SOUTH AFRICAN 2013 ChildGauge

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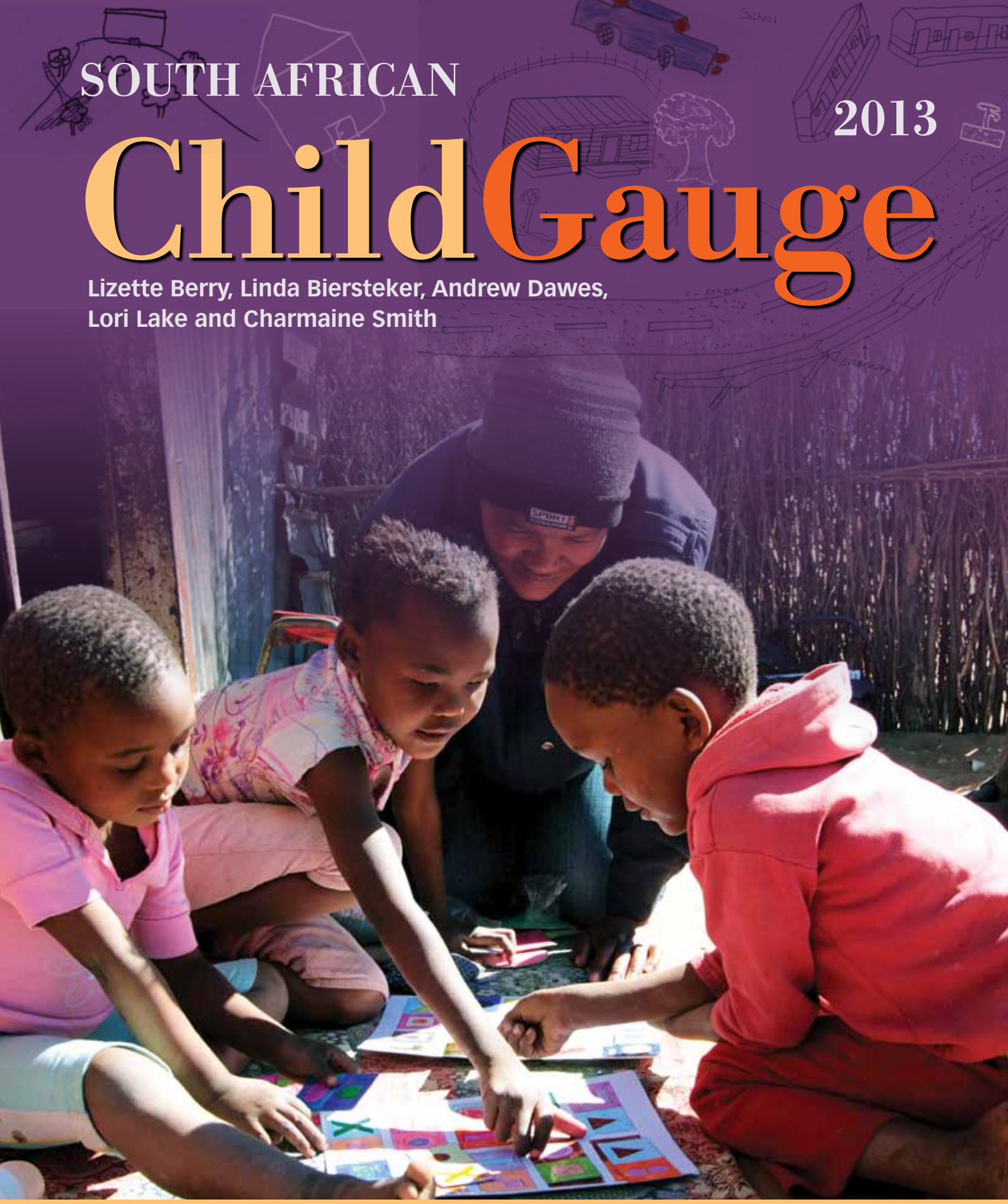
Lori Lake and Charmaine Smith



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Broad overview of the *South African Child Gauge 2013*

The *South African Child Gauge* is published annually by the Children's Institute, University of Cape Town, to monitor government and civil society's progress towards realising children's rights. This issue focuses on essential services for young children.

The *South African Child Gauge* is divided into three parts:

PART ONE: Children and law reform

Part one discusses recent legislative developments affecting children. This issue comments on litigation, law reform and policy developments including the Green Paper on National Health Insurance, the Integrated School Health Policy, a High Court ruling on consensual sex between adolescents, a Constitutional Court judgment on schools' learner pregnancy policies, norms and standards for school infrastructure, and the Policy for Social Service Practitioners. See pages 12 – 21.

PART TWO: Essential services for young children

Part two presents nine essays – the first two essays present a rationale for and outline a package of essential services and support for young children, and what is needed to build an effective system for early childhood development. The following six essays explore key service areas including nutrition, maternal and child health, caregiver support, parenting programmes, early learning opportunities and early schooling. The final essay identifies important next steps to improve service access and quality. See pages 22 – 81.

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 special subset selected from the website www.childrencount.ci.org.za. See pages 82– 114.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANAs	Annual National Assessments
ASSA	Actuarial Society of South Africa
BANC	Basic Antenatal Care
CCL	Centre for Child Law
CDG	Care Dependency Grant
CHWs	Community Health Workers
CSG	Child Support Grant
EC	Eastern Cape
ECD	Early Childhood Development
ECI	Early Childhood Intervention
DBE	Department of Basic Education
DoH	Department of Health
DoJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
EE	Equal Education
ELRU	Early Learning Resource Unit
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
FBDG	Food-Based Dietary Guidelines
FCG	Foster Child Grant
FS	Free State
GHS	General Household Survey
GP	Gauteng
GPLMS	Gauteng Literacy and Mathematics Strategy
HIV	Human Immunodeficiency Virus
HoD	Head of Department
IDP	Integrated Development Plan
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ISHP	Integrated School Health Policy
IQ	Intelligence Quotient
IUGR	Intrauterine Growth Restriction
KYB	Kago Ya Bana
KZN	KwaZulu-Natal
LP	Limpopo
MDG	Millennium Development Goal
MP	Mpumalanga
NDP	National Development Plan
NELDS	National Early Learning and Development Standards for Early Learning and Development of Children from Birth to Four Years
NHI	National Health Insurance
NIDS	National Income Dynamics Survey
NIP for ECD	National Integrated Plan for Early Childhood Development in South Africa 2005 – 2010
NQF	National Qualifications Framework
NC	Northern Cape
NW	North West
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PIRLS	Progress in International Reading Literacy Study
PMHP	Perinatal Mental Health Project
PMTCT	Prevention of Mother-To-Child Transmission
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RMS	Rapid Mortality Surveillance system
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SACSSP	South African Council for Social Service Professionals
SANHANES-1	South African Health and Nutrition Examination Survey
SASSA	South African Social Security Agency
Schools Act	South African Schools Act
SGBs	School Governing Bodies
SOCPEN	Social Pensions database
Stats SA	Statistics South Africa
STIs	Sexually-Transmitted Infections
TIMSS	Trends in International Mathematics and Science Study
U5MR	Under-5 Mortality Rate
UN	United Nations
UCT	University of Cape Town
VAD	Vitamin A Deficiency
WC	Western Cape

Foreword

Linda Richter

Distinguished Research Fellow, Human Sciences Research Council

Children develop more rapidly in the womb and during early childhood than at any other time during the human lifespan. This enables the young child to adapt proactively to the kind of world they are likely to live in. If the intrauterine[i] and early childhood environment is safe and nurturing, the child's neuro-physiological structures and functions develop according to plan. All the child's energy for growth and maturation goes into building body and brain, to forming relationships with loved ones, learning and exploring, and acquiring the knowledge and skills of their language and culture.

If these early environments are not safe or nurturing, alarms are set off in defence to ensure the child's survival. Physiological systems conserve nutrients when their supply is insufficient or unpredictable, creating the risk of later obesity, diabetes and heart disease. Babies withdraw when affection isn't available as consistently as young children need to feel safe, laying the foundation for insecure future relationships. Young children lose interest in exploring the world and asking questions when their caregivers don't encourage them, and in the face of danger and violence, infants become hyper-vigilant with raised stress levels that erode their future mental and psychological well-being.

Research over the last three decades has demonstrated beyond doubt that child and adult health, security and achievement are being formed from the moment life begins. The developing child is highly dependent on their environment and adapts to it, laying down patterns of response that become entrenched as virtuous cycles of health and capability or vicious cycles of vulnerability.

In this cycle of life, there is no going back. Children born with challenges or into a challenging environment need support, and they need it quickly. Their best chances are all stacked in the first few years of life. Children can recover quickly and get back on the path to reach their developmental potential if they and their families get the help they need. As time goes by, difficulties grow because they build on each other. A small, sickly child may make fewer friends and learn less, they may get shouted at because they're slow, and their self-esteem may suffer. All these conditions worsen if the child goes to school later, is held back in class, is teased by others and has few supportive adults to turn to. Such accumulating problems get harder to overcome, more needs to be done to address them, at greater cost, and with diminishing possibilities for success.

This is why the National Development Plan recognises that the protection and promotion of the development of young children must be part of our vision for the society we want to live in. A good beginning, during pregnancy, birth and in early childhood lays the foundation for lifelong health, learning, productivity, and harmonious relationships with others.

A *South African Child Gauge* focused on early child development comes at a very auspicious time. The Diagnostic Review of Early Childhood Development (ECD) completed in 2012 was not only the first conducted under the National Evaluation Plan, but laid the foundations for work currently underway to develop both a national ECD policy and a national ECD programme. There is growing enthusiasm and commitment, around the world and in South Africa, for broad integrated approaches to giving all children a better chance to start well, especially those who are likely to face challenges along their way.

i Inside the womb or uterus.

© Annette Champion, Bulungula Incubator

Reflections on early childhood development

The honourable Bathabile Dlamini

Minister of Social Development

It is almost 20 years since South Africa adopted its progressive Constitution. Chapter 2 of the Constitution contains the Bill of Rights, a human rights charter that protects the civil, political and socio-economic rights of all people in South Africa. In addition, the Bill of Rights contains a dedicated clause which gives children the right to a range of socio-economic rights in section 28(1)(c). The right to education is amongst others recognised in the Universal Declaration of Human Rights. For this reason the current administration has put education at the apex of its priorities.

A range of research studies and policy declarations assert that early childhood education makes a real and lasting difference in children's lives. In this regard, government is fully committed to providing the building blocks for access to quality early stimulation, education and care for all the children, with particular focus on children in vulnerable communities.

South Africa is presently on the brink of significant development in relation to the realisation of children's right to quality early education. During the 53rd National Elective Conference of the African National Congress, held in Mangaung, Free State province, we identified the provision of early childhood development (ECD) as key to our success towards achieving the goals of the National Development Plan (Vision 2030). To this end, the conference resolved to provide universal ECD services by 2014.

During the tabling of the Budget Vote this year, we set out major priorities for ECD over the Medium-Term Expenditure Framework period. We are on course to deliver on this commitment as we intensify our efforts to tackle poverty on all fronts, with particular focus on prevention and early intervention to break the cycle of intergenerational disadvantage, particularly in poor communities. In 2010, we committed ourselves to expand the coverage of ECD services. Many of the changes we promised have since been implemented. To date, over 900,000 children benefit from government's Early Childhood Development programme.

Following the Diagnostic Review report and the resolutions of the ECD conference held in 2012, we have approved a Five-Year Integrated Programme of Action, which identified the urgent need to improve rural infrastructure, human resource capacity, a new comprehensive funding model and amendment of the Children's Act.

As part of our long-term plan, the National Development Agency will continue to contribute to the ECD sector through interventions that include, amongst others, food security at ECD sites, strengthening the institutional, leadership and management capacity, as well as improve ECD infrastructure.

The government's present thrust is on the development of cohesive and integrated services through a national policy which will define the ECD service package and make it a public good.

The attainment of the commitment and priorities will make a significant difference to the lives of our children and also contribute to the attainment of the ambitious goals outlined in Vision 2030.

We welcome the publication of the *South African Child Gauge 2013* and I would like to thank both UNICEF and the Children's Institute for their long-standing commitment and contribution to improve access to quality education for the majority of South Africa's children.

We will continue to work together with our social partners to ensure implementation of the recommendations of this publication as part of our commitment to provide each child with an early start for a better future.

The honourable Angelina Motshekga

Minister of Basic Education

Early childhood is a critical period in an individual's development as this is when the foundations for physical, cognitive and emotional development are laid. The first two years of life are particularly important as a child's development during this time forms the basis for future growth and achievement.

Numerous studies have provided evidence that exposure of children to biological and psycho-social risk factors associated with poverty leads to inequalities in early development, and in turn impact on later educational achievement and life opportunities, which reinforces the cycle of poverty.

It is now commonly held that earlier educational interventions can be expected to have greater returns than later remedial interventions. Preschool education represents one such intervention. There is a considerable international literature to support the view that attending preschool can produce educational benefits that persist at least several years into schooling. Some research has even found that the benefits of preschool, and specifically of learning to read effectively at an early stage, can be compounded over time as positive effects spill over into other subject domains.

It is within the light of the above that the South African government recognises that increasing access to, as well as improving the quality of, early childhood development (ECD) provision, particularly for poor children, will contribute significantly to improving the learning outcomes of children within the basic education sector. ECD is given specific attention in the National Development Plan and also occupies pride of place in the Action Plan to 2014: Towards the Realisation of Schooling 2025.

The Diagnostic Review of Early Childhood Development records significant achievements made in the delivery of comprehensive ECD services in the country. We are proud of these. There are, nonetheless, still considerable challenges that need to be addressed.

Under the leadership of the Department of Social Development, a National Integrated Programme of Action has been developed. This plan outlines the responsibility of each of the respective departments in relation to services for young children. The Department of Basic Education is responsible for the following:

- Developing curriculum and stimulation materials (for children in the birth to four years age cohort); these inform the ECD services as articulated in the Education White Paper 5 on Early Childhood Education of 2010 and the Integrated Programme of Action for Early Childhood Development – Moving Ahead (2013 – 2018).
- Training and paying a stipend for practitioners working at registered ECD centres as part of the Expanded Public Works Programme.
- Monitoring and supporting provinces in the implementation of the services provided by the Department of Basic Education.
- Collaborating with all other departments as required.

Some of our key achievements include the following:

- A National Curriculum Framework for children birth to four years has been developed and gazetted for public comment.
- A total of 13,742 ECD practitioners have undergone training between 2009 and 2012 towards a qualification.
- A joint plan has been developed in collaboration with the ETDP SETA to develop a Recognition of Prior Learning project to address the training needs identified in the sector for implementation in 2014.
- An Integrated Programme of Action for Early Childhood Development – Moving Ahead (2013 – 2018) has been finalised in collaboration with the Department of Social Development.
- Monitoring and support visits to provinces have been conducted regularly.

Among the key challenges that are being addressed are:

- The lack of reliable data to inform the sector plan: this is being addressed through a comprehensive ECD facility audit by the Department of Social Development.
- Low minimum entry requirements for ECD practitioners working with younger children (NQF level 1): these are under consideration.

We need to continue to work together to do more for the children of this country. Quality ECD services will ensure that all children have the best start in life. Congratulations on this publication; which will add to the vast body of knowledge that we have in the country. "Every child deserves a fair chance".

The honourable Aaron Motsoaledi

Minister of Health

The vision of the Department of Health is "a long and healthy life for all South Africans".

Early childhood – especially between birth and two years of age – is increasingly recognised as a critical window of opportunity for shaping the long-term physical, cognitive, and emotional health and development of the country's future citizens.[1] Child mortality rates in South Africa have fallen substantially in recent years. Whilst efforts to consolidate these child survival gains must continue, the situation allows for, and in fact necessitates, a shift in emphasis from improving child survival to a more holistic approach to early childhood development (ECD), which focuses on ensuring that every child reaches his or her full potential. In other words, our goal is to ensure that every child enjoys their right to optimal health, nutrition and development.

In providing ECD services, the health sector is required to define an appropriate, evidence-based package of care, and then ensure that this package of services is delivered to all families, mothers and children, including and especially the most vulnerable.

With regard to the package of services, our first responsibility is to ensure that each mother receives adequate care during pregnancy and delivery in order to optimise both her own health and the health of her newborn infant. HIV infection and failure to recognise and manage obstetric emergencies appropriately have been identified as the leading causes of maternal death in South Africa[2]. Whilst the successes of the national antiretroviral programme have been well-documented, the Campaign for Accelerated Reduction in Maternal and Child Mortality in Africa strategy aims to improve maternal survival and health through intensifying training of front-line health workers in emergency obstetric care, and ensuring better access to care for women in labour through introduction of obstetric ambulances and maternity waiting homes[3].

Our package of care for young children is encapsulated in the Road-to-Health booklet, which every newborn infant receives at birth, and which can be regarded as the child's passport to health and development. The booklet contains a set of key child care messages. These include messages on infant and young child feeding which emphasise the importance of exclusive breastfeeding for six months, followed by introduction of appropriate complementary feeds. Other messages encourage caregivers to interact with and provide stimulation for their children, and alert caregivers to danger signs in the child which indicate that the child should be taken to a health facility as soon as possible.

The booklet is also a record of key health interventions which the child receives – this includes a record of the child's growth, development and the services such as immunisations and vitamin A supplementation that the child has received.

The Road-to-Health booklet therefore contains all the elements of the department's contribution to ECD, and provides a tool for coordinating the services which the child receives. The booklet should ideally be used in all interactions between the child's caregiver and health workers; this includes both professional and community health workers.

Preventive and promotive health services for young children have historically been provided at primary health care (PHC) facilities, with 2.7 million visits by children under five years being recorded at these facilities in the 2012/13 financial year.[4] The PHC restructuring process aims to ensure that services are brought closer to communities and households through deployment of PHC or ward-based outreach teams. Each outreach team comprises a nurse and a number of community health workers who play an important role in providing health education and other health promotion activities, and in ensuring and assisting mothers and children to access preventive and curative health services, as well as services provided by other sectors. Outreach teams in collaboration with school health services will also ensure that children attending ECD centres receive preventive and promotive health services.

Although the Diagnostic Review of Early Childhood Development[5] undertaken in 2012 concluded that many elements of comprehensive ECD support and services were already in place, important gaps were also highlighted. Reducing stunting among young children and improving services for children with disabilities represent important challenges for the health sector. The Department of Health is committed to working with other government departments as well as other stake-holders in addressing these and other challenges and working tirelessly to improve the health and development of young children in South Africa.

1 Grantham-McGregor S, Cheung YB, Cueto S, Glewwe P, Richter L, Strupp B (2006) Developmental potential in the first 5 years for children in developing countries. *The Lancet*, 369(9555): 60-70.
2 National Committee for Confidential Enquiry into Maternal Deaths (2012) *Saving Mothers 2008 – 2010: Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa*. Pretoria: Department of Health.
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5 Richter L, Biersteker L, Burns J, Desmond C, Feza N, Harrison D, Martin P, Saloojee H & Slemming W (2012) *Diagnostic Review of Early Childhood Development*. Pretoria: Department of Performance, Monitoring and Evaluation & Inter-Departmental Steering Committee on ECD.

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PART ONE:

Children and Law Reform

Part one examines recent policy and legislative developments that affect children in South Africa.

These include the:

- Green Paper on National Health Insurance
- Integrated School Health Policy
- High Court ruling on the Sexual Offences Act
- Schools' learner pregnancy policies
- Norms and standards for school infrastructure
- Policy for Social Service Practitioners

Legislative and policy developments 2012/2013

Paula Proudlock, Lori Lake, Lucy Jamieson (Children's Institute) and Lisa Draga (Equal Education Law Centre)

This review provides a description of and commentary on key legislative and policy developments affecting children over the past year. These include:

- Two new policies that promise improved health services for children – the Green Paper on National Health Insurance and the Integrated School Health Policy.
- Progress towards binding Minimum Norms and Standards on School Infrastructure which will contribute towards improvements in the quality of education.
- Direction from the Constitutional Court that schools' policies on pregnant learners should support pregnant learners to complete their schooling.
- A judgment by the High Court declaring the Sexual Offences Act unconstitutional for criminalising consensual sexual activity between adolescents.
- The finalisation of the Policy for Social Service Practitioners which aims to introduce a more equitable system for recognising and regulating the different categories of practitioners required to implement the Children's Act.

Green Paper on National Health Insurance

Globally, many countries are moving towards universal coverage in health care – this includes strengthening health systems to ensure equal access to quality services, and pooling financial risks so that health care costs do not put undue burden on poor and vulnerable households.[1]

In South Africa, the re-distribution of resources between the private and public health sector is key to achieving universal coverage. Private health insurance accounts for 44% of total health care expenditure, yet covers a relatively small proportion of middle- and high-income households concentrated in urban areas, while the under-resourced public health system is under pressure to deliver services to 85% of the population.[2] A further area of concern is the unequal distribution of health professionals between urban and rural areas. For example, only 12% of doctors work in the rural areas[3] which are home to 47% of the child population[4].

A Green Paper on National Health Insurance (NHI), outlining plans to ensure a more equitable distribution of financial and human resources, was released for public comment in 2011, and a White Paper is expected by the end of 2013.

The vision

The aim is to create a more equitable health system by:

- providing better access to quality health services for all South Africans;
- creating a single NHI fund to pool risks and resources;
- procuring services from accredited public and private providers on behalf of the whole population; and
- strengthening the performance of the public health system.

The Paper proposes a comprehensive, evidence-based, rights-based and cost-effective package of health services at all levels of care. Funds from the state fiscus, employers and individuals will be pooled in an NHI Fund to purchase health services on behalf of the population from accredited public and private health care providers.

The re-engineering of primary health care (PHC) is a core element of the plan and aims to revitalise the district health system. There is a strong emphasis on health promotion and prevention in addition to curative and rehabilitation services, and on community outreach to ensure that health care services reach those most in need. These PHC services will be delivered through three complementary streams:

1. District clinical specialist support teams will provide leadership at a district level with a focus on maternal and child health. The teams will provide training, mentoring and support to all health personnel to improve access to, and the quality of, services, and to ensure better health outcomes. These teams should comprise a principal obstetrician, gynaecologist, paediatrician, family physician, anaesthetist, midwife and PHC nurse. The Paper indicates that this composition is a starting point and districts can add to the team over time.
2. School health teams led by a professional nurse will do learner assessments, referrals, and health education with a focus on hygiene, nutrition, HIV and AIDS, abuse, mental health, and sexual and reproductive health.
3. Municipal ward-based outreach teams comprising community health workers, environmental health officers, health promotion practitioners and a professional nurse will extend the reach of health services.

Implementation

A phased implementation plan identifies the key systems needed to support the full transition by 2025. These include:

- setting national standards and quality assurance;
- investing in human resources;
- assessing and modernising health infrastructure and equipment;
- improving hospital management, administration and accountability;
- strengthening district health authorities;
- improving information management systems; and
- establishing pilot districts to cost and field test systems at district level.

Phase 1 (2011 – 2015) is currently underway:

- The National Core Standards for Health Care Establishments[5] provide a benchmark against which the quality of health establishments can be assessed, a national baseline audit of health care facilities[6] has been conducted, and an Office for Health Standards Compliance has been established to monitor standards.
- Eleven pilot districts, identified in 2012, are testing new interventions needed for the successful implementation of the NHI.[7]
- The National Human Resources for Health Strategy[8] has started to outline norms, staffing and training requirements and recognises the need to provide incentives to strengthen services in rural areas.

Commentary

The strong focus on primary health care, maternal and child health, and the proposed multidisciplinary composition of the various district health teams reflects the plan's emphasis on improving child and maternal health outcomes.

The adoption of a PHC approach gives effect to South Africa's obligations in terms of the child's right to health in the United Nations Convention on the Rights of the Child.[9] However, the lack of any reference to palliative health care services as part of the continuum of health care services under a PHC approach is of concern given South Africa's high HIV-prevalence rates.

Current shortages of health and allied professionals pose a major barrier to the implementation of the plan in all districts, especially in rural areas. The system will need to be flexible and innovative in addressing staff shortages and ensure a more equitable geographical spread of human resources.

Given the high rates of child abuse and neglect in South Africa and their impact on child health and development, it is important that the district health teams include or are expressly linked to child protection practitioners. This is a clear gap in the Green Paper that will hopefully be addressed in the White Paper. Due to chronic staff shortages in the child protection system, the categories of child protection practitioners that can serve on or support these teams need to include the full range of available social service practitioners.

Integrated School Health Policy

With nearly 11 million children attending school in 2011,[10] schools provide one of the most effective locations for providing health services to children. School health services aim to promote the physical, mental and social well-being of learners in order to maximise their learning capabilities. Health services at schools contribute therefore both to the realisation of children's rights to health and their rights to education.

A review[11] of South Africa's school health services notes large inequities between and within provinces, with low coverage at sub-district, school and child level. This stems in part from the challenges of integrating school health services into a new and still developing District Health System, where school health services are often put "on the back-burner" due to staff shortages and competing clinic-based demands.

> *In one of the rural research sites one of the nurses has 70 schools in her area, but she only managed to cover 20 since 2005. This coverage rate suggests that all 70 schools will be covered over a 12 year period only. This situation is especially prevalent in schools that are located far from clinics, many of these invariably being schools in the most disadvantaged areas.*[12]

A recent audit of health care facilities[13] reveals serious staff shortages at primary level and raises questions about health facilities' ability to respond to referrals from school health teams: 47% of clinics report no visit from doctors, whilst 52% of community health centres cannot offer proper dental services. Most facilities have no optometrists (89%), physiotherapists (72%), occupational therapists (74%), psychologists (82%), speech therapists (89%) or social workers (70%).

Acknowledging these challenges, the Departments of Health (DoH) and Basic Education (DBE) published the Integrated School Health Policy (ISHP)[14] in 2012. It aims to:

- *provide preventive and promotive services that address the health needs of school-going children and youth with regard to both their immediate and future health,*
- *support and facilitate learning through identifying and addressing health barriers to learning,*
- *facilitate access to health and other services where required, and*
- *support the school community in creating a safe and secure environment for teaching and learning.*

The policy aims to achieve broader provision and more equitable coverage of school health services. While implementation of the 2003 policy[15] focused primarily on screening for visual and hearing impairments of grade R and grade 1 learners, the new policy aims to introduce a comprehensive package of health care services for all learners from grade R to grade 12.

The package has a strong focus on health education and supplements the health education in DBE's life orientation

curriculum, with co-curricular activities to prevent risk behaviour; educate children about sexual and reproductive health, chronic illnesses and abuse; and promote good health and nutrition. These health education activities will be provided by health promoters, community health workers and/or non-governmental organisations.

While the 2003 policy focused on screening in the foundation phase, the new policy aims to assess each learner during each of the four education phases (grades R, 4, 8 and 10). Assessments include anthropometric[i] screening; assessments of oral health, vision, speech and basic hearing, fine and gross motor problems, chronic illness (including tuberculosis and HIV/AIDS); and psycho-social risk assessments.

Assessments in the foundation phase will focus on identifying barriers to learning, whilst mental health and sexual and reproductive health will be emphasised in high school including contraception, HIV counselling and testing for sexually-active learners either on site or at the nearest primary health care (PHC) clinic.

The ISHP outlines both departments' responsibilities at national, provincial, district, primary health care facility and school levels and recognises that strong partnerships between schools, communities and service providers are essential.

The policy describes how school health teams (as outlined in the National Health Insurance Green Paper) will be based in PHC clinics and led by a professional nurse, and may be assisted by an enrolled nurse or nursing auxiliary, with one nurse for every 2,000 learners. The professional nurse will coordinate the delivery of school health services, do learner assessments and provide on-site services, while health education will be delivered by health promoters or community health workers.

The policy includes a section on children's consent to school health services and states that:

> *Learners below the age of 18 years should only be provided with school health services with written consent of their parent or caregiver. However learners who are older than 14 years may consent to their own treatment, although they should be advised to inform and discuss their treatment with their parent or caregiver.*[16]

Commentary

It is vital to address potential barriers to the successful implementation of the ISHP. These include staff shortages; a lack of transport; insufficient basic equipment such as scales to weigh children; a lack of privacy at schools; inadequate referral systems;[17] and insufficient public sector physiotherapists, occupational therapists and psychologists to provide follow-up services at health facilities.[18] Possibly in recognition of these barriers, the ISHP provides for a progressive, phased implementation starting with younger learners in the most disadvantaged schools and extending services upward and outwards to reach all learners.

A mapping exercise will be needed to identify schools and districts with poor child health and education indicators, schools where health care services are non-existent, and districts where school health care nurses have unmanageable case loads. Provincial Health Departments are ultimately responsible for ensuring that the most disadvantaged districts receive the necessary capacity development and financial and human resources to implement the ISHP effectively.

For some unexplained reason, the ISHP's provisions on children's right to consent to treatment is based on the 1983 Child Care Act[19] which enabled children to consent to medical treatment from the age of 14. However, this Act's provisions were repealed on 1 April 2010 and replaced by new provisions in the Children's Act.[20] The new Act reduced the age of consent to medical treatment to 12, provided the child is mature enough to understand the risks, benefits and other implications of treatment. The Act also stipulates that the health status of children is confidential and health professionals may only breach confidentiality if it is in the child's best interests (as in the case of abuse).

The ISHP's stipulation of 14 as the age at which children can consent to health care services is also out of sync with another recently published DoH policy – the National Contraception and Fertility Planning Policy and Service Delivery Guidelines[21] which correctly follows the Children's Act and stipulates the age of consent as 12 years.

Sexual Offences Act: High Court rules criminalisation of consensual sex between adolescents unconstitutional

The primary intention of the Sexual Offences Act[22] is to protect children from abuse and exploitation by adults by setting the age of consent to sexual activity at 16. However, the Act also makes it a sexual offence for children aged 12 – 16 to engage in consensual sexual activities (ranging from kissing to penetration). The Act obliges adults to report a known sexual offence to the police – even if those involved are consenting adolescents. The constitutionality of these provisions was challenged by the Teddy Bear Clinic and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) in the North Gauteng High Court on the grounds that they do not serve the best interest of children. The Minister of Justice and Constitutional Development opposed the application.

In the judgment, the court noted that all the parties to the case, including the Minister (even though he had opposed the application), agreed that "it is a common and normal part of sexual development for children to explore and experiment in sexual behaviours with their peers".[23] The court further noted that the duty to report sexually active adolescents limits the ability of adults to provide education, guidance and support to children in their sexual development.

The court found that the Act constitutes an "unjustified intrusion of control into the intimate and private sphere of children's relationships in a manner that will cause severe harm"[24]

i Measuring children's weight and height to assess their nutritional status.

and declared that the criminalisation of consensual teenage sexual activity, and consequent reporting to the police, violate a number of constitutional rights. These include the best interests' principle, dignity, bodily and psychological integrity, and privacy. In finding the provisions unconstitutional, the court concluded that "[t]he use of damaging and draconian criminal law offences to attempt to persuade adolescents to behave responsibly is a disproportionate and ineffective method which is not suited to its purpose".[25]

As the case concerns a declaration of unconstitutionality of an Act of national Parliament, it has to be confirmed by the Constitutional Court, which heard the case on 30 May 2013.[26] The Department of Justice and Constitutional Development (DoJ&CD) is opposing the application for confirmation by the Teddy Bear Clinic and RAPCAN. Based on the assumption that the law acts as a deterrent, the DoJ&CD claims that the prohibition protects "the bodily and psychological integrity of adolescents by delaying their choice on matters which may have a harmful consequence"[27] and that "parents, guardians and other responsible adults will be empowered to drive the message of risks of early sexual intimacy through these prohibitions"[28]. The department further argues that "there are no other less restrictive means to achieve the purpose of the prohibitions".[29]

The Constitutional Court will consider all the arguments before making a ruling.

Commentary

Sexual experimentation by adolescents is a normal part of growing up. However, adolescents' health and well-being may be at risk if they engage in sexual activity without the necessary knowledge about contraception, sexually-transmitted infections (STIs) and HIV, and before they are mature enough to understand and handle the emotional and health consequences. Everyone agrees that it is in the best interests of children to minimise these risks; the debate is about the most reasonable and effective way to do this.

Research has shown that while a mandatory reporting and abstinence-only approach is not an effective deterrent, "comprehensive sex education programmes have shown an increased likelihood in delaying sexual initiation and reduced likelihood of teen pregnancy".[30] Using an evidence-based approach, all adolescents should therefore be offered appropriate education and guidance on sexual and reproductive health from their parents and caregivers and at school and health care facilities.

Criminalising adolescents for engaging in developmentally normal behaviour is an extreme measure that not only violates their rights but may also prevent them from approaching their parents, educators, social workers, nurses and other support people for guidance, information, contraception, treatment of STIs and HIV, and advice on options and services if they fall pregnant. The DoH has explicitly recognised these risks in its 2012 Contraception Policy and therefore advises health professionals to enable adolescents to have access to counselling, contraception and health care services rather than follow a rigid approach to the reporting obligations:

> *The overarching public health imperative to prevent teenage pregnancy and prevent HIV and STIs needs to guide the provision of quality health services for young people. Every effort should therefore be made to provide accessible sexual and reproductive health services that take into account young people's vulnerability, psychosocial needs and their right to confidentiality. All initiatives should focus on prevention and, where this fails, to provide safe, quality youth-friendly services. This needs to be the overriding ethos, and should be counter-balanced with the rigid implementation of the reporting obligations.*[31]

The Child Justice Act[32] and Sexual Offences Act give discretion to police officers and prosecutors on whether or not to arrest and prosecute adolescents for consensual sexual activity. Would it not be more appropriate for health and social professionals – who are better qualified to assess the psychological and other risks to the child – to assess what is in each child's best interests? Parents and social and health professionals should have the freedom to determine their actions based on the best interests of the child; however, the Sexual Offences Act compels them to report even healthy sexual experimentation. The decriminalisation of consensual sexual activities between adolescents would allow parents and professionals to balance children's rights to protection, access to health services and confidentiality.

South African Schools Act: Schools should support pregnant learners

In March this year the Constitutional Court heard argument concerning the learner pregnancy policies of two Free State schools: Welkom and Harmony High. The schools' pregnancy polices excluded pregnant learners from school for a period of up to one year while pregnant and after giving birth.

Based on their policies the schools excluded two learners from school due their pregnancies. The head of the Free State Department of Education (HoD) instructed the schools to re-admit the learners. While the schools' principals eventually agreed to re-admit the learners, their school governing bodies (SGBs) launched a High Court application to prevent the HoD from interfering with the implementation of school policies on the basis that the HoD had no authority to override SGB policies in terms of the South African Schools Act (Schools Act). The HoD argued that the policies were unconstitutional and that he was obliged to intervene to protect the learners' rights. The SGBs succeeded in both the High Court and the Supreme Court of Appeal, so the HoD appealed to the Constitutional Court. Equal Education (EE) and the Centre for Child Law (CCL), University of Pretoria, acted as *amici curiae* (friends of the court).

The case was primarily concerned with the balance of power between HoDs who, through principals, are responsible for the management of schools (including implementing school policies), and SGBs, who are given certain defined powers under the Schools

Act to govern schools (including the power to craft school policies). The Court therefore had to consider whether the HoD had the authority under the Constitution and the Schools Act to instruct the principals to act against policies adopted by the SGB. The second issue which the Court was asked to rule on was whether the schools' policies on pregnant learners were constitutional from a content perspective.

EE argued that HoDs do have the power to intervene because they are obliged by the Constitution to respect, protect and fulfil pregnant learners' rights to human dignity, to receive a basic education, and not to be subjected to unfair discrimination. EE also contended that the pregnancy policies constitute unfair and double discrimination on the basis of both gender and pregnancy. It was submitted that the discrimination on the basis of gender in the pregnancy context is even more reprehensible when viewed in light of the societal dynamics that lead to young girls falling pregnant, which include skewed power relations, lack of organised sexual counselling in schools, non-availability of condoms and, sometimes, impregnation by teachers.[33]

The CCL made similar arguments concerning the content of the policies and also brought to the Court's attention that the policies were contrary to the state's obligations in terms of the African Charter on the Rights and Welfare of the Child, which requires states' to adopt policies and practices that encourage pregnant learners to return to school.[34]

As the High Court case was framed on the scope of the HoD's powers under the Schools Act, and not as a constitutional challenge to the content of the policies, the majority of the Constitutional Court judges did not make a definitive pronouncement on the constitutionality of the policies. Instead the Court stated that, on face value, the policies violated pregnant learners' rights to basic education, dignity, privacy and equality.[35] The Court ordered the two SGBs to revisit their pregnancy policies in consultation with the HoD and to furnish the Court with the revised policies.

Commentary

While the Court did say that pregnancy policies which punish pregnant girls are unacceptable and that learner pregnancy policies should be aimed at supporting pregnant learners, and while the Court ordered the two schools involved in the case to revise their policies, the judgment does not provide a systemic solution to the on-going exclusion of pregnant pupils from schools across the country.[36]

The kind of discriminatory practices evident in these two schools has been caused in part by unclear national policy on the rights of pregnant learners. The Department of Education's 2007 Measures for the Prevention and the Management of Learner Pregnancy[37] – while aiming to address discriminatory practices – also champion the view that a pregnant learner may be required to take a leave of absence of up to two years to "exercise full responsibility for parenting". In addition, it states that pregnant learners will not be allowed to return to school in the same year that they took time off to give birth. As a result many schools tailored pregnancy policies that compel pregnant learners to leave schools for extended periods of time. Notwithstanding a 2009 letter by the Director-General to all HoDs stating that "the measures have caused significant confusion",[38] they have not been clearly revoked or amended and schools are still excluding pregnant learners.

The Minister can remedy this by unequivocally revoking the 2007 policy and publishing a new national policy on pregnant learners based on the direction provided by the Constitutional Court. This would provide the necessary clarity to schools across the country.

South African Schools Act: The need for binding norms and standards on school infrastructure

Most public schools in South Africa lack the necessary resources and facilities to provide learners with quality education. Of the 24,793 public schools in the country, 14% of schools have no electricity, 46% use pit-latrine toilets and 95% have no science laboratories.[39]

Parliament added section 5A to the Schools Act in 2007 to empower the Minister of Basic Education to adopt regulations prescribing national minimum norms and standards for school infrastructure. When promulgated, these standards will set the basic level of infrastructure that every school must meet to function properly. The National Development Plan also recognises that it is only through minimum standards carrying the force of law that the Minister (and provincial ministers) can ensure that officials involved in planning, constructing and improving school infrastructure do not deliberately ignore these standards.[40] However there has been a long delay in finalising the regulations.

After many years of dialogue and advocacy without results, Equal Education (EE) filed an application in the Bhisho High Court. EE argued that the Minister's failure to promulgate the regulations was a violation of learners' rights to a basic education, dignity and equality, and a breach of obligations under the Schools Act. Twenty-four affidavits from principals, teachers and parents from public schools across the country detailed the poor conditions of school infrastructure and the negative impact of inadequate school facilities on teaching and learning. The poor conditions highlighted included unhygienic and non-functioning toilets; leaking roofs; decaying walls and floors; overcrowded classrooms; and the lack of running water, electricity, libraries and computer and science laboratories. The Minister's court papers acknowledged the "serious inadequacies and shortcomings in relation to infrastructure at many schools … across the country".[41]

In November 2012, just before the court case was to be heard, the Minister entered into a settlement agreement with EE in which she committed to publish draft regulations for comment by January 2013, and promulgate final regulations by May 2013. However the draft regulations published in January failed to set minimum standards and lacked detail on a number of crucial areas.

When the May deadline passed and the Minister had not introduced the regulations, EE turned back to the court for assistance. In July the High Court made an "order by consent" that the Minister should publish amended draft regulations for

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Mud schools in the Eastern Cape highlight the need for norms and standards.

comment by 12 September 2013, and final regualtions by 30 November 2013. The regulations must also contain timeframes for the provincial departments to comply with the minimum norms and standards.

Commentary

The key virtue of binding minimum norms and standards coupled with tangible deadlines is that they will introduce better planning and greater accountability into the education system. This includes top-down accountability of the Minister over provinces who are not delivering, by HoDs over principals who are not delivering, and most importantly accountability bottom-up from communities, parents and children themselves.

Policy for Social Service Practitioners

The Children's Act allocates tasks to "social service professionals", whom it defines as a "probation officer, development worker, child and youth care worker, youth worker, social auxiliary worker and social security worker".[42] However, the Act provides that only professionals who are registered under the Social Service Professions Act[43] may perform these functions.

Currently the only social service professionals that can register with the South African Council for Social Service Professionals (SACSSP) are social workers, social auxiliary workers and student social workers. While child and youth care workers have been performing child care and support services for more than three decades, they have faced many obstacles in gaining professional recognition. The recently inaugurated Professional Board for Child and Youth Care Workers has drafted regulations and a code of ethics that will allow child and youth care workers to register; however, these regulations have not yet been approved by the SACSSP.

The purpose of regulating professions is firstly to ensure that services are delivered by appropriately trained and skilled people who are bound by a code of conduct and ethics. Secondly, it is to ensure that professionals are supported by standardising education and training, and by developing career paths. In this way, people are attracted to the profession allowing numbers to grow and services to reach more children.

The Social Service Professions Act treats social workers differently to other social service professionals, for example, social workers are overrepresented on the SACSSP and elect six representatives, whilst other professions elect only three. This has made it difficult for new professions to gain recognition. For these and other reasons there is a need for new policy and legislation to regulate the different professions and to provide a more equitable regulatory framework. This will enable professions to grow and will assist the creation of a truly multidisciplinary workforce to implement the Children's Act effectively.

After stakeholder consultation, the Department of Social Development (DSD) published the Policy for Social Service Practitioners in January 2013[44] which seeks to address the obstacles to the expansion of the social service workforce by:

- recognising all practitioners in the field;
- creating mechanisms for planning the workforce;
- acknowledging the right to self-determination of existing practitioner groups such as child and youth care workers and community development practitioners; and
- improving education and training initiatives.

Commentary

The finalisation of the policy paves the way for the completion of a new law to recognise and regulate all social service practitioners. There is some urgency in this to enable recognition, career paths and regulation for the 10,000 child and youth care workers that will be trained and deployed to reach vulnerable children over the next five years as part of the Isibindi[ii] roll-out. The DSD has committed to finalise the new law in 2014/15.[45]

Conclusion

The developments outlined above promise improved health care services, education, and care and protection for children. However, the realisation of these improvements is heavily dependent on coherence across the various policies and laws and on the various departments ensuring that they plan and implement together. Such a coordinated approach will not only ensure improved access to quality services for children but would also enable the various sectors to pool resources and therefore deliver services more cost effectively.

The partnership approach followed by the national Department of Health (DoH) and the Department of Basic Education (DBE) in developing and publishing the Integrated School Health Policy (ISHP) bodes well for partnership at the provincial level of implementation. While the national Department of Social Development (DSD) was unfortunately not a formal partner in the development and publication of the ISHP, the policy does refer to a commitment by the DoH and the DBE to closer collaboration with the DSD.

At a national and provincial level, the three departments need to plan and implement together to be able to respond appropriately to the social and health needs of the high numbers of abused, neglected, orphaned and otherwise vulnerable children that will be identified in the school health assessments. Given that civil society organisations deliver the majority of child care and protection services in the provinces, the participation of civil society service providers in planning and implementing the National Health Insurance (NHI) and ISHP is also essential.

The lack of coherence between the Sexual Offences Act, Children's Act, the ISHP and the National Contraception Policy in relation to the provision of sexual and reproductive health and social services to adolescents is concerning. The preference of Department of Justice and Constitutional Development (DoJ&CD), as set out in the Sexual Offences Act and demonstrated by their arguments in court, is for adolescents between the ages of 12 and 16 who engage in consensual sexual activity to be dealt with via the criminal justice system. The Children's Act however guarantees children's right to development and therefore enables children's access to contraception and to make decisions about medical treatment from age 12. The ISHP, published jointly by the DoH and DBE, confuses matters by stipulating 14 as the age at which children can consent to health services despite being bound by the Children's Act to stipulate the age of 12. On the other hand, the Contraception Policy, also issued by the DoH, adheres to the Children's Act's prescribed age of 12 and encourages health professionals to focus on preventing HIV, sexually-transmitted infections, and teenage pregnancy by providing accessible and sensitive adolescent reproductive and sexual health services rather than following a rigid approach to the reporting requirements set out in the Sexual Offences Act.

The result of these contradictory policies and laws is confusion amongst the various officials and professionals tasked with serving children's best interests. To address this lack of coherence and ensure accessible health care services for adolescents, both the Sexual Offences Act and the ISHP and all future policies, including the national learner pregnancy policy, should be brought in line with the provisions of the Constitution and the Children's Act.

The successful implementation of each of these laws and policies is dependent on the successful implementation of the others. For example, the ISHP and PHC re-engineering with their strong focus on child health, are dependent on schools having the necessary infrastructure to ensure children have access to clean water and adequate sanitation. The ability of district-based health teams and school nurses to assist abused and neglected children is dependent on the DSD ensuring that there are sufficient numbers of appropriately trained social service practitioners to provide a timeous and caring protective and therapeutic response for traumatised children. Making sexual and reproductive education and health services accessible to adolescents will help reduce learner pregnancy while a national policy that supports pregnant learners to finish their schooling will improve young mothers education outcomes and the health, development and education outcomes of their children.

The successful implementation of both the NHI and ISHP is hampered by a critical shortage of health and allied professionals as well as social service professionals, particularly in rural areas. While there are plans to increase the numbers of professionals available and to incentivise work in rural areas, the shortages are so bad that more inventive approaches are needed to see improvements in the short to medium term. If the three departments involved could pool their existing human resources – particularly community health workers and child and youth care workers – to work in an integrated manner and align their selection of districts most in need, we could see major improvements in child health and well-being.

ii Isibindi is a support programme for orphaned and vulnerable children developed by the National Association of Child Care Workers (NACCW) and implemented by a range of non-governmental organisations in all the provinces.

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PART TWO:

Essential services for young children

Part two presents a series of nine essays that motivate for a package of essential services and support for young children and their caregivers, in order to step up national development.

The essays motivate for:

- an essential package of services for young children
- an effective ECD system
- improved delivery of nutritional support services
- an expanded role for health care services
- greater support for caregivers
- effective parenting programmes
- increased access to early learning programmes
- quality schooling in the foundation phase
- important next steps to enhance service delivery

Overview

Part 2 motivates for early investment in the lives of young children and presents a package of *essential services and support for young children* in order to enhance their developmental outcomes and improve their life chances, thereby significantly contributing to national development in the long run.

1. Getting the basics right: An essential package of services and support for ECD

(pages 26 – 33)

Early childhood development services play a critical role in mitigating the effects of poverty and giving South Africa's children the best start in life. This essay outlines an essential package of services for young children that can be delivered through a variety of different channels in order to support children and caregivers throughout the early childhood period – from conception to the foundation phase of schooling.

2. Strengthening ECD service delivery: Addressing systemic challenges

(pages 34 – 43)

South Africa needs to address a range of systemic challenges in order to improve quality and ensure more equitable access to ECD services. This essay outlines the key ingredients for an effective ECD system which include: enabling policies, population-based planning, good governance, adequate resourcing and effective service delivery at local level.

3. Promoting healthy growth: Strengthening nutritional support for mothers, infants and children

(pages 44 – 49)

Good nutrition in the first 1,000 days of life is associated with improved health and education outcomes so the high levels of malnutrition amongst young children in South Africa is a serious concern. This essay outlines a series of six key interventions that are known to address malnutrition and identifies a number of different strategies to ensure these interventions are extended to all young children, especially those most in need.

