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

ECD in South Africa: Policy, Demographics, Child Outcomes, Service Provision and Targeting

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Acronyms

AC	African Charter on the Rights and Welfare of the Child
ART	Anti-Retroviral Therapy
ASSA	Actuarial Society of South Africa
C-IMCI	Community Integrated Management of Childhood Illnesses
CBO	Community-based Organisation
CDG	Care Dependency Grant
CDW	Child Development Worker
CRC	Convention on the Rights of the Child
CSG	Child Support Grant
DHIS	Department of Health Information Systems
DHS	Demographic and Health Survey
DoE	Department of Education
DoH	Department of Health
DoSD	Department of Social Development
EFA	Education for All
EPWP	Expanded Public Works Programme
ETDP SETA	Education, Training and Development Practices Sector Education and Training Authority
FAS	Foetal Alcohol Syndrome
FBO	Faith-based Organisation
FSW	Family Support Worker
HAART	Highly Active Anti Retroviral Therapy
HCBC	Home and Community-based Care
IMCI	Integrated Management of Childhood Illnesses
MDG	Millennium Development Goal
MEC	Member of the Executive Council (provincial government)
MIC	Municipal Interdepartmental Committee
NGO	Non-governmental Organisation
NIC	National Interdepartmental Committee
NIP	National Integrated Plan
ORC	Office of the Rights of the Child
OVC	Orphans and Vulnerable Children
(P) MTCT	(Prevention of) Mother to Child Transmission
PHC	Primary Health Care
PIC	Provincial Interdepartmental Committee
PTSD	Post Traumatic Stress Disorder
SSA	Statistics South Africa
VCT	Voluntary Counselling and Testing

Executive summary

Purpose

The purpose of the paper is 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 aged 0-4;
- Provide a profile of vulnerable children aged 0-4 (child outcomes and demographics) in South Africa and flag data gaps in this regard;
- Provide an overview of provision of the primary National Integrated Plan (NIP) for ECD service components to children aged 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 different 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 the 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 of 2007, the National Integrated Plan for ECD, the Massification of ECD Concept Document and the ECD component of the Expanded Public Works Programme (EPWP) Social Sector Plan. 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 to more children.

These legislative and policy commitments and plans for 0-4 year-olds signal a significant shift in principle towards providing for a range of ECD services extending beyond the ECD centre. These services 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.

However, 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 one driving budgeting and integrated service delivery at provincial and municipal level, which is where the

budgetary and 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 of 2007 (Republic of South Africa, 2007) and the Guidelines to ECD Services (Department of Social Development, 2006b) privilege the ECD centre model and do not clearly reflect other types of ECD services;
- 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, though regulations under the Children's Amendment Act may provide for this;
- Funding norms for the Department of Social Development (DoSD) currently provide only for ECD centres. Further, the level of government funding of ECD services (delivered at the centre level and to community groups and in homes) is extremely small 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 (for example, Health, Social Development and Education) and programmes (for example, EPWP and NIP) are entirely separate;
- Proposals for emerging categories of ECD jobs and training for workers in different ECD service types need to be developed and concretised;
- Some of the categories of vulnerable children prioritised for service delivery are very large, while others are not necessarily direct indicators of vulnerability (for example, child-headed households per se are not necessarily a direct indicator of vulnerability as the care available to them has been shown to vary considerably), but the NIP does not suggest how decisions about how to target services will be made; and
- Finally, the ECD centre is suggested as the point of choice for expansion of outreach services for young children but there still needs to be exploration of other options such as the potential of the Primary Health Care centres as a node for integrated service delivery in the policies and plans.

Profile of vulnerability in children 0-4 years

Data on the status of young children (0-4 years) indicate that this age group has the highest mortality in the South African population (at 57.6 per 1,000), and that over a quarter of child deaths are due to diseases related to poor living conditions. Nutritional status is a concern with unacceptable stunting and underweight rates, especially for children 1-3 years.

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. An estimated 3.7% of children 0-4 years are HIV positive. Few HIV-positive infants, including those who were part of Prevention of Mother to Child Transmission (PMTCT) programmes, are on Anti Retroviral Therapy (ART) and many die during their first year.

Very many young children are exposed to conditions that threaten their development – two thirds are living in poverty[1]. 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 childbearing 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 National Integrated Plan

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;
- 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 (immunisation coverage increased from 63% in 1998 to over 90% in 2005, 76% of Primary Health Facilities implement IMCI, and over 90% of births occur in a health facility), social grant uptake (86% of 0-4 year-olds are estimated to be eligible to receive the Child Support Grant, or CSG), and progressive introduction of improved per capita subsidies for poor children in ECD centres and numbers of children receiving these. However, as with child status, there is unevenness across provinces and there are many data gaps on the primary NIP deliverables, such as recent data on nutritional status, access to early learning stimulation and to psychosocial programmes and on actioned referrals to social services and health. Further, there is little service quality information.

[1] 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 if he/she was found to live in a house with an expenditure level of less than R1,200 (see Table 10).

Targeting for implementation of the National Integrated Plan

In view of the large vulnerable groups identified for receipt of the NIP service package, a recommendation is made in this paper for more specifically **targeting** to particular risk levels. The proposal is that:

- The NIP service components are viewed as being delivered on a continuum basis, from universal (such as birth registration, primary health care and parent awareness messages) to early interventions to more vulnerable groups (such as grants, IMCI, psychosocial support, parent education groups) to specialised interventions including statutory interventions for children who are more seriously at risk (such as HIV-positive children, children 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 is 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; and
- A simple risk screen be developed and administered to determine the service components required by different children and their caregivers.

Inferences for the design of demonstration projects

The key inferences from this review of policy, demographics, child outcomes, service provision and targeting are as follows:

- Different ways of cost-effectively achieving delivery of the integrated NIP service package through formal, community and home-based ECD services 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;
- The demonstration projects need to trial mechanisms for improving quality in the delivery of the NIP service package with job creation and skills development and ways of measuring and monitoring this;
- The demonstration projects could explore a two-phase targeting process; first general targeting to particular areas on the basis of how the basic NIP service package has been delivered (for example, health status, birth registration, immunisation status and access to ECD stimulation programmes) and second risk screening within the community to carefully target very high-risk caregivers and children requiring intensive interventions. This will involve adapting or developing screening tools for this purpose and validating them.

1. Introduction

This paper is one of a series developed to inform the Scaling up ECD Services (0-4 years) Research Project. The purpose is to improve the evidence base supporting implementation of government's vision for ECD as set out in the NIP for ECD and the EPWP of scaling up integrated services and creating jobs in the ECD sector.

The purpose of *this* background paper is 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 aged 0-4;
- Provide a profile of vulnerable children aged 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 service components to children aged 0-4 and flag data gaps in this regard;
- Make recommendations for targeting in implementation of the policy for scaling up services;
- Draw inferences for the design of demonstration projects to test options for scaling up ECD services that will improve child outcomes and create jobs.

The paper is organised as follows: Section 2 sketches the core legal and policy commitments to young children aged 0-4 and highlights the gaps in the interface between policy and law. In Section 3 a profile is given of 0-4 year-olds in South Africa, with particular reference to groups designated as vulnerable in policy. Section 4 collates existing information on service delivery in relation to the primary service package identified for 0-4 years olds in the NIP for ECD and identifies data gaps. In Section 5 we comment on targeting in relation to the ECD scaling up vision. Finally, we draw some conclusions and identify areas that should be considered in the design of demonstration projects to test ways of facilitating the upscaling of ECD services for 0-4 year-olds of an acceptable quality while creating skills and jobs.

2. Legal and policy commitments to children aged 0-4 years

ECD policy and legislation in South Africa have been developed by different departments and reflect the overlapping of sectoral responsibilities for addressing children's needs. The three departments primarily responsible for ECD policy development to guide ECD service delivery are the DoSD, the Department of Education (DoE) and the Department of Health (DoH), while the Office on the Rights of the Child in the Presidency has a monitoring role.

The legislative framework and different departmental policies and plans at national, provincial and local government level have numerous implications for service provision for young children, and one of the challenges identified in expanding ECD programmes has been the lack of coherence between legislation, policies and plans (for example, Biersteker, 2007 and Departments of Social Development & Education, 2006).

2.1 Legal framework

2.1.1 The South African Constitution and child rights obligations

The basis for service delivery for young children in South Africa rests on government's commitment to child rights as specified in the Constitution and leading rights instruments ratified by government. Regarding the latter, South Africa is a signatory to the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (AC) and commitments to young children in the South African Constitution (Republic of South Africa, 1996) articulate with these. They build on the general principles of the best interests of the child, non-discrimination, survival and development and participation. Both recognise the primary responsibility of the parents for bringing up children and the need for states to provide necessary assistance. The implications of rights provisions under the CRC and AC are more fully discussed in Biersteker (2007) and Biersteker & Kvalsvig (2007).

Chapter 2 in the Bill of Rights confirms the basic needs of children, such as nutrition, shelter, basic health care services and social services as the right of every child. It also confirms the right of every child to be "protected from maltreatment, neglect, abuse or degradation". 28 1 b reflects the child's right to family care or parental care. While progressive realisation of socioeconomic rights within available resources applies to adults, there are no limitations on the realisation of these rights for children, implying that children in particular have the right to having their basic rights met.

