (90%) have piped water at their home. All of these provinces started from a high base in terms of water access, and there has not been significant change over the past two decades. The provinces that have experienced substantial improvements in water provision are those which had the lowest levels of access to start with: the Eastern Cape (a significant improvement in the provincial share of children with water on site, from 24% in 2002 to 40% in 2022), KwaZulu-Natal (from 46% to 60%); Limpopo (a more modest improvement from 45% to 55%) and Mpumalanga (from 71% to 76%). The Eastern Cape, with its large under-serviced former homeland areas, remains the only province in which more than half of all children do not have piped water to their home.

Inequality in access to safe water is also pronounced when the data are disaggregated by income group. Only 57% of children in the poorest 20% of households have access to water on site, while 96% of those in the richest 20% of households have this level of service. In this way, inequalities are reinforced: the poorest children are most at risk of diseases associated with poor water quality and the associated setbacks in their development.

Children's access to basic sanitation

This indicator shows the number and percentage of children living in households with basic sanitation. Adequate toilet facilities are used as proxy for basic sanitation. This includes flush toilets and ventilated pit latrines that dispose of waste safely and that are within or near a house. Inadequate toilet facilities include pit latrines that are not ventilated, chemical toilets, bucket toilets, or no toilet facility at all.

A basic sanitation facility was defined in the government's *Strategic Framework for Water Services* as the infrastructure necessary to provide a sanitation facility that is "safe, reliable, private, protected from the weather and ventilated, keeps smells to a minimum, is easy to keep clean, minimises the risk of the spread of sanitation-related diseases by facilitating the appropriate control of disease carrying flies and pests, and enables safe and appropriate treatment and/or removal of human waste and wastewater in an environmentally sound manner".[8]

Adequate sanitation prevents the spread of disease and promotes health through safe and hygienic waste disposal. To do this, sanitation systems must break the cycle of disease. For example, the toilet lid and fly screen in a ventilated pit latrine stop flies reaching human faeces and spreading disease. Good sanitation is not simply about access to a particular type of toilet. It is equally dependent on the safe use and maintenance of that technology; otherwise toilets break down, smell bad, attract insects and spread germs.

Good sanitation is essential for safe and healthy childhoods and for reducing inequalities for children.[9] It is very difficult to maintain good hygiene without water and toilets. Poor sanitation is associated with diarrhoea, cholera, malaria, bilharzia, worm infestations, eye infections and skin disease. These illnesses compromise children's health and nutritional status. Using public toilets and the open veld can also put children in physical danger. The use of the open veld and bucket toilets is also likely to compromise water quality in the area and to contribute to the spread of disease. Poor sanitation undermines children's health, safety and dignity.

The data show a gradual and significant improvement in children's access to sanitation since 2002, although the number of children without adequate toilet facilities remains worryingly high. In 2002, less than half of all children (46%) had access to adequate sanitation. By 2018, the share of children with adequate toilets had risen to 79% and it has remained at that level since. Around 4.3 million children still use unventilated pit latrines, buckets or other inadequate forms of sanitation, despite the state's reiterated goals to provide adequate sanitation to all and to eradicate the bucket system. The majority of these children (3.4 million) use unventilated pit toilets, while 280,000

children have no sanitation facilities at all (open defecation or buckets). Children (21%) are slightly more likely than adults (17%) to live in households without adequate sanitation.

As with other indicators of living environments, there are striking provincial disparities. In provinces with large metropolitan populations, like Gauteng and the Western Cape, around 90% of children have access to adequate sanitation (mostly in the form of flush toilets), while provinces with large rural populations tend to have the poorest sanitation. Provinces with the greatest sanitation improvements in numeric terms are the Eastern Cape (where the number of children with access to adequate sanitation more than tripled from 626,000 to over 2.2 million, resulting in an increase in access for 1.6 million children), KwaZulu-Natal (an increase of 1.9 million children) and Gauteng (an increase of 1.7 million children with adequate sanitation facilities on site). In the Free State, the share of children with sanitation improved from 53% in 2002 to 85% in 2022.

