SCALING UP EARLY CHILDHOOD DEVELOPMENT (ECD) (0-4 YEARS) IN SOUTH AFRICA

Overview of Findings

June 2008
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A Introduction

A.1 Background

The role of Early Childhood Development (ECD) services is increasingly being recognised as a critical area for Government intervention, with the aim of ensuring that poor children are able to reach their full potential during these first critical years in their life. This sets the scene for the future, and is the first step in breaking the inter-generational poverty cycle. Historically, ECD has been seen as an informal unpaid service performed by mothers, grandmothers, relatives or community. Very weak child development indicators however show that poor South African children are severely disadvantaged and require more explicit and targeted support.

The last 12 years have seen the ongoing development of new policies and programmes aimed at promoting the rights of young children, including free primary health care and social grants and phasing in of a reception year of schooling from 2001. In May 2004, policy development for younger children (0-4 years) moved forward when Cabinet mandated the social sector cluster (social development, health and education) to develop an integrated plan for ECD. Political commitment for the expansion of ECD services has been demonstrated by increased budgetary provision and inclusion in high-profile programmes, such as the EPWP. Ratcheting up implementation of ECD programme is a government APEX priority, or special focus area, announced by the President in his State of the Nation address in February 2008.

As the state becomes more involved, and particularly with an aim to rapidly expanding quality services, the ECD sector itself will need to transform – become more formal, professionalised, and able to interact with the state and the quality standards sought. This will be a major challenge.

Government’s engagement with the ECD sector could have a number of important impacts on ECD providers themselves. First, the HSRC estimated that about 345,000 jobs could be created in ECD (0-4). This was work prepared for the Director-General’s Social Cluster in 2004. The opportunity for job creation arises out of the great service delivery gap that currently exists. Second, a large proportion of these jobs will be undertaken by women, with a wide geographical spread. Third, many of these providers are amongst the most marginalised in society with little access to training. These opportunities could now enable access to the labour market, formal training and career paths.

A rapid mass scaling up of services aimed at young children must be done to an accepted quality. Such a process, particularly when aimed at vulnerable ‘voice-less’

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groups can be dangerous if not done to a standard and with checks and balances. It is essential that this scaling up be done on the basis of the best available evidence. To address the need for evidence, the national Government of South Africa through its Director-General’s Social Cluster, the W.K. Kellogg Foundation and the HSRC have provided generous support for this research.

A.1.1 Key elements of the National Integrated Plan (NIP) for ECD 0-4 years

The NIP for ECD aims to bring greater synergy and co-ordination to the range of government programmes aimed at young children.

Early childhood is the period during which the platform for later health and development is established. The NIP for ECD stresses the importance of providing environments within which children can thrive, be safe and develop, and seeks to:

- “Create environments and situations in which children, particularly vulnerable children, can learn, grow and thrive socially, emotionally, physically and cognitively;
- Increase the opportunities for young children to prepare for entering formal schooling;
- Provide support to adults who care for young children and the communities in which they live, in order to enhance their abilities to care for and educate these children; and
- Reduce the adverse developmental effects of poverty and other forms of deprivation on children from zero to four” (p. 17).

The NIP also seeks to provide:

“an integrated approach for converging basic services for improved child care, early stimulation and learning, health and nutrition, water and sanitation – targeting” (p. 19).

Three levels of intervention are envisaged:

- The primary level is the family. The goal is to ensure “quality care, nutrition, hygiene, safe shelter, water provision, primary health care and many other key caregiving practices” (NIP p. 34).
- The second is the community. Here the goal is to provide “access to services at clinics, community help groups and care centres, one-stop service centres, playgroups, parental support programmes, community management of childhood illnesses, etc.” (pp. 34-35).
- The third includes formal services such as crèches, day-care centres and preschools.

A.1.2 What does ‘scaling up’ mean?

In a context of widespread exclusion, which is the legacy of apartheid, it is common to talk about “massifying” or “scaling up”. It is worth defining what this means. Scaling up has several possible dimensions, including increasing:
The number of service recipients;

- The range of services offered; and

- The quality or intensity of the service offered.

South African government policies and programmes involve all these dimensions. For example, the APEX goal of doubling the number of sites and child beneficiaries by the end of 2009 and expanding trained staff involves increasing both access and quality.

The NIP for ECD is an example of scaling access to a broader, integrated service package as well as significantly increasing the numbers of poor and vulnerable children who receive services. Current EPWP priorities for training staff in registered ECD centres and increasing subsidies exemplify scaling up of quality of services to which children already have access.

For scaling up at least the following needs to be in place:

- Good policies and evidence-based plans;

- Adequate resource inputs (finance, training, infrastructure, etc.);

- Excellent inter-sectoral collaboration with appropriate staffing and other supports;

- Good programme information; and

- Systems for monitoring and evaluation of interventions.

Regardless of how scaling is defined, it is important to consider scaling up access to services that are likely to make the most difference to the most needy populations in the most cost efficient manner.

Comprehensive services are more beneficial and are preferable to many small-scale project-based interventions that are high cost and do not reach many children. We need to scale up access to comprehensive interventions if we wish to make a significant difference to young vulnerable children.

All the papers completed for this series take their cue from the NIP for ECD and seek to enhance the implementation, scalability and quality of services in the age group 0-4 years. Early childhood services are provided by the Departments of Health, Social Development and Education. The papers focus on centre, community and home based services for children aged 0-4 years as outlined in the NIP. With a few exceptions, primary health care system delivery is not considered, as there is a range of other authoritative sources. Grade R is excluded, as these children are older than the age band considered in this study. The focus is therefore largely on services that fall under the DoSD with the training and curriculum inputs to this age range of the DoE.

Over the past year, the research team has worked to provide background studies to inform interventions that can demonstrate scalable access to quality early childhood services for vulnerable children. The studies focus on services that fall within the responsibility of the ECD cluster with a particular emphasis on the Department of Social Development (DoSD) and Department of Education (DoE) responsibilities as outlined in the National Integrated Plan (NIP) for ECD and the ECD component of the EPWP.
This document has three functions:

- To make present findings from the background research accessible to government and other providers of ECD services for immediate discussion and reflection.
- To inform efforts to improve ECD service delivery and integration, as well as to assist programme staff in providing evidence-based and better quality ECD interventions that can be scaled up.
- To identify critical innovations that could be tested within the ECD (0-4) programme, where it is believed that they could have a major impact on enabling rapid scaling up of quality ECD services.

The paper provides an overview of the findings of each research paper prepared in Phase 1. Key findings and recommendations are summarised at the end of this introduction.

A.2 Project overview

The context for this project is the intersection of two priority programmes of the South African government – the expansion of early childhood development (ECD) services for children under 5 years and the expansion of employment through social sector jobs. The Social Cluster aims to improve access to quality ECD services for children in poor households. To this end, the National Integrated Plan for ECD services outlines a range of services including home and community programmes which are not well established or tested in the sector. The Expanded Public Works Programme (EPWP) is the current vehicle for creating jobs and career paths for low skill workers in the social sector and there is a great deal of pressure to expand quickly. However, this needs to be balanced with concerns about the sustainability and quality of the service that can be offered.

The overall objective of this research project is to improve the evidence base supporting implementation of government's vision of rapid mass expansion of quality ECD services for poor children under five.

This is done under the guidance of the National Integrated Plan for ECD 0 – 4 years and the Expanded Public Works Programme.

There has been specific emphasis on identifying possible institutional barriers to mass scaling up at an accepted quality. To identify these barriers, we undertook a broad review of the objectives, the programme approach, and the ECD sector itself. We hope that these investigations will be useful to stakeholders in the immediate term on their own merits. However, we were also looking for a small number of critical innovations in ECD programme design that might have a major impact on enabling the desired expansion. The idea was to identify a set of innovations that might be tested in the field – in other words, a demonstration project that would operate within the existing ECD programme and in partnership with key stakeholders including Government and delivery agents.

The programme elements fall into three phases:
Phase 1 is project initiation and scoping, including background studies and design of demonstration projects. This is the current Phase, being reviewed in this document.

Phase 2 is implementation of the demonstration projects and data gathering for evaluation (this will include gathering of baseline and follow up data on participants including both children and delivery agents).

Phase 3 is final evaluation and information dissemination.

The monitoring of outcomes for children and their caregivers will provide solid evidence of which interventions really make a difference for young children and what they cost to provide as a basis for future planning and implementation.

The deliverables produced in Phase 1 include:

1. Policy, demographics, child outcomes, service provision and targeting in ECD (0-4).
2. Review of current Early Childhood Development service delivery in South Africa
   2.1. Government indicators for monitoring the NIP for ECD.
   2.2. Training: qualifications, provision and delivery.
   2.3. Local case studies of on the ground service delivery.
   2.4. Governance and budgeting.
3. Innovations to inform improved Early Childhood Development outcomes, scaling and job creation
   3.1. Child and caregiver outcome indicators.
   3.2. Inputs for quality ECD interventions.
   3.3. Job hierarchies and supervision in ECD provision.
   3.4. Alternative support structures in the ECD sector.
   3.5. International case studies.
4. Integrated finding of background studies (this document)
5. Final research design and draft measures and instruments for demonstration project/s. (to be completed after the workshop)
A.3 Project team and oversight

The project has been implemented as a partnership between the Centre for Poverty, Employment and Growth (CPEG) and the Child Youth Family and Social Development Research Programme (CYFSD) at the Human Sciences Research Council (HSRC). Dr. Miriam Altman, Executive Director, CPEG mobilised resources and acted as principal investigator for the project. Prof Linda Richter, Executive Director, CYFSD provided essential guidance and support to the project. The research team was co-ordinated and led by Linda Biersteker (CPEG, seconded from ELRU) and Prof Andy Dawes (CYFSD).

The National Interdepartmental ECD Committee acted as a Reference Group for the project. Regular presentations were made, and the papers prepared in Phase 1 have been reviewed by them. This was an essential element that ensured relevance of the findings for policy and action.
B Overview of findings

B.1 Legislation and policy

The South African legislative and policy framework for young children is rights-based and very sound. However:

1. It is important to regulate role specifications, coordination, and funding responsibilities across departments and at different levels of government. This has proved to be important in scaling up ECD in other countries.

2. Currently, the NIP for ECD is very broadly targeted. It does not sufficiently differentiate levels of child and caregiver vulnerability, nor does it provide adequate definitions of ‘vulnerable groups’ for targeting purposes.

3. While there are funding norms and monitoring regulations for formal services, this does not apply to home and community based ECD services. These are central components of the strategy to expand access and quality.

4. Career paths with provision for horizontal and vertical progression in ECD jobs have proved to be important for professionalisation and for upgrading the sector.

5. Minimum wages and service conditions for the sector do not exist in South Africa. This is a barrier to the improvement of sustainable quality services.

B.2 Systems

1. Funding

Budget allocations for ECD subsidies and training have significantly increased, resulting in increased access to subsidised ECD and to training. However:

- DoSD budgets are inadequate for scaling up ECD relative to the target population.

- Responsibility for provision of infrastructure (buildings) for centres is not clear.

- ECD practitioner salaries are not included in budget formulae.

- Per child subsidies are not standardised across provinces, and the means test has not been adjusted since 1994.

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The equitable share mechanism through which national treasury allocations for ECD are transferred to provinces does not necessarily result in the funds being used for ECD. Provincial treasuries have discretion to spend as they choose.

There may be a need for stronger intermediary organisation(s) to facilitate the flow of funding to the ECD services.

2. Human resources

Due to public support access to training has been significantly scaled up. However:

- The sector remains poorly supplied with suitably qualified staff at all levels of government, and in NGOs and training institutions – particularly the tertiary sector.
- There is insufficient human capacity to provide support to ECD services at all levels of government.
- Training providers and job creation schemes are not taking sufficient account of the new job categories outlined in ECD policy.
- A lack of higher-level leadership, management and supervisory training for ECD practitioners, government officials and training institutions impacts access and quality of services.

3. Monitoring and evaluation

- M&E resources are extremely inadequate. This will pose danger to Government intention to rapidly scale up services for vulnerable children.
- Regular departmental quality assurance and support does not take place at DoSD District level;
- Very poor data availability hampers planning and budgeting. For example, it is not possible to track ECD spending in current provincial budget reporting systems. Also, there is no data on service quality.

4. Infrastructure

- In a number of countries with similar challenges to South Africa, primary health services are successfully used as nodes for expanded holistic ECD for birth to 3 years.

5. Integrated working

- The interdepartmental committee is a key organ of government. However, accountability for decisions taken by this body does not seem to be sufficiently clear.
• In the two provinces studied by this project, departments of Health and local governments were not sufficiently involved with the integrated strategies for ECD.

• Scaling up might be assisted by intermediary organisations, which could facilitate the coordination of the package of services as foreseen in the NIP.

6. Advocacy

• In other countries, advocacy campaigns to inform parents, government officials and others of the importance of ECD have been important in scaling up.

B.3 Programme level

At programme level, study findings indicate:

1. Elements associated with quality in centre-based interventions:

   • There is a well-known set of structural (e.g. ratios) and process parameters (e.g. practitioner education, ongoing staff supervision, programme, etc.) associated with good child outcomes in group care settings.

   • Particularly for younger children, small group sizes with low child-adult ratios are preferable.

   • For all children ‘positive’ (warm accepting and sensitive) care-giving is necessary.

   • Safe, clean and stimulating physical environments are essential.

   • The setting must not simply provide for health and hygiene but also work toward the psychosocial development of the child.

   • Active individualised support by staff for children’s learning is necessary to scaffold the child’s development of skills relevant to school.

   • Quality centre-based direct intervention with the child is more likely to improve language and cognitive outcomes than home-based parent early learning and stimulation – half a day in a good programme improves school outcomes.

   • Poor quality centres make no difference and can cause damage.

2. Quality in home-based interventions:

   • Interventions require active regular motivated parent participation over extended periods (there is a strong relationship between frequency and duration of contact and child outcomes).

   • A positive relationship between participant and staff is important.

   • Joint interventions to improve child development involving direct activities with the child and parent training, plus joint activity with both, work best to improve parenting as well as cognitive and language development.
3. Promotion of sensitive care in home-based interventions:

- Programmes that focus on assisting caregivers with their daily life challenges; help them to learn more adaptive problem solving skills and lend emotional support have the potential to reduce caregiver stress and promote more sensitive caring.

- Promising interventions include those which provide parenting advice and support to vulnerable and very young mothers starting with antenatal care, and followed up with home visits and support groups thereafter.

4. Early stimulation in home-based interventions:

- Integrate early stimulation programmes in the home with other interventions that are offered to parents (e.g. nutritional support, food gardens, HBC, etc.).

- Parents and children must be actively involved in the intervention. Simply providing parenting information is likely to have little or no effect on child outcomes.

- Interventions for child maltreatment commonly involve multi-problem families. These require intensive specialist interventions.

**B.4 Key summary conclusions**

Clearly there is a need for greater access to quality service provision in terms of the NIP package, intended to promote child health and development. Therefore:

1. Regardless of the services and programmes to be scaled up, they must draw on evidence of programme effectiveness and attract priority government resources.

2. Quality in any service requires training and monitoring. Therefore, the goal should be to increase access to appropriate training (and continued supervision in the job).

3. More children will have access if more services are subsidised. Subsidisation is also likely to provide more secure jobs. Scaled up quality services are therefore opportunities for job creation. Underemployed people should increasingly be able to secure sustainable jobs in the ECD sector. Through the other programmes, and as the sector expands, many other jobs are opening up. These changes have significant implications for budgeting, infrastructure, training and career paths.

4. To ensure quality as scaling up occurs, supervision and monitoring of services is essential. At provincial level, the DoSD has the responsibility for capacitating District DoSD Offices to support registered facilities and to assist those that are not to register. In order to scale up quality in existing registered and subsidised facilities, significant increases in both budgets and human resources are required. Without such inputs, services will continue to struggle to provide access to the quality programmes that disadvantaged children require to overcome the challenges of growing up in poverty.

5. The private and non-profit sector plays a major role in building the capacity of non-profit ECD services in the social sector. Private sector training and support
may acceptable but it is costly. Taking support and supervision of ECD services to scale and quality will require strengthening of the existing responsibilities of the state with public-private partnerships where necessary.
C Overview of findings

C.1 Policy, demographics, child outcomes, service provision and targeting in ECD (0-4)

Purpose

The purpose of the paper was to:

- Describe the principal government commitments to children 0-4 years, including priority targets as set out in the leading policy statements and legislation relating to children age 0-4;
- Provide a profile of vulnerable children age 0-4 (child outcomes and demographics) in South Africa and flag data gaps in this regard;
- Provide an overview of provision of the primary NIP for ECD service components to children age 0-4 and flag data gaps in this regard;
- Make recommendations for targeting in implementation of the policy for scaling up services; and
- Draw inferences for the design of Demonstration Projects to test options for scaling up ECD services that will improve child outcomes and create jobs.

Legislative and policy commitments to children 0-4 years

The legislative framework and departmental policies and plans at national, provincial and local government level have numerous implications for service provision for young children. One of the challenges identified in expanding ECD programmes has been a lack of coherence between legislation, policies and plans.

The rights framework of the Convention on the Rights of the Child, African Charter on the Rights and Welfare of the Child and South African Constitution provide the basis for the key legislative and policy commitments and plans for 0-4 year-olds. These include the Children’s Amendment Act 41 of 2007; the NIP for ECD; the Massification of ECD Concept Document and the ECD component of the EPWP Social Sector Plan.

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In addition the concept of ECD Centres as Resources of Care and Support for Poor and Vulnerable Children and their Families provides an important example of an approach for extending ECD services for more children.

These commitments signal a significant shift towards providing for a range of ECD services extending beyond the ECD centre. They aim to address young children’s rights and needs holistically with a particular focus on vulnerable groups, and to better integrate planning and delivery across key ECD service delivery departments at all levels of government.

Many of the enabling mechanisms for both the wider ranges of services and for integrated delivery are not yet in place. The NIP in particular, needs to be seen at this juncture as a plan set out at national level and not yet as driving budgeting and integrated service delivery at provincial and municipal level, which is where the service delivery action that matters for young children takes place. The absence of enabling mechanisms is seen for example in the following:

- The Children’s Amendment Act 41 of 2007 and the Guidelines to ECD Services of the DoSD, privilege the ECD centre model;
- To date there is no regulatory and support framework for community and household programmes which is essential if a quality service is to be rendered; regulations under the Children’s Amendment Act may provide for this;
- Funding norms for DoSD currently provide only for ECD centres, and the level of government funding of ECD services (delivered at centres, to community groups and in homes) is extremely limited, and there is no mechanism in the legal framework or budget process for ensuring that more financial and human resources flow to ECD (age 0-4);
- Monitoring and evaluation systems for different departments (e.g. Health, Social Development and Education) and programmes (e.g. EPWP and NIP) are entirely separate (see the paper on government monitoring systems);
- Proposals for emerging categories of ECD jobs and training for workers in different ECD service types need to be developed and concretised;
- Some categories of vulnerable children prioritised for service delivery are very large, while others are not necessarily direct indicators of vulnerability The NIP does not suggest how decisions about targeting should be made;
- Finally, the ECD centre is suggested as the node for expansion of outreach services for young children. However, particularly for infants and very young children, options such as the primary health care system may be more effective.

Profile of vulnerability in children 0-4 years

The NIP prioritises services to the following categories of vulnerable young children

- Children from poor households and communities;
- Children affected and infected by HIV and AIDS;
- Children with (physical) disabilities and incurable diseases;
- Orphaned children;
Overview of Findings

- Children in homes headed by other children; and
- Children from ‘dysfunctional’ families.

Current data indicates that two thirds of young children live in poverty. Nutritional status is correlated with poverty. In 1999, a quarter of children under 1-3 years were reported to be stunted. By the time they reach school, the development of a significant number of South African children is already severely compromised. This will impact on their capacity to benefit from education.

At 57.6 per 1,000, children under five have the highest mortality rate in the South African population. Over a quarter of child deaths are due to diseases related to poor living conditions.

HIV and AIDS is the major driver of child mortality today. An estimated 3.7% of children 0-4 years are HIV positive. Few HIV-positive infants, including those who were part of PMTCT programmes, are on Anti Retroviral Therapy and many die during their first year.

Definitions and measures of disability vary considerably but based on an estimate of 3%, some 155,000 children aged 0-4 years have a moderate to severe disability and need extra services.

While there are relatively few children 0-4 years who are orphaned (2%) and only 0.2% live in child-headed households, many live in situations in which caregiving may be compromised. This includes being in the care of elderly carers or born to teen mothers, or living with caregivers who are exposed to a combination of stress factors that may compromise their ability to provide adequately for their young children’s emotional and intellectual development. For example, maternal depression is very high and about a third of women of child-bearing age are HIV positive. For many of these factors there is unevenness across provinces, with children in rural areas generally being worst off.

Service provision for the primary components of the NIP

The NIP provides for a basic service package including:

- Universal registration of births;
- Integrated Management of Childhood Illnesses (IMCI);
- Promoting healthy pregnancy, birth and infancy;
- Immunisation;
- Nutrition;
- Referral services for health and social services;

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4 This estimate is from measurement based on the General Household Survey 2005, which used household expenditure as the welfare indicator and set the poverty line at less than R1,200 per month. A child was hence defined as poor is he/she was found to live in a house with an expenditure level of less than R1,200.
- Early learning stimulation; and
- Development and implementation of psychosocial programmes.

Service access information indicates improvements in recent years: in birth registrations (from 25% in 1998 to 72% in 2005); access to maternal and child health care has improved (immunisation coverage increased from 63% in 1998 to over 90% in 2005); and 76% of Primary Health Facilities implement IMCI (over 90% of births in a health facility). Regarding social grant uptake, 86% of 0-4 year-olds estimated to be eligible receive CSG. Per capita subsidies for poor children in ECD centres have improved and cover has increased. However, there is considerable unevenness across provinces.

There are many data gaps on the primary NIP deliverables, including nutritional status, access to early learning stimulation and to psychosocial programmes, and on referrals to social services and health. There is very limited service quality information.

**Targeting for implementation of the NIP**

In view of the large vulnerable groups identified for receipt of the NIP service package, we recommend more specific targeting taking particular risk levels into account as follows:

- NIP service components are viewed as being delivered on a continuum from **universal** (e.g. birth registration, primary health care, parent awareness messages), to **early interventions** to more vulnerable groups (e.g. social grants, IMCI, psychosocial support, parent education groups) to **specialised interventions** which would include statutory interventions for children who are more seriously at risk. These would include HIV positive children, those with disabilities, children in households where caregivers are unable to care for them due to physical and mental illness, substance abuse or those experiencing abuse and neglect;
- Better data should be collected and managed to enable more directed service planning and delivery at **local level**, so that high risk areas and groups can be targeted for particular interventions;
- A simple risk screen should be developed to determine vulnerability and the service components required by children and their caregivers.

**Inferences for programme implementation aimed at improving quality and scaling up ECD (0-4)**

- Different methods of achieving delivery of the integrated NIP service package through formal, community and home based ECD services in a cost effective manner need to be tested. The model in the *Massification of ECD* Concept and *ECD Centres as Resources of Care and Support* documents, may be useful for providing guidance in this regard;
- Methods of improving quality in the delivery of the NIP service package with job creation and skills development and ways of measuring and monitoring this should be tested; and
- Research studies could explore the effectiveness of a two-phase targeting process:
• First, an assessment of how the basic NIP service package has been delivered (e.g. health status, birth registration, immunisation status and access to ECD stimulation programmes); and

• Second, risk screening within the community in order to target very high risk caregivers and children requiring intensive interventions.
C.2 Government indicators for monitoring the NIP for ECDs

This paper reviewed the extent to which data on input and outcome / impact indicators that can be utilised for monitoring and the package of services covered by the NIP for ECD are available in the Government system. The paper also draws attention to indicators recommended for tracking the situation of children infected and affected by HIV and AIDS in inter-sectoral plans.