All three spheres of government have responsibility in relation to providing ECD services to children aged 0-4. National government has responsibility for policy and monitoring responsibility (the three departments noted above), whilst provinces have

responsibility for service delivery. Municipalities have the constitutional power to provide child care facilities, but this is not mandatory.

In September 2005, the United Nations Committee on the Rights of the Child adopted General Comment No 7 (Committee on the Rights of the Child, 2005). This was in response to State reports on young children which were narrowly focused on health and birth registration indicators, and makes a number of recommendations to ensure recognition that young children "are holders of all rights enshrined in the Convention and that early childhood is a critical period for the realization of these rights" (Paragraph 1). This implies a broad interpretation of the services to which young children are entitled and the partnership between government, parents and non-governmental agencies in service delivery. For example, States Parties are encouraged to:

- Develop rights-based, multidimensional and multi-sectoral strategies towards an integrated approach to ECD, taking into account children in different contexts, such as prisons, refugee children, HIV/AIDS, and children of alcohol or drug-addicted parents;
- Increase human and financial resource allocations for ECD services and programmes through partnerships between government, public services, families and the private sector; and
- Work with local communities in home- and community-based programmes in which parents' empowerment and education are main features.

2.1.2 ECD in the Children's Amendment Act No. 41 of 2007

The Children's Act of 2006 (including the Children's Amendment Act) is a comprehensive and progressive piece of legislation for children, which when finalised will provide the necessary mandates for a wide range of the provisions of the Bill of Rights, CRC and AC.

In the Children's Amendment Act, ECD issues are included in Chapter 5 (partial care [facilities]), Chapter 6 (early childhood development programmes) and Chapter 8 (early prevention and intervention services). Chapter 7 (child protection) is also very significant for young children in that children under five years are at the greatest risk of physical neglect and abuse, resulting in statutory interventions (Dawes *et al.*, 2006). This underlines the need for seeing early prevention and intervention as an ECD issue. Chapter 13 covers child and youth care centres, which include young children in increasing numbers as a result of the AIDS pandemic (Kvalsvig, Chhagan & Taylor, 2006).

Chapter 6 (ECD) defines ECD services as including those offered by someone other than the child's parent or caregiver and together with Chapter 5 (partial care) provides for the registration and monitoring of such services. Only registered services are eligible for subsidisation. The registration process is cumbersome for many service providers. This is both due to limited capacity in the agencies and registration

authorities as well as the procedural requirements. In view of this problem the legislature has provided for a category of conditional registration.[2]

Chapter 8 contains a number of provisions relating to families and there are clear links to the emerging ECD service focus on prevention and household and community level services (*cf.* the NIP for ECD below). For example, Article 144 specifies some focus areas for prevention and early intervention services or programmes, including:

> *(b) Developing appropriate parenting skills and the capacity of parents and care-givers to safeguard the well-being and best interests of their children, including the promotion of positive, non-violent forms of discipline; (c) developing appropriate parenting skills and the capacity of parents and caregivers to safeguard the well-being and best interests of children with disabilities and chronic illnesses; (d) promoting appropriate interpersonal relationships within the family; (f) preventing the neglect, abuse or inadequate supervision of children and preventing other failures in the family environment to meet children's needs; (g) preventing the recurrence of problems in the family environment that may harm children or adversely affect their development; and (i) avoiding the removal of a child from the family environment.*

It also indicates that such services and programmes may include assisting families to obtain the basic necessities of life, empowering families to obtain such necessities for themselves. A participatory approach is required, with families, parents, caregivers and children involved in identifying and resolving their problems.

Clauses 78 (partial care) and 93(1) (ECD) provide that provincial Members of the Executive Council (MECs) for Social Development *may* provide and fund such services, but provisioning is not compulsory. However, the Act does require that funding of ECD programmes must be prioritised in communities where families lack the means of providing shelter, food and basic necessities of life for their children and for children with disabilities.

2.2 Policy framework: overview

This concise policy summary will focus specifically on the ECD provisions of the three key social cluster approved interdepartmental plans and programmes relating to the roll-out of services for young children 0-4 years. These are:

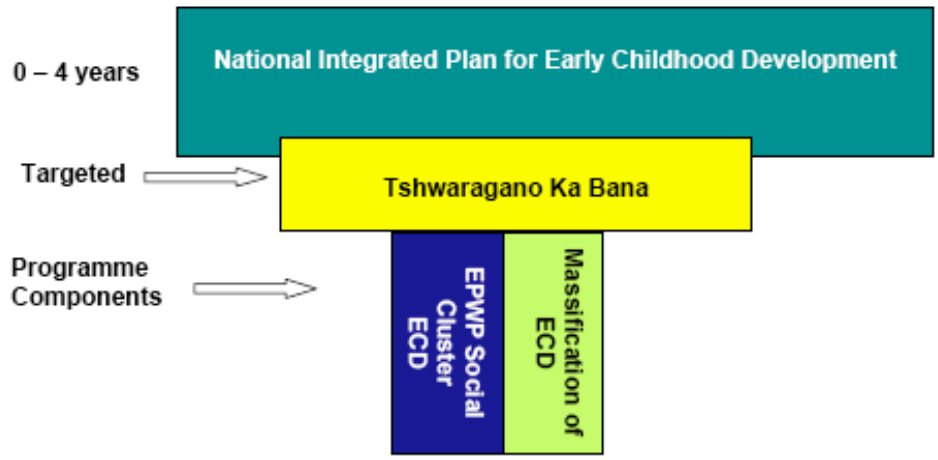
- The National Integrated Plan for Early Childhood Development in South Africa 2005-2010 (2005);
- The Expanded Public Works Programme Social Sector Plan 2004/5-2008/9 Version 7 (March 2004); and
- The Massification of Early Childhood Development Concept Document (2006).

[2] Even with the subsidy, many centres in poorly resourced communities where unemployment is high struggle to provide a quality service.

These policies and plans are conceptualised as fitting together, as shown in Figure 1. This illustrates that the NIP is the overarching framework for the EPWP Social Sector ECD component and Massification of ECD.

Another programme that is very significant and which is referred to in the discussion of the policy and legal framework is the Concept: ECD Centres as Resources of Care and Support for Poor and Vulnerable Children and their Families (Departments of Social Development & Education, 2006). This programme provides an important example of how the full continuum of services for the NIP might be provided from a service node. Appendix 1 provides a summary of this and Appendix 2 lists other ECD-related policies, legislation and programmes.

Figure 1 – Links between the NIP and other ECD programmes



2.2.1 The National Integrated Plan for Early Childhood Development in South Africa 2005-2010

This plan, released in 2006, and which is a Social Sector Cluster responsibility, caters for children 0 (prenatal) to 4 years (i.e. up to their fifth birthday) recognising that the needs within this age range differ depending on developmental stage**.** The NIP signals government's intention to implement the integrated, multi-service approach spoken of in both the DoSD (Department of Social Development, 1997) and DoE White Papers (Department of Education, 1995 and Department of Education, 2001a). The four key features of the plan are:

- Stimulating more integration in service provision to children aged 0-4;
- Improving quality of service delivery;
- Provision of comprehensive services; and
- Moving beyond the current focus on centre-based delivery to include delivery at home (to the family) and at community levels.

The term integration is used in the NIP to mean an approach where services and programmes are provided in a comprehensive and interwoven manner, with the aim of ensuring the holistic development of children. It is explicitly seen as describing: "the relationships and links that are being developed between government departments, NGOs and communities in order to provide comprehensive ECD programmes to the children of South Africa" (Departments of Education, Health & Social Development, 2005:16).

Recognising the challenges of integrating service delivery, the NIP proposes a number of mechanisms to promote an integrated approach. Key among these are: intersectoral collaborative planning and service delivery for ECD; ensuring that each department (national and provincial) makes a budgetary commitment to the task at hand to give them a stake in its success, development of management systems across government and NGO structures and a monitoring and co-ordinating system.

The vision driving the plan is for all children to access a range of quality ECD programmes with trained staff and comprehensive services to support their health, nutrition and social well being. Within this vulnerable children are a particular focus and are defined as including:

- Orphaned children;
- Children with (physical) disabilities and incurable diseases;
- Children affected and infected by HIV and AIDS;
- Children from "dysfunctional"[3] families;
- Children in homes headed by other children; and
- Children from poor households and communities.

The NIP recognises multiple approaches to developing young children, including:

- Direct services to them;
- Training caregivers and educating parents;
- Promoting community development; and
- Building public awareness.

[3] While the term "dysfunctional" is used in the NIP, we advocate and will be using the alternative and less stigmatising term "vulnerable families" used in the Draft National Family Policy (Department of Social Development, 2005). A vulnerable family is defined as one who is socially isolated, subjected to the least empowering circumstances, who is without support systems and or adult supervision, not linked to resource, does not function due to various challenges and who exposes their family members to circumstances that are detrimental to their development.

The range of services, which recognises diverse needs, brings to the fore a variety of sites of care, moving from the past conflation of ECD services with crèches and preschools. Sites of care include homes, formal ECD centres, community childcare settings, informal ECD settings, prisons, child and youth care centres, and places of safety. These have been categorised as **home**, **community** and **formal ECD services**, with 50% of service delivery at the home level, 30% at community level and 20% in formal settings.

Services and programmes that need to be provided to children aged 0-4 in an integrated manner are divided into primary and secondary components.