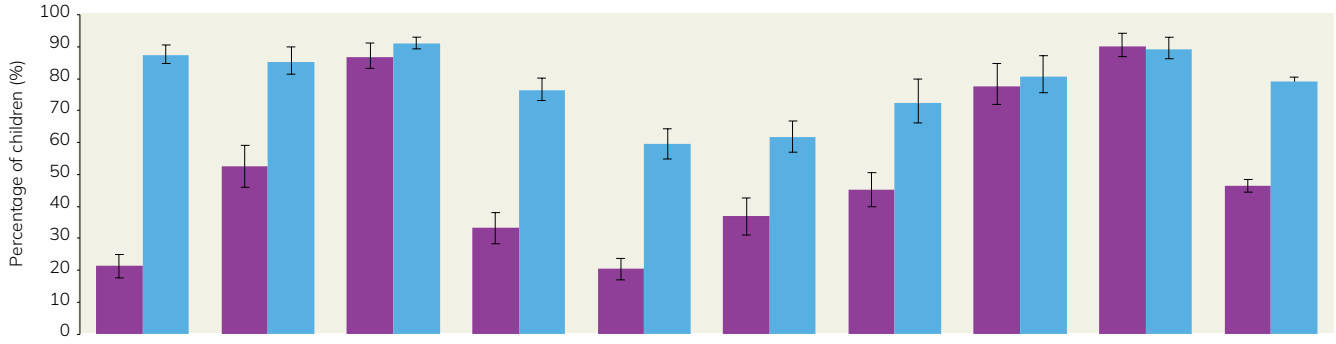
The dramatic improvement in access to sanitation from 21% in 2002 to 87% in 2022 in the Eastern Cape is due to increased provisioning of ventilated pit latrines, which may be provided by the state or built by households themselves. In other words, the achievements in sanitation access have not necessarily been accompanied by improved or more extensive bulk infrastructure. Of the nearly 90% of children in this province who are defined as having adequate sanitation, over 60% have pit latrines while only 39% have flush toilets. Similarly, the substantial improvements in KwaZulu-Natal and Limpopo have been achieved without corresponding expansion of bulk infrastructure to rural households. Sanitation infrastructure needs to be maintained to be safe and hygienic, but the available data do not enable us to determine whether flush toilets are working properly, nor do they provide any indication of the quality and maintenance of pit latrines.

Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 59% of children living in households with adequate sanitation. It is unclear why the vast majority of children in Limpopo are reported to live in formal houses, yet access to basic sanitation is the poorest of all the provinces. Definitions of adequate housing such as those in the UN-Habitat and South Africa's National Housing Code include a minimum quality for basic services, including sanitation.

The statistics on basic sanitation provide yet another example of persistent racial inequality: almost 100% of Indian and White children had access to adequate toilets in 2022 and 93% of Coloured children had adequate sanitation, while only 77% of African children had access to adequate basic sanitation. This is, however, a marked improvement from 37% of African children in 2002.

Children in relatively well-off households have better levels of access to sanitation than poorer children. Among the richest 20% of households, 97% of children have adequate sanitation, while 71% of children in the poorest 20% of households have this level of service.

Figure 6b: Children living in households with basic sanitation, by province, 2002 & 2022



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	21,4%	52,5%	86,7%	33,4%	20,6%	37,0%	45,3%	77,7%	90,0%	46,5%
	626,000	525,000	2,549,000	1,384,000	499,000	562,000	528,000	309,000	1,448,000	8,427,000
2022	87,4%	85,2%	91,1%	76,4%	59,5%	61,7%	72,4%	80,8%	89,2%	79,2%
	2,211,000	882,000	4,208,000	3,324,000	1,496,000	1,091,000	1,072,000	354,000	1,895,000	16,532,000

Source: Statistics South Africa (2003;2023) *General Household Survey 2002; General Household Survey 2022*. Pretoria: Stats SA. Analysis by Katharine Hall and Neo Segoneco, Children's Institute, UCT.

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About the contributors

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Colin Almeleh is the Director for Knowledge, Information and Data Solutions (KIDS) at Ilifa Labantwana, a non-governmental organisation focused on early childhood development (ECD). His work contributes to building the ECD information eco-system in South Africa, particularly through designing the government's management information system for ECD, and through systems research with academic and government partners. Colin holds a PhD in Sociology, an Honours in Social Anthropology, and a BSc in Electrical Engineering. He is a past Fox Fellow at Yale University.

Lesley Bamford is a paediatrician who also holds post-graduate degrees in the Social Sciences and Public Health. She has worked in child, youth and school health in the national Department of Health (DoH) since 2006, and has extensive experience in knowledge management, policy and guideline development, programme design, implementation, and monitoring and evaluation of national health programmes. Lesley currently oversees the DoH's programmes for maternal, women's and child health, and also holds an appointment with the Department of Paediatrics and Child Health at the University of Pretoria.

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Linda Biersteker is a psychologist and adult educator focusing on early childhood development. Previously the Research Director at the Early Learning Resource Unit, she has extensive research, policy and programming experience in South Africa and the African region. She has played an active role in the education and training of university students, teachers, non-governmental organisation staff and government officials; and in the development of materials and qualifications for parents and ECD practitioners. Linda's particular interest is in good quality, effective and sustainable interventions targeting vulnerable young children and their parents and teachers, and her technical expertise guided the development of the Early Learning Outcomes Measure (ELOM) suite of tools for early learning programmes and the Quality Assessment and Support System for the Department of Basic Education.