Findings

The DoE is charged with monitoring the NIP. However, all relevant Departments are required to have monitoring and evaluation systems so as to ensure quality services to children. Reports have to be sent to the Office on the Rights of the Child in the Presidency.

To assist this process, “Guidelines for the implementation of the national integrated plan for early childhood development” have been developed, and include recommendations (in Section 7) for monitoring ECD plans and activities from Provincial through to Municipal and District level (Departments of Education, Health, & Social Development, 2007). These are preliminary guidelines rather than fully developed monitoring systems.

Data on child outcomes, access to services and quality of services is most readily available from the Department of Health (DoH) in their Essential Data Sets for children. These facilitate outcome monitoring for the policy goals in the Health system. Service quality is assessed against the standards formulated for the Comprehensive Primary Health Care Package, which is delivered at primary health care level to pregnant women and children 0-4. Standards for Community Home-based Care are also available.

Data in the social ECD sector is very limited. The DoSD reports on access to registered ECD services but not on other programmes for ECD. However, a range of data on child and family well-being is gathered at facilities that could be used by government for monitoring purposes if it was collated. Programme information remains with implementing agencies. Less formal programmes and on community or home-based interventions is not regularly reported. Programme quality staff qualifications and performance data is not routinely available. Indeed standards for quality assurance in the social ECD sector need to be finalised. Data on the training opportunities and supply of ECD staff should be available from the relevant training authorities (see paper 2.2 on training).

Of particular relevance to ECD is data that could be obtained from forms completed for purposes of registering Partial Care Facilities and ECD Programmes; from Quality

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Overview of Findings

Assurance Reports; from the Norms and Standards for partial care in terms of Section 79(2) of the Children’s Amendment Act; and from the Norms and Standards for prevention and early intervention {section 147(2)}. None of these processes are finalised.

An opportunity for strengthening administrative data exists at this point in time: if services, municipalities and relevant provincial departments construct information systems in terms the data to be collected under the new regulations, then a cost efficient way of monitoring ECD provision will be facilitated.

Four relevant government M&E systems are in development but not finalised.

The first is the draft Early Childhood Development framework of indicators under development in the DoSD.

The second is the DoE proposal for indicators of child outcomes in relation to the ECD curriculum. These are not finalised and need to be validated in selected sites.

The third is the proposed Government Wide system for monitoring public policies under the leadership of the Presidency. We were not able to establish the current state of the system and were unable to determine whether it includes indicators relevant to ECD.

Indicators are in development for the EPWP. Draft proposals for M&E in the EPWP focus mainly on monitoring access to the EPWP, and outcomes for trainees in terms of jobs secured.

We recommend that the Interdepartmental Committee on ECD track all these developments.

Inferences for improvements to government information systems for monitoring the NIP for ECD

The conclusion of this review is that a range of data is available but that there are major gaps (particularly in the social ECD sector). Measurement of the inputs and quality of services is absent for the range of non-health interventions proposed in the NIP. Also there definitions of vulnerable groups are required so as to assist targeting and monitoring.

It is recommended that the social sector ECD indicator development follow the example of the DoH Essential Data Set. The same information should be collected in the identical manner using a common platform in every province, to permit a comprehensive view of the situation for policy makers from district level up.

A major challenge is the intersectoral nature of ECD and the separate practices of administrative data collection across departments. The creation of an Essential Data Set for ECD would be a worthwhile endeavour to support this process.

An ECD information hub located in an appropriate unit and to which data from the relevant departments can be sent on a regular basis would be an important contribution to information integration, monitoring, and service planning. While a
considerable challenge, agreement must be reached on common definitions and measures of terms likely to be used across departments (vulnerable groups, poverty, etc).

Data collection for monitoring the NIP may also be enhanced by the Regulations formulated in terms of the Children’s Amendment Act 41 of 2007.

Finally, we recommend the development of small area descriptions of the situation of young children using Geographical Information Systems technology to identify communities where children are most vulnerable and services are limited, so as to facilitate targeting.

Table 1 lists the NIP vulnerable groups and Table 2 lists the various components of the NIP phases that require monitoring. The tables note the presence or absence of administrative data in the government system.

Comprehensive sets of indicators for child and caregiver wellbeing are included in the companion paper that addresses these topics (3.1). Reference is made there to child health and psychosocial outcomes, caregiver health and well-being, and household conditions.
### Table 1 – Government department administrative data sources for monitoring elements of the NIP for ECD (0-4): NIP vulnerable groups

<table>
<thead>
<tr>
<th>NIP vulnerable groups</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children living in poor households and communities.</strong></td>
<td>The best approach is to obtain data for the area (e.g. districts, wards, etc.) in which the intervention is being conducted. <strong>Sources:</strong> Provincial Government Population Units of DoSD and DoH, Statistics South Africa (Stats SA) and the HSRC for the Provincial Indices of Multiple Deprivation 2001 (for ward-level household poverty and other deprivations, including services and infrastructure). A common definition of ‘poor households’ must be agreed upon and used for programming purposes. This should be the current poverty level used by provincial departments or some other commonly used measure. These definitions vary across departments. For example, the South African National AIDS Council (SANAC) Plan defines poverty as living below $1 per day. Others use households in the lowest 40% or 20% of the population. Provincial DoSD data on numbers of children qualifying for subsidies in registered ECD services may be used to indicate numbers of poor children in such services (see below).</td>
</tr>
<tr>
<td><strong>Children having physical disabilities and incurable diseases.</strong></td>
<td>Data is limited. <strong>Sources:</strong> District Health Information System (DHIS), Social Pensions data from the South African Social Security Agency (SASSA) provides data on the number of disability grants for children &lt;4 years. Neither source will be fully reliable due to limited disability assessments in the public health system, and inability of parents of children with disabilities to apply for or obtain grants. If registered services were to record and provide such data to provincial DoSDs, it could be used to indicate numbers of children with physical disabilities in such services (cases outside such services would not be captured) (see below).</td>
</tr>
<tr>
<td><strong>Children affected and infected by HIV and AIDS.</strong></td>
<td>Sources: 1. For children and carers who are HIV positive: DHIS, DoH Demographic and Health Surveys. 2. Data proposed for collection by the DoH in terms of the SANAC National Strategic Plan (NSP) 2007-2011: ▪ HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission (DHIS). ▪ Infants born to HIV-infected mothers who are infected (based on programme coverage treatment protocols and efficacy studies). ▪ Adults and children &lt;5 with HIV known to be on treatment (DHIS). ▪ Infants in national prevention of mother-to-child transmission (PMTCT) programme receiving Polymerase Chain Reaction (PCR) (proposed for DHIS). ▪ HIV+ pregnant women initiated on ART (proposed for DHIS). ▪ Adults and children with advanced HIV infection receiving ART (based on cohort surveillance and M&amp;E data captured in terms of the Comprehensive HIV and AIDS Plan). ▪ HIV+ adults and children on ART receiving supplement meals and micronutrient supplements (based on M&amp;E data). 3. The National Strategic Plan for Orphans and Other Children made vulnerable by HIV and AIDS proposes the collection of a number of the above data items. In addition, the Plan notes the need to collect data on the following which all affect the young child: ▪ Food security systems for orphans and vulnerable children (OVC) and their families; ▪ Succession planning into intervention programmes for OVC; ▪ Mechanisms to provide psychosocial support to OVC and their families;</td>
</tr>
</tbody>
</table>
Scaling up Early Childhood Development (ECD) (0-4 Years) in South Africa

- Mechanisms for early identification of OVC; and
- Mechanisms to co-ordinate services to OVC and their families at local level.

**Notes:** Government administrative data on the above is not routinely available. For registered ECD services, the provincial DoSD could report information on children affected by HIV and AIDS attending services if they recorded this information (cases outside such services would not be captured) (see below).

**Children living in homes headed by other children**

- The Census and Community Survey Data can be used to provide estimates at provincial and national level.
- For registered ECD services, the provincial DoSD could report information on these children attending services if they recorded this information (cases outside such services would not be captured) (see below).

**Children living in ‘dysfunctional’ families.**

- Government administrative data is not readily available and would have to be constructed from several sources.
- The term ‘dysfunctional’ families should be defined for NIP purposes and draw on the National Family Policy (2006) which defines a vulnerable family as one that is:
  - “socially isolated, subjected to the least empowering circumstances, who is without support systems and/or adult supervision, not linked to resources, does not function due to various challenges and who exposes their family members to circumstances that are detrimental to their development”.

- Vulnerable families may include families living in poverty who tend to be socially excluded and vulnerable in a number of ways. Poverty conditions may be associated with and be exacerbated by particular forms of households:
  - Those with young single parents (including pregnant teenagers);
  - Skip-generation or elder-headed households;
  - Child-headed households; and
  - Crowded households.
- Other examples include families in which a member is:
  - Chronically ill or disabled through HIV/AIDS or for other reasons;
  - Subject to violence and maltreatment, is a crime victim, is involved in drugs or crime, or has a serious mental or physical disability.

- A system of indicators has been developed for the Western Cape (Ward, Dawes, Willenberg, Gwete & Latief, 2007) for this purpose which draws on administrative and survey data.

**Orphans.**

- Stats SA Census and Community Survey Data can be used to provide estimates at provincial and national level.
- For registered ECD services, the provincial DoSD could report information on orphans attending services if they recorded this information (cases outside such services would not be captured) (see below).
### Table 2 – Government department administrative data sources for monitoring elements of the NIP for ECD 0-4

<table>
<thead>
<tr>
<th>NIP Phase 1: Delivery of Primary Services and Phase 2: Extension of Primary Services</th>
<th>NIP Phase 3: Mother-Child Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal registration of births.</strong></td>
<td><strong>Home visiting programmes and workshops on early care and development, stimulation ‘starter’ kits and appropriate referral.</strong></td>
</tr>
<tr>
<td>Data available: Stats SA and Department of Home Affairs (DoHA).</td>
<td>No sources of government data. Proposals are included in the Draft ECD monitoring system under review by DoSD.</td>
</tr>
<tr>
<td><strong>Comprehensive Primary Health Care Package indicates the range of services that should be delivered at primary health care level to pregnant women and children under 5 years.</strong></td>
<td><strong>Development and implementation of psychosocial programmes.</strong></td>
</tr>
<tr>
<td>Data available: DoH (District Health Information System) Provincial Essential Data Sets. Reports on practitioners trained in IMCI are also available as is information on the utilisation of Primary Health Care services by children under 5 years.</td>
<td>No sources of government data. Proposals are included in the draft ECD monitoring system under review by DoSD.</td>
</tr>
<tr>
<td>The package includes the Integrated Management of Childhood Illnesses (IMCI) (as part of the primary health service to pregnant women and children under 6 years).</td>
<td><strong>Referral services for health and for social security grants.</strong></td>
</tr>
<tr>
<td>Priority indicators in the IMCI include measurement of nutrition practices and status (exclusive breastfeeding under 4 months, breast milk and complimentary feeding for children 6-9 months) and underweight rates for children less than 2 years old.</td>
<td>No sources of government data on actual referral practices. However, Primary Health Clinic Attendance Rates and uptake of social grants can be tracked.</td>
</tr>
<tr>
<td><strong>Immunisation.</strong></td>
<td><strong>Early learning stimulation.</strong></td>
</tr>
<tr>
<td>Data available: DoH (District Health Information System) Provincial Essential Data Sets. Immunisation is also covered in the IMCI (specifically vaccination against measles).</td>
<td>No monitoring systems are in place for monitoring the development of children in the years 0-4. Developmental screening data is also not available. The DoE has the function of assessing school readiness once the child is in Grade 1, and for assessing the Gross Enrolment Ratios in Grade R. Adult Literacy Levels, an indicator of the potential quality of the home learning environment, are collected by provinces in terms of performance measures required by the Public Finance and Management Act (PFMA). A number of the proposed DoE indicators for service delivery could readily be adapted for monitoring ECD services.</td>
</tr>
<tr>
<td><strong>Nutrition.</strong></td>
<td><strong>Development and implementation of psychosocial programmes.</strong></td>
</tr>
<tr>
<td>Data available: DoH (District Health Information System) Provincial Essential Data Sets. Nutritional deficiencies are addressed through the Integrated Nutrition Programme (INP) available to children under 6 years, at-risk pregnant and lactating women and those affected by communicable and chronic diseases of lifestyle (Hendricks, Eley &amp; Bourne, 2006).</td>
<td>No sources of government data. Proposals are included in the draft ECD monitoring system under review by DoSD.</td>
</tr>
</tbody>
</table>
NIP Phase 4: Strengthening the Programmes and Institutional Structures

This phase seeks to ensuring stability and strengthening of programmes and institutional structures. This applies to the Health and Social Development mandates in particular.

For ECD programmes, elements may be central: the quality of formal and informal programmes, including governance, financing, infrastructure, programme delivery and staffing.

Studies reveal that government data is limited (Biersteker et al., 2006). However, certain data is available from information required for facility registration and subsidy purposes. This data should be available at both DoSD district and provincial levels and at municipal level for infrastructure inspections and environmental approval in terms of the relevant legislation and regulations (e.g., information on physical services. square meters/child by age, sanitation services, first aid, TB clearance of staff, fire clearance and zoning approval).

The Guidelines to Early Childhood Development Services (2005) require services to keep up-to-date records on the following:

- Child’s name and birth registration (birth certificate or identity number is required for subsidy purposes); medical record including the Road to Health Card; communicable illness; immunisation, allergies and any other disease; a copy of the child’s birth certificate; child’s home language, name and sex; home address and contact details as well as work address and contact details of parent/family as well that of another responsible person; income of parents or guardians; details on persons responsible for fetching the child; date of enrolment; gross monthly income of father/guardian/mother and joint income (collected for subsidy purposes);
- Daily attendance;
- Staff attendance; and
- Number of dependents for whom the parent/s or guardian/s is/are responsible.

Other information available at the facility includes the following:

- A health clearance certificate from the local authority;
- The facility’s constitution;
- The facility’s food menus; and
- Certificate of registration.

All this data, if collected and reported at district and provincial level, could be used for monitoring aspects of the NIP. However:

Staff qualifications and training data (a key indicator for service quality) is only captured on facility subsidisation forms; and services are not required to provide information about children receiving grants or children with disabilities or any other indication of family vulnerability on their admission forms or on other forms that record child information. If regular visits to services were conducted by welfare planners (as required but not complied with in many instances), data on facility quality assessment would be available from biennial reviews.

The numbers and levels of personnel trained in ECD may be obtained from the relevant Further Education and Training (FET) Colleges, the National Learner Record Database held by the South African Qualifications Authority (SAQA), Sector Education and Training Authorities (SETAs) and tertiary institutions, and from the EPWP learnerships.

For the health sector, the NIP aims to strengthen services to improve child and maternal health in the primary health sector in particular.

Standards for measuring the Comprehensive Primary Health Care Package for pregnant women and those with children 0-4 are available from the DoH. The Department carries out assessments (see above).
### Guidelines for the Implementation of the NIP for ECD (2007)

<table>
<thead>
<tr>
<th>The Guidelines specify items for regular monitoring. Those below are relevant for monitoring the service package of the NIP (they are not yet in place and no government data is available):</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Progress, effectiveness and efficacy of projects/programmes;</td>
</tr>
<tr>
<td>- Budgeting (for ECD); and</td>
</tr>
<tr>
<td>- Approaches to reach households and communities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data is available (using secondary data analysis) for budget inputs for ECD. No further data of the kind envisaged in the NIP Guidelines is readily available for assessing the quality of programme inputs or child and parent/caregiver outcomes (where these have been the target of interventions).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budgeting (for ECD):</strong> Suggested input indicator (based in the DoE) Macro indicator set:</td>
</tr>
<tr>
<td>- Public current expenditure on services to children 0-4 by the DoSD and the DoH.</td>
</tr>
<tr>
<td>- Public current expenditure per child aged 0-4 by the DoSD and the DoH, as a percentage of gross national product (GNP) per capita.</td>
</tr>
</tbody>
</table>
C.3 Training: qualifications, provision and delivery

Introduction

Purpose of the review

Qualifications of teachers/practitioners have been found to be associated with improved child outcomes in many contexts and are often used as a service quality indicator. In South Africa the majority of practitioners lack formal qualifications. Parents and other caregivers also often have low levels of education. Human resource development is therefore one of the supporting components for implementation of the NIP for ECD and the EPWP social sector plan provides for a range of training opportunities to develop the skills and employability for people in the ECD sector.

Given the backlog in terms of practitioner qualifications and plans for the expansion of the ECD system both for Grade R and for 0-4 year-olds, a supply of accessible and appropriate training opportunities at different levels for different ECD jobs is critical. Finding the most effective and efficient delivery strategies for training is an essential requirement for rapid expansion.

Method of investigation

The methods used for this study included a documentary review including key departmental and SAQA documents, local research studies, memoranda and minutes on training provision issues; a survey training providers in the Eastern and Western Cape provinces to which 37 of 41 responded (as a case study of training provision in two different contexts) and key informant interviews with selected national and provincial government officials.

Training commitments in the NIP and EPWP ECD Social Sector Programme

The NIP proposes a range of services to support children’s holistic development delivered at different sites of care. These include home and community services as well as the formal ECD services we know as ECD sites, preschools or crèches. The human resource development component of the NIP, for which the DoE is the lead department, therefore entails the training of teachers and ECD practitioners, parents, caregivers and child development workers (CDWs).

The EPWP focuses on training, job creation and expanding services in ECD, targeting the unemployed and/or underemployed parents and caregivers in all ECD programmes. Components include learnerships at Levels 1, 4 and 5 for practitioners; skills programmes for ECD centre staff who work with children and support staff including cooks, gardeners and administrators, and a programme to train parents as peer educators/playgroup facilitators working outside of formal ECD provision.

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Findings

Qualifications framework

ECD qualifications at Levels 1, 4 and 5 first registered with SAQA in 2002/3 have subsequently been revised to better meet emerging needs in the field including those of the NIP. In addition there are a variety of existing and incoming qualifications including the National Certificate (Vocational) in ECD and community development qualifications with ECD specialisation options, which are well suited for the training needs of the sector including support and community ECD workers. As a result of the ECD standards review the Level 1 ECD qualification will phase out and training providers have expressed concerns about this because of low skill levels of many workers in the sector. The phase-out also has implications for meeting of EPWP Level 1 targets, as roll-out of the programme in several provinces has been very slow.

A recent SAQA study has found that the introduction of qualifications has impacted very positively on the sector both for learners and training providers. The study also noted some challenges in relation to difficulties that many learners have with mathematical literacy components for the qualifications and a serious lack of the articulation between different training providers at the same level or vertically from FET providers to HEIs.

Quality assurance process

In 2007, there were 156 providers accredited to offer ECD qualifications, mostly with the ETDP SETA but some with the Council for Higher Education. While the quality assurance process including provider accreditation, approval of learning programmes and verification of results is seen to be positive in theory, a number of concerns have been raised by training providers who perceive a lack of consistency with which the processes are applied, the administrative and paper work burden and whether the system measures quality at all.

The requirement for all private providers and NGOs offering FET qualifications to register with the DoE as a Private FET institution has been subject to a number of difficulties, and very few ECD NGOs and private providers had yet done so although this is mandatory from January 2008. The Department was in discussion with NGOs through umbrella structures. However, a number of providers appeared either to be unaware of the need to register or not to consider this to be an urgent matter. Should this not be resolved, it could lead to a reduction in the number of training providers eligible to offer full qualifications, including those for the EPWP social sector plan.

The ECD training situation

Learners

In terms of available data on educational levels of practitioners most training needs were at Levels 4 and 5 but there is still a substantial number who, due to fundamentals requirements, may not manage a Level 4. Parents targeted for outreach training may have very low levels of education, which should be taken into account when creating materials and programmes.
Resourcing

Public funding supports a significant amount of ECD training, for example 58% of all current training in the Western and Eastern Cape. The EPWP is the vehicle for the most substantial public support of ECD training and is making a considerable impact. However, even if the targets for the period 2004/5 – 2008/9 are met, there will still be a huge number of workers currently employed in the sector who require training as well as to provide for the expansion signaled in government policy. Much of the present training feeds Grade R classes, either due to specific selection for this need or because practitioners move to Grade R jobs because of the somewhat better salary paid to Grade R teachers. NGOs and Private Providers also offer training with donor funding with negligible fee input. Where providers were fee reliant this tended to exclude disadvantaged learners.

Training providers

There are a number of training providers, including NGOs and increasing numbers of public FET colleges, accredited to offer ECD qualifications and standards but they tend to be concentrated in urban areas and in particular provinces. More Level 1 and 4 is offered than Level 5, though this is a growing need, and there is a serious lack of Degree and Post Graduate opportunities in ECD which is retarding professionalisation of this sector. At this point most training is aimed at ECD centres and there is a lack of providers offering accredited options for other kinds of ECD services. Take-up of training opportunities was affected by the lack of access in some areas and also by poor wages and service conditions, which did not encourage commitment to training.

Training providers face a number of constraints which will affect their capacity to scale up and improve the quality of the training they offer. These include:

- The need for training of trainers at higher levels;
- The need for more assessors and moderators;
- The need to develop capacity for RPL;
- The need for specialist staff who can teach fundamentals, which would enable them to offer full qualifications;
- The need for community development staff to help develop outreach training;
- The need for trainers who can speak local languages;
- Difficulties meeting statutory requirements; and
- The need for funding and infrastructure.

Quality of ECD services

While many practitioners have been trained, this does not necessarily improve service quality, which is often not sustained over time. Poor salaries, service conditions and poorly resourced ECD may well contribute to this situation. Sustainable quality improvements depend also on selection of suitable staff for training and ongoing monitoring and support. Those doing the quality assurance support should be qualified to provide guidance on all aspects of ECD programming. This would require either interdisciplinary training or the formation of some sort of multi-disciplinary
team such as a district support team. Once the DoE curriculum guidelines for birth to four year-olds are implemented, provincial education departments will have a significant role to play in support and monitoring of pre-Grade R services.

Training models

A variety of training delivery models operates. Research suggests that distance education, which seems better suited to learners with higher formal education levels, may with proper support systems be a way of dealing with the lack of accredited Level 5 training providers in many areas. The learnership model faces a number of challenges but is seen to be the best option for upgrading the qualifications of those already working in the sector. With the development of model work sites/centres of excellence in different areas for practical experience it could be even more effective. RPL is still very undeveloped but given tight time frames for public funded learnerships becomes even more important so that training could focus on top up of existing competencies. More research is needed on the effectiveness of different delivery formats including IT based technologies with less reliance on face to face training.

Curricula

The flexibility of registered qualifications and standards in relation to the curriculum used has allowed for a range of curricula for children to be promoted through training. Most of these are play based and child centred, and Western developmental theory predominates. For programmes aimed at training those who will work with parents and community groups in outreach activities, a strengths based, holistic approach with a strong human rights focus is commonly used and the range of content shows responsivity to particular contexts. While providers claim the incorporation of indigenous elements in curricula for children and especially those aimed at parents and other caregivers, not much is known about what this means in practice.