The *primary* components of the NIP service package include:

- 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 (social security grants and accompanying services);
- Early learning stimulation; and
- Development and implementation of psychosocial programmes.

The *secondary* or *supporting* components for implementation of the plan include:

- Human resource development of parents, caregivers and community development workers;
- Upgrading infrastructure of ECD centres and improving water and sanitation;
- Research to determine the effects on children's development of the different programmes; and
- Monitoring and evaluation.

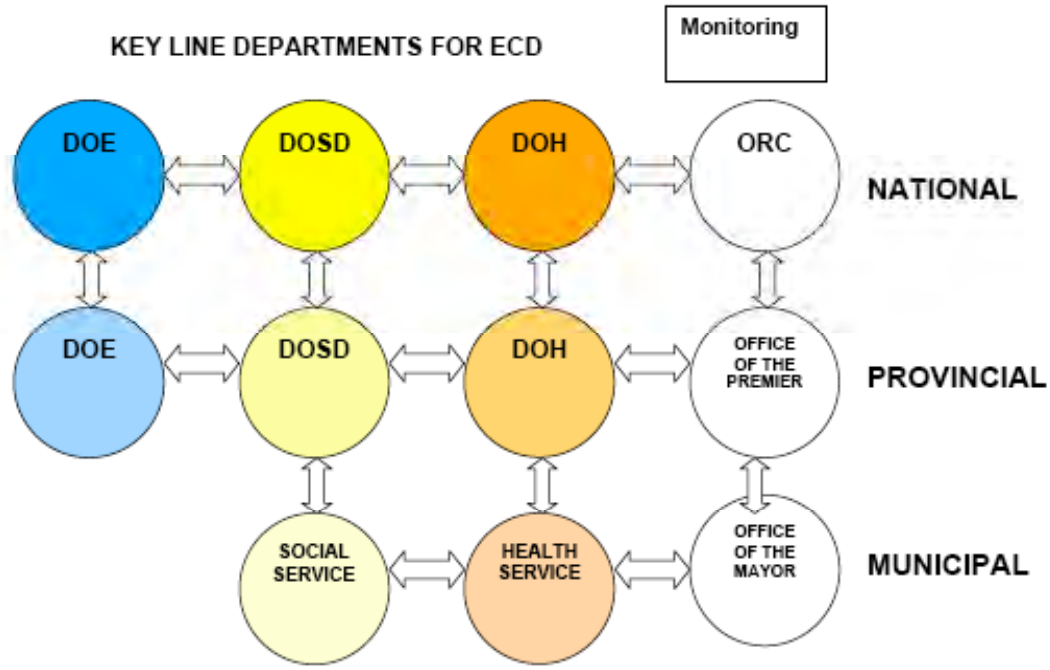
The NIP highlights a sub-programme – the poverty targeted component, known as *Tshwaragano Ka Bana*. This sub-programme is aimed at delivering integrated services to 2.5-million to three million children, one million of whom are already receiving DoSD and DoE services (in the form of ECD centres). The plan is for progressive implementation, starting with the upgrading of formal ECD programmes through training and infrastructure programmes. For programmes aimed at household and community level the plan requires development of a new category of ECD worker who will operate at local level linking families to services at household and community level.

Institutional arrangements

The Ministers of Health, Education and Social Development and the Minister in the Office of the President are identified in the NIP as having to provide leadership to and guidance for the implementation of the Plan. Service delivery is to be led by national and provincial line-function departments. These include the DoSD, DoE and DoH. While it is intended that planning and implementation will be coordinated through interdepartmental coordinating committees at national and provincial level, line-function departments are responsible only for budgeting and delivery of components of their core functions. Lead departments are responsible for ensuring that the budgets are secured from the provincial equitable share, conditional grants, municipal budgets or donor funding.

Successful delivery of the NIP depends on a functional intersectoral coordinating mechanism. The responsible structures are a National Interdepartmental Committee (NIC) for ECD, with DoE, DoSD, DoH and ORC in the Presidency as equal partners and other national departments and institutions drawn in as required. At Provincial Level there would be a similar structure and at municipal level, a municipal interdepartmental committee (MIC) for ECD will be established in each municipality, with the municipal departments responsible for social development and health, and the mayor's office as equal partners. Figure 2 provides an illustration of the intersectoral links. At present the NIC has been established and some provinces have a PIC but most provincial and municipal levels are still in the process of development.

Figure 2 – Lead and related departments responsible for delivery of the NIP services



One of the responsibilities of the interdepartmental structures is to review all ECD related policies, and if necessary develop new ones. This is aimed at ensuring coherence and coverage of all young children's needs. At provincial and municipal level this will involve ensuring compliance of policies and by-laws with national policy and legislation. The lack of articulation of local by-laws with national and provincial ECD guidelines and policy has been extremely challenging (for example registration of ECD facilities) and ensuring coherence will be essential for an integrated service delivery plan. Planning, ensuring the availability of financial and human resources for the plan, forming linkages with Provincial Growth and Development Plans and Integrated Development Plans at local level, partnerships with other stakeholders and support and monitoring of implementation at the different levels of government are other key functions.

Building the partnership between government and the not for profit sector is flagged as critical in the NIP for the effective implementation of the NIP, as NGOs are seen as delivering some aspects of it.

The NIP will be implemented in phases including a strong focus on upgrading of existing ECD sites through training, linking to the Expanded Public Works Programme ECD component as well as service delivery to households.

2.2.2 Expanded Public Works Programme Social Sector Plan 2004/5-2008/9

Nature of the programme, objectives and its relation to ECD

In 2003, in his State of the Nation address, President Mbeki announced that government planned to implement the Expanded Public Works Programme (EPWP) as a new short-to-medium term initiative to tackle poverty and unemployment. The primary objective of the programme is to provide work opportunities coupled with training and thereby raise income-earning capacity of individuals not benefiting from the mainstream economy (Departments of Social Development, Education and Health, 2004:7). A secondary objective of the programme is to expand infrastructure and services that are in short supply and also important for alleviating poverty and promoting development.

The EPWP programme relates to ECD because it includes, within its social sector component, a sub-programme that focuses on training, job creation and expanding services in ECD. ECD was selected as an area for investment in training and jobs under the social sector part of the EPWP due to limited provisioning of ECD services (ibid: 8 and see also Department of Education, 2001b).

The vision of public investment in training, job creation and scaled up quality ECD service delivery in the ECD sub-programme of the EPWP is set out in the *Expanded Public Works Programme Social Sector Plan 2004/5-2008/9*. This is a policy and planning document developed jointly in 2004 by the Departments of Social Development, Education and Health.

Targeted beneficiaries of the ECD EPWP: For training, jobs and services

With respect to who is to benefit from training and job creation under the ECD EPWP initiative unemployed and/or underemployed parents and caregivers in all ECD programmes, and particularly women are identified as the primary target. The rationale for this is that they carry the heaviest burden of poverty and unemployment. The broader EPWP programme policy includes youth and people with disabilities as particular target groups for training.

With respect to who the target is for ECD service delivery, the Social Sector plan defines ECD as "an umbrella term that applies to the processes by which children from birth to at least 9 years grow and thrive, physically, mentally, emotionally, spiritually, morally and socially" – acknowledgment that ECD covers the period 0-9. Children targeted for better quality services under the programme are not those in the full ECD age category 0-9. Instead, the target includes those who are not yet in formal/compulsory schooling (which begins in Grade R or when a child is five), as well as those in Grade R. The former age cohort (0-4 years) is primarily the responsibility of their parents and with respect to service provision and protection from government, the Department of Social Development. Most pre-Grade R ECD services are provided by volunteers and employees working in the not-for-profit sector (NGOs, CBOs and FBOs) and this feature of the sector is highlighted as one that makes the ECD sector a good candidate for inclusion under the EPWP.

Strategy – training options, exit avenues and job paths

The plan is to skill 19 800 practitioners (over five years) through a four-pronged strategy, involving a partnership between provincial government departments and the Education, Training and Development Practices Sector Education and Training Authority (ETDP SETA).

- Plan A targets learnerships and the existing Grade R Department of Education programme. In partnership with the EDTP SETA, 6,500 NQF level 1 and 8,800 learnerships at NQF level 4 are planned. In addition there is a plan to train 4,500 grade R teachers under the Department of Education.
- Plan B targets 9,224 unemployed people in a work place employment and skills programmes in sites receiving the Department of Social Development subsidy in the five-year period.
- Plan C targets the unregistered ECD sites in poor areas for subsidies and employment creating 13,776 work opportunities.
- Plan D has two components. The first is labelled "parents informing parents" and involves designing and running a programme which will provide short three-month employment opportunities for 3,000 unemployed parents through existing schools and local authorities. The other involves training for support staff posts at schools such as gardeners, cooks and administrators in 4,000 schools.

Exit strategies for the various kinds of training / work opportunities are suggested in the document and as discussed below are highly dependent on additional funding and demand in the sector.