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Liesel du Plessis has been with Project Preparation Trust (PPT) since 2005 in various roles including that of Programme Manager of PPT's early childhood development (ECD) and special needs housing programmes. She has more than 30 years of experience in

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Tamryn Frank is a Researcher at the University of the Western Cape's School of Public Health and has a PhD in Public Health. Prior to this appointment she was a public health care Dietitian working for the Department of Health for eight years. She spent 2022 as a Visiting Scholar at the University of North Carolina's global food research programme and has served on the scientific task team advising the national Department of Health on front-of-package labelling. Tamryn's research interests include a focus on policies to promote a healthier food environment, nutrient profiling, front-of-package labelling, ultra-processed products and child-directed marketing.

Sonja Giese has a diverse career in development spanning over 30 years. She is founding Executive Director of DataDrive2030, a South African-based social enterprise that supports the collection and use of high-quality data to drive improved child outcomes in the first six years of life. Prior to this, Sonja established and led Innovation Edge, an impact first investor focused on solving early childhood challenges through seed capital and strategic support. Sonja has also held senior leadership positions within the Children's Institute at the University of Cape Town, international non-governmental organisation Absolute Return for Kids, and a national early childhood development donor consortium, Ilifa Labantwana. She has consulted extensively to government, philanthropy and private sector on policy reform and systems change, led large research initiatives and demonstrated her ability to take ideas from source to scale in the various programmes that she has spearheaded.

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Aaron Motsoaledi is the Minister of Health. He holds a Bachelor of Medicine and Surgery from the University of KwaZulu-Natal. He served as Minister of Home Affairs from 2019 to 2024, and served in his current portfolio prior to that. He is a member of the African National Congress (ANC) National Executive Committee. Minister Motsoaledi has also previously served as a member of the Limpopo Provincial Legislature; as Limpopo Education MEC, Transport MEC, and MEC for Agriculture, Land and Environment.

Leigh Morrison was introduced to the Vrygrond and Overcome communities in 2012 as a lay counsellor, offering play therapy to young children. Her love for the community and connection to the preschools led her to join the organisation True North in 2014, and she soon became an indispensable part of the team. Her servant-heartedness and ability to lead people to their full potential, saw her step into the project leadership role at True North in 2017. Leigh grew in her knowledge and passion for strategic planning and

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Tess Peacock is the founder and Executive Director of the Equality Collective. A qualified attorney, she has experience working in education and early childhood development at the grassroots, grant-making, and policy levels, having worked at the Bulungula Incubator, for Tshikululu Social Investments, and as a consultant for Ilifa Labantwana and the Nelson Mandela Foundation. She has been an Atlantic Fellow for Racial Equity, Salzburg Global Fellow, and DGMT Innovation Fellow; previously served as Treasurer of Equal Education; and is an advisory Board member of Bulungula College. Tess has a BSocSci in Politics, Philosophy and Economics; an LLB from the University of Cape Town; and an LLM from Harvard University.

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Linda Richter is a Distinguished Professor at the University of the Witwatersrand. She is a Developmental Psychologist with over 300 peer-reviewed research publications covering research, programmes and policies to improve child, adolescent, and family health and well-being across the life course and intergenerationally. Linda is a National Research Foundation A-rated researcher and serves on several editorial boards, funding committees and policy forums.

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Andrew Rudge is a "reformed" banker. Over the past 10 years he has gained significant experience in the education technology space as the founder and Chief Executive Officer of The Reach Trust. His interests lie in the pragmatic use of technology to improve learning outcomes, particularly in the early childhood development space, with programmes focusing on enhancing literacy and mathematics foundations in preschool children. Recently the projects have begun to incorporate a greater focus on executive functions. Andrew holds a Masters in Applied Economics from Imperial College, London.

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Sasha Stevenson is a human rights lawyer and the Executive Director of SECTION27, a public interest law centre. She has been working for over a decade to secure health system change that realises rights. She has represented bereaved families in the Life Esidimeni arbitration and inquest following the deaths of 144 mental health care users, and represented the applicants in litigation to re-start the school feeding programme to mitigate child hunger during the COVID-19 lockdown. Her work also includes litigation and advocacy on migrant health, access to abortion and access to medicine, among others.

Sisisi Tolashe is the Minister of Social Development. She was previously Deputy Minister in the Presidency for Women, Youth and Persons with Disabilities. Minister Tolashe cut her teeth in student and youth movement politics during apartheid, leading to lengthy detentions under different states of emergency. The imprisonment she suffered did not break her spirit but strengthened her resolve to fight for the liberation and empowerment of women and children.