Inferences for scaling up ECD services

On the basis of the literature review and survey of training providers in the Eastern and Western Cape Provinces, we recommend the following:

Public funding for ECD training should be continued and expanded

This should take account of both pre-service training including the NCV ECD specialisations being phased in and other forms of pre-service training as well as in-service training through learnerships and skills programmes.

- At present, much EPWP funded training is addressing backlogs in the sector, which is essential for expanding quality but not sufficient for expanding access to services. Grade R, which offers a better salary package, tends to draw practitioners currently working with pre-Grade R children once trained.
- The focus on training of practitioners in ECD centres only addresses one of the ECD settings identified in the NIP and training opportunities should be extended to practitioners working on community education and outreach programmes
especially the child development worker identified in the ECD Massification Concept Document.

- Leadership and management training is a critical area for development for those servicing the ECD sector including all levels of government, training providers and those delivery services in institutions, communities and to households.

- Public funding for training should include subsidies for RPL to make this a viable training option.

Attention should be given to increase the supply of and access to training provision for different types of ECD practitioners

- Training supply is uneven both geographically and in terms of access to higher levels of qualification starting at Level 5. A supply strategy will have to be developed and possibilities of distance learning, satellite campuses and increased allocations for learnerships and skills programmes in remote and underserviced areas considered.

- Incentives should be offered for learners undertaking degrees and post graduate studies in ECD to increase take up of these opportunities which tend to be undersubscribed when offered.

- Requirements for access to higher education institutions for learners who have completed Levels 4 and 5 need to be addressed urgently, so that vertical progression is enabled and achievements credited.

- Language and literacy levels are a major challenge at all levels of training. Quality assurance of training provision should monitor the availability of bridging programmes, availability of home language instruction where appropriate and ensure that the lower skill categories are able to cope with the training programmes offered.

Information on ECD practitioner education and qualification levels should be collected and regularly updated to facilitate planning and budgeting

This should include:

- The numbers of learners completing different ECD (and related) qualifications annually and the numbers of accredited providers offering them. This should be available from quality assurance bodies such as the ETDP SETA and CHE.

- Information on practitioners working in the sector. The Grade R Annual Survey will provide this information for practitioners working in Grade R classes in public and community (independent) schools. For DoSD data systems the recommendation is that as well as being an item in provincial ECD audits, this information is routinely collected as part of the annual quality assurance and registration processes at district level and aggregated to assist provincial planning.
Overview of Findings

Successful expansion of training opportunities and sustainability of training inputs needs to be located within a comprehensive approach to upgrading the ECD sector

- The take-up of higher-level qualifications and the retention of trained ECD practitioners in the sector are dependent upon sustainable jobs and opportunities for career pathing and progression. It is recommended that government and civil society stakeholders initiate a process to determine minimum salaries for the ECD sector and make recommendations for salaries linked to qualifications and responsibility. In addition DoSD should develop and implement policy on the proportional allocation of the per capita subsidy to salaries, food and other operational costs.

- Training is not on its own sufficient to improve quality service delivery. Very high priority should be given to providing ongoing monitoring and support to ECD services by provincial and local government staff who are conversant with what a quality service for young children entails.

Research is required to inform the development of training curricula and delivery and quality assurance

- Areas in which research is needed include how training for practitioners and parents takes account of indigenous child rearing beliefs and practices; the effectiveness of different training delivery formats including costs, and whether the current system for quality assurance of training provision is valid, reliable and practical.

Inferences for programme innovations or adaptations that might strengthen training environment

- Include a ‘top-up’ component of leadership and management training for staff in supervisory positions for different types of ECD services and evaluate its effects;

- Capacitate local and provincial government staff involved in delivering any of the primary NIP service components about all aspects of the service package so that they are informed enough to be able to provide ongoing support and referrals where necessary;

- Assess whether the training for different categories of workers takes sufficient account of contextual factors and addresses indigenous child rearing beliefs and practices and add these if necessary;

- Undertake an independent quality assessment of the practice of a sample of practitioners deemed competent at different NQF levels by different training providers using the ECD outcomes or other standard measures in order to investigate the consistency and appropriateness of current quality assurance practices.
C.4 South African case studies

Introduction

Purpose

Selected case studies were undertaken to provide an understanding of the issues faced in delivering different kinds of ECD services for 0-4 year-olds from the perspective of on-the-ground service provision. The case studies sought to understand the ways services meet children’s holistic needs; critically examine factors that contribute to effectiveness and barriers to effective functioning and from this to make suggestions to inform the development of demonstration projects.

Method

Three ECD centre services and three home based services were selected all of which worked with poor children, the NIP target group. The centres included:

- An unregistered site operating as a small business from a garage;
- A large established custom-built preschool; and
- A registered and subsidised site (informal structure).

The home programmes aimed at primary caregivers included:

- A home visiting and toy library project operating from a preschool centre. This had stimulation and service linkage aspects;
- A psychosocial support programme offered to mothers at risk of rejecting, abusing their infants; and
- A rehabilitation programme for caregivers of malnourished infants and young children, chosen for its health and nutrition focus.

Service delivery was documented on the basis of observations, interviews with different role-players, scanning of administrative and programme records and evaluation reports where available. Names and identifying details of participating projects and respondents have been excluded so that they would not be prejudiced in any way by their disclosures or the researchers’ findings.

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Findings

**Links to government services**

The case studies showed that there was limited linking between government services at the ECD centres. Among the linkages identified in the case studies were:

- Sound relationships between staff members of the three ECD centres and the local clinic sisters;
- Two of the centres were benefiting from training under the EPWP programme;
- On occasion information from of local government or DoSD was disseminated by their representatives at meetings of the educare forums;
- The principal of the private centre had become familiar with local government and DoSD officials in her four-year struggle to have her facility registered;
- The large custom built preschool though registered and subsidised by both DoSD and the provincial education department for Grade R, had had no visit from either in at least the last four years; and
- None of the centres had any contact with local primary schools.

The home visiting ECD services were very effective at providing linkages between ECD services, local and provincial government. Home visitors were more successful enablers of access to grants and links to a broad range of health, social and education services as well as with a range of complementary NGO services. This reflects their organisations’ clear definition of their role in the community as ‘weavers of children’s and primary caregiver’s safety nets’, and their own regular meetings with well trained and informed supervisors who were able to broaden and deepen their knowledge of relevant services and how to access these.

**Training, sustainability and jobs in the case study projects**

Finances were a struggle for all the case study projects. For centres, even the very efficiently run non-profit preschool, which received all available state subsidies, struggled financially.

Home visiting services were almost entirely dependent on financial support from donor organisations and/or from the DoSD. The psychosocial support home visiting service to at risk mothers had very high training and mentoring costs and had had to close in some areas. Budgets for the other service were very tight and in one project when funding was over three months late the service was closed for a year, and the home visitors in that community had to find alternate employment. To save and sustain these ‘safety-net’ jobs more realistic and longer-term service organisation budgets and larger and more efficiently managed government subsidies were needed.

None of the centres could afford to pay for staff training. **Sponsored and accredited training** (through donor support or the EPWP) had provided centre staff with training opportunities and enhanced their commitment to their work and interest in further professional development.
Scaling up Early Childhood Development (ECD) (0-4 Years) in South Africa

Good working conditions such as supportive and fair management and interested oversight by the principal or service co-ordinators were shown to be as important as salary levels in determining ECD workers’ commitment to and stability in, their jobs.

In the two cases where the well-trained founder-principals of centres tended to be inconsiderate and autocratic, caregivers only lasted for short periods in their jobs.

The large centre who had a principal with good administrative skills and sufficient experience as an ECD caregiver for her to understand and oversee the work of her colleagues was able to offer the most effective programme.

Findings related to NIP programme components

Registration of births and referral services for health and social security grants

Almost all parents who could afford centre based care had ID documents and birth certificates and were able to access child support grants. The principal of the unregistered centre only kept copies of Road to Health cards and was unaware whether children had birth certificates. In the home visiting services, staff played a key role in registration of all births and in assisting families to access available health, social and education services.

Child health

ECD principals and home, family or maternal visitors had good links with the local clinics or maternity facilities. In all cases the ECD workers were keenly aware of the necessity for every child to have up-to-date immunisations which were recorded on Road to Health cards. Children were referred to a health facility when necessary. Home visitors were more involved in addressing treatment of HIV/AIDS in babies and young children.

Nutrition

All the home services promoted breastfeeding and nutrition. Nutrition was an important component of the centre programmes which all provided meals, though budget limitations meant that they could not make up for situations where families could not feed children at home. The specialised nutrition service to underweight infants and their mothers was shown to be particularly successful in respect of infant recovery.

Healthy pregnancy, birth and infancy

The service which supported expectant mothers ‘at risk’ of neglecting or abusing their babies, played a vital role in reducing their sense of isolation and helplessness and helped reluctant, often teenage, mothers to understand, to accept and to ‘care’ for their pregnancies. After the baby was born, the service educated and supported the mothers in how to care for, stimulate and feed (if possible breastfeed) their infants.

The home visiting nutrition service focused on very young children, promoting the use of cheap local food and breastfeeding whenever possible.
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Early learning and stimulation

All home visiting programmes included some parent or caregiver education in how to stimulate early learning but it was a significant focus of the one linked to the ECD centre.

The centre programmes varied. The large preschool had a varied and generally interesting early learning programme for all ages though less so for the babies who received good and warm care with a few activities. In both the privately owned and the informally built centres, caregivers were less experienced, less trained and less motivated than their dominant principals. In these situations there were many sessions of minimally supervised ‘play and observation’ and planned pre-literacy and pre-numeracy learning stimulation was only provided to the Grade Rs.

Development and implementation of psychosocial programmes

Maternal education in their babies’ and children’s emotional and psychosocial development was an element of all three community visiting services. It was a particularly a strong feature of the service for mothers and infants ‘at risk’.

At the preschool most staff members were seen to be effective in interacting warmly with all the children as individuals. In the other ECD centres there was a lack of opportunity for children to play or to learn independently and negative forms of discipline, such as shouting, threatening, withdrawing food and smacking, were used to resolve conflicts and to restore order.
C.5  Governance and budgeting

Purpose and scope

This paper reports a study on the South African government’s governance and budgeting for scaling up ECD 0-4 years with a spotlight on the EPWP component of government’s strategy for scaling up ECD 0-4 years. It addressed the following issues:

- **Policy, governance arrangements and funding streams** including the relationship between the NIP for ECD 0-4 years policy and the EPWP ECD initiative; the responsibilities of key government and non-government role-players in ECD 0-4 years in budgeting for and implementing the EPWP ECD; and government funding streams supporting ECD (0-4 years) and the EPWP ECD initiative.

- **Budget system and process** including the budget system/process governing allocations for ECD 0-4 years and the EPWP ECD initiative; the funding instrument used to transfer funds from the National Revenue Fund (NRF) to provinces and municipalities for use on ECD 0-4 year programmes; key factors affecting size of budget allocations to ECD 0-4 year programmes.

- **Provincial budgets supporting implementation** including the level of provincial DoSD and DoE budgetary support for EPWP ECD; the level and sufficiency of DoSD budgetary support for ECD 0-4 years; the level and sufficiency of the per child subsidy paid to subsidised ECD centres, the proportion of poor children reached and the size of DoSD subsidy budgets.

- **The level and nature of local government funding** for ECD (0-4 years) and the EPWP ECD initiative.

- The primary **implementation challenges** confronting the EPWP ECD initiative and the broader scaling up strategy for ECD 0-4 years.

- The primary **weaknesses in governance arrangements and budgeting** for scaling up ECD 0-4 years.

- **Recommendations** for policy makers and implementers and for demonstration projects.

Method

This included:


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- Budget analysis: Following the division of funding and implementation responsibilities for ECD, this focused on the provincial and local levels of government, with particular emphasis on two case study provinces – Eastern and Western Cape – and two municipalities – City of Cape Town and Buffalo City. Analysis included (i) DoE and DoSD votes in the 2007 Provincial Estimates of Expenditure; (ii) DoPW budget data from Quarterly Reports on implementation of the EPWP; (iii) budget data on the EPWP ECD initiative and ECD more broadly, gathered from the Eastern and Western Cape provincial DoSD and DoE; (iv) data from the nine provincial DoSDs on the level and reach of their ECD centre subsidy; and (v) local government-level budget analysis of the two case study municipalities’ Integrated Development Programmes (IDPs) and 2007 Budget Statements.

- Interviews with key informants from government, including representatives from national and provincial government (Treasury, DoSD, DoE and DoPW), local government, practitioners working in ECD centres and representatives of NGOs involved in capacity development in the sector.

Findings

Policies, governance arrangements, and funding flows

The NIP is an umbrella policy for the ECD 0-4 year sector designed to enhance integration, improve access and quality in service delivery. The EPWP ECD initiative, of the EPWP Social Sector Plan 2004/05-2008/09, falls under, and is part of this broader ECD 0-4 year policy.

The EPWP ECD initiative aims to expand access to ECD services and improve the quality of service delivery whilst developing skills, creating jobs and raising income-earning opportunities. It is focused on scaling up centre-based ECD service delivery provisioning for 0-4 year-olds but also includes training for Grade R. It has two key thrusts:

- **DoSD thrust** – involves increasing the number of registered ECD centres for 0-4s, the number of children receiving the per child subsidy and the value of the per child subsidy (to enhance service delivery quality).

- **DoE thrust** – involves training ECD practitioners, paying stipends whilst in training, developing and disseminating learning materials.

Similar to governance arrangements in other countries, three departments Health, Education and Social Development have the primary responsibility for providing for ECD 0-4 years in South Africa. National government’s responsibility is largely limited to policy and monitoring. Hence its budgets – which are largely to pay for staff to conduct policy and monitoring work – are small. Provincial departments have the overwhelming responsibility for funding and implementation of programmes / service delivery. The most important role played by local government is inspection activities to ensure that facilities servicing children meet minimum health and safety requirements. This is required for registration with DoSD as an ECD service. To be entitled to receive the provincial DoSD’s ECD centre per child subsidy, a centre has to be non-profit and registered and the child has to pass an income means test.
Prior to the introduction of the EPWP ECD initiative, there were two primary government funding streams for ECD (0-4 years):

- **DoH funding** – supporting various primary health programmes and services catering for children age 0-4.

- **DoSD funding** – in this regard two separate streams need to be distinguished, of which the first has traditionally been, and is, the larger: (i) The per child subsidy stream flowing to registered ECD sites for children of parents / caregivers who pass the income means test; and (ii) the service plan stream for not-for-profit organisations (NPOs) to deliver various other programmes, including home- and community-based integrated service provision, capacity-building and awareness-raising programmes.

The **DoE** had responsibility for funding the schooling component of ECD (Grade R to 3) but had no responsibility for funding ECD (0-4 years). Within the EPWP ECD initiative they have an enlarged funding role of financing training of ECD practitioners, payment of stipends to learners, and development and dissemination of teaching and learning materials.

The non-government sector (NPOs and corporate sponsors) has, in the context of government’s limited funding relative to need for services, played a critical role in funding ECD 0-4 years in South Africa. Non-government actors also have a key role to play in the implementation of the EPWP ECD initiative. The EDTP SETA is responsible for managing training, quality assurance and also funds training. Various NGOs provide training and ECD centres play a key role in employing ECD practitioners who have received training and by delivering services to children.

**Budget, process, funding instrument and its implications**

The National Revenue Fund (NRF) is the primary source of funding for ECD programmes, and services, including the EPWP ECD initiative and ECD 0-4 years broadly. After the NRF has been top-sliced (to service debt and cover contingencies) it is divided into equitable shares for the three levels of government. The equitable shares of provincial and local levels are then divided between the 9 provinces and 281 municipalities according to a formula.

A first critical point about the division of revenue and determination of each province’s share is that estimates of the demand / need for ECD 0-4 year services, and implementation capacity in this regard is not factored in, aside from a variable used to reflect different levels of poverty across provinces. A second is that South Africa’s governance and budget system is such that **once the total revenue has been shared across the three levels of government each has discretion over how to divide its slice across the different programmes and services for which it has responsibility.** The only exception is when the conditional grant mechanism is used to fund a programme, service or infrastructure. Then money sourced from the NRF is ‘ring-fenced’ for provincial departments to spend on a particular purpose. The conditional grant mechanism is not favoured by Treasury because experience has proven that it runs the risk of provinces under-spending due to limited implementation capacity.
When the EPWP ECD initiative was conceptualised, the DoE and DoSD advocated for the conditional grant funding mechanism to be used. However, a decision was taken by National Treasury that provinces should fund it out of the provincial equitable share allocation. This means that the programme is budgeted through the normal provincial and municipal budget process, through the budgets of line-function departments.

At the beginning of 2006, and in the presentation of the National Budget for the 2006/07 MTEF budget cycle, National Treasury flagged implementation of the EPWP Social Programme as a key priority. An additional R4.2 billion above baseline\(^9\) was sent through the equitable share to provinces for provinces to implement the EPWP Social Sector programme (HCBC and ECD) over 2006/07, 2007/08 and 2008/09. National Treasury did not reveal (and this information could not be gathered from National Treasury or Provincial Treasury in our research):

- How the R4.2-billion sent through the equitable share was distributed over the three years.
- The proportions of the amounts distributed for each province, in each year that were for the HCBC as opposed to ECD.

Some have argued that because the R4.2-billion of funds were not ring-fenced for the intended purpose, they were diverted to other purposes in many provinces. This study clarified that it is impossible without National and Provincial Treasury data on the amount of revenue actually sent through the equitable share for spending in each province on the EPWP ECD to make any true statements about whether the provincial allocations (social development or/and education department) are more, less or equal to the amounts ‘required’ by the R4.2-billion extra above baseline sent through the equitable share.

### Provincial government budgets

#### Size of budgets for EPWP ECD initiative and ECD 0-4 years

The study highlighted the difficulty of obtaining accurate data on provincial government budget allocations and spending on the EPWP ECD initiative and ECD 0-4 years more broadly. Whilst all nine 2007 Provincial Estimates of Expenditure were reviewed (DoSD and DoE) only the Western Cape and North West included a line item for the EPWP ECD initiative.

Budget allocation data was gathered from the provincial DoSD and DoE in our two case study provinces for the period 2006/07 to 2009/10. Unfortunately, no expenditure data for 2006/07 or 2007/08 was made available. The allocation data revealed that:

- Whilst the Western Cape allocated a smaller amount (R29,426,000) for the programme in 2006/07 than Eastern Cape (R32,982,000) the EPWP ECD initiative has grown more rapidly in the former province and the forecasted budget

\(^9\) Above the amount of money made available the previous year.
The National DoPW database on provincial government budget allocations for the EPWP ECD initiative under-reports the size of actual allocations. For example, for the year 2007/08 the Western Cape allocation is under-reported by R59,522,450 and the Eastern Cape allocation by R12,332,026.

The interviews revealed that spending the Education Department component of the EPWP budget allocation in the Eastern Cape has to date been a major problem. In December 2007 – training under the EPWP ECD programme had not yet begun. Of major concern, interviewees revealed that the current size of the budget being allocated to the two DoSDs for expanding the reach and raising the value of the ECD centre per child subsidy, are insufficient to fulfil this policy objective. Provinces are therefore faced with the challenge of trading off fulfilling the requirement of expanding coverage (the response of Western Cape to date) with increasing its value (the response of Eastern Cape to date). In the Western Cape a proportion of the allocation given to DoSD to fulfil the EPWP ECD objective has been used to train and develop the capacity of young previously unemployed individuals. Officials argue that this use of funds facilitates the EPWP objectives of employment and income generation and capacity building and is worth the trade-off in terms of less funds available for raising the value of the ECD centre subsidy.

The data gathered on the two case study provinces budget allocations for the years 2005/06-2007/08 made to DoSD for ECD 0-4 year spending, illustrates that:

- In each province, for the year 2007/08 the share of the EPWP budget allocation in the total ECD 0-4 year budget allocation is about 35%.
- In each province, for the year 2007/08 the share of ECD 0-4 year budget is less than 1% of the total equitable share allocation of the province. It is 0.28% in Eastern Cape and 0.59% in Western Cape. This reflects a very low level of priority being afforded ECD 0-4 year scaling up in the provincial budget process.

In addition to highlighting the very small size of the Social Development budgets relative to the size needed to fulfil the mandate of expanding the number of registered and funded centres, and improving quality of ECD service delivery at centres, the interviews revealed the problem of insufficient money being allocated (at least in the two case study provinces) to DoSD for funding non-centre programmes and infrastructure.

Level and sufficiency of per child subsidy paid to ECD centres

The study found that there:

- Remains variation across provinces in the value of the subsidy.
- Is insufficient clarity about how the value is informed by the costs of providing a quality service to children age 0-4 in ECD centres.
- Is lack of clarity over what precisely the subsidy is intended to cover and whether it is sufficient to cover costs. In this regard, prior to the EPWP ECD the subsidy was not supposed to contribute to the salary of the ECD practitioner in a site and was not determined informed by the cost of practitioners. However, in practice, in
the face of resource constraints at the centre level (parents of poor children can
afford to pay only very low or no fees) it was used in part to cover practitioner
salaries. The interviews reveal that there has been a policy shift in that the
increased subsidy being driven through the EPWP ECD initiative is intended to be
used in part to cover ECD practitioner salaries, and thereby increase retention of
staff and quality of service delivery in centres.

**Proportions of poor children reached by ECD centre subsidy**

Data on the reach of the ECD centre subsidy (coverage of sites and children) for the
years 2006/07 and 2007/08 reflects differential performance across provinces in
increasing coverage of children between these two years. Estimation of the percentage
of poor children covered by the latter quarter of 2008 reveals starkly the need for
more rapid progress in expanding access to the subsidy. Only 10% of poor children
were, by the end of 2007, covered by the subsidy. Coverage varied substantially across
provinces with Eastern Cape having the poorest coverage (3%) followed by North
West (4.7%) and Western Cape the best (23.7%).

**Social Development Department ECD centre subsidy budgets**

ECD centre subsidy budgets for the year 2007/08 were estimated based on the data
provided by the nine provincial DoSDs on the number of children being subsidised
and the value of the subsidy in 2007/08. The assumption that the subsidy was paid
264 days per year was made. The most important finding that needs to be flagged
from this analysis is that in Western Cape, in 2007/08, the subsidy budget of
R88,416,900 comprised 97% of the total ECD budget for 2007/08. This reflects the
problem of centre-based programming crowding out other ECD expenditure.

**Local government budgets**

Neither of the Integrated Development Plans (IDPs) and Budgets for 2007/08 of the
City of Cape Town and Buffalo City mentioned any activities, plans and budgets for
scaling up ECD or the EPWP ECD initiative. Interviews with representatives of the
two municipalities confirmed that their role in funding delivery of ECD 0-4 year
services is minimal, including funding infrastructure development, which is regarded
by some in the sector to be an area where local government should be playing a larger
role.

**Stakeholder views on implementation challenges**

Key informants were asked their views on the primary challenges containing roll out
of the EPWP ECD initiative and broader vision for scaling up ECD 0-4 years in the
NIP.

The implementation challenges highlighted by government officials were similar
across the Eastern and Western Cape. They were:

- Insufficient human resource capacity at the provincial government level relative to
  the demands of policy;
The poor state of infrastructural, programme and human capacity in the majority of unregistered ECD centres in poorly resourced communities relative to requirements for registration;

Insufficient prioritisation of ECD 0-4 years in the budget process at provincial and local government levels;

The rapid increase in the value of the ECD centre subsidy to be paid by social development departments relative to funds made available to social development departments for spending on ECD;

Insufficient involvement by the DoH in planning for implementation of the NIP and with respect to the EPWP ECD initiative, insufficient involvement of local government;

Conflict between the goals of ECD policy and the profit-seeking motive driving some ECD service delivery agencies; and

Insufficient clarity around which government department is leading the ECD scaling up initiative and linked to this, insufficient accountability structures.