4. Beyond survival: The role of health care in promoting ECD

(pages 50 – 55)

This essay outlines a range of interventions that can be integrated within a broader package of maternal and child health services to promote children's development, and stresses the need to address systemic barriers and to shift thinking towards supporting the well-child. It also motivates for the improvement of early intervention and referral systems to support children at risk.

5. Caring for the caregiver: A framework for support

(pages 56 – 61)

The health and wellbeing of caregivers is the single most important contributor to children's survival and development. Yet poverty, illness, violence and social isolation can affect caregivers' ability to cope and care for children. This essay motivates for caregivers' access to good health care, nutrition, child care, psycho-social and material support so that they are better able to respond to their children's needs.

6. Rising to the challenge: Towards effective parenting programmes

(pages 62 – 65)

Parenting programmes can help caregivers understand how to support children at different stages of development, manage their children's behaviour and build their self-esteem. There are very few parenting programmes in South Africa – particularly in poor and rural settings, and those that exist struggle to provide services effectively. This essay offers possibilities for strengthening and extending the delivery of parenting programmes in South Africa.

7. Learning begins at birth: Improving access to early learning

(pages 66 – 71)

Children from birth to five years are learning at a rapid rate. While younger children learn best within the home environment, this essay argues that older children (3 – 5 years) benefit from group programmes where a focus on emerging literacy and numeracy skills provides a strong foundation for school readiness. The essay motivates for a multi-pronged approach to the delivery of quality early learning programmes.

8. Building strong foundations: Improving the quality of early education

(pages 72 – 77)

While South Africa has made significant progress in increasing access to grade R and schooling in the foundation phase, learner performance is poor. This essay argues that the quality of children's early schooling needs to be addressed before considering introducing an additional year of preschool education, and that teacher education is key to improving outcomes.

9. ECD services in South Africa: What are the next steps?

(pages 78 – 81)

This essay highlights key conceptual shifts that need to underpin future policy and programme development, and identifies critical next steps to address service gaps, improve service delivery and reach priority groups.

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It is vital that affordable and well-resourced early childhood development programmes reach children in rural areas.

Box: Key terms

Early childhood development: The processes by which children from conception to at least nine years grow and thrive – physically, mentally, emotionally, spiritually, morally and socially.[1]

Primary caregiver: The person primarily responsible for the daily care and well-being of a child.

ECD service: An ECD *service* promotes the development of young children, and is usually provided by someone who is not the child's caregiver.

ECD programme: An ECD *programme* consists of planned activities, offered within an ECD service, such as a maternal and child health service, to provide interventions to support a child's development.

Centre-based services: ECD services that are provided at a facility, such as an ECD centre.

Non-centre-based services: ECD services that are provided in communities or family homes. They are also referred to as home- and community-based services or out-of-centre sersvices. They include home-visiting services, playgroups and toy and book libraries.

Integrated: An integrated approach to service delivery involves thinking about the whole child and what is needed to meet the child's physical, psychological and social needs. Integrated services often involve partnerships between different role-players. Formal integrated services are usually jointly funded, managed, implemented and evaluated and operate seamlessly at a local level.[2]

Inter-sectoral: Two or more sectors such as health, education and social development working closely together to ensure that the full range of children's needs is met.

Multisectoral: More than one sector involved in the delivery of services to young children.

Delivery channels/platforms: The vehicle or mechanism through which an ECD service is delivered. These may include home visits, ECD centres, health facilities and playgroups.

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Getting the basics right: An essential package of services and support for ECD

Lizette Berry (Children's Institute), Andrew Dawes (Department of Psychology, University of Cape Town and Ilifa Labantwana) and Linda Biersteker (Early Learning Resource Unit)

South Africa sits on the cusp of a new dispensation. The National Development Plan (NDP)[1] recognises investment in early childhood development (ECD) and education as central in building a more developed and productive society by 2030. The prioritisation of ECD in the NDP provides an opportunity to fashion the next generation of South Africa's citizens, and improve the nation's economic, social and political environment.

Over the next 17 years, South Africa has a unique opportunity to do things differently, and to ensure that children born in 2013 will be far better equipped for a productive adult life by 2030. At the same time, a child rights lens demands a focus beyond children's potential contribution to the adult workforce, and the recognition, promotion and nurturing of their intrinsic value and abilities as young citizens. How do we seize the opportunity? And where do we start?

This *South African Child Gauge* recognises that child development begins *before birth*, and outlines a package of essential services and support from conception to early schooling aligned with national policy and international child rights instruments.[i]

This essay responds to the following questions:

- Why is early childhood a critical stage?
- Why should ECD be prioritised in South Africa?
- What are ECD services?
- Delivery is a major challenge – where do we start?
- How are essential ECD services and support delivered appropriately?

Why is early childhood a critical stage?

Recent research reaffirms the significance of ECD in determining future health, behaviour and learning.[2] The first 1,000 days of life (from conception to two years old) is a particularly sensitive and rapid period of development. Healthy brain development largely depends on the quality of the environment before birth and in the first 24 months.[3] Infants and young children develop best when caring adults respond with love, warmth and consistency, providing opportunities for interaction and learning.[4]

Poverty and related problems such as poor health and nutrition, deficient care, and limited stimulation – particularly when they act together – have negative effects on early development.[5] These factors can contribute to a trajectory of poor health and schooling outcomes that perpetuate the cycle of poverty.[6]

However, protective influences such as good nutrition, health care, supportive parenting and opportunities for early learning can nurture positive development – including good health and academic outcomes, economic productivity, responsible citizenship and effective parenting of the next generation.[7] Such opportunities must be maximised for children in poverty who bear the brunt of developmental risks[8] and who have been shown to benefit most from ECD interventions[9].

Why should ECD be prioritised in South Africa?

Early childhood is a vulnerable period and a supportive living environment and enabling social and political context are fundamental to ensure children's sound development.

Multiple risks affect young children's development

Young children[ii] in South Africa grow up in a profoundly unequal society[10] in which poverty threatens the sound early development of the majority of children. Exposure to crime and violence is significant[11] and South Africa's under-five mortality rate is inordinately high for a middle-income country[12]. Malnutrition, HIV and childhood illnesses remain key drivers of under-five mortality.[13] Many of these deaths can be avoided through simple and timely responses. While South Africa has, in recent years, experienced a decline in child mortality rates due to significant take-up in HIV prevention and treatment programmes, a large number of children are living with HIV.[14]

Unfavourable environmental conditions such as poor housing infrastructure, lack of access to adequate water, sanitation facilities and poor hygiene in the home contribute to infections and disease, particularly in young children. Malnutrition, childhood illness and a lack of early stimulation continue to compromise children's cognitive development and later school performance.

Table 1 starkly presents the multiple risks and vulnerabilities children are exposed to early in life. If the NDP's vision is to be realised, access to sound programmes that nurture children's basic health and nutrition, improve their living environments, support caregivers, offer stimulation for early learning, and provide referrals to appropriate health care and social services[15] are essential.

i For example: the United Nations Convention on the Rights of the Child and related General Comment No. 7: Implementing Children's Rights in Early Childhood; the African Charter on the Rights and Welfare of the Child; White Paper 5 on Early Childhood Education; the National Integrated Plan for ECD 2005 – 2010, and the National Plan of Action for Children.

ii In this essay, the term "young children" refers to children from birth to 9 years old (inclusive), unless stated otherwise.

National policy imperatives

The state has put in place a number of laws, policies and programmes across a range of government departments to improve the lives of young children.[iii] However, a recent review[16] indicates that current services are not sufficient to prevent many of the risks faced by children, or to promote their optimal development.

Government is exploring new strategies to respond to these challenges and to ensure that the most vulnerable young children are reached with quality services. For example, the Department of Social Development hosted an inaugural ECD conference in 2012, which resulted in an Integrated Programme of Action for ECD 2013 – 2018. Other processes that fed into the development of this programme were a review of the National Integrated Plan for ECD 2005 – 2010 (NIP for ECD), and the ECD Diagnostic Review[17]. The primary health care re-engineering strategy has a strong focus on improving maternal and child health and on school health promotion, while the NDP recognises the development of young children as a national priority. These mark critical opportunities for improving and extending the reach and quality of existing interventions through effective implementation.

What are ECD services?

There are a broad range of services to promote or support the development of young children and respond to their needs across interdependent developmental areas: physical, social, emotional, language and cognitive.[18] Progress or otherwise in one area is likely to affect that in others. For example, children experiencing malnutrition in the first two years of life are likely to underperform academically.[19] The multidimensional nature of early development requires that multiple role-players, with different skills and expertise, deliver a range of services to young children to ensure all-round development.

South African policy and law encapsulate a broad view of service provision and recognise the need for a multisectoral approach across health, education, social protection and socio-economic development. Services are provided by a range of government departments (eg Health, Social Development and Basic Education), non-profit organisations and the private sector. The NIP for ECD and the Integrated Programme of Action for ECD 2013 – 2018 recognise the need for a multisectoral approach through a variety of service delivery channels, including homes, communities and

Table 1: The status of young children (0 – 9 years*) in South Africa

Domain	Measure	Number, rate or proportion
Child population	Number of young children[a]	10,127,000
Income poverty	Young children living in households with a monthly per capita income of less than R604[b]	58%
Rural status	Young children living in rural areas[c]	45%
Child mortality	Under-five mortality rate[d]	42 per 1,000 live births
Malnutrition	Children under three years who are stunted[e]	27%
Disability and chronic illness	Estimated child disability prevalence rate (moderate-to-severe disability among all children)[f]	4 – 6%
	National mother-to-child HIV transmission rate[g]	3%
Childhood infections	Incidence of pneumonia (cases in children under five years of age)[h]	84 per 1,000 children
	Incidence of diarrhoea with dehydration (cases in children under five years of age)[i]	15.2 per 1,000 children
Early schooling	Average score for grade 3 mathematics[j]	41%
	Average score for grade 3 literacy[k]	52%

* This standard age group applies for all measures, except where stated otherwise.

Sources: a., b. & c. K Hall analysis of *General Household Survey 2011*, Children's Institute, UCT.
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h. & i. Department of Health (2012) District Health Information System. In: Bamford L (2013) Maternal, newborn and child health. In: Padarath A & English R (eds) *South African Health Review 2012/13*. Durban: Health Systems Trust.
j. & k. Department of Basic Education (2012) *Report on the Annual National Assessments 2012.* Pretoria: DBE.

iii For example, the Children's Act (38 of 2005); the National Integrated Plan for ECD 2005 – 2010, free health care for children under six years and their mothers; the roll-out of antiretroviral treatment; the National School Nutrition Programme; the introduction and roll-out of grade R; and many other programmes.

facilities (eg ECD centres). Primary caregivers[iv] remain central in providing a healthy, nurturing and stimulating environment[20] and further attention should be given to how external service providers can best support primary caregivers to fulfil their roles.

South Africa has made positive strides in certain service areas since the late 1990s, as illustrated in table 2. Improvements in the provision of basic services are significant (also see *Part three: Children Count – The Numbers* on pp. 84 – 114). Largely due to overall improved birth certificate registration, approximately 6.6 million young children are accessing the Child Support Grant (CSG),[21] the country's primary child poverty alleviation programme.

Access to educational and early learning opportunities has increased substantially in recent years. However, the academic performance of young learners in the foundation phase of the public education system is less than satisfactory (see table 1). Learning is cumulative, and urgent attention must be given to improving the

Table 2: Progress in ECD service delivery

Service	Measure	Progress	Access, equity and quality
Maternal and child health	Antenatal care		In 2011, 40% of pregnant women attended antenatal visits early, before 20 weeks.[a] Women attending antenatal care on average only attend three visits.[a] Overall coverage is high, at over 90%.[22]
	Immunisation		In 2011, 95% of one-year-olds were fully immunised. Significant provincial and district disparities exist.[b]
	HIV testing		In 2011, 63% of HIV-exposed infants received a PCR test[v] at eight weeks.[c] Infants living in rural districts are less likely to get tested.[23]
Nutrition	Breastfeeding		In 2003, 8% of infants were exclusively breastfed for the first six months.[d] Subsequently, a 2008 survey suggested 26%, but the sample was very small.[24]
	Vitamin A		In 2011, 43% of children 1 – 5 years received vitamin A supplements.[e] Provincial variation is a concern,[25] and malnutrition is highest in rural and urban-informal areas, and in children under three years[26].
Birth registration and social grants	Birth registration		In 2011/12, 90% of births were registered within the year of birth.[f] In 2008, 90% of 0 – 9-year-olds had a birth certificate, while only 11% of 0 – 3-year-olds did not.[g] In 2011, only 11% of children under three years were not birth registered.[27]
	Child Support Grant (CSG)		In 2011, 6.6 million young children received the CSG. Access is lower for children under three years.[h]
Early learning	Access to early learning and support for children aged 0 – 4 years		In 2012, 485,500 children under five years received a subsidy at an ECD centre.[i] However, there are age, geographic, race and income disparities.[28]
	Access to early learning for children aged 5 – 6 years		In 2011, 89% of 5 – 6-year-olds attended an ECD centre or formal school.[j] 735,000 children attended school-based grade R classes[29] while others attended community-based ECD centres. Quality remains a challenge.[30]
	Access to early schooling for children aged 7 – 9 years		In 2011, 99% of 7 – 9-year-olds attended school. Quality and educational outcomes are a concern.[k]

Key: Insufficient progress Some progress, needs attention Good progress

Sources: a. Department of Health (2012) District Health Information System, 2011 data. In: Bamford L (2013) Maternal, newborn and child health. In: Padarath A & English R (eds) *South African Health Review 2012/13*. Health Systems Trust.
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e. Health Systems Trust (2011) *Health indicators. Vitamin A coverage children 12 – 59 months (%)*. Department of Health, District Health Information System 2011 data. Accessed 23 August 2013: www.hst.org.za.
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g. K Hall analysis of the *National Income Dynamics Study 2008, Wave 1*, Children's Institute, UCT.
h. K Hall analysis of Social Pensions (SOCPEN) database 2011, Children's Institute, UCT.
i. Department of Social Development data, 2012. Personal communication: Louise Erasmus, Social work policy manager: Partial care and ECD.
j. & k. K Hall analysis of *General Household Survey 2011*, Children's Institute, UCT.

iv Primary caregivers may be biological or foster parents, grandparents and others responsible for the day-to-day care of the child at home.
v Polymerase chain reaction (PCR) tests are performed on infants to determine their HIV status.

quality of interventions for young children and to understanding the relationship between early development and learning and its impact on academic performance in later childhood.

Children living in poverty and rural areas, and those with disabilities, generally struggle to access quality services.[31]

While remarkable progress has been made to improve access to a range of essential services among the most disadvantaged, gaps and inequitable provision persist. Priorities for intervention are:[32]

- Parenting support, especially for 0 – 2 years.
- Maternal health and well-being, including nutrition during pregnancy and breastfeeding.
- Child health and nutrition.
- Safe and affordable child care for families who need it.
- Educational stimulation opportunities for those not in early learning facilities (the majority of the poorest children), including children with disabilities.

These and other challenges need urgent attention. If disadvantaged children do not receive appropriate interventions early enough and their environments remain unchanged, they are likely to endure lifelong consequences,[33] and the vision of the NDP for South Africa in 2030 will simply not be realised.

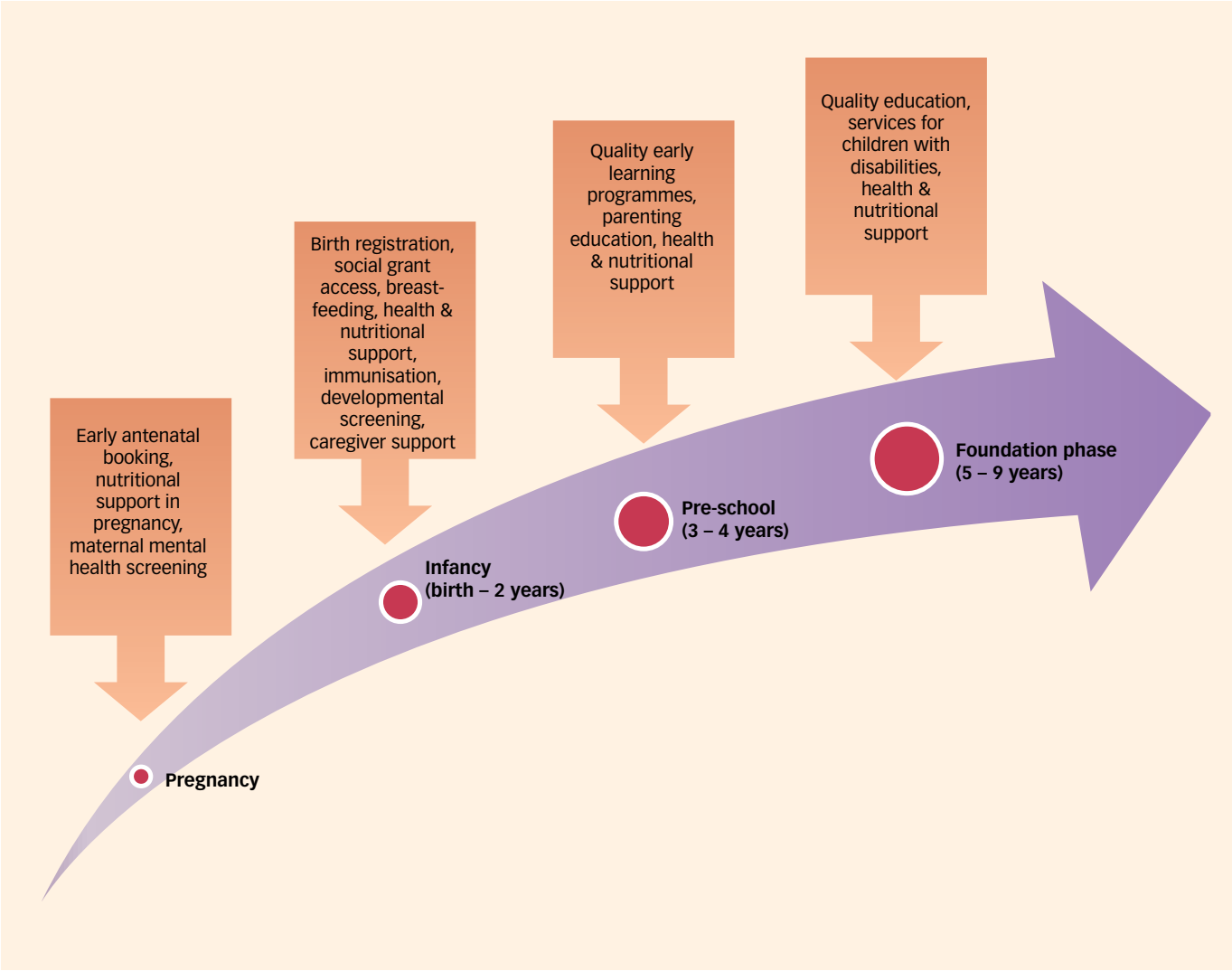
Delivery is a major challenge – where do we start?

While universal provision of a full range of services to address all children's developmental needs is optimal, it is too challenging a task given limited resources. A service delivery approach is required that aligns with current policy, is evidence based, and capable of reducing risks while promoting the capacities of young children. In effect, an approach which defines and ensures essential services.

The NIP for ECD provides a useful starting point by identifying a range of core services for children younger than five years, targeting the most vulnerable children and households, and building on existing services in health, social development and education.[34] This view is supported in other policies, such as the Integrated Programme of Action for ECD 2013 – 2018.

However, there is a need to go further – to consolidate and expand the intentions of the NIP and provide concrete recommendations for a well-defined package of services and support for children aged 0 – 9 years in poor households.

Figure 1: Examples of a developmentally-appropriate continuum of early childhood services



Source: Adapted from: Richter L, Biersteker L, Burns J, Desmond C, Feza N, Harrison D, Martin P, Saloojee H & Slemming W (2012) *Diagnostic Review of Early Childhood Development*. Pretoria: Department of Performance, Monitoring and Evaluation & Inter-Departmental Steering Committee on ECD.

An essential package of services and support

This section presents a proposed "essential package of ECD services and support" (the essential package), drawing heavily on the work of Ilifa Labantwana[vi].[35]

Different inputs are required at various stages of a child's development. It is therefore necessary to build a continuum of services appropriate to the stages of development, from conception throughout pregnancy through to the first years of school (see figure 1 on p. 29).

The examples of services illustrated in figure 1 can be clustered in five basic components. These make up the notion of an essential package:

1. Nutritional support
2. Social services
3. Maternal and child health services
4. Support for primary caregivers
5. Stimulation for early learning

Such an essential package of services must be viewed within the context of a broader set of provisions such as poverty alleviation, food security, basic household services and violence prevention that create an environment conducive to young children's development.[36]

The proposed essential package includes services that are *already mandated in policy and law*, only adding others where there are gaps that must be filled, as indicated by evidence.

Each component of the proposed essential package is outlined in figure 2.

Nutritional support for mothers and children

Poor nutrition in young children is a serious health concern in South Africa. The first 1,000 days of life are most critical for nutritional support to ensure optimal growth and development. The Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition 2012 – 2016[37] and the new Infant and Young Child Feeding Policy[38] are two key policies providing a framework for essential nutrition services.

Social services

Timely birth registration enables access to other services such as social grants, free health care and education. Access to social grants is associated with improved nutrition,[39] and therefore take-up needs to be strengthened in the first year of life.

Social services are a vital support to families and children, including prevention and protection from abuse and neglect. Many children in South Africa experience violence, abuse, neglect and the loss of caregivers, and psycho-social support services may be needed to help children cope with grief, loss and trauma.

Maternal and child health services

Early development begins at conception, and maternal and child health services are crucial for laying the foundation for optimal maternal health and child development. Primary level services for pregnant women and young children serve to prevent illnesses, and promote good care and nutrition. Early intervention is essential to minimise risks and prevent develpoment delay and disability.

Support for primary caregivers

Support for primary caregivers includes information sharing on parenting and psycho-social support. Many caregivers living in poverty carry significant burdens of care. Depression is common and may compromise their capacity to care for young children.[40] Psycho-social support for caregivers is therefore essential to promote the well-being of caregivers and to reduce the risk of poor caregiving. In addition, the Children's Act[41] provides for parenting programmes that support parents to provide responsive care for young children.

Safe and affordable child care (including after-care for school-age children) provides much needed support for caregivers who work, study or are unable to care for their children.

Stimulation for early learning

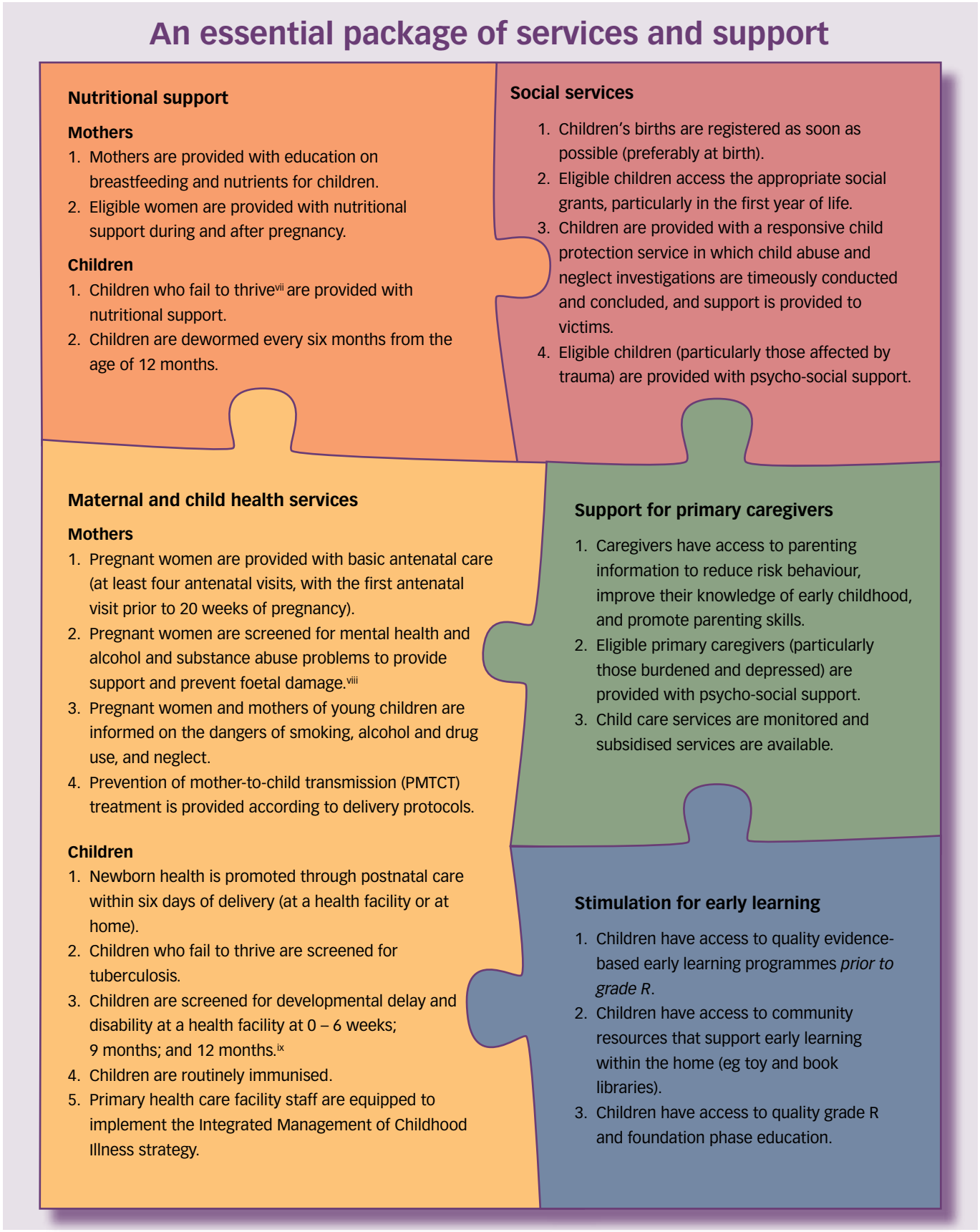
Access to quality early learning stimulation prior to grade R significantly enhances the ability of children from impoverished backgrounds to benefit from schooling.[42] Early development and learning are inextricably tied to nurturing contexts and the home is therefore a key site for intervention.[43]

Readiness to learn is not solely an outcome of engagement in early learning opportunities. Children should also be demonstrating their emerging ability to exercise self-control, concentrate, and plan and reflect on their actions by the time they enter school.[44] A range of early learning opportunities are available before school and can be delivered through home visiting, community playgroups, toy libraries and centre-based programmes.

Stimulation for early learning prior to the foundation phase of formal schooling is not enough. Quality education is crucial throughout the foundation phase to improve outcomes and prepare learners for later schooling.

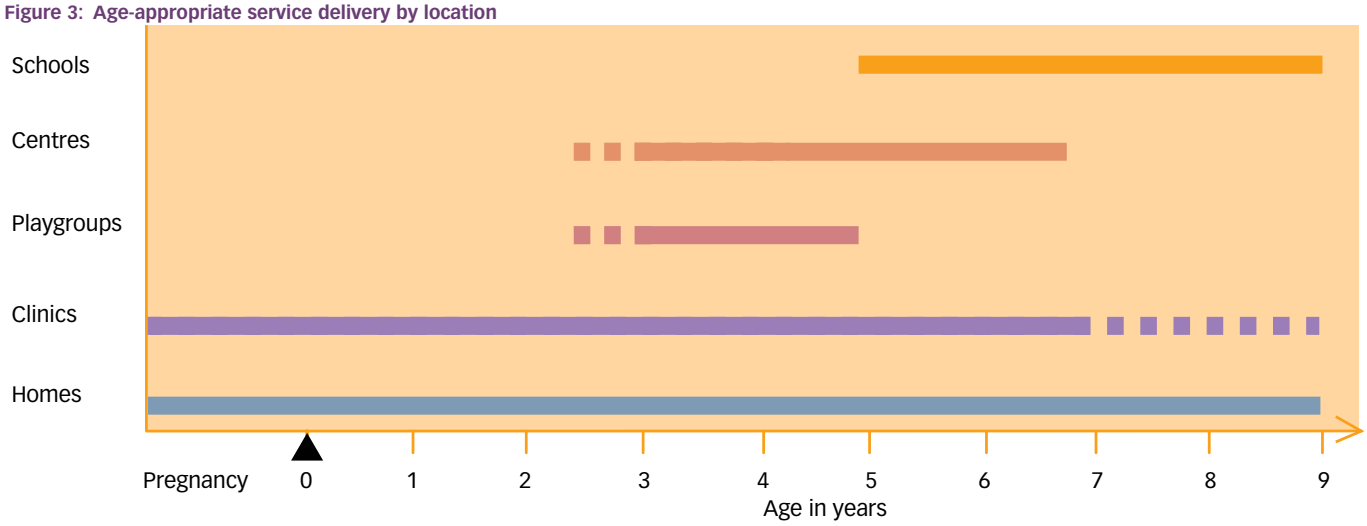
vi Ilifa Labantwana is a multi-donor partnership which develops models for scaling up integrated ECD in South Africa.

Figure 2: Essential services for young children



vii "Failure to thrive" refers to children who do not gain weight as expected, or continue to lose weight.
viii This service, with accompanying referral, is largely unavailable. Every effort must be made to provide this essential service.
ix Urgent attention needs to be given to the provision of appropriate services for identified children.

Figure 3: Age-appropriate service delivery by location



How are essential services and support delivered appropriately?

Poor and vulnerable adults should not have to spend money and time to access basic services, so it is important to design services that are convenient and easily accessible. The design of services should therefore take into account where young children are located and which delivery channels will be most effective in reaching the majority of children, prioritising children who live in poverty, rural areas and those with disabilities.

On the basis of current evidence, the most appropriate delivery channels – particularly for vulnerable and hard-to-reach families – are proposed in figure 3.

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Early intervention and inclusion helps children with disabilities reach their full potential.

Services should also be age-appropriate and respond to children's changing needs as they grow and develop. For example, most young children are cared for within the home, and home care is, in fact, desirable for children younger than three years.[45] Essential services are therefore best delivered through multiple delivery channels, including:

1. Home-based strategies (support for child and caregiver)
2. Community-based strategies (eg playgroups, mobile clinics)
3. Facility-based strategies (eg community health centres, ECD centres)

Conclusion

Early childhood services present critical opportunities to invest and intervene in the lives of young children as early as possible to minimise developmental risks and strengthen protective factors. Within current service delivery constraints and challenges, innovative approaches must be adopted to ensure that services reach the most vulnerable children and households.

A package of essential services, aligned with current policy, is recommended as the vehicle for cost-effective and efficient delivery that maximises opportunities for early childhood interventions. The essays that follow draw on this notion of an essential package of services and support, highlighting critical challenges and opportunities to improve the reach and quality of services for South Africa's most vulnerable young children.

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Strengthening ECD service delivery: Addressing systemic challenges

André Viviers (UNICEF South Africa), Linda Biersteker (Early Learning Resource Unit) and Sinah Moruane (Department of Women, Children and People with Disabilities)

Young children[i] need to be supported in various ways to ensure their well-being and development. Such support is encapsulated in rights guaranteed by the Constitution and international treaties that South Africa has agreed to.[1] The provision of early childhood development (ECD) services can be regarded as a public good, based on the recognition that ECD services not only contribute to the development and outcomes of the child, but also to the growth and development of society as a whole in the medium and long term.[2]

South African policies[ii] and the National Development Plan[3] (NDP) recognise the state's responsibility for children's development by emphasising the need for an effective and integrated system to ensure essential ECD services are accessible to all, especially those children whose development is most at risk. The Children's Act also requires the state to develop a "properly resourced, coordinated and managed early childhood development system".[4]

A window of opportunity to redefine ECD services in South Africa is currently open and calls for a model to be put forward that will take into account policy and legislative frameworks; recent reviews and recommendations; and rigorous scientific evidence to ensure an integrated, transformed ECD system rooted in quality, scale, access and investment.

Currently there is a significant gap between the vision[iii] and policy and the realities of limited access and poor quality.[5] As South Africa is embarking on a strategic and targeted transformation of ECD service provision, the transformation agenda should be supported by a well-designed, funded and implemented system. This essay explores three questions:

- What is required for effective service delivery?
- What are the current obstacles to effective delivery?
- What systemic changes are needed to support effective service delivery?

What is required for effective service delivery?

The Children's Act sets out that an ECD system must be properly resourced, coordinated and managed, and should include children with special needs, and be based on collaboration between the social development, basic education, health, provincial and local

Table 3: Systemic barriers to effective ECD service delivery in South Africa

Policy and planning	• Limited integration across policies • Fragmented and uncoordinated planning for young children • No shared vision, goals and accountability • Uneven quality of information systems and data • A significant gap between policy and practice • Lack of planning based on population (age) and geographical coverage
Good governance	• Poor institutional arrangements, insufficient inter-sectoral collaboration, coordination and service integration • Limited accountability at all levels and across sectors
Resources	• Inadequate funding and inappropriate funding models • Limited human resources • The absence of an integrated human resource policy and strategy across all sectors • Insufficient service infrastructure
Delivery	• Unequal access and quality of services within and across sectors (poor targeting mechanisms) • Limited monitoring and support to ensure quality • Delivery skewed towards urban and centre-based services

Sources: National Planning Commission (2011) *Diagnostic Overview*. Pretoria: The Presidency; Richter L, Biersteker L, Burns L, Desmond C, Feza N, Harrison D, Martin P, Saloojee H & Slemming W (2012) *Diagnostic Review of Early Childhood Development*. Pretoria: Department of Performance Monitoring and Evaluation & Inter-Departmental Steering Committee on ECD.

i The term "young children" refers to children from birth to nine years old.

ii Such as the White Paper on Education and Training (1995), the White Paper for Social Welfare (1997), the White Paper for the Transformation of the Health System in South Africa (1997), the Education White Paper 5 on Early Childhood Education (2001) and the National Integrated Plan for Early Childhood Development in South Africa 2005 – 2010 which was led by the then Department of Education and co-authored by the Departments of Social Development and Health to transform service delivery for young children based on an integrated, synergised and collaborative system.

iii The NDP sets "high-quality, universal early childhood education" as one of its targets. It perceives ECD as a comprehensive set of interventions, inclusive of health, nutrition, early learning and development, parenting support, social protection, amongst others. Similarly, the Minister of Social Development has stated the need to "provide transformed, integrated, accessible and quality partial care and ECD services..." (Department of Social Development (2012) *Keynote address by the Minister of Social Development, Ms Bathabile Dlamini, on the occasion of the Early Childhood Development Conference at the International Convention Centre, East London, 12 March 2012*. Pretoria: DSD). This is linked to the NDP's vision of a transformed, universal and comprehensive ECD system.

government, finance and transport sectors.[6] Such a system includes governance, provisioning, and capacity development for implementation and is linked to effective monitoring methods.[7] Hence, the coming together of core delivery systems (i.e. health, care and protection, education and governance) within government and at community level ensures accessible, quality and integrated services to all young children, with special provisions for those whose development is most at risk.

Features of an effective system for ECD service delivery that will drive and sustain transformation include:

- an enabling and adequate[8] policy and legal framework, and planning for delivery at scale;
- institutional arrangements which allow for coordination within and across sectors, strong leadership and accountability, clearly defined roles and responsibilities of government and civil society partners at national, regional and local level;
- resourcing including financing, human resources, infrastructure, materials and support services; and
- integrated service delivery which achieves universal coverage (scale), with effective monitoring and quality assurance.

What are the current obstacles to effective delivery?

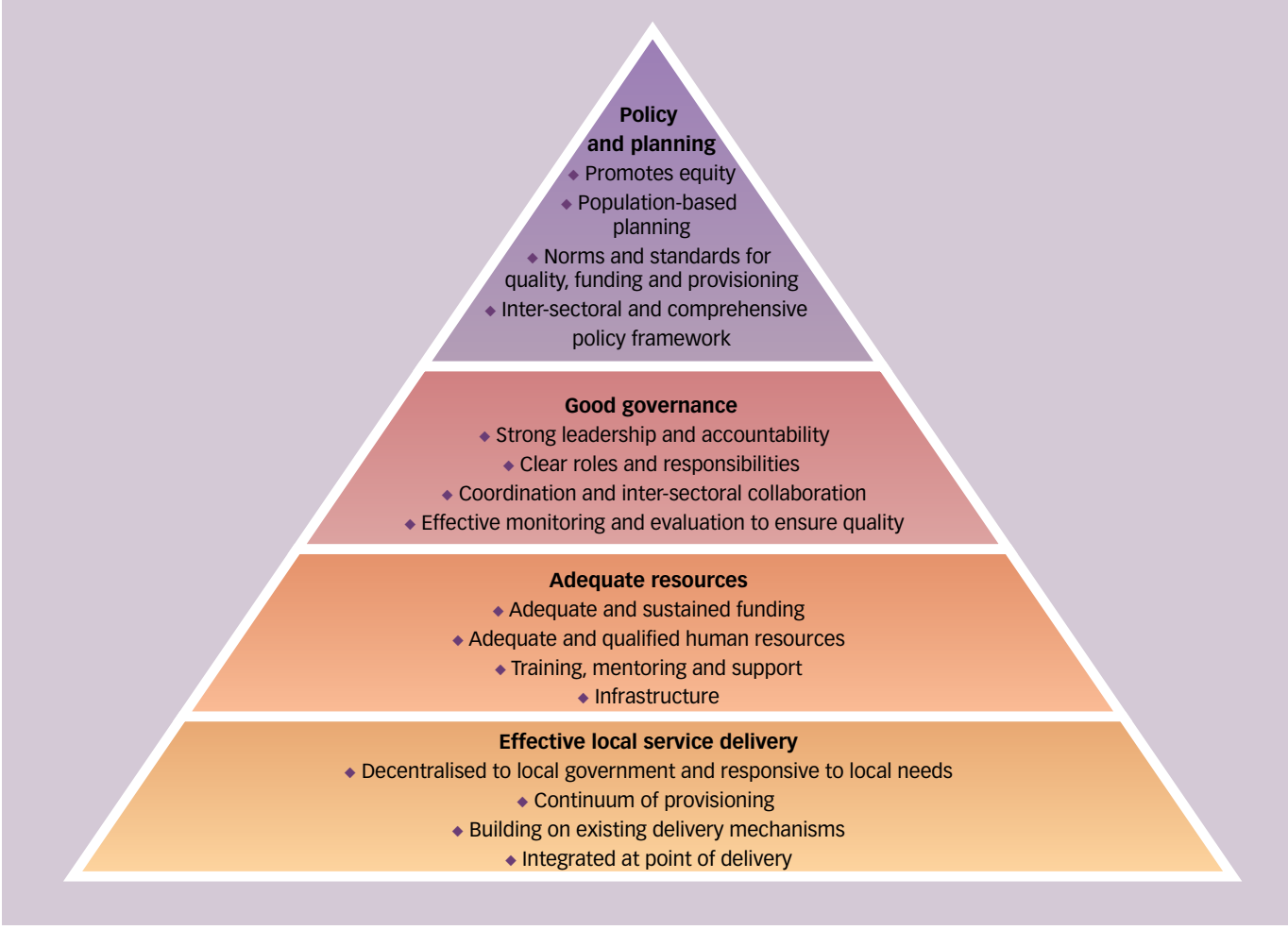
Scaling up essential services for children prior to school-going age is complex and involves different departments, all three spheres of government, and civil society. Also, services differ depending on children's needs and involve multiple delivery sites, as well as child and caregiver beneficiaries.[9]

Recent diagnostic reviews identify a series of systemic problems that hinder effective service delivery (collated in table 3). A 2011 National Planning Commission review[10] acknowledged that "implementation in the poorest communities lags behind" and that the sector is "underfunded" by government, while the 2012 ECD Diagnostic Review described how different sectors continue to work in isolation[11].

What systemic changes are needed to support effective service delivery?

Transforming the ECD sector from its current status to an adequately resourced, universally accessible and high quality system requires urgent and on-going attention to four key components: policy, governance, resourcing and service delivery, as illustrated in figure 4.

Figure 4: Core components of an effective ECD system



Case 1: Kago Ya Bana – working with local government

André Viviers (UNICEF South Africa) and Ntjantja Ned (Hollard Foundation)

Kago Ya Bana (KYB) means "building together for our children" and is the name of a partnership formed in 2007 between the Hollard Foundation, the Midvaal Local Municipality and the Gauteng Departments of Social Development and Education with the shared goal of improving developmental outcomes of young children.

The partners identify problems or bottlenecks that prevent universal access to ECD services in the area and look for alternative, innovative ways of addressing them through practical action on the ground while working at a broader systemic level to bring about sustainable change.

KYB partners have identified five main reasons why services do not reach children in the municipality and the broader Sedibeng district:

- **Accountability**: Children are everybody's responsibility – from caregivers to government – but no-one is held accountable. Local municipalities are the sphere of government closest to where children live, though they are least involved in supporting children's early development.
- **Location**: Implementation of policies and legislation is uneven and often reflects the legacy of apartheid. Children living in poorer townships, informal settlements or in rural areas have poor access to ECD services and the services are of lower quality compared to those in the cities.
- **Integration**: Lack of integration and a misalignment of policies or by-laws within the system.
- **Planning**: Insufficient integrated planning and coordination between the province and local municipality result in contradictions and gaps in the implementation process.
- **Multiple factors**: These factors combine to create a system and practices that are dysfunctional at best and undermine the national agenda of making ECD services accessible to all children.

The KYB partnership identified eight key strategies for bringing about immediate improvement while aiming to make sustainable and systemic changes in the delivery system:

- **Building and formalising partnerships**, based on agreed roles and responsibilities, and establishing a governance structure.
- **Mobilising of communities** through dialogues to increase parental responsibilities and unlock community resources.
- **Collecting and consolidating data and auditing of existing services and gaps** to improve planning and budgeting, focusing on children in the system as well as children not included.
- **Building capacity**, mainly among ECD practitioners to enable them to meet the required norms and standards.
- **Mobilising human and financial resources**, including unlocking existing material resources within the respective government departments.
- **Learning by doing** by exploring a range of models to address the needs of young children, where they live; effectively using local resources such as day mothers, parental programmes or engagement; and creating a referral system for additional support.
- **Institutionalising responsibilities and processes** to ensure alignment of policies and by-laws. This included the development of protocols for the assignment of ECD functions as contemplated in the Children's Act, and effectively getting ECD service provisioning included in the municipality's Integrated Development Plan (IDP).
- **Monitoring and tracking progress** based on clearly defined indicators that track direct impact on children and system change such as the number of ECD programmes registered and the use of ECD policy by the municipality to guide services.

Through the KYB, 108 children who would otherwise not access ECD services are cared for by 18 day mothers who provide early stimulation, nutrition, and referrals to other services. A further 1,243 children receive the same package of services through 23 ECD centres. Eighteen of the ECD centres now meet the minimum requirements for registration as set by the Children's Act. Of these, 12 are registered, 10 of which also receive subsidies from the provincial government. Children's nutritional levels have improved from 47% in November 2012 to 98% in March 2013. The municipality has adopted the day mother model and its IDP includes a plan to scale up the model throughout its 14 wards.

The KYB's ultimate goal is that local government takes full responsibility for ensuring access to ECD services for all children and that all partners contribute to creating a strong foundation for children to realise their full potential. This means a system that does not depend on the on-going support of the private sector. In the words of the chief executive officer of the Hollard Foundation: "We want to leave behind a municipality that is able to take care of its own children."

For more information, contact Ntjantja Ned at Ntjantjan@hollard.co.za

Enabling policy and effective planning

An enabling policy should outline a long-term vision for ECD services that will give effect to children's rights and support the development of an ECD system that is responsive to the needs of young children. Such a policy should draw on a solid evidence base, and outline the resources, technical and implementation support necessary for effective and efficient delivery. It should accommodate the needs of diverse groups, and allow for a measure of flexibility in responding to local conditions.[12]

Post-1994 policies that promote the rights of young children span many government departments, particularly Basic Education, Social Development and Health. These policies and legislation create strong commitments within sectors but generally lack the ability to bring key issues for delivery together. The National Integrated Plan for ECD 2005 – 2010 intended to address uncoordinated service delivery by promoting multisectoral planning and delivery.[13] However, its life span was not adequate to facilitate the intended transformation of a very complex, fragmented and poorly-resourced sector. But, it did thoroughly embed and reflect the principles of integration, intersectoral collaboration, and the essential components of ECD services in South Africa's policy discourse. It also provided impetus for the development of good practices of integrated ECD programmes across the country.

The Children's Act uses a broad definition of ECD and requires the Minister of Social Development to consult with ministers of other key departments to develop a comprehensive national strategy for a properly resourced, coordinated and managed ECD system. The Act calls for the prioritisation of services for vulnerable groups – children without basic necessities, and children with disabilities and chronic diseases. While the development of a national strategy is commendable and essential for the sector, these provisions have not been effected yet.

Norms and standards to guide the delivery of quality and adequately resourced services are important. These include norms and standards[14] that facilitate pro-poor funding support for the grade R system; the National Early Learning and Development Standards (NELDS) for children from birth to four years;[15] and the Children's Act norms and standards[16] that provide infrastructure and programme standards for ECD programmes. However, a key gap is the lack of norms and standards for funding and provisioning of ECD programmes for children prior to grade R.

The role of municipalities in delivering ECD services is key and is recognised in the Constitution and in early policy statements.[17] Some municipalities have started to play a stronger role in providing ECD programmes. The Children's Act outlines for the first time a clear role for local municipalities in the provision of ECD programmes specifically relating to the assignment of functions by the provincial government to local government. Since the Act came into force in 2010, no such functions have been assigned; however this is under discussion by the Department of Social Development (DSD) and local municipalities.[iv] There are also many municipalities that are providing support to young children and their caregivers in addition to their role in the registration of ECD centres.[18] One such example is discussed in case 1 on the opposite page.

Health policies that provide for free health care services for pregnant and breastfeeding women and children younger than six years are a significant contribution to ECD.[19] The emphasis on population-based health services and outcomes as part of the current re-engineering of primary health care is a further opportunity for integrated ECD service delivery.

In order to strengthen the policy and legislative framework, a thorough review of South Africa's policies affecting young children is needed, focusing on:

- the rights of children;
- a national vision for ECD services and the inter-related nature of services for young children;
- ensuring equity;
- mechanisms for delivery;
- clear norms and standards on quality, provisioning (including targeting) and funding (emphasising state-led funding); and
- a human resource policy and strategy that responds to the system.

In addition to well coordinated policy, planning should be based on evidence and take into account the child population (age and geographical spread). This requires good quality child and service data that can be disaggregated to local level to identify service needs and gaps as well as effective interventions.

Supporting good governance

Essential to good governance is leadership that clarifies the roles and responsibilities of government departments and the national, provincial and local spheres of government. It includes mechanisms for coordination and inter-sectoral collaboration, particularly at a national government level, to oversee policy; monitor quality, delivery and knowledge; and provides clear lines of accountability. An independent mechanism with high-level influence and authority, a clear and specific mandate and the required resources (human, financial and expertise) to oversee such coordination and collaboration has been proposed.[20] Options for integrated governance structures include an ECD council, institute or agency, and integrated ECD directorates or units within departments.[21]

There needs to be stronger accountability for the development and implementation of policies at all levels of government, as illustrated in case 2 on p. 38. This includes a well-resourced and developed monitoring, support and evaluation mechanism, which draws on input from beneficiaries, collects and analyses data, and initiates evaluations to assess the provision and impact of services.