Implementation arrangements: key actors and their responsibilities

A key feature of the ECD sub-programme in the EPWP is that responsibility for implementation is shared across two lead government departments at provincial level. Other departments have supporting roles to play. Effective co-ordination between the government departments and the ETDP SETA and partnership between government departments and ECD service delivery and training agencies is also critical. The responsibilities of the different actors responsible for implementing the ECD EPWP sub-programme are not sufficiently specified in the policy documents. However, it can be inferred that the main responsibilities of the key actors are as follows:

- Department of Public Works – Responsible for monitoring implementation;
- Department of Social Development – Responsible for driving the initiative aimed at increasing the number of registered ECD sites for children aged 0-4, expanding the number of sites receiving the ECD subsidy as well as increasing the value of the per child subsidy paid to ECD sites;
- Department of Education – Responsible for identifying work / training opportunities and administering training / work opportunities;
- EDTP SETA – Responsible for managing training, quality assurance and funding training also creating learnerships;
- Department of Labour – Responsible for assisting EDTP in development of training and funding of training;
- CBO service providers – Role to play in ensuring the sustainability of the programme in that they need to employ learners / ECD practitioners that have received training. For this role they require government financial support, or else there is the threat of them losing newly qualified staff (for example to Grade R employment, which typically pays higher wages);
- Non-governmental organisations and other providers of ECD training – Responsible for training those employed in work opportunities.

Funding: mechanisms and where substantial additions over baseline are required

With respect to the mechanism of funding ECD EPWP sub-programme, it is vital to understand that when the EPWP programmes started – in the 2004/05 financial year – a decision was taken not to ring-fence a portion of the total revenue collected every year and allocate it as a conditional grant to relevant provincial departments for spending on implementation of the programme. Instead it was decided that, "EPWP projects will… be funded through the *normal* budgetary process, through the budgets of line-function departments, provinces and municipalities" (ibid:8).

Risks identified in the policy

The social sector plan highlights a number of risks / implementation challenges that contain the pace of implementation. The primary ones are:

- The small size of the pool of registered ECD sites delivering pre Grade R services and within this group, the small number receiving funding (per child subsidies) from Provincial Departments of Social Development. The planning document highlights the need for an auditing and registration drive to expand registration as well as for additional subsidy allocations by Provincial Social Development Departments to ensure that there is sufficient demand for learners exiting the training opportunities if the ECD EPWP plan is to be a success.
- Budget constraints. The Social Sector Plan raises the concern that many competing priorities in the provincial budget processes and insufficient prioritisation of the ECD EPWP plan may lead to insufficient allocations being made by Provincial Treasuries to support expansion of subsidisation of ECD sites by Provincial Social Development Departments.
- The "absence of an integrated inter-departmental implementation framework and clear coordination between the departments" (Departments of Social Development, Health and Education, 2004:14).
- Limited training capacity in training providers particularly at Levels 4 and 5.
- The absence of an integrated plan for implementation of a comprehensive ECD service as a key constraint to rapid implementation of the vision of training, job creation and expanded service delivery in the EPWP (ibid: 12).

Subsequently, however, the National Integrated Plan for ECD was developed as a guide to ECD age 0-4 service delivery.

Relationship between the NIP and the EPWP

Government documents (Departments of Social Development & Education, 2006) as well as individuals leading policy development in the ECD sector clarify that the NIP is the umbrella policy designed to guide scaling up of services to children aged 0-4. Moreover, that the EPWP goals of skills development, job creation and expanding access to quality services in the sector fall under the larger umbrella policy, at least in principle.

2.2.3 Massification of the ECD concept document

In August 2006 the Social Cluster, decided that the ECD plan should be massified with a specific focus on unemployed youth. This was seen as one way towards linking, more clearly, the National Integrated ECD plan and the EPWP. The proposed goals are:

- The improvement of quality in ECD sites through registration;
- An increase of job opportunities for ECD practitioners in the registered ECD sites catering for young children, who receive a subsidy from DoSD; and
- Supporting families at household level with a view to expansion of ECD services.

The Concept Document proposes new work opportunities for the ECD sector including use of unemployed youth with a tertiary qualification in social work, health or education to provide assistance to social workers responsible for registration who could take up vacancies or new posts in DoH, DoSD, DoE; increased job opportunities for ECD practitioners in registered ECD sites and a new category of worker, the child development worker (CDW). CDWs would work at municipal level supporting implementation of the NIP by monitoring the development of children ensuring that they are receiving the given package of services and facilitating this. It uses the existing registered sites as "the central point of convergence."(Department of Education, 2006:2).

Proposals for these new categories of ECD jobs and training for workers need to be concretised.

2.3 Challenges in the legal and policy framework

Government programmes and policies signal a strong commitment to providing integrated support for a holistic early childhood development service package delivered in a range of settings, including ECD centre programmes, household- and community-level interventions. However, the law, policy framework and plans give few indications of mechanisms to translate this into practical support.

The key weaknesses in the policy and legal framework that need to be noted are:

- The law, policy framework and plans give insufficient guidance on mechanisms to support implementation through development of financial budgets and human resource capacity.
- The Children's Amendment Act No. 41 of 2007 (Republic of South Africa, 2007) and the Guidelines to ECD Services (Department of Social Development, 2006b) privilege the ECD centre model and do not reflect other types of services. This includes the lack of a regulatory and support framework for household-based types of programmes, which is essential if a quality service is to be rendered. However, regulations under the Act, which are still in development, may to some extent provide an opportunity to address these issues.
- There is insufficient linking of the different types of services for young children dealt with in the different chapters of the Children's Amendment Act. The law should stress the need for linking the different services in order to provide a comprehensive ECD service. The need for integration of services for more effective and efficient delivery is widely recognised (for example, Departments of Education, Health & Social Development, 2005).

- The registration process under the Children's Amendment Act is still cumbersome, despite requests for its simplification.
- Funding norms for DoSD currently provide only for ECD centres and there is no clear legislative mandate in the Children's Amendment Act for the funding of ECD services of any kind. Clear legislative mandates would prevent continuation of the current situation where for example the National Treasury allocates substantial additional money (billions) through the equitable division of revenue for provinces to spend on implementing the ECD (0-4 years) scaling up vision, but the provinces used some of these funds for other priorities.[4]
- The EPWP social sector plan itself highlights a number of risks in relation to achievement of the goals, other than the challenge of budget prioritisation, including poor integration, the lack of funded jobs as exit opportunities and the limited number of registered ECD sites, which the Massification of ECD Concept and the NIP are seriously attempting to address.
- There are some problems in the way in which vulnerable groups to be targeted are defined in the National Integrated Plan. The first is vagueness. For example, it is unclear who is to be classified as a child from a poor household or community[5] and who is to be classified as a child from a vulnerable ('dysfunctional') family. This is critical, as the vagueness makes it difficult to estimate those to be targeted in practice. The second is inclusion of the category children "affected by HIV and AIDS". Some would maintain that almost all children are affected in some way, what is needed is to determine those children whose development is compromised by being affected. The third is that some vulnerable groups may have been omitted. For example, children living in households headed by elderly individuals may be as vulnerable in *some cases* as those living in child headed households? This group of children may be included under those in dysfunctional families, but this is unclear. The point is that the targeting approach in policy needs to be revisited, and this is something that we return to in Section 5.
- While the NIP outlines required structures for integration between provincial and local government, different departments as well as NGOs and CBOs, the workings of these are not elaborated. Some recent departmental documents suggest that while the social cluster is committed to the National Integrated Plan, responsibilities such as monitoring and evaluation are still being seen as relating to individual departments (Department of Social Development, 2006a).
- With regard to the NIP and the EPWP there is still some way to go in terms of integration between the two plans. For example, the two plans are still being

[4] Proudlock, P., Budlender, D. & Jamieson, L Draft submission to the National Assembly on the Children's Amendment Bill B19B. Children's Institute, University of Cape Town, July 2007.

[5] It is not clear how the target of 2.5-million to three million children for Tshwaragano ka Bana was arrived at and how numbers are distributed across provinces.

co-ordinated and monitored by different units in government with different indicators of performance being tracked.

- Proposals in the Massification of ECD and ECD Centres as resources for poor and vulnerable young children Concept documents are to use ECD sites as points for extending ECD services beyond the centre to the community and household. Government recognises the significant challenge for implementing this of the variable levels of development and resourcing of ECD centres (Departments of Social Development & Education, 2006), and departmental programmes are currently focusing on upgrading centres and getting them registered. Even if these centres are strengthened and offer outreach services to more children, we would caution that they should not be seen as the only potential service nodes for implementing the NIP. The potential of the health sector as a vehicle for mass expansion of services for young children is significant as it is the public service with the widest reach to children under three (Armecin *et al.*, 2006 and Engle *et al.*, 2007).
- It is unclear how the Family Support Workers proposed in the Programme document ECD Centres as Resources of Support for Poor and Vulnerable Children would link with proposals for CDWs (in the Massification of ECD Concept Document) whose functions include some of these responsibilities but also higher level responsibilities.

3. A profile of vulnerability in children aged 0-4 years in South Africa

3.1 Child population 0-4 years

There are an estimated 5.16-million children birth to four years, 86.1% of whom are African, 7.8% Coloured, 1.7% Indian/Asian and 4.4% White[6]. The largest numbers live in KwaZulu-Natal, Gauteng and the Eastern Cape (see Table 2). Numbers of boys and girls are nearly equal making up 50.4% and 49.6% respectively.