The challenges identified by principals and practitioners in ECD centres were:

Insufficient funding, in particular for ECD practitioner salaries (which undermines quality and staff retention);

Inadequate skills of some ECD practitioners;

Inefficiencies in the process for registering an ECD centre with the provincial DoSD; and

Obstacles to receiving the per child ECD centre subsidy once registered and uncertainty about payment levels and regularity of the funding flow.

In expressing their opinions on the key challenges, representatives from capacitated NGOs working in the ECD sector flagged another critical constraint. This constraint, which lies at the heart of the NIP strategy, was disjointed service delivery by different government role players.

Concerns and associated recommendations

General

Funding responsibilities are not comprehensively defined and budgeted for. In particular, ECD practitioner needs and infrastructure needs are not fully costed or budgeted for. The study revealed the urgent need for a comprehensive costing of quality service delivery in ECD centres and of non-centre-based programmes, which includes the cost of quality practitioners. The recommendation is that the critical items in the ECD input package should be fully costed and adequate funding streams for them be should be developed. In addition, policy governing use of the ECD centre subsidy needs to be clarified and benchmarked against the cost of items it is meant to cover.

The DoSD has recently taken over the leadership responsibility in the implementation of the scaling up vision for ECD 0-4 years from the DoE. However, the delegation of responsibility to lead the ECD scaling up initiative is
Overview of Findings

not sufficiently clear and in practice it is not clear that this department is fulfilling this responsibility. The recommendation is that government clarify where leadership and associated accountability for non-delivery rests and ensure that adequate human resources are employed in the department to allow it fulfil its responsibility.

- Insufficient human capacity, in both government departments and in ECD centres undermines effective implementation of the vision. This constraint includes insufficient staff in provincial DoSD relative to the need to monitor and register ECD centres, inadequate capacity to deal with tender management in provincial DoEs and insufficient financial management expertise in ECD centres. The recommendation is that more resources be applied to building this necessary capacity.

- The equitable share funding mechanism leaves the door open for funds sent through the equitable share to provinces to be spent on the scaling up of ECD 0-4 years to be diverted to other purposes during the provincial government budget process. The recommendation is that the funding mechanism be changed to a conditional grant.

- The level of DoSD subsidies paid to ECD centres varies across provinces. This is at odds with the right to non-discrimination in the Constitution. The recommendation is that immediate action be taken to eliminate this inequality.

- The means test used to allocate government’s funding to ECD centres through the ECD centre subsidy, is insufficiently understood by staff, and difficult to implement. It also has three design problems: the value of the means test threshold has not been adjusted since 1994; the test is different from that used in targeting the Child Support Grant; the test is different in at least one province (Free State). The recommendation is that the means test be reviewed.

- There are insufficient norms and standards to direct funding to the DoSD led non-centre based ECD programmes for children age 0-4 years. This is a major concern because many children at risk will never (and should never) be serviced at centres and the budget analysis conducted for this study revealed that there is very little funding for non centre based programmes. The recommendation is that norms and standards for non-centre programmes are developed and an adequate flow of funding to implement the vision of scaling up non-centre programmes, set out in the NIP, be developed.

- The DoH does not as yet interact sufficiently with the DoE and DoSD in ECD 0-4 year planning and implementation despite its significant role in providing services and programmes to very young children. The local government role player is also as yet not sufficiently engaged in the process of scaling up ECD 0-4 years. The recommendation is that the local government’s role in ECD scaling up – particularly in relation to infrastructure development – be clarified, and that action is taken to enhance the contribution of this player as well as the DOH.

- There is insufficient integration between different government departments in delivery of services and programmes to children age 0-4 years. This if of course well known and the reason why the NIP has been developed. The recommendation is that resources be allocated to fast track the implementation of the NIP.
The system for reporting and recording budget allocations and spending in government does not allow tracking of allocations and spending on ECD 0-4 years or on the EPWP ECD scaling up initiative by the DoSD and DoE. The recommendation is that it be adjusted to allow such tracking.

Provincial DoSD budget allocations to support the EPWP ECD initiative are too small. This reflects insufficient prioritisation of ECD 0-4 years in the provincial government budget process. The recommendation is that government develops a programme of action to raise the level of priority give to DoSD budgets for ECD 0-4 years (ECD centre subsidy and out of centre programme budgets) and civil society becomes more active in monitoring progress in this regard.

**Implications for future investigations on budgeting and governance**

1. The inputs required to achieve minimum quality ECD services need to be clarified (delivered at centre, home or community level);

2. The cost of the package of inputs identified as vital for delivery of the minimum quality programmes needs to be fully costed. It is suggested that this costing be done on a per child basis and in a way that separates out the cost of different inputs. It also needs to include the cost of infrastructure, and associated investments and depreciation;

3. More exploration is needed about the respective roles of Government versus NGO funding in supporting the delivery of the integrated package of ECD services in home, centre and community based programmes. This includes thinking about which government departments should fund what elements of the package or the whole package through what instrument (s);

4. More investigations are needed in respect of the means test criteria for targeting government funding streams for ECD (0-4 year) programmes, as well as on how to implement the criteria cost effectively.
C.6 Child and caregiver outcome indicators

Purpose

The purpose of this paper was to recommend a minimum set of health and psychosocial outcome indicators and measures for children, caregivers and households to be used for monitoring and in demonstration projects. It complements paper 2.1, which reviews government indicator systems. Two indicator sets are provided:

1. A Core Set based on readily available data and which should be regularly monitored by government;
2. An Additional Set that could be used to assess the impacts of interventions in terms of the NIP (including demonstration projects).

Not all would be suitable for all programmes. The final list will depend on programme design and inputs.

The paper is based on a review of peer, grey and South African policy literature from 1990 to the present pertaining to:

- Indicators and measures for ECD outcomes in appropriate domains.
- Studies designed to improve these outcomes were also sourced including those conducted by the authors.
- Material on measures of the home environment and caregiver outcomes that have been studied in research designed to improve the home environment caregiver wellbeing and behaviour in domains known to be associated with positive and negative developmental outcomes for young children.

A rationale for the selected indicators linked to the package of services provided in the NIP for ECD is provided, and is based on the child development programme and policy literature

Findings

It is important to appreciate the sensitive, rapid and uneven nature of early development. This presents a challenge for the design of measures for early psychosocial development in particular.

The powerful influence of culture and socio-economic contexts on child rearing practices and approaches to early learning and stimulation also play important role in early child outcomes, as does the capacity of the caregiver to provide the support for

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the child’s development. Where health and psychological wellbeing are compromised, this may impact negatively on child outcomes.

Positive early environments that ensure good nutrition, health and protection together with attention to psychosocial development, have huge potential for enhanced child wellbeing and long-term development. Indeed studies in both the minority and majority regions of the world show that early investments are likely to have a significant impact on social development as well.

Insults to child health, particularly malnutrition and HIV and AIDS have a significant impact on aspects of psychological development, compromising the child’s ability to capitalise on the opportunities provided by schooling.

However, many of conditions that threaten child development are preventable. For example, Many studies have demonstrated the critical role that nutritional and micronutrient supports can play both during pregnancy for nutritionally compromised women) and in the first few years, to prevent long term brain damage and impaired cognition. Appropriate administration of PMTCT significantly reduces vertical transmission of HIV.

Deep long-term poverty is a major distal cause of these problems. It exercises its impact indirectly, mediated by members of the family who are responsible for the child. In addition to compromising health and nutrition, household poverty impacts negatively on the psychosocial development of children, in particular cognitive, intellectual, language and socio-emotional domains. All are deeply affected by the quality of care and stimulation in the home and in poverty contexts; in spite of the best efforts of families, childcare is often compromised due to the many strains of living with little money, food and opportunity, often in a context of illness and all too frequent death.

The home environment may therefore present significant risks to the developing child. Apart for under-nutrition and injury (for example due to paraffin stove burns or violence), a less obvious threat is the impact of poverty and illness on caregiver mental health, depression in particular.

A number of other risk factors in the family impact negatively on child psychological outcomes: low caregiver literacy and occupational levels; single parent status; a high care dependency burden (more than four children to care four); social isolation; high levels of stress in the home; rigid parental perspectives on child rearing; low levels of affection to the young child; and low levels of stimulation and play.

Evidence from longitudinal studies shows that it is it is not single risk factors that are the major threat to sound development (although of course there are exceptions). Rather, the more risk factors present in a child’s early family life, the greater the probability of poor outcomes in areas that are associated with intellectual and socio-emotional development.
Inferences for improving quality and scaling up ECD (0-4), and for monitoring and evaluating interventions

The caregiver and household outcomes listed in Tables 1 and 2 take these points into account. They are informed by the NIP for ECD, as well as the Millennium Development Goals (MDGs) and the Education for All goals, as these are international commitments. A section on child safety has been added because the importance of reducing morbidity and mortality due to accidents – many of which occur in the home. In addition a section on child maltreatment has been included given the extent of the problem in this country.

The set of indicators is limited rather than fully comprehensive due to a wish to focus on core issues to be measured as well as the probability of measures being available.

The set of indicators selected for possible use in a Phase 2 demonstration project is not final, as this must await decisions as to demonstration project design. It is not appropriate to finalise measures for a demonstration project prior to these matters being settled.

Tables 3 and 5 include core indicators that should be collected regularly and which are based on data that is likely to be readily available. Some may be appropriate for demonstration project purposes.

Tables 4 and 6 present additional indicators for which data is not readily available, but which could be obtained from information gathered in demonstration projects or special interventions (depending on the programme inputs and desired outcomes).

Finally, for special interventions, consideration should be given to the development of a composite child development risk indicator. This would be based on both local and international research studies that point to key environmental risk variables for early development. Similar indices are used elsewhere.
### Table 3 – Core household and caregiver outcomes

<table>
<thead>
<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
<th>Definition, measure, period and data source</th>
</tr>
</thead>
</table>
| The NIP targets children in poverty and seeks to address the impact of vulnerabilities caused by poverty. | **Indicator:** Living Environment Deprivation for children < 5 years  
**Reason for use:** This indicator can be used for targeting purposes. Can also be used to assess the impact of service delivery. | **Definition & Measure:** Proportion of children living in households without:  
- Piped potable water inside the dwelling or in the yard or within 200 metres of the dwelling;  
- Adequate sanitation (pit latrine with ventilation);  
- Access to electricity (clean power) in the dwelling; and  
- Adequate housing (living in a shack – excluded traditional dwellings).  
**Source:** Stats SA Census and Household Surveys (or Demonstration Project Data). |
| The NIP targets children in poverty and seeks to address the impact of vulnerabilities caused by poverty. | **Indicator:** Children < 5 living in Workless Households  
**Reason for use:** This indicator can be used for targeting purposes. Can also be used to assess the impact of EPWP. | **Definition & Measure:** Proportion of children living in households where no adults aged 16 or over are in employment.  
**Source:** Stats SA Census and Household Surveys (or Demonstration Project Data). |
| The NIP targets children in poverty and seeks to address the impact of vulnerabilities caused by poverty. | **Indicator:** Under 5 Child Poverty Rate  
**Reason for use:** This indicator can be used for targeting purposes. Can also be used to assess the impact of EPWP. | **Definition & Measure:** Proportion of children living in households that have a household income (need-adjusted using the modified OECD equivalence scale) that is below 40% of the mean equivalent household income, or children living in households with <R1,200 per month income (or other measure agreed by government).  
**Source:** Stats SA Census and Household Surveys (or Demonstration Project Data). |
| The NIP aims to improve access to social grants. | **Indicator:** Social Grant Uptake  
**Reason for use:** This indicator can be used for monitoring integration of services and grant access. | **Definition & Measure:** Proportion of eligible children under 5 years who have the relevant grant. Grants include the CSG, Care Dependency Grant, Foster Care Grant and food parcels.  
**Source:** SASSA or Demonstration Project Data. |
| Improvement of adult literacy levels could be linked to the EPWP and the NIP. The desired outcome would be improved literacy, which would support the child’s learning of language and literacy. | **Indicator:** Caregiver Literacy Level  
**Reason for use:** Caregiver literacy is associated with child cognitive outcomes and school readiness. This indicator can be used for targeting carers for programmes such as ABET. | **Definition & Measure:** Proportion of carers with children < 5 years who have passed grade 8 / ABET Level 4 certificate (or ABET Level 4 assessment).  
**Source:** Stats SA Surveys. |
Table 4 – Additional indicators for household and caregiver outcomes

<table>
<thead>
<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
<th>Definition, measure, period and data source</th>
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</thead>
</table>
| The NIP seeks to improve the nutritional status of children and improve household food security. | **Indicator:** Household Food Security  
**Reason for use:** This indicator can be used for monitoring impacts of programmes to improve household food security. | **Definition & Measure:** Proportion for children <5 years living in food insecure households using the NFCS measure (score of 5 or more).  
**Source:** Demonstration Project Data. |
| The NIP seeks to improve the nutritional status of children and improve household food security. | **Indicator:** Households that have Food Gardens  
**Reason for use:** This indicator can be used for monitoring impacts of programmes to improve household food security through food garden projects. | **Definition & Measure:** Proportion for children <5 years living in poor households (as defined above) that have food gardens  
**Source:** Demonstration Project Data. |
| The NIP seeks to target vulnerable families and to provide support to adults who care for young children. Carers with mental disabilities or high levels of emotional distress require support. | **Indicator:** Caregiver Mental Health Status  
**Reason for use:** This indicator can be used for monitoring impacts of programmes designed to improve carer well-being through provision of support and access to professional care if need be. | **Definition & Measure:**  
1: Proportion of adults with children < 5 years who have a mental illness that is incapacitating (is eligible for disability grant).  
2: Proportion of adults with children < 5 years who score in the clinical range of an appropriate measure of Depression (e.g. CES-D) and or Anxiety (e.g. Spielberger).  
**Source:** Demonstration Project Data. |
| The NIP seeks to target vulnerable families (affected by HIV) and to provide support to adults who care for young children. | **Indicator:** Caregivers Living with AIDS  
**Reason for use:** This indicator can be used for targeting of services to caregivers who have AIDS. | **Definition & Measure:** Proportion of adults with children < 5 years who have been diagnosed as having AIDS (have symptomatic infection) (based on clinic data?).  
**Source:** Demonstration Project Data. |
| The NIP seeks to target vulnerable families (affected by HIV). | **Indicator:** Caregivers Living with AIDS on HAART  
**Reason for use:** This indicator can be used for monitoring impacts of programmes designed to improve access to the necessary medication in carers with young children. | **Definition & Measure:** Number of adults with children < 5 years on HAART per 100 adults eligible for HAART (based on clinic data?)  
**Source:** Demonstration Project Data. |
| The NIP seeks to strengthen the capacity of families to protect and care for children. | **Indicator:** Comfort  
**Reason for use:** The indicator estimates whether the key basic personal needs for children are being met. The items include conditions that threaten health to those that cause sleep disturbances and other discomforts which interfere with daily life. | **Definition:** Suggested items for comfort are availability of a blanket, shoes and two sets of clothes.  
**Measure:** Proportion of children who have a blanket, shoes and two sets of clothes.  
**Source:** Demonstration Project Data. |
| NIP targets expectant and nursing mothers and seeks to improve preventive services to pregnant women and women with children under age 5 via the Comprehensive Primary Health Care | **Indicator:** Pregnant and Lactating Mothers are adequately nourished and do not use alcohol or tobacco  
**Reason for use:** Both are risks for child development, particularly in utero (e.g. risk of FAS). This indicator can be used for monitoring impacts of prevention programmes in antenatal services. | **Definition & Measure:**  
1. Proportion of eligible pregnant women who receive nutrition supplements.  
2. Proportion of eligible lactating mothers who receive nutrition supplements.  
3. Proportion of pregnant women attending a public health clinic who are:  
**Source:** Demonstration Project Data. |
<table>
<thead>
<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
<th>Definition, measure, period and data source</th>
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</table>
| **Package**                  |                             | a) aware of the risks of alcohol and tobacco consumption in pregnancy; and  
b) do not consume alcohol or smoke (confirmed by other household members) / or alternative standard measure.  
**Source:** Demonstration Project Data. |
| The NIP seeks to target vulnerable families. These could include elders and carers with disabilities. | **Indicator:** Caregiver Health status  
**Reason for use:** This indicator can be used for targeting of services to vulnerable carers. | **Definition & Measure:** Proportion of adults with children < 5 years who are over 65 years of age, disabled, has an illness that is incapacitating (has or is eligible for a pension or grant).  
**Source:** Demonstration Project Data. |
| NIP parenting programmes seek to improve parenting skills and childcare with the objective of positive psychosocial outcomes for the child. | **Indicator:** Caregiver Behaviour to Child 1: Acceptance  
**Reason for use:** An accepting approach to the child is associated with positive psychosocial outcomes. This indicator can be used for monitoring impacts of parenting programmes. | **Definition & Measure:** Proportion of carers who show Acceptance as assessed on the HOME  
**Source:** Demonstration Project Data. |
| NIP parenting programmes seek to improve parenting skills and childcare with the objective of positive psychosocial outcomes for the child. | **Indicator:** Caregiver Behaviour to Child 2: Responsiveness  
**Reason for use:** Responsiveness encourages the child to approach the carer for information and is associated with good early learning outcomes. This indicator can be used for monitoring impacts of parenting programmes. | **Definition & Measure:** Proportion of carers who show Responsiveness as assessed on the HOME  
**Source:** Demonstration Project Data. |
| NIP parenting programmes seek to improve parenting skills and childcare with the objective of positive psychosocial outcomes for the child. | **Indicator:** Child Stimulation  
**Reason for use:** This indicator can be used for monitoring impacts of parenting and early stimulation programmes. | **Definition & Measure:** Proportion of carers who show age-appropriate behaviour; homes with the necessary materials and resources:  
Measured by Carer Activities with the child: MICS Early Childhood Stimulation Index (MICS-ECSI)  
Equipment for Stimulation and Learning (MICS-ESL) (available stimulation materials: books, play, environment etc).  
**Source:** Demonstration Project Data. |
| NIP parenting programmes seek to improve parenting skills and childcare with the objective of positive psychosocial outcomes for the child. | **Indicator:** Caregiver Parenting Behaviour (including discipline)  
**Reason for use:** This indicator can be used for monitoring impacts of parenting programmes. | **Definition & Measure:** Proportion of carers (and practitioners) who:  
1. Have knowledge of age-appropriate positive discipline practices;  
2. Use age-appropriate positive discipline practices;  
3. Do not support the use of physical punishment in the home with children <5 years; and  
4. Do not report the use of physical punishment in the home with children <5 years (use of
### Overview of Findings

**Policy goal / desired outcome** | **Indicator and reason for use** | **Definition, measure, period and data source**
--- | --- | ---
Parent education in the NIP can contribute to child safety in the home. | **Indicator:** Child Safety Practices at Home  
**Reason for use:** This indicator can be used for monitoring impacts of parenting and home safety initiatives. | objects such as a stick/belt indicates risk for abuse and injury).  
**Source:** Demonstration Project Data.  
**Definition & Measure:** Proportion of carers who take precautions to protect child from traffic, household injuries (poisoning, drowning and burns) and violence and abuse.  
**Source:** Demonstration Project Data.

Parent education in the NIP can draw on the Key Family Practices of the IMCI to improve child survival and wellbeing and also to promote links to health services. | **Indicator:** Caregiver Knowledge of the 16 UNICEF-WHO IMCI Key Family Practices  
**Reason for use:** This indicator can be used for monitoring impacts of training programmes. | **Definition & Measure:** Proportion of caregivers familiar with how to prevent illness and the danger signs which indicate that child must be referred (Key Family Practices of the IMCI)  
**Source:** Demonstration Project Data.