Mark Tomlinson is the Co-Director of the Institute for Life Course Health Research in the Department of Global Health at Stellenbosch University. He is also a Professor of Maternal and Child Health in the School of Nursing and Midwifery, Queens University, Belfast, United Kingdon. His scholarly work has involved a diverse range of topics such as improving early childhood development, mental health, adolescent health, and on life course approaches to build human capital in the first two decades of life.

Nicolette van der Walt is the National Manager for Child Protection at ACVV National Council. She has a Masters in Social Work. Prior to her current role she was the Regional Manager for the Southern Cape area as well as the Manager for Transformation at ACVV National Council, following a few years with the Department of Social Development as a Social Worker. She has extensive experience in the management of child protection services, supervision, the writing and facilitation of training programmes for social service practitioners and considers herself an activist for child protection. Nicolette serves as a council member of the South African Council for Social Service Professions.

Andries Viviers (André) is currently the Education Manager specialising in early childhood development (ECD) at UNICEF in South Africa. He holds a Masters in Social Work from the University of Pretoria; a Bachelor of Social Science from the University of the Free State; and a Postgraduate Certificate in Education Sector Reform from the World Bank Institute, Washington, DC. André is a Research Fellow at the Department of Social Work and Criminology at the University of Pretoria; an elected member of the South African Council for Social Service Professions; a member of the academic advisory board of the Department of Social Work at the University of the Free State; and a member of the advisory board of the Centre for the Study of Resilience at the University of Pretoria. He has 34 years' experience in social work and development, of which over 24 years are directly related to ECD. His research interests are in early childhood development (governance, early learning and parenting in the early years), human rights and social justice.

About the *South African Child Gauge*

The *South African Child Gauge* is an annual publication of the Children's Institute, University of Cape Town, that monitors progress in the realisation of children's rights. Key features include an in-depth analysis of a particular dimension of children's lives; a summary of new legislative and policy developments affecting children; and child-centred statistics which track the demographic and socio-economic status of South Africa's children.

Previous issues of the *South African Child Gauge*:

2021: Child and adolescent mental health
2020: The slow violence of malnutrition
2019: Child and adolescent health: Leave no one behind
2018: Children, Families and the State: Collaboration and contestation
2017: Survive – Thrive – Transform
2016: Children and social assistance
2015: Youth and the intergenerational transmission of poverty
2014: Preventing violence against children
2013: Essential services for young children
2012: Children and inequality: Closing the gap
2010/2011: Children as citizens: Participating in social dialogue
2009/2010: Healthy children: From survival to optimal development
2008/2009: Meaningful access to basic education
2007/2008: Children's constitutional right to social services
2006: Children and poverty
2005: Children and HIV/AIDS

All issues of the *South African Child Gauge*
are available for download at www.ci.uct.ac.za

The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge*® since 2005 to track progress towards the realisation of children's rights.

This seventeenth issue of the *South African Child Gauge* focuses attention on early childhood development – from conception until the start of formal school. It collates the latest evidence to reflect on progress, identify challenges and point the way forward. At a time when South Africa is seeking solutions to complex societal challenges, it reminds that the answers lie in early childhood. With nurturing care and the proactive support of families, communities, and the whole of society we can protect young children from harm, enable them to thrive and build a strong foundation for national development.

> The *Child Gauge* collates and interrogates the latest research evidence from a child-centred and policy perspective. In the process of seeking to make research relevant and accessible to policymakers and practitioners, it helps to identify blind spots, knowledge gaps and areas for further enquiry.
> **Linda Richter, Distinguished Professor – DSI-NRF Centre of Excellence in Human Development, University of the Witwatersrand**

> The annual *South African Child Gauge* is without question the pre-eminent national publication on the subject of children, and society owes a debt of gratitude to the Children's Institute for this evidence-led investment in the future.
> **Jonathan Jansen, Distinguished Professor, Faculty of Education, University of Stellenbosch**

> Within the South African context, the *Child Gauge* fulfils a three-fold purpose. First it mobilises the resources of the university to promote engaged scholarship that seeks to better understand and address the challenges faced by South Africa's children. Second, it makes this evidence accessible to those in government who are responsible for the design and delivery of services for children. Last, but not least, it supports the efforts of civil society and an informed citizenry who can then challenge rights violations and hold government accountable.
> **Benyam Mezmur, Special Rapporteur on children and armed conflict in Africa – African Committee of Experts on the Rights and Welfare of the Child, and member of United Nations Committee on the Rights of the Child**

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