Table 1 – The number and proportion of children 0-4 years living in South Africa by province

Province	Estimated population 0-4 years	% of 0-4 year population*
Eastern Cape	781,700	15.13
Free State	298,600	5.78
Gauteng	944,200	18.28
KwaZulu Natal	1,100,200	21.3
Limpopo	675,500	13.07
Mpumalanga	372,300	7.2
Northern Cape	95,500	1.84
North West	434,300	8.43
Western Cape	462,300	8.95
All provinces	**5,164,500**	**100**

Source: Statistics South Africa, 2006
*Note * 0-4 is used inclusively to mean children up to their fifth birthday*

3.2 The health and nutritional status of young children

Young children 0-4 years are especially vulnerable to illness and death and the highest number of all deaths in the population in 2005 was for this age group (Statistics South Africa, 2007b). Preliminary estimates from the 2003 South African Demographic and Health Survey (cited by UNICEF, 2007) indicate an Infant Mortality Rate of 42.5 per 1,000 and an under-five mortality rate of 57.6 per 1,000. This suggests that rates have remained stable since the 1998 DHS. However, the reliability of this data has been queried as certain surveillance sites report an increase in the under five mortality rates

[6] In this paper we make use of these apartheid state terms, as they are still referred to in post-apartheid South Africa to indicate discriminations, present and past. They are used however, with the proviso that they are socially constructed and politically imposed terms which have been used to socially mark people for a variety of purposes

as does data from the Medical Research Council and national modeling projections (Abrahams, Berry & Hendricks 2006). One third of infants below one year died of respiratory and cardiovascular diseases and a fifth of digestive conditions. Nearly a quarter of children one to four years died of intestinal infectious disease and 13% of influenza and pneumonia (Statistics South Africa, 2007b).

The Burden of Disease Study (Bradshaw *et al.*, 2004) found HIV AIDS to be the leading cause of death at 40% of all child deaths, with diarrhoea, lower respiratory infections and low birth weight accounting for 27% of others, all three of which are attributable to poor living conditions.

Nutritional status impacts significantly on child well being and is a serious concern in South Africa where 35% of the population is vulnerable to food insecurity especially in rural areas (SARPN, 2004). The National Food Consumption Survey (Labadorius, 1999) found stunting of 21%, underweight 10.3% and severely underweight 1.4% in children 1-9 years. Children 1-3 years were worse affected with 25.5% stunted, 12.4% underweight and 2.2% severely underweight. Micronutrient deficiencies in children led to anaemia in 21.4% of children, and a third of children were Vitamin A deficient.

Under-nutrition is an even more serious problem in children with HIV infection, where more than half become stunted or underweight and one in five develops wasting (Hendricks, Eley & Bourne, 2006). Vitamin A deficiency is associated with increased morbidity and mortality in HIV-positive children, as well as increased MTCT of HIV in pregnant women, and coverage is low in all provinces, especially for children 12-59 months.

Exclusive breastfeeding for the first four months is associated with optimal nutrition and protection against infection but preliminary results of the 2003 DHS, cited by Hendricks *et al.* (ibid) indicate that only 11.9% of children are exclusively breastfed and 20% were never breastfed. Despite the advantages of breastfeeding, the measure to which breastfeeding contributes to the vertical transmission of HIV is still a hot debate and formula is provided as part of the PMTCT programme (Visser & Wambi, 2007).

3.3 Children with disabilities and chronic illnesses

Children with disabilities[7] and chronic illnesses are a vulnerable group requiring specialised services. Some of the diagnosable health conditions include epilepsy, brain damage, physical abnormalities, genetic syndromes such as Down's syndrome, conditions affecting vision and hearing, and chronic illnesses such as juvenile diabetes

[7] The DoH definition of disability as approved by cabinet in 2005 means a moderate to severe limitation in a person's ability to function or ability to perform daily life activities as a result of a physical, sensory, communication, intellectual or mental impairment.

and HIV/AIDS (Schneider & Salojee, 2007). Other conditions include autism, childhood depression and mild, moderate and profound intellectual impairment.

In South Africa, 61,000 children per year are born with a serious congenital disorder. Heart disease and HIV are the most prevalent, affecting about 6% of children. About seven per 1,000 children suffer from epilepsy and more than half of them have developmental and neurological problems. Other chronic diseases are acquired such as asthma, which can affect up to 10% of children in urban areas (Robertson, 2006).

Foetal Alcohol Syndrome (FAS), associated with heavy episodic drinking by pregnant women, is a serious problem in South Africa. Prevalence for a wine-growing region in the Western Cape is 65 to 74 per 1,000 in the Grade 1 population, which is the highest in the world (Viljoen *et al.*, 2005). But is also high in other communities – 19 per 1,000 children in Johannesburg communities (Viljoen, Hymbaugh, Boyle & Blount, 2003).

Due to complexity in how disability is conceptualised, defined and measured there is considerable variation in prevalence figures (Schneider *et al.*, 2007). There are indications that it increases with age and is higher in rural areas. For example, Couper (2002) found prevalences in a rural area of KwaZulu-Natal for children under 10 years of 60 per 1,000: 61% mild, 20% moderate and 19% severe. For children under five, perceptual disabilities were most common, followed by cerebral palsy and hearing loss.

Working on an estimated prevalence of 3%, this would indicate that 155,000 children (birth to four years) have a moderate to severe disability.

3.3.1 HIV and AIDS

Children in the 0-4 year age group have the highest risk of HIV infection. Estimates from the ASSA 2003 model suggest an increase from 2.2 % in 2000 to 3.6% prevalence in 2006. Provincial prevalence rates vary, reflecting overall provincial prevalence and the reach and efficacy of PMTCT programmes in the provinces.

Table 2 – Estimated HIV prevalence for children 0-4 years

Province	Prevalence projections ages 0-4 years, 2007 (%)
Eastern Cape	3.7
Free State	4.4
Gauteng	4.3
KwaZulu-Natal	5.3
Limpopo	2.5
Mpumalanga	4.3
North West	2.3
Northern Cape	3.9
Western Cape	1.9
All provinces	**3.7**

Source: ASSA (2005)

Children with vertically transmitted HIV infections are at higher risk of neurological problems, developmental delays and lower cognitive scores than uninfected children (Kvalsvig *et al.*, 2006).

Implications of this are both for the additional care and support needs of young children who are themselves infected, including indications of special learning needs and behavioural problems (Dunn, 2005 and Sher, 2005), and for those whose mothers or caregivers are HIV positive who may require a range of material and psychosocial supports. Support is also needed in respect of young children requiring ARV therapy. The recent situation analysis (Michaels, Eley, Ndhlovu & Rutenberg, 2006) is heartening in that most children on ART are compliant with their dosing schedules. However very few infants under one year are on the treatment. In many parts of the country diagnosis at six weeks is not being accessed and "currently 85% with HIV are lost to follow up from the PMTCT program and an estimated 40% of these infants die during the first year of life without treatment" (p. 53). Awareness raising and support for caregivers for an early diagnosis is critical as is assisting caregivers of HIV positive children to access nutritional support for them and to ensure that the children are immunised.

3.4 Poverty

As explained above, the policy to govern scaling up of quality integrated services to children aged 0-4 flags poor children as a priority target group. The NIP sub-programme, *Tshwaragano Ka Bana*, has been created specifically to ensure that poor children are prioritised in implementation of the integrated service delivery vision. The focus on poor children as a target group in the policy framework is commendable. There is a strong evidence base showing that resource constrained environments present a range of risks to early childhood development, particularly in the earliest years (see, for example, Anderson & Shinn, 2003; Dawes & Donald, 2001; and Maggi & Hertzman, 2005).

As already pointed out above, a problematic feature of the policy framework is that the notion of who a poor child is is not clarified. This makes estimation of the numbers of poor children who need to be targeted in the different provinces, and operationalisation of the plan to target "poor children" difficult. The latter task is particularly difficult because there is as yet in South Africa no general consensus about how poverty or child poverty should be conceptualised, defined and measured (Studies in Poverty and Inequality Institute, 2007).

The research literature measuring child poverty in South Africa in the post 1994 period is in its infancy. Most of the research studies conducted have focused on the full age cohort of children – in other words children aged 0-18. Various definitions (absolute and relative) of child poverty and different data sets have been used. An overview of the ten measurement studies conducted to date is given in Appendix 3. It explains the different definitions (poverty lines) and data sets used in the measurement. The table shows the large variation in the estimates of child poverty at a national level as well as provincial child poverty rates depending on which definition and data set is used in measurement.

In the absence of consensus in South Africa (including in government policy making and implementation circles) about what definition of child poverty (child poverty line) should be used for the purposes of estimating the numbers and distribution of poor children for planning service delivery, some researchers and policy makers in South Africa have used a definition that is similar to that used for targeting the Child Support Grant (CSG). This involves defining a child as poor if he/she lives in a household that is found in the survey data set being used to have less than R1,200 per month of income or expenditure. Expenditure is a better indicator to use than income as income is often underreported and expenditure is less erratic over time.[8] Table 3 shows the number of poor children in South Africa as well as the provincial shares from a recent estimated by Budlender that adopted this type of approach to setting the poverty line. In this study, Budlender used Statistics South Africa's 2005 General Household Survey Data and counted a child as poor if he/she lived in a household with reported expenditure of less than R1,200 per month (regardless of size, composition and differential needs of members).

[8] Of course, there is a need for more research to be conducted on whether this is a sensible child poverty line to use, in other words one that takes into account budgetary concerns, expert opinion on the needs and costs of raising a child as well as generally accepted values in society about what should be included in a basic basket of goods for children of different ages.