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**Table 5 – Core indicators for child health outcomes**

<table>
<thead>
<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
<th>Definition, measure, period and data source</th>
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</thead>
</table>
| Expectant and nursing mothers are key NIP targets for services. Improve antenatal care and neonatal services. Reduce the number of stillbirths and early neonatal deaths. | **Indicator:** Perinatal Mortality Rate  
**Reasons for use:** Measure of antenatal care as well as neonatal services. | **Definition:** Number of perinatal deaths within 28 days per 1,000 live births in a given year. Sum of stillbirths.  
**Measure:** The sum of stillbirths (≥28 weeks gestation or 1,000g or more) + early neonatal deaths (≤7 days of age) per 1,000 live births + stillbirths in same calendar year.  
**Note:** Current WHO definition of perinatal mortality rate is different from the definition used in South Africa, being the number of deaths from 24 weeks gestation/500g to 28 days neonatal life.  
**Sources:** StatsSA, SADHS, DHIS, hospital data, PPIP and Maternal Registry. Presently available at national and provincial level only.  
**Period:** Annual. |

The NIP seeks to improve access to basic health services in vulnerable communities. Reduce the number of infants dying in the first year of life. | **Indicator:** Infant mortality rate (IMR)  
**Reason for use:** IMR is a basic indicator of well-being and service access. Proxy measure of determinants of survival: socio-economic level and health service access and quality. Determinants of infant mortality include access to safe water, sanitation, nutrition and maternal education level. Determining factors within the health system include the quality of maternal care, availability of vaccines in the first year of life and effective referral systems. | **Definition & Measure:** Number of deaths between birth and exactly 1 year of age per 1,000 live births in same calendar period. Disaggregated by male and female.  
**Sources:** Provincial and national DoH, SADHS,Stats SA and Maternity Registry.  
**Period:** Annual. |
<table>
<thead>
<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
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</table>
| The NIP seeks to improve access to basic health services in vulnerable communities. Reduce the number of children dying in the first 5 years of life. | Indicator: Under 5 mortality rate (U5MR)  
Reason for use: Basic indicator of well-being and service access. Appropriate for national and international reporting: Unicef State of the World’s Children, MDGs, Unicef Multiple Indicator Cluster Survey (MICS) and CRC. | Definition: The U5MR is the probability of children dying between birth and their 5th birthday, expressed per 1,000 children born alive.  
Measure: Number of deaths between birth and exactly 5 years of age per 1,000 live births in same period. Disaggregated by male and female.  
Sources: Provincial and national DoH, SADHS, and Stats SA.  
Period: Annual.  
Definition & Measures: Fully immunised children are defined at first visit where all required vaccinations are completed. The primary course of immunisation includes BCG, OPV1, 2 & 3 and DTP-Hib. The denominator is the expected doses (based on mid-year estimates of number of children <12 months and number of required doses for each vaccine) in the same period. Immunisation rate is expressed as children aged 0-12 months inclusive having completed primary courses of immunisation per 100 expected doses (in children <1 year) in the same period. The proportion of children 0-12 months inclusive who are fully immunised divided by the population <1 year in each province.  
Source: DHIS.  
Period: Monthly, annually. |
| The NIP seeks to improve access to services for vulnerable groups. Monitor the prevalence of childhood disability in children <5 years. Plan for disability services to young children. | Indicator: Age-specific prevalence rate of children with 1 or more activity limitations  
Reason for use: To identify the group of children who require services over and above those required by non-disabled children. | Definition: Children <5 years with a health condition and related impairments, together with activity limitations in one or more domains of functioning.  
Measure: Proportion of children <5 years with a health condition and related impairments, together with activity limitations in one or more domains of functioning.  
Sources: Census, SADHS and DHIS (if a disability demographic variable is included in the survey).  
Period: Every 5 years. |
| The NIP seeks to improve access to services for vulnerable groups. | Indicator: Children <2 years with moderate and severe disabilities  
Reason for use: Early identification of children with developmental disabilities for early intervention. | Definition: Children <2 years screened for developmental disability at 6 weeks, 9 months and 18 months in the provincial primary healthcare system. |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Identify children with moderate to severe disabilities for early intervention.</td>
<td>Important for CRC reporting. To identify children in ECD services to be monitored for follow-up action.</td>
<td>Measure: Proportion of children attending health facilities who test positive using provincial DoH developmental screening tools. Sources: DHIS and facility/ECD service level data – captured on admission forms and from Road to Health Card. Note: There are currently no provincial databases of children identified as disabled on screening. These should be established to provide routine administrative data. Period: Annual when provincial level data are available, otherwise audit every 5 years.</td>
</tr>
<tr>
<td>The NIP seeks to improve access to nutrition in vulnerable groups. Reduce the prevalence of wasting among children &lt;5 years.</td>
<td><strong>Indicator</strong>: Underweight rate <strong>Reason for use</strong>: Measure of the nutritional status of young children. Indicator associated with vulnerability to poor developmental outcomes. Appropriate for national and international reporting State of the World’s Children, Unicef MICS and CRC. To identify children in ECD services to be monitored for follow-up action.</td>
<td><strong>Definition &amp; Measure</strong>: Proportion of children under 5 years with WFA Z &gt; – 2SD below median weight for age reference value per reporting year in a specific area (e.g. province) in a defined population of &lt;5s per 100 children under the age of 5 years in that population in the same period (disaggregated by male and female). Source: Provincial and national DoH, SADHS, and National Food Consumption Survey (NFCS). Period: Every 5 years if data available.</td>
</tr>
<tr>
<td>The NIP seeks to improve access to nutrition in vulnerable groups. Reduce the prevalence of stunting among children &lt;5 years.</td>
<td><strong>Indicator</strong>: Stunting rate <strong>Reas reasons for use</strong>: Measure of nutritional status of children. May indicate economic hardship, infection or neglect. To identify children in ECD services to be monitored for follow-up action. Appropriate for national and international reporting State of the World's Children, CRC, Unicef MICS and MDGs.</td>
<td><strong>Definition &amp; Measure</strong>: Proportion of children &lt;5 years with more than 2 standard deviations below the median weight for height reference value in a defined population of &lt;5s in a given period (WFH Z). Source: Provincial and national DoH, SADHS, and NFCS. Period: Every 5 years if data are available.</td>
</tr>
<tr>
<td>The NIP seeks to improve access to nutrition and food security in vulnerable groups. Ensure survival and development of young children. Reduce household food insufficiency and child hunger.</td>
<td><strong>Indicator</strong>: Child hunger, household food insecurity (insecure and at risk) <strong>Reason for use</strong>: Under-nutrition and hunger affect attention and concentration and have a major bearing on growth and cognitive development, especially for &lt;5s.</td>
<td><strong>Definitions</strong>: Household food insecurity: experience hunger: A score of 5 or more on the Hunger Scale Questionnaire of the NFCS. At risk for hunger: A score of 1 to 4 is an at-risk household. Child hunger in the last 30 days: an affirmative response to any child question on the NFCS Hunger Scale (as used in the NFCS). <strong>Measures</strong>: Proportions of children &lt;5 years in food insecure households and at-risk households; proportion households with children &lt;5 years in which children were reported to have experienced hunger in the last 30 days. Source: NFCS (national DoH). Period: Every 5 years if possible.</td>
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</table>
### Scaling up Early Childhood Development (ECD) (0-4 Years) in South Africa

<table>
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<tr>
<th>Policy goal / desired outcome</th>
<th>Indicator and reason for use</th>
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</table>
| A NIP goal is to promote the registration of births. Ensure the right to a name, nationality, and access to social security for young children. | **Indicator:** Birth registrations in children <5 years.  
**Reason for use:** Registrations are essential for access to social security and other services. | Note: Not regularly monitored in this manner. Food insecurity is measured in some other household surveys but not with the degree of precision used in the NFCS.  
**Definition:** Children <5 years whose births are registered with the Department of Home Affairs (DoHA).  
**Measure:** Proportion of births not registered relative to estimated population for 0–5 years.  
**Sources:** DoHA and Stats SA population estimates.  
**Period:** Annual. |
| The NIP seeks to improve access to support for health development and reduce health risks in young children. Reduce the prevalence of vitamin A deficiency among children less than 5 years. | **Indicator:** Vitamin A deficiency rate  
**Reasons for use:** Measure of nutritional status and dietary intake. | **Definition & Measure:** Number of children <5 years of age with biochemical evidence of vitamin A deficiency in a defined population and a given period per 100 children under the age of 5 years in that population in the same period.  
**Sources:** SADHS and periodic nutrition surveys.  
**Period:** Annual. |
| The NIP seeks to improve access to support for health development and reduce health risks in young children. Reduce the prevalence of iodine deficiency among children less than 5 years. | **Indicator:** Iodine deficiency rate  
**Reasons for use:** Measure of nutritional status and dietary intake. | **Definition & Measure:** Number of children <5 years of age with evidence of iodine deficiency in a defined population and a given period per 100 children under the age of 5 years in that population in the same period.  
**Sources:** SADHS and periodic nutrition surveys.  
**Period:** Annual. |
| The NIP seeks to improve access to support for health development and reduce health risks in young children. Promote exclusive breastfeeding. | **Indicator:** Breastfeeding  
1. Initiation rates  
2. Exclusive breastfeeding rate  
3. Duration of breastfeeding  
**Reasons for use:** Breastfeeding is associated with improved infant health and development; in the case of HIV positive women current evidence indicates that exclusive breastfeeding reduces the risk of vertical transmission in the first 6 months of life. | **Definition:** Exclusive breastfeeding rate: Percentage of living children receiving only breast milk from birth to various ages.  
**Measures:** 1. Proportion of newborn children exclusively breastfed at hospital discharge or immediately after birth.  
2. Proportion of 6-month-old children receiving only breast milk or expressed breast milk.  
3. Proportion of 12-month-old children receiving breastfeeding at 12 months.  
Each of above per 100 live births in the same period.  
(Denominator for all: Live births in the same period).  
**Sources:** SADHS; periodic nutrition surveys.  
**Period:** Annual. |
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<th>Definition, measure, period and data source</th>
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</thead>
</table>
| The NIP seeks to improve access to supports for health development and reduce health risks in young children. Reduce the vertical transmission of HIV to children. | **Indicator:** Infant HIV incidence rate  
**Reasons for use:** Measure of (among others) access to PMTCT. | **Definition:** Children born to HIV-positive women who are polymerase chain reaction (PCR) positive at 6 weeks of age in a given period.  
**Measure:** Proportion of children born to HIV-positive women who are PCR positive at 6 weeks of age.  
**Source:** Provincial Prevention of Mother to Child Transmission (PMTCT) Programme  
**Period:** Annual. |
### Table 6 – Additional indicators for child health outcomes (possibilities for demonstration projects)

<table>
<thead>
<tr>
<th>Policy goal / desired outcome in terms of the NIP</th>
<th>Indicator and reason for use</th>
<th>Definition, measure, period and data source</th>
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</thead>
</table>
| The NIP seeks to improve access to support for health development in young children. Identify children with developmental delay for early intervention, thereby increasing the opportunities for young children to benefit from early learning and to prepare for entering formal schooling. | **Indicator:** Developmental delay  
**Reason for use:** It is essential to establish developmental delay in young children as this may indicate the presence of more serious problems that need treatment (which can prevent more serious problems). | **Definition:** Children who are delayed on developmental assessment – based on appropriate population norms.  
**Domains covered:**  
1: Motor  
2: Sensory (including hearing)  
3: Emotional & social  
4: Speech (language)  
**Measure:** Children under 3 years presenting at health facilities assessed as developmentally delayed per 1,000 under 3 attendances in a given period. For the Demo Project (DP), one could compare children in the DP with clinic attendees who are not in the DP. |
| The NIP seeks to support the creation of environments where children can grow and thrive. Create safe home environments for children. | **Indicator:** Children under 5 sustaining non-fatal injuries as a result of unintentional poisoning and burns  
**Reason for use:** Burns and poisoning are major causes of morbidity and mortality in young children. The indicators enable monitoring the extent to which housing and ECD services are safe. | **Definition and Measure:** Children under 3 years presenting at health facilities with burns and poisoning per 1,000 under 5 attendances in a given period: disaggregate: all under 5, 2-5 and < 2 years. For the Demo Project, one could compare children in the DP with clinic attendees who are not in the DP. |
| The NIP seeks to support the creation of environments where children can grow and thrive. Reduce the incidence of diarrhoeal disease in children. | **Indicator:** Children under 5 years with diarrhoea at health facilities  
**Reasons for use:** Measure of an important cause of child morbidity. Also an indicator of risks for disease and infection in the home. | **Definition:** Diarrhoea is defined as 3 or more watery stools in 24 hours, but any episode diagnosed and/or treated as diarrhoea after an interview with the adult accompanying the child should be counted.  
**Measure:** Children <5 years presenting to health facilities with diarrhoea per 1,000 <5-year-old attendances in a given period.  
**Sources:** DHIS and SADHS.  
**Period:** Monthly. For the Demo Project, one could compare children in the DP with clinic attendees who are not in the DP. |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>The NIP seeks to support the creation of environments where children can grow and thrive. Promote safety in the home and reduce common injuries for children.</td>
<td><strong>Indicator:</strong> Incidence of poisoning, burns and serious injuries in children under 5 and under 2 years that occur in the home and in ECD services. <strong>Reasons for use:</strong> Measure of safety provisions at home and in services. Measure of impact of support and training for caregivers.</td>
<td><strong>Definition and Measure:</strong> Children under 5 years presenting at health facilities with poisoning, burns and serious injuries in children under 5 and under 2 years that occurred in the home and in ECD services, per 1000 under 5 attendances in a given period: Disaggregate: all under 5, 2-5 and &lt; 2 years. <strong>Sources:</strong> District Clinics. For the Demo Project, one could compare children in the DP with clinic attendees who are not in the DP.</td>
</tr>
<tr>
<td>The NIP seeks to support the creation of environments where children can grow and thrive socially, emotionally and physically. Promote child protection at home and in the community.</td>
<td><strong>Indicator:</strong> Incidence of serious child maltreatment in children under 5 and under 2 years. <strong>Reasons for use:</strong> Measure of impact of support and training for vulnerable caregivers and families.</td>
<td><strong>Definition and Measure:</strong> Children under 5 years referred to a Children’s Court Inquiry (CCI) for confirmed physical or sexual abuse per 1,000 children in the magisterial district or court catchment area in a reporting year: disaggregate: all under 5, 2-5 and &lt; 2 years. <strong>Sources:</strong> District Clinics For the Demo Project, one could possibly compare rates of reporting for children in the DP with others who come before the Commissioner and who are from the same district.</td>
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C.7 Quality: what makes a difference to child outcomes in the period 0-4? Inputs for quality ECD interventions

Purpose

This paper provides a review of the evidence for programmes that are effective in improving child outcomes in the years 0-4. The focus is on populations, outcomes and interventions identified in the NIP for ECD.

We concentrate on evidence from majority country settings and take our cue from the recent Lancet series and related papers which provide the most concise and current summary of evidence for a range of child outcomes (Engel et al., 2007; Walker, Chang, Powell & Grantham-McGregor, 2005 and Grantham-McGregor et al., 2007). As is evident from these accounts, beyond the child health domain, information on programme effectiveness and efficacy from majority country contexts is very limited. Therefore information from the minority countries, particularly as regards child development programmes, is included where appropriate.

The main objective is to answer the question: What are the ingredients and design parameters of:

1. **Home-based programmes** that are effective in changing parenting and other aspects of caregiver behaviour that are associated with improvements in children’s nutrition, protection and development – in particular motor, language cognition and socioemotional domains – and that link families to services for the benefit of the child?

2. **Formal setting programmes** that are shown to be associated with improvements in children’s psychological development, and that link families to services?

The answers are related to the question of what programme delivery process and quality elements are needed in order to make a difference, particularly in low resource majority country settings.

In research undertaken for this paper we reviewed literature to ascertain the specific factors that have been identified as being associated with programme effectiveness in ECD, and their main ingredients.

Potential topics covered considerable ground. One cannot do justice to each (e.g. nutrition, care, quality, etc.) in an integrated paper covering all the issues relating to health and development in the period 0-4 years. Therefore, based on a Rapid Evidence Assessment, the paper summarises the findings from empirical research on

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12 In this series the term ‘majority country’ is used to refer to the majority of countries in the world which are sometimes referred to as ‘developing’, ‘third world’ and ‘low income’. Similarly ‘minority country’ refers to well-resourced countries, for example in Europe, North America and Australasia. These terms are preferred as they are regarded as less pejorative than the other forms.
what works to improve early outcomes in the following areas: nutrition, early psychological development, parenting, early stimulation and child care (in the home and group settings), and systems that promote access to services. It does not consider interventions to improve child health other than those that increase parents’ awareness of factors that promote health and provide them with links to health services.

Quality refers not only to the standards of programme delivery, but also to its evidence base. When it comes to home and facility-based programmes designed to improve child development, the elements of ECD programme quality are highly contested, particularly in majority country contexts.

Project 11 (Ratchet up implementation of ECD programmes) of the Apex Priorities announced by the President in his 2008 State of the Nation Address seeks to: “Massively speed up implementation of ECD programme” including doubling the number of delivery sites and child beneficiaries in the next two years.

However, less than 20% of South African children are currently likely to attend a formal facility programme and it is unlikely that numbers of children in formal facilities will increase substantially. In part this is due to a pattern common to countries with high maternal unemployment, where children are much more likely to be cared for at home rather than in other settings. It is therefore of critical importance that we ensure provision of alternative ECD interventions designed to reach the majority of poor children who will continue to be cared for at home or in community settings such as play groups.

**Findings**

There is no recent South African data on the quality and effectiveness of formal early childcare and development programmes for toddlers and pre-school children.

Similarly, there are no studies on the impact of home visiting to improve early stimulation or parenting. As these forms of intervention are key components of the NIP for ECD, there is an urgent need to draw on evidence from elsewhere in the world to identify the factors that contribute to their effectiveness in changing caregiver behaviour, and improving child outcomes.

There is only one South African peer-reviewed randomised controlled trial (RCT) study of a home visiting intervention for poor women designed to improve maternal sensitivity and infant-mother attachment. A 15 home-visit intervention improved maternal sensitivity and reduced intrusiveness at 12 months post intervention. At 18 months, these children were more securely attached than controls.

**Inferences for deepening the impact of ECD (0-4) while scaling up**

To scale up, interventions for ECD should be tailored to the most pressing threats to child development. On the basis of their prevalence in South Africa, there are probably nine key threats to sound early childhood outcomes:

1. Poor maternal nutrition and substance abuse during pregnancy which may impact on infant survival and may result in low birth weight and foetal alcohol syndrome;
2. The impact of HIV and AIDS on the young child (clinical treatment and vertical transmission of HIV are not addressed in this paper);

3. Inadequate access to health care – particularly during infancy and toddlerhood – including failure to immunise and seek care when needed;

4. Diseases associated with inadequate sanitary and water services as well as poor hygiene practices which result in diarrhoea (not addressed in this paper);

5. Stunting due to malnutrition;

6. Inadequate affectional care;

7. Forms of early childhood stimulation that are not well aligned with what is demanded from the school system;

8. Morbidity and mortality due to unintentional child injuries; and


In most cases the upstream cause is long term poverty in households without the material or human resources needed to provide adequate, shelter, care, nutrition, and stimulation.

Programmes that have the greatest impact on child growth and development:

1. Commence prenatally and extend into infancy and early childhood as a continuous chain of support;

2. Combine interventions that utilise several simultaneous ‘delivery channels’ (e.g. home visits, group counselling, childcare centres and mass media); combined interventions include a package of (for example): child nutrition, parental education on diet and feeding practices, supplementary foods or micronutrient supplements, and parenting and child development education; they are more efficient and cost effective, they avoid duplication and families access an integrated package of services which reduces their service access costs. Evaluations indicate that these programmes have positive effects on child health, nutrition and cognitive outcomes. Comprehensive programming is supported by the evidence.

For all programming, five elements of programming need to be considered:

- The goals and pathways through which the programme is expected to have its influence on the child (the theory of change) must be explicit;

- The main targets of the intervention must be clear;

- The intervention must be clearly described;

- The method of delivery, dosage and duration criteria must be clearly specified (inputs) and monitored; and

- Outcomes must be clearly specified, realistic and measurable.

In the case of interventions designed to improve parenting and early stimulation through home-based programmes, the following apply:

1. Parental participation needs to be active, engaged, and regular, normally over extended periods.
2. Home visiting needs to be frequent – weekly visits have the best chance of success (there is a linear relationship between frequency of home visits and improvements in child development); as regards duration, contact (home visits and group meetings) over at least a year is desirable.

3. For good outcomes to occur the relationship between participant and programme staff needs to be stable, warm, supportive and uncritical. Also, the practitioner skill in working with parents is a key determinant of success.

4. Joint interventions to improve child development (e.g. language and cognition) that involve direct activities with the child and training with the parent, plus joint activity with both work best to improve cognitive and language development.

5. A combination of formal setting-based and home-based interventions is best.

With regard to children affected by HIV and AIDS, the message is clear: it is rarely good practice to target young children affected by AIDS for interventions that do not include other vulnerable children and households.

Children with disabilities need particular support for development in the early years. It is essential to detect their problems early on, and ensure that they receive the necessary services and stimulation that will mitigate their disability and assist them to develop to their fullest potential.

Finally, which is the best node from which to scale up integrated access to services for vulnerable young children and families?

There are a number of examples which suggest that the primary health system is key to child health and development at least in the first three years of life, and as these systems are often best developed and have widest coverage, this is the place from which to start.

In South Africa, ECD centres and other community-based initiatives (e.g. programmes directed at families and children affected by HIV and AIDS) are also important nodes but may reach fewer children.

Demonstration projects to scale up ECD 0-4 and improve child outcomes should ensure that the interventions have been tested using the best design possible, so as to provide a robust test of the intervention. Six points are relevant

1. Programmes must have an explicit curriculum that is delivered as intended. If this does not occur, it is not possible to determine what produced the programme outcome.

2. It is essential to identify the mechanisms that mediate programme efficacy.

3. Randomised controlled trials provide the best test of programme effects. It is always desirable to determine the efficacy of an intervention under optimal research conditions before testing the intervention under less controllable circumstance.

4. Sound research evaluations must be long term (if early findings suggest that the programme is having the desired effect).
5. In any intervention, there are likely to be subgroups who require a variation of the programme or a different intervention. The study monitoring system must be able to detect such groups.

6. The study should be able to tell us the extent to which whether the findings apply across a range of contexts.

Randomised Controlled Trials are not always possible for both cost and ethical reasons. Where this is the case, quasi-experimental procedures with control groups matched on key variables, must be used. The key message is that poor design not only produces confusing results, but may also lead to expensive consequences when untested and possibly ineffective interventions are rolled out.

Table 7 summarises the evidence as to ‘what works’ to improve child outcomes in key risk areas identified above. With a few exceptions, child health is excluded, as the focus is on social sector ECD.
### Table 7 - What works to improve early childhood outcomes?

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>What works: implications for interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention of Low Birth Weight</td>
<td>• Improving the diets of pregnant women reduces risk of low birth weight and stunting;</td>
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<td></td>
<td>• Ensure that every pregnant woman has adequate antenatal care (at least four antenatal visits with an appropriate health care provider);</td>
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<td></td>
<td>• The mother also needs support in seeking care at the time of delivery and during the postpartum and lactation period.</td>
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<tr>
<td>2. Prevention of Foetal Alcohol Syndrome (FAS)</td>
<td>• Early identification of at risk mothers during pregnancy is critical;</td>
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<td></td>
<td>• Primary health practitioners who can screen for, diagnose and manage alcohol-exposed pregnancies play a key prevention role;</td>
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<td></td>
<td>• Delaying pregnancy in the women at highest risk and who already have a child with FAS;</td>
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<tr>
<td></td>
<td>• Brief Motivational Interviewing (BMI) techniques are efficacious with substance abusers and could be considered for at risk mothers who present at antenatal clinics;</td>
</tr>
<tr>
<td></td>
<td>• Education of communities as to risks and that address norms have a role to play in increasing awareness, but no trials have been conducted in South Africa to demonstrate impact.</td>
</tr>
<tr>
<td>3. Promotion of hygiene practices, child safety and injury prevention practices and knowledge of when to seek health care</td>
<td>• Educate carers in the UNICEF/WHO IMCI 16 Key Family Practices;</td>
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<tr>
<td></td>
<td>• Supervise children's activities;</td>
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<tr>
<td></td>
<td>• Reduce or prevent where possible caregiver alcohol and/or drug use in high risk individuals;</td>
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<td></td>
<td>• Alert caregivers to potentially hazardous substances and objects in and around the home;</td>
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<td></td>
<td>• Encourage caregivers to use of child-resistant containers for harmful substances (including paraffin);</td>
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<td></td>
<td>• Encourage use of paraffin stoves that adhere to the South African Bureau of Standards safety standards for paraffin stoves;</td>
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<td></td>
<td>• Electrification avoids the dangers of paraffin stoves and ingestion, but the risk of burn or thermal injuries remains in relation to boiling liquids;</td>
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<tr>
<td></td>
<td>• Use fire resistant or retardant materials for informal housing.</td>
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<td></td>
<td>• Provide a storage space for dangerous substances and appliances;</td>
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<td></td>
<td>• Use stair gates and safety barriers on bunk beds and infant high chairs;</td>
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<td>• Preset geyser hot water temperature to 54°C or less;</td>
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<td></td>
<td>• Use appropriate swimming pool fencing.</td>
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<tr>
<td>4. Prevention and remediation of malnutrition</td>
<td>• Commence in pregnancy where appropriate;</td>
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<tr>
<td></td>
<td>• Integrate nutrition programmes for infants and children under 3 years with psychosocial support for caregivers;</td>
</tr>
<tr>
<td></td>
<td>• Provide iron and Vitamin A supplementation where appropriate;</td>
</tr>
<tr>
<td></td>
<td>• Programmes should combine early stimulation through responsive parenting, together with improved nutrition;</td>
</tr>
<tr>
<td></td>
<td>• Assess for caregiver depression and distress and address if necessary.</td>
</tr>
</tbody>
</table>

13 BMI is a directive, client-centred counselling style for eliciting behaviour change. http://www.motivationalinterview.org/clinical/whatismi.html
## Desired outcome

### 5. Promotion of sensitive, responsive and affectional care in all developmental settings including in contexts within which children are affected by HIV and AIDS

- Programmes that focus on assisting caregivers with their daily life challenges; help them to learn more adaptive problem solving skills and lend emotional support have the potential to reduce caregiver stress and promote more sensitive caring;
- Promising interventions include those which provide parenting advice and support to vulnerable and very young mothers starting with antenatal care, and followed up with home visits and support groups thereafter. Contacts must be frequent, regular and of at least a year’s duration;
- South African research shows that home visits and support groups with depressed women can assist but must be of high intensity and be sustained;
- The only way to effectively protect, promote and enhance the health and wellbeing of young children is to improve the quality and stability of the care they receive from those closest to them from their caregivers and families;
- Provide HAART to eligible mothers of young children.