Essential in good governance is the participation of all stakeholders, including the recipients of services, in the design, implementation and monitoring of the services. This does not only enhance governance, but also strengthens quality and accountability.[22]

iv The assignment of functions by the Children's Act in relation to ECD relates only to a more formal agreement on services. Local government, by virtue of its status as a sphere of the state, has an obligation and mandate to realise young children's rights. Thus, many municipalities have "ECD policies", provide services to young children and their families, contribute to the regulation of partial care facilities (ECD centres) through environmental health assessments, and regulate and support child-minding or day mothers who take care of less than six children.

Case 2: An effective provincial coordinating structure
Linda Biersteker (Early Learning Resource Unit)

Strong leadership and coordination of essential ECD services are critical for effective delivery. The Western Cape government is using an innovative workstream mechanism to achieve transversal management. A number of workstream structures have been set up to deliver on the different strategic objectives of the provincial government.

The ECD workstream falls under the Provincial Strategic Objective 8: Promoting Social Inclusion and Reducing Poverty. Members include research and ECD programme staff from the Department of Social Development, policy staff from the Department of the Premier and representatives from Agriculture, Health, Education, Community Safety, Local Government, the City of Cape Town and two non-governmental organisations. The workstream is chaired by the provincial Department of Social Development, which is responsible for management, monitoring and evaluation.

In the first six months of its operation, an integrated ECD strategy was drafted and subsequently endorsed by the provincial cabinet, which allows for resource mobilisation. Key projects were prioritised to support effective implementation. Current efforts are focused on designing new models of ECD provision, programme registration, nutrition support, training, identifying centres of excellence in targeted areas, and developing an integrated management information system for ECD services. For example, the Health Department is working with Social Development and Education to ensure that cooks are trained to prepare nutritious meals in ECD centres.

Areas for pilot projects are identified based on multiple criteria including school results, nutritional status and poverty data. Different departments are responsible for different projects, jointly or singly, but they all report regularly to the workstream whose leader in turn reports monthly to the chair of all the Provincial Strategic Objective 8 workstreams on what has been jointly achieved. From here reports go to the Human Development Strategy Sector provincial cabinet cluster.

A range of factors can be cited for the success of this approach. One is having the right stakeholders involved. This means not only that they cover key services, are committed and see the value of working in a coordinated way, but also that they are senior enough to take or support decisions. Strong leadership and accountability mechanisms also contribute to the success of this approach. The Premier's advisor, who chairs all the strategic objective workstreams, has the power and authority to hold all members and departments to account. ECD services are also included on the Premier's electronic dashboard which monitors performance against targets on a regular basis, an indication of strong political support.

Improving resource allocations

ECD programmes and services can be an avenue for achieving equity, but this requires access to services of sufficient quality to promote positive outcomes for children.[23] While ECD policy, legislation and the NDP prioritise ECD services for the most vulnerable, there are age, spatial, racial and income disparities both in service access and quality.[24]

For example, access to formal schooling, including grade R, is high across all income groups, but poor schooling outcomes in poorer schools[25] are a stark indication of quality challenges. Similarly, most ECD funding from the DSD is directed to poor children in ECD centres, yet access and service quality tend to be worse for younger and poorer children.[26] Current resourcing is not only insufficient to meet the needs of the poorest children but is not directed to key programming areas such as support for caregivers of very young children.[27]

Funding

The Child Support Grant, which impacts positively on nutritional status, preschool and school enrolment[28] is the most widespread protective measure for young children living in poverty. It is accessed by 6.6 million 0 – 9-year-olds, although take-up is still low in the first two years.[29]

Health budgets do not separate out spending on pregnant women and young children, though these groupings benefit from free public health services. While 85% of children depend on the under-resourced public health system, a privileged few have access to private health insurance which accounts for 44% of total health care spending.[30] The proposed National Health Insurance aims to extend financial risk protection to poorer households and provide for a more equitable distribution of resources between the public and private health care system, in the long term.

Public funding for ECD services has increased significantly over time. Provincial budgets for grade R increased from R1 billion in 2008/9 to R3.5 billion for 2014/15[31] and are based on pro-poor funding norms. DSD funding for ECD care and stimulation services for younger children is the area which needs most attention. There is no clear legal obligation for the funding of ECD programmes for children pre-grade R. While subsidies for poor children attending registered non-profit ECD centres increased from approximately R422 million in 2007/8[32] to R1.6 billion in 2013/14, this does not adequately reach the poorest and youngest children who mostly do not access registered centres (see case 3 on pp. 41). Many centres lack the necessary resources to offer a basic learning programme and food.[33] Alternative models for funding non-centre-based programmes are also needed to support very young children and their caregivers.

Infrastructure

Greater attention needs to be paid to infrastructure to facilitate access to services, particularly in the traditional rural areas where only 35% of children have access to adequate water and sanitation,[34] and informal settlements where children are often exposed to danger due to unsafe play spaces, shack fires and floods, paraffin use and other environmental risks.

Poor infrastructure prevents many ECD facilities from getting registered and accessing the DSD subsidy, and a lack of funding for infrastructure and start-up costs hampers the establishment of ECD programmes in poor communities. ECD infrastructure development could be funded by local government through the Municipal Infrastructure Grant but this remains a challenge given competing demands for basic services and because local government is not obliged by law to build ECD infrastructure in areas of greatest need. Infrastructure gaps highlight the need to prioritise funding of infrastructure for children in under-serviced areas and to make better use of available infrastructure such as clinics, libraries and Thusong centres[v] to provide multiple points for delivery of different services for young children. Within education there is also a need for additional classrooms and safe, secure accommodation for grade R learners, with play areas separated from older children, small toilets and sufficient indoor play space.[35]

Human resources

ECD services depend on human resources from a number of sectors (mainly health, education and social services). There is a general shortage of appropriately trained staff for direct service delivery as well as insufficient staff for effective supervision, oversight and management. For example, the poor progress with registration of ECD programmes can partly be attributed to insufficient numbers of social service professionals and local government officials.[36] Similarly, the poor quality of services illustrates a lack of regular mentoring and quality assurance from understaffed district staff in Health, Education and Social Development.[37] The establishment of government posts for ECD services has been identified as a priority for 2014.[38]

Sectors have their own staffing structures but insufficient numbers of trained and capacitated staff pose problems across them all. Health and Education fund posts for the delivery of services and, while DSD funds posts for the general delivery of social welfare services, it does not fund posts for the delivery of ECD programmes.

Staff shortages at primary health care facilities raise further concerns about the quality and scope of services. For example: most community health centres do not have access to rehabilitation services or social workers.[39] Inequities persist with only 12% of doctors and 19% of nurses working in rural areas[40] (which are home to 45% of young children).[41] Gaps in key skills, problems with staff motivation and performance, fraud and corruption, and inadequate supervision and management have also been noted.[42] So it is vital to prioritise these areas. The re-engineering of primary health care will require a significant increase in the numbers of community health workers, nurses, pharmacists and specialists as well as reorientation of existing staff to enable a shift from the clinical hospital-based services to a primary health care approach.[43] Mentoring, support and quality assurance functions of the district support teams will be key (see the essay on pp. 50 – 55).

Grade R educators are not yet fully integrated into the education post and remuneration structure and many are undertrained.[44] The Department of Higher Education has introduced the National Diploma in Grade R as an interim upgrading measure and by 2020 all educators will need a professional qualification.

There is a need to upgrade the qualifications of existing staff for 0 – 4 years and grade R, and to train new practitioners for an expanding sector.[45] There are no recent national data on the qualifications of practitioners working with younger children but studies suggest that between 25 – 50% of ECD centre managers and larger numbers of practitioners have no ECD qualifications.[46] Substantial training opportunities for practitioners in ECD centres have been offered through the ETDP SETA, Education and Social Development Departments in the last few years; yet there is no career path framework providing for progression linked to qualifications. However, the Department of Basic Education is leading the development of an integrated professional registration system for ECD practitioners working with children from birth to pre-grade R.[47]

A serious gap is the lack of funded training opportunities for practitioners employed in out-of-centre programmes. A range of home- and community-based workers from different sectors reach young children and their families, including community development workers, community health workers, community caregivers and child and youth care workers. If their training included a core package of ECD messages, they could provide a significant human resource for young children. For example, Isibindi workers have received child stimulation training from the Early Learning Resource Unit in the Western Cape, and ward committee members and community development workers from Khululeka in the Eastern Cape.

Ensuring effective local delivery

Service delivery must be state-led[vi] to ensure it is taken to scale and reaches poor, vulnerable and marginalised children in both urban and rural areas.[48] As was outlined in the previous essay, services also need to be available across a continuum of provisioning[49] from support for primary caregivers to health and nutrition interventions and early learning opportunities through home-, community- and/or facility-based programmes.

v Thusong centres are one-stop integrated service hubs driven by local government, predominantly in rural areas, which provide access to services such as the Departments of Home Affairs, Labour, Social Development, Health, the South African Social Security Agency, agricultural extension services, communication and education services such as adult basic education and training, libraries etc. Community development workers, non-governmental organisations and others also offer services through the centres. According to the Thusong website, there were 171 of these centres in March 2012. However, they are not all sufficiently close to needy communities and there are challenges with service quality (Department of Public Service Administration (2009) *Optimizing the Footprint of Thusong Service Centres in the Poverty Nodes*. Pretoria: DPSA).

vi This will require a shift from a service delivery model that relies heavily on non-governmental and private sector implementation with regulation by the state towards one that is based on partnership and close collaboration and where the state plays a more active and central role.

Much has been said about the importance of integration in ECD service delivery, both for efficiencies and for access. The NIP for ECD sees integration as providing services in a comprehensive and interwoven manner to ensure children's holistic development.[50] This package of ECD services should be easily accessible; provide consistent information; and providers from different sectors should be able to make referrals to services that they do not provide.[51] At a systemic level this implies joint planning, targeting, monitoring and coordination between government and non-profit service providers.

The Diagnostic Review[52] concentrates on integration at the point of delivery where several services are linked to take advantage of the synergies and efficiencies associated with inter-sectoral collaboration. Consistent with this approach is that existing delivery mechanisms (eg clinics, ECD centres, one-stop centres and municipal services) should be used for the delivery of a range of ECD services. For example, an ECD centre may serve as a base for other services for young children in the community, or any service that reaches into homes (eg via community development workers) could have an ECD element.

What seems most critical and achievable in our current context is to ensure that *each child* is linked to needed services, and as early as possible. This requires coordinated planning and monitoring which can be facilitated in different ways. For example, home-based workers can inform caregivers about how to access services, or the Thusong centres can provide a range of different services within a single multipurpose centre.

Service delivery must be responsive to local risk and protective factors.[53] This suggests that where there is adequate capacity, decentralisation to *local government* would enable better targeting of specific groups of children, including children who are poor and vulnerable, and children with disabilities. This would also allow for innovation and flexibility to suit local needs.[54] The Kago ya Bana programme in the Midvaal is an example of how local government can be more proactive in delivering services to young children (see case 1 on page 36).

Conclusion

It is not an easy task to bring together an array of complex interventions, delivered through multiple agents (whether government, private sector or non-governmental sector), to ensure that the rights of all young children are fulfilled.[55] The recent reviews of the ECD sector also show that a national integrated model to deliver an essential package of ECD services in South Africa has not emerged as strongly as was envisaged by policy mandates since 1997, which leaves those children most in need and most vulnerable in dire straits.

It is evident that, while the ECD system is entering its most significant and exciting era of transformation, the immediate need is for effective and accountable governance. This includes strong government leadership to drive an agenda of change, and a state-led approach to resourcing the system to safeguard young children's rights to survival, healthy development and early learning. Integral to this is sufficient and sustained funding; uniform norms and standards; evidence- and population-based planning that prioritises children at risk, and adequate infrastructure and qualified human resources to improve access and quality.

It is, today more than ever before, essential that the ECD system delivers on its constitutional and legislative obligations to the country's youngest citizens and their caregivers. This can only happen with a clear conceptual understanding and model, as well as accountability for implementation. A strong policy at national level is essential, together with an even stronger service delivery system at a local level. This will necessitate an integrated and effective ECD system where, in the words of Aristotle, "the whole is greater than the sum of its parts".

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Access to educational resources in homes and early learning settings is vital.

Case 3: Government funding of centre- and community-based early childhood programmes prior to grade R

Conrad Barberton, Cornerstone Economic Research

How much does government spend on early childhood development (ECD) services? This question is usually answered by referring to the amounts that provincial Social Development departments allocate to subsidise ECD centres, which in 2013/14 was R1.6 billion (see table 4). This excludes what government is already spending on other essential ECD services, such as free health care for pregnant women and children younger than six years, social welfare services for children, nutrition support, the Child Support Grant and the roll-out of grade R.

This case argues that government funding needs to be extended beyond subsidies to ECD centres to include home visiting, community playgroups and toy libraries.

The Children's Act requires each provincial Minister of Social Development to compile a provincial profile of ECD programme needs at prescribed intervals. The national Minister of Social Development must use this information to develop "a comprehensive national strategy aimed at securing a properly resourced, coordinated and managed early childhood development system".[56] Provinces are also required to develop similar provincial strategies. The Act clearly anticipates that the ECD system should incorporate both ECD centres and community-based programmes.

Each province has the primary responsibility for funding ECD programmes through the provincial budget, from the province's equitable share.[vii] However, the Children's Act does not oblige provinces to fund ECD programmes.

Does national government allocate sufficient funding to provinces to fund these programmes adequately?

There is no evidence of funds being added to the provincial equitable share for the subsidy for ECD centres prior to the 2012 Budget when national government announced that it would add R650 million for ECD in 2013/14, and another R700 million in 2014/15. These amounts are intended to enable provinces to equalise the subsidies at R15 per child per day over 264 days per year in 2013/14. The subsidy is intended to cover food (50%), staff (25%) and other costs (25%).[57] However, national government has not explicitly added funding for non-centre-based ECD programmes to the provincial equitable share.

Do provinces prioritise these ECD services adequately in social development budgets?

Provinces structure their budgets according to provincial priorities, but in so doing they are required to provide for obligations set out in the Constitution and national legislation.

Table 4: Provincial funding of ECD centre subsidies in 2013/14 Budgets

PROVINCE	Number of children in poverty quintiles 1 and 2		2013/14 Budget for ECD subsidy (Rands)	Value of subsidy paid over 264 days in 2013/14 (Rands)	Number of children covered by R15 per day subsidy for 264 days	% of poor children covered by subsidy in 2013/14 if policy targets children	
	0 – 5-year-olds	3 – 5-year-olds				0 – 5-year-olds	3 – 5-year-olds
Eastern Cape	464,404	231,551	188,753,000	15	47,665	10	21
Free State	122,832	61,228	181,083,000	14	45,728	40	80
Gauteng	353,108	175,501	265,589,000	15	67,068	19	38
KwaZulu-Natal	634,193	315,607	211,333,000	15	53,367	8	17
Limpopo	396,094	194,453	252,000,000	15	63,636	16	33
Mpumalanga	249,502	123,453	188,000,000	15	47,475	19	38
Northern Cape	56,697	28,177	71,026,000	15	17,936	32	64
North West	212,682	105,684	64,586,000	15	16,310	8	15
Western Cape	139,536	69,735	210,872,000	15	53,251	38	76
Total	**2,629,048**	**1,305,390**	**1,633,242,000**	**15**	**412,435**	**16**	**32**

Note: Some provinces pay the subsidy for fewer than 264 days. This means they reach more children with a lower subsidy.
Sources: Provincial 2013/14 Estimates of Revenue and Expenditure, National Treasury, Department of Social Development; Statistics South Africa (2012) *Census 2011*. Statistical release – P0301.4. Pretoria: Stats SA; Statistics South Africa (2010) *Income and Expenditure Survey 2010*. Pretoria: Stats SA.

vii In terms of the Constitution, a province is entitled to "an equitable share" of nationally collected revenues, which is determined each year by the annual Division of Revenue Act.

However, this does not guarantee that the funds allocated to ECD in the equitable share will reach ECD services in provincial budgets largely because there are no legislated funding norms for ECD services. Table 4 shows that access to the ECD subsidy is very unequal across provinces.

The Children's Act requires that funding of ECD programmes must prioritise poor families and children with disabilities. While access to the subsidy is subject to a means test, it is only available to children who attend registered ECD centres. Most children younger than three years do not attend centres, and so do not benefit from the subsidy.[58] Moreover, poor 3 – 5-year-old children living in rural and informal urban areas where there are few registered centres do not benefit from the subsidy either.[59] There is also nothing in the design of the subsidy that prioritises children with disabilities.

While the current budgets are sufficient to reach about 412,000 children with ECD subsidies, if all poor 3 – 5-year-old children were to attend an ECD centre, the total budget required for the subsidy would be in the region of R5.2 billion. More importantly, to move toward more equitable access, provinces would need to facilitate the establishment of ECD centres particularly in the poorest, rural areas. This will require capital funding for building and upgrading centres. Government should also consider funding the set-up furniture, playground and other equipment and educational toys for ECD centres serving poor communities.

The subsidy amount itself is arbitrary and insufficient to cover the full running costs of an ECD centre. It is assumed that the difference will be covered by parents paying fees, but this is not realistic where most or all of the children attending a centre come from poor families. In such circumstances additional support is needed. The Free State Department of Social Development has estimated that a subsidy of around R36 per day is required to fund an ECD centre catering for 60 children.[viii] This suggests that the subsidy design and amount need to be re-examined towards ensuring equitable coverage of poor children.

ECD centres are not the only approach to providing early learning opportunities for young children. Some provinces have already begun allocating limited funds to reach young children through home-visiting programmes, community playgroups and toy libraries. The extent of these budgets is not known, though coverage is poor. It is calculated that to operate 1,000 home-based visiting teams, 5,000 playgroup teams and 1,000 toy libraries will cost about R5 billion per year. This would enable 400,000 families to be part of a home-visiting programme and 625,000 children to attend playgroups once a week. The number of children that would benefit from the toy libraries is difficult to determine.[60] If provinces were to contract out these services, they should ideally be funded on a programme basis, as opposed to using a subsidy approach.

Are these funds available?

Given the current economic circumstances, government is probably not in a position to immediately fund the mentioned amounts. It would also not be wise to do so, given that provincial Social Development departments do not have the plans or the institutional capacity to manage a significant expansion of ECD services. The strategy therefore needs to be to keep ECD on the political agenda so that additional funds are made available as provinces develop the necessary plans and capacity to roll out additional ECD centres and non-centre-based programmes.

Is it possible to ensure that provinces allocate additional funds to ECD services?

Two ideas are often put forward in this regard:

- The funding of these ECD services must be made mandatory when the Children's Act is reviewed (currently underway).[ix] Through this change Parliament would be signalling that the provision of ECD services must be prioritised when provinces prepare their budgets. However, none of the "must fund" services in the Act are being fully funded by government, and it remains to be seen to what extent such "must fund" provisions are enforceable through the courts.
- The allocations for ECD need to be ring-fenced. However, the Constitution does not allow portions of a province's equitable share to be ring-fenced, so the only other option would be to provide a national conditional grant. This would represent a departure from the current purposes for which national government uses conditional grants,[x] as it would mean ring-fencing funding for on-going operations. If government were to go down this route, it would raise questions as to why funding for other priority services should not be treated similarly, and ultimately why provinces should exist at all.

A far more certain approach to ensuring ECD services are properly funded by provinces is for the national Department of Social Development to regulate uniform norms and standards on the content and funding of the ECD centre subsidy and non-centre-based programmes. This would create specific, enforceable legislative obligations that provinces are required to implement, as opposed to the current ECD guidelines, which are not enforceable.

Ultimately, the most effective way of ensuring that provinces fund ECD services is through advocacy. Once policy-makers recognise the critical importance of early intervention, they can become champions to ensure that funds are made available to give every young child the best opportunity to grow and develop.

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x National government generally only uses conditional grants to: fund cross-boundary spill-overs associated with some provincial services; facilitate the introduction of a new function or the shifting of a function away from provinces; fund infrastructure; and to address short-term priorities, such as capacity-building or incentivising job creation.

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Promoting healthy growth: Strengthening nutritional support for mothers, infants and children

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The first 1,000 days[i] offers a critical window of opportunity to address the nutritional needs of children and enable them to grow into healthy productive adults.[1] After this time, the effects of undernutrition may be irreversible. It is estimated that, in developing countries, 200 million children fail to realise their developmental potential because of poverty, poor health and nutrition, and lack of care.[2] Investing in nutrition interventions in early childhood can enhance cognitive function, schooling outcomes and economic productivity later in adulthood.[3] Nutrition interventions should therefore be seen as a critical component of an essential package of early childhood development (ECD) services and support (see the essay on pages 26 – 33).

This essay seeks to answer the following questions:

- What key factors place young children at risk of malnutrition?
- What is needed to support children's optimal growth and nutrition?
- How can we improve the reach and quality of nutrition services for young children?
- What interventions are critical in the short and long term?

What key factors place young children at risk of malnutrition?

Undernutrition is a leading cause of child morbidity and mortality in Sub-Saharan Africa.[4] In South Africa, malnutrition is associated with more than 60% of all child deaths in hospitals.[5] The recent South African Health and Nutrition Examination Survey (SANHANES-1),[6] which included children aged 0 – 14 years, showed that 15.4% of children were stunted and 5.4% were underweight[ii]. This suggests a decrease in the overall rates of stunting and underweight compared to 2005.[7] High rates of stunting were especially prevalent in children aged 0 – 3 years (26.9% for boys and 25.9% for girls. There were also high rates of overweight and obesity (16.5% and 7.1% for girls compared to 11.5% and 4.7% for boys respectively).

There are also high levels of micronutrient deficiencies. The national prevalence of vitamin A deficiency (VAD) was 43.6%, with all the provinces having a significant public health problem of VAD. Of the children sampled, 10.5% were anaemic, 11% were iron deficient and 2.1% had iron deficiency anaemia. High levels of deficiency in other critical micronutrients reported in the 2005 survey included zinc (45%) and iodine deficiency (15%).

Immediate and underlying causes of malnutrition

The immediate determinants of malnutrition in childhood include inadequate food intake and illness. For example, diarrhoea is a leading cause of death in young children and is strongly associated with stunting, with the odds of stunting increasing with each episode of diarrhoea in the first two years of life.[8]

Lack of access to food and micronutrients (eg iron) and exposure to infection such as HIV/AIDS during pregnancy can result in maternal undernutrition and low birth weight, which in turn contribute to underweight and stunting in children.[9] Iron deficiency anaemia in the mother can also impact on the mother's emotional and cognitive functioning, on mother–child interaction and on the baby's development.[10]

The underlying determinants of malnutrition in childhood include food insecurity, inadequate maternal care, insufficient health services and an unhealthy environment. The SANHANES – 1 survey found that 45.1% of households nationally were food secure with 28.3% at risk of hunger and 26% experiencing hunger.[11] Severe acute malnutrition in children younger than 12 months is increasing in South Africa,[12] which points to poor infant feeding practices, most notably inadequate or no breastfeeding, the early introduction of other fluids and food before the age of six months, and inappropriate diets for older children.[13]

Overweight and obesity

The prevalence of overweight and obesity in children under five is increasing globally and child overweight is an important contributor to obesity, diabetes and other chronic diseases in adulthood.[14] Maternal overweight and obesity during pregnancy increase the risk for childhood obesity,[15] while breastfeeding protects children from overweight and obesity[16].

Consequences for child development

Childhood malnutrition is associated with poor developmental outcomes. Studies show links between height-for-age and cognitive or language ability at five years, school enrolment, and grades attained by late adolescence. Long-term outcomes associated with stunting include reduced formal employment at 20 – 22 years and poor psychological functioning.[17]

Micronutrients are also critical for children's development. For example, iron deficiency anaemia in infancy and the preschool

i Pregnancy and the first two years of life.
ii Underweight (low weight-for-age), stunting (low height-for-age) and wasting (low weight-for-height) are based on cut-offs of < - 2 standard deviations from the norm. Underweight reflects acute and chronic malnutrition; stunting points to chronic malnutrition; and wasting is the result of acute malnutrition.

period is associated with poor cognitive, motor, and social–emotional development.[18] Iodine deficiency during pregnancy impairs growth, motor and mental development of the foetus and could even lead to reduced intelligence quotient (IQ) when there is a chronic deficiency in the population.[19]

National policy context

A 2012 Save the Children global report noted that South Africa was not making sufficient progress towards Millennium Development Goal 4,[iii] and identified a lack of political commitment to reducing malnutrition as the main reason for South Africa's underperformance. Examples of underperformance included: only 60% of babies were put to the breast within an hour of birth, 8% were exclusively breastfed, 70% were introduced to complementary feeds between six and nine months, and 50% were breastfed until two years.[20]

The National Development Plan (NDP) places important emphasis on nutrition for pregnant women and young children. The Department of Health has also put in place a range of policies and programmes to address malnutrition:

- A dedicated Nutrition Directorate and an Integrated Nutrition Programme;
- A Roadmap for Nutrition in South Africa 2013 – 2017;
- The Tshwane Declaration of Support for Breastfeeding in South Africa (promoting exclusive breastfeeding regardless of the mother's HIV status);
- The Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa 2012 – 2016;
- The launch of the global Campaign for Accelerated Reduction of Maternal and Child Mortality in Africa;
- The revision of the guidelines on the prevention of mother-to-child transmission (PMTCT) to allow all HIV-positive women to continue breastfeeding their infants up to 12 months of age.

While the recent SANHANES-1 survey provides updated information against which to measure progress, the absence of robust monitoring and evaluation systems makes it difficult to assess on-going progress.[21] It is anticipated that the diagnostic review on nutrition for children under five years undertaken by the Department of Health and the Department of Planning, Monitoring and Evaluation in the Presidency will shed light on the current challenges and opportunities. The results are expected in October 2013.

What is needed to support children's optimal growth and nutrition?

There is strong evidence that proven interventions have a positive impact on maternal and child undernutrition.[22] Intervention during the first 1,000 days is crucial, and a curative rather than preventive approach to malnutrition is less successful as it intervenes too late. Studies describing the scaling up of critical and effective early interventions demonstrated high cost effectiveness, with high returns in cognitive development, individual earnings and economic growth.[23]

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Vegetable gardens help make nutritious food available to families and children.

There are currently six nutrition interventions which could save lives and prevent malnutrition and stunting in children: breastfeeding, complementary feeding, folate and iron, vitamin A, zinc and hygiene. These interventions should be linked to a broad range of services to promote or support the development of young children and respond to their multiple needs (see the essay on pp. 26 – 33 for a detailed discussion of these services). These interventions, discussed below, can be delivered at less than $20[iv] per child during the first 1,000 days.[24]

Breastfeeding

Significant protective effects can be achieved with exclusive breastfeeding in the first six months, the introduction of complementary feeding at six months, and continued breastfeeding until two years. Breastfed babies are more likely to survive and to have higher IQ scores and school grades than non-breastfed babies.[25]

iii MDG 4 requires a two-thirds reduction in under-five mortality between 1990 and 2015.
iv This amount is the equivalent of R207 as at August 2013.

Complementary feeding

Frequent, complementary feeds (five small meals are recommended) of locally available foods adequate in nutrients and micronutrients and safely prepared could decrease stunting by 20% at 12 months.[26] Optimal feeding from birth to two years can prevent 19% of all under-five deaths, which is more than any other intervention.[27] Food supplements to promote better growth benefit reading, comprehension and reasoning when given from birth to 24 months.[28]

Micronutrients

Zinc supplementation with oral rehydration solution reduces diarrhoea incidence, severity and duration.[29] A course of zinc treatment for diarrhoea costs about R2.20 (22 cents a tablet). Similarly, vitamin A can reduce child deaths by 23% at a cost of 20 cents per child a year for two capsules. Supplementation with multiple micronutrients improves motor development in children, while fortifying feeds with iron improves IQ.[30]

Hygiene

Poor access to safe water and sanitation exposes children to the risk of diarrhoea and dysentery. Hand washing with soap and water is one of the most inexpensive ways of preventing diarrhoea and lower respiratory tract infections. There is evidence to show that hand washing and hygiene can reduce the risk of diarrhoea by 30%.[31]

Maternal health, nutrition and well-being

Another critical area for intervention is ensuring adequate nutrition for mothers during the antenatal and postnatal period to meet their babies' nutritional and development needs. Inadequate nutrition in pregnancy impacts on maternal health, results in foetal growth restriction, and contributes to neonatal deaths[v] and higher rates of stunting in the children who survive.[32]

The emotional well-being of mothers is a key ingredient, since depressed mothers are likely to be less engaged with and responsive to the needs of their children, who may then become malnourished.[33] Programmes that use mother-to-mother support and home visits can enhance maternal well-being and improve children's nutritional outcomes. It is essential that ECD services integrate stimulation for early learning, nutrition and maternal psycho-social support as these interventions all impact on children's growth and development.

How can we improve the reach and quality of nutrition services for young children?

South Africa's "Nutrition Roadmap"[34] incorporates these six key interventions and emphasises adequate nutrition during the first 1,000 days (see table 5 on p. 48). It also proposes integrating the key nutrition interventions into existing policies and programmes and making use of a variety of delivery platforms including home visits, community-based services, health facilities and population-based services.[vi]

It is essential that programmes address co-occurring risk factors (such as poverty, stunting and lack of stimulation) by linking stimulation for early learning with nutrition interventions to optimise growth.[35] Improved access to social security (such as the Child Support Grant) and parental education and support programmes are other necessary components for improving children's nutrition and development (see the essay on pp. 56 – 61).

ECD centres

Incorporating key nutrition interventions into formal ECD centres could enhance young children's nutritional and developmental outcomes. These interventions include: growth monitoring and promotion; nutrition counselling for caregivers and centre managers using the Food-Based Dietary Guidelines (FBDG);[vii] vitamin A supplementation; deworming; modelling hygienic practices; and food security measures such as menu planning, providing nutritious meals, and establishing food gardens. Community health workers can now dispense vitamin A capsules, a service which could easily be integrated into ECD centres.

Therefore, the development of nutritional support materials and training of ECD workers are necessary. For example, the nutritional needs of children attending ECD centres in the Western Cape are being met by training ECD workers in meal preparation, developing a manual of affordable and nutritious meals, and establishing food gardens for meals and income generation. These activities can be replicated in other settings.

ECD centres provide a useful mechanism for the delivery of nutrition support to older children, as attendance is poor amongst 0 – 3-year-olds and amongst children in poor communities.[36] Hence, it is vital that nutrition services are provided through home visits by community health workers (CHWs), community-based services and parent support groups, focusing on the poorest communities.

Home- and community-based services

Primary health care (PHC) re-engineering aims to strengthen the health care system by establishing district specialist teams, community-based outreach teams and school health teams with a strong focus on maternal and child health. Community-based outreach teams could bridge the gap between health facilities and households and improve access to nutrition services for young children.[37] The district paediatrician is in an ideal position to coordinate the inclusion of nutrition across a range of services, and a dietician should be included in the district specialist team. CHWs have successfully implemented key nutrition interventions in Vietnam, Cambodia and Nepal. For example, stunting in Vietnam was reduced by 60% over two decades through screening for malnutrition, treating diarrhoea, and providing counselling about infant feeding and hygiene.[38]

v Neonatal deaths are deaths within 28 days of life.
vi For example, mass media campaigns on the value of breastfeeding.
vii The Department of Health's 2004 document, *South African Guidelines for Healthy Eating,* provides guidance on the appropriate content of meals to support adequate nutrition.

Community-based nutrition interventions can be delivered through:

- structured home visits starting within three days of birth;
- breastfeeding and other support groups;
- outreach from PHC clinics;
- child health-focused days or weeks to increase coverage of interventions such as vitamin A and deworming; and
- support to ECD centres.[39]

Some of these community services could include the key nutrition interventions to prevent malnutrition; assess children for malnutrition; treat common childhood conditions; and offer counselling and support for caregivers. CHWs, who are often from the community, understand local culture, practices and beliefs, and are thus in an ideal position to implement effective health care (see case 4 below).

If CHWs are to become frontline nutrition workers, they will need adequate support, training and remuneration. While CHWs now administer vitamin A, their scope of practice will need to be widened so they can administer other micronutrients (eg iron, folate and zinc) and treat common childhood conditions.

Health facilities

It is recommended that PHC facilities focus on improving the quality of health care by:

- scaling up existing programmes such as the integrated management of childhood illness (IMCI) and basic antenatal care (BANC), and incorporating nutrition-related interventions;[40]
- linking nutrition assessments with nutrition counselling messages;
- strengthening implementation of nutrition guidelines;
- providing assessment support and care for those with HIV or tuberculosis, especially as these conditions contribute to malnutrition;
- developing supervision tools; and
- strengthening linkages between facility- and community-based nutrition services to ensure that children with health and nutrition problems are referred to health facilities and those who are malnourished or at-risk are accessing an ECD service.

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Preparing lunch for young children at Jujurha preschool.

Schools

Schools provide an ideal site to reach older children and the National School Nutrition Programme provides meals to school-going children in the poorest quintiles. Schools also have the potential to promote good nutrition by incorporating the Food-Based Dietary Guidelines into the foundation phase curriculum.[41]

What interventions are critical in the short and long term?

This section identifies short- and long-term interventions that, if implemented at scale, are likely to prevent and manage childhood malnutrition. Table 5 on the next page illustrates key interventions in the short term, and potential delivery platforms.

Case 4: Mentor mothers reach into vulnerable homes
Elizabeth Brouckaert, Siyabhabha Trust – Caritas South Africa

The Yakhumndeni Mentor Mother Project operates in 11 neighbourhoods in the Endumeni local municipality in KwaZulu-Natal. Nineteen mentor mothers, trained by the Philani Child Health and Nutrition Project, do house-to-house and follow-up visits, where their brief is to *screen, refer, support, monitor* and *advise*.

The mentor mothers screen expectant mothers and malnourished young children within neighbourhoods regarded as vulnerable. They are equipped with precision medical scales, mid-upper arm circumference tape measures, cord care and rehydration kits. Caregivers and expectant mothers are advised about nutrition and how to access local services and resources. Detailed case folders are maintained for families and case details are communicated by sms to the project office where a registrar captures the data.

Linkages are maintained with government via the local project leader who participates in the Endumeni Local Task Team for Operation *Sukuma Sakhe* – the provincial "war on poverty". There is a detailed escalation process that monitors and documents actions by the clients and government services to ensure maximum benefit for vulnerable women and children.

For more information, see www.siyabhabhatrust.org.za.

Table 5: Nutrition interventions and multisectoral approaches to ECD services in South Africa

Life cycle		Evidence-based interventions	Delivery platforms	Existing programmes
First 1,000 days	Pregnancy	• Preconception care • Identification of malnutrition in pregnancy and prevention of low birth weight • Micronutrient supplements (iron, folate and calcium) • Iodised salt • Deworming • Reduction of air pollution and smoking • Prevention and treatment of malaria • Optimal weight management	• Basic antenatal care at primary health care clinics and hospitals • Community-based services	• Prevention of mother-to-child transmission • Mother and Baby-Friendly Hospital Initiative • Basic antenatal care • Infant and young child feeding
	Birth	• Immediate and exclusive breastfeeding • Delayed cord clamping (increase newborn's iron stores) • Access to the Child Support Grant	• Maternity units • Hospitals • Community-based services	• Mother and Baby-Friendly Hospital Initiative • Primary health care
	0 – 6 months	• Exclusive breastfeeding • Promotion of hand washing and hygiene • Management of infectious diseases eg diarrhoea, pneumonia • Treatment of moderate and severe acute malnutrition • Access to the Child Support Grant	• Primary health care clinics and hospitals	• Mother and Baby-Friendly Hospital Initiative • Primary health care, including Road-to-Health booklet
	6 – 24 months	• Continued breastfeeding • Complementary feeding • Micronutrient supplements (vitamin A, iron and zinc) • Food fortification and iodised salt • Promotion of hand washing and hygiene • Zinc supplementation for diarrhoea • Deworming • Growth monitoring and promotion • Prevention and treatment of moderate malnutrition • Treatment of severe acute malnutrition • Targeted supplementary feeding • Access to the Child Support Grant	• Primary health care clinics and hospitals • Early childhood development facilities • Community-based services	• Child health primary health care package • Community-based programmes
Continued investment in nutrition 2 – 9 years	2 – 5 years	• Growth monitoring and promotion • Treatment of severe acute malnutrition • Food fortification and iodised salt • Micronutrient supplementation (vitamin A, iron and zinc) • Deworming • Hand washing and hygiene • Nutrition education on healthy diets and risks associated with poor diets • Access to the Child Support Grant	• Primary health care clinics and hospitals • Early childhood development facilities • Community-based services	• Primary health care
	5 – 9 years	• Health screening • Deworming • Food-Based Dietary Guidelines • Hand washing and hygiene • School feeding • Access to the Child Support Grant	• Primary health care facilities • Hospitals • Schools • Community-based services	• Child health primary health care package • School health • National School Nutrition Programme

Sources: Modified from: Department of Health (2012) *Roadmap for Nutrition in South Africa 2012 – 2016*. Pretoria; Save the Children (2012) *Nutrition in the First 1,000 Days: State of the World's Mothers*. Westport, USA: STC.

Long-term progress will require political commitment and leadership to address policy and implementation challenges to ensure that every child gets the best start in life. This includes:

- Making nutrition a national priority, ensuring adequate funding and setting realistic targets for progress.
- Establishing a functional district health system which incorporates the PHC re-engineering strategy and strengthens the PHC system at facility and community level.
- Implementing key nutrition interventions during the first 1,000 days and integrating them into existing programmes (see table 5) by using multisectoral approaches that are sustainable and implemented at all levels.
- Strengthening inter-sectoral coordination and integrated service delivery by establishing a national task team which includes civil society and the Departments of Health, Education and Social Development.
- Targeting children living in poor communities and those with disabilities who are at risk of malnutrition.
- Ensuring the availability and equitable distribution of PHC workers, including CHWs who are trained and have the resources to implement nutrition interventions.
- Ensuring on-going monitoring and evaluation of a core set of nutrition indicators to track progress and inform decision-making at district level.
- Creating and building enabling environments in the community to support nutrition interventions and programmes to enhance growth and development.

Conclusion

Current nutrition policy in South Africa supports the prevention and management of malnutrition in early childhood and places a special focus on the first 1,000 days. There are six key nutrition interventions that can be implemented in the short term and linked to ECD services. However critical challenges within the health care system need to be addressed as a matter of urgency in order to achieve positive nutritional and developmental outcomes for children. This requires a shift from producing state-of-the art policies to action and effective policy implementation.

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Beyond survival: The role of health care in promoting ECD

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The public health care system reaches more children and their families during the first three years of life than any other service. It thus has a specific responsibility to use these contact opportunities to strengthen families' efforts to promote the health, growth and development of children.

During the early years, children exhibit great plasticity[i] and respond better to intervention and stimulation than at any other time in life. However, the health sector has been slow to recognise its role in delivering an essential package of early childhood development (ECD) services (see the essay on pp. 26 – 33). Many health professionals still confuse ECD services with early childhood education, while others equate ECD with developmental screening.

In reality, ECD services should foster physical growth, social and emotional development, language and cognitive skills. Ensuring children's optimal development across all these domains is a major objective of the health service. Good antenatal care, breastfeeding, growth monitoring and immunisation should be considered core ECD interventions, as should efforts to support neuro-cognitive development.[ii]

The Department of Health does not refer to any of its interventions as ECD services, nor did it explicitly align itself with the vision outlined in the National Integrated Plan for ECD 2005 – 2010. However, recent policy initiatives such as National Health Insurance (NHI) and primary health care (PHC) re-engineering offer opportunities for the health system to assume a lead role in the provision of essential early childhood interventions, particularly in the critical first 1,000 days.[iii]

This essay highlights the pivotal role of the health care system in ECD service delivery, and attempts to answer the following critical questions:

- What are the early risk factors for poor child health and development?
- Why should the health sector play a lead role in ECD services?
- What are essential health sector-led actions for promoting ECD?
- What are the opportunities and barriers to effective service delivery in the health sector?

What are the early risk factors for poor child health and development?

Many factors disrupt early child health and development. Four risks affect at least a quarter of young children in developing countries: malnutrition that is chronic and severe enough to cause stunting, inadequate stimulation or learning opportunities, and iron and iodine deficiencies.[1] Other recognised risks include malaria, worm infestations, maternal depression, intrauterine growth restriction[iv] and exposure to violence and environmental toxins.[2] Poverty is a pervasive underlying risk.

South Africa's children are unduly affected by HIV/AIDS and tuberculosis, either directly through infection or indirectly through illness or death of their caregivers. Despite antiretroviral therapy, HIV-infected children's growth and development often lag behind their peers.[3] Over a quarter of the country's child population are exposed to (but not infected by) HIV[4] and are at increased risk of economic, social and food insecurity.[5]

A single risk factor does not necessarily lead to poor health and development outcomes.[6] Risk factors are cumulative, interactive and tend to compound each other; the more adversity children experience, the more likely they will suffer poor outcomes. Many risks cluster in the same individuals.

Why should the health sector play a lead role in ECD services?

There are two main ways in which health and child development interact. One is the effect of poor health on the development of children, and the other is the health sector's potential to promote optimal child development.

The health care system provides the only existing public infrastructure in South Africa to reach all children under three years regularly, and health care encounters offer an ideal opportunity for professionals to have a positive influence on the development of young children. Health care providers can influence the health of the growing foetus through antenatal care, the infant immediately after birth, and the young child through regular clinic visits. Health care encounters can also act as a gateway to other services such as social grants, child protection and psychological care.

i "Plasticity" refers to the brain's ability to change as a result of experience.
ii The development of the brain and thinking skills.
iii Pregnancy and the first two years of life.
iv "Intrauterine growth restriction" refers to the poor growth of a baby while in the mother's womb. Specifically, it means the developing baby weighs less than 90% of other babies at the same gestational age.

The role of the health sector in promoting optimal nutrition, disease prevention and control is well recognised. All infants in South Africa should be immunised four times in the first year of life. Monthly well-baby visits (for services such as growth monitoring, oral health and developmental screening) are encouraged and sick child visits may also occur. Further well-child visits are scheduled for older children, but up-take is poor.

As child survival improves, the health sector increasingly must regard the optimal development of all children as a key outcome. As trusted sources of information and support, skilled health workers can help families understand the importance of child development, and provide guidance and support to caregivers.

What are essential health sector-led actions for promoting ECD?

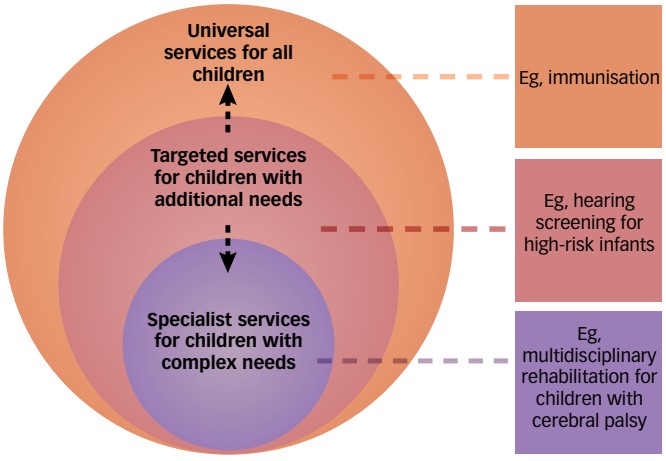
A review[7] of health programmes to support ECD service delivery in disadvantaged settings concluded that effective programmes should:

- focus on the first two to three years of life as this has the greatest impact on future growth and development;
- target children who are most at risk, as improvements are greatest in the poor and undernourished;
- involve parents and other caregivers in improving the child's care; and
- combine interventions such as promoting nutrition, mother–child interactions and psycho-social development.

Levels of health provisioning for young children

ECD should be regarded as a progressive universal[v] service. It should comprise a universal prevention and early identification service offered to all young children and families, and a smaller subset of specialist services for those with specific needs and risks (see figure 5). Children's needs are not fixed but can alter as circumstances change and children may move back and forth between different levels of service. An effective ECD system should be able to identify children at high risk and ensure their families receive a personalised service.

Figure 5: Progressive universalism in child health services



Case 5: Gauteng initiatives for early childhood intervention

In 2010, the Rehabilitation Directorate of the Gauteng Department of Health started a consultative process on early childhood intervention (ECI) as many children were not identified or referred early enough for much needed therapeutic and support services.

In response, a provincial multidisciplinary task team on ECI was formed, comprising representatives from the therapeutic professions; social workers; academics in child health and development; and the provincial Health, Social Development and Education departments. The Gauteng Early Childhood Development Institute and the Office of the Premier are also represented.

Over the past two years a framework for delivering ECI in Gauteng has been developed in consultation with health professionals. With no additional financial or human resource investment, most districts in Gauteng have implemented targeted ECI programmes. These range from hearing screening for high-risk infants in tertiary and secondary hospitals, to support groups for parents of children with disabilities and developmental delay, and workshops for parents on how to make toys from recyclable waste.

At district level, therapists have provided screening and intervention for children, and trained early educators to identify and support children with developmental difficulties and disabilities.

The enthusiasm and innovation that health professionals have shown in developing ECI initiatives is encouraging and suggest that such initiatives could be introduced in all provinces if the required strategic framework, guidance, support and resources are provided.

Early identification and intervention

Current services focus on rehabilitating health and developmental problems. Children with developmental problems or disabilities are often identified too late, and there are numerous difficulties in ensuring that they receive the required intervention and support.[8]

By addressing problems early in life, and intervening as soon as possible, the negative effects of risk factors (eg low birth weight, illness or developmental delay) are likely to be reduced.

At a local level, some coordinated attempts have been made to promote ECD within the public health service, including the Gauteng Early Childhood Intervention task team (see case 5) which aims to strengthen prevention and early intervention services.

The role of primary health care

The new Road-to-Health booklet includes a simple monitoring chart that clinic staff can use to track children's progress in relation to developmental milestones. This can be used to raise awareness of what a healthy child should be able to do at different stages

v 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.

of development, but it is not clear how well it is implemented. Children who are not progressing should then be referred to early intervention services.

Some international programmes use screening tests to identify children with potential developmental delays.[9] However these tests are difficult to design and standards are affected by cultural and family practices.

Currently, developmental assessments are not routinely carried out at PHC level and there are shortages of appropriately skilled staff and resources to conduct assessments and provide follow-up care. Providing support for children with disabilities or developmental delays is a complex process. It requires high quality assessments by trained professionals; effective information-sharing and collaboration by practitioners; working with parents to develop joint action plans; locating needed services within and beyond the clinic or hospital; arranging successful referrals; and conducting on-going monitoring and evaluation of intervention impacts.[10] Rehabilitation services are thinly spread and not available at over 70% of public health facilities.[11] In the absence of integrated, readily available and accessible early intervention services, the World Health Organisation has recommended the use of a counselling approach. This builds on the integrated management of childhood illness (IMCI) counselling process, by including a Care for Child Development module, as outlined in case 6.[12] In addition, referral mechanisms and specialist services need to be strengthened.

Community-based health interventions

Many health promotion and prevention strategies are ideally delivered through community-based interventions. Community health workers (CHWs) are a critical component of PHC re-engineering, and it is envisaged that they will support early development, promote good parenting, and refer children to services when required. However, there is a significant risk that these responsibilities may be unrealistic and overwhelming since their roles will not be restricted to maternal and child health.

Non-governmental ECD organisations have successfully used community agents to deliver home-based ECD initiatives to children outside formal ECD centres,[19] which generally have a limited health focus. The ECD community agent operates within an ever-expanding range of mid-level workers providing services at a home- and community-based level. Due consideration would have to be given to the overlap of roles (with other community agents); coordination and regulation of these workers at a district or ward level; as well as whether a discrete package of ECD services delivered by these workers would be most effective when implemented as a vertical or an integrated service.