Table 3 – Child (age 0-4) poverty rates, numbers who are poor and receiving the child support grant in South Africa's provinces

Province	Poverty rate (%)	Number of poor children (N)	Number of child support grant beneficiaries, July 2007 (N)
Eastern Cape	79	643,148	506,213
Free State	67	213,248	172,126
Gauteng	43	369,937	359,790
KwaZulu-Natal	71	712,353	679,261
Limpopo	81	556,669	459,990
Mpumalanga	68	262,289	229,774
North West	74	317,506	223,269
Northern Cape	59	55,574	63,616
Western Cape	40	187,823	163,301
All provinces	**66**	**3,318,546**	**2,857,340**

Source: Child poverty rates and shares, Budlender 2007 calculations based on 2005 General Household Survey (Memo supplied to HSRC in July 2007).
The number of child support grant beneficiaries was supplied by the South African Social Security Agency (SASSA)

For the task of allocating resources that are available at national level for delivery of services to support poor children aged 0-4, it is vital to know the relative shares (proportions) of poor children aged 0-4 in each of the nine provinces. Some provinces, like the Free State, have a relatively high child poverty rate, but due to the relatively small number of children aged 0-4 in the province, have a far smaller share of the total number of poor children aged 0-4 in the country. Figure 3 provides information on the provincial shares of poor children aged 0-4 in South Africa. The pattern of provincial distribution in the shares of poor children aged 0-4 should be used, together with data on current access levels and implementation capacity in the provinces to inform the horizontal division of any additional revenue available for spending on expanding ECD age 0-4 services, amongst the provinces.

Figure 3 – Provincial shares of poor children aged 0-4 in South Africa

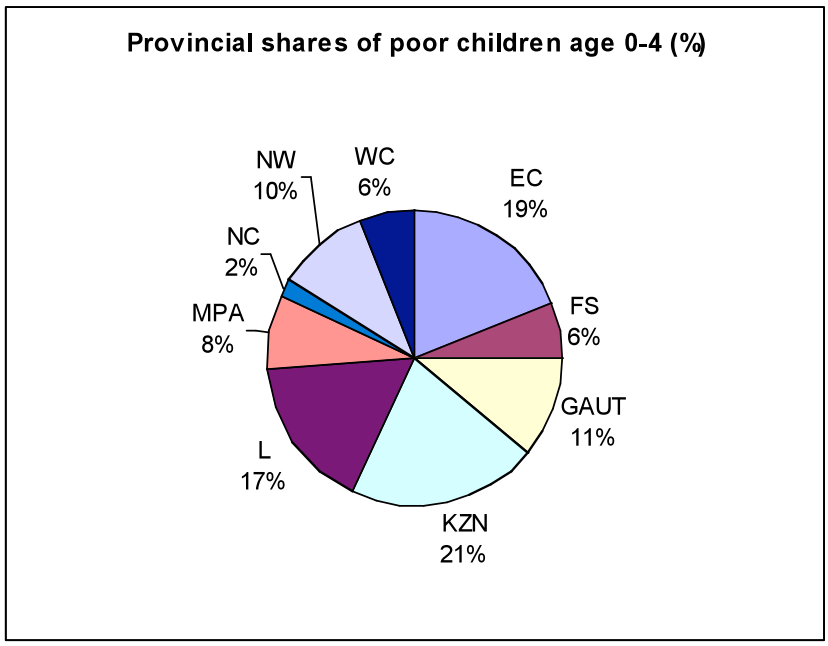
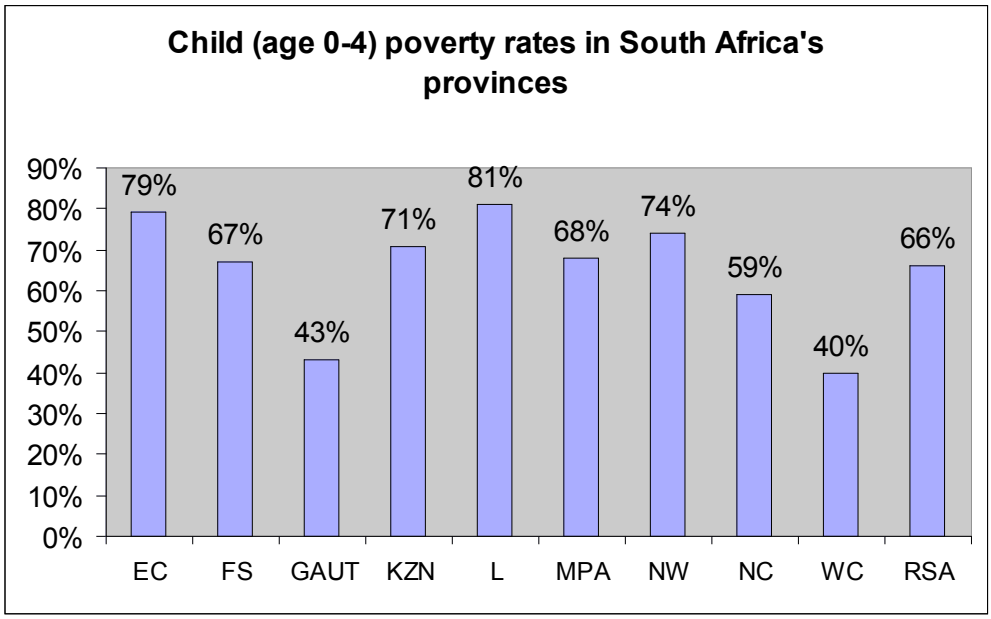


Figure 4 provides a graphic representation of the data on provincial child poverty rates supplied in Table 3.

Figure 4 – Child (aged 0-4) poverty rates in South Africa's provinces



Of course, knowledge about the depth of child poverty in South Africa and the provincial shares of very poor versus not so poor children (i.e. those that fall very far below the poverty line versus those lying just below it), is vital for informing budgeting and service delivery to children aged 0-4. At present there is no available evidence on the depth of child poverty in South Africa. Measures of the depth of child poverty amongst children aged 0-4 are a priority for further research.

3.5 Vulnerable families: caregiving in challenging circumstances

Young children's development is dependent on the interaction of a number of factors including both personal and structural features. Personal factors include their genetic makeup, prenatal influences, their temperament and the way they interact with the world, and how their health, nutrition and psychosocial needs are met by their caregivers. Structural factors include demographic and household structures. An ecological approach is useful in taking account not only of children's developmental needs but also parent or caregiver ability to respond to these appropriately and wider family and environmental factors including their access to service and interventions to support those at risk (Dawes, 2008a).

For very young children, because of their dependence on their caregivers, home influences are most significant for their well-being. Caregiver knowledge, capacity, warmth and availability can improve development outcomes in difficult circumstances while a lack of consistent caregiving and stimulation can both increase vulnerability to disease and lead to long-term cognitive and psychosocial damage (Dunn, 2005 and Richter, 2004). The capacity of caregivers for caring is subject to a number of factors, including household income, household structure and maternal health – mental and physical. Where carers lack support, are too old or young, are ill or subject to violence and abuse or dealing with very demanding care situations, they may not be in a position to provide for the needs of young children. Long-term deep poverty is a particular risk factor for children.

While many environmental variables affect young children's development, it is the existence of multiple risk factors that is of major concern. A combination of risk factors reliably predicts poor outcomes for children (Sameroff, 2005). Conversely where there are promotive factors in the care environment, children in difficult circumstances may do substantially better than their peers.

Regarding multiple risk factors, Ward, Dawes, Willenberg, Gwele & Latief (2006) point out that poverty conditions may be associated with and exacerbated by particular forms of household:

- Those with young single parents (including pregnant teenagers);
- Skip-generation or elder-headed households;
- Child-headed households;
- Crowded households;

- Families where a member is chronically ill or disabled through HIV and AIDS or for other reason; and
- Families where a family member abuses alcohol or drugs or where there is maltreatment or abuse within the family (domestic violence).

For these reasons, government policy prioritises certain types of care arrangements for support and intervention, including vulnerable families, orphans and child-headed households. In this section we have collated information on the types of family/household and care risk factors that young children currently experience in South Africa.

3.5.1 Families, households and caring arrangements

42.8% of young South African children have both parents living with them though 93% have both parents alive. 38% live in households where a grandparent or great grandparent is the head of household (UNICEF, 2007).

Having a teen mother may be a risk factor for young children both for health and quality of care. Moultrie and Dorrington (2004), analysing Census 2001 data, indicate that 74 per 1,000 births were to 15-19 year-olds. Almost one in 14 African girls is expected to give birth each year. There is considerable provincial variation, with one in five births in Mpumalanga, Limpopo and KwaZulu-Natal to teen mothers and one in 10 in the Western Cape and Gauteng. The 2006 General Household Survey found 13.9% of girls aged 11-19 years were not in school because of pregnancy.

According to calculations on the General Household Surveys in 2004 and 2005 (accessed on Children Count website www.childrencount.ci.org.za/), younger children (0-5 year-olds) are more likely to be living with their mothers (whether their fathers are present or not) than older children (6-18 years) who are more likely than younger children to be living with neither parent. While 13% of children aged 0-5 years were not resident with either parent in June 2005, this situation applied to 27% of children aged 6-17 years.

In 2005, 2% of 0-4 year-olds were maternal orphans, and 7.4% paternal orphans. 81% of young children who are orphaned or fostered are cared for by grandparents or great-grandparents (UNICEF, 2007). Where these grandparents are elderly, ill and caring for many dependents, young children's care could be compromised.