### 6. Promotion of early stimulation for child development;

- Have systems for early detection of developmental delay and disability in the public health system linked to Road to Health Card assessments;
- Stimulation programmes are particularly important for children with disabilities, chronic illness, as well as HIV and AIDS;
- Integrate early stimulation programmes in the home with other interventions that are offered to parents (e.g. of nutritional support; food gardens; CHBC etc);
- Home-based early stimulation programmes must be regular, intensive (not less than twice monthly for in excess of a year), culturally appropriate, and build on existing household activity;
- Both parents and children must be actively involved in the intervention. Simply providing parenting information has little or no effect on child outcomes.

### 7. Key quality parameters for formal ECD settings

- Infant and toddler care:
  - In general, small group sizes with low child-adult ratios are preferable, together with non-authoritarian child-rearing beliefs are associated with ‘positive’ (warm accepting and sensitive) caregiving;
  - Safe, clean, and stimulating physical environments are also associated with positive caregiving;
  - Children who spend extended periods of the early years in centre-based are more at risk for aggressive behaviour;
  - Group care centres must contribute to child health and development by linking parents to services;
  - The setting must not simply provide for health and hygiene but also work toward the psychosocial development of the child.

- Preschools key findings:
  - ECD programmes are recommended because they prevent delays in cognitive development and improve disadvantaged children’s readiness to learn in school;
  - Attending pre-school from an early age enhances children’s development (particularly the disadvantaged child), and half time attendance is good enough;
  - The home learning environment is an important factor, but it is what parents do (stimulation, reading, scaffolding of learning) that makes the difference in child outcomes.

- Pre-school quality parameters:

- Structural parameters:

- Facilities and their surroundings/physical environment (cleanliness; safety; opportunities for a range of stimulation in a range of developmental domains);
### Desired outcome | What works: implications for interventions
---|---
- A variety of learning materials is required;  
- Low ratio of children to adults (as for younger children, small group sizes with low child-adult ratios are preferable);  
- Finance/resources/management/planning/organisation/leadership/conditions of service and wages.  
- Process quality parameters:  
  - Trained practitioners: Staff with greater knowledge and understanding of the curriculum and of how young children learn is associated with better quality and child outcomes. Their ability to help parents to support children’s learning in the home is also associated with better child outcomes  
  - Ongoing supervision of staff;  
  - Integration of education and care;  
  - Partners/parental and community participation including communication with parents about children’s progress  
  - Active parental involvement in the centre;  
  - Teaching strategies need to be culturally appropriate (using local materials and practices on which to build activities;  
  - Teaching strategies include frequent, warm and responsive interactions; good communication and listening; children have better outcomes when the emotional climate in the classroom is positive (sensitive, warm and positive teachers);  
  - Activities that occur alone and in groups and which cover multiple dimensions development and encourage problem solving.  
  - Active individualised support by staff for children’s learning scaffolds the child’s development of skills relevant to school;  
  - If children have more free choice activities than regulated activities controlled by the teacher they do better;  
  - Children who spend less time in large group activities do better;  
  - Consistency in discipline and responsiveness;  
  - Good time management;  
  - Equal treatment regardless of factors such as gender and ethnicity

8. Prevention of maltreatment
- Target in particular teen parents and first time parents; single parents with limited support; parents with substance abuse problems such as alcohol and TIK;  
- Low-birth-weight and preterm infants, and children with chronic illness and disabilities are particularly vulnerable to maltreatment and their carers need support;  
- Efforts to strengthen parenting knowledge and capacities in the antenatal period should be linked to other antenatal clinic visits;  
- Carers should be assisted to have a basic understanding of how children grow and develop so that their expectations are realistic – particularly in the case of infants and young children;  
- Clinic, crèche, ECD facility staff need training in observation and respond to early warning signs of abuse and neglect;  
- Centres play an important role in child protection as the child is in a safe monitored environment.

9. Improved access to social security and health services at local level
- Strong local government support for integrated ECD through local multi-service hubs within walking distance of households.  
- Use of locally recruited outreach workers from clinics and other facilities (e.g. ECD sites) to facilitate family connection to required services.
C.8 Towards a job hierarchy for ECD provision and supervision in South Africa, and the fit of low-skill service providers

Introduction

**Background and purpose**

The purpose of this background paper was to:

- Identify the job hierarchies and career paths in ECD service provision and supervision needed to deliver access, quality and child outcomes;
- Relate these to the career opportunities for low and semi skilled workers and the use of the ECD service sector as a route to job creation and capacity building;
- Consider the location of certain of these jobs e.g. NGOs, local government, district offices, community-based organisations and small private businesses;
- Review the range of pay scales and expectations, from volunteerism, to pay according to a public works stipend, to aligning the service delivery agent to some extended pay scale (thereby seeing it as a proper job rather than a special make-work opportunity);
- Analyse the implications of these for EPWP training and job hierarchies and the mass expansion of ECD and how these align with requirements of the NIP; and
- Make recommendations to government with regard to developing the job hierarchy, service conditions and on how job creation initiatives could better address the current mass expansion programme and NIP for ECD.

Any mass expansion of ECD jobs for service provision of a quality that will impact positively on outcomes for children requires that staffing is given serious consideration. Due to historical neglect, the ECD sector is faced with numerous challenges to quality including an underskilled workforce with low pay and poor conditions of service. If the sector is to grow and be upgraded it will need to become more attractive as a career option with incentives to improve qualifications.

White Paper Five: Early Childhood Development (WP5) mainly attributes the variable quality of ECD services and programmes to:

- Absence of a mechanism for the professional registration of ECD practitioners/educators and of the requirement that they be registered with the South African Council of Educators;
- Inequities in the qualifications of ECD practitioners/educators; and

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14 Linda Biersteker, Senior Research Associate: CPEG, HSRC and Early Learning Resource Unit (research@elru.co.za, lbiersteker@hsrc.ac.za).
• Absence of an accreditation system for trainers of ECD practitioners/educators (Paragraph 2.2.6).

To address these problems (the DoE) “undertakes to expand, over the medium term, its work on practitioner development and career pathing for Reception Year practitioners and Pre-Reception Year practitioners (the target group for this research project). It undertakes to develop best practice models for the management and quality development of Pre-Reception Year programmes” (Paragraph 5.3.4).

Similarly, the NIP for ECD recognises that all ECD practitioners should be supported as professionals with a career path. The NIP and other ECD programmes also point to new types of jobs for ECD workers at a variety of levels, for example, family support workers and child development workers. In addition, expansion of the system will create the need for more and different kinds of capacity-building, supervisory, monitoring and support job opportunities.

In view of the very broad service package proposed for 0-4 year-olds, many of the service providers will be health practitioners but in keeping with the ECD job creation focus, this paper discusses the jobs which fall under the DoSD and DoE.

Method of investigation

The methods used for this study included a literature review and interviews with key informants. The literature scanned included information on South African social sector employment projects including proposals for job creation, a review of the international ECD job hierarchy literature, information from local case studies and South Africa’s ECD policy and programmes. Key informants from the public sector, NGOs and on the ground service providers (at national, provincial and local level) were interviewed.

Possible career paths for ECD workers in South Africa

What are career paths and why is it important to map these for ECD in South Africa?

Mapping of possible jobs and career paths is important for:

• Providing a structure that can taken into account in the development of common norms and standards for regulation (licensing);
• Indicating the possible horizontal and vertical progressions between these so that these can as far as possible be taken into account in the development of core qualifications and specialisations;
• Helping to define the upward mobility or exit opportunities for those who enter low wage ECD jobs and allow for a broader focus in social sector job creation programmes targeting this sector and in the South African context may be used to motivate for additional public support for different kinds of jobs.

Job mappings may either follow a career ladder or career lattice approach. A ladder gives the jobs within a single professional setting and a lattice indicates possible horizontal as well as vertical progression opportunities. For this reason a lattice is the recommendation for ECD jobs in South Africa, though there are certain articulation
challenges to be addressed. A concern is whether the ECD employment structure could reasonably be expected to raise mobility rates substantially as this will depend both on supply of better jobs and whether there is a qualifications ‘ceiling’ to be broken through to reach them. A well-organised sector to negotiate for institutional commitments to fill openings with people from lower down the ladder can facilitate mobility.

Types of ECD jobs and career paths in South Africa: what are the current opportunities?

ECD career paths: international comparisons

International evidence indicates that service integration, professionalisation, improving service conditions and linking to career paths are issues for ECD in many countries.

Those countries currently seriously tackling professionalisation and career opportunities tend to be higher income countries than South Africa and the qualification base from which they are working is higher than South Africa’s where minimum standards call for school leaving certificate as the basic supervisory qualification for an ECD centre and interim qualification for a Grade R teacher. Career lattices for jobs in a range of ECD settings have been developed by a number of states. Job roles to provide more integrated ECD opportunities are emerging. In Europe social pedagogues are expected to include and support parents in a range of ways and work with other professional agencies and in the UK a lead professional role has been introduced to support effective integrated service delivery. A lead professional is responsible for coordinating services for children and young people with additional needs and to act as a single contact point for the child and their family. In both cases evidence is that coordinated service delivery has been difficult to achieve for a variety of reasons.

A recommended South African career lattice for ECD takes account of previous mappings in South Africa by the Interim Accreditation Committee and in the EPWP Social Sector Plan, international mappings in particular the career lattices used in the USA and current jobs outlined in new ECD policies.

A recommended South African ECD career lattice

See table 8 below.
### Table 8 – Recommendations for a South African ECD career lattice

<table>
<thead>
<tr>
<th>NQF level</th>
<th>Home</th>
<th>Formal</th>
<th>Outreach</th>
<th>Regulation, monitoring, training and capacity building</th>
<th>Support services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 7/8</strong></td>
<td>In home care</td>
<td>Registered ECD programme 0-4 year-olds</td>
<td>Foundation phase class</td>
<td>Centre-based community services</td>
<td>Community outreach services</td>
</tr>
<tr>
<td>Au pair</td>
<td>Teacher R - 3</td>
<td>Director</td>
<td>Manager of several outreach services</td>
<td>ECD Director/Manager</td>
<td>Researcher</td>
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<td></td>
<td>HOD</td>
<td>Children’s Centre</td>
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<td></td>
<td>Special Ed teacher</td>
<td>Director of ECD service organisation</td>
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<tr>
<td><strong>Level 6/7</strong></td>
<td>Degrees and professional qualifications(B Ed; B Soc Work, B Admin etc)</td>
<td>Supervisor/mentor</td>
<td>Teacher</td>
<td>Centre manager</td>
<td>Project manager (outreach, child minder networks, IEC projects)</td>
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<tr>
<td></td>
<td>Au pair</td>
<td>Lead teacher</td>
<td>R - 3</td>
<td>Toy library manager</td>
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<td></td>
<td>Director of several programmes</td>
<td>HOD</td>
<td>Director</td>
<td>Director</td>
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<td>Children’s Centre</td>
<td>of ECD</td>
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<td>NQF level</td>
<td>Home</td>
<td>Formal</td>
<td>Outreach</td>
<td>Regulation, monitoring, training and capacity building</td>
<td>Support services</td>
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<td></td>
<td>Home</td>
<td>Formal</td>
<td>Outreach</td>
<td>State offices</td>
<td>Education and training institutions</td>
</tr>
<tr>
<td></td>
<td>In home care</td>
<td>Registered ECD programme</td>
<td>Centre-based community services</td>
<td>Community outreach services</td>
<td>Coordinator, QAS Officials</td>
</tr>
<tr>
<td></td>
<td>Level 5 (diplomas and certificates)</td>
<td>Au pair, Lead teacher, Teacher, Supervisor/Principal Mentor for Level 4 ECD practitioner</td>
<td>Grade R teacher</td>
<td>Outreach coordinator, Toy library manager, Toy librarian</td>
<td>Project manager, Programme developer, Community development worker (ECD)</td>
</tr>
<tr>
<td></td>
<td>Level 4</td>
<td>Au pair, Childminder, Babysitter</td>
<td>ECD practitioner, Mentor for Level 1</td>
<td>Grade R teacher assistant, Toy librarian, Parent educator, Child and youth care worker</td>
<td>Support and development worker/team leader, Community development worker (ECD spec)</td>
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## Overview of Findings

<table>
<thead>
<tr>
<th>NQF level</th>
<th>Home</th>
<th>Formal</th>
<th>Outreach</th>
<th>Regulation, monitoring, training and capacity building</th>
<th>Support services</th>
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</thead>
<tbody>
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<td>In home care</td>
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<td>Foundation phase class</td>
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<td>Community outreach services</td>
<td>State offices</td>
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<tr>
<td>Level 3</td>
<td></td>
<td></td>
<td>Hospital child visitor</td>
<td>Educational home visitors</td>
<td>Professional development officers (municipal)</td>
</tr>
<tr>
<td>Level 1</td>
<td>Child minder</td>
<td>ECD care worker (EPWP term) Assistant</td>
<td>Playgroup assistant</td>
<td>Hospital visitor</td>
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<tr>
<td>Skills Progs at Levels 1/2/3/4 plus at least</td>
<td>Child minder Nanny/ Babysitter</td>
<td>Volunteer</td>
<td>Toy library assistant</td>
<td>Family outreach worker (link to services)</td>
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<tr>
<td></td>
<td></td>
<td>Volunteer</td>
<td></td>
<td></td>
<td>Driver Gardener Caretaker</td>
</tr>
</tbody>
</table>
### Scaling up Early Childhood Development (ECD) (0-4 Years) in South Africa

<table>
<thead>
<tr>
<th>NQF level</th>
<th>Home</th>
<th>Formal</th>
<th>Outreach</th>
<th>Regulation, monitoring, training and capacity building</th>
<th>Support services</th>
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<td>In home care</td>
<td>Registered ECD programme 0-4 year-olds</td>
<td>Foundation phase class</td>
<td>Community outreach services</td>
<td>State offices</td>
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<td>ABET</td>
<td>Child minder (under 7 children)</td>
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<td>domestic</td>
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Linking ECD jobs to professional norms and standards

Two possible routes for linking ECD jobs to norms and standards are in development in South Africa.

Registration with a professional body (professional licensing of individual practitioners): The function of these bodies is to safeguard standards within the profession. It also raises the status of those working in the sector, which may but does not necessarily improve salaries and service conditions. Only registered persons may practice in the sector and registration requires specified professional qualifications, continuing professional education and adherence to a code of conduct.

Currently ECD practitioners working in Grade R classes are required to register with the South African Council of Educators (SACE) and a possibility is that this could be extended to other practitioners working directly with children. An alternative route is the Social Services Professions Council. This is more aligned to community and outreach ECD service jobs but could also apply to practitioners working in centres as new draft legislation is providing for a category of child and youth care worker.

Issues to be considered before going the professional registration route include the limited number of levels of registration of which the lowest is NQF Level 4 as an auxiliary social services professional or conditional registration as an educator. At this stage many workers in the ECD sector are below this level and the professional registration process might become an exclusionary rather than an enabling mechanism. Registration fees are also a burden for low paid practitioners. Finally, consideration needs to be given to the implications for job mobility of having more than one professional registration in the sector.

Regulations by government notice under relevant legislation e.g. the Children’s Act (licensing of ECD facilities and programmes which includes staffing determinations) is the other route. The specification of staff qualifications and programme responsibilities by government notice as an aspect of broader requirements for registration of ECD facilities is an established practice and is a way that norms and standards are enforced. Whilst staffing information currently required for the quality assurance process is currently limited, it would be very simple to develop this. An advantage is that it is inclusive of all job levels.

A combination of the two routes is also a possibility and is the approach being introduced in some states in the US particularly.

The ECD sector as a route for job creation, capacity building and career opportunities for low and semi-skilled workers

Job opportunities in the sector

The EPWP ECD plan provides for a number of training opportunities at Levels 1, 4 and 5 and is well aligned to addressing training backlogs in the ECD sector and upgrading of existing provision. However it is rolling out slowly and would not in its present form allow for significant expansion of the sector as a whole as it is targeted to practitioners in existing employment. To improve quality some provinces are tracking the same participants through different training levels which reduces the
number of beneficiaries but is realistic in terms of challenges to paying exit opportunities and serves the sector need for improved qualifications.

Certain job categories indicated in the Massification of ECD document and NIP are not included in current EPWP plans but could be made possible by a further EPWP allocation for social sector job creation announced in President Mbeki’s 2008 State of the Nation address. These include child development workers and graduates to assist with registration, monitoring and support of centre facilities for young children.

Childminders caring for 6 or less children in their homes is a potentially significant small business opportunity, particularly if it could be linked with supervisory support and should be further explored.

**Institutional locations for different ECD jobs**

A lack of clarity about institutional locations for certain categories of jobs – in particular those falling into the community and home based ECD servicing options - needs to be resolved. Currently these services are run by NGOs although erratic funding streams are a problem. Significant scaling up would require the establishment of larger more viable intermediary structures and/or expansion of government posts at provincial and especially local level.

**Determining minimum conditions of service/remuneration levels**

The issue of wages and services conditions for ECD practitioners of all kinds needs to be addressed. Local and international evidence is clear that reasonable wages and service conditions for those working with young children are essential to attracting and retaining good quality workers in the sector. In a sector that is largely private and informal there should be immediate and concerted efforts to secure a sectoral determination of a minimum wage via the Department of Labour. The fact that such a process is underway for workers in the welfare sector suggests that this could be achieved. Concerns that going the route of a sectoral determination might affect mobility into the education sector must be addressed.

A clear distinction should be made between volunteerism, make work opportunities and the need for salaried jobs. So-called volunteers tend to be performing too many core functions which should be paid and accountable. Volunteerism on an ad hoc basis in support of core ECD jobs should be encouraged. Staff and capacity building investments are often lost due to ECD workers not being able to afford to continue in their low paid jobs. In the context of the EPWP practitioners who have received stipends while training are often required to return to salaries lower than these once they have qualified. Higher per capita ECD subsidies for qualifying children in subsidised ECD facilities are expected to ameliorate this but subsidisation will not on its own address the needs. The possibility of establishment posts for ECD facilities similar to the option for Grade R classes provided for in the DoE’s Grade R funding norms should be investigated.
Implications for scaling up of ECD services (0-4 years) and creating ECD jobs

On the basis of this review the following recommendations are made with regard to the ECD supervisory and job hierarchy needed for the mass expansion of ECD services for children aged 0-4 years through both formal and community and home based services.

1. There should be a consultation process with sectoral stakeholders to discuss and agree on a South African ECD career lattice. This would involve
   - Agreeing on the different jobs and determining of experience levels as well as qualifications for the different jobs;
   - Resolving issues of horizontal as well as vertical progression particularly where there is a cross over of ‘education’ and ‘social welfare’ job functions;
   - Once career paths are established stakeholder groups negotiating with relevant government departments about different institutional locations for core jobs, management and supervisory roles; and
   - Putting measures in place to facilitate workers in lower job categories in different institutional settings to progress to higher-level jobs.

2. The implications of professional registration should be considered in terms of
   - Possibilities of registration with SACE for those working directly with children and with the Council for Social Service Professionals for workers in community and outreach positions and whether this would hinder horizontal mobility in the career lattice;
   - Where lower skill levels will fit if a professional registration route is taken and whether this will unintentionally act as an exclusionary factor;
   - How professional councils would play an enabling role for ECD members in terms of professional development; and
   - Whether the current mechanism of ensuring norms and standards by regulation under legislation is not a simpler route to quality assurance which could be developed to have a greater focus on staffing.

3. A sectoral determination for minimum service conditions especially wage levels for ECD workers should be explored by stakeholders with the Department of Labour and as part of this process clarity should be gained to ensure that this does not cut off professional opportunities e.g. through registration with SACE or the Social Services Professions Council.

4. Job creation schemes should provide for additional job categories. These would include “registration assistants” and child development workers as outlined in the Massification of ECD Strategy and childminder, playgroup leaders and parent educators as outlined in the NIP and EPWP. Childminders caring for small groups of children at home are a potentially significant area for developing of small businesses provided that adequate support and supervision is available and should be considered for skills programmes.
C.9 Support structures for scaling up the NIP for ECD

This paper forms part of a larger research project concerning ECD, commissioned by the HSRC in 2007. What the various papers in this series present are the considerations for scaling up ECD ranging from budgeting to monitoring outcomes. The aim of this paper is to consider various options for support structures and mechanisms that could facilitate the implementation of the National Integrated Plan for ECD (NIP), and address the strategic priorities contained therein for scaling up of ECD in South Africa. In particular, we focus on how state and civil society institutions can work together using different models of support including social franchising; networks and associations; and capacity building and resource organisations.

Findings

In order to reach the sheer numbers of children and caregivers as intended by the NIP, Government is likely to have to employ a number of different strategies. The paper highlights that support structures could be useful to facilitate the integration that is foreseen in the NIP. The use of support structures should assist government to extend the reach and quality of ECD services, considering the gap that exists between the huge state bureaucracy and the community level organizations at the grassroots. The use of support structures does not preclude the need for Government to bolster its own service delivery capacity, which in fact may be necessary anyway or government to engage effectively with intermediaries. It should be noted that “intermediary support” does not necessarily refer to the establishment of new institutions, but rather to mobilizing the support of existing organizations and service providers to the sector.

The paper identifies the different role players in the sector and the range of services needed for center based and home based (child minder / primary caregiver) provision in order to understand the type of linkages that improved integration should facilitate. Understanding the context in which ECD organizations operate is also important to inform the role of support organizations. Two critical constraints in the sector are funding and capacity constraints, which is typical of the not for profit sector generally. To facilitate access to centre based care, ECD centres can qualify for subsidies, but many find it difficult to navigate the red tape and meet the requirements for registration. There are also backlogs in registration with the DoSD. Regarding funding, even though there are massive state resources allocated to ECD, they are not reaching the grassroots as effectively as intended, and Provincial Departments have to choose between scale and quality of service provision. Further, many NPOs, such as the well established resource and training organizations that could assist the sector do

15 Dena Lomofsky, Partner: Southern Hemisphere Consultants (dena@southernhemisphere.co.za); Valerie Flanagan, Director: Development Alternatives (valerie.flanagan@enablis.org); and Liezl Coetzee, Senior Consultant: Southern Hemisphere Consultants (liezl@southernhemisphere.co.za).
not have sufficient funds to reach enough of the target and beneficiary groups. The ISDM of the DoSD provides six different funding mechanisms to engage the non-state sector and these mechanisms should be harnessed for the ECD sector. Other means for ensuring the flow of funding to the sector should be considered. Quality is another critical consideration and again the DoSD currently does not have sufficient internal capacity to monitor registered centres as per their legal mandate. Support organizations could really facilitate improvements in these three key areas namely support to organizations and to government regarding registration of providers, seeing that funds and capacity flows to the sector and thirdly monitoring and supervising quality implementation.

There is also a need to develop more programmes and means to reach the caregivers and children that are not linked to formal centres, as well as to upgrade the quality of service provision in these centres. Support organizations could be critical for rolling out tested models into the sector.

Support organizations could facilitate critical linkages within and between the state, NPO and private sector service providers, academic institutions, local government, community structures and the ECD site (e.g. family, community and formal). Support organizations can serve primarily as brokers of information and appropriate technologies; mobilisers of resources; networkers to strengthen institutional linkages; and trainers and product enhancers. The specific services that need to be rendered in the sector are professional and personal development for improving caregiving and management; access to improved nutrition and welfare services; materials and resources; organizational development (including fundraising); and networking and external relations. Although professionalizing the sector may be controversial, it is unavoidable when massification and upscaling quality is concerned.