Integrated child health services

Over the past two decades there has been a shift from treating diseases to preventing illness by providing a continuum of care from homes and communities to clinics and hospitals. There has also been a move to integrate different child health programmes by linking key interventions into existing services. This approach reduces costs, increases efficiency and achieves better outcomes, particularly for children who "fall through the gaps".[20]

However ECD interventions (such as nutrition, health promotion and child development) are currently provided in separate maternal, reproductive, child health, HIV/AIDS, nutrition and health promotion programmes. A more ambitious and comprehensive approach would be to integrate all these services under a mother and child (or family) umbrella. Figure 6 illustrates one such integrated package delivered at community, primary care and hospital levels. It deliberately differentiates "traditional" services from those with a "developmental" focus (highlighted in *italics*). Traditional services have long been offered by the health service (with variable success), while the developmental interventions would require new and/or specific actions to ensure effective delivery.

Case 6: Care for Child Development

The Care for Child Development module focuses on what caregivers can do to respond to their children's needs, and introduces activities to stimulate children's physical growth and intellectual and social development. Where specialised services are available, children with difficulties and delays can be referred to professionals for further assessment and support.

Studies have shown the effectiveness of the module in improving the quality of health professionals' interaction with caregivers. Trials in Brazil,[13] South Africa,[14] and Turkey[15] have found that it took relatively little time (7 – 11 additional minutes per consultation), resulted in increased satisfaction with health care visits, and increased participation in other visits. A home visit, one month after the intervention, found significantly more homemade toys, and children being read to.[16] This is an attractive approach for South Africa as it allows health professionals with limited skills and experience in child development to identify and respond to growth or developmental faltering. Using what is already available, and building on the skills and strengths within the family unit, it enables caregivers to provide age-appropriate and responsive care to young children.

Overburdened facility-based health workers do not prioritise child development and assess it routinely,[17] and many health workers display an aversion to counselling activities.[18] So it is worth exploring the feasibility of community health workers using the module at household level.

Figure 6: Integrating ECD services into the package of maternal, newborn and child health

Places of caregiving

	Pre-pregnancy	Pregnancy	Newborn/postnatal	Childhood
Clinical	• Contraception • Sexually-transmitted infections case management • HIV counselling and testing	• Termination of pregnancy • Antenatal care • HIV services, including antiretroviral treatment and prevention of mother-to-child transmission • *Mental health screening* • *Counselling on feeding choice after delivery*	• Institutional delivery • Emergency obstetric and newborn care • Prevention of mother-to-child transmission of HIV • Extra care of pre-term babies (eg kangaroo mother-care) • Contraception • *Maternal mental health screening* • *Social support for parents* • *Breastfeeding support* • *Maternal and neonatal infection prevention (education and screening)*	• Hospital care of childhood illness • HIV care and antiretroviral treatment for mother and child • *Early intervention for children with identified developmental problems or disabilities*
Outreach/outpatient	• Contraception • HIV and sexually-transmitted infections prevention • *Folic acid for women of child-bearing age*	• *Nutrition and micronutrient supplementation* • *Counselling on obstetric "danger signs", birth preparedness, post-delivery feeding choices or practices* • *Mental health screening*	• Early detection and referral of maternal and newborn illness • Additional care and support for "high-risk" babies (eg low birth weight, prematurity and those with established disabilities) • Prevention of mother-to-child transmission of HIV • *Nutrition counselling and supplementation (where required)* • *Counselling on key caregiving practices that promote child health, growth and development* • *Integrated management of childhood illness: Care for Child Development module*	• Immunisation • Growth monitoring, nutrition support, vitamin A supplementation and deworming • Integrated management of childhood illness: Chronic illness • *Breastfeeding support* • *Child development screening (Road-to-Health booklet)* • *Integrated management of childhood illness: Care for Child Development module (well- and sick-baby visits)* • *Outreach to early care and education settings to provide screening or assessment; care and support to children with disabilities; and education of staff on appropriate care and intervention* • *School health screening and health promotion*
Family/community	• Family planning awareness and education • HIV and sexually-transmitted infections prevention • *Adolescent nutrition* • *Education and promotion on adolescent sexuality and health*	• *Promotion of key caregiving practices* • *Mental health screening* • *Promotion of adequate maternal nutrition*	• *Promotion of key newborn care and hygiene practices* • *Promotion of key caregiving practices* • *Maternal mental health screening*	• Integrated school health programme • *Promotion of key caregiving practices* • *Early detection, referral and intervention for childhood illness and developmental problems* • *Injury prevention*

Caregiving throughout the lifecycle

Source: Adapted from: Kinney MV, Kerber KJ, Black RE, Cohen B, Nkrumah F, Coovadia H, Nampala PM & Lawn JE, on behalf of the Science in Action: Saving the lives of Africa's mothers, newborns, and children working group (2010) Sub-Saharan Africa's mothers, newborns, and children: Where and why do they die? *PLoS Medicine*, 7(6): e1000294. doi:10.1371/journal.pmed.1000294.

Despite calls for integrated care, there are only a handful of efficacy trials and even fewer examples of integrated interventions that have been taken to scale.[20] The re-engineering of PHC, with its focus on district-based specialist teams, school health services and community health workers, provides an ideal opportunity to test new models of integrated delivery in a local context.

What are the opportunities and barriers to effective service delivery in the health sector?

For integrated ECD interventions to be successful, a variety of challenges must be addressed. These include the work-load of staff and supervisors, especially CHWs, and communication and coordination among different sectors. ECD service delivery in the health system also requires a paradigm shift from a "sick-care" to a "well-care" approach,[2] and a fundamental shift in the way health professionals and health services interact with children and caregivers.

Table 6 identifies what is needed to strengthen the delivery of ECD services across the continuum of care, and outlines the current situation as well as medium- and long-term goals.

Some critical investments required to promote ECD within the health sector are:

- Increased availability of required human resources (all cadres), particularly at clinic and community level.

Table 6: Strengthening the delivery of ECD services in maternal and child health

	Current situation	Possible situation (medium term)	Future situation (long term)
Prioritising child health	Limited focus on maternal and children's primary care services, despite political commitment.	A special focus on improving maternal (antenatal) and children's health services.	Maternal and child health considered an explicit priority in all health system planning.
	No core programme or package of services supporting maternal and child health and development.	Minimum core programme or set of interventions (universal package of services).	Universal core package, plus programme and services to meet different needs and risks (progressive universalism).
	Variation of service provision according to location.	Less provincial and district variation in service provision (greater equity).	Variation in provision according to individual need.
Coordination	Separation of maternal and child services, and different types of services (eg growth monitoring, immunisation, developmental screening). Changes introduced independently, responsible to different directorates, with little overlap.	Integration of various maternal and child clinical services and programmes, within an age-specific package, in a continuum of care framework.	Better integration and information-sharing between maternal and child services, as well as reproductive, school health and mental health services.
Redefining health: from treatment to prevention	A focus on treatment.	A focus on surveillance and health promotion and prevention.	A greater focus on parenting/caregiving support, as well as surveillance and health promotion/prevention.
	Limited needs assessment.	Active assessment of current need.	Assessment of current need and future risk.
	Little attention to individual needs during consultation.	A focus on individual health promotion during face-to-face contact in various settings.	Consultations use skills and tools that promote behaviour change. Better use of media and social communication tools.
	A programme that deals opportunistically with problems.	A programme that identifies and addresses problems, deficits and risks.	A programme that seeks and builds on individual strengths and protective factors – as well as ameliorating risks.
	Well-child service centred on immunisation.	Well-child schedule influenced by physical developmental stages and screening tests.	Schedule determined by social and emotional developmental stages, parental receptiveness and parents' priorities.
Capacity-building	Programme delivered by nurses (and by doctors for a few).	Programme delivered by a team of health practitioners (eg doctors, dentists, nurses, allied professionals, community health workers).	Programme managed by home visitors (nurses, community health workers), drawing on a range of practitioners, and delivered through homes, primary health care centres and children's centres.
	Poor supervision of staff. Little focus on quality improvement and outcomes.	Increased supervision and mentoring. Focus on quality improvement and outcomes.	Regular supervision and mentoring. Monitoring of quality and outcomes of individual practitioners and teams.

- Expansion of prevention and health promotion programmes, such as the Care for Child Development module of the IMCI, at a facility or community level.
- Coordinated efforts to deliver the majority of ECD services at community level.
- Stronger linkages with early learning programmes to ensure health services (eg screening, immunisation) reach preschool children.
- Reduction of environmental risks to child health, especially through the provision of adequate water, sanitation and electricity.

In particular, the following three actions are critical to improve the reach and quality of essential ECD health services:

- Greater efforts to strengthen services for pregnant women and children in the first 1,000 days of life, with a particular focus on caregiving, community- and home-based care, and support for young children not in ECD centres.
- Improved mechanisms for early identification, referral and intervention for children at risk, especially those with disabilities, and those with emerging conditions or illnesses.
- Creative thinking about how to effectively integrate and package interventions both within the health sector and between the health sector and external partners.

Both the NHI and PHC re-engineering offer opportunities to prioritise the ECD agenda within the health sector and to explore innovative delivery mechanisms for key ECD interventions or services. While the benefits of ECD services are easily recognisable, it is not obvious how best to establish these interventions within an NHI framework. Undoubtedly, this requires champions to develop innovative solutions, demonstrate their feasibility and effectiveness, and to advocate for wider implementation. Although opportunity clearly exists, there are too few champions at present.

Conclusion

This essay has explored how stronger linkages for the promotion of ECD can be created within and outside the health system. The early intervention task team in Gauteng shows that early intervention services can be strengthened without huge investment if the necessary strategic coordination and guidance are in place. However, for successful outcomes and longevity, ECD services need to be backed with the necessary financial and human resources, and political will to make them priority in the health sector.

With the expansion of community-based services currently underway, much more discussion and advocacy is needed about how to incorporate an ECD lens into the primary health care re-engineering focus on maternal and child health. This essay promotes a vision to work in the long term towards progressive universalism where every child will benefit from the support and services that s/he requires at the right time and in the right place, with seamless transitions of care across the life course.

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Caring for the caregiver: A framework for support

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The health and well-being of caregivers is the single most important contributor to ensure child health and survival, and to create conditions that enable children to meet their developmental potential. Yet caregivers living in adverse conditions face a broad range of challenges that may affect their ability to be effective parents and to promote early child development.

Providing support to caregivers from pre-pregnancy through childhood must therefore be part of an essential package of services and support (see the essay on pp. 26 – 33). This essay highlights the importance of such support and addresses the following questions:

- Why are caregivers important for children's development?
- How does adversity impact on caregiving?
- What support do caregivers need?
- How can support for caregivers be strengthened?

Why are caregivers important for children's development?

Young children are dependent on others for their survival and well-being, and need adequate food, warmth, shelter and a clean, healthy environment. In addition, caregivers play a key role in ensuring that infants and children receive care that is sensitive to their developmental needs. More than four decades of research has conclusively shown how sensitive caregiving, characterised by responsiveness and the ability to follow a child's interests and activities without the caregiver imposing their own agenda or taking over the interaction (low intrusiveness), has substantial benefits for the mother–infant relationship and for infant and child development[1] (see the essay on pp. 62 – 65).

Sensitive caregiving is associated with reduced behavioural problems,[2] improved social functioning, better relationships with peers,[3] and enhanced school performance[4]. Warm, sensitive and non-intrusive caregiving helps children to regulate their behaviour and emotions, and provides the foundation for the development of positive problem-solving strategies. When such parenting is not available because of caregiver depression, absence, maltreatment or illness, infants and young children may fail to develop secure attachments[i],[5] leaving them particularly vulnerable to the effects of negative environments[6].

It is important to stress how infants and children influence the interaction with their caregivers. Infant temperament and other characteristics may make some children more difficult to parent. This places additional strain on what may already be a vulnerable caregiving system, and may result in negative caregiving practices that further compromise development. So, for example, a young infant who has severe colic will put a poor single parent under extreme stress, whilst the very same infant in an environment with social support and sufficient financial resources may be engaged with in quite a different way, and with different outcomes. What is clear, however, is that nurturing and sensitive parenting – that is responsive to children's needs – can protect infants and children against the impact of even the most stressful environments, and is therefore essential to ensure optimal child development.

How does adversity impact on caregiving?

Caregivers living in poverty face a broad range of challenges that may affect their ability to be effective caregivers and to promote good child development outcomes. These challenges include material deprivation, low levels of education, lack of access to jobs and services, social isolation, mental and physical ill health, and domestic violence.[7] Caregivers in South Africa face intersecting epidemics of HIV, alcohol, drug abuse and undernutrition compounded by non-communicable diseases and poor access to basic services and educational opportunities.

South Africa has the highest documented rate of Foetal Alcohol Syndrome (FAS)[8] and children with Foetal Alcohol Spectrum Disorders (FASD) are likely to have a variety of concentration and behavioural difficulties.[9] Rates of FAS are as high as 41 – 74 per 1,000 children.[10] The addition of children diagnosed with partial FAS reveals rates between 68 – 89 per 1,000. Similarly high rates have been noted in two cities in the Northern Cape, reaching levels as high as 67 per 1,000 for FAS and 100 per 1,000 for partial FAS.[11]

South Africa has the highest number of persons known to be living with HIV globally (5.2 million).[12] It has been estimated that by 2015 there will be 2.2 million maternal AIDS orphans in South Africa,[13] many of whom will be cared for by elderly grandparents[14]. Globally, women are the primary caregivers of children and spend more time on domestic tasks and care work than men.[15]

In South Africa, low birth weight rates are high. These children may show less interest in exploring their environment, be less vocal and less happy[16] and may have lower cognitive scores at ages two and three years – all factors that contribute to greater stress in early caregiving.

i Attachment is the affectional bond between a child and their caregiver. Securely attached infants are able to freely explore in the presence of their caregiver, and when separated will become appropriately upset, but the caregiver will be able to soothe them, allowing the child to explore once more.

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Philani Mentor Mothers visit homes and support mothers and children in their community.

Parenting children with serious illness, injury, disability and emotional and behavioural difficulties can result in higher levels of psychological distress in caregivers. A lack of material and social support and poor access to appropriate services escalates caregiver stress.[17]

All these factors are either related to poverty or exacerbated by it, and in turn may impair infant and child functioning.

What support do caregivers need?

The increasing use and popularity of the term "the first 1,000 days of development"[ii] have harnessed greater attention from policy-makers to this crucial period in children's development. However, this essay argues that caregivers require support and services throughout children's lives – including pre-conception, early childhood and the foundation phase of formal schooling. For instance, nutrition interventions with women prior to pregnancy are more strongly associated with foetal nutritional status than nutritional interventions during pregnancy,[18] while there is substantial evidence that significant brain development continues well into adolescence[19].

The potential of antenatal care

During pregnancy, one of the main sites of support is antenatal care. South Africa's antenatal coverage is good: 95% of pregnant women attend an average of four antenatal clinic visits.[20] However this masks the fact that coverage is significantly lower in rural areas. Only 40% of expectant mothers receive antenatal care before 20 weeks which results in lost opportunities for early identification and clinical management of foetal abnormalities, HIV, anaemia, and hypertension.[21] The extent to which high antenatal coverage can be harnessed in order to deliver additional interventions (without over-burdening existing cadres such as nurses) such as psycho-social support requires exploration (see the essay on pp. 50 – 55).

The role of community health workers

The government is currently implementing a re-engineering of the primary health care system. One of the aims is to improve the link between facilities and the household or community, and to bring skilled community health workers (CHWs) into the formal health system. It is likely that the most vulnerable households in South Africa will only be reached by community-based health workers who, with sufficient support from the health and social service sectors, will deliver essential early interventions. This could include internationally promoted programmes such as the Care for Child Development[22] module of the integrated management of childhood illness programme to promote language and learning during routine health visits (also discussed in the essay on pp. 50 – 55).

Community-based programmes with potential

Some examples of home-visiting programmes that have the potential to reach the most vulnerable caregivers include the Philani Mentor Mother programme,[23] the Family and Community Motivators of the Early Learning Resource Unit (ELRU),[24] and Khululeka's Family Home-Visiting programme[25]. Philani community health workers or mentor mothers[iii] deliver home-based interventions that address the constellation of risk factors affecting women and their children. These include interventions to address nutrition, HIV, tuberculosis, maternal and child health, the early mother–infant relationship, maternal mental health and early child development.

Mentor mothers conduct approximately four antenatal visits and up to eight postnatal visits. In situations of high risk or crisis these visits may be increased and extended. Philani also offers a nutrition support programme for all children younger than six years.

The ELRU Family and Community Motivator programme consists of 20 home visits that take place twice a month, monthly workshops with other caregivers and informal playgroups. The programme provides information on accessing social grants and creating safe, stimulating and healthy environments for children, and an opportunity for the motivator and caregiver to play with the child, using locally-made toys.[iv]

The Khululeka Community Education Development Centre offers services such as a preschool enrichment programme (20 week-long workshops over two years); a family home-visiting programme (eight or more visits twice month) focusing on access to social grants, health and nutrition, and caregiver support; and an infant and toddler support programme for caregivers of children aged

ii From pregnancy through to the end of the second year of life.
iii Mentor mothers recruited by Philani live in the same poor neighbourhood as the caregivers receiving the intervention, yet have children who are thriving. For more information, see: www.philani.org.za.
iv For more information, see www.elru.co.za.

0 – 6 years (weekly group sessions for between 16 – 19 weeks). All three programmes provide generalised counselling to caregivers in one form or another.[v]

The Philani intervention has been shown to have significant benefits for mothers and infants in the areas of children's health and cognitive intelligence, and maternal adherence to health care and HIV prevention strategies. It also benefitted particular subgroups – such as HIV-positive caregivers adhering better to the prevention of mother-to-child transmission tasks. Similarly, caregivers using alcohol during pregnancy reduced their episodes of drinking, especially those women who drank heavily.[26] In a recent evaluation of Khululeka and ELRU, their home-visiting programmes were found to improve parenting, caregiver coping, affectional care, academic and language stimulation as well as improving safety and hygiene in the home.[27]

The extent to which all these programmes can feasibly and cost-effectively be scaled up nationally remains to be established.

Mental health screening and referral

The programmes above follow a generalised community-based approach. The Perinatal Mental Health Project (PMHP), illustrated in case 7, is an example of facility-based approach. In a re-engineered primary health care system, programmes such as the PMHP would offer a more targeted service to support women with mental disorders. The feasibility at scale and cost effectiveness of using trained counsellors need to be established, but the principle of screening and referral for maternal mental disorders should be a core component of any system that supports caregivers.

Social support services

Caregivers also require social support and protection. The Children's Act[28] provides for a range of mandatory prevention and early intervention programmes that encourage parenting education, caregiver support and well-being, including access to basic necessities. Caregivers may need support to get social grants, identification documents, and access job creation programmes, for example. Other areas of support include capacity-building to enhance job and life skills, and interventions to address domestic violence and other social problems (see the essay on pp. 62 – 65).

A multisectoral approach

Multisectoral coordination and engagement are central. One example is the Thusong Service Centres[vi] (formerly known as Multi-Purpose Community Centres) that bring together the departments of Home Affairs, Labour, Health and Social Development, and the South African Social Security Agency. Another is the location of Home Affairs and Social Security officials within maternal obstetric units to ensure that child grant application procedures can take place in one setting immediately after birth, thus improving access to child grants for those who may be eligible.

How can support for caregivers be strengthened?

The care and development of children is the responsibility of both the public and private spheres – including the family and extended family networks, as well as the health system, early childhood education centres, and the formal schooling system. While maternal and child health has in recent years received significant attention,[29] the focus has been on mortality and morbidity, and less on the broader components of caregiving such as mental health, social and emotional support, accessing social grants, and parenting skills. A continuum of care provides a useful way of considering care across the life cycle, within different contexts.[30] This is illustrated in figure 7, which outlines a (non-exhaustive) list of essential interventions that are needed to support caregivers across the continuum.

Depending on the context, different cadres of workers would be responsible for delivering services across this continuum of care. In South Africa, most women deliver within health facilities and therefore nurses are the primary cadre at birth and at facility level. In terms of community-based postnatal care, community health workers are increasingly being seen as the primary interface.

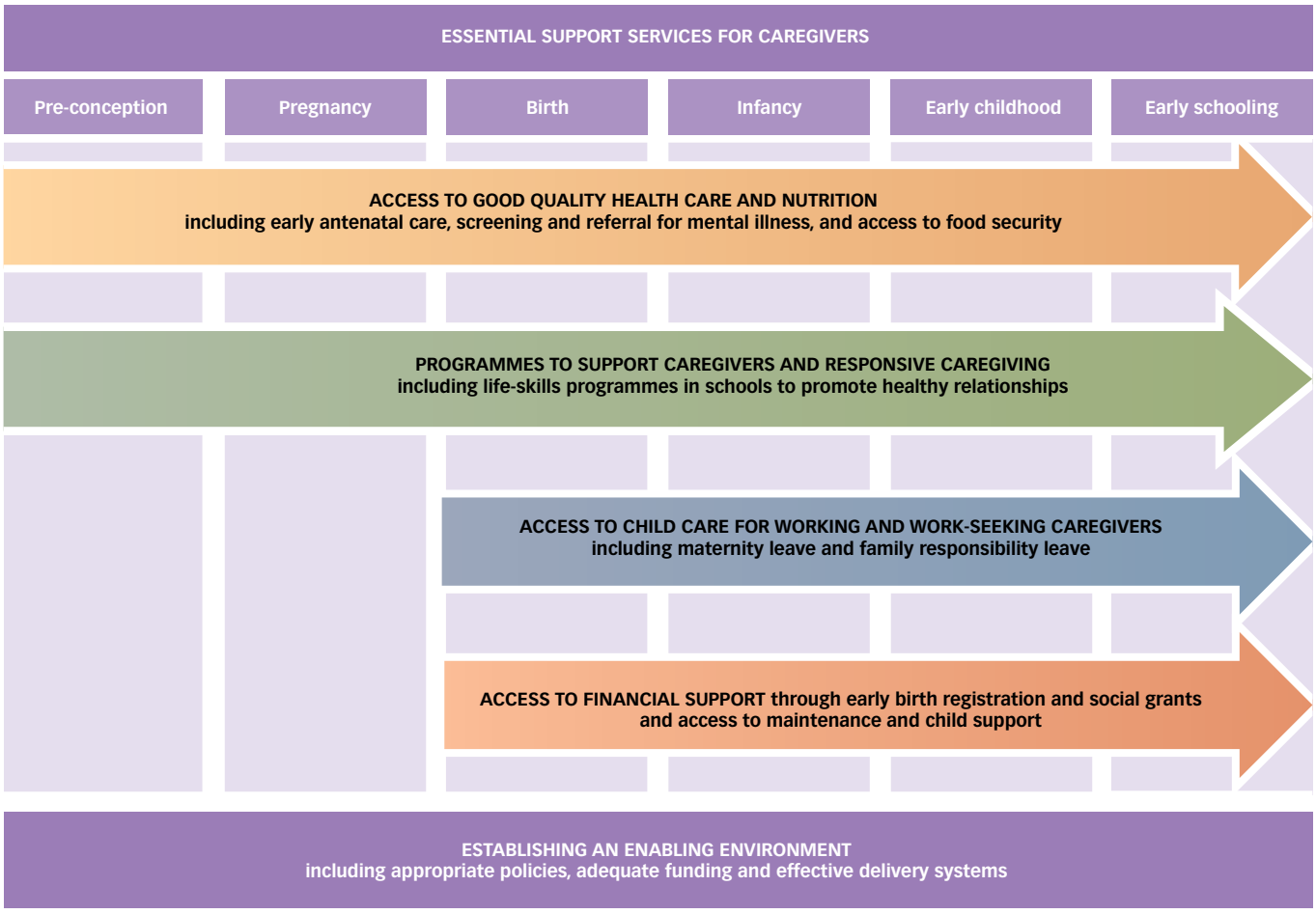
Creating an enabling environment

Effective scale-up of community health worker programmes (who are central to the primary health re-engineering strategy) has met many challenges. Large-scale CHW programmes have been marked by high levels of attrition in countries such as Bangladesh, Senegal and Nigeria – often related to low pay (volunteerism in many cases), but also to factors such as poor selection, family disapproval and moving on to better-paid positions elsewhere.[31] Infrequent and poor quality supervision has also undermined many large-scale programmes.[32] This is less likely in smaller initiatives where supervision is often more intense and consistent.[33] While the use of CHWs has achieved many successes,[34] the system has been characterised by the lack of consistent supervision, heavy workloads, low pay (if at all) and poor linkages to the central health system[35]. These are significant barriers and the degree of control and oversight that is possible in small-scale studies does not necessarily translate to the implementation of large-scale interventions, which is a key barrier to sustained impact. An important part of this process lies in building effective strategies to support the management and supervision of CHWs to ensure quality of implementation.[36] Finally, efficient referrals and the management of transitions across and between services are key.

There are a number of systemic functions that create an enabling environment and facilitate the successful completion of tasks across the continuum of care (see the essay on pp. 34 – 43). Establishing an enabling environment is, in the first instance, a function of government and there are three main levers that contribute to this.[37] These levers, as described on the opposite page, are essential but can only be realised in the medium to long term.

v See www.khululeka.org.za.
vi See www.thusong.gov.za.

Figure 7: Support and services across a continuum of care



1. An appropriate legal framework that provides support to caregivers across all domains, such as social assistance, maternity leave and quality child care. This would include the implementation of child-focused legislation such as the Children's Act to provide care and protection of children in a developmental way with an emphasis on the continuum of care.
2. The availability of adequate financing and monitoring systems. Part of the solution is simply fiscal (more money should be spent in traditionally neglected areas), but equally important is the better redistribution and use of existing resources.[38] Adequate financing of standard CHW visits coupled with the establishment of a robust national data system on postnatal care (whether in the home or in the facility) are essential. Another component is quality and appropriate supervision and management systems.
3. The final lever is that of inter-sectoral coordination. In South Africa, as in many other countries, roles and functions that are intrinsically linked in the everyday lives of caregivers are in fact artificially split across government departments. For example, social grants are managed by the Department of Social Development while many other support or clinical services are driven by the Department of Health. The result may be a "silo" approach to service provision and costly task replication resulting in missed opportunities to deliver essential services. In a financially constrained system, improving inter-sectoral coordination is vital, particularly as support for caregivers cuts across numerous systems such as Health, Social Development and Education.

Even with the most efficient, well-functioning system the issue of implementation is core. This would include coverage and equity and the extent to which the most vulnerable and at-risk caregivers are reached by interventions. Even when community-based interventions reach vulnerable populations there are frequently unforeseen barriers that make the actual delivery at the household difficult. These include attitudes and beliefs of family members, as well as family members acting as gatekeepers and controlling key aspects of programme delivery, including the focus, meeting times and duration of CHW visits.[39]

Creating the impetus for change

Ensuring the well-being of caregivers in conditions of poverty and limited resources will require systemic responses across multiple domains. The following three actions are critical in order to provide the impetus for wider change.

1. A commitment to scale up CHW programmes is essential. The current re-engineering of the primary health care system with its significant focus on CHWs offers a potential avenue for scaling up home-visiting programmes, circumventing the current lack

Case 7: Caring for mothers – a case for maternal mental health

Simone Honikman and Ingrid Meintjes, Perinatal Mental Health Project, University of Cape Town.

The most effective and cost-efficient time to intervene for early childhood development is before birth and in the early years of life.[39] The Perinatal Mental Health Project (PMHP) provides maternal mental health services that are integrated into routine antenatal care.[40] The interventions are located in primary level antenatal care settings. This enhances efficiency as vulnerable women are reached when and where they access health services. The approach is particularly relevant because postnatal care coverage in South Africa remains poor, yet antenatal care coverage is extremely high.[41]

PMHP services are based at three obstetric facilities which provide primary level care, in Cape Town. Service integration requires considerable preparation of the environment. Thus, the project conducted a careful process of developing buy-in and commitment from front-line health workers, and provided capacity-building. On-going engagement and support are also required.

Screening

Midwives and other clinic staff are trained to screen women for risk for and symptoms of depression and anxiety. This takes place during the first antenatal visit. Eligible women are offered referral for on-site counselling. Counselling appointments are made to coincide with subsequent antenatal visits or when convenient for the women.

Counselling

Individual counselling is provided free, on an appointment basis, during pregnancy and up to one year after the birth. Women receive an average of three sessions. A full-time clinical psychologist coordinates the clinical services, counsels clients with complex problems, and manages the counselling team. Other members of the counselling team are three trained counsellors and a psychiatrist who works on a part-time basis. The PMHP counsellors are integrated into the obstetric service and are considered part of the maternity care team.

Counselling sessions can assist women with difficult relationships, unhealthy thinking, overcoming losses, and problem-solving. Women with alcohol and substance misuse problems are referred to the hospital's social worker for further intervention. The counsellors collaborate, as required, with psychiatrists, mental health nurses, social workers and allied health workers. Care is frequently supplemented by non-governmental organisations.

Women receive consistent and structured follow-up including phone calls to those who miss appointments or are unable to attend appointments. All urgent cases, such as psychoses, are referred to tertiary facilities. Ongoing supervision, debriefing, training and feedback are provided to both obstetric staff and PMHP counsellors.

Postnatal follow-up care

Every woman counselled receives a routine follow-up phone call between 6 – 10 weeks after birth. This structured interview includes questions about the birthing experience, adjustment to life with the baby, the experience of counselling, and whether she needs further intervention. This contact often takes the form of a telephonic counselling session which is useful for women who are unable to access the service but who still require follow-up care.

Phumza's story

Phumza[vii] was abandoned by her baby's father when she became pregnant. She discovered she was HIV positive and was scared her baby might be affected. At her first antenatal visit, Phumza was offered mental health screening and referred for counselling. After her baby was born, Phumza lost her job and grew more desperate about her financial situation:

> *I don't know what is wrong with me. My memory is very poor. On Monday I lost money in the taxi. Yesterday, I lost my jacket. I don't know what I'm doing these days. And I'm sad. Maybe this virus works in my mind, and I'm suffering. I'm always thinking about my future and my children. What if I can't take care of them?*

When she sent a text message to the PMHP counsellor – "I just want it all to end" – the support system kicked in. The PMHP counsellor began providing telephonic counselling, arranged for Phumza to receive medication for her depression, and referred her to her local clinic for on-going psychiatric care. She also introduced Phumza to a community project that helped with food and child grants.

These interventions have resulted in improvements in Phumza's life. Although there are still many challenges, she feels better able to cope and care for her children.

The PMHP is a partner of the Alan J Flisher Centre for Public Mental Health at the University of Cape Town. The project also engages in training, research and advocacy to take maternal mental health services to scale. For more information, see: www.pmhp.za.org.

vii Not her real name.

of coverage, and providing sustainable interventions for all families and children.

2. Caregiving in contexts of high adversity is extremely stressful. Improving awareness of the signs of caregiver burden and appropriate referrals amongst health care staff, CHWs, early childhood development and social service practitioners should improve caregiving and mitigate the negative impact of poor caregiving on child development.
3. Pregnancy and infancy are critical developmental phases with lifelong consequences, and small changes that become habits can have substantial impact over a lifetime. Ensuring that services such as the PMHP are integrated within existing services together with the cost-effective use of cadres of staff such as counsellors will strengthen coverage and reduce the impact of poor maternal mental health on caregiving practices.

Conclusion

Caregivers require supportive (albeit different) interventions across a child's life cycle. It is vital that the government focuses on a life-cycle approach that includes screening for maternal mental health; appropriate services for referral; centre- as well as home-based parenting and other supportive interventions; quality early learning opportunities (centre- and home-based); and a commitment to providing good quality child care in order to reduce the burden of care.

The re-engineered primary health care model that is currently being piloted has the potential to meet some of these needs, but will need significant re-modelling and a broader conceptualisation of care and support services. Success will depend on what happens in the household in combination with responsive and supportive health, education and social service systems.

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Rising to the challenge: Towards effective parenting programmes

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Good caregiving for children – especially in the early years – is fundamental not only to each individual child's well-being and development, but also to realising a safe and productive South Africa in line with the National Development Plan. Parenting support – including parenting programmes – is a crucial element of an essential package of early childhood development (ECD) services (see the essay on pp. 26 – 33).

The term "parenting programme" is applied to a range of interventions in South Africa, including efforts to improve parents' knowledge of young children's development, their stimulation for early learning, their management of children's behaviour, and their relationships with their children.

This essay focuses on programmes that provide support around child behaviour management and parent–child relationships, and addresses the following questions:

- Why are parenting programmes important?
- What kinds of parenting programmes are needed in South Africa?
- How are parenting programmes best delivered?
- How can the quality of parent training programmes in South Africa be improved?

Why are parenting programmes important?

In the early years of life, children are dependent on their parents[i] to have their needs met – to be fed, to be cleaned and clothed, to be nurtured, to be stimulated, and to be kept safe. Children whose needs are met in these areas are well prepared to succeed at school, to have good relationships with others, and, in the long run, to become productive adult members of society.[1] By contrast, child abuse and neglect – the most serious forms of poor parenting – have been shown to increase the body's stress response so that the development of children's brains and other organs are harmed, and to increase the risk for physical and mental illnesses, as well as other problems such as delinquency.[2] Supporting parents to be effective therefore saves costs in the long term – costs to the health system in treating illnesses, costs to the criminal justice system in dealing with crime, and a loss in tax revenue (as adults who were abused as children may not achieve their full working capacity).[3]

Caregiving incorporates not only practical tasks, such as providing adequate nutrition, but also providing affection, stimulation and appropriate discipline. Sound child behaviour management (including non-violent discipline), encouragement of positive relationships within the family and beyond, and helping to build the child's sense of self-worth and competence, are key. Good parenting is responsive.[4] In order to respond appropriately, parents need to know what to do (for instance, when the child needs comforting or when s/he has broken a rule), and what not to do (such as using harsh forms of discipline such as beatings), and to be able to do these things consistently.

This is a tall order for any parent at the best of times, but many caregivers in South Africa are parenting under extreme conditions. Poverty,[5] exposure to violence,[6] health conditions such as HIV,[7] as well as single parenthood,[8] are all factors that may increase the stress of parenting, and make poor outcomes for children more likely. Caregivers who have children with disabilities (including serious psychiatric disorders) often experience additional stress, particularly if their children's behaviour is hard to manage.[9] Unfortunately, many (if not most) parents in South Africa face exactly these conditions. Yet positive parenting (warm, affectionate parenting that provides appropriate boundaries for children without using violent discipline) can buffer the effects of risk factors, such as poverty, on children.[10] Recent South African work[11] suggests that improving parents' knowledge about caregiving may improve child outcomes, even in families where there has been intimate partner violence.

Internationally, parenting programmes (in which parents acquire specific parenting skills,[12] such as giving clear instructions, or using time out instead of spanking) have been shown to be effective in improving parenting and in leading to better outcomes for children.[13] Programmes designed to improve parenting of the 0 – 9 age group have been delivered through home visits (often starting during pregnancy), group workshops, and longer courses (typically delivered once a week).

Some programmes aiming to prevent child abuse and neglect have experimented with media interventions, and found these at least to shift parenting attitudes (for instance, caregivers' expectations about what is appropriate at different developmental stages),[14] but as stand-alone interventions they are unlikely to change parent behaviour, and so are unlikely to affect child outcomes.[15] More recently, programme developers have experimented with a variety of other delivery methods, such as providing internet-based information and developing smartphone "apps".[16] Although these have yet to be tested thoroughly, there is

i In this essay, the terms "caregiving" and "parenting", or "caregiver" and "parent", are used interchangeably as many people in South Africa are caring for children who are not their biological children. It is not the biological relationship that is important, but the quality of care that children receive. All caregivers are worthy of support.

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Warm, responsive parenting lies at the heart of early childhood development.

an explosion of interest in them, particularly because most group-based parenting programmes place high demands on parents, who consequently often drop out and do not receive the full training.[17] These innovative delivery methods may help to increase the accessibility of programmes for parents, reinforce key messages, and maintain contact with parents during and after the programme.

What kinds of parenting programmes are needed in South Africa?

Chapter 8 of the Children's Act[18] provides for prevention and early intervention programmes, which include the development of appropriate parenting skills, and norms and standards to ensure that quality programmes are delivered. The Act aims to give effect to children's rights to care and protection,[19] and places a responsibility on government to provide and fund prevention and early intervention programmes. For example, the Department of Social Development and UNICEF have developed a training package for parents and caregivers.[20]

Parenting programmes need to be responsive to the development of the child as well as the needs of parents. Supporting parents is particularly important during pregnancy and the first two years of life. Parents need to understand child development and the importance of early relationships, and warm and responsive care to promote positive attachment. A South African programme has demonstrated that parenting and attachment can be improved through home visiting.[21] There is also evidence from the United States that a home-visiting programme for at-risk mothers through the first two years of a child's life can reduce the risk for child maltreatment and child behaviour problems at age 15,[22] although for other home-visiting programmes the evidence is not as clear.[23]

From age 18 months through age nine, group-based parent training programmes can successfully reduce child behaviour problems[24] and the risk of child maltreatment[25]. Most parenting programmes aim to prevent problems before they begin. However, once serious problems such as child abuse and neglect, or delinquency, have started, more intensive programmes may be needed. These are usually directed to individual families, and not to groups of parents, and need highly trained clinicians to deliver them.[ii]

Intensive programmes are thus far more expensive to deliver than group-based programmes that can be delivered by trained lay workers and reach several families at once. Although prevention and early intervention should be a priority, there will always be some who need specialised services, no matter how much prevention is done. These intensive interventions therefore should form part of a continuum of services.

How are parenting programmes best delivered?

Parenting programmes must strive to be effective and scalable. If programmes are to meet these criteria, they must incorporate several elements.[26] Broadly speaking, programmes should have:

- a clearly defined target population;
- a programme design and delivery system that is tailored to the needs and cultural background of participating parents;
- a programme theory[iii] that is plausible and based on evidence of what works;
- realistic and measurable goals;
- a sufficient amount of intervention;
- well-trained and well-supervised staff; and
- rigorous monitoring and evaluation processes to ensure that the programme is implemented as intended and that it is, in fact, effective.

A recent survey of 21 group-based parent training programmes in South Africa showed that they were concentrated in urban areas and that very few meet these standards[iv] of effective practice.[27] Thirteen were delivered by non-profit organisations, and the remaining eight were businesses. This indicates that parenting programmes are poorly distributed and generally inaccessible to the poor. Table 7 on the next page shows the very limited supply of parenting programmes in relation to child population in each of the nine provinces.

ii For example, multisystemic therapy (an intensive family- and community-based treatment programme that focuses on addressing all environmental systems that impact on chronic and violent juvenile offenders), and functional family therapy (a short-term, high quality intervention programme conducted in a variety of settings). For more information, see www.mstservices.com and www.fftinc.com.

iii "Programme theory" refers to a statement that describes the mechanisms by which the programme goals are to be achieved.

iv While home-visiting programmes were not included in this survey, many of the same principles will apply.

Table 7: Parenting programmes in South Africa, by province, 2011

Province	Number of programmes[a]	Number of children (0 – 17) in 2010 (millions)[b]
Eastern Cape	4	2.7
Free State	6	1.1
Gauteng	11	3.3
KwaZulu-Natal	8	4.7
Limpopo	6	2.3
Mpumalanga	5	1.5
North-West	5	1.3
Northern Cape	4	0.4
Western Cape	16	1.8

Sources: a. Wessels I (2012) Parenting Programmes in South Africa: Investigating Design and Evaluation Practices. Unpublished Masters thesis, UCT;
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Shortcomings of programmes that participated in the survey included that:

- few programmes conducted formal needs assessments;
- few programmes based their programme content on practices shown in the literature to be effective;
- only 14 programmes provided training and supervision for programme facilitators, with the rest running the risk of inadequate programme implementation; and
- only two programmes had been evaluated by independent evaluators.

Many programmes, especially those located within the non-profit sector, experienced significant challenges in adopting some of these best practices. Scarce financial resources were noted as a barrier to implementing monitoring and evaluation processes, and to providing parents with child care and transport money (strategies that have been shown to enhance the retention of parents in programmes).

In sum, there is very little evidence of the effectiveness of parent training programmes in South Africa. Research is urgently needed to provide evidence of which programmes have the potential to be taken to scale. This will take both political will and significant funding but is essential in order to use resources effectively to achieve the intention of the Children's Act.

A brief description of a promising programme is provided in case 8 on the opposite page. This particular programme was selected not only because it included many principles associated with programme effectiveness, but also because it is well known within the parenting sector in South Africa and provides a basis for many other programmes in the country.

How can the quality of parent training programmes in South Africa be improved?

There are several key steps that need to be taken to strengthen the field of caregiver training in South Africa:[28]

1. The child outcomes to be targeted by parenting programmes must be clearly identified through careful survey work in the context where the programme intends to work, and the prevalence of those outcomes must also be measured. This will enable priority targets to be selected. Appropriate targets for programmes may include: the prevention of child abuse and neglect as rates appear to be high;[29] and cognitive stimulation which is likely to enhance school readiness[30] and improve children's educational outcomes. It is important that identified targets are consistent with the cultural norms of the targeted population.
2. Interventions that may be effective must be identified – either through evaluations of existing local programmes, or by taking programmes which have proven effective elsewhere and adapting these for the South African context. Ways to integrate parenting interventions into other services, such as ECD or primary health care services, should also be explored[31] as this may be more cost effective than stand-alone programmes. In the South African context, it is also important to explore the conditions under which paraprofessionals can deliver effective parenting interventions.
3. The effectiveness of these interventions must be established, preferably through rigorous outcome evaluations using the randomised controlled trial design. Most parenting programmes in South Africa have not yet been tested and their effectiveness must therefore be established before considering taking these to scale. The same applies to established programmes adapted from other contexts: adaptations can affect a programme's effectiveness, and the adapted programme needs to be tested to ensure that it continues to be effective in the new context. The World Health Organisation has recently produced guidelines to help parenting programme managers understand outcome evaluations, which may be helpful.[32]
4. Cost-effectiveness should be established. There is some evidence from high-income countries that investment in parenting programme reaps huge dividends in children's healthy development.[33] Demonstrating that a programme is cost-effective may assist in arguing for the continued investment of public funds.

Conclusion

Supporting South Africa's caregivers in the complex task of raising children to effective adulthood should be a national priority. Not only will it improve the lives of individual children and their parents, it is likely, in the long term, to contribute to the economy both through reducing the costs of poor parenting and increasing the

Case 8: Positive Parenting Skills programme, The Parent Centre

The Parent Centre is a registered non-profit organisation based in the Western Cape. They run a Positive Parenting Skills programme which predominantly serves parents from poor communities who have children aged 0 – 18 years. The programme also serves parents who have been mandated by the courts to attend. Seven weekly sessions of three hours each are delivered by well-trained and well-supervised staff.

The programme adopts an eclectic approach to parenting and parent empowerment which draws on a variety of theoretical views. It is largely based on the STEP (Systematic Training for Effective Parenting) programme, which recognises that children's behaviours are motivated by various goals and that encouragement and praise are extremely important for children. The Parent Centre programme includes content on understanding children's behaviour and feelings, building children's self-esteem, learning how to be assertive, engaging in cooperation and problem-solving effectively, and appreciating the importance of positive discipline.

Expected programme outcomes include parents understanding the stages of child development and being able to build children's self-esteem and to apply positive discipline techniques successfully. Process and outcome monitoring is conducted. As yet there has been no formal external evaluation of the programme although this is being planned.

A comprehensive "Train-the-Trainers" programme for professionals, community leaders, religious organisations, parent bodies and community workers wanting to disseminate the Positive Parenting Skills programme is also available. Once this programme has been completed, a Mentoring and Support programme is offered to encourage sustainability.

For more information, see www.theparentcentre.org.za

number of children who become productive, tax-paying citizens. To provide the parenting support services envisaged by the Children's Act, especially for parents faced with multiple challenges, requires political will, resources and evidence of effectiveness.

Signs of political will are evident in the Department of Social Development's capacity building programme for parents[34] and in the White Paper on Families;[35] the next task is to identify quality parenting support programmes and to take them to scale across the nation.

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Learning begins at birth: Improving access to early learning

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Early learning is a complex process involving interactions between the child's brain and experiences. The required early stimulation must be appropriate to the child's developmental level, and is a central consideration in the design of early learning programmes.

Formerly, early learning was closely associated with cognitive development. Today, it is recognised that self-regulation, perseverance, motivation and socio-emotional development all underpin children's ability to learn.

Ideally early learning should start at home, progressing to playgroups and more formal programmes for older children. Yet only 20% of South Africa's poorest children under 5 years access a formal early learning programme.[1] While the National Development Plan[2] promotes universal access to early education for 4 – 5-year-olds and acknowledges the need to improve nutrition and education for 0 – 3-year-olds, there is no agreement yet on how these services will be provided.

Recognising stimulation for early learning as a critical component of an essential package of services for young children, this essay poses three questions for discussion:

- What are young children's learning needs?
- What kind of early learning programmes are effective?
- What can be done to improve access and quality?

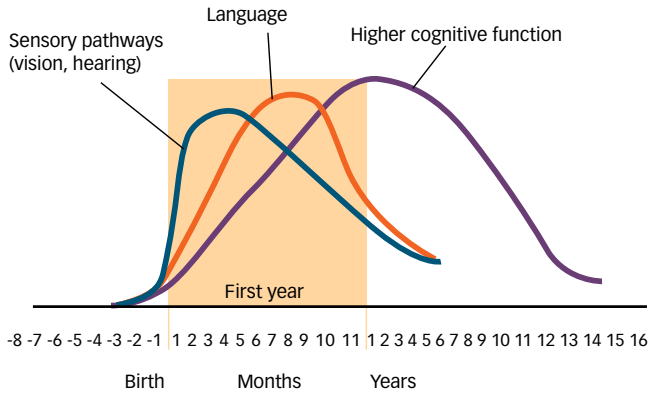
What are young children's learning needs?

Children's capacity to learn is dependent on the health and functioning of their brain. The basic architecture of the brain is well established by birth, with areas responsible for early learning developing rapidly during pregnancy and the first 24 months of life, as illustrated in figure 8.

Children are therefore born ready to learn from their interactions with the environment. In response to the stimulation they receive, neural networks associated with language, memory and higher cognitive functions evolve rapidly.[3]

Children from birth to age five are learning at a rapid rate. Attention needs to be paid to their holistic development (physical–motor, social–emotional, communication–language and cognitive abilities) in integrated ways.[4] Each area of development has indicators which can guide adults to help children learn. Table 8 provides an example of how to organise the developmental and learning needs of children from birth to five.

Figure 8: Human brain development – making critical connections in the first year of life



Source: Nelson CA In: Shonkoff J & Phillips D (2000) *From Neurons to Neighbourhoods. The Science of Early Childhood Development*. Washington, DC: National Academy Press.

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Adults can help children reach out and explore the world around them.

Table 8: Example of how developmental and learning needs of young children (0 – 5 years) can be organised

0 – 3 years (babies and toddlers)	3 – 5 years (nursery children)
Focus for adults: Promoting babies' and toddlers' healthy development and exploration of the life world	Focus for adults: Continuation of 0 – 3 focus with greater emphasis on preparation for school
Physical and motor development	
• Physical health and well-being • Sensory, gross and fine motor development	
Social and emotional development	
• Safety and security • Awareness of the self • Self-regulation • Relationships with peers and adults • Creative play	
Communication, early language and literacy development	**Early language and literacy**
• Verbal and non-verbal communication • Listening • Speaking	• Listening • Speaking • Print awareness • Letter knowledge • Vocabulary and phonemic awareness • Book awareness and story sense • Early reading and writing
Cognitive development (early mathematics)	**Early mathematics**
• Memory • Problem-solving • Imitation and symbolic play • Sifting, sorting and classifying	• Number concepts, relationships and operations • Patterns • Shape and space • Measurements

Source: Adapted from: Ahola D & Kovacik A (2007) *Observing and Understanding Child Development – A Child Study Manual*. New York: Thomson/Delmar; Department of Education & UNICEF (2009) *The National Early Learning and Development Standards for Children from Birth to Four.* Pretoria: UNICEF; Scott-Little C, Kagan SL & Frelow VS (2006) Conceptualisation of readiness and the content of early learning standards: The intersections of policy and research? *Early Childhood Research Quarterly*, 21: 153-157.

For children from birth to three years, a health-promoting environment that is safe, stable and characterised by nurturing relationships can stimulate learning. Learning should take place at home and in group programmes such as playgroups and preschools. Parents, caregivers and teachers at ECD centres contribute to what children learn and how they learn.[5] The content for early learning in families is influenced by culture, religion, child-rearing practices, caregivers' images of children (eg as obedient and respectful) and their views on early education. At formal ECD centres it is influenced by the philosophies and goals of curricula, learning programmes and government priorities.

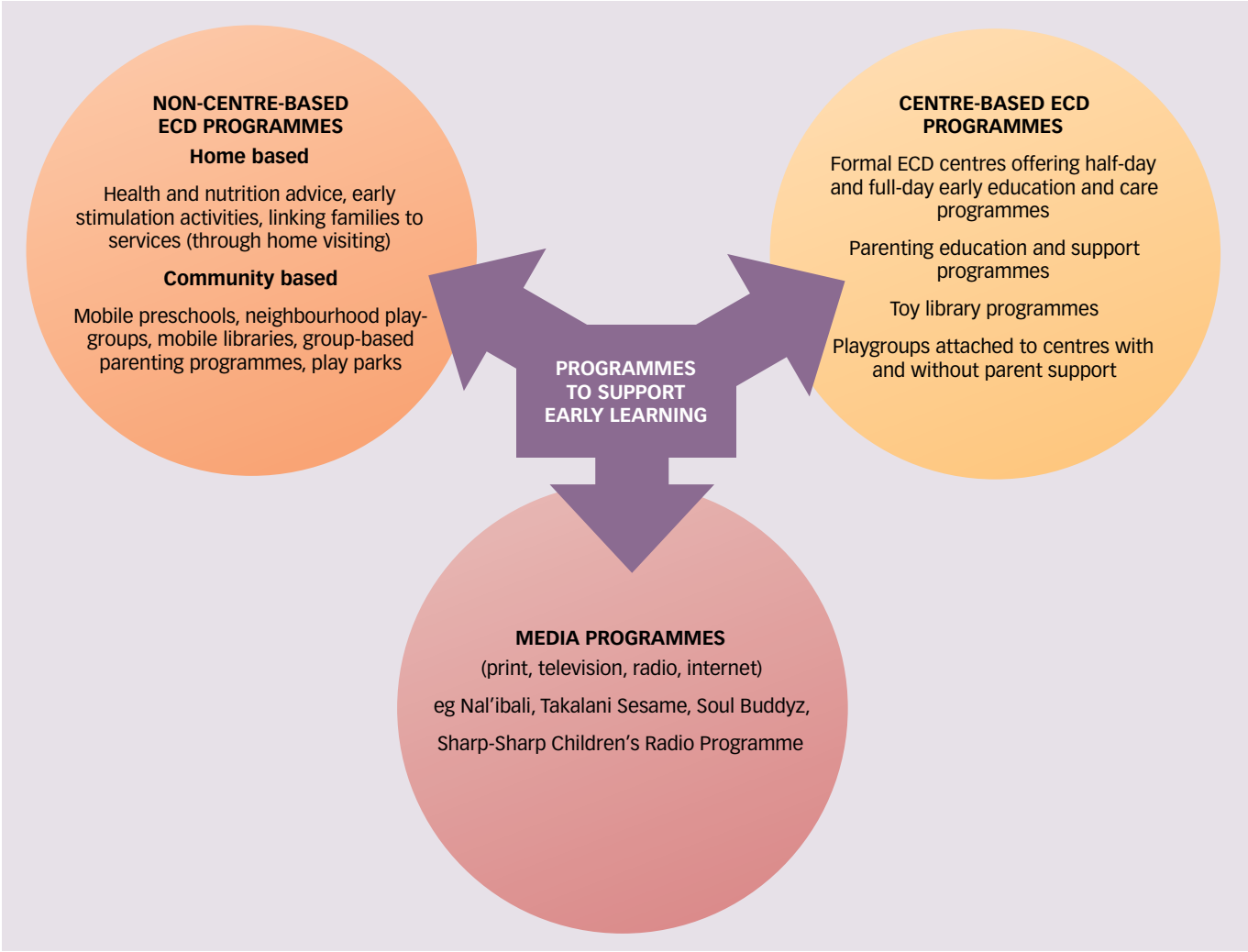
There are key considerations in supporting children's learning at different stages of development. From birth to three, learning needs can be understood as an active process. Active learning in babies and toddlers has been described as "the process by which they explore the world either through: observing (gazing at their hand), listening, touching (stroking an arm/bottle), reaching, grasping, mouthing, letting go, moving their bodies, smelling, tasting or making things happen with objects (putting things in and out of a box …)".[6] When this type of learning takes place babies and toddlers get to know more about people, objects and materials around them.[7]

To be confident explorers, children from birth to three need to experience secure attachments, trusting relationships and interactions that are developmentally appropriate.[8] Early stimulation involves touching, talking to the child, making sounds, massaging children and responding to their reactions and need for attention. For sensory motor development, children from birth to three years need to be exposed to materials and objects that allow them to manipulate and explore. They also need opportunities to make choices, solve problems, experiment with language and develop their social skills.[9]

From 3 – 5 years, children need stimulation that prepares them for school. In order to shape quality early experiences for this age group, learning environments need to continue to pay attention to health and nutrition in addition to behavioural, academic and social skills for school readiness.[10] Attention to the developmental domains continues together with greater focus on content areas such as emergent literacy and emergent mathematics (see table 8 on the previous page). Children are best supported through a play-based approach which creates a balance between adult-directed and child-initiated activities.

Poor and vulnerable children run the risk of not having their learning needs met. The achievement gap between more and less

Figure 9: Programmes to support early learning



advantaged children is created by "the difference in the quality of environments which young children experience during the time of rapid development".[11] In South Africa, poverty makes families more vulnerable due to their low levels of education and economic and environmental deprivations.[12] The distress of living in poverty can result in harsh and less responsive parenting, including corporal punishment.[13] Early learning is negatively affected by the lack of enrichment, stress and trauma experienced in the home together with the lack of quality government services to offer compensation for developmental deficits.

The lack of early learning impacts on how children learn at school: In the United States, it was noted that when poor children start school they are six months behind their more advantaged peers.[14] Based on children's poor performance in literacy and numeracy in the foundation phase in South Africa,[15] it is reasonable to assume that the achievement gap is greater. Children from poor families are more likely to repeat grades, develop special education needs in their later school years, and leave school early.[16] Therefore, early interventions are needed to reduce the school readiness gap for children from families with low socio-economic status.

What kinds of programmes are effective, and how can quality be strengthened?

The National Integrated Plan for ECD 2005 – 2010[17] provides for a range of programmes, including home- and community-based programme interventions, which show promise in reaching very young children and those who cannot afford to pay ECD centre fees. Figure 9 shows different types of programmes that can support early learning.

Non-centre-based programmes

Non-centre-based ECD programmes that focus on early stimulation through home visiting can positively influence cognitive skills and school outcomes.[18] Effective home-based interventions require quality design, delivery and duration. The joint involvement of the caregiver and child (sometimes known as "two generation" programming) is generally more effective than parent education alone, as home visitors improve child development by working directly with the child and by enhancing the caregiver's knowledge and ability to support all aspects of early development.[19]

Positive child outcomes can be achieved when joint activity with parents and children stimulates active participation over an extended period of time. The relationship between the visitor, child and caregiver is a critical factor. It is also essential to integrate early stimulation with other interventions such as nutrition, health and social protection to mediate multiple disadvantages.

Several home-visiting interventions in low-income settings have been evaluated. An example is a Jamaican intervention that provided stimulation and nutrition at weekly home visits delivered by paraprofessionals from birth to 24 months.[20] When compared with a control group, these children had better schooling and employment outcomes.[21] A Turkish programme for mothers with older preschool children also showed improved school outcomes and long-term impacts into adulthood.[22]

There are no robust experimental studies of this kind in South Africa. An evaluation of the Sobambisana programme compared the impact of home visiting on children in grade R with children from similarly deprived communities who had attended preschool. While home visiting improved parenting practices, children who attended good quality preschools performed significantly better on cognitive and language and other academic readiness measures, possibly due to programme content, length and frequency of inputs.[23]

A user-perception study of four family support programmes in South Africa which included home-based interventions with children[24] noted that the main gain for families was access to early learning experiences at no cost. Caregivers stated that this exposure helped children prepare for school. However, the actual impact on the children is not known.

Playgroup models are frequently advocated. They have considerable potential to be a cost-effective alternative to centre-based provision provided the programme is well designed, delivered by trained and supervised ECD practitioners, and children's attendance is sufficient[25] (see, for example, case 9).

Two local projects show promise for inclusion of caregivers and children in interventions to support early learning (see case 9 below, and case 10 on p. 70). However, they need to be costed.

Centre-based programmes

In South Africa, children below grade R currently have limited access to centre-based early learning because of costs and the distance from home.[26]

Internationally, studies point to positive outcomes for children in low-income countries who attend good centre-based programmes.[27] These include better cognitive outcomes, and school attendance, retention and performance. Adult employment outcomes are also enhanced.

Attention to quality is also essential to ensure centre-based programmes are effective in making up for the disadvantages experienced by poor children. High quality centre-based

Case 9: The Ntataise Mosupatsela Playgroup Programme

This programme targets children of ages 3 – 5 years who cannot access early education at ECD centres because their parents are unable to afford fees. The children and parents participate in a weekly two-hour playgroup session at community sites with a trained ECD teacher, where the children are exposed to school readiness activities. Parent attendance is encouraged to help them to support their children at the sessions, and at home.

An evaluation of this programme noted that, although the levels of parental participation was low, children who attended 15 or more sessions were more likely to be within the norm for cognitive development than those who attended less.[28]

Case 10: The Family Literacy Project

This project operates in deep-rural sites in KwaZulu-Natal to develop literacy at different generational levels. It aims to improve literacy and language skills of adults and children; build the early learning and literacy capacities of young children in the home; promote health and well-being of young children; and increase access to contextually appropriate reading materials and toys.[29]

In the first seven years, adult learners develop their own literacy skills to help themselves and their children. In the next seven years, they take on the role of facilitators of literacy for non-project households and create networks for self- and community development. The home-based interventions make use of book reading and literacy activities through a play-based approach in the children's mother tongue. Information sessions with primary caregivers also promote key family and health practices.

The evaluation of this project[30] showed a range of benefits: changes in adults' literacy abilities leading to greater access to information; better approaches to dealing with money; and more confidence to teach children. The findings also noted changes in attitudes and behaviour towards children, reading and playing with children, and improved health practices.

interventions which are suitable for older children tend to be more effective in improving language and cognitive outcomes than home-based early stimulation interventions.[31]

In addition to quality infrastructure, the following are recognised key programme quality parameters for centre-based provision in both low- and high-income countries:

- Learning materials provide opportunities for stimulation across developmental domains and encourage problem-solving.
- Well-trained practitioners receive ongoing post-qualification support.
- Teaching strategies consider cultural and linguistic diversity as well as children with disabilities.
- Teaching strategies include frequent, warm and responsive interactions that scaffold the development of skills for schooling.
- Children experience both individual and group activities, with more of the former than the latter.
- Practitioners engage children's caregivers on their progress.[32]

A study of ECD centre quality in the Western Cape[33] showed that the quality of interaction between teachers and children was generally good, and the quality of children's care and learning environments in classrooms fell within the minimum standards. However, activities were of poor quality, as was language facilitation, indicating limited opportunities for scaffolding early learning. The main factors found to affect ECD centre quality were the quality of centre management and whether fees were charged.

Children with disabilities

Training for early intervention for children with disabilities in South Africa needs greater attention. Early identification of children with special needs is difficult unless the disability is clearly visible. It escapes adults' attention due to several factors: perceptions that children in early childhood are still young and developing; poor practitioner training; lack of resources to seek help; and cultural values and religious beliefs around the inclusion of children with disabilities.

Government support in terms of early identification, intervention and rehabilitation services is also weak. Interventions for young children with disabilities can offer support. For example, deaf and hard of hearing children (0 – 3 years) and their parents are supported in a South African home-based early intervention programme.[34] Parents gain information and skills, and children are exposed to developmental opportunities to prepare them for school.

What can be done to improve access and quality?

Establishing more centres only partially addresses existing problems[35] because such centres are often inaccessible to rural children, unaffordable to many poor children, and frequently not sustainable. In addition, government does not currently have the capacity to regulate existing centres and ensure quality. Therefore, a mix of provision is required.

Age-appropriate interventions

From birth to three years:

- Home visiting has the potential to reach significant numbers of the many poor children in this age group who are not in centre-based care. The potential of this approach has been proven but quality must be assured through appropriate design, training and supervision.
- Infants and toddlers should preferably be cared for at home, but for many working parents this is not an option. For these children it is essential that the quality of care and stimulation at the centre they attend is enhanced and monitored. In many instances, day care and ECD centres are of poor quality and likely to have a negative impact on development.[36]

For three- to five-year-olds:

- Where feasible, centre-based programmes that are subsidised and closely monitored for quality[i] are an essential part of the mix. Access could be increased if systemic and funding challenges are addressed (see the essay on pp. 34 – 43).
- For those not in centres, other programmes – such as quality community playgroups, access to community toy and book libraries, story-telling and early reading programmes – are options that would support early learning and have potential to be taken to scale.

In considering scaling up these programmes, it is essential to couple quality to access, and to pay attention to evidence of effectiveness in improving early learning outcomes. Thus, it is not

i As provided for by the Norms and Standards of the Children's Act.

just about increasing the numbers of children having access to early learning programmes, but also about increasing the quality of those programmes. Equally important is the concerted inclusion and support of children with disabilities and special needs in early learning programmes.

Cost

Costing home- and centre-based early learning programmes is complex, but essential in order to deliver quality programmes at scale. Current subsidies for poor learners attending registered ECD centres do not cover the full start-up or operating costs, and this hampers access and the quality of centre-based programmes in poorer communities, while there is no costing model for home-based services. These and other implementation challenges are discussed in the essay on pp. 34 – 43.

Curriculum and quality assurance mechanisms

Commitment to sound early education starts with the recognition that the needs of young children are different from those in formal schooling. To improve early education programmes it is essential to finalise the National Curriculum Framework for birth for four, (made available for public comment in late August 2013), and to establish an effective monitoring and support system.

Staff and qualifications

High quality early education depends on the qualification and motivation of staff to design and deliver effective learning experiences. Currently there are qualifications for early childhood practitioners at National Qualifications Framework levels 4 and 5. The Expanded Public Works Programme, further education and training/private colleges, non-governmental organisations and some higher education institutions are contributing teachers with some qualification. This, however, will not be enough to meet the demand for qualified teachers in an expanded focus on early education. Career pathing and progression are crucial for the professionalisation of the workforce. In addition, attention should be paid to salaries in order to attract and retain early childhood teachers and ensure stability in the sector.

Conclusion

Meeting the National Development Plan priorities by shaping sound early stimulation and learning experiences for children prior to formal schooling is challenging, but there are a number of promising programmes. Some of these programmes still need evaluation and a cost-benefit analysis in order to make informed decisions about scaling up.

A variety of delivery models such as ECD centres, home visiting, community playgroups, libraries and media programmes can be strengthened to improve access and promote quality. Similarly, basic qualifications for ECD practitioners can be expanded to ensure progression and career pathing. It is important to build on existing programming strengths if early learning interventions are to serve as a solid foundation for early schooling and an effective vehicle for transforming South African society.

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Building strong foundations: Improving the quality of early education

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In 2012, the National Planning Commission reasserted the government's commitment to early childhood education and care in a succinct statement on one of its "enabling milestones" towards addressing poverty and inequality:

> *Increase the quality of education so that all children have at least two years of preschool education and all children in grade 3 can read and write*.[1]

The statement draws attention to three key issues which will be addressed in this essay: quality provision of early learning as an essential service (see previous essay), early intervention for children entering formal schooling, and the need to establish the fundamental skills for formal schooling by the end of grade 3.

Although great gains have been made in getting most children into institutions of early formal education, it is clear that there is much to be done to provide children with a schooling experience of acceptable *quality*. Quality at this level of schooling refers specifically to fostering positive social and cognitive learning in an environment that is safe, nurturing and stimulating, thus laying the basis for future learning and enhanced life chances. It is the tension between access and quality[i] that emerges as a key issue in considering current early learning and its expansion in future. This essay explores this issue and addresses the following questions:

- What is the current status of early schooling for young children in South Africa?
- What are the key sources of underperformance?
- What is needed to enable learning in the foundation phase (grades R – 3)?

What is the current status of schooling for young children in South Africa?

Whilst access to school has improved for the youngest learners, the quality of learning remains a serious issue, especially as measured in educational outcomes.

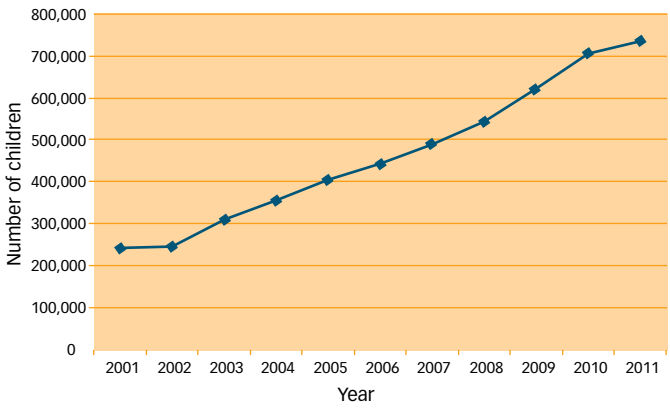
Access

The Education White Paper 5 set the explicit target of achieving universal access to a reception year (grade R) for five-year-olds by 2010.[2] Although this deadline has now been shifted to 2014,[ii] public funding and the use of existing school infrastructure have ensured that increasing numbers of children throughout the country have access to formal early education.[3]

In 2011, about 40% of five-year-olds had access to grade R in schools; 11% were enrolled in primary schools and approximately 32% were attending a less formal preschool, such as a crèche.[4] *Only about 17% of five-year-olds were not enrolled* in any form of schooling or preschool.[5]

Enrolment in grade R more than doubled in the poorer provinces of Limpopo, Northern Cape and North West between 2002 and 2011.[6] Using data from the General Household Survey, the Department of Basic Education reported that, in 2011, 88% of grade ones had received formal grade R the previous year.[7] Figure 10 shows the rapid growth in grade R enrolments from 2001 – 2011.

Figure 10: Grade R enrolments in South Africa, 2001 – 2011



Source: Department of Basic Education (2012) Annual survey of schools. Pretoria: DBE. In: Taylor S (2012) *Early Educational Inequalities and the Impact of Grade R*. Paper presented at "Towards Carnegie3: Strategies to Overcome Poverty & Inequality", UCT, 3 – 7 September 2012.

Similarly, high participation rates for grades 1 – 3 have been established for some time. In 2011, 99% of children aged 7 – 15 years attended school.[8] Participation in early formal education is thus high, and expanding, especially in poorer provinces. The question however is *what* children have access to in grades R – 3. Learner performance in the first grades of school is dismally low. There also has increasingly been a call for more thought around the strategy for implementing grade R, and one that pays heed to quality. In addition, a more phased approach, which builds on existing quality provision in schools and community sites, and expands provision over a period of years, has been recommended.[9]

i Debates around access and quality, particularly in developing country contexts, are well articulated in the research literature. See for example: Tikly L & Barrett A (2013) *Education Quality and Social Justice in the Global South*. Abingdon, UK; New York, USA: Routledge.

ii The draft Policy Framework for Universal Access to Grade R was made available for public comment in late August 2013.

Educational outcomes

The central measure of quality educational outcomes has been data from international and national standardised tests.[iii] Despite some of their limitations, across tests there is a *consistent* picture of low performance and by the end of grade 3 it is clear that the vast majority of learners cannot read, write, count and calculate at the appropriate grade level.[10]

Large inequalities in educational achievement exist and do not diminish as children progress through school.[11] Essentially, there are "two education systems":[12] a well-resourced system serving about 25% of the school-going population, where learning happens and students perform adequately to well, and a low-performing 75% of schools where largely poor and Black students are persistently failed by their schooling and attain extremely poor outcomes. A pattern of bimodal performance can be seen as early as grade 3.[13] Figure 11 shows the distribution of grade 6 literacy scores in relation to the wealth of the school community, and highlights the stark differences between the wealthiest 25% of schools, and the remaining 75% of schools.

Recent research shows that the current grade R has very little measurable impact on learners' subsequent school performance.[14] Emerging findings suggest that results are better for higher quintile schools and educationally stronger provinces (Western Cape, Northern Cape and Gauteng). This makes the quality imperative even more urgent. In particular it seems that the current low impact of grade R should be addressed before considering introducing an additional year of preschool education.

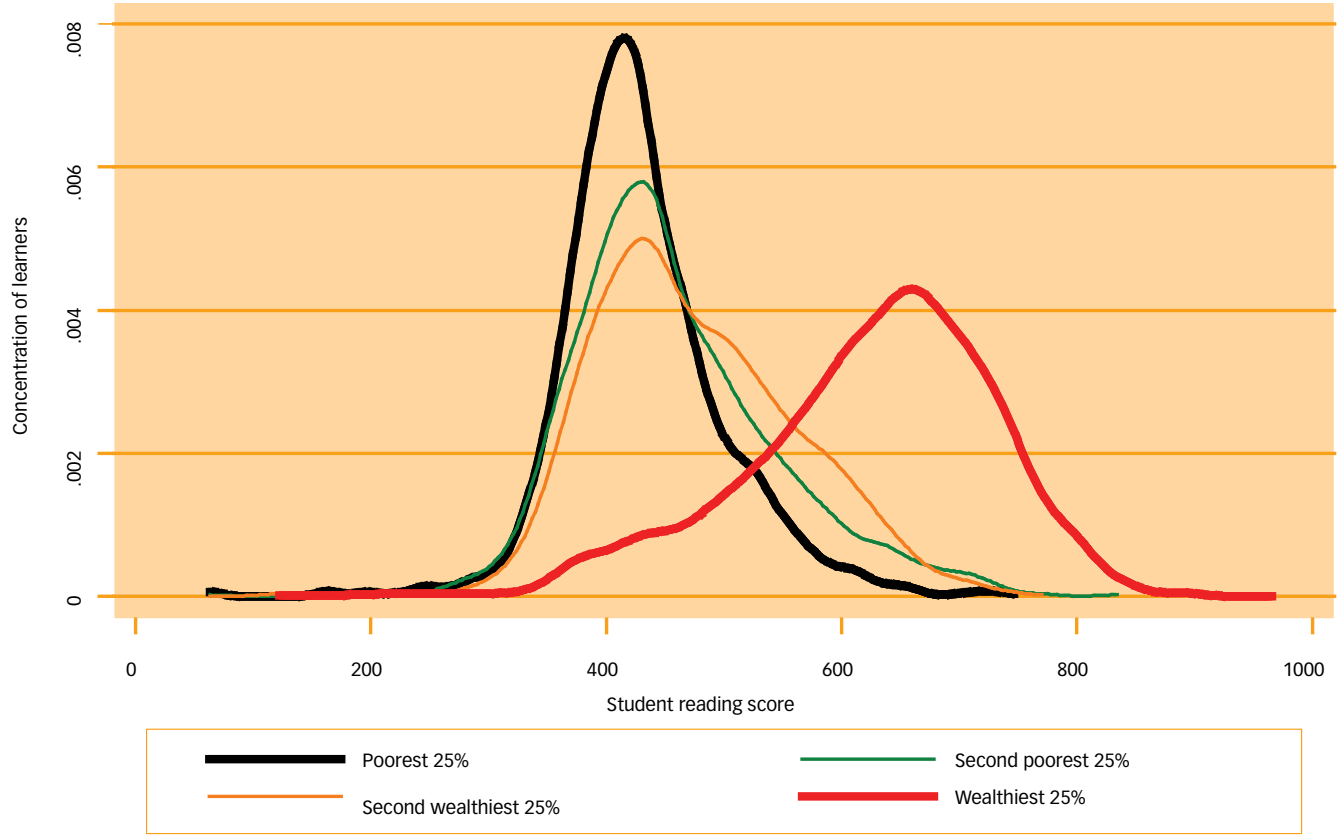
What are the key sources of underperformance?

The sources of underperformance are primarily located in the homes and communities of children, particularly for those living in poverty. Depending on their level of economic advantage, children are physically, psychologically, cognitively and socially differentially prepared for schooling when they arrive at the school gate. Once in school, particular forms of teaching, learning and conceptualising grade R impact on the educational outcomes of children.

Home background and preparation for school

Before children even enter school they are differentially prepared for formal education by their home backgrounds. There are two aspects to this: child-rearing practices (see the essay on pp. 62 – 65) and children's social and physical readiness for school. Children who come from homes that expose them to books, computers and what and how to read achieve better school outcomes. In these situations (mostly middle-class) children are often encouraged to actively participate in adults' conversations. Given the kinds of work that parents do, children in these households learn to engage in ways of thinking, reasoning and

Figure 11: Distribution of grade 6 reading performance, by income



Source: SACMEQ (2007) Grade 6 literacy scores. In: Spaull N (2011) *A Preliminary Analysis of SACMEQ III South Africa*. Stellenbosch working paper series no. 11, Department of Economics, Stellenbosch University.

iii Internationally, South Africa has participated in major cross-national comparisons of primary school student achievement, namely SACMEQ, TIMSS and PIRLS. In addition there have been a number of national standardised tests, including the most recent Annual National Assessments (ANAs).

speaking consonant with those ways required by school. They have access to resources, support and encouragement for learning, and parents interact more with the school.[15]

Social and physical readiness relates to children's health and nutrition, disability status, access to grants, psycho-social support and early stimulation. In South Africa, one in five children under nine years of age is stunted and stunting is as high as 48% among preschool children in Limpopo.[16] Stunting is associated with later cognitive defects,[17] poor school achievement and drop-out. It is the *combination* of risk factors that reliably predicts poor outcomes for children.[18] Improving school results therefore depends on strengthening inputs much earlier on, with a focus on maternal health and education, and adequate nutrition[19] (see the essay on pp. 24 – 29 and pp. 30 – 35). The case for early intervention and a supportive home environment has been made repeatedly.[20] And the importance of high quality early childhood education and care and its subsequent influence on children's success in formal schooling is now well established (as illustrated in the previous essay).[21] But once children are in school, what are the sources of poor outcomes?

The school and teachers

Infrastructure, resources, support, inspection and management all play a role in the quality of children's learning. But research confirms that, amongst school factors, it is what happens in the classroom that makes the greatest difference to children's learning outcomes.[22]

In summary, primary school classrooms in South Africa are characterised by an impoverished pedagogy (or process of teaching and learning). There is an emphasis on oral discourse, with limited opportunities for reading and writing. Classes are often large, with inappropriate teacher–learner ratios for early learning activities. Dominant forms of student participation involve chorusing rather than individual response in the classroom. Assessment and feedback to learners from teachers is weak, and there is very little direct or explicit instruction. The level of cognitive demand made on children in classrooms is low, and textbooks and other guiding materials are under-utilised. Instructional time is eroded by other activities in the school and classroom and the pace is generally very slow, resulting in children falling far behind the curriculum requirements for their age.[23]

The teaching of reading specifically is often based on oral drill sequences.[24] There are aspects to these practices that appear not to have changed from the findings of early studies in classrooms, which never progressed beyond technical decoding skills, and fostered little understanding of the meaning of texts.[25]

A number of studies of grade R classrooms in particular attest to the low quality of classroom provision. An Eastern Cape study, which went into 250 classrooms, concluded:

> *The province has increased access to Reception Year. The quality of the classrooms and of the educational programmes, however, may generally be harmful to the wellbeing of children.*[26]

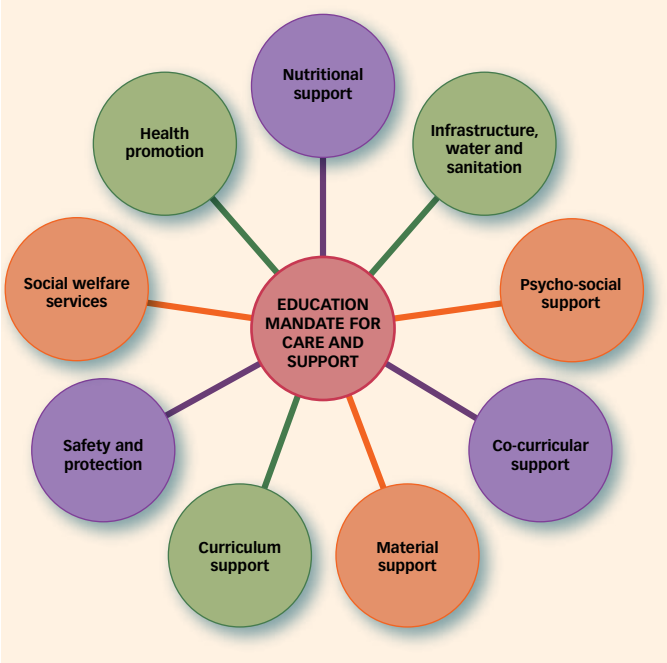
Some work in classrooms also suggests that very little by way of stimulation is happening in classrooms, and that there is a tendency towards offering a "watered-down" grade 1.[27] Several of these issues speak to the concern around the conceptualisation of grade R and of what learning at this level entails.

Conceptualising grade R

Grade R is positioned between Early Childhood Development (ECD) programmes (ages 0 – 4) and the start of formal schooling in grade 1. Conceptualising what learning consists of in grade R is unclear and contested. ECD is rooted in informal and structured play which focuses on the social, emotional, physical, intellectual, aesthetic and moral development of each child, including gross and fine motor skills. Grades 1 – 3 are focused on the learning of formal curriculum content, and crucially on the development of domain-specific learning of reading, writing, counting and calculating. A dichotomy is often invoked in the literature between a more developmental, play-based pedagogy and one that focuses primarily on emergent literacy and numeracy (in places referred to as an "instrumentalist approach").

Perhaps one of the reasons why these are presented as mutually exclusive is the idea of grade R as a watered down version of grade 1, and the perception that there is a drift towards formalism (i.e. a domain-specific approach) in grade R classrooms. Although there is little evidence of the latter, it is clear that managing the relation between play and domain-specific learning is a challenge both conceptually and potentially in practice. It may be useful to think of play as a necessary pedagogical strategy at this level, referring to *how* children learn. Structured play is always deployed,

Figure 12: The policy mandate for care and support within the schooling system



Source: Department of Basic Education (2012) *Care and Support for Teaching and Learning: Creating an enabling environment to improve learning outcomes*. Presented at the 5th South African AIDS Conference Durban, 9 June 2012.

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A print-rich environment supports the development of literacy and numeracy skills.

however, in relation to a *what* – either domain-specific knowledge or the development of certain cognitive and social skills. Both the "what" and the "how" need attention, and their relation needs to be made clear.

Currently clear specification of the "what" and "how" is lacking in both the Curriculum Assessment Policy Statements documents (especially in terms of what and why structured play should be included) and in training stipulations for teachers. It is worth bearing in mind that the international and South African literature shows emphatically that early literacy, including exposure to reading, pictures and the mediation of text by an adept reader, are primary determinants of later school success.[28] This is particularly important for children who have not acquired the rudiments of literacy in the way that middle-class children do through long-term exposure to reading, books and a print-rich environment in the home. The development of emergent literacy should therefore lie at the heart of both the "what" and the "how" in the earliest years.

In sum: Play is a necessary *pedagogy* at this level, which should not undermine the teaching of domain-specific *curriculum* contents. At the same time, a more formal, direct mode of instruction should not obscure the learning and developmental affordances for young children of learning through play. This in turn would require very clear specification of *what* should be taught and *how*, especially for teachers who lack experience, training or understanding in the developmental, pedagogical and knowledge requirements of learning at this level.

What is needed to enable learning in the foundation phase?

Across the literature there is consistency in what is problematic and what is required to enable better quality learning in the foundation phase (grades R – 3).[29] A number of the main issues have been raised already. In addition, there are significant gaps in relation to grade R policy. For example, the South African Schools Act has yet to be amended to make grade R a compulsory part of schooling, and the law's norms have not been amended to provide for grade R posts. These gaps mean that a very fragile system is in place for practitioner recruitment, remuneration and retention.

Comprehensive and integrated services for young children

There is a broad literature that draws attention to the nutrition, health, safe transport and after-school care of young children in grade R.[30] In response to these challenges the Department of Basic Education has introduced the Care and Support for Teaching and Learning[31] framework, which uses schools as "nodes of

Case 11: The Gauteng Literacy and Mathematics Strategy (GPLMS)

Now in its third year, this initiative of the Gauteng Department of Education works with schools that performed particularly poorly on the Annual National Assessmentss (ANAs). The GPLMS model draws on four key elements:

- Supporting teaching and learning through the use of trained coaches and provision of lesson plans and materials.
- Supporting the use of school-based assessment and ANAs to improve learner performance.
- Providing a programme of extra school support, particularly for homework assistance.
- Offering school management support to district officials and members of school management teams.

A central feature of the GPLMS is the use of lesson plans, which are carefully aligned with the Curriculum Assessment Policy Statements to address the problem of very slow pacing in schools. The project commissioned the publication of 16 sets of graded readers in each official language and a customised set of mathematics materials for learner use.

Reliable data on the impact of the GPLMS are not yet available. However, certain test data are encouraging and indicate that the GPLMS might be having a positive effect on learner literacy, even at this relatively early stage of the programme. Although the scripted nature of the material is not beyond criticism, it appears to be positively received in schools, in particular where teachers were previously unsure of what to teach and what resources to use on a daily basis. The programme has also improved monitoring of teaching and a heightened awareness of the foundation phase at head office. The support and monitoring of teachers at district level remains a weakness.

care and support" for the most vulnerable children and families. CSTL aims to address barriers to learning by using schools as a site for the delivery of a range of primary health care, nutrition and psycho-social support services and promoting greater parental involvement, represented in figure 12 on p. 74.

The emphasis is on comprehensive and integrated services for young children including the provision of food, health care, affectional care, stimulation and early learning activities.[32]

In 2013 the Department of Basic Education reported exceeding its targets for school feeding and the screening of learners at school and district level.[33] On these two measures, at least, there appears to have been some success in creating a more enabling environment. However it is unclear whether a full range of support services is reaching all learners in need – especially those in the most remote (and disadvantaged) rural areas. In addition, data for the screening and broader care and support of the youngest learners in the system specifically are not available.

Professional development

Grade R teachers are overwhelmingly under-qualified, with preliminary research showing that the majority only have a matriculation without exemption.[34] Further, there is a lack of cohesion and articulation between different ECD qualifications and a clear career path for ECD practitioners has not been mapped out in relation to existing and new qualifications. The fact that the South African Council for Educators registers level 5 practitioners, which would include most grade R teachers, shows signs of moves to professionalise teaching at this level. Grade R training, qualifications and remuneration have, however, still to be fully integrated into the education post structure. It will take some time to fulfill the new minimum requirements for teacher education which propose a level 6 diploma in grade R.[35] Finally, questions have also been raised regarding the capacity to train new teachers given the rapid scale-up of grade R.

It has become clear across the system that teachers know little more about the subjects they teach than the curriculum expects of their learners, and that some teachers know considerably less than this.[36] In particular, a vast number of teachers don't know how children learn to read, and consequently don't know how to teach reading.

There is a growing call to move beyond generic training of teachers towards intensive and *targeted* training.[37] In the foundation phase, training should be focused on the development of reading and writing and number concept, with a focus on difficult topic areas and how to teach these. Training needs to be intensive and ongoing as opposed to once off.[38] For grade R, specifically, teachers need to understand the cognitive and physical development of young children, the logic and basis for structured play as an important pedagogy, and the curriculum requirements regarding emergent literacy and numeracy knowledge and skills.

Case 12: Improving the quality of mathematics and science in grade R classes

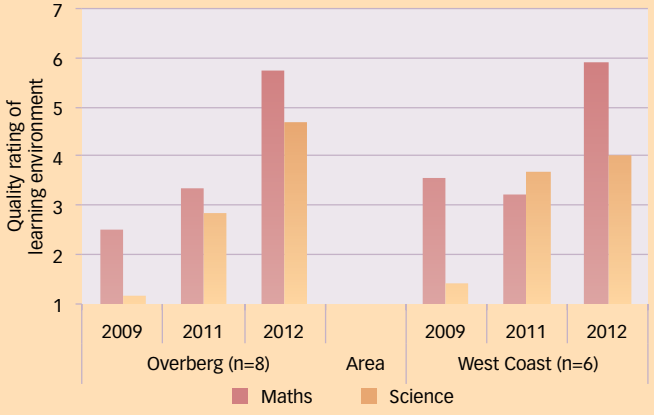
A three-year intervention to improve the quality of maths and science learning was piloted by the Early Learning Resource Unit[iv] in a sample of 51 community and public grade R classes in the Overberg and West Coast districts in the Western Cape. Challenges identified at baseline were the lack of educator knowledge and resources, especially in relation to science and a focus on number rather than the other learning outcomes for mathematical learning.

Each year, participating educators received 15 days of training, three site visits to support implementation, and resources. A series of science- and maths-focused children's books and educator guides were developed for use in the pilot. Participants also visited places of interest such as museums and nature reserves to develop their understanding of how the natural world is an effective tool for teaching maths and science.

Before there could be a focus on maths and science, the general quality of facilitation, classroom organisation and management had to be improved. Classrooms of 14 educators who participated in the entire pilot were tracked using subscales of the Early Childhood Environmental Rating Scale – Revised and Extended.[40] Results showed overall improvement on classroom organisation, scheduling, interaction, using language to facilitate reasoning and maths and science learning opportunities.

The outcomes confirmed the importance of working on the learning programme as a whole, improving mediation and group work skills, and increasing educator confidence in the subject area. Developing these capacities required sustained inputs over the period.

Figure 13: Quality of maths and science learning environments including materials and activities, 2009, 2011 & 2012



iv As part of the Systemic Education and Extramural Development and Support Programme funded by the Kingdom of the Netherlands.

Conclusion

There have been substantial gains in political and budgetary commitment to grade R, and there is now near-universal access to formal schooling across the foundation phase. Research shows that early educational intervention can make a significant difference to children's later life chances. This difference, however, depends on the *quality* of the educational experience. The quality of children's learning experiences from grades R – 3 is critical and needs to be seriously addressed before the National Planning Commission's suggestion of a pre-grade R is even considered.

This includes recognising that:

- Teachers are pivotal in providing good quality instruction to children. Serious attention needs to be given to developing foundation phase teachers' content knowledge in mathematics and language, and assisting them in *how* to teach reading, writing, counting and calculating. The Gauteng Literacy and Mathematics Strategy (see case 11 on p. 75) and the SEEDS maths and science study (case 12) in rural Western Cape provide useful lessons in how teachers can be supported and developed.
- Grade R needs to be clearly conceptualised. The relationship between grade R, prior early learning and formal schooling needs to be better understood and managed at all levels of the system. This includes clear guidance for teachers so they understand the "what" and "how" of teaching and learning at this level. Good, targeted training would help, as would clearly stipulated curriculum guidance, written in plain language that teachers can easily access.
- Educational interventions are only part of the solution. Family background remains the most powerful influence on how children will fare in school. Many of South Africa's children enter formal school with their developmental potential considerably compromised, and with limited attention to their physical and psychological well-being, which affect their ability to learn. It is therefore important to find ways to secure the nutrition, health, safe transport and after-school care of young children in the foundation phase, in addition to improving the quality of teaching and learning.

Early schooling has the potential to either reproduce current inequalities, or interrupt cycles of disadvantage. It is therefore imperative that a solid foundation and quality learning experiences are provided for our youngest learners.

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Early childhood development services in South Africa: What are the next steps?

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A nation that invests in its youngest citizens shows wisdom and foresight, and can therefore be assured of a promising future.[1] This essay argues for investment in essential services that support and promote young children's development and the realisation of their full potential. It describes pertinent conceptual shifts and related actions needed to improve and extend current service delivery, and considers strategies to ensure that early childhood development (ECD) interventions are implemented effectively at community level.

The essay answers the following questions:

- Investing in ECD interventions – what difference will it make?
- From concepts to action – how do we move ECD services forward?
- Making ECD services work – how do we apply an ecological approach?

Investing in ECD interventions – what difference will it make?

Global evidence is increasingly demonstrating that quality ECD interventions provide both immediate and long-term benefits for children and communities, and this strengthens the rationale for effective and sustained investment. Investing in ECD yields tangible returns, especially for young children living in poverty. As such ECD serves as an effective equaliser in the long-term, and a more concerted investment in ECD would have contributed towards the attainment of the Millennium Development Goals by 2015.

ECD interventions have the potential to, amongst others:

- reduce child mortality through the use of volunteer community health agents (as shown in Brazil's Pastoral da Crianca[i] and Primeira Infância Melhor programmes[2]);
- build social capital[ii] as early interventions can enhance academic performance and strengthen community networks, social infrastructure and service delivery through community participation (as illustrated in Cuba's national ECD programme,[3] Nigeria's COLONISA[4] and South Africa's Impilo[iii] project);
- lessen the drain on national resources by reducing school grade repetition and social welfare expenditure (as demonstrated in Brazil's Pastoral da Crianca programme);
- prevent developmental delay through intensive early intervention and responsive community-based programmes (as shown in the Chicago longitudinal study[5] and Brazil's Pastoral da Crianca programme); and
- improve gender relations by promoting better socialisation (as illustrated in Malawi[6]).

An estimated 58% of children in South Africa live in poverty (with a per capita income of less than R604/month)[7] and glaring racial and geographic disparities persist – 66% of African children continue to live in poverty compared to Coloured (30%), Indian (8%) and White (2%) children. Child neglect and malnourishment is a serious consequence of poverty. ECD interventions therefore play a critical role in identifying and responding to children who are most vulnerable[8], and have the potential to break intergenerational cycles of poverty.

South Africa therefore needs political commitment and sustained investment in effective ECD programmes and services. As was articulated in the Diagnostic Review on ECD,[9] these interventions need to be comprehensive, with an emphasis on addressing the continuum of early development across health, cognitive development and social well-being. The review asserts that without prevention and prompt intervention, disadvantages will accumulate and create passages for failure and exclusion, contributing to widening social and achievement gaps.

It is not possible to specify the government's total investment in ECD interventions. The Department of Basic Education, primarily responsible for training ECD practitioners in ECD centres, spends less than 1% of the total basic education budget[10] on learning opportunities for children 0 – 4 years of age – pointing to the need to revisit current roles and responsibilities. The Department of Social Development's current expenditure on ECD centres is progressive[11] as subsidies are well-targeted to children in the poorest quintiles[iv].

However, more than 80% of children aged 0 – 4 years in the poorest 40% of the population are entirely excluded from registered ECD programmes and thus do not feature in national budget calculations. To forgo greater investment in ECD interventions means compromising the well-being of South Africa's communities, perpetuating cycles of poverty, poor educational attainment, ill health, inequality and socio-economic challenges.

i Programme foci include stimulation and cognitive development, adequate nutrition education, parenting skills, compliance with immunisation and school readiness.
ii Social capital can be defined as the links, shared values and understandings in society that enable individuals and groups to trust each other and so work together.
iii Impilo is a network of caregivers who are the backbone of the *Sizabantwana* – Caring for Children project. Impilo caregivers care for especially vulnerable children with no caregivers; they feed them and interact with them. They act as foster parents for the children and earn a stipend of R250 a month. See www.sizabantwana.org.
iv With a concentration coefficient of -0.219.

From concepts to actions – how do we move ECD services forward?

Services for young children in South Africa are on the brink of transformation as the country is developing its first national ECD policy and strengthening its ECD policy and legislative framework. The essays in this issue of the *South African Child Gauge* have outlined critical conceptual shifts that should inform short- to medium-term planning. This should result in significant improvements in the delivery of an essential package of ECD services[v] to a large number of young children who are currently not receiving support (see the essay by Berry, Dawes and Biersteker on pp. 26 – 33). The following conceptual shifts and actions are critical to improve service delivery.

1. Provide a package of essential services and support

Young children's developmental needs are multi-faceted and interdependent. Berry, Dawes and Biersteker (pp. 26 – 33) describe an array of essential services to support children's development which should be provided with equal attention given to health, nutrition, early learning, caregiver support and social services. Multiple actors and sectors are needed to deliver this range of services, and roles and responsibilities of various state and non-state actors must be clearly delineated to ensure harmonious and efficient service delivery. Programme content and resources must be described, costing undertaken, and population-based planning performed to determine needs at local level.

2. Prioritise maternal health and caregiver well-being

The health and well-being of the infant and young child are intrinsically linked to foetal development and maternal health before, during, and after pregnancy (see Slemming and Saloojee on pp. 50 – 55). The first 1,000 days provide the foundation for all aspects of human development, but particularly for healthy neurological and socio-emotional development.[12] It is therefore crucial to target pregnant women as early as possible through quality antenatal services, and to offer support to caregivers throughout the early years.

Caregiver health and well-being is considered to be "the single most important contributor" to children's survival and development (see Tomlinson's essay on pp. 56 – 61). Therefore, maternal health and nutrition, psycho-social support, social assistance and other forms of caregiver support require increased attention and prioritisation within existing programmes.

3. Maximise service delivery through multiple channels

Early childhood provision for early learning is not just about centre-based programmes. Interventions that support young children's development should be delivered through a variety of channels that can reach young children and their families in different contexts. Planning of local service delivery should aim to make age-appropriate services as accessible as possible (see Berry, Dawes and Biersteker's essay on pp. 26 – 33). In South Africa, a small proportion of children younger than three years attend ECD centres,[13] while the majority are cared for at home. So greater emphasis on home- and community-based programmes (eg playgroups) is crucial to reach very young children. Careful consideration of how the state can execute a multi-pronged approach to local service delivery, with clear institutional arrangements and population-based planning, is key.

4. Create an enabling policy and programming environment

Several essays (see for example Viviers, Biersteker and Moruane on pp. 34 – 43) emphasise the importance of an enabling policy and programming environment to facilitate the delivery of quality ECD interventions to all children, especially those most vulnerable. Such an environment would ensure that the essential pillars of a responsive and equitable ECD system are in place, including adequate financial and human resourcing, state-led leadership, accountable and coordinated governance, and decentralised service delivery. A critical missing ingredient for the consolidation of an effective ECD system in South Africa is a national coordinating mechanism[14] with the ability and authority to oversee activities, foster collaboration and monitor implementation against set targets. The forthcoming policy must foreground these crucial elements of an effective system, and guide the establishment and operation of such a coordinating structure.

Attention must be given to addressing service gaps, improving the quality of existing services and reaching all young children, especially those most vulnerable. Table 9 summarises the main service gaps and priority groups, and identifies the most salient actions needed to improve service access and quality.