In general, high dependency ratios are a risk factor for optimal child development and well-being. There is also some evidence that higher household densities may be related to more negative child outcomes (Richter, 1989).

Child-headed households

Children living in households without adult members are potentially very vulnerable and this category of children is therefore a policy concern. As yet however, there is no robust data on child-headed households in South Africa. Figures generated from the General Household Survey 2005 may not be reliable because of the small number of child-headed households accessed. They indicate that of the overall 0.7% of all

children 0-17 years living in 66,500 child-headed households, only 14,640 or 0.2% of the child population 0-5 years were living in child-headed households. Furthermore, research suggests that child-headed households are frequently temporary households, and often exist just for a period, for example after the death of an adult and prior to other arrangements being made to care for the children (Meintjies & Giese, 2006). Bray and Brandt (2007) note that child-headed households per se are not necessarily a direct indicator of vulnerability, as the care available to them has been shown to vary considerably depending on the involvement of neighbours, non-resident kin and family members.

Children in residential care

Generally residential care is the choice of last resort for young children as there is a wealth of documentation indicating the negative effects of institutional care on their well-being and development (for example, Giese & Dawes, 1999). In particular there are often reduced opportunities for children to develop stable attachments to specific adults (Williamson, 2005). However, there are some indications that the numbers of young children in residential care are increasing (Kvalsvig *et al.*, 2006). Meintjies, Moses, Berry & Mampane (2007) report that draft findings from a national audit of residential care facilities for the Department of Social Development identify 193 registered children's homes with a registered capacity of 12,920, half of which were located in KwaZulu-Natal and Gauteng. This revealed a 25% increase in capacity in Children's Homes since 2005.

Meintjies *et al.* (ibid) conducted an audit of children in 28 registered and unregistered children's homes in four study sites in Gauteng, KwaZulu-Natal, Limpopo and the Western Cape provinces and found that 17% of children were under two years, and 13% 3-5 years of age. Homes in the study providing residential care through foster care or private place of safety legislation, predominantly cared for infants and toddlers. Abuse, neglect and abandonment were the predominant reasons for admission, rather than orphanhood. A high proportion of children in children's homes were HIV positive.

Children in prison with their mothers

Department of Correctional Services' policy currently allows for the children of female offenders to stay with their mothers up until they are five years old.[9] While prisons are reflected as a setting for ECD programming and are one in which particular efforts should be made to ensure young children's well being, it should be noted that the number of children in this situation is extremely low. Table 4 gives the numbers of children in prison as at 12 July 2007.

[9] However, changes to the regulations are currently under consideration to limit this to children up to two years, an established international norm (personal communication Julia Sloth Nielsen, 15/8/07).

Table 4 – Numbers of children 0-4 years living with their mothers in prisons, July 2007

Province	N children living with their mothers in prison			
	0 -1 years	1- 2 years	2-3 years	3-4 years
Eastern Cape	4	10	1	1
Free State/Northern Cape	12	5	2	
Gauteng	28	24	8	5
KwaZulu-Natal	11	5	1	
Limpopo/Mpumalanga/North West	13	4	1	
Western Cape	10	6	4	
All provinces (total)	**78**	**54**	**17**	**6**

Source: Department of Correctional Services, Media Services, August 2007

In view of the risk to well-being that a prison environment might have for very young children, the 2005 White Paper on Corrections in South Africa, provided for the establishment of "mother and child units" within the correctional centre with separate sleeping accommodation for mothers and their children, as well as a crèche facility. The intention is to normalise the environment to promote the child's physical and emotional development and care. Breast-feeding is encouraged, unless contra-indicated for health reasons, and there is a ration scale for babies, which is subject to amendment by medical personnel, as necessary.

A range of services is provided for at different institutions including crèche attendance internally or outside playgrounds, outings, educational materials for mothers to stimulate the babies. Various service organisations are involved in stimulating activities with the children and involving their mothers.

3.5.2 Caregiver characteristics

While poverty has been shown to affect children's development, research indicates that psychological resources such as family networks of support, high maternal education, and positive maternal mental health, mediate child outcomes (for example, Maggi *et al.*, 2005).

Education

Maternal education levels are strongly associated with positive child outcomes. According to the 2006 General Household Survey, 12.6% of females had no education. While there has been a steady improvement and younger women have higher education levels overall, many young children are cared for by elderly caregivers and this is still a concern. A high 14% of men and women were in the category of "some primary education", which is not sufficient to meet UNESCO's definition of functional literacy (Statistics South Africa, 2007a).

Factors which may compromise caregiving capacity

Coping capacities of caregivers can be undermined by a variety of stress factors in living conditions. Bray and Brandt (2007) found that permanence, rights to residence had a strong influence on caregivers sense of worth and stability and confidence in being able to provide care for their children. Dawes and Donald (2001) note that poor social cohesion leading to social isolation can have negative developmental outcomes for children. This is associated with high population mobility, recent migrants and in South Africa with large informal settlements outside major cities.

Substantial research evidence indicates the negative impact on the quality of the relationship between mothers and their young children of maternal depression and adverse social conditions. Maternal depression predicts poor monitoring of children. In the absence of comprehensive studies of prevalence rates for psychiatric disorders in South Africa or gender disaggregation, it is impossible to estimate the numbers of children whose caregivers have mental health difficulties. However we do know that depressive disorders, panic disorder, post traumatic stress disorder (PTSD) are notably higher in women, while alcohol and substance abuse are in men (Moultrie & Kleintjies, 2006).

A study in Khayelitsha (Cooper, Landman, Tomlinson, Molteno & Anderson, 2002) indicated a one in three prevalence of maternal depression at two months post partum – three times higher than international estimates. Significant predictors of maternal depression include unemployment, lack of social support, poor interpersonal relationships, and lack of financial or other support from the father.

There is also a significant correlation between HIV seropositivity and the range of psychopathology and psychological distress, including delirium, dementia, personality disorders, mood disorders, PTSD, suicide and suicidal ideation (Moultrie & Kleintjies, 2006). For example, a recent study (Brandt, 2007) found that HIV-positive women had significantly more symptoms of depression and anxiety than seronegative women, regardless of stage of disease. However, a period on Antiretroviral Therapy led to significant decline in anxiety. Evidence is mixed but studies have found that infected mothers and caregivers engage in lower levels of effective parenting behaviours, including reduced parental support for child, fewer efforts and discipline, changes in family routines, and lack of attention or parental absence due to the reorganisation of family around illness.

The National HIV and Syphilis Antenatal Seroprevalence Survey in 2005 (Department of Health, 2006) indicates the very high proportion of child-bearing women infected. Similarly, the South African National Prevalence of HIV (Shisana *et al.*, 2005) found the highest prevalence in young females, peaking at 33.3% in the 25-29 year age group.

Table 5 – HIV prevalence in pregnant women in 2005

Province	HIV prevalence in pregnant women (%)
Eastern Cape	39.1
Free State	30.3
Gauteng	32.4
KwaZulu-Natal	39.1
Limpopo	21.5
Mpumalanga	34.8
North West	31.8
Northern Cape	18.5
Western Cape	15.7
All provinces	**30.2**

Source: DoH (2006)

The care of young children is at risk in situations where a family member abuses alcohol or drugs or where there is maltreatment or abuse within the family (domestic violence). Both of these situations are common in South Africa. One third of adult drinkers drink at risky levels at weekends, and according to the 1998 DHS, 10% of females and more than a quarter of males are alcohol dependent (Parry, 2005). Female drinking is a risk for Foetal Alcohol Syndrome but alcohol abuse is also associated with domestic violence, abuse and neglect.

A recent South African study (Dawes, Kafaar, de Sas Kropiwnicki, Pather & Richter, 2004) indicates that young children are exposed to high levels of violence and to abuse by caregivers, often multiple episodes. Sometimes this is direct abuse but children also witness abusive interactions in their homes. Local evidence is that a 20% of adults are involved in violent relationships with their partners. Corporal punishment is also extremely prevalent and children aged 3-5 years are especially vulnerable to this (Dawes, 2007).

4. Current service coverage for key NIP deliverables

Taking into account basic children's needs and rights, which are food, shelter, care, protection and education, the National Integrated Plan has committed itself to the comprehensive service package described in 2.2.1 above. In this section, we examine current indicators in relation to primary components of the NIP programme areas for which there is some information available.

A concise summary of information indicating current service delivery by programme component is given in Table 6.

One of the key features of the NIP is integration. The Plan has not yet been funded and rolled out and at present departments are not offering ECD services in an integrated way. Little research has been conducted in South Africa on the integration (or lack thereof) in service delivery to children, including for children aged 0-4. That which has been conducted flags lack of integration as a key weakness (see, for example, Streak & Poggenpoel, 2005; the Children's Institute Means to Live research findings, reported in Monson, Hall, Smith & Shung King, 2006; and Biersteker & Kvalsvig, 2007). As the plan moves to implementation there will be a need to include an indicator for the extent of integration in service delivery.

Table 6 – Current service access information by NIP for ECD programme components

Programme component	Related service goal/s	Current service access data
Universal registration of births	Complete registration of births to allow children to access services such as grants, schooling and to enable service planning. Reduction in late registration.	SSA study indicates a great improvement from 25% of current registrations in 1998 to 72% in 2005 (Dobbie, Masebe, & Nhlapo, 2007). See Table 1 in Appendix 4.
IMCI	60% of all health workers in facilities implementing IMCI to be trained by 2005 (DoH Goal for 2005)	76% of PHC facilities nationally implementing IMCI and 48% have trained 60% professional nurses. Coverage is poorest in EC at under 50%, followed by NC. Best in FS and MP. Household and community component (an important aspect of IMCI for NIP) requires further investment and strengthening. (Salojee & Bamford, 2006)
Immunisation	90% immunisation coverage in first year of life for all vaccines. 90% for measles. (DoH goals for 2005)	Over 90% achieved nationally in 2005 but not in four provinces – WC, NW, GP and MP. Coverage in all provinces well over 1998 DHS rate of 63%. Measles still endemic though fatality has decreased (Salojee & Bamford, 2006)
Promoting healthy pregnancy, birth and infancy	Baby-friendly health facilities (support breast feeding).	Doubling of facilities in SA since 2003, with 178 baby-friendly facilities by September 2005 (i.e. 37% of all birthing centres in SA). (Salojee & Bamford, 2006)
	Reduce low birth weight.	In 2002, low birth weight ranged from 14% - 22% in LP, MP; NW 14%, EC 15%; KZN &WC 18%; FS & GP 19%; NC 22%. (Ijumba & Padorath, 2006)
	Increase antenatal attendance to 95%.	Antenatal care coverage is high. DHIS calculates 95.5% coverage. Lower in NW.
	Increase proportion of deliveries supervised by trained birth attendants to 90%.	Less than 8% of births occur at home, which means the target has been met.
	Reduce by three quarters the maternal mortality ratio.	DHS 1998 150 per 100,000 maternal deaths but estimations are 175 to 2,000 per 100,000. Over a third of maternal deaths due to non-pregnancy-related infections 2001-4; about half HIV-related. (Beksinska, Kunene & Mullick, 2006)
	PMTCT/Paediatric ART.	PMTCT programme has 75% geographical access coverage and 55% uptake by HIV-positive pregnant women in 2004.
	Scale up and reduce MTCT to 5%.	Reduction of HIV transmission in those taking up PMTCT 28%. (Salojee *et al.*, 2006)
	Provide comprehensive services including wellness care and ART to infected, affected, exposed children (HIV/AIDS & STI Strategic Plan for SA 2007-2011).	Currently 85% of children with HIV are lost to follow-up from the PMTCT programme and an estimated 40% of these infants die during the first year of life without treatment. (Michaels et al, 2006)
Promoting healthy pregnancy, birth and infancy (continued)	Access to PHC services.	In 1998, 75% of children 12-13 months had a Road to Health Chart and the DoH goal was for this to increase to 85% by 2007. (Hendricks, Eley & Bourne, 2006) PHC facilities utilisation suggests national utilisation of 4.5 visits per child under 5 annually (most of these would be in

Programme component	Related service goal/s	Current service access data
		first year). (Salojee & Bamford, 2006)
Nutrition	Reduction of malnutrition.	Children 1-3 years: 25.5% stunted, 12.4% underweight and 2.2% severely underweight. (Labadorius, 1999). Micronutrients: anaemia under 6 years 21.4 % Vitamin A: one third of children deficient (Labadorius, 1999). Supplementation introduced in 2001. No recent data. (Salojee, 2007)
	Increase breastfeeding.	Breastfeeding: 10.4% exclusively breastfeed first 3 months and drops to 1.2 by 6 months.
Early learning stimulation	EFA goal: expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.	2006 General Household Survey attendance in a preschool facility for children 0-4 years had steadily increased from 7.6 % in 2002 to 16.6 in 2006 (SSA, 2007) DoSD has 9,726 registered ECD centres and 5,631 subsidised. In addition some 32,000 children under 5 in Pre-Grade R classes at public and independent schools (UNICEF, 2007). Previous research indicated that only 27% of ECD sites were registered with DoSD (Department of Education, 2001b). See Tables 3.1, 3.2 and 3.3 in Appendix 4. A recent UNICEF study of home- and community-based programmes for young children found that a small but growing number of programmes of this type operate in every province but mostly in WC (17), EC (12) and Gauteng (12). There is a fairly even spread across urban, rural and informal settlement contexts but only two providers are working on farms. Programmes include: ▪ Location-based integrated ECD strategies. ▪ Community child protection strategies. ▪ Use of ECD centres as supports for outreach work and other service hubs. ▪ Parent education courses. ▪ Playgroups. ▪ Home visiting. ▪ Toy-libraries. ▪ Support to childminders. ▪ Care & support for HIV+ and affected. (Biersteker, 2007)
Referral services for health and social services	For example, improve social grant take-up for children.	86% of estimated eligible children 0-4 years received child support grants in July 2007. Whilst the provincial and national level take-up is high, this masks the research finding that take-up is, in many districts, and particularly in rural areas, still low amongst the poorest two quintiles in the income distribution. Hence, there is still need to expand the reach of the CSG to children aged 0-4 and their caregivers, particularly in poorly resourced rural areas. See Table 2.1 for take-up in July 2007 and 2.2 for estimated take-up of eligible children per province in Appendix 4 (SASSA data).

Programme component	Related service goal/s	Current service access data
Referral services for health and social services (continued)		12,871 children were receiving the Care Dependency Grant and 18,838 the foster grant.
	Disability screening and referrals.	Developmental screening involves testing for disability in the PHC setting during routine visits and referring children with risks. Though identified as a national priority (Michelsen, 2003), this is only policy in WC where screening for moderate and severe disability when children visit health facilities at 6 weeks, 9 months and 18 months is seen as part of comprehensive PHC service delivery. Even in the WC, delivery is limited; almost a quarter of facilities do not deliver *any* developmental screening, and only 11% conducted screening according to protocol. No register of children who have failed the screening is kept. There is a general lack of community-level services for children with disabilities and need for training all nurse and clinic staff on: ▪ Causes of impairment and disability. ▪ Early identification of risk factors and conditions that could result in impairment. ▪ Available resources and mechanisms for referral and communication skills. (Philpott, 2006)
Development and implementation of psychosocial programmes	Develop appropriate parenting skills and capacity of parents and caregivers to safeguard the well-being and best interests of the child.	Recommended that referral to mental health services is incorporated into routine practice of public sector HIV clinics to address the substantive psychological needs of HIV-infected women. (Brandt, 2007)
	Prevent neglect, abuse or inadequate supervision of children and prevent other failures in family environment to meeting children's needs. (Children's Amendment Act 2007)	Several NGOs offer support for caregivers especially in the context of HIV. Home- and community-based ECD programmes often have this element (Biersteker, 2007)

5. Recommendations for targeting the implementation of the National Integrated Plan

5.1 The NIP approach to targeting

While national policies provide for all young children, the NIP notes that:

> *"International experience has… shown that, with limited financial resources, it always makes good sense to adopt targeting as an approach to the delivery of ECD services. In the first instance, a government could use income as a criterion for targeting. In the case of a developing country like ours, prioritising the provision of access to quality ECD services to the poorest and most vulnerable children needs no justification" (Department of Education et al., 2005: 8 [10]).*

In the section above, available data on each of these has been collated. In this section we take a brief look at some of the issues with regard to targeting.

The NIP has identified these vulnerable groups using a combination of socio-economic factors, special needs and situations in which children might be at risk because of compromised caregiving. But, while the NIP identifies particular vulnerable groups as targets, it does not indicate whether different levels of risk will be applied within these groups or whether there will be progressive efforts to service every child in these categories with the full service package.

Above we indicated some difficulties with this definition of target groups, which might in practice make it difficult to target accurately during service implementation. These were vagueness in the definition of poor children and children from dysfunctional families, the broadness of the category of children affected by HIV and AIDS, as it might be argued that almost all children are affected in some way, and a concern that certain groups such as those with elderly caregivers might have been excluded.

[10] Whilst it is true that in all countries the fiscus has limited resources to spend on service delivery, it also needs to be understood that South Africa is, currently in a relatively good position in terms of resources available for spending by the state on programmes of support for the poor and vulnerable. This favourable position is reflected in South Africa's low budget deficit to GDP ratio and the generous tax relief given by the Finance Minister over the recent past. In South Africa, the scarcity of state funding for ECD age 0-4 is more the outcome of insufficient human capacity and planning in the ECD sector and insufficient prioritisation of vulnerable children in the budget process (particularly provincial) than due to insufficient financial resources at the consolidated government level.

Lessons from others' experience with targeting

For effective targeting criteria for defining vulnerability and risk levels should be as specific as possible. Possible approaches as outlined by Knitzer and Lefkowitz (2006) include:

- Risk indices (usually combining demographic, child, family and environmental risks such as single parenthood, teen parent, being a grant recipient, low level of education, etc.);
- Identifying young children in circumstances known to place them at risk because of ineffective parenting or absence of parents (for example, victims of abuse and neglect, parents in prison); and
- Using prevalence data based on known parental risk factors for impaired parenting (for example, domestic violence, young children who live with parents with clinically significant depression, parents who are substance abusers/substance dependent).

A broader approach that is often used is to target particular areas. For example, Sure Start in the UK has chosen a universal area-based intervention strategy for all families with young children to limit the stigma that might affect those who are targeted. But areas selected had a high rate of disadvantage (Rutter, 2006). The issue of further stigmatising vulnerable groups such as orphans by exclusively providing services to them has been widely raised in South