Three main models of support structures that are investigated in the paper are social franchises; networks, associations and support organizations; and capacity building and resource organizations. Each of these could be used in different ways to support the integration envisaged in the NIP, and in fact already exist in the sector in various forms. Social franchising is a terms used fairly loosely to describe a number of different methodologies related to scaling up delivery of a particular social programme concept. Social franchising facilitates a situation where an organization has developed a blueprint model, and then seeks to scale-up or scale-out their models using a hub and spoke approach. It is based on the business franchising concept but has social rather than profit making goals. Social franchising should be viewed on a continuum where the degree of replication of the model is the key differentiator. Examples of franchises in the ECD sector in South Africa are NOAH, and the Isibindi model of the National Association for Child Care Workers. Another well known example of a social franchise in South Africa is loveLife. Pure social franchising is there the model is replicated exactly no matter where the programme is delivered, and adaptive social franchising is where the model is adapted to degrees. However, the common denominators within a franchise should always be branding; adherence to norms and standards; working towards common objectives; and collecting and report on monitoring data. In social franchising situations, institutions or organisations are able to quickly step into a social franchise-type model without having to bear the development costs of designing the model, and avoids other pitfalls such as duplication. In addition, because the model has already been proven to be effective,
this allows the organisation to tap into funding resources on its own account without necessarily having to rely only on the central organisation to access these. Franchisees can either be stand-alone organisations or a franchised product could be added to an existing offering. Typical social franchising techniques include promotion and marketing; training and capacity building; quality assurance and standardisation of services; information sharing and referral mechanisms; cost recovery mechanisms (if possible); and use of franchise contracts. Although very useful for extending the reach of a social programme concept, social franchising itself needs a pool of suitable potential franchisees, and particular skill sets are needed for implementation. It must be noted that few of the examples in the literature refer to reaching the vast numbers of beneficiaries that the NIP envisages. In fact, one of the main challenges with social franchising is maintaining quality standards as networks rapidly expand and as supervision structures became stretched. The possible solution is to have a number of franchises that operate in different geographical locations and/or that offer a particular sets of services. Further, franchises can decentralise aspects (such as training) to local NGOs which also allows the program to support local capacity for service.

**Networks and associations** are another modality of support that exist in the sector. Here organisations associate with each other yet are not required to implement a specific model. Networks can have differing degrees of formality, ranging from highly structured and formalised to loose associations. Networks typically facilitate information exchange, collaboration, mutual support, capacity building, research and/or distribution of funding to member bodies. Membership could include NGOs, CBOs, relevant government departments, representatives of local government, community forums and faith based groups. Prominent examples of networks in the ECD sector are the African Self Help Association that supports 40 pre-schools, Ikamva Labantu that supports the Ikamva Labantwana network of 350 member ECD sites, and the Ntataise Network Support Project which has 16 training organisations as members and who are all licensed to conduct the Ntataise training. The latter includes a social franchising component in terms of its training model. Networks are good means of creating linkages in the sector and can strengthen the organisations that participate in the network. Members of networks can also form consortia to tender for a range of government services. Grassroots networks can also assist to draw in home based child minders. Networks and associations can also provide good monitoring mechanisms. Potential limitations of networks include the possibility of inducing competition for funding among member organisations; poor governance structures; unequal power relations between members in the network; networks can give the appearance of providing greater coverage than is often the reality in practice; and networks themselves will need investment in their capacity if they are to take on new responsibilities.

**Capacity building and resource models** are the third form of support that can be used in the sector. Capacity building is used in this document as meaning a combination of training (including on-site, in-service and follow up support); mentoring and monitoring. Capacity building and resource models would employ cascading type methodologies to build a cadre of NPOs that can provide this type of support at the grassroots level. This type of capacity building model is being piloted in the Home and Community Based Care Sector by the Department of Social Development (HCBC management capacity building model). Capacity building and resource models can be advantageous in that they can focus on building capacity in
the sector; can build a layer of capacity building and resource NGOs that will remain in under-serviced areas and can assist organisations in other sectors as well; capacity building organisations themselves are mostly NPOs and understand the challenges faced by the not-for-profit sector and have stronger community linkages than government departments; they can provide the on-going mentoring needed to help organisations mature; through research, monitoring and evaluation they can apply best practices directly in their service delivery and training; and they can tailor make the intervention depending on the stage of development of the organisation that they are assisting. Despite these positives there are also numerous challenges that these support organisations face: professionalisation does not always have the desired impacts and at times can disrupt the organic cohesion that exists amongst small community based organisations. As mentoring is a very personal process, personality differences between mentor and mentoree do occur. Mentoring is a specialised skill and it is difficult to find good mentors. There is also the possibility that a culture of dependency can occur whereby the organisation becomes reliant on the mentee and is not able to stand on their own two feet.

Having looked at these possible models of support, it can be seen that they often employ similar techniques and methods (i.e. social franchisees can also form networks, and typically also employ capacity building for their members). Further, they are not mutually exclusive and a franchisee could belong to a community based network and benefit from the services of a capacity building and resource organisations. The key, however, is that each of these models provides inherent support and coordinating mechanisms that could be useful to assist government with the integration required to extend the reach of quality ECD to the ground.

In the last section the importance of community participation and the use of partnerships is highlighted, irrespective of which model is employed. Various approaches to owning and operating social franchises are also covered namely joint venture or partnership approaches; private provider model and he governmental model.

**Conclusions**

In conclusion, the paper raises certain key issues for consideration by Government stakeholders when considering the relevance and usefulness of support structures.

The contribution of this paper to the broader series is to explore whether support organisations as intermediaries between Government and CSOs could assist with the rapid scaling up of quality ECD in South Africa. In this paper the role players and linkages in the sector are presented in relation to the three levels of service provision as foreseen in the NIP namely family, community and formal. Understanding the role players, linkages and constraints in the sector helps to define the role that support organisations could play. A full sector and situation analysis was, however, beyond the scope of this paper, and would be beneficial exercises when planning the roll out of the NIP. The purpose of support models or intermediary organisations would be to facilitate integration in the ECD sector between government, state and the civil society sector. The aim therefore has been to look for models of supervisory structures (franchise approaches; networks and associations; and capacity building and resource organisations) that can pull together and assist service providers so that more
consistent delivery of agreed programs of ECD can be delivered. The use and strengthening of support organisations does not preclude the bolstering of Government’s own capacity to scale up ECD. Rather, models of support should be seen as enablers, and used to unblock some of the constraints that arise from the structural gaps between Government, as a large bureaucracy, and the CSOs working at community level. Support structures should facilitate the integration as envisaged in the NIP, particularly between Government and Civil Society, and between Civil Society Organisations, and to build a stronger more cohesive sector in order to allow government to meet its policy obligations as contained in the NIP and take quality ECD up to scale.

Support organisations could assist with integration

The inter-departmental structures envisaged in the NIP should co-ordinate the co-operation between Government Departments. The NIP speaks about the important role of the Non-Governmental Sector in helping to deliver on it’s objectives, and says that civil society organisations will be included, consulted and co-opted through appropriate legal procedures to assist the state with service delivery. However, it does not suggest any concrete mechanisms for doing this. The role of support structures, whichever form they take, could primarily be to provide these mechanisms; to facilitate the work of the inter-departmental committees and to structure the relationship between the State and Civil Society so that the ECD can be delivered in an integrated manner with true inter-sectoral collaboration. The overall aim will be to facilitate “NIP in action”.

Support organisations could assist with the pace, reach and quality of scaling up ECD

Given current capacity, Government alone is not likely to cope with the extending the reach and pace of scaling up and maintaining or improving quality. The CSO sector and caregivers in the communities need assistance to be able to take advantage of the opportunities that the NIP provides. As such support organisations could be instrumental in assisting with the reach and pace of scaling up – noting however, that setting up the systems for support structures will in-itself require some time and lessons will be learned along the way. In addition, there is the need to develop and test models of service provision for all three of the NIP sites (family, community, formal), which will also take some time.

Models will need to be 100% funded as cost recovery will be low.

As the budget for ECD at provincial level is already stretched (Streak, 2008), and the Department of Social Development is engaging in the play-off between quality and reach, the provinces alone can not be expected to fund these supporting mechanisms from existing budgets. If intermediary organisation(s) are deemed necessary, then the feasibility of including them in the funding stream needs to be considered. Further, a National Funding Window should be considered as this would allow for the roll-out of national programmes and avoid being restricted to applications for funding to provincial departments (this would also interfere with the replication of social franchises).
The main current funding mechanisms for NPOs include tendering and service level agreements.

- There is currently very little information on the actual costing of models, so there is a need to get more information first.
- Since cost recovery would be low, there is a need to determine what level of sustainability can be expected and the corresponding commitment from government needs to be sought.

**What model would be most appropriate, relevant, sustainable and feasible?**

Whatever approach is decided upon, the correct process for project cycle management and project design should be followed. This means that situation analysis, feasibility studies and project development and design need to be conducted and proper monitoring and evaluation systems put in place. The feasibility studies would be able to answer which methods are most appropriate, sustainable and feasible given the various NIP sites and contexts. Each of the models presented in this paper could facilitate Government and civil society provision of the package of services as envisaged in the NIP but the coordinating mechanisms and obligations would be different:

1. **Social franchising** – where a model is replicated in different geographic locations, and is supported and controlled by a centralised hub. The degree of replication (or the amount of flexibility) that will be required is a point to consider.

   **Should the package of services as envisaged in the NIP be implemented in a standard way in each site like a Kentucky or would a greater degree of flexibility be more desirable?**

   The main determining factors will be:

   a. The extent to which there are enough funds to replicate the model as the case studies suggest that standardised franchising requires a very significant investment in marketing and supervision.

   b. Whether there will be a strong enough intermediary organisation(s) (or hubs) that can manage the roll out of a standardised model

   c. Whether there will be receptivity in the sector, at all levels, to standardisation

   d. Whether standardisation is realistic and can accommodate regional and local contextual concerns

   e. The type of services to be offered and

   f. Whether standardisation will in fact be beneficial for scaling up quality ECD.

2. **Networks and associations** – where organisations form a network of service provision around the package of services contained in the NIP, but there is no requirement for association with a particular brand or methodology. The network would rely on the integrity of the member organisations to adhere to the norms
and standards as there is unlikely to be any way to compel network members to do so.

**Should networks be used as mechanisms for implementing the NIP?**

In this model one should consider whether:

a. A network is a strong enough cohesive force that can ensure quality delivery and

b. Networks are powerful enough coordination mechanisms.

3. **Capacity building and resource models** – where an intermediary organisation(s) would facilitate the provision of capacity building and resources to the sector in relation to the needs identified by the inter-departmental structures, and where a layer of capacity building and resource organisations could be developed through a cascading methodology.

**Would a capacity building and resource model play enough of an integrating and co-ordinating role?**

In this case, one should consider whether: capacity building and resource organisations can play enough of an integrating and coordinating role or whether they should be used in combination with social franchising or networking techniques.

The fact that networks, associations and capacity-building and resource organisations have existed in the ECD sector for many years may mean that they could be more easily introduced as means of scaling up. On the other hand, evidence shows that social franchising methods can be excellent for facilitating reach and quality in a fairly rapid manner.

This paper suggests that all models could be useful in different situations. Considering the large numbers that are intended to be reached, Government could make use of a number of different models or modalities depending on the circumstances, geographical location, type of service to be delivered and so forth.

**Government can draw lessons from existing modes of implementation**

It should be noted that Government is familiar with all of these support formats, as it is either involved in directly piloting or in funding variations of these models. Thus, there is a strong base of evidence to draw on from within the Departments. Those responsible for ECD should harness current experience that has been developed in other sectors (e.g. HCBC) in support of delivering the NIP. Government could consider facilitating a learning network / conference on models of provision and draw lessons based on this.

**Proper strategy and planning presupposes the selection of appropriate models**

The NIP suggests a three-phased approach, and different models could be appropriate in different stages and for different purposes. The NIP needs to be followed by a strategy for scaling up, as well as an implementation plan that can then be translated into annual performance plans and operational plans. Through strategy
Overview of Findings

and planning it will become clearer which models will be well suited to assist with delivery. The situation analysis and feasibility studies suggested in this paper will be useful to inform implementation planning.
Scaling up Early Childhood Development (ECD) (0-4 Years) in South Africa

C.10 International case studies

Introduction

The purpose of this deliverable is to:

- Compare selected international approaches to scaled-up community-based ECD services. Issues covered include policy, funding, targeting, institutional factors, service delivery models, programme components, service integration, staffing, training and accreditation, monitoring and evaluation;
- Provide a critical reflection on factors that facilitated or constrained the roll out of ECD programmes;
- Contribute an analysis of lessons learned from the comparison; and
- Contribute to ideas for the design of Demonstration Projects to test approaches to scaling up ECD services that will improve child outcomes and create jobs.

Method

The aim was to include a literature-based country case study from each of Africa, South America and the Asia/Pacific regions. Parameters for selection as a country case study included:

- A similar scale of vulnerable child population;
- A comparable split of government departments responsible for ECD services (i.e. similar to South Africa);
- Contexts where there has been rapid scaling up and/or rapid quality improvements;
- Efforts at job creation at significant scale, and/or creative approaches to job creation;
- Low- to middle-income countries; and
- Availability of country-based literature and suitable local researchers.

16 A summary for the International Case Studies report was written by Linda Biersteker, Senior Research Associate: CPEG, HSRC and Early Learning Resource Unit (research@elru.co.za, biersteker@hsrc.ac.za) and Andrew Dawes, Research Director: CYFSD, HSRC and Psychology Department, University of Cape Town (adawes@hsrc.ac.za).

The ECD Services in Brazil case study was written by Silvia H. Koller, Professor of Psychology: Centro de Estudos Psicológicos sobre Meninos e Meninas de Rua (CEP-RUA), Instituto de Psicologia, Universidade Federal do Rio Grande do Sul, Porto Alegre, RS, Brazil (silvia.koller@pesquisador.cnpq.br); and Ana Paula Lazzaretti de Souza & Camila de Aquino Morais, both researchers at CEP-RUA.

The ECD Services in The Philippines case study was written by Feny de los Angeles-Bautista, Executive Director: Community of Learners Foundation (teachfen@philonline.com.ph).
Selection of countries for case studies

On the basis of a brief literature scan and suggestions from key international ECD organisations including UNICEF, the Consultative Group for ECD, the ECD Virtual University and the Bernard van Leer Foundation, we identified Ghana, Brazil and the Philippines as appropriate for this purpose. Local experts were then sourced to undertake the case studies according to standard terms of reference.

The Philippines was selected for the following reasons: the country has similar governance structures to South Africa; its ECCD service covers many similar areas to South Africa’s National Integrated Plan; it has been rolled out to a large population via municipal ECCD coordinating structures; a major study has been completed measuring the impact of health and early stimulation inputs, integration of services on 0-4 year-old outcomes; the country has initiated Child Development Workers (as proposed in South Africa), and makes extensive use of outreach workers.

Brazil was selected for the following reasons: like the Philippines the administration of ECD services is highly localised in the municipal government system; the state government system has similarities to South Africa; like South Africa (and the Philippines) Brazil experienced many years of authoritarian rule, and recently adopted rights-based children’s legislation with a strong commitment to early childhood services; Like South Africa and the Philippines, Brazil has a diverse population, with high levels of vulnerability in certain sectors; they have interesting funding models including conditional cash transfer programmes and public-private ventures to support local ECD; the country has a range of home-based workers. Brazil has unresolved inter-departmental challenges (between Education and Social Development).

Ghana is currently trying to scale up ECCE. Its policy, which is designed to address access and quality, was developed in 2004 through a broad consultation process. Ghana like South Africa has had coordination difficulties between the Departments of Social Welfare responsible for crèches and children under three and Education responsible for curriculum for 3-5 year-olds. There are moves to make the kindergarten part of universal, free and compulsory education. Birth registration for children under three is a programme focus.

Unfortunately the Ghana case study was not completed in time for this report. This document presents only Brazil and the Philippines. The two country case studies are preceded by a summary, which includes a brief description of ECD in each country, and a section that compares factors which have facilitated and constrained ECD service expansion. The implications of each country’s experience for ECD demonstration projects in South Africa are noted.

We are most grateful to the country teams who assisted with this research.
C.10.1 ECD services in Brazil

Population and context

At around 184 million people, Brazil has the world’s fifth largest population. 60 million are under the age of 18.

Brazil shares borders with every South American country, except Chile and Ecuador. It consists of 26 states and one federal district, divided into five regions. The population is culturally, linguistically and racially diverse. While a democracy today, the country was ruled by a military dictatorship for two decades, commencing in the 1960s. Similar to South Africa, the oppression of this period gave rise to a strong rights movement that is evident in current law and policy for children.

Social inequality is marked, even though the Gini coefficient has fallen from 58.5 in 2003 to 56.7 in 2007. 22 million Brazilians live below the poverty line, with indigenous and black communities most likely to be poor. In 2000, the poorest 40% of the Brazilian population received just 8% of the nation’s total income, whereas the richest 20% received 64% of the nation’s income. Adult literacy for both men and women is 85%, while fertility rates are 2.1 (lower than the regional average of 2.6).

Brazil has an under-six population of about 23 million. Their status was assessed on the Index of Early Childhood Development (IDI) between 1999 and 2004 and an improvement in early child health and wellbeing was evident over this period. 95% of children are enrolled in primary school, but only two thirds of primary school entrants reach grade 5; just over a third (35%) graduate from secondary school, and fewer than 10% of the working age population has any post-secondary education. The Child Mortality Rate dropped from 53.7/1,000 in 1990 to 33.7/1,000 by 2002. However, the indigenous child mortality rate of 51.4/1,000 remains much higher than the rest of the child population. Malnutrition is significant among indigenous and black communities (the latter being descendents of slaves imported by the Portuguese colonial rulers).

The country has a well-established public health system. Vaccination rates are high (over 95%), 86% of pregnant women have prenatal care and 88% of births are assisted by a skilled birth attendant. Almost 100% of Brazilian children are born in hospitals, and almost 50% of mothers had six prenatal medical visits.

Policy, purpose, targeting and principles of success for ECD services

Brazil is a signatory to the Convention on the Rights of the Child and services to children are embedded in a strong child rights ethos. The Child and Adolescent Statute (known as the ECA in Brazil), was introduced in 1990 to cover all persons under 18 years. Under the ECA, children have the right to food, care, education, protection and participation. The ECA informs child policy and political decisions regarding the realisation of the rights of children from the highest federal structure through state, to local government level and below to communities.
Table 9 – Major service types

<table>
<thead>
<tr>
<th>Target group/beneficiaries</th>
<th>Programme/services</th>
<th>National government agencies</th>
<th>Implementing institutions/level of governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Family Health Program (including clinics and home visiting services)</td>
<td>Departments of Health &amp; Social Development</td>
<td>Municipality</td>
</tr>
<tr>
<td>All</td>
<td>Birth Registration (Brazilian Law 9534/1997)</td>
<td>Department of Social Development</td>
<td>State</td>
</tr>
<tr>
<td>Children in poverty 0-6 years</td>
<td>Better Early Childhood Program (Primeira Infância Melhor) (PIM)</td>
<td>Department of Health with others</td>
<td>Municipality</td>
</tr>
<tr>
<td>All 0-3 year-olds</td>
<td>Day Care Centres</td>
<td>Department of Education</td>
<td>Municipality</td>
</tr>
<tr>
<td>All 4-5 year-olds</td>
<td>Preschools</td>
<td>Department of Education</td>
<td>Municipality</td>
</tr>
<tr>
<td>Families with children under age six living below US$60.00 per month.</td>
<td>Family Fund Grant: Conditional Cash Transfer Programme that is conditional on children attending school, mothers attending pre- and postnatal care, practicing breastfeeding, and having their children immunised.</td>
<td>Social Development</td>
<td>State</td>
</tr>
</tbody>
</table>

Child health

The Department of Health (DoH) provides a comprehensive free primary health service to the whole Brazilian population. The DoH provides a range of targeted services to pregnant women and young children including (among others), prenatal and neonatal care, developmental screening, immunisation, IMCI, family planning, free access to anti-retroviral treatment. In collaboration with the postal services, the DoH distributes information on breastfeeding and childcare to families via the “Friendly Postman.”

The Family Health Programme is the main government initiative (that involves both the Health and Social Development Departments) to improve a wide range of primary health care. Services include (among other elements): Integrated Management of Childhood Illness (IMCI), antenatal care and services to pregnant women at risk, neonatal screening, immunisation and micronutrient supplementation, breastfeeding support, free ARV provision for mothers with HIV. Preventive and curative health care services delivered by a team composed of one physician, one nurse, a nurse assistant, and several community health workers who are responsible for the care of all families in a specific geographic area (comprising about 3,500 people).
Home-based programmes

In the Family Health Programme, Community Health Agents provide health services through home visiting. This service is complemented by the Indigenous Healthcare Subsystem, which accommodates indigenous people and gypsy communities.

The most important early childhood policy initiative stemming from the ECA is the Better Early Childhood Programme (Primeira Infância Melhor, known by the acronym PIM). It is coordinated by the Department of Health in association with the other relevant government departments. PIM is designed to address the needs of vulnerable children under the age of 6 years and pregnant women. The objective is to promote the holistic development of children. In 2006, 30,000 households and 45,000 children were beneficiaries. PIM Diversity, launched in 2006, seeks to provide culturally sensitive services as well as addressing the needs of particularly marginalised groups including Afro-Brazilians and indigenous groups.

In PIM, the ECD delivery models are based on local childcare systems and practices that are incorporated into the Brazilian culture. Home visitors work with women in groups or individually at home, community centres or at the health services. Support and advice is provided from pregnancy through childbirth with follow-up visits to assist with information on nutrition and childcare. Parents are linked to the services they require, and the home visitors provide emotional support if required.

Centre-based programmes

Early childhood education for children under age 6 years is a constitutional right. In 1996, the National Education Guidelines and Framework Law was passed. Since that time, Brazil has attempted to locate administrative responsibility for these services within the Ministry of Education. Municipalities (using local education funds provided by the State government) are responsible for provision of public sector services to 0-3 year-olds and preschools for 4-6 year-olds (State governments are responsible for education at school level). In 2001, the net enrolment ratio of children ages 0-3 years in day care centres was 9%, with 61% of 4-6 year-olds in preschools. These public ECD services are free.

There are an expanding number of centres in the recent years. In 2002, almost 40% (7.2 enrolments) of children 0-6 years of age were attending childcare centres, crèches (1.4 million: 0-3) or preschools (5.8 million: 4-6), highly concentrated in the public sector.

Prior to 1996, day care was the responsibility of the social sector. The process of integration of these services under municipal education has not gone as well as intended and reports indicate that municipalities have not received sufficient support to carry out their mandate. According to UNESCO, “Public early childhood services attended by the poor tend to be of lower quality, especially with regard to facilities and pedagogical environment, and private services of good quality are available mostly among the rich. Quality problems are more urgent and pronounced in day care centres” (http://unesdoc.unesco.org/images/0015/001512/151271e.pdf).

While it retains some involvement with ECD, the social sector is responsible for social assistance (http://ww.unesco.org/education/earlychildhood/brief).
Organisation and co-ordination

In Brazil, the institutions for funding, governance, administration and implementation, including public/private and institutional in all geographical levels are integrated to the policies of the Brazilian Child and Adolescent Statute (ECA). Governance and delivery is highly decentralised to municipal level.