Making ECD services work – how do we apply an ecological approach[iv]?

Policy-makers need to focus on how to invest in quality ECD interventions that provide social, economic and political benefits and reach mothers and children where they are located. The earlier interventions start, the greater the return on investment in the long run. Early childhood is the time when the brain develops most rapidly and it is a critical window of opportunity for establishing a child's immunity and other health outcomes. It is the foundation of good health, education and optimal productivity for the future.[15]

The essays in this issue of the *South African Child Gauge* focus to a large extent on getting South Africa to increase investment in effective ECD programming by strengthening state service delivery systems and the capacity of families and community institutions to promote children's survival, health and development, and therefore the socio-economic well-being of the nation.

It is common knowledge that the responsibility for ECD spans over many sectors, underpinning the fact that effective delivery is not just the forte of one sector.[16] Attention needs to be paid to institutional arrangements to ensure that convergence of services

v The delivery of an essential package of ECD services and support is considered to be a short-term priority, while provisioning for and implementation of a comprehensive set of services should be seen as a long-term objective.

vi An ecological approach refers to the multiple contexts that young children interact with, from their immediate family contexts to their local communities and the broader political sphere that impacts on their life space. Each context provides opportunities to shape and support the development of young children.

Table xx: Priority service targets and expanding ECD service access and quality

Essential service	Priority groups and key service gaps	Actions to improve service delivery
Nutrition	• Extend nutritional support to pregnant women. • Prioritise at-risk young children, especially those younger than three years.	• Prioritise delivery of key interventions (breastfeeding, complementary feeding, micronutrient supplementation, hygiene and maternal health and nutrition). • Link the key interventions to existing services and use home visits, community-based services and health facilities to reach young children.
Health	• Strengthen early identification and referral systems to support children at risk, especially those with disabilities. • Strengthen health services for pregnant women and children in the first 1,000 days of life. • Strengthen health care for 3 – 5-year-olds, especially those not in ECD centres.	• Use primary health care re-engineering as an opportunity to promote the care and development of young children. • Design effective linkages between services both within the health sector and between the health sector and external partners. • Strengthen the delivery of community- and home-based programmes.
Caregiver support	• Provide mental health and substance abuse screening and referral of pregnant women and mothers of young children. • Provide safe child care options for caregivers who are occupied during the day (eg working or seeking work).	• Utilise and extend the reach of home-visiting programmes to support vulnerable caregivers, including improving access to psycho-social and material support. • Improve the capacity of health care and social service practitioners to recognise and respond to the signs of caregiver burden, including making appropriate referrals. • Ensure the provision of staff to provide both basic counselling and specialised services, with strong links to existing services. Synergy with the primary health re-engineering strategy is a key opportunity.
Parenting	• Strengthen parenting support services especially for the caregivers of children younger than three years.	• Conduct community needs assessments to determine the priorities for localised parenting programmes. • Identify and implement parenting interventions likely to be effective, and consider ways of linking these with other ECD services. • Establish the effectiveness and cost-effectiveness of parenting programmes.

Early learning	• Extend access to young children not yet benefitting from early learning programmes	• Improve access and quality of early learning programmes in an age-appropriate manner:
		  • Home visiting is an effective way of supporting the early learning needs of children younger than three years.
		  • Older children (prior to grade R) benefit mostly from early learning group programmes.
		  • The quality of early learning programmes must be ensured through regular monitoring of programme effectiveness, staff training and supervision.

Early schooling	• Improve the quality of early schooling	• The quality of children's learning experiences in the foundation phase needs urgent attention. Specifically:
		  • develop and support foundation phase teachers by improving their content knowledge and numeracy and literacy teaching strategies;
		  • clearly conceptualise the role of grade R and its relationship to prior early learning and formal education;
		  • increase attention to young children's physical and psychological well-being by securing the nutrition, health, safe transport and after-school care of children in the foundation phase.

becomes a reality as outlined by Viviers, Biersteker and Moruane on pp. 34 – 43. As South Africa has a system of decentralised governance, it will be prudent to enable local government actors, service providers and community workers to work together and deliver, circumventing the entrenched bureaucracies in national and provincial capitals. Building the capacity of available local role-players is critical. Systems exist at municipal level through the Integrated Development Plans (IDPs), which need to be translated into action and monitored to ensure effective implementation and accountability.

Any failure by the designated state entities (in the case of South Africa, the leading departments would be Health, Social Development and Basic Education) to develop systems to enable the delivery of effective ECD services is tantamount to a lost opportunity which will contribute to the perpetuation of poverty and inequality, violence, ill health, and poor educational performance, among others. The government of South Africa is finalising a national ECD policy, which will enable effective local service delivery and create the space where families and communities can genuinely care for pregnant mothers and young children.

While the role of families and communities in caring for young children is central to the development of a national programme for ECD; the obligation to ensure the fulfilment of young children's rights extends beyond the family and community to all levels of government.

The development of the policy will be guided by a range of international rights instruments[vii] and local regulatory frameworks that enable and promote ECD programming. The policy will also define mechanisms for the adequate allocation of resources within the national budget. The policy is intended to, among others, facilitate greater multi-sectoral integration and programming.

Underpinning all of the above is the need to ensure essential services reach caregivers and young children where they are located. This requires the use of a variety of different platforms, including home visits, community-based informal and formal development and learning opportunities, home and day care facilities, ECD centres and schools (see Berry, Dawes and Biersteker's essay on pp. 26 – 33). Therefore the programming package must include accessible and responsive systems that reach out to and are inclusive of the most vulnerable children and families – and that mobilise families and communities to take action to ensure that the needs of young children are met satisfactorily.

Conclusion

Prioritising essential services for young children benefits not only individual children and families, but also communities and the broader society. The National Development Plan recognises the value of investing in ECD interventions for the life-long development of children and society as a whole, and identifies the provision of high quality, universally available ECD services as a key target for 2030, and as a state-led responsibility.

Strategies to expand and strengthen the quality of essential services must include delivery of population-based services through multiple delivery channels, especially home- and community-based programmes, and the development of strong linkages within and across existing services to optimise resources and efficiencies. The conceptualisation, management, monitoring and evaluation of ECD interventions also need strengthening to improve effectiveness. An effective ECD system depends on the allocation of sufficient resources, including appropriately trained and supervised staff and applicable funding mechanisms. Ultimately, ECD is everyone's business and all families, communities, government and civil society have a responsibility to act now to improve the lives of young children in South Africa.

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PART THREE:

Children Count – The Numbers

Part three presents child-centred data to monitor progress and track the realisation of children's socio-economic rights in South Africa. This year it presents data from 2002 – 2011, and identifies main trends over this 10-year period.

A set of key indicators track progress in the following domains:

- Demography of South Africa's children
- Income poverty, unemployment and social grants
- Child health and nutrition
- Children's access to education
- Children's access to housing
- Children's access to basic services

A full set of indicators and detailed commentary are available on www.childrencount.ci.org.za.

Introducing Children Count – *Abantwana Babalulekile*

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?* In order to answer this question, it is necessary to monitor the situation of children, which means there is a need for regular information that is specifically about them.

A rights-based approach

Children Count, an ongoing data and advocacy project of the Children's Institute, was established in 2005 to monitor progress for children. It provides reliable and accessible child-centred information which 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 be a fairly data-rich country. There is an array of administrative data sets, and the national statistics body, Statistics South Africa, undertakes regular national population surveys which provide useful information on a range of issues. However, most information about the social and economic situation of people living in South Africa does not focus on children, but rather counts all individuals or households. This is the standard way for central statistics organs to present national data, but it 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, but 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 what proportion of households is without adequate sanitation, but when a child-centred analysis is used, the proportion 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 2002 and 2011, and many of the indicators in this issue compare the situation of children over this 10-year period.

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 on demographics and socio-economic rights. The project's website contains the full range of indicators and more detailed data, as well as links to websites and useful documents. It can be accessed at **www.childrencount.ci.org.za.**

Confidence intervals

Sample surveys are subject to error. The proportions or 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 proportion 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 sub-groups are real: the wider the confidence interval, the more uncertain the proportion. Where confidence intervals overlap for different sub-populations or time periods, it is not possible to claim that there is a real difference in the proportion, even if the mid-point proportions 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 number of data sources. Most of the indicators draw on the General Household Survey conducted by Statistics South Africa, 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 strengths and limitations of each are outlined on the project website. Technical notes for the indicators are included on pp. 113 – 114, and can also be found on the website.

Here are a couple of examples of how to reference *Children Count* data correctly:

When referencing, for example, from the Demography *section in this publication:*

Meintjes H & Hall K (2013) Demography of South Africa's children. In: Berry L, Biersteker L, Dawes A, Lake L & Smith C (eds) *South African Child Gauge 2013*. Cape Town: Children's Institute, University of Cape Town.

When referencing from the Housing and Services *online section:*

Hall K (2013) Housing and Services – Access to adequate water. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 20 July 2013: www.childrencount.ci.org.za.

Demography of South Africa's children

(pages 86 – 89)

This section 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, the number and proportion of orphans, and children living in child-only households. There were 18.5 million children in South Africa in 2011. Twenty-one percent of children are orphans who have lost a mother, father or both parents; 24% of children do not live with either of their biological parents; and 0.4% of children live in child-only households.

Income poverty, unemployment and social grants

(pages 90 – 94)

In 2011, nearly two-thirds of children (58%) lived below the poverty line (with a per capita income below R604 per month), and 35% lived in households where no adults were employed. Social assistance grants are therefore an important source of income for caregivers to meet children's basic needs. In March 2013, over 11 million children received the Child Support Grant; 532,000 children received the Foster Child Grant; and a further 120,000 children received the Care Dependency Grant.

Child health and nutrition

(pages 95 – 100)

This section monitors child health across a range of indicators. The most recent and reliable estimates suggest that under-five mortality is decreasing and stood at 42 deaths per 1,000 live births in 2011. The infant mortality rate has followed a similar trend and is estimated at 30 deaths per 1,000 live births for 2011. In the same year, 29.5% of pregnant women were estimated to be HIV positive. Nearly 24% of children travel far to reach their health care facility and 14% of children live in households that reported child hunger.

Children's access to education

(pages 101 – 107)

Many children in South Africa have to travel long distances to school. One in six children (15%) live far from their primary school and this increases to one in five children (20%) in high school. Despite these barriers, South Africa has made significant strides in improving access to education with a gross attendance rate of 97% in 2011. Access is also increasing in the preschool years, with 90% of 5 – 6-year-olds, and 55% of 3 – 4-year-olds attending some kind of educational institution or care facility. However, this does not necessarily translate into improved educational outcomes or progress through school. In 2011, 84% of 10 – 11-year-olds had completed grade 3, and only 60% of 16 – 17-year-olds had completed grade 9.

Children's access to housing

(pages 108 – 110)

This section presents data on children living in rural or urban areas, and in adequate housing. The latest available data show that, in 2011, 53% of children were living in urban areas, and 74% of children lived in formal housing. Just under two million children lived in backyard dwellings and shacks in informal settlements, and one in five children (21%) lived in overcrowded households.

Children's access to basic services

(pages 111 – 112)

Without water and sanitation, children face substantial health risks. In 2011, two-thirds of children (66%) had access to drinking water on site, while children's access to adequate toilet facilities rose to 69%.

Demography of South Africa's children

Helen Meintjes and Katharine Hall (Children's Institute)

The 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 number and proportion of children living in South Africa

In mid-2011, South Africa's total population was estimated at 50 million people, of whom 18.5 million were children (under 18 years). Children therefore constitute 37% of the total population. The child population has grown by about 6% (one million) over the 10-year period from 2002 to 2011.

Half of all children live in three of the nine provinces: KwaZulu-Natal (23%), Eastern Cape (14%) and Limpopo (12%). A further 18% of children live in Gauteng, a mainly metropolitan province, and 10% in the Western Cape.

It is not uncommon in South Africa for children to live separately from their biological parents, in the care of other relatives. The distribution of children across provinces is slightly different to that of adults, with a greater proportion of children living in provinces with large rural populations (Limpopo, the Eastern Cape and KwaZulu-Natal) and with greater proportions of adults in the largely metropolitan provinces. Despite being the smallest province in the country, Gauteng accommodates a quarter of all households and adults, but less than a fifth of children. This is because of the relatively large number of adult-only households in that province.

There have been striking changes in the provincial child populations over time. While there are slight decreases in the number of children living in the Eastern Cape, Limpopo and the North West provinces, the number of children living in Gauteng has risen by 22%. This may be caused by the migration of children to join existing households, or new births within the province. Either way, the increase suggests a more permanent migration pattern. The apparent increase in the child population in the Northern Cape is very pronounced due to the relatively small population in that province.

We can look at inequality by dividing all households into five equal groups or quintiles, based on total income to the household (including earnings and social grants): with quintile 1 being the poorest 20% of households, quintile 2 being the next poorest and so on. Quintile 5 consists of the least-poor 20%. Nearly 70% of children live in the poorest 40% of households.

Children are fairly equally distributed across the age groups, with on average just over one million children in each year under 18. The gender split is equal for children, while it is slightly skewed towards females (52%) in the adult population. The early childhood development (ECD) period, which is the focus of the essays in this issue (pp. xx – xx), extends from birth to the age at which children are expected to complete the foundation phase of schooling (0 – 9 years). There are 10.1 million children in this ECD age group, making up a fifth of the national population.

Table 1a: Distribution of households, adults and children in South Africa, by province, 2011

PROVINCE	Households		Adults		Children		
	Number	%	Number	%	Number	%	% change 2002 – 2011
Eastern Cape	1,627,000	13	3,970,000	12	2,687,000	14	-5.3
Free State	824,000	6	1,872,000	6	1,060,000	6	7.1
Gauteng	3,199,000	25	7,614,000	24	3,336,000	18	21.7
KwaZulu-Natal	2,383,000	18	6,419,000	20	4,214,000	23	9.9
Limpopo	1,241,000	10	3,024,000	10	2,241,000	12	-10.4
Mpumalanga	912,000	7	2,193,000	7	1,473,000	8	12.8
North West	980,000	8	2,219,000	7	1,282,000	7	-10.4
Northern Cape	289,000	2	724,000	2	435,000	2	44.5
Western Cape	1,491,000	12	3,751,000	12	1,814,000	10	14.0
South Africa	**12,948,000**	**100**	**31,783,000**	**100**	**18,541,000**	**100**	**5.8**

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living with their biological parents

South Africa has a long history of children not living consistently in the same dwelling as their biological parents as a result of poverty, labour migration, educational opportunities or cultural practice. 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.

The vast majority (90%) of children live in households where there are two or more co-resident adults. This indicator examines co-residence between children and their biological parents specifically. Although many children live with just one of their biological parents (invariably their 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 proportion of children living with both parents decreased from 38% in 2002 to 33% in 2011. Thirty-nine percent of all children – more than seven 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-four percent do not have either of their biological parents living with them. This does not necessarily mean that they are orphaned: in most cases (78%) children have at least one parent who is alive but living elsewhere, and over half of all children living without co-resident parents have both parents living elsewhere.

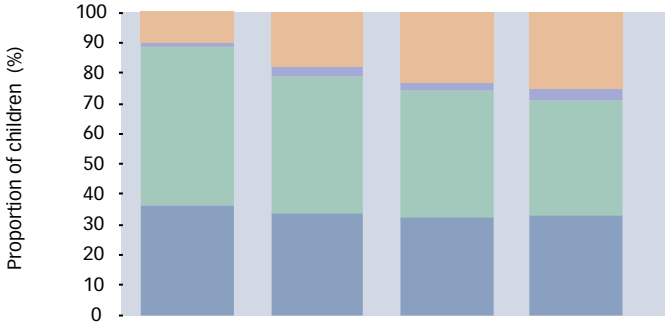
There is some provincial variation in these patterns. In the Western Cape and Gauteng, the proportion of children living with both parents is significantly higher than the national average, with around half of children resident with both parents (53% and 48% respectively). Similarly, the number of children living with neither parent is low in these two provinces (12% and 13%). In contrast, over a third of children (35%) in the Eastern Cape live with neither parent. These patterns are consistent from 2002 to 2011.

Children in the poorest households are least likely to live with both parents: only 18% have both parents living with them, compared with 73% of children in the least-poor 20% of households.

Less than one third (27%) of African children live with both their parents, while the vast majority of Indian and White children (83% and 74% respectively) are resident with both biological parents. Just over a quarter (27%) of all African children do not live with either parent and a further 42% of African children live with their mothers but without their fathers. These figures are striking for the way in which they suggest the limited presence of biological fathers in the domestic lives of large numbers of African children.

Younger children are more likely to be living with their mothers (whether or not their fathers are present) than older children, who are more likely than younger children to be living with neither parent. For example, while 10% of children under two years were not resident with either parent in 2011, this situation applied to a quarter of children aged 7 – 9 years, and to almost one third (32%) of children aged 12 – 17 years. Overall, 19% of children aged 0 – 9 years were not resident with their biological parents in 2011.

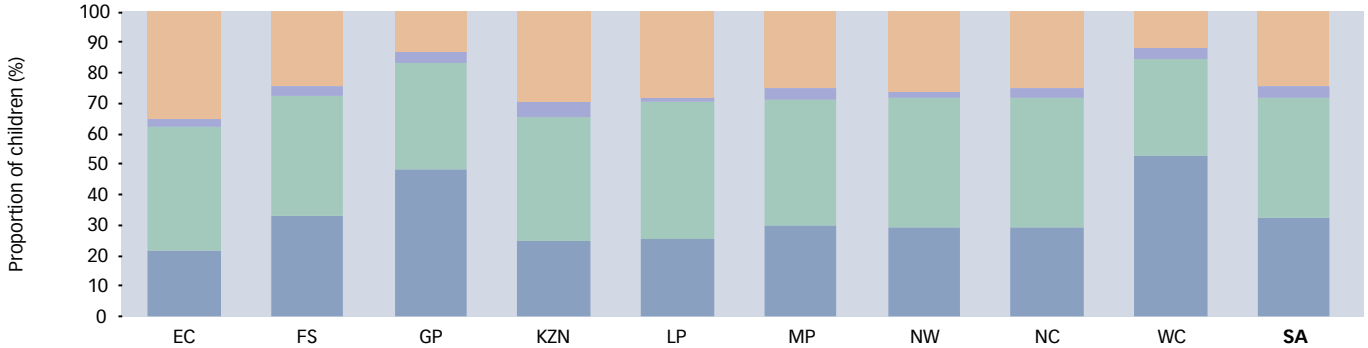
Figure 1b: Child and parent co-residence for young children, 2011



	0 – 2 years	3 – 4 years	5 – 6 years	7 – 9 years
Both parents	36,6% 1,090,000	34,0% 680,000	32,7% 743,000	33,2% 955,000
Mother only	52,0% 1,549,000	44,9% 897,000	41,3% 938,000	37,6% 1,081,000
Father only	1,6% 48,000	3,2% 64,000	2,8% 64,000	4,1% 117,000
Neither parent	9,9% 294,000	17,9% 358,000	23,2% 528,000	25,1% 721,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Figure 1a: Children living with their parents, by province, 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
Both parents	21,6% 580,000	33,2% 352,000	48,1% 1,605,000	24,5% 1,034,000	25,7% 576,000	29,8% 439,000	29,3% 375,000	29,4% 128,000	52,9% 959,000	32,6% 6,044,000
Mother only	40,4% 1,087,000	39,2% 415,000	34,9% 1,164,000	40,7% 1,716,000	44,5% 998,000	41,4% 610,000	42,2% 541,000	42,6% 185,000	31,7% 575,000	39,3% 7,293,000
Father only	2,9% 78,000	3,5% 37,000	4,4% 146,000	5,1% 217,000	1,7% 39,000	3,9% 58,000	2,2% 28,000	3,2% 14,000	3,5% 63,000	3,7% 678,000
Neither parent	35,0% 942,000	24,1% 256,000	12,6% 422,000	29,6% 1,247,000	28,0% 628,000	24,9% 366,000	26,3% 337,000	24,8% 108,000	12,0% 217,000	24,4% 4,526,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of orphans living in South Africa

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 died.

The total number of orphans is the sum of maternal, paternal and double orphans. This definition differs from those commonly used by United Nations agencies and the Actuarial Society of South Africa (ASSA), where the definition of maternal and paternal orphans includes children who are double orphans. As the orphan definitions used here are mutually exclusive and additive, the figures differ from orphan estimates provided by the ASSA models.

In 2011, there were approximately 3.85 million orphans in South Africa. This includes children without a living biological mother, father or both parents, and is equivalent to 21% of all children in South Africa. The total number of orphans has increased substantially, with 853,000 more orphaned children in 2011 than in 2002.

Orphan numbers do not indicate the nature or extent of care that children are receiving. 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. For example children who are maternal orphans are slightly more at risk of poorer educational outcomes than paternal orphans.[2]

In 2011, 17% of children in South Africa did not have a living biological father; 8% did not have a living biological mother; 3.3% were maternal orphans with living fathers; and a further 5% were recorded as double orphans. In other words, the vast majority (around 60%) of all orphans in South Africa are paternal orphans (with living mothers). The numbers of paternal orphans are high because of the higher mortality rates of men in South Africa, as well as the frequent absence of fathers in their children's lives (1.9%, or 350,000 children, have fathers whose vital status is reported to be "unknown").

The figures illustrate notable increases in the number and proportion of double orphans over a 10-year period. The number of double orphans has more than doubled since 2002 (from approximately 350,000 to 950,000), indicating an increase of three percentage points (2002: 2.0%; 2011: 5.1%). These increases are likely to be driven primarily by the AIDS pandemic. Three provinces carry a high burden of care: 7% of children living in KwaZulu-Natal, the Free State and the Eastern Cape have lost both parents.

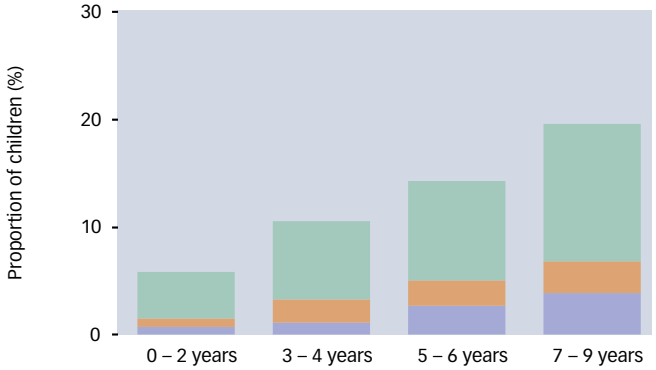
Roughly half of all orphans in South Africa live in KwaZulu-Natal and the Eastern Cape. KwaZulu-Natal has the largest child population and the highest orphan numbers, with 27% of children in that province recorded as orphans who have lost a mother, a father or both parents. Orphaning rates in the Eastern Cape are similarly high, at 26%, followed by the Free State, at 25%. The lowest orphaning rates are in the Western Cape (9%) and Gauteng (14%).

Children are more likely to be orphaned as they get older. In 2011, 10% of orphans were 0 – 4 years old and 67% were10 years and older.

Over half of all orphans are resident in the poorest 20% of households. Around a quarter of children in the poorest 20% of households are orphans, compared with the richest 20% where total orphaning rates are around 6%.

Figure 1d: Orphaning amongst young children, 2011

(Y-axis reduced to 30%)

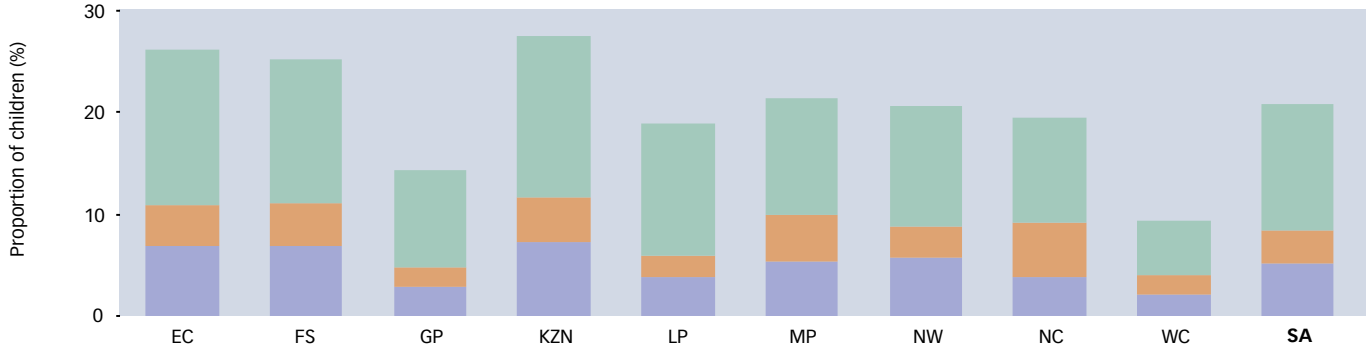


	0 – 2 years	3 – 4 years	5 – 6 years	7 – 9 years
Double orphan	0,7% 21,000	1,1% 23,000	2,6% 60,000	3,9% 112,000
Maternal orphan	0,7% 22,000	2,2% 43,000	2,4% 55,000	2,9% 84,000
Paternal orphan	4,4% 131,000	7,2% 143,000	9,2% 208,000	12,6% 363,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall Children's Institute, UCT.

Figure 1c: Orphans in South Africa, by province, 2011

(Y-axis reduced to 30%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
Double orphan	6,9% 186,000	6,8% 73,000	2,8% 94,000	7,2% 304,000	3,9% 87,000	5,4% 79,000	5,7% 73,000	3,9% 17,000	2,2% 40,000	5,1% 952,000
Maternal orphan	4,0% 108,000	4,2% 44,000	1,9% 63,000	4,5% 190,000	2,1% 47,000	4,5% 66,000	3,0% 39,000	5,3% 23,000	1,8% 32,000	3,3% 613,000
Paternal orphan	15,1% 405,000	14,1% 149,000	9,6% 320,000	15,6% 658,000	12,8% 288,000	11,4% 168,000	11,8% 152,000	10,2% 44,000	5,4% 99,000	12,3% 2,283,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in 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 known as "child-headed households".

There is much concern within government and civil society that the number of children living in child-only households is escalating as the number of orphaned children increases due to AIDS-related deaths of parents. Many argue that kinship networks are stretched to their limits and are struggling to provide support to orphaned children. 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 have feared. Rather than seeing increasing numbers of orphaned children living without adults, the vast majority of orphans live with family members, and child-headed households are not primarily the result of orphaning.[3] Nevertheless it will be important to monitor the prevalence and nature of child-headed households as the HIV/AIDS pandemic continues.

There were about 82,000 children living in a total of 47,000 child-only households across South Africa in 2011. This equates to 0.4% of all children. While children living in child-only households are rare relative to those resident in other household forms, the number of children living in this extreme situation is of concern.

Importantly, however, there has been no significant change in the proportion of children living in child-only households in the period between 2002 and 2011, nor has there been any change in the proportion of child-only households over the same period. This is despite a marked increase in orphans in South Africa over the same period. Predictions of rapidly increasing numbers of child-headed households as a result of HIV are at this point unrealised. An analysis of national household surveys to examine the circumstances of children in child-headed households in South Africa reveals that most children in child-only households are not orphans.[4] These findings suggest that social phenomena other than HIV may play important roles in the formation of these households.

While it is not ideal for any child to live without an adult resident, it is positive that over half (57%) of all children living in child-only households are aged 15 years and above, and a small proportion – less than 10% – of children in child-headed households are in the ECD age group (0 – 9 years).

Research suggests that child-only households are frequently temporary households, 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).[5]

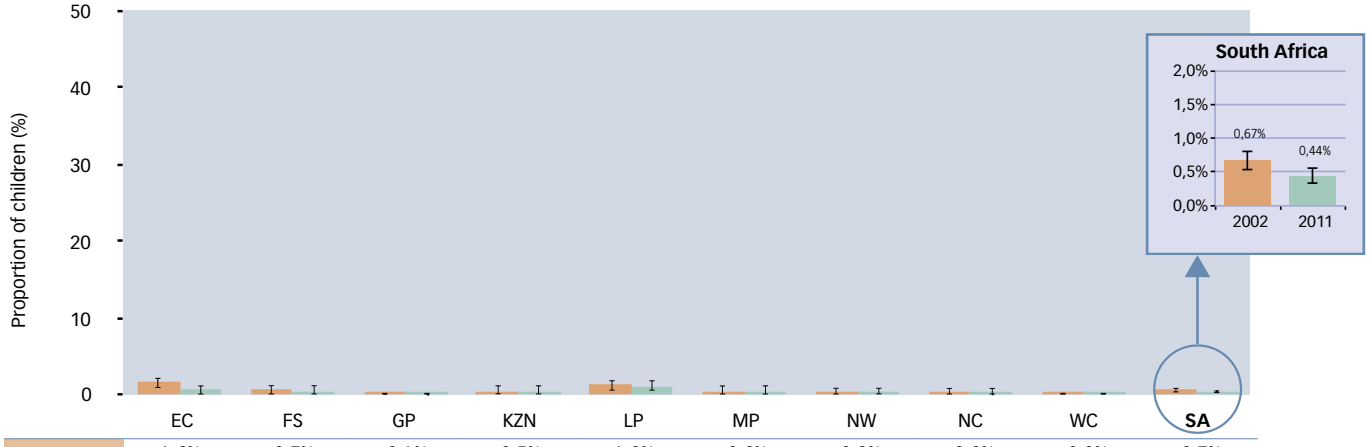
Three-quarters of all children in child-only households live in three provinces: Limpopo (which accounts for 34% of children in child-only households), Eastern Cape (20%) and KwaZulu-Natal (20%). From 2002 to 2011, these provinces have consistently been home to the majority of children living in child-only households.

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 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 particular, we caution against reading too much into the provincial breakdowns, or into apparent differences between the 2002 and 2011 estimates.

Figure 1e: Children living in child-headed households, by province, 2002 & 2011

(Y-axis reduced to 50%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	1,6%	0,7%	0,1%	0,5%	1,3%	0,6%	0,3%	0,2%	0,0%	0,7%
	46,000	6,000	3,000	18,000	32,000	8,000	5,000	0	0	118,000
2011	0,6%	0,5%	0,0%	0,4%	1,2%	0,6%	0,4%	0,1%	0,1%	0,4%
	16,000	6,000	1,000	16,000	27,000	9,000	5,000	1,000	2,000	82,000

Sources: Statistics South Africa (2003, 2012) *General Household Survey 2002; General Household Survey 2011. Pretoria: Stats SA.*
Analysis by Katharine Hall, Children's Institute, UCT.

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1 United Nations Children's Fund (1990) *First Call for Children. World Declaration and Plan of Action from the World Summit for Children.* New York: UNICEF.

2 Ardington C & Leibrandt M (2010) Orphanhood and schooling in South Africa: Trends in the vulnerability of orphans between 1993 and 2005. *Economic Development and Cultural Change*, 58(3): 507-536;
Case A, Paxson C & Ableidinger J (2004) Orphans in Africa: Parental death, poverty and school enrollment. *Demography*, 41(3): 483-508.

3 Meintjes H, Hall K, Marera D & Boulle A (2010) Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care*, 22(1): 40-49.

4 See no. 3 above.

5 Hill C, Hosegood V & Newell M-L (2008) Children's care and living arrangements in a high HIV prevalence area in rural South Africa. *Vulnerable Children and Youth Studies*, 3(1): 65-77;
Hosegood V, Floyd S, Marston M, Hill C, McGrath N, Isingo R, Crampin A & Zaba B (2007) The effects of high HIV prevalence on orphanhood and living arrangements of children in Malawi, Tanzania and South Africa. *Population Studies* 61(3): 327-336;
Meintjes H & Giese S (2006) Spinning the epidemic: The making of mythologies of orphanhood in the context of AIDS. *Childhood: A Global Journal of Child Research*, 13(3): 407-430.

Income poverty, unemployment and social grants

Katharine Hall (Children's Institute)

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 dependents, 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 his or her 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]

The number and proportion of children living in income poverty

This indicator shows the number and proportion of children living in households that are income-poor. These households fall below a specific income threshold. The measure used is a lower-bound "ultra" poverty line, set at R322 per person per month in 2000 prices.[3] The poverty line increases with inflation and was equivalent to R604 in 2011. Per capita income is calculated by adding all reported income for household members older than 15 years, including social grants, and dividing the total household income by the number of household members.

One way of identifying how many children are living without enough resources to meet their needs is to use a poverty line and measure how many children live under it. As money is needed to access a range of services, income poverty is often closely related to poor health, reduced access to education, and physical environments that compromise personal safety. A lack of sufficient income can therefore compromise children's rights to nutrition, education and health care services, for example.

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 are in need of 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 with severely constrained resources.

South Africa has very high rates of child poverty. In 2011, 58% of children lived below the lower poverty line (R604 per month). Income poverty rates have fallen consistently since 2003. Significant decreases in child poverty occur across all provinces except the Northern Cape. This poverty reduction is largely the result of a massive expansion in the reach of the Child Support Grant over the same period.

There are substantial differences in poverty rates across the provinces. Using the lower poverty line, over 70% of children in Limpopo and the Eastern Cape are poor. Gauteng and the Western Cape have the lowest child poverty rates – calculated at 34% and 32% respectively.

There are glaring racial disparities in income poverty: while two-thirds (66%) of African children lived in poor households in 2011, only 2% of White children lived below this poverty line, and poverty rates for Coloured and Indian children were 30% and 8% respectively.

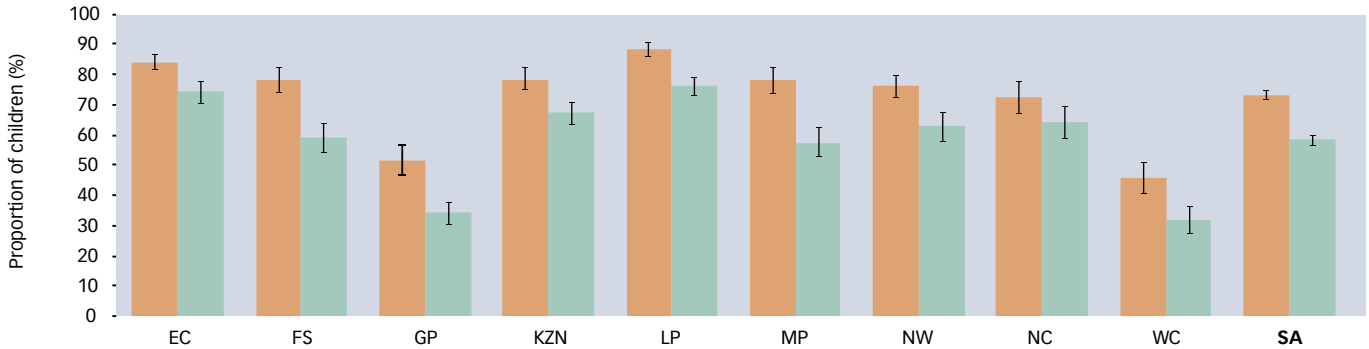
There are no significant differences in child poverty levels across gender or age groups.

While other *Children Count* indicators span the period from 2002 onwards, the poverty analysis uses 2003 as its baseline. This is because the General Household Survey (GHS) did not capture information on social grants in its first year, so income from grants could not be included in household income for 2002.

Other poverty lines can be used to analyse and compare different levels of income poverty. See **www.childrencount.ci.org.za** for additional poverty lines.

Figure 2a: Children living in income poverty, by province, 2003 & 2011

("Lower bound" poverty line: Households with monthly per capita income less than R604, in 2011 Rands)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2003	84,2%	78,2%	51,7%	78,5%	88,1%	77,9%	76,1%	72,5%	45,6%	73,1%
	2,688,000	843,000	1,350,000	3,004,000	2,346,000	1,028,000	1,123,000	245,000	696,000	13,185,000
2011	74,2%	58,9%	34,1%	67,1%	76,1%	57,4%	62,7%	64,2%	31,8%	58,2%
	1,993,000	625,000	1,139,000	2,828,000	1,706,000	846,000	804,000	279,000	578,000	10,796,000

Sources: Statistics South Africa (2004; 2012) General Household Survey 2003; *General Household Survey 2011.* Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of 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 get income from labour or income-generating activities.

Unemployment in South Africa continues to be a serious problem. In mid-2011 (the same time as the 2011 GHS), the official national unemployment rate was 25%.[4] This 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 for some reason voluntarily at home) who actively looked but failed to find work in the four weeks preceding the survey.[5] 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, would give a higher, more accurate, indication of unemployment. Gender differences in employment rates are relevant for children, who are more likely to co-reside with their mother than their father (see p. 87). Unemployment rates remain considerably higher for women than for men.

Apart from providing regular income, an employed adult may bring other benefits to the household, including health insurance, unemployment insurance and maternity 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 2011, 65% of children in South Africa lived in households with at least one working adult. The other 35% (over 6.5 million children) lived in households where no adults were working. There has been only a small decrease in unemployment from 2003 to 2011, with the proportion of children who live in unemployed households hovering around 35%.

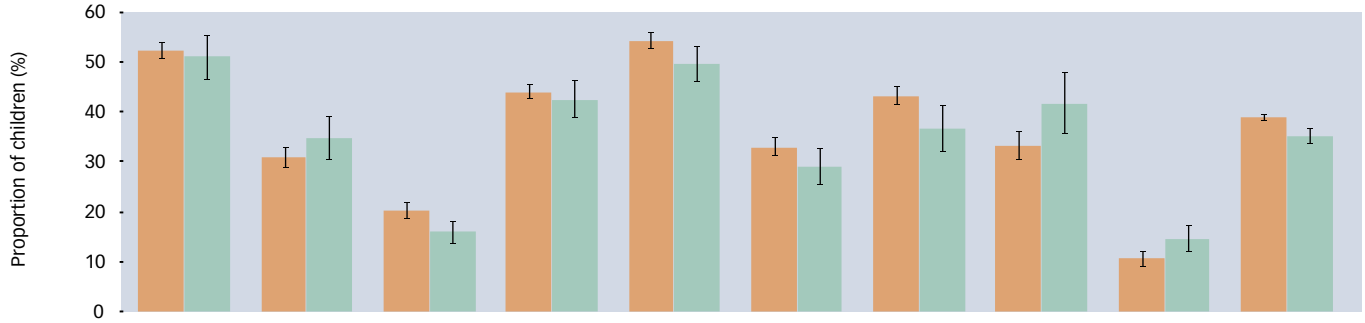
This indicator is very closely related to the income poverty indicator in that provinces with relatively high proportions of children living in unemployed households also have high rates of child poverty. Gauteng and the Western Cape have the lowest levels of income poverty, and less than 20% of children in these provinces live in unemployed households. In contrast, around 50% of children in the Eastern Cape and Limpopo live in households without any employed adults. These two provinces are home to large numbers of children, and have the highest rates of child poverty.

Racial inequalities are striking: 40% of African children have no working adult at home, while 15% of Coloured children, 10% of Indian children and 3% of White children live in these circumstances.

There are no significant differences in child-centred unemployment measures when comparing age groups or sex. But child poverty is clearly associated with unemployment. Two-thirds of children in the poorest income quintile (5.2 million) live in households where no adults are employed.

Figure 2b: Children living in households without an employed adult, by province, 2003 & 2011

(Y-axis reduced to 60%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2003	52,3%	30,8%	20,3%	44,0%	54,3%	32,9%	43,2%	33,2%	10,5%	38,9%
	1,652,000	327,000	547,000	1,707,000	1,462,000	442,000	617,000	111,000	155,000	7,019,000
2011	51,0%	34,7%	16,0%	42,5%	49,5%	29,1%	36,6%	41,7%	14,7%	35,1%
	1,370,000	368,000	532,000	1,789,000	1,110,000	428,000	469,000	181,000	266,000	6,513,000

Sources: Statistics South Africa (2004) *Labour Force Survey 2003*. Pretoria: Stats SA. Analysis by Matthew Chennells, Children's Institute, UCT.
Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of 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 are able to meet basic subsistence needs. Government is obliged to support children directly when their parents or caregivers are too poor to do so. Income support is provided through social assistance programmes, such as the CSG, which is an unconditional cash grant paid to the caregivers of eligible children.

Introduced in 1998 with a value of R100, the CSG has become the single biggest programme for alleviating child poverty in South Africa. Take-up of the CSG has increased dramatically over the past decade and, at the end of March 2013, a monthly CSG of R290 was paid to over 11.3 million children aged 0 – 17 years. The amount of the grant increased to R300 per month in October 2013.

There have been two important changes in eligibility criteria related to the age and income thresholds. The first concerns age eligibility. Initially the CSG was only available for children 0 – 6 years old. Later it was gradually extended to older children up to the age of 14. Since January 2012, following a second phased extension, children are eligible for the grant until they turn 18.

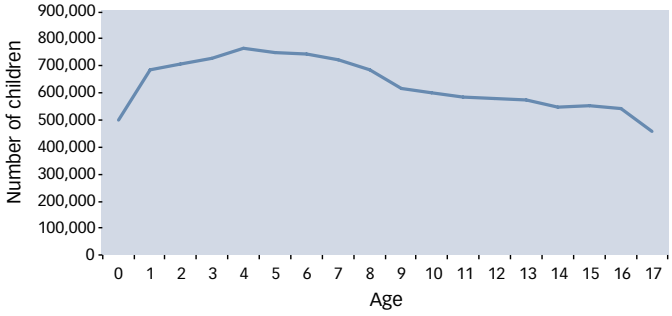
The second important change concerns income eligibility. From 1998, children were eligible for the CSG if their primary caregiver and his/her spouse had a joint monthly income of R800 or less and lived in a formal house in an urban area. For those who lived in rural areas or informal housing, the income threshold was R1,100 per month. This threshold remained static for 10 years until a formula was introduced for calculating income threshold – set at 10 times the amount of the grant. From October 2013 the income threshold is R3,000 per month for a single caregiver and R6,000 per month for the joint income of the caregiver and spouse, if the caregiver is married.

Using the 2004 GHS, it was calculated that 65% of all children under the age of 14 were eligible for the CSG in that they passed the old means test.[6] Following the adjustment of the means test in 2008, the calculation was repeated, this time using the new means test and the 2007 GHS, which suggested that around 82% of children aged 0 – 13 years were eligible for the grant.[7] Applying this eligibility rate to Stats SA mid-term population estimates for children aged 0 –17 years (the eligible age group in 2011), it is estimated that 76% of eligible children are accessing the CSG (although the actual take-up rate would be lower due to errors of inclusion).

There is substantial evidence that grants, including the CSG, are being spent on food, education and basic goods and services. This evidence shows that the grant not only helps to realise children's right to social assistance, but is also associated with improved nutritional, health and education outcomes.[8]

Given the positive and cumulative effects of the grant, it is important that caregivers access it for their children from as early as possible. One of the main concerns is the slow take-up for young children. Grant take-up only peaks at around four years of age, and then gradually declines. This is likely to be a residual effect of the previous age cut-offs. The Department of Social Development has now commissioned research to investigate the low take-up amongst young children.

Figure 2c: Children receiving the Child Support Grant, by age, 2013



Source: South African Social Security Agency (2013) SOCPEN database – special request. Pretoria: SASSA.

Table 2a: Children receiving the Child Support Grant, by province, 2008 – 2013

PROVINCE	Number of child beneficiaries at end March					
	2008	2009	2010	2011	2012	2013
Eastern Cape	1,478,176	1,564,602	1,668,408	1,769,949	1,837,801	1,843,684
Free State	453,730	467,743	527,077	583,524	617,311	637,075
Gauteng	954,500	1,022,984	1,153,481	1,276,109	1,387,159	1,581,756
KwaZulu-Natal	2,094,613	2,282,246	2,439,781	2,623,772	2,726,635	2,746,888
Limpopo	1,270,893	1,358,313	1,460,328	1,584,855	1,497,044	1,588,489
Mpumalanga	655,695	690,944	750,661	806,581	1,008,223	1,051,626
North West	629,539	661,807	715,997	752,026	793,189	751,195
Northern Cape	180,982	200,387	224,346	246,233	262,488	277,835
Western Cape	471,847	516,328	630,208	728,901	797,881	863,440
South Africa	**8,189,975**	**8,765,354**	**9,570,287**	**10,371,950**	**10,927,731**	**11,341,988**
CSG amount	R 220	R 240	R 250	R 270	R 280	R 290

Notes:
1. SOCPEN figures are taken from the end of March each year (the financial year-end).
2. For the years 2005 – 2008, the CSG was only available to children aged 0 – 13 years (under-14s). In 2009, the grant was extended to include children aged 14 years (under-15s), in 2010 to children aged 15 years (under-16s), and in 2011 to children aged 16 (under-17s). From 2012 the CSG has been available to children until they turn 18 years.

Source: South African Social Security Agency (2008 – 2013) SOCPEN database – special request. Pretoria: SASSA.

The number of 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 the SOCPEN administrative data system of the SASSA.

The FCG is available to foster parents who have a child placed in their care by an order of the court. It is a non-contributory cash grant valued at R800 per month in 2012. The grant was initially intended as financial support for children removed from their families and placed in foster care for protection in situations of abuse or neglect. However, it is increasingly used to provide financial support to caregivers of children who are orphaned. The appropriateness and effectiveness of this approach have been questioned.[9]

The number of FCGs remained stable for many years while foster care was applicable only to children in the traditional child protection system. Its rapid expansion since 2003 coincides with the rise in HIV-related orphaning and an implied policy change by the Department of Social Development, which from 2003 started encouraging family members (particularly grandmothers) caring for orphaned children to apply for foster care and the associated grant. Over the following five years the number of FCGs increased by over 50,000 per year as orphans were brought into the foster care system. The increases were greatest in provinces with large numbers of orphaned children: the Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga.

However, by 2009 the foster care system itself was struggling to keep pace with the number of FCGs due to the required initial investigations and reports by social workers, court-ordered placements through a children's court, and additional two-yearly social worker reviews and court-ordered extensions. Neither the welfare services nor the courts had the capacity to keep up with the two-yearly extensions. SASSA, which administers the grants, is not allowed to pay the FCG without a valid court order or extension order. Over 110,000 FCGs lapsed in the two years between April 2009 and March 2011 because of backlogs in the extensions of court orders.[10] This is reflected on the graph as a leveling of FCGs, as new FCGs were still being processed during this period.

In 2011 a 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 until December 2014, by which date a comprehensive legal solution must have been found to prevent qualifying families from losing their grants in future.[11]

Since 2011, the number of new FCGs appears to have declined, and there has been a substantial increase in the number of grants that terminate at the end of each year, when children turn 18. These patterns are likely to explain the fairly static overall numbers over the past two years. Nearly half of all grants go to just two provinces: KwaZulu-Natal (135,000) and Eastern Cape (117,000). By March 2013, 532,000 FCGs were paid each month to caregivers of children in foster care.

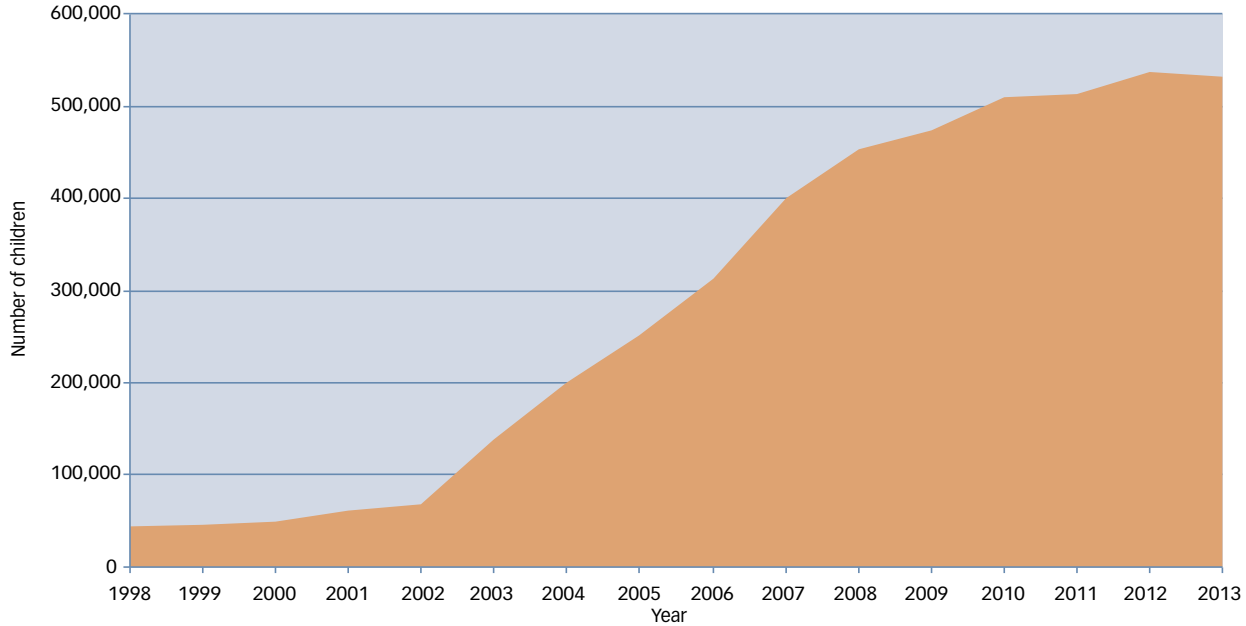
It is not possible to calculate a take-up rate for the FCG as there is no accurate record of how many children are eligible for placement in foster care – and indeed, no clear guidelines about how it should be targeted in the context of rising orphaning rates. The systemic problems which caused FCGs to lapse will be addressed through legislative amendment, which will need to clarify the eligibility criteria for foster care and the FCG.

Table 2b: Children receiving the Foster Child Grant, by province, 2013

PROVINCE	Number of child beneficiaries
Eastern Cape	117,231
Free State	41,317
Gauteng	58,722
KwaZulu-Natal	135,442
Limpopo	58,953
Mpumalanga	35,359
North West	42,215
Northern Cape	14,342
Western Cape	28,578
South Africa	**532,159**

Source: South African Social Security Agency (2013) SOCPEN database – special request. Pretoria: SASSA.

Figure 2d: Growth in Foster Child Grant beneficiaries, 1998 – 2013



Sources: Department of Social Development (1998 – 2002) SOCPEN database – special request. Pretoria: DSD; National Treasury (2005) *Provincial Budgets and Expenditure Review 2001/02 – 2007/08*. Pretoria: National Treasury; National Treasury (2008) *Estimates of National Expenditure 2008*. Pretoria: Treasury; South African Social Security Agency (2008 – 2013) SOCPEN database – special request. Pretoria: SASSA.

The number of 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 severe 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 severe 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 severe 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.[12]

It is not possible to calculate a take-up rate for the CDG because there is little data on the number of children living with disabilities in South Africa, or who are in need of permanent care or support services. At the end of March 2013, 120,000 children were receiving the CDG, valued at R1,260 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 and the Eastern Cape, receive the largest share of CDGs. There has been a consistent and gradual increase in access to the CDG since 2005.

Table 2c: Children receiving the Care Dependency Grant, by province, 2008 – 2013

PROVINCE	Number of child beneficiaries at end March					
	2008	2009	2010	2011	2012	2013
Eastern Cape	19,484	19,297	18,915	18,417	18,235	18,429
Free State	4,104	4,228	4,577	4,925	5,419	5,864
Gauteng	12,680	12,834	13,248	13,649	14,170	15,783
KwaZulu-Natal	29,763	32,040	33,866	34,377	34,969	36,012
Limpopo	11,812	12,353	12,844	12,650	11,318	11,913
Mpumalanga	5,306	5,617	5,877	6,050	7,950	8,652
North West	8,192	8,946	8,553	8,668	8,736	8,339
Northern Cape	3,552	3,790	3,952	4,094	4,236	4,485
Western Cape	7,399	7,960	8,899	9,355	9 960	10,791
South Africa	**102,292**	**107,065**	**110,731**	**112,185**	**114,993**	**120,268**
CDG amount	R 940	R 1,010	R 1,080	R 1,140	R 1,200	R 1,260

Source: South African Social Security Agency (2008 – 2013) SOCPEN database – special request. Pretoria: SASSA.

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Child health and nutrition

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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".[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]

The infant mortality rate and under-five mortality rate

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 the fifth birthday. The U5MR refers to the number of 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, under-reporting of births and deaths renders the South African system inadequate for monitoring purposes. For example, the vital registration data reported by Statistics South Africa in 2009 showed a stark increase in the number of under-five deaths, more than doubling from under 35,000 in 1997 to over 78,000 in 2006.[4] However it is not possible to determine the extent to which this observed increase was the result of improved death registration, as opposed to an increase in the actual number of deaths.

Like many middle-income countries, South Africa is 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 in child survival, the lack of reliable data since 2000 has led to considerable uncertainty around the level of child mortality. This lack of reliable survey data, together with incomplete vital registration, has made it very difficult to track South Africa's progress towards the Millennium Development Goal (MDG) 4,which requires a two-third reduction in the U5MR by 2015.[5]

The 2007 Community Survey included questions to women of reproductive age about the number of children they had given birth to, and the number of surviving children. Such information can be used to estimate child mortality rates using demographic models. The survey results provided information on the level of under-five mortality from which to estimate the extent of under-registration of infant and 1– 4-year-old deaths. Importantly, this showed improvement in overall registration of deaths under age five, from 50% in 1997 to about 90% in 2006.[6]

In the absence of any more recent survey data, great achievements have been made in the development of a rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs.[7]

The RMS data have been recommended by the Health Data Advisory and Coordinating Committee because corrections have been made for known biases. In other words, the indicators shown in table 3a are representative of the national trends by age. The vital registration data are adjusted for under-reporting and the recent RMS estimates allow evaluation of annual trends. They suggest the IMR was 46 per 1,000 in 2006 and decreased to 30 per 1,000 in 2011. During the same period the under-five mortality rate decreased from 69 per 1,000 to 42 per 1,000, which equates to a 10% annual rate of reduction.

Table 3a: Child mortality indicators, rapid mortality surveillance system, 2009 – 2011

INDICATOR	2009	2010	2011
Under-five mortality rate per 1,000 live births	56	53	42
Infant mortality rate per 1,000 live births	40	37	30

Source: Bradshaw D, Dorrington RE & Laubscher R (2012) *Rapid Mortality Surveillance Report 2011*. Cape Town: Medical Research Council.

The decline in infant- and under-five mortality has occurred mostly amongst HIV-related deaths and is consistent with the findings of a 2012 evaluation of the prevention of mother-to-child transmission (PMTCT) programme, where observed national transmission rates at six weeks after birth had dropped to below 3%.[8] Although dependent on a range of inter-related factors, it is generally assumed that, in the absence of any intervention, vertical transmission ranges between 25% and 30%. The South African Every Death Counts Working Group has identified an additional five categories of death requiring action to achieve the health-related MDGs: non-HIV deaths due to pregnancy, childbirth complications, newborn illness, childhood infections and malnutrition.[9]

The successes in the PMTCT programme and the improvement in completeness of registration over the past decade signify commendable progress. However, if South Africa is committed to the health targets enshrined in the MDGs, it should prioritise the collection of detailed pregnancy histories through a national survey. This information is necessary in order to understand the changes in the relative contribution of the neonatal, post-neonatal and child components which together make up under-five mortality. Such a survey would not only provide provincial mortality profiles (which are much needed as the 2000 estimates are seriously out of date),[10] but would also help to determine the extent of provincial under-reporting of births and deaths.

In the spirit of South Africa's progress towards improving child survival, it is essential to build equitable and sustainable administrative systems across the provinces, which will lay the basis for improved delivery in all public sector initiatives that affect the survival and development of children.

HIV prevalence in pregnant women

The HIV status of pregnant women is vitally important for children. Around 70% of maternal deaths in South Africa are due to HIV,[11] and half of under-five child deaths are related to HIV[12].

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. By 2005 the proportion of pregnant women who were routinely tested was still below 50%. By 2009 HIV testing was almost universal.[13] The most recent evaluation of the PMTCT programme shows that transmission rates have declined to 2.7%.[14]

HIV prevalence 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 2011, is 29.5%. Prevalence rates increased steadily from 1% in 1990 when the first antenatal prevalence survey was conducted, to 25% in 2000 and 30% in 2005, and have remained at around this level since. Results are reported in five-year age bands, and show that HIV-prevalence rates are consistently high amongst women in their early 30s (a prevalence rate of 42% in 2011) followed by those in their late 30s (40%). Prevalence rates amongst women in their 30s have continued to rise slightly in recent years, while rates amongst women in their early and late 20s have declined slightly and now stand at 36% in the 25 – 29 age group, and 25% for women aged 20 – 24 years.

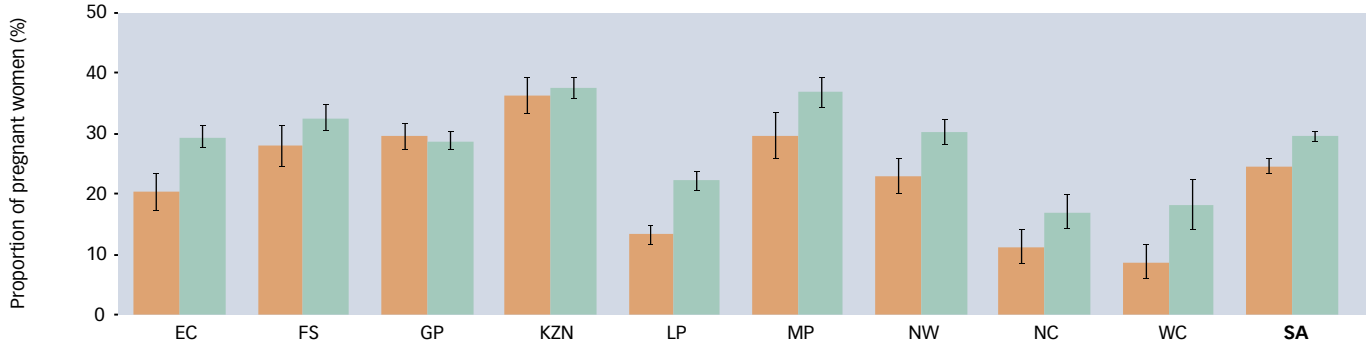
There are substantial differences in HIV prevalence between South Africa's provinces. KwaZulu-Natal has consistently had the highest HIV rates, with prevalence in excess of 35% since 2002. In contrast, the Western Cape has had relatively low prevalence, although the rate has increased by nearly 10 percentage points to 18% over the 12-year period since 2000. Other provinces with relatively low HIV prevalence are the Northern Cape and Limpopo, with HIV-prevalence levels at 17% and 22% respectively in 2011.

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,[15] and its prevalence differs substantially between South Africa's provinces[16]. 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 a relatively low prevalence of HIV.[17] Thus the surveys, which are conducted only in public health facilities, are likely to over-estimate HIV prevalence in pregnant women generally.

Table 3b: HIV prevalence in pregnant women attending public antenatal clinics, by province, 2000 & 2011

(Y-axis reduced to 50%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2000	20,2%	27,9%	29,4%	36,2%	13,2%	29,7%	22,9%	11,2%	8,7%	24,5%
2011	29,3%	32,5%	28,7%	37,4%	22,1%	36,7%	30,2%	17,0%	18,2%	29,5%

Sources: Department of Health (2001; 2012) *National HIV and Syphilis Prevalence Survey 2000; National HIV and Syphilis Prevalence Survey 2011*. Pretoria: DoH.

The number and proportion of 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 through a proxy indicator: 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.

The health of children is influenced by many factors, including nutrition, access to clean water, adequate housing, sanitation and a safe environment. Primary health care facilities provide important preventative and curative services such as immunisation and antiretroviral therapy, and increased access to such facilities could substantially reduce child illness and mortality. Primary health care facilities are also a key location to provide caregivers with support, information and appropriate referral. In South Africa, primary health care in the public sector is free for everyone, while secondary and tertiary level care is free to children under six years, disabled children, grant beneficiaries and pregnant women. Patients who are not in these categories are charged on a sliding scale, depending on their income. Despite efforts to ensure that essential health services are affordable, the cost of reaching a health care facility can still be a barrier, with potentially severe consequences for children.

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.[18] Preventative measures include 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 the 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), affordable and of good quality.[19] 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, patterns of health care utilisation are 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 up-take of services that are required for all children, including immunisation and maintaining the clinic card (Road-to-Health booklet).[20]

A quarter (24%) of South Africa's children live far from the primary health care facility they normally use, and over 90% attend the facility closest to their home. Amongst households with children, only 8% do not usually attend their nearest health facility, and within the poorest 40% of households, only 5% do not use their nearest facility, while 17% of children in upper quintile households (the richest 20%) travel beyond their nearest health facility to seek care. The main reasons for attending a more distant health service relate to choices based on perceptions of quality: preference for a private doctor, long waiting times at clinics and the non-availability of medicines.[21]

In total, 4.4 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 6.4 million children) lived far from their nearest clinic.

It is encouraging that the greatest improvements in access have been made in provinces which performed worst in 2002: the Eastern Cape (where the proportion of children with poor access to health facilities dropped from 53% in 2002 to 31% in 2011), KwaZulu-Natal (down from 48% to 35%), Limpopo (from 42% to 32%) and North West (from 41% to 30%) over the 10-year period. Provinces with the highest rates of access are the largely metropolitan provinces of Gauteng (10%) and the Western Cape (8%).

There are also significant differences between population groups. Over a quarter (27%) of African children travel far to reach a health care facility, compared with only 3% – 8% of Coloured, Indian and White children. Racial inequalities are amplified by access to transport: if in need of medical attention, 93% of White children would be transported to their health facility in a private car, compared with only 7% of African children and 28% of Coloured children.

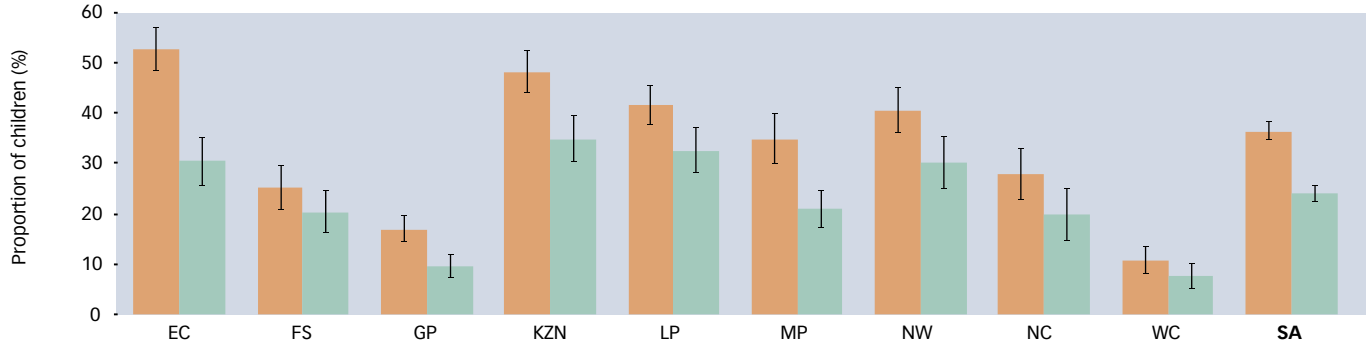
Poor children bear the greatest burden of disease, partly due to poorer living conditions and limited access to services including health facilities. A third of children (34%) in the poorest 20% of households have to travel far to access health care, compared with only 5% of children in the richest 20% of households.

There are no significant differences in patterns of access to health facilities when comparing children of different sex or age groups.

The decline in households reporting lengthy travel to their health facilities is largely the result of a sudden drop from 37% in 2010 to 24% in 2011. Indeed, this indicator has been fairly bumpy for the past four years. This is partly the result of a question change between 2008 and 2009, but in the absence of a clear reason for the more recent changes, these figures should be regarded with some caution.

Figure 3a: Children living far from their health facility, by province, 2002 & 2011

(Y-axis reduced to 60%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	52,7%	25,2%	16,9%	48,2%	41,5%	34,8%	40,5%	27,9%	10,8%	36,4%
	1,494,000	249,000	464,000	1,847,000	1,039,000	454,000	580,000	84,000	172,000	6,382,000
2011	30,5%	20,3%	9,5%	34,8%	32,4%	20,9%	30,1%	19,9%	7,6%	23,9%
	819,000	215,000	317,000	1,468,000	727,000	308,000	386,000	86,000	138,000	4,438,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in households where there is reported child hunger

Section 28(1)(c) of the Bill of Rights in the Constitution gives every child the right to basic nutrition. The fulfilment of this right depends on children's access to sufficient food. 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.

The government has introduced a number of programmes to alleviate income poverty and to reduce hunger, malnutrition and food insecurity, yet 2.5 million children (14%) lived in households where child hunger was reported in 2011. There was a significant drop in reported child hunger, from 30% of children in 2002 to 16% in 2006. Since then the rate has remained fairly consistent, suggesting that despite expansion of social grants, school feeding schemes and other efforts to combat hunger amongst children, there may be targeting issues which continue to leave households vulnerable to food insecurity.

There are large disparities between provinces and population groups. Although the Northern Cape has the smallest child population, it has the highest rates of reported child hunger, at 36% in 2010 and 34% in 2011. These estimates deviate from previous years when hunger rates in that province fell within the national average. Either there has been a significant increase in household food insecurity in the Northern Cape, or misreporting from within the very small provincial population has caused this sudden spike in 2010 and 2011.

Other provinces with relatively large numbers of children and high rates of child hunger are the Eastern Cape (18%) and KwaZulu-Natal (16%), which collectively have over a million children living in households which report having insufficient food for children. These provinces reported high rates of child hunger throughout the 10-year monitoring period, although the proportion of children experiencing hunger has declined substantially over the period. Child hunger rates are lowest in Limpopo (4%) and Gauteng (10%). Gauteng is a relatively wealthy and urbanised province and performs well on most child indicators. By contrast, Limpopo has a large rural child population with high rates of unemployment and income poverty, yet reported child hunger has remained well below the national average.

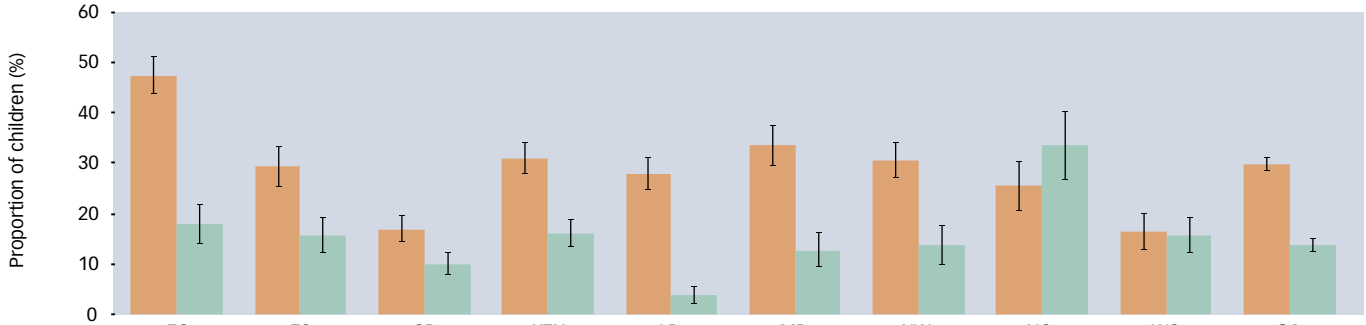
Hunger, like income poverty and household unemployment, is most likely to be found among African children. In 2011, some 2.4 million African children lived in households that reported child hunger. This equates to 15% of the total African child population, while relatively few Coloured (12%) children lived in households where child hunger was reported, and the proportions for Indian and White children were below 1%.

Although social grants are targeted to the poorest households and are associated with improved nutritional outcomes, child hunger is still most prevalent in the poorest households: 21% of children in the poorest quintile go hungry sometimes, compared with 1% in the wealthiest quintile of households.

There are no significant differences in reported child hunger across age groups. It should be remembered that this is a household-level variable, and so reflects children living in households where children are reported to go hungry often or sometimes; it does not reflect the allocation of food within households.

Figure 3b: Children living in households where there is reported child hunger, by province, 2002 & 2011

(Y-axis reduced to 60%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	47,4%	29,2%	17,0%	30,9%	27,9%	33,4%	30,5%	25,4%	16,3%	29,7%
	1,346,000	290,000	465,000	1,186,000	698,000	437,000	436,000	77,000	260,000	5,203,000
2011	17,9%	15,7%	10,0%	16,2%	3,8%	12,8%	13,7%	33,5%	15,6%	13,7%
	480,000	166,000	333,000	682,000	85,000	188,000	176,000	146,000	283,000	2,537,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

that more than 200 million children under five years globally will not realise their full cognitive development due to poverty, lack of proper care, poor health and inadequate nutrition.[22] Research suggests that poor nutrition affects the educational outcomes of children, adult working capacity and economic productivity.[23] Under-nutrition in childhood could therefore lead to lower wages in adulthood, perpetuating intergenerational cycles of poverty and exacerbating poverty rates.

Globally, undernutrition contributes to more than a third of deaths in children under five.[24] A local study of child deaths in audited hospitals indicated that 34% of children who died between 2005 and 2009 were severely malnourished and another 30% were underweight for their age.[25] Early childhood is a critical period for growth and development, and nutritional deficits may be irreversible after the second year.[26] The effects of early undernutrition are long-reaching, and are associated with life-threatening diseases such as diabetes, cardiovascular disease and hypertension in adult life.[27]

UNICEF distinguishes between the immediate, underlying and basic causes of malnutrition.[28] Immediate causes of malnutrition include inadequate dietary intake and illness. This can lead to a potentially vicious cycle of illness and malnutrition, where malnutrition impairs children's immunity leading to recurrent bouts of illness, which further undermine children's nutritional status.[29] Underlying causes include household food insecurity, inadequate maternal care, poor access to services and unhealthy living environments, which in turn are driven by the unequal distribution of resources in society.[30]

Efforts to monitor malnutrition in South Africa are constrained by the shortage of regular and reliable anthropometric data (measures of height and weight, for example). Nationally representative surveys that have yielded usable data on the height and weight of children are the Project for Statistics on Living Standards and Development (PSLSD) of 1993, the Demographic and Health Survey of 1998, the National Food Consumption Survey of 2005 and the National Income Dynamics Study (NIDS) of 2008.

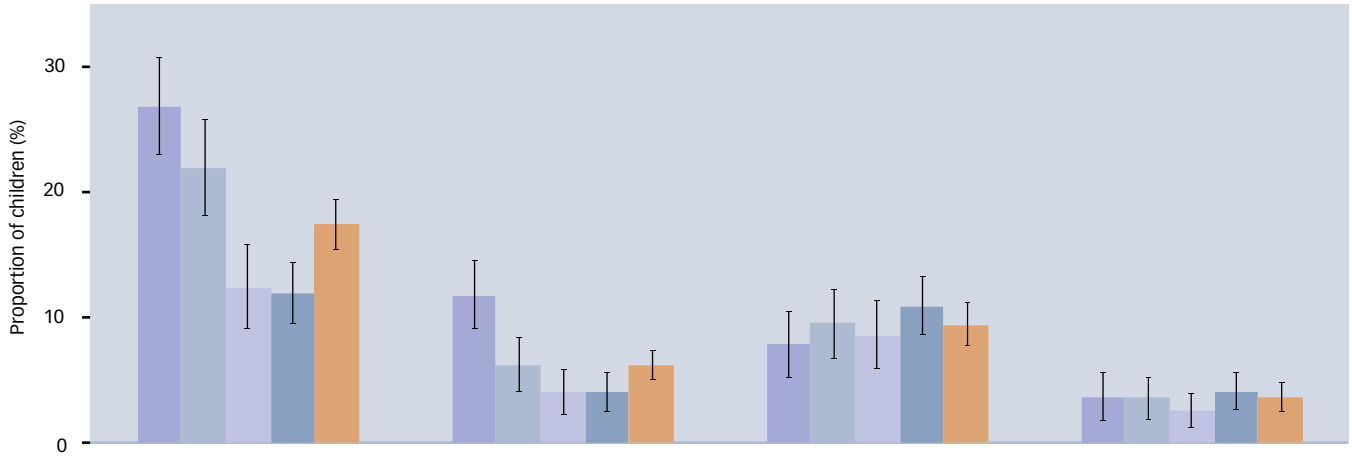
It is notoriously difficult to collect anthropometric data of good quality. Statistics South Africa's Living Conditions Survey of 2008/09 collected anthropometric data from a large sample but did not publish it because the quality was too poor. Subsequent iterations of the NIDS panel survey have collected anthropometric data, but although changes in children's nutritional status over time are plausible,[31] the representivity of the sample diminishes after the first wave. The analyses presented here are therefore based on the most recent reliable and nationally representative data: NIDS 2008. A more recent survey, the South African National Health and Nutrition Examination Survey,[32] was undertaken in 2012, and may provide more up-to-date data for analysis of child anthropometry. The data have not yet been made available.

Unless otherwise specified, the results below are based on analyses of NIDS (2008) and the PSLSD (1993) by Winnie Sambu of the Children's Institute, UCT. In both cases, the malnutrition rates have been derived based on the World Health Organisation's Child Growth Standards.[33]

Stunting is defined as low height-for-age and is associated with chronic undernutrition. It arises if a child's height-for-age measurement is less than two standard deviations from the globally accepted reference cut-off point. When the child's height-for-age measurement is less than three standard deviations from the globally accepted norm, then the child suffers from severe stunting.

Figure 3c: Stunting and underweight rates in early childhood, 2008

(Y-axis reduced to 30%)



	Stunting	Servere stunting	Underweight	Severe underweight
6 mths – 2 yrs	26,9%	11,8%	7,9%	3,7%
	718,000	316,000	210,000	99,000
3 – 4 yrs	22,0%	6,2%	9,5%	3,6%
	427,000	121,000	185,000	69,000
5 – 6 yrs	12,5%	4,1%	8,6%	2,5%
	250,000	82,000	172,000	51,000
7 – 9 yrs	11,9%	4,1%	10,9%	4,2%
	385,000	131,000	352,000	134,000
Total ECD age group	17,4%	6,2%	9,4%	3,6%
	1,716,000	615,000	929,000	353,000

Source: Southern Africa Labour and Development Research Unit (2012) *National Income Dynamics Study 2008, Wave 1* [dataset]. Version 4.1. Cape Town: Southern Africa Labour and Development Research Unit, UCT [producer]; DataFirst [distributor]. Analysis by Winnie Sambu, Children's Institute, UCT.

Stunting is associated with poor socio-economic conditions, poor nutrition and increased risk of frequent and prolonged exposure to infectious diseases.[34] The national rate of stunting for children aged below 10 years in 2008 was approximately 17%. About 6% were severely stunted. Stunting rates appear to decrease with age. For younger children (below three years), low height-for-age is an indication of on-going failure to thrive, while for older ages it indicates children who have previously failed to grow.[35]

In 2008, stunting rates are higher amongst boys (19%) than girls (16%) and higher in rural areas than urban areas. Twenty-four per cent of children living in rural formal areas (commercial farms) and 19% of children in tribal authority areas (former homelands) are stunted.

A comparison between 1993 and 2008 data shows that stunting rates in children under five have reduced from 30% to 25%. Results from the 2012 SANHANES-1 suggest that this may have reduced further, to 22%.[36] Normally, a decrease in the stunting rates of a country is seen as an indicator of improvement in its socio-economic conditions.[37] In 1993, stunting rates amongst children from households in the poorest quintile (40%) were five times higher than the rates recorded amongst children in the wealthiest quintile (8%). In 2008, stunting rates were still highest in the poorest quintile, but the gap between the income quintiles had narrowed: 21% of children in the poorest quintile were stunted, compared to 12% of children in the richest quintile.

Wasting is also referred to as acute malnutrition, and is defined as low weight-for-height. Normally, a healthy child is expected to gain 2 – 3 kg of body weight every year. A child whose weight-for-height measurement is less than two standards deviation from the globally accepted reference cut-off point is considered to be wasted. Severe wasting occurs when the child's weight-for-height measurement is less than three standard deviations from the globally accepted norm. Wasting is caused by infection and inadequate nutrition. It can change rapidly depending on the availability of food and the presence of illness, and is therefore a measure of acute (rather than chronic) malnutrition.[38]

In 2008, 4.8% of children under five years were wasted, and 2% severely wasted. Wasting rates were highest in urban informal areas (8%) followed by the former homelands (4%). No statistically significant differences in wasting were found amongst male and female children. The incidence of wasting and severe wasting has declined since 1993, when the rates were 9% and 4% respectively.

Underweight – A child is considered underweight if the child's weight-for-age measurement is less than two standard deviations from the globally accepted reference cut-off point, or three standard deviations in the case of severe underweight. Underweight is an indicator of both chronic and acute malnutrition.[39] In 2008, nearly 10% of children aged six months to nine years were underweight. About 4% were severely underweight. Children living in rural areas were more likely to be underweight, while 13% and 10% of children in rural formal and tribal areas were underweight compared to 8% and 9% in the urban formal and urban informal areas respectively. Rates were lowest amongst children in relatively wealthy households (5%), compared to 11% amongst children in the poorest quintile.

The proportion of underweight children under five years decreased from 15% in 1993 to 9% in 2008, and may have declined further to 5.2%, according to the SAHANES-1 report.[40]

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Children's access to education

Katharine Hall (Children's Institute)

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 realisation of this right and shall in particular ... provide free and compulsory basic education".[2]

Article 28 of the UN 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]

Number and proportion of children attending an educational institution

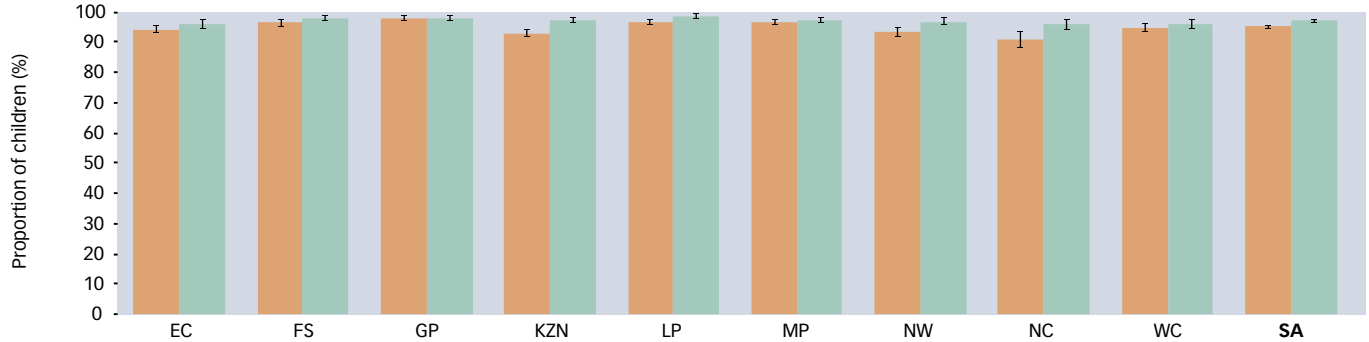
This indicator reflects the number and proportion of children aged 7 – 17 years who are reported to be attending a school or educational facility. This is different from "enrolment rate", which reflects the number of children enrolled in educational institutions, as reported by schools to the national Department of Basic Education early in the school year.

Education is a central socio-economic right that provides the foundation for life-long learning and economic opportunities. Children have a right to basic education and are admitted into grade 1 in the year they turn seven. Basic education is compulsory in grades 1 – 9, or for children aged 7 – 15. Children who have completed basic education also have a right to further education (grades 10 – 12), which the government must take reasonable measures to make available. South Africa has high levels of school enrolment and attendance. Amongst children of school-going age (7 – 17 years) the vast majority (97%) attended some form of educational facility in 2011. Since 2002, the national attendance rate has seen a two percentage point increase. Of a total of 11.3 million children aged 7 – 17 years, 330,000 are reported as not attending school in 2011.

At a provincial level, the Northern Cape, North West and KwaZulu-Natal have all seen significant increases in attendance rates. In the Northern Cape, attendance increased by five percentage points from 91% in 2002 to 96% in 2011, while attendance in KwaZulu-Natal and North West increased by four percentage points. There has been a small but real increase in reported attendance rates for African and Coloured children over the 10-year period since 2002. Attendance rates for Coloured children remained slightly below the national average in 2011, at 94%.

Overall attendance rates tend to mask the problem of drop-out among older children. Analysis of attendance among discrete age groups shows a significant drop in attendance amongst children older than 14. Whereas 99% of children in each age year from seven to 13 are reported to be attending an educational institution, the attendance rate drops to 98% and 97% for 14- and 15-year-olds respectively. Schooling is compulsory only until the age of 15 or the end of grade 9, and the attendance rate decreases more steeply from age 16 onwards, with 93% of 16-year-olds, 88% of 17-year-olds, and 81% of 18-year-olds reported to be attending school (based on those who have not successfully completed grade 12).[4] Although there are differences in school attendance rates between boys and girls in the upper teens, with boys more likely to be attending school, the difference is not significant if one excludes those who have successfully completed matric, because girls are more likely to have completed matric by the age of 18.

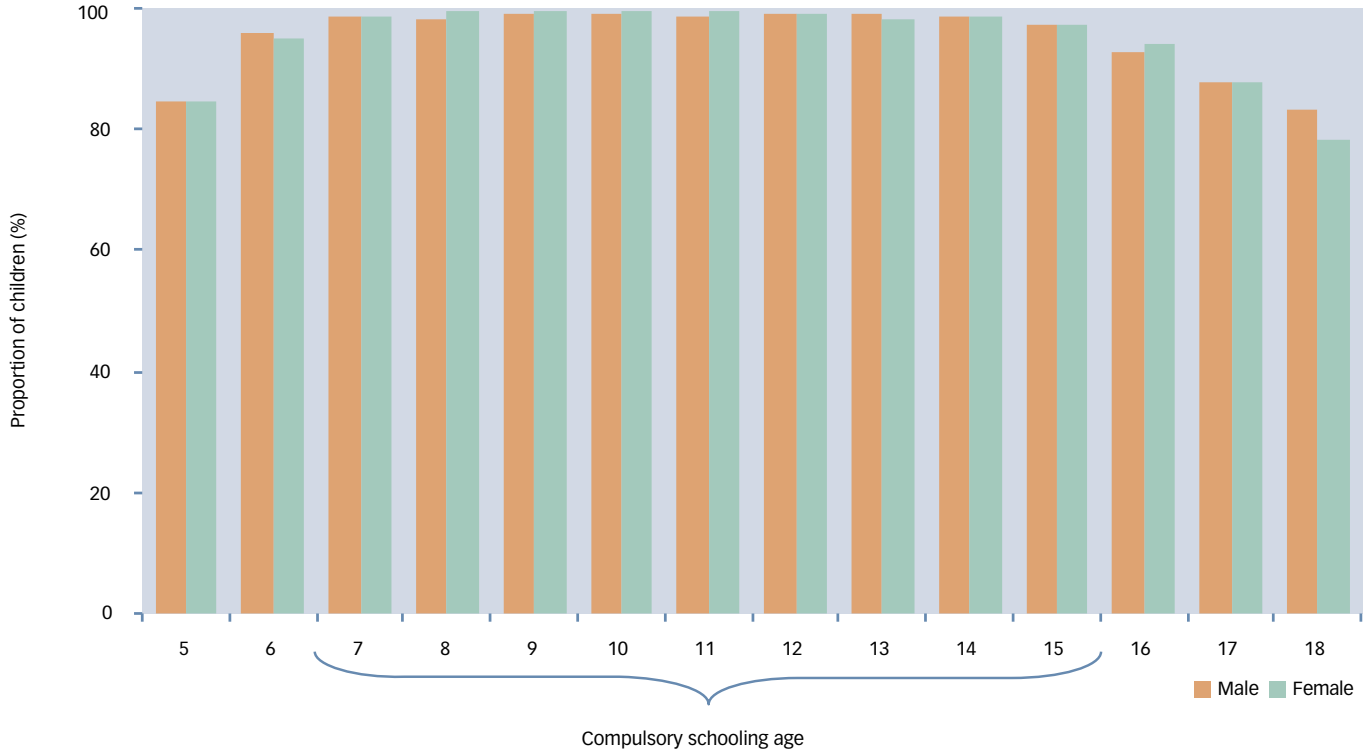
Figure 4a: School-age children attending an educational institution, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	94,1%	96,4%	97,6%	93,0%	96,7%	96,5%	93,4%	90,8%	94,7%	95,0%
	1,761,000	607,000	1,653,000	2,315,000	1,596,000	798,000	827,000	163,000	931,000	10,651,000
2011	95,8%	97,7%	97,8%	97,1%	98,5%	97,3%	96,9%	95,7%	95,7%	97,1%
	1,590,000	633,000	1,894,000	2,537,000	1,365,000	911,000	749,000	253,000	1,026,000	10,958,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Figure 4b: Reported attendance at an educational institution, by age and sex, 2011



Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Amongst children of school-going age who are not attending school the main set of reasons for non-attendance relate to financial constraints. These include the cost of schooling (17%), or the opportunity costs of education, where children have family commitments such as child minding (6%) or are needed to work in a family business or elsewhere to support household income (5%). The second most common set of reasons is related to perceived learner or education system failures, such as a perception that "education is useless" (15%), feeling unable to perform at school (11%), or exam failure (4%). Other reasons for drop-out are illness (7%) and disability (6%). Pregnancy accounts for around 13% of drop-out amongst teenage girls not attending school (or 6% of all non-attendance).[5]

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 one or both parents – are indeed less likely to enrol in school and are more prone to dropping out or progressing more slowly than their more advantaged peers. Racial inequalities in school advancement remain strong.[6] Similarly, school attendance rates tell us nothing about the quality of teaching and learning.

There is little variation in school attendance rates across the income quintiles. Irrespective of whether children live in the poorest or wealthiest 20% of households, school attendance rates remain high – between 96% and 99%.

Access to early childhood learning programmes

This indicator reflects the number and proportion of children aged 3 – 6 years who are reported to be attending an ECD centre or educational institution – in other words, those attending out-of-home care and learning centres. For children aged 3 – 4 years the indicator measures those who are reported to attend a day-care centre, crèche, play group, nursery school or pre-primary school. For children aged 5 – 6 years it includes those who attend ECD centres as well as those attending 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. Children under three years are not included in this analysis because a group care and learning environment is not necessarily more appropriate than home-based care at such a young age.

Educational inequalities are strongly associated with the structural socio-economic (and therefore also racial) inequalities in South Africa.[7] These inequalities are evident from the early years, even before entry into primary school. They are exacerbated by a very unequal schooling system[8] 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.[9] 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.

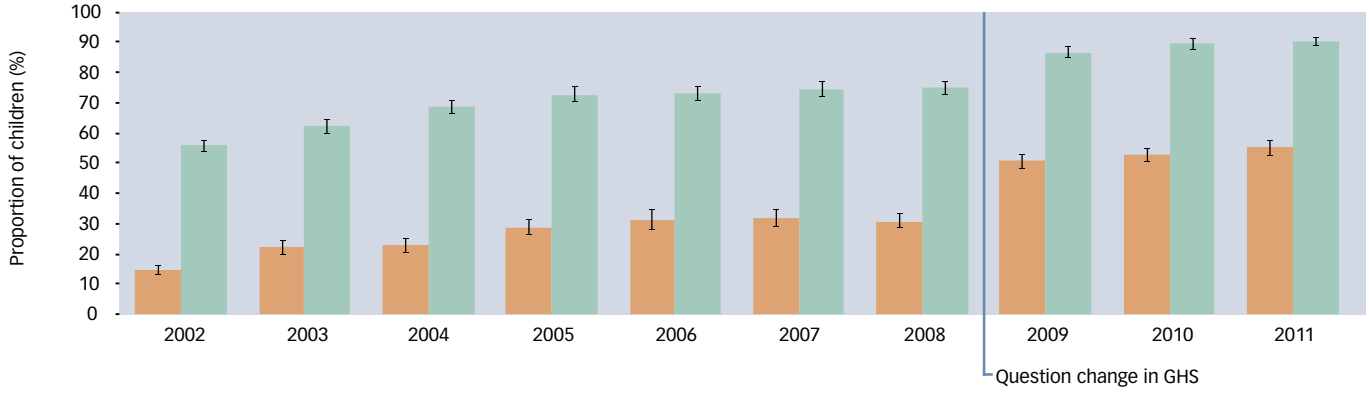
The Action Plan[10] of the Department of Basic Education (DBE) includes a broad goal to "improve the access of children to quality early childhood development below Grade 1", and specifically to improve the quality and achieve universal access to grade R by 2014 (thus extending the original deadline of 2010). The plan does not mention pre-grade R learning programmes, but current evidence suggests that quality group learning programmes are beneficial for cognitive development from about three years of age.[11] The DBE funds and monitors thousands of community-based grade R centres in addition to the school-based grade R classes. The National Planning Commission has proposed the introduction of a second year of pre-school education, and that both years be made universally accessible to children.[12] It therefore makes sense to monitor enrolment in early learning programmes of children in the 3 – 4 age group as well as the traditional 5 – 6 pre-school age group.

In 2011, there were 284,595 "learners" attending 4,607 ECD centres in South Africa, according to the DBE's administrative data. The DBE snap survey counts another 784,680 learners attending grade R or pre-grade R at primary schools, of whom 94% were at public (government) schools while 6%, or 48,000, were at independent schools.[13]

In 2011, 90% of children (just over two million) in the preschool age group (5 – 6-year-olds) were reported to be attending some kind of educational institution, almost doubling the figure of 1,047,000 from 10 years before. In the younger age group (3 – 4 years), 55% were attending an educational institution or ECD facility in 2011, whereas 15% were reported to be attending an educational institution in 2002. A question change in 2009 is likely to have affected response rates of the younger age group in particular, so this trend should be treated with caution.

Overall, 73% of children in the 3 – 6 year age group attended some kind of early care and learning facility in 2011. The numbers captured in the 2011 survey exceed those reported by the DBE in the same year, although a direct comparison is not possible as the department's numbers are based on enrolment of children of any age at accredited ECD institutions or grade R, while the Stats SA data reflect reported attendance at any institution or ECD centre, and the analysis is restricted to particular age groups. Of the two million 5 – 6-year-olds which Stats SA recorded as attending an educational institution in 2011, 39%, or nearly 800,000 were already in grade 1.

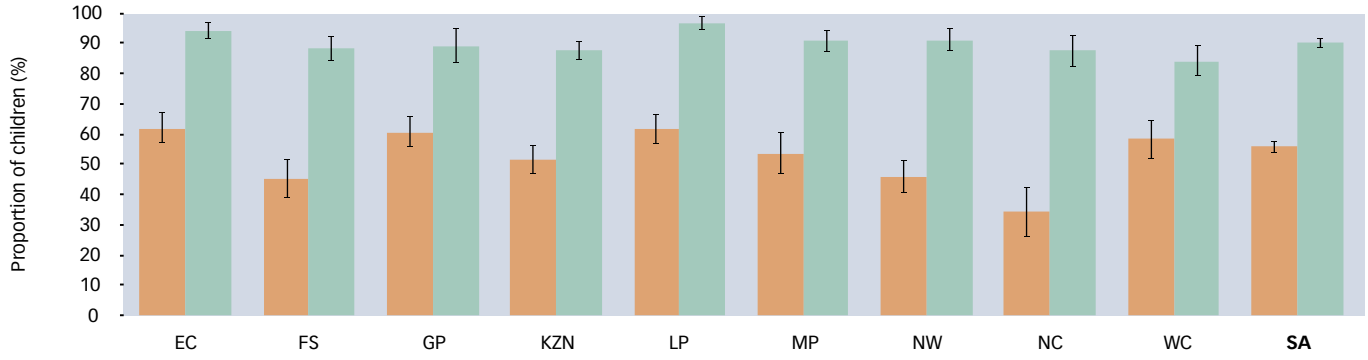
Figure 4c: School or ECD facility attendance among children aged 3 – 6 years, 2002 – 2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
3 – 4 years	14,8%	22,0%	22,7%	28,9%	31,3%	31,6%	30,8%	50,6%	52,9%	55,1%
	274,000	482,000	485,000	586,000	654,000	652,000	654,000	1,036,000	1,074,000	1,101,000
5 – 6 years	55,7%	62,0%	68,8%	72,5%	73,1%	74,4%	75,0%	86,5%	89,4%	90,0%
	1,047,000	1,261,000	1,269,000	1,398,000	1,470,000	1,417,000	1,531,000	1,827,000	1,969,000	2,047,000

Sources: Statistics South Africa (2003 – 2012) General Household Surveys 2001 – 2011. Pretoria: Stats SA.
Analysis by Katharine Hall, 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 in the 2009 survey, and are likely to have resulted in higher response rates.
(For a more detailed technical explanation, see www.childrencount.ci.org.za).

Figure 4d: School or ECD facility attendance among children aged 5 – 6 years only, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	61,9%	45,2%	60,7%	51,4%	61,6%	53,7%	45,8%	34,3%	58,3%	55,7%
	190,000	48,000	180,000	206,000	169,000	73,000	75,000	12,000	95,000	1,047,000
2011	94,1%	88,2%	89,1%	87,4%	96,6%	90,8%	91,0%	87,4%	84,1%	90,0%
	331,000	109,000	371,000	455,000	251,000	148,000	151,000	44,000	186,000	2,047,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Focusing more specifically on 5 – 6 year-olds (who would be eligible for grade R or pre-grade R), attendance rates have increased substantially over time and are high across all provinces. The highest attendance rates in 2011 were in Limpopo, the Eastern Cape and North West (all over 90%), and the lowest in the Western Cape (84%). This pattern differs from many other indicators, where the Western Cape usually outperforms the poorer and more rural provinces like the Eastern Cape and Limpopo. Similar patterns were found in analyses of the 2007 Community Survey and the 2008 National Income Dynamics Survery data.[14]

Given the inequities in South Africa, it is pleasing to see that there are no substantial racial differences in access to educational institutions by African and White children of preschool age, although levels of enrolment among Coloured children remain below the national average, at 80%. It is also encouraging that, as with formal school attendance, there are no strong differences in preschool enrolment across the income quintiles. As would be expected in the South African context, no gender differences in access to early learning are observed.

As with the indicator that monitors school attendance, it should be remembered that this indicator tells us nothing about the quality of care and education that young children receive. High rates of attendance provide 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.

The number and proportion of children living far from school

This indicator reflects the distance from a child's household to the school s/he attends. Distance is measured through a proxy indicator: length of time travelled to reach the school attended, which is not necessarily the school nearest to the child's household. 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.

Three-quarters of South Africa's learners walk to school, while 9% use public transport. Around 2% report using school buses or transport provided by the government. The vast majority (81%) of White children are driven to school in private cars, compared with only 8% of African children.[15] These figures illustrate pronounced disparity in child mobility and means of access to school.

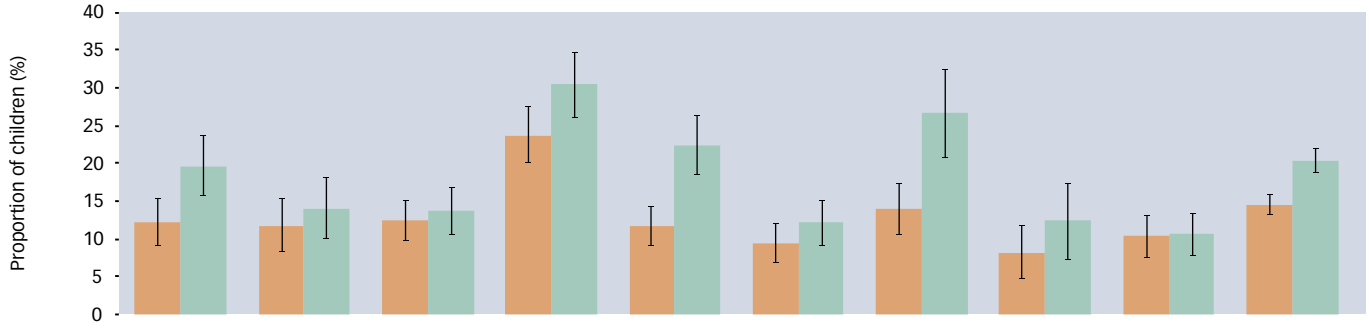
Assuming that schools primarily serve the children living in communities around them, the ideal indicator to measure physical access to school would be the distance from the child's household to the nearest school. This analysis is no longer possible due to question changes in the General Household Survey. Instead, the indicator shows the number and proportion 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. School-age children not attending school are therefore excluded from the analysis.

Overall, the vast majority (83%) of the 11 million children who attend school travel less than 30 minutes to reach school, and most learners (81%) attend their nearest school. Children of secondary age are more likely than primary school learners to travel far to reach school. In mid-2011 there were approximately seven million children of primary school age (7 – 13 years) in South Africa. A million of these children (15%) travel more than 30 minutes to and from school every day. In KwaZulu-Natal this proportion is significantly higher than the national average, at 24%. Of the 4.3 million children of secondary school age (14 – 17 years), 20% travel more than 30 minutes to reach school.

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.[16] A number of rural schools have closed since 2002, making the situation more difficult for children in these areas. Nationally, the number of public schools has dropped by 8% (over 2,000 schools) between 2002 and 2011, with the largest decreases in the Free State, North West and Limpopo. Over the same period, the number of independent schools has risen by 328 (28%).[17]

Figure 4e: School-aged children living far from school, by province, 2011

(Y-axis reduced to 40%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
Primary	12,3%	11,8%	12,5%	23,8%	11,7%	9,5%	13,9%	8,3%	10,3%	14,5%
	118,000	49,000	161,000	381,000	92,000	54,000	67,000	14,000	72,000	1,008,000
Secondary	19,6%	14,1%	13,7%	30,4%	22,4%	12,2%	26,6%	12,4%	10,6%	20,3%
	138,000	33,000	88,000	307,000	134,000	44,000	78,000	12,000	40,000	875,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

Children's progress through school

Systemic evaluations by the Department of Education have recorded very low pass rates in numeracy and literacy amongst both grade 3 and grade 6 learners.[18] Revisions to the legislative and policy framework and to the school funding norms aim to address inherited inequalities in the education system, yet 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]

Children are required to attend school from the year they turn seven, and to stay in school until they have completed grade 9 or reached the age of 15. School attendance rates are very high during this compulsory schooling phase. However, attendance tells us little about the quality of education that children receive, or how well they are progressing through the education system. South Africa has poor educational outcomes by international standards and even within Africa[20] and high rates of grade repetition have been recorded in numerous studies. For example, a study of children's progress at school found that only about 44% of young adults (aged 21 – 29) had matriculated, and of these less than half had matriculated "on time".[21]

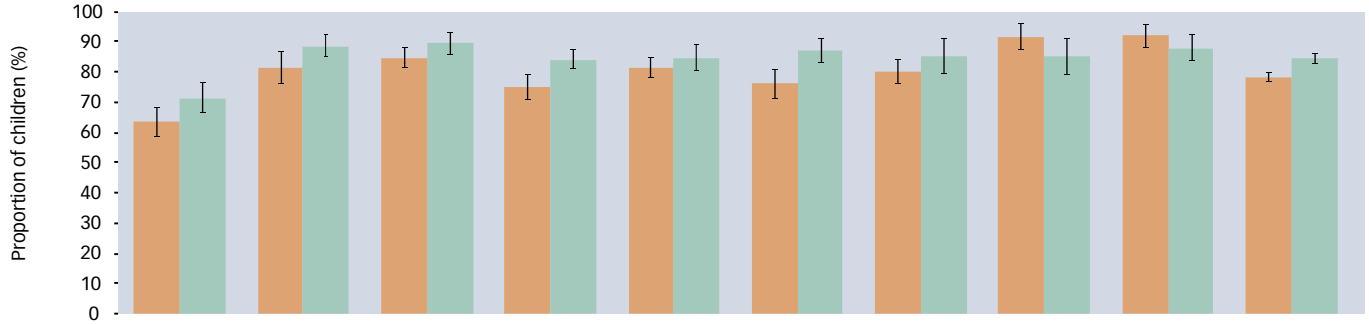
In South Africa the labour market returns to education only start kicking in on successful completion of matric, not before. However it is important to monitor progress and grade repetition in the earlier grades, as slow progress at school is a strong determinant of school drop-out.[22]

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: it measures the number and proportion of children aged 10 and 11 years who have completed a minimum of grade 3, and the proportion of those aged 16 and 17 years 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, or more if they started school in the year before they turned seven.

In 2011, 84% of all children aged 10 and 11 were reported to have completed grade 3. This was up from 78% in 2002. The slight improvement in progress through the foundation phase was evident across most of the provinces, with significant improvements in KwaZulu-Natal (from 75% to 84%) and Mpumalanga (from 76% to 87%). The best performing provinces in 2011 were Gauteng, the Free State and the Western Cape – although by 2011 provincial variation was not very pronounced. Only the Eastern Cape lagged behind, with 71% of its 300,000 children in this age group having completed the foundation phase.

Figure 4f: Children aged 10 – 11 who passed grade 3, by province, 2002 & 2011

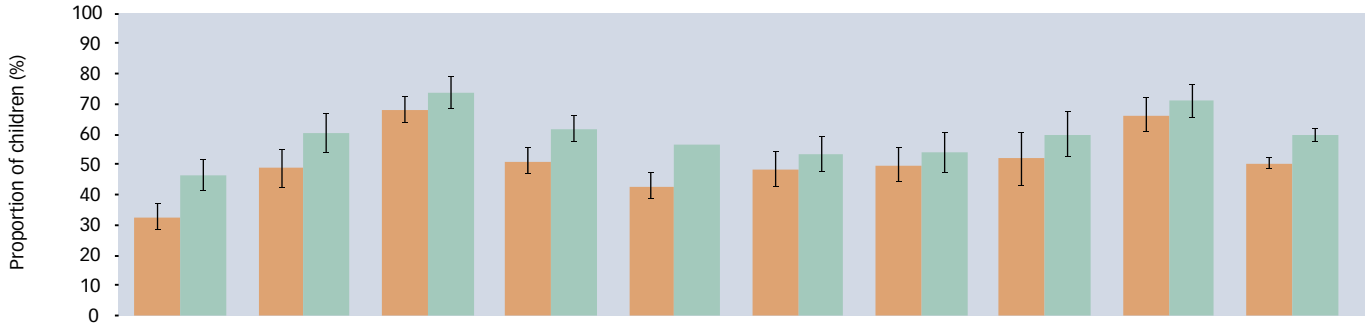


	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	63,4%	81,1%	84,7%	74,8%	81,3%	76,0%	80,1%	91,7%	92,0%	78,1%
	205,000	93,000	253,000	332,000	241,000	111,000	134,000	33,000	165,000	1,568,000
2011	71,3%	88,5%	89,3%	84,0%	84,7%	87,1%	85,3%	84,9%	87,9%	84,3%
	216,000	112,000	329,000	418,000	215,000	148,000	121,000	45,000	196,000	1,800,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

As would be expected, the rate of progression through the entire general education and training band (grades 1 – 9) is lower, as there is more time for children to have repeated or dropped out by grade 9. Sixty percent of children aged 16 – 17 years had completed grade 9 in 2011. This represents an overall improvement of nearly 10 percentage points over the 10-year period, from 51% in 2002. Provincial variation is slightly more pronounced than for progress through the foundation phase: Gauteng had the best rate of progress (74%), followed by the Western Cape (71%). Progress was poorest in the Eastern Cape, where less than half (47%) of children had completed grade 9 by the expected age.

Figure 4g: Children aged 16 – 17 who passed grade 9, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	32,7%	48,8%	68,3%	51,1%	42,8%	48,5%	49,9%	51,8%	66,2%	50,5%
	112,000	60,000	220,000	246,000	128,000	74,000	78,000	17,000	122,000	1,057,000
2011	46,5%	60,5%	73,6%	61,8%	56,8%	53,4%	54,0%	60,0%	71,1%	59,6%
	169,000	66,000	223,000	314,000	175,000	99,000	82,000	30,000	134,000	1,291,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

As found in other analyses of transitions through school,[23] educational attainment (measured by progress through school) varies along economic and racial lines. These differences become more pronounced as children advance through the grades. Gender differences in school progression, on the other hand, 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 2011, 88% of girls aged 10 – 11 had completed grade 3, compared with 81% of boys. In the same year, 67% of 16 – 17-year-old girls had completed grade 9, compared with only 51% of boys in the same age cohort. This finding is consistent with analyses elsewhere.[24]

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 the assessment of teachers, so the measure may be confounded by the extent of the teacher's competence to assess the performance of the child. Analyses of the determinants of school progress and drop out 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 successfully complete matric.[25] This in turn suggests that improved educational outcomes for children will have a cumulative positive effect for each subsequent generation.

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Children's access to housing

Katharine Hall (Children's Institute)

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 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]

Distribution of children living in urban and rural areas

This indicator describes the number and proportion of children living in urban or rural areas in South Africa.

Location is one of the seven elements of adequate housing identified by the International 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 which are not densely populated. In South Africa, service provision and resources in rural areas lag far behind urban areas.

The General Household Survey captures information on all household members, making it possible to look at the distribution of children in urban and non-urban households and compare this to the adult distribution. Nearly half of South Africa's children (47%) lived in rural households in 2011 – equivalent to almost nine million children. Looking back over nearly a decade, there seems to be a slight shift in the distribution of children towards urban areas: in 2002, 46% of children were found in urban households, and this increased to 53% in 2011. Urbanisation trends will be calculated with greater certainty once Statistics South Africa re-weights its sample on the basis of the 2011 Census.

Over the years, children have consistently been more likely than adults to live in rural areas: 65% of the adult population is urban, compared with only 53% of children.

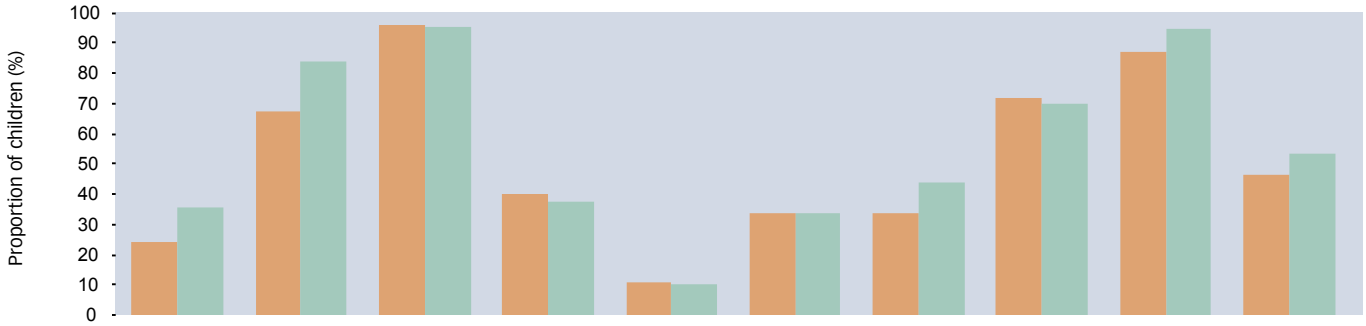
There are marked provincial differences in the rural and urban distribution of the child population. This is related to the distribution of cities in South Africa, and the legacy of apartheid spatial arrangements, where women, children and older people in particular were relegated to the former homelands. The Eastern Cape, KwaZulu-Natal and Limpopo provinces alone are home to about three-quarters (74%) of all rural children in South Africa. KwaZulu-Natal has the largest child population in numeric terms, with 2.6 million (63%) of its child population being classified as rural. The province with the highest proportion of rural children is Limpopo, where only 10% of children live in urban areas. Proportionately more children (43%) live in the former homelands, compared with adults (31%), while 58% of adults live in urban formal areas, compared with 46% of children. Seven percent of children live in urban informal areas, and the remaining 4% live in "formal rural" areas – these being mainly commercial farming areas. Over 99% of children living in the former homeland areas are African.

Children living in the Western Cape and Gauteng are primarily urban-based (95% respectively). These provinces have historically had large urban populations. The greatest provincial increase in the urban child population has been in the Free State, where the proportion of children living in urban areas increased from 67% of the child population in 2002 to 84% in 2011. In the Eastern Cape, the urban child population has increased by over 10 percentage points, signifying a possible urban trend.

Rural areas, and particularly the former homelands, are known to have much poorer populations. Children in the poorest income quintile are more likely to be living in rural areas (67%) than those in the richest quintile (10%). These inequalities also remain strongly racialised. Over 90% of White, Coloured and Indian children are urban, compared with 46% of African children.

Children under two years may be slightly more likely than older children to be based in urban households – 56% of under-twos are urban, compared with 52% of children over 10 years, for example. However these differences are not statistically significant.

Figure 5a: Children living in urban areas, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	24,4%	67,4%	96,1%	39,9%	10,8%	33,7%	33,6%	71,6%	87,1%	46,1%
	771,000	734,000	2,482,000	1,563,000	292,000	445,000	502,000	239,000	1,318,000	8,347,000
2011	35,3%	83,9%	95,4%	37,4%	10,0%	34,0%	43,7%	70,2%	94,6%	53,4%
	949,000	890,000	3,183,000	1,574,000	224,000	501,000	560,000	305,000	1,716,000	9,901,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002*; *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in adequate housing

This indicator shows the number and proportion of children living in formal, informal and traditional housing. For the purposes of the 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. "Informal" housing consists of: informal dwellings or shacks in backyards or informal settlements; dwellings or houses/flats/rooms in backyards; caravans or tents. "Traditional dwelling" is defined as a "traditional dwelling/hut/structure made of traditional materials". These dwelling types are listed in the General Household Survey, which is the data source.

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".[4] 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 makes up the bulk of the housing backlog in South Africa. "Traditional" housing in rural areas is a third category, which is not necessarily adequate or inadequate. Some traditional dwellings are more habitable than new subsidy houses – 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 are more exposed to hazards such as shack fires and paraffin poisoning.

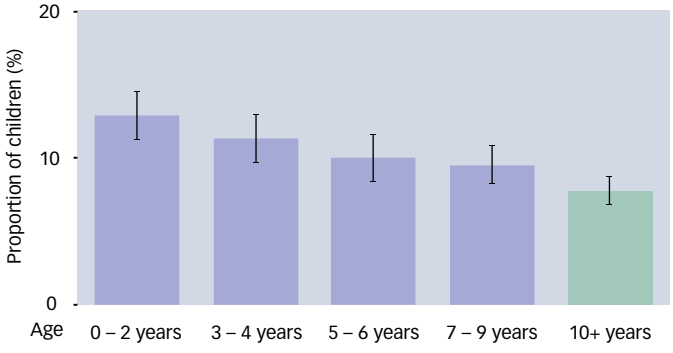
The environmental hazards associated with informal housing are exacerbated for very young children. Forty-one percent of children in informal housing are in the 0 – 5-year age group. Of children under two years, 13% live in informal dwellings, after which the rate declines slightly with age. Eight percent of children over 10 years are informally housed. Given that this trend has remained consistent over a number of years, it seems likely that it is the result of child mobility or changing housing arrangements for children as they get older, rather than indicating an increase in children living in informal housing over time.

In 2011, nearly 1.8 million children (10%) lived in backyard dwellings or shacks in informal settlements. The number of children in informal housing has declined slightly from 2.4 million (14%) in 2002. The main provinces with informally-housed child populations are Gauteng (19% of children), North West (16%), and the Western Cape (16%). Limpopo has the lowest proportion (2%) of children in informal housing and the highest proportion in formal dwellings. The Eastern Cape and KwaZulu-Natal have by far the largest proportions of children living in traditional dwellings (52% and 35% respectively).

The distribution of children in formal, informal and traditional dwellings has remained fairly constant over a 10-year period since 2002. But racial inequalities persist. Almost all White children live in formal housing, compared with only 71% of African children. Access to formal housing increases with income. Virtually all children in the wealthiest 20% of households live in formal dwellings, compared with only 64% of children in the poorest quintile.

Figure 5c: Children living in informal dwellings, by age group, 2011

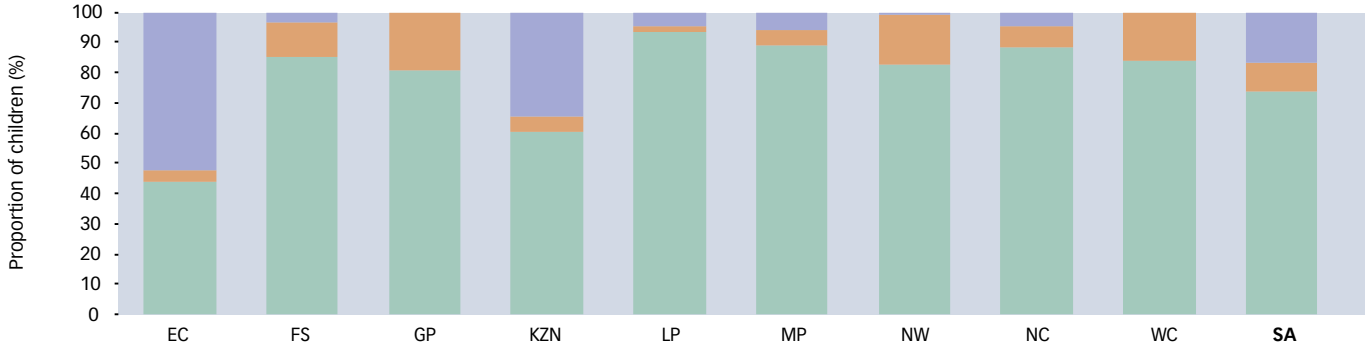
(Y-axis reduced to 20%)



Age	0 – 2 years	3 – 4 years	5 – 6 years	7 – 9 years	10+ years
% children	12,9%	11,3%	10,1%	9,5%	7,7%
Number	384,000	225,000	229,000	274,000	652,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 5b: Children living in formal, informal and traditional housing, by province, 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
Formal	43,8%	84,9%	80,6%	60,3%	93,3%	89,0%	82,5%	88,1%	83,6%	74,0%
	1,178,000	901,000	2,688,000	2,542,000	2,091,000	1,311,000	1,058,000	383,000	1,518,000	13,715,000
Informal	3,9%	11,9%	19,3%	5,2%	2,0%	5,0%	16,3%	7,0%	16,2%	9,5%
	106,000	126,000	643,000	219,000	44,000	74,000	209,000	30,000	295,000	1,764,000
Traditional	52,2%	3,2%	0,1%	34,5%	4,7%	6,0%	1,1%	5,0%	0,1%	16,5%
	1,403,000	34,000	4,000	1,453,000	105,000	89,000	15,000	22,000	2,000	3,062,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of 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.[5] 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 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 2011, 3.9 million children lived in overcrowded households. This represents 21% of the child population – much higher than the proportion of adults living in crowded conditions (12%). Overcrowding is associated with housing type: 59% of children who stay in informal dwellings also live in overcrowded conditions, compared with 28% of children in traditional dwellings and 14% of children in formal housing.

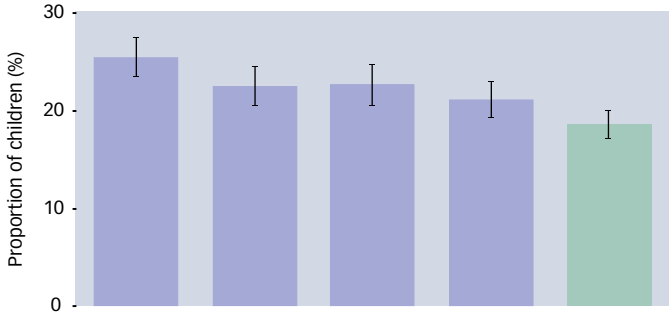
Young children are significantly more likely than older children to live in overcrowded conditions. Over 25% of children below two years live in crowded households, compared to 19% of children over 10 years.

There is a strong racial bias in children's housing conditions. One in four African children and one in five Coloured children live in crowded conditions, whereas virtually no White and Indian children live in overcrowded households. Children in the poorest 20% of households are more likely to be living in overcrowded conditions (28%) than children in the richest 20% of households (3%).

The average household size has gradually decreased from 4.5 in 1996 to around 3.7 in 2011, indicating a trend towards smaller households, which may in turn be linked to the provision of small subsidy houses. Households in which children live are much larger than the national average. The median household size for adult-only households is two people, while the median for households with children is five members.[6]

Figure 5e: Children living in overcrowded dwellings, by age group, 2011

(Y-axis reduced to 30%)

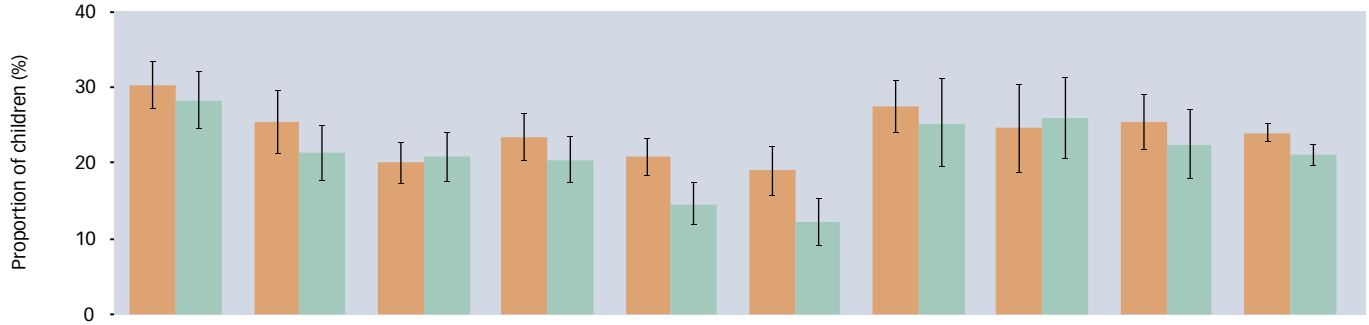


Age	0 – 2 years	3 – 4 years	5 – 6 years	7 – 9 years	10+ years
% children	25,5%	22,5%	22,6%	21,1%	18,5%
Number	760,000	450,000	515,000	607,000	1,560,000

Source: Statistics South Africa (2012) *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

Figure 5d: Children living in overcrowded households, 2002 & 2011

(Y-axis reduced to 40%)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	30,3%	25,4%	20,0%	23,5%	20,8%	19,0%	27,4%	24,6%	25,4%	24,0%
	860,000	252,000	548,000	899,000	520,000	248,000	393,000	74,000	404,000	4,199,000
2011	28,2%	21,3%	20,8%	20,5%	14,6%	12,2%	25,3%	25,9%	22,5%	21,0%
	759,000	226,000	693,000	862,000	326,000	180,000	324,000	113,000	408,000	3,891,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002*; *General Household Survey 2011*. Pretoria: Stats SA. Analysis by Katharine Hall, Children's Institute, UCT.

References

1 Constitution of the Republic of South Africa, 1996.
2 Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly resolution 44/25*. Geneva: United Nations.
3 Office of the United Nations High Commissioner for Human Rights (1991) *The Right to Adequate Housing (art.11 (1)): 13/12/91. CESCR general comment 4*. Geneva: United Nations.
4 See no. 3 above.
5 See no. 3 above.
6 K Hall analysis of *General Household Survey 2008*, Children's Institute, UCT.

Children's access to basic services

Katharine Hall (Children's Institute)

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 UN Convention on the Rights of the Child says that states 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]

The number and proportion of children living in households with basic water

This indicator shows the number and proportion of children who have access to a safe and reliable supply of drinking water at home – either inside the dwelling or on site. This 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 water is of poor quality. The indicator does not show whether the water supply is reliable or if households have broken facilities or are unable to pay for services.

Clean water is essential for human survival. The World Health Organisation has defined the minimum quantity of water needed for survival as 25 litres per person per day.[4] This includes water for drinking, cooking and personal hygiene. This water needs to be supplied close to the 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.

Although there are no statistically significant age differences in levels of access to adequate water, 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,[5] and intermittent outbreaks of cholera. Lack of access to adequate water is closely related to poor sanitation and hygiene. In addition, children may be responsible for fetching and carrying water which is a physical burden and can place them at risk.

Over six million children live in households that do not have access to clean drinking water on site. In 2011, around three-quarters (76%) of adults lived in households with drinking water on site – a significantly higher proportion than children (66%). A year-on-year comparison from 2002 – 2011 suggests that there has been little improvement in children's access to water over this period.

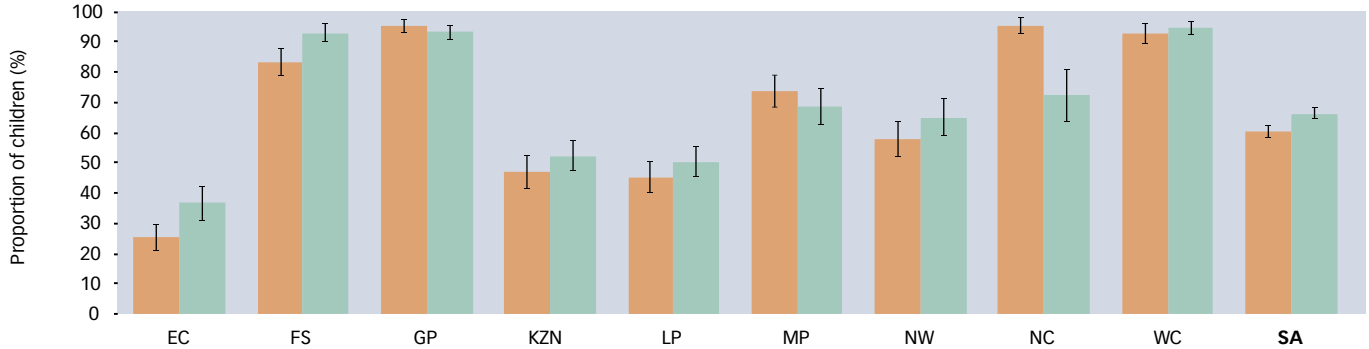
Provincial differences are striking. Over 90% of children in the Free State, Gauteng and the Western Cape provinces have an adequate supply of drinking water. However, access to water remains poor in KwaZulu-Natal (52%), Limpopo (50%) and the Eastern Cape (37%). The Eastern Cape appears to have experienced the greatest improvement in water provisioning since 2002 (when only 25% of children had water on site). The significant decline in access to water in the Northern Cape may represent a deterioration in water access, or may be the result of weighting a very small child population.

Children living in formal areas are more likely to have services on site than those living in informal settlements or in the rural former homelands. While the majority (80%) of children in formal dwellings have access, it decreases to 66% for children living in informal dwellings. Only 17% of children living in traditional housing have clean water available on the property.

The majority of children living in traditional dwellings are African, so there is a pronounced racial inequality in access to water. Just 61% of African children had clean water on site in 2011, while over 95% of all other population groups had clean drinking water at home.

Only half (49%) of children in the poorest 20% of households, have access to water on site, while over 90% 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.

Figure 6a: Children living in households with water on site, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	SA
2002	25,2%	83,2%	95,1%	46,8%	45,1%	73,6%	58,0%	95,0%	92,9%	60,6%
	715,000	824,000	2,607,000	1,792,000	1,128,000	961,000	830,000	286,000	1,477,000	10,623,000
2011	36,6%	93,1%	93,3%	52,2%	50,4%	68,6%	65,1%	72,2%	94,5%	66,4%
	984,000	987,000	3,112,000	2,200,000	1,129,000	1,010,000	835,000	314,000	1,714,000	12,306,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey 2002; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

The number and proportion of children living in households with basic sanitation

This indicator shows the number and proportion 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 is defined in the government's Strategic Framework for Water Services as the infrastructure necessary to provide a sanitation facility which 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".[6]

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. 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 which compromise children's health and nutritional status. Using public toilets and the open *veld* (fields) 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 over the 10-year period 2002 – 2011, although the proportion of children without adequate toilet facilities remains worryingly high. In 2002 less than half of all children (47%) had access to adequate sanitation. By 2011 the proportion of children with adequate toilets had risen by over 20 percentage points to 69%. But 5.7 million children still use unventilated pit latrines, buckets or open land, despite the state's reiterated goals to provide adequate sanitation to all, and to eradicate the bucket system. Children (31%) are more likely than adults (25%) to live in households without adequate sanitation facilities.

There are great provincial disparities. In provinces with large metropolitan populations, like Gauteng and the Western Cape, over 90% of children have access to adequate sanitation, while provinces with large rural populations have the poorest sanitation. The provinces with the greatest improvements in sanitation services are the Eastern Cape (where the number of children with access to adequate sanitation nearly tripled from 0.6 million to 1.7 million over 10 years), KwaZulu-Natal (with an increase of over 1.2 million children) and the Free State (where the proportion of children with adequate sanitation improved from 55% in 2002 to 82% in 2011).

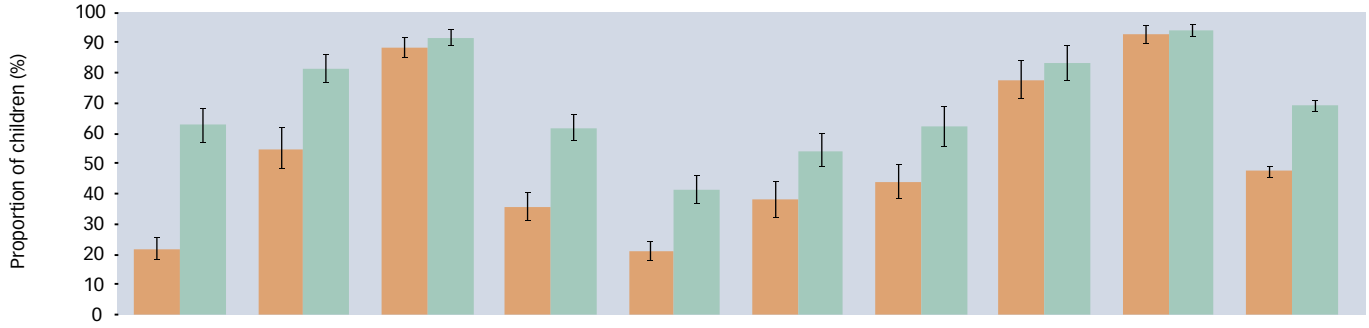
Although there have also been significant improvements in sanitation provision in Limpopo, this province still lags behind, with only 41% of children living in households with adequate sanitation in 2011. It is unclear why the vast majority of children in Limpopo are reported to live in formal houses, 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: Over 95% of Indian, White and Coloured children had access to adequate toilets in 2011, while only 64% of African children had access to basic sanitation. This is a marked improvement from 38% of African children in 2002.

Children in relatively well-off households have better access to sanitation than poorer children. Amongst the richest 20% of households, 96% of children have adequate sanitation, while only 57% of children in the poorest 20% of households have this level of service.

Due to the different distributions of children and adults across the country, adults are more likely than children to have access to sanitation. However, there are no significant age differences in levels of access to adequate sanitation within the child population.

Figure 6b: Children living in households with basic sanitation, by province, 2002 & 2011



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	**SA**
2002	21,9%	54,9%	88,4%	35,5%	21,0%	38,1%	43,9%	77,8%	92,6%	47,4%
	622,000	544,000	2,424,000	1,361,000	526,000	497,000	629,000	234,000	1,473,000	8,307,000
2011	62,7%	81,5%	91,6%	62,0%	41,2%	54,3%	62,3%	83,3%	93,9%	69,1%
	1,684,000	864,000	3,057,000	2,611,000	923,000	800,000	799,000	362,000	1,703,000	12,820,000

Sources: Statistics South Africa (2003; 2012) *General Household Survey; General Household Survey 2011*. Pretoria: Stats SA.
Analysis by Katharine Hall, Children's Institute, UCT.

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Technical notes on the data sources

General Household Survey:[1]

The GHS is a multi-purpose annual survey conducted by the national statistical agency, Statistics South Africa (Stats SA), to collect information on a range of topics from households in the country's nine provinces. The survey uses a sample of approximately 30,000 households. These are drawn from Census enumeration areas using a two-stage stratified design with probability proportional to size sampling of primary sampling units (PSUs) and systematic sampling of dwelling units from the sampled PSUs. The resulting weighted estimates are representative of all households in South Africa.

The GHS sample consists of households and does not cover other collective institutionalised living-quarters such as boarding schools, orphanages, students' hostels, old-age homes, hospitals, prisons, military barracks and workers' hostels. These exclusions should not have a noticeable impact on the findings in respect of children.

Changes in sample frame and stratification

The sample design for the 2011 GHS was based on a master sample that was originally designed for the Quarterly Labour Force Survey (QLFS) and was used for the GHS for the first time in 2008. The same master sample is shared by the GHS, the QLFS, the Living Conditions Survey and the Income and Expenditure Survey. The previous master sample for the GHS was used for the first time in 2004. This again differed from the master sample used in the first two years of the GHS: 2002 and 2003. Thus there have been three different sampling frames during the 10-year history of the annual GHS, with the changes occurring in 2004 and 2008. In addition, there have been changes in the method of stratification over the years. These changes could compromise comparability across iterations of the survey to some extent, although it is common practice to use the GHS for longitudinal monitoring and many of the official trend analyses are drawn from this survey.

Provincial boundary changes

Provincial boundary changes occurred between 2002 and 2007, and slightly affect the provincial populations. The sample and reporting are based on the old provincial boundaries as defined in 2001 and do not represent the new boundaries as defined in December 2005.

Weights

Person and household weights are provided by Stats SA and are applied in Children Count analyses to give estimates at the provincial and national levels.

Survey data are prone to sampling and reporting error. Some of the errors are difficult to estimate, while others can be identified. One way of checking for errors is by comparing the survey results with trusted estimates from elsewhere. Such a comparison can give an estimate of the robustness of the survey estimates. The GHS weights are derived from Stats SA's mid-year population estimates. For this project, weighted GHS population numbers were compared with population projections from the Actuarial Society of South Africa's ASSA2008 AIDS and Demographic model (full version), which is regarded as a "gold standard" for population estimates.

Analyses of the 10 surveys from 2002 to 2011 suggest that some over- and under-estimation may have occurred in the weighting process:

- When comparing the weighted 2002 data with the ASSA2008 AIDS and Demographic model estimates, it seems that the number of children was under-estimated by 5% overall. The most severe under-estimation is in the youngest age group (0 – 9 years) where the weighted numbers of boys and girls yield under-estimations of 15% and 16% respectively. The next age group (5 – 9 years) is also under-estimated for both boys and girls, at around 7% each. The difference is reduced in the 10 – 14-year age group, although boys are still under-estimated by around 1% and girls by 3%. In contrast, the weighted data yield over-estimates of boys and girls in the upper age group (15 – 17 years), with the GHS over-counting these children by about 5%. The pattern is consistent for both sexes, resulting in fairly equal male-to-female ratios of 1.02, 1.01, 1.03 and 1.01 for the four age groups respectively.
- A comparison of the 2011 GHS to ASSA2008 (projected to 2011) suggests that the GHS weights produce an under-estimation of 2% for children below two years and an over-estimation in the region of 7% for children aged 14 – 17 years. For the middle age groups the difference in the estimates is less than 1%. This pattern holds for both boys and girls. The under-estimation is particularly pronounced for babies under a year, at 8%. The male-to-female ratios for all children under 17 are similar across the two sources: 1.00 in ASSA, and 1.01 in the GHS.

The apparent discrepancies in the 10 years of data may slightly affect the accuracy of the Children Count estimates. From 2005 to 2008, consistently distorted male-to-female ratios mean that the total estimates for certain characteristics would be somewhat slanted toward the male pattern. This effect is reduced from 2009, where more even ratios are produced, in line with the modelled estimates. A similar slanting will occur where the pattern for 10 – 14-year-olds, for example, differs from that of other age groups. Furthermore, there are likely to be different patterns across population groups.

Reporting error

Error may be present due to the methodology used, i.e. the questionnaire is administered to only one respondent in the household who is expected to provide information about all other members of the household. Not all respondents will have accurate information about all children in the household. In instances where the respondent did not or could not provide an answer, this was recorded as "unspecified" (no response) or "don't know" (the respondent stated that they didn't know the answer).

National Income Dynamics Study:[2]

NIDS is the first national panel survey to be conducted in South Africa. The baseline survey, or first "wave" of data collection, was undertaken in 2008, with subsequent waves planned at intervals of two years. In the first wave, data were obtained for every member of each sampled household, and these individuals became the permanent sample members or panel – even if they were children or babies. Subsequent waves endeavour to return not only to the original households, but also to each original household member, even if members have moved out of the household. The advantage of a panel survey is that it enables longitudinal analysis of the variables or outcomes under study, while effectively controlling for variation in individual characteristics.

Wave 1 data collection began in February 2008, and involved 7,305 households and 28, 255 individuals. The primary sampling units were selected from Stats SA's master sample. During the survey, data collected included household demographics, income and expenditure patterns, living conditions, and anthropometric measurements among other indicators.

The anthropometric measurements provide the data for the nutrition analyses in Children Count. To obtain the measurements, fieldworkers recorded two height and two weight measurements for each child, and a third one if the one and two sets of measurements were more than one centimetre or one kilogram apart respectively. An average of the first two measurements was in each case taken for the purposes of Z-scores derivation while the third measure was used for Z-scores derivation if the first two were more than centimetre or one kilogram apart in the height and weight measurements respectively. The weights and heights collected during the study were converted to Z-scores based on the 2006 World Health Organisation's international child growth standards for children aged up to five years.[3] In the case of children older than five years, the WHO growth standards for school-going and adolescent children were used.

Data on height-for-age and weight-for-age covers children aged up to 10 years, while height-for-weight only covers children aged up to five years. In the process of derivation, absolute Z-scores for height-for-age and weight-for-age greater than 6 were treated as biologically implausible and excluded from further analysis.[4] Likewise, absolute Z-scores for weight-for-height of greater than 5 were also found to be implausible and excluded. While it is a nationally representative survey, further disaggregation is limited due to the small sample size used.

SOCPEN database:[5]

Information on social grants is derived from the Social Pensions (SOCPEN) national database maintained by the South African Social Security Agency (SASSA), which was established in 2004 to disburse social grants for the Department of Social Development. Prior to this, the administration of social grants and maintenance of the SOCPEN database was managed directly by the department and its provincial counterparts.

There has never been a published, systematic review of the social grants database, and the limitations in terms of validity or reliability of the data have not been quantified. However, this database is regularly used by the department and other government bodies to monitor grant take-up, and the computerised system, which records every application and grant payment, minimises the possibility of human error. Take-up data and selected reports are available from the department on request throughout the year. Children Count provides grant take-up figures at the end of March.

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About the contributors

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Lizette Berry holds an MA in social policy and management. She has more than 10 years' experience in child policy research and previously worked as a social worker. Her main areas of research have been child poverty and social grant systems. Lizette has an interest in the care and development of children and recently contributed to a Southern Africa Development Community policy framework that promotes learner care and support. She also co-authored a legal guide on the Children's Act for early childhood development practitioners, and contributed to research on government's funding of early childhood development, and to the Department of Social Development's draft White Paper on Families.

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Andy Dawes is an associate professor emeritus in the Department of Psychology at the University of Cape Town, and research advisor to the Ilifa Labantwana Early Childhood Development programme. His primary endeavour over the past ten years has been to encourage an evidence-informed approach to South African policy making and interventions for child protection and the promotion of early childhood development. He has recently led the development of a national rights-based approach to child wellbeing indicators for South Africa. Currently, his primary interest is in population-level interventions that enhance the rights, wellbeing and development of children living in disadvantaged circumstances.

Bathabile Dlamini was appointed Minister of Social Development in October 2010. She studied for a BA degree in social work at the University of Zululand in 1989, and worked as a social worker with the physically disabled in Pietermartizburg. Bathabile became a member of parliament following the first democratic elections in 1994, and from 1998 – 2008 she served as secretary general of the ANC Women's League. Bathabile is currently a member of both the ANC National Executive Committee and National Working Committee.

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Ingrid Meintjes was the advocacy & communications coordinator for the Perinatal Mental Health Project, UCT until August 2013. She is now a PhD Fellow at the Women's, Gender & Sexualities Studies Department at Emory University, Atlanta, Georgia. She has a Masters in gender and development and has a special interest in the intersections between gender, socio-economic status and health.

Sinah Moruane is chief director for child rights advocacy and mainstreaming at the Department of Women, Children and People with Disabilities. She holds a Masters degree in social work from the University of Johannesburg. Sinah has 25 years' experience in social work, community development, management and advocacy and was the principal lead in the development of South Africa's National Plan of Action for Children 2012-2017. Her key interests are the inclusion of excluded and marginalised children (particularly children with disabilities), early childhood development and children in vulnerable situations. She is passionate about the promotion of child rights with emphasis on child participation and the importance of children taking responsibility as young citizens of South Africa.

Angelina Motshekga is the Minister of Basic Education since 2009; prior to this she was the MEC for Education in Gauteng from 2004 – 2009. She is president of the ANC Women's League and a member of the National Executive Committee and National Working Committee. She holds a BA education from the University of the North and a Masters in education from the University of the Witwatersrand. Her experience as an educator includes teaching at Soweto's Orlando High and lecturing at the Soweto College of Education and University of the Witwatersrand. She has researched and published in education, women's development and language studies.

Aaron Motsoaledi was appointed the Minister of Health on 11 May 2009 and is a member of the ANC National Executive Committee and National Working Committee. He is a medical practitioner by profession, and holds an MBChB degree. Dr Motsoaledi worked in public hospitals early in his career, and later as a private medical practitioner in Limpopo province, serving remote and underserved rural areas. In the 1990s, he served in various portfolios as a Member of the Executive in Limpopo and was instrumental in developing provincial policy and strategies to address poverty, unemployment, and access to services, amongst others.

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Charmaine Smith is the communication and knowledge manager of the Children's Institute, University of Cape Town. A radio journalist in background, she has been applying her media and communication skills in the development sector for the past 10 years. She is mainly responsible for the communication and marketing of the Institute and its work, and has served on all the editorial teams of the *South African Child Gauge* since its start-up in 2005.

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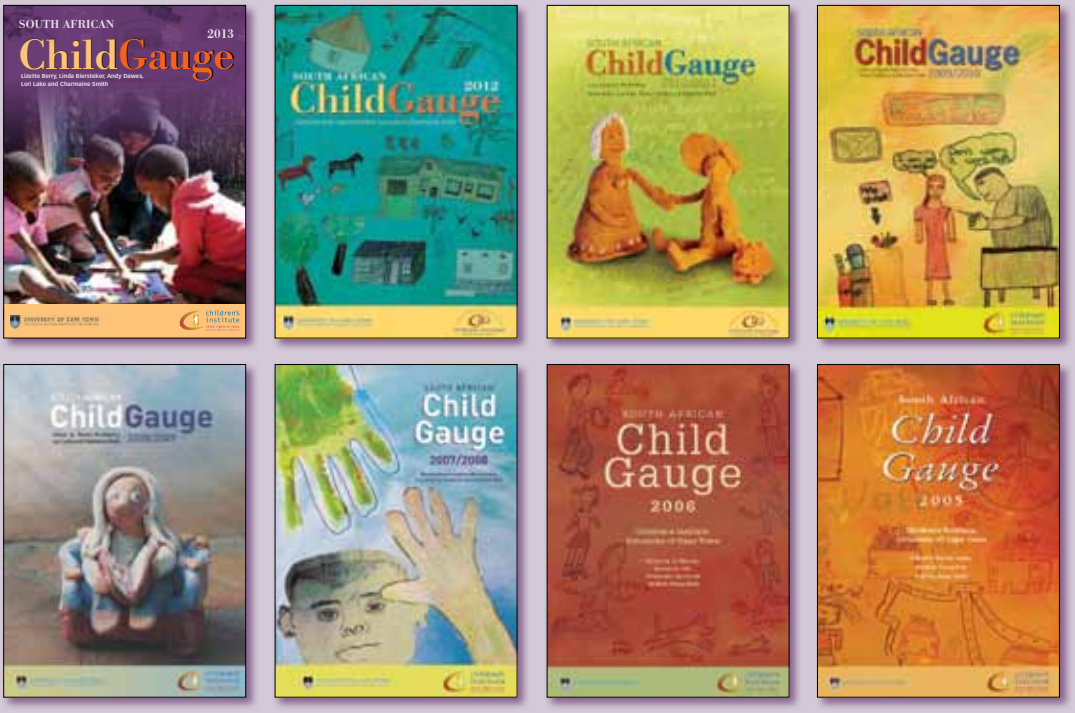
Catherine Ward is an associate professor in the Department of Psychology at the University of Cape Town. She has a PhD in clinical-community psychology and is interested in violence prevention from the perspective of children's development, and particularly in public health approaches to this – in developing evidence-based approaches to violence prevention that have a wide reach and are effective in improving children's development and reducing their likelihood of becoming aggressive.

Inge Wessels is a research assistant in the Department of Psychology at the University of Cape Town. She has a Masters in psychological research and is interested in the field of developing effective parenting programmes, particularly within low- and middle-income countries.

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 a series of essays to inform national dialogue on a particular area which impacts on South Africa's children; a summary of new legislative and policy developments affecting children; and quantitative data which track demographic and socio-economic statistics on children.



Previous issues of the *South African Child Gauge*:

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.org.za**

The Children's Institute, University of Cape Town, has been publishing the *South African Child Gauge* every year since 2005 to track progress towards the realisation of children's rights.

The *South African Child Gauge 2013* is eighth in the series and focuses on essential services and support for young children. This issue also discusses recent legislative developments affecting children, and provides child-centred data on children's access to social assistance, education, health care, housing and basic services.

The Children's Institute aims to contribute to policies, laws and interventions that promote equality and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

What readers say about the *South African Child Gauge*

"The most important investment that we can make as a country is to invest in the well-being and development of our children so that they can go on to lead healthy and active lives. The *South African Child Gauge* makes an important contribution to the debate on how we can best achieve this objective."

Trevor Manuel, Minister in the Presidency: National Planning Commission

"The *South African Child Gauge* is a tremendous resource. What is most useful is the data and the information that it provides. It helps us with lobbying, it helps us with our advocacy work, and it generally informs both practitioners and the public about the situation of children in the country.

Eric Atmore, Centre for Early Childhood Development/Department of Social Development, University of Cape Town

"You'll find information here that's near impossible to obtain elsewhere. The Children Count section offers the most authoritative and up-to-date data on the health and well-being of South African children – an essential resource for under- and post-graduate students and health professionals completing child health projects or preparing for exams."

Professor Haroon Saloojee, Division of Community Paediatrics, University of Witwatersrand

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