These structures play a role in promoting awareness of children’s rights as well as ensuring that children’s rights to health, education and protection services are realised as illustrated in Figure 1 below. Councils also have influence over the design and monitoring of programmes in the public and non-profit sector. Both government and community representatives are involved in these structures.

Figure 1 – Children’s rights councils and protective levels

The municipality is the key node for ECD services and financing.

Financing and sustainability

Funding for public sector ECD services (child care and preschools) proceeds from the Federal Education Department level through State allocations to the municipal level.

The Health Ministry contributes significantly to the PIM and the comprehensive primary health care services at local level.
The Ministry of Social Development and Hunger Eradication is responsible for the Zero Hunger food security campaign which includes the Bolsa Família (Family Fund). Bolsa Família is a conditional cash transfer programme that includes school grants, food programmes, food cards and petrol allowances for targeted poor families. Grants are conditional on children attending school, and mothers and young children availing themselves of clinical services such as immunisation and antenatal services. Evaluations indicate that living standards among beneficiary families and young children have improved. Although there is some local development thanks to the allocation of resources in small communities, beneficiaries remain dependent on the continuation of the transfers.

In regard to private sector funding, the Millennium Fund for Early Child Development (ECD) is a new World Bank initiative to support community-based initiatives for the well-being of children from 0-8 years of age. Private sector support is sought for local community ECD initiatives. Corporate contributors are recognised with “Millennium Entrepreneur Certificates”. Contributions in kind are also welcomed and may include provision of equipment, human resources, and technical or administrative services. The goals are to:

a. To strengthen capacity for ECD initiatives; and
b. To support development of ECD programmes.

Small grants are provided to communities and non-profits to establish and maintain quality ECD services for young children. The Funds are managed at local level by Education Boards, which support a group of childcare and education organisations.

Brazil’s Millennium Fund for Early Childhood relies on partnerships and commitments among local, regional, national, and international participants and integrates the contributions of individuals, communities, corporations, and NGOs to build capacity for ECD and to deliver ECD services to children and families, alongside government.

The experience in Brazil shows that it is possible to make strategic alliances with the private sector to support early child development in poor communities.

**Staffing, training and accreditation**

Different levels of worker are required in the field. Home visitors have relatively low skills, while day care service staff are provided with training at professional secondary schools or at technical colleges.

However, ECD issue is, furthermore, more frequently the focus in non-formal teaching environments than in the formal one.

NGOs have played a significant role in practitioner training. ECD training is not that well established in the tertiary sector. However, there are initiatives to involve professionals trained in such disciplines as Psychology, Education, Medicine, Nutrition, and Nursing in providing more specialised education on aspects of ECD.

The organisation of ECD jobs depends on the programme. PIM staffing is illustrated in Figure 2. PIM staff consists of a State Technical Group (GTE) and a City Technical
Group (GTM). GTE manages and monitors the program at state level. It consists of social assistants, psychologists, educators, nurses, phonoaudiologists, and educators, among others. GTM performs similar functions at the municipality level, except that staff in this group is responsible for ensuring the implementation of the programme by home visitors, who deliver services to the activities to parents/caretakers under the supervision of monitors.

**Figure 2 – PIM staff structure**

![Diagram of PIM staff structure]

**Programme components and curriculum**

The early childhood curriculum is based on the Guidelines and Bases of the National Education (LDB) Act, Act 9394/96. Articles 12 and 13 stipulate that institutions for early child education have to compile daily programmes and lesson plans with teacher participation.
The National Curriculum Reference for Childhood Education recommends that themes be developed that will favour the development of autonomy and the children’s identities, and that include the following knowledge objects: Music; Visual Arts; Movement; Oral Language and Writing; Nature and Society; and Mathematics. The curriculum covers six years, of which the first two years apply to crèches, while the next four are regarded as true early childhood education.

The creation of Educational Boards is the main strategy for improving quality education and early child development. The Educational Boards assure permanent space, with learning materials, and also provide venues for teacher training and mentoring. Each Board accommodates up to five Early Childhood Care and Education (ECCE) institutions and is coordinated by an ECCE expert who, in many cases, is a civil servant of the Municipal Education Secretariat. The functioning of each Educational Board is supported by a Local Council consisting of representatives from at least three local entities, including the municipal government. The Management Council is responsible for following up on the activities of all Local Councils and Educational Boards.

**Evaluation studies**

The Secretariat for Information Management and Evaluation (Secretaria da Avaliação e Gestão da Informação, SAGI) is responsible for commissioning longer-term impact and implementation evaluations (qualitative and quantitative) of Brazilian programmes.

A search conducted for this project did not reveal any studies on the effects of early childhood care and education programmes in Brazil. Although many universities conduct research on early childhood topics, they rarely address applied early childhood research.

The World Bank is currently conducting a study of the outcomes of the Bolsa Família conditional cash transfer programme. It consists of a longitudinal study that measures impact on food expenditures and diversity of food intake; the anthropometric status of children under seven; expenditures on schooling, health and clothing; school outcomes; and health-care use. The World Bank also provided technical support to strengthen the overall monitoring and evaluation of the programme.

**Enabling factors and key challenges for scaling up ECD services**

A key challenge for Brazil is the continuation of widespread poverty. The historical absence of a strong state welfare policy has meant that NGOs have born the brunt of support to the poor. It remains the case that Brazil lacks a well-organised welfare system to deliver services.

While there is much merit in the decentralised approach to ECD, coordination of services needs strengthening. Many ECD programmes highlight the importance of working at local level, but at the same time, they point out that local competence and will is frequently low.

The Brazilian experience raises considerable questions about the value of decentralisation, which increases the challenge of implementing public policies, particularly in a context in which local level administrative capacity is frequently weak.
The Brazilian experience points to the necessity for a national coordinating body at a high level; articulated policies and programmes; focus on the best interests of children and their rights; and effective monitoring and evaluation. Community participation is also very important, as it gives a sense of belonging, which is a protective factor in the lives of people.

Good data is needed on ECD is needed to inform policy and practice. Quality standards need to be developed, and knowledge of policy and programme implementation needs to be disseminated more widely. An evaluation and monitoring policy would make it possible to provide feedback on policies through the use of data and information, with transparency and accountability to improve the performance, increasing efficiency and efficacy in the use of public resources. There is considerable experience and potential in existing ECD institutions that can be drawn upon but this is not currently realised.

A final but most important challenge is to develop a stronger culture of children’s rights in the country so that services to young children in particular are well informed by a rights ethos.

C.10.2 ECD services in the Philippines

Population and context

88.7-million people of diverse ethnic, cultural and linguistic backgrounds are geographically dispersed across the 300,000m² archipelago in South-east Asia. There are 9.6-million children under five, about half of whom live in urban areas.

Socioeconomic development is uneven with wide regional and population group disparities. People living in extreme poverty have decreased from a baseline figure of 24.3% in 1991 to 13.5% in 2003 but poverty is widespread particularly in rural areas. The economy is growing at 4.5% with unemployment at 11.7%. 84% of the adult population is functionally literate.

Infant mortality rates have declined from 57 to 24 deaths between 1990 and 2006 but maternal mortality rates are still high with only half of married women 15-49 years accessing reproductive health care in 2006. Many children die of preventable diseases, including pneumonia and diarrhoea. The under-five mortality rate (U5MR) per 1,000 live births in rural areas (52) is higher than in urban areas (30). Among 0-5 year-olds, 27% are underweight, 30% are stunted, 5.5% are wasted and 1.4% are overweight.

Filipino families prefer to care for children in homes or the immediate neighbourhood and most young children are cared for in the extended family in urban and rural communities. Enrolments in centre ECCD programmes pick up from three-and-a-half to six years, mainly as preparation for formal schooling. Child-rearing practices are based on a blend of indigenous, pre-colonial cultures with Chinese, Spanish and North American influences due to migrations and colonization by Spain and the US.
Policy, purpose, targeting and principles of success of ECD services

At the national level, the Departments of Social Welfare and Development, Health and Education are directly involved in ECCD policy development and implementation. Implementation of national social and health services is the responsibility of local governments at provincial, municipal and barangay (village) level.

Republic Act 8990 of 2002, “The ECCD Act”, provides a comprehensive framework for all ECCD service delivery and defines the scope to include childcare and well-being, support for families and parent education, and early education for young children up to age six. The two most significant features this Act are 1) the definition of the national ECCD programme comprised of already existing services and the clarification of roles and responsibilities among service providers, programme managers and policy-makers; and 2) the provision of additional financial resources and technical support to enable local government units to implement the national programme in the villages where these public services are necessary but not yet available or levels quality are low.

ECCD is multi-sectoral and multidisciplinary and to support integration the Council for the Welfare of Children (CWC), the existing inter-agency and multi-sectoral structure for policy development and oversight of all child focused programmes and services – is tasked to focus on promoting access to, improving quality and strengthening ECCD programmes and services.

The “Education Act”, which covers the entire Philippines education system, is the basis for the expansion of kindergarten classes and ECCD programmes within the public school system. Within the school system, national policies are implemented at all levels, from field offices ( regional, provincial, or city) to schools.
### Table 10 – Major service types

<table>
<thead>
<tr>
<th>Target group/beneficiaries</th>
<th>Programme/services</th>
<th>National government agencies</th>
<th>Implementing institutions/level of governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 year-olds</td>
<td>Integrated Management of Childhood Illnesses (Maternal &amp; Child health programmes)</td>
<td>Department of Health</td>
<td>Municipal and Barangay Health Centres</td>
</tr>
<tr>
<td></td>
<td>Child-Minding centres</td>
<td>Department of Social Welfare and Development</td>
<td>Barangay day care centres</td>
</tr>
<tr>
<td>3-5 year-olds</td>
<td>Day Care Centres, ECCD Centres</td>
<td>Department of Social Welfare and Development</td>
<td>Barangay day care centres</td>
</tr>
<tr>
<td></td>
<td>Preschools, Nursery, Kindergarten</td>
<td>Department of Education</td>
<td>Public schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Private schools</td>
</tr>
<tr>
<td>6 year-olds</td>
<td>ECCD in Grade One</td>
<td>Department of Education</td>
<td>First grade classes in public schools</td>
</tr>
<tr>
<td>Parents</td>
<td>Maternal &amp; Child Health (pre-natal to post-natal care, nutrition counselling)</td>
<td>Department of Health</td>
<td>Provincial and Municipal Hospitals and Barangay Health centres</td>
</tr>
<tr>
<td></td>
<td>Parent Education Service (PES)</td>
<td>Department of Social Welfare and Development</td>
<td>Municipal Social Welfare Office</td>
</tr>
</tbody>
</table>

There is no accurate data on access to services for children under 3 years. 34% of 3-4 year-olds attend day care and other ECCD programmes and 78% of 5 year-olds attend preschools.

#### Home-based programmes

Few under threes attend full day child minding programmes but there are some usually set up by NPOs which provide custodial care for a group of children in the caregiver's home.

The DSWD’s **Parent Effectiveness Service** (PES) aimed at infants and young children is designed around parent discussion groups that meet regularly. It includes supervised neighbourhood playgroups. These are facilitated by a trained community member/parent volunteer and convene in a home in the village from 1 to 5 times a week. Coverage is limited as it is reliant on volunteers and receives very little, if any, public funds and there is little understanding of its importance compared with centre care programmes.
**Centre-based, workplace-based and community-based ECCD programmes**

The public day care system is the largest provider of centre-based ECCD programmes for 3-5 year-olds, though few young threes attend. There is a public day care centre in virtually every village of the country and local government units are directly responsible for their management and operation. These operate on weekdays for three to four hours some operating for two shifts. Sessions include supervised play and learning and centres offer a snack, health education and conduct growth monitoring and developmental screening.

Other provisions include a smaller number of community-based ECCD centres, operated by NGOs usually serving children from two years with more flexible hours and some workplace childcare centres, encouraged by national policy.

Complementary to the public day care programme is the barangay health centre which is the main setting for primary health care services and most accessible to mothers and infants and young children. These are also managed and operated by the local government unit. The public health nurse and rural health midwife are the main service providers assisted by a cadre of volunteer barangay health workers and nutrition education workers. These provide pre-and post-natal care services for pregnant and lactating mothers, infant and well-child clinics and nutrition counselling including home visits for pregnant and lactating mothers. “Mothers classes” have also been promoted in the primary health care delivery system at the barangay level. These group sessions focus on child health, care and nutrition. Integrated Management of Childhood Illnesses (IMCI) programmes also operate to build on and strengthen the parent education components of the public primary health care system.

In highly-functional and well-supervised local government units, these community health workers jointly implement health and nutrition activities like growth monitoring and supplemental feeding with the day care workers for the children in their day care centres.

The Kinder Plus project, 2000 to 2003, operated in more than 114 rural barangays in Nueva Ecija province to support and promote existing government home- and centre-based ECCD programmes. “ECCD corners” were set-up in the village health centres to encourage parent-child interaction around storybooks and improvised educational playthings. Print materials on child growth and development were made available to parents who brought their children to the health centre. These parent education programmes designed to support parents and improve the quality of care they provide infants and very young children are explicitly and appropriately linked to basic social services and health care services.

**Organisation and co-ordination**

Public ECCD services developed and initiated by the Departments of Social Welfare and Development and Health national programmes are implemented by the local government units at these three levels, starting with the level closest to the young child and family: 1) barangay (village); 2) municipal or city government; and 3) provincial government. The Education Department is responsible for early education programmes within the public school system (primarily 5 and 6 year-olds).
Overview of Findings

National government agencies set standards have monitoring and oversight functions and provide some funding for programme development, technical support and evaluation of programmes, supplemental resources for infrastructure, materials and equipment. LGUs are directly responsible for management, recruitment and supervision of staff and volunteers and the provision of resources necessary to establish and operate these ECCD services, e.g. salaries and training of personnel, supplies, infrastructure, facilities, supplies and materials. This is financed through their tax share.

ECCD is designed to address the physical, psychosocial and learning needs of young children and support their caregivers. Integration is achieved through: a) complementary approaches applied at the various levels of government (e.g. combination of information and education with direct services to children) and b) convergence of the basic social services at the level of direct service delivery to children and families (group care and socialization for early learning primary health care and nutrition).

A crucial component of ECCD service development in the Philippines has been an investment by national government in advocacy and social mobilization to secure political commitment to the process and for partnership building. Efforts were directed towards local government leaders as well as private organisations (corporations, philanthropic organisations, civil society partners), international donors and intergovernmental institutions.

ECCD stakeholders in the Philippines were geared towards active partnership-building between 1) public and private sector or civil society actors (child-focused organisations, educational institutions, community-based and grassroots people’s organisations) on the one hand; and 2) across various disciplines, i.e. health, education, social development, on the other hand.

The challenge has been to consolidate efforts, expand coverage, apply more systematic and focused targeting approaches in order to reach those who are at highest risk and/or still excluded and improve overall quality of services.

**Financing and sustainability**

Service providers for the public centre-or home-based ECCD programmes serving 0-4 year-olds at the village level (barangay) are given in the table below.
Table 11 – ECD service providers and volunteers in local government units

<table>
<thead>
<tr>
<th>ECCD programme / service &amp; location</th>
<th>Service provider</th>
<th>Supervisor in local government</th>
<th>National government agency (accreditation, technical support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barangay Day Care Centre</td>
<td>Day Care Worker</td>
<td>Municipal Social Welfare Officer</td>
<td>DSWD</td>
</tr>
<tr>
<td>Child Minding Centre</td>
<td>Day Care Worker/Parent volunteer</td>
<td>Municipal Social Welfare Officer</td>
<td>DSWD</td>
</tr>
<tr>
<td>PES supervised neighbourhood playgroups</td>
<td>PES (parent) volunteer</td>
<td>Municipal Social Welfare Officer</td>
<td>DSWD</td>
</tr>
<tr>
<td>Rural Health Unit/ Barangay Health Centre</td>
<td>Rural Health Midwife</td>
<td>Public Health Nurse (Municipal/City Health Office)</td>
<td>DOH</td>
</tr>
<tr>
<td>Mother’s Classes &amp; Nutrition Counselling</td>
<td>Community Health Volunteers Barangay Nutrition Scholars</td>
<td>Rural Health Midwife</td>
<td>DOH</td>
</tr>
</tbody>
</table>

Supervisors are based at the municipal or city offices and are responsible for monitoring the various centres and home-based programmes. Supervisory and monitoring functions include facilitating or organizing training for the service providers. However, without additional sources of funds for training, generally very little attention is given to organised and regular in-service training. Field visits by supervisors who are responsible for other social services and health programmes are also limited or hampered both by a lack of resources from the city or municipal government and a lack of awareness and understanding of the supervision as support rather than inspection.

There are two types of private sector-run ECCD programmes or schools that serve children aged 0-4, those that rely on fees paid by families; and those that rely mainly on grants but also require monthly or annual contributions from families. Nurseries and kindergartens register with the DoE and satisfy all requirements and standards to qualify for a permit to operate. Private day care centres serving 0-4 year-olds register with the local office of the DSWD.

**Staffing, training and accreditation**

Staffing for private preschools or ECCD centres and non-profit community-based ECCD programmes varies but generally provides for a teacher and a second adult e.g. a teacher-aide or assistant teacher or a parent volunteer. The community-based ECCD programmes run by NGOs may include a health worker or work with the public health care service providers in the barangay. Private preschools serving middle to higher income families employ qualified teachers with a bachelor’s degree in ECE or elementary education. Non-profits serving poor urban and rural communities recruit teachers from the community, who have completed secondary education and
may have some further education. Enrolment in specialised ECE pre-service teacher education has increased in the last decade.

Child development workers were a new type of service provider intended to link home and centre based services. Their task was to complement the role of midwives and health workers in nutrition and health support and parent education (Armecin et al., 2006). 17 De Los Angeles (personal communication) indicates that these were either the health community workers or a few newly recruited day care workers or active parent effectiveness service volunteers who were given training under the auspices of the project, but are not yet as widespread as envisioned. The responsibilities are being integrated in the work of existing community health workers or parent effectiveness volunteers in various provinces. The idea was not to create new positions but to ensure stability and continuity with existing volunteer workers at local level or new recruits without “plantilla positions” (in bureaucratic terms no position, no pay). In the Kinder Plus project the same concept of such a worker with such responsibilities was promoted but using the existing worker positions with revised terms of reference because it takes too long to create new positions in local government structures.

**Programme components and curriculum**

Play based day care curriculum with a variety of activities organised by theme: dramatic play, songs, games, manipulative play, group activities involving music and dance, storytelling, arts and crafts. The less structured neighbourhood playgroups focus on language and psychomotor development. Instruction is in home language and indigenous songs, stories, visuals and experiences are part of the programme. Supplementary feeding and nutrition education is meant to be included but this varies and may be provided through donations or by parents.

**Evaluation studies**

Longitudinal study of the effects of local government parent education interventions on children’s physiological, cognitive and social development on 6,000 children indicated a significant positive impact with two years of exposure for overall psychosocial and gross motor development but not as much for language and cognitive development. No significant impact on health and nutritional status except for reducing the proportion of underweight and wasted children in one Region.

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Enabling factors and key challenges for scaling up ECD services

- Legislation (especially Republic Act No. 8980 or the ECCD Act) which has strengthened convergence and coordination and determined roles and responsibilities at national, provincial and local government level.

- Devolving of responsibility for services and funding to Local Government Units (LGUs) with support and additional funds from national especially to poorer municipalities.

- The Council for Welfare of Children, which acts as national coordinating council for ECD in partnership with LGUs.

- A Bright Child campaign, which raised the profile of ECD and advocacy efforts targeted towards local chief executives and politicians, which in turn generate more resources and more attention to public ECCD programmes.

- Buy in from LGU and mainstreaming ECD in local development and investment plans for children has been important.

- Partnerships with NGOs and the private sector.

Further work needs to be done to:

- Create dynamic partnerships with families, communities and local institutions.

- Strengthen governance of ECCD centres and coordination between centres and local child protection councils.

- Creating and operationalise a user-friendly ECCD monitoring system.

- Build capacity for supervisors and programme managers and training and support for service providers.

C.10.3 Implications of the country case studies for scaling up ECD services in South Africa

These two international case studies suggest the following would be useful to explore in the context of scaling up ECD services for 0-4 year-olds and jobs in the sector:

- The significant role that legislation has played in enabling the scaling up process – a legislative mandate for the delivery of certain services for young children, specifying roles, coordination and funding responsibility has been significant in the Philippines via the ECCD Act and in Brazil through the National Education and Framework Law. No similar mechanism exists in South Africa where the Children’s Amendment Act of 2007 does not prescribe the funding of ECD Services (it merely requires prioritisation of vulnerable groups of children). In Brazil, public ECD services are a right and are provided free through municipalities. In South Africa free primary health care services for young children were however legislated, and there is significant coverage as a result.

- In both countries, the use of the health services as a key node for outreach to children under three years and their mothers for health education, support and also for parenting education has been significant. Given that health is also the primary
service point for children under three years in South Africa, this is an important potential point for ECD service expansion and integration.

- In both Brazil and the Philippines, high-level co-ordination of ECD services at national level is evident, with responsibility for service delivery devolved to municipality level. In South Africa the departments responsible for the NIP for ECD are equal partners (including the DoSD, DoE, DoH, and the ORC). The DoSD plays the coordinating role. According to the NIP, the key role of the relevant ministers is to provide leadership and guidance for the implementation of the Plan. However, the process whereby decisions made by the national interdepartmental committee are implemented is not clear. Each Department according to the NIP is responsible for its own mandate. The integrative function requires much greater clarity in order for the goals of the NIP to be realised.

- Neither Brazil nor the Philippines have a developed evidence-base for ECD. In both instances, there is a need for better monitoring and evaluation systems. Improved administrative data is seen as important to ECD service expansion and also for monitoring child development outcomes. Similar challenges are evident in South Africa.

- In both Brazil and the Philippines, ECD services (health and social welfare services) are delivered at municipal level while education is a state or national responsibility. The South African NIP for ECD proposes stronger municipal level service delivery but it is worth noting some challenges identified in both Brazil and the Philippines in this regard. While it is seen as important to work at local level, in Brazil the experience has been that local competence and will is frequently low. Similarly, in the Philippines mobilising commitment to ECCD service delivery or improving service quality was contingent upon “effective marketing efforts with local chief executives”. In the Philippines, there is provision for additional funding and technical support for municipalities to enable local government units to implement national programmes in areas where services are necessary but not yet available or levels of quality are low. This is clearly relevant in South Africa for strengthening local level services.

- An important lesson from the Philippines is that the introduction of new types of ECD worker (e.g. Child Development Worker) in the sector has been challenging for a range of reasons. Most important is that creating new job categories takes considerable time. It may be more efficient to build new roles into existing job categories.

- In regard to sustainability and funding, the Brazil experience shows that it is possible to make strategic alliances with the private sector to support early child development in poor communities. An example is the Millennium Fund for Early Child Development (ECD). Private sector support is sought for local community ECD initiatives. The Fund relies on partnerships among local, regional, national, and international participants. It integrates the contributions of individuals, communities, corporations, and NGOs to build capacity for ECD and to deliver ECD services to children and families, alongside government.

- In both countries, significant advocacy efforts are made to inform parents, government officials (especially at local level), and other stakeholders, of the importance of ECD. This has been a significant factor in the scaling up of services in these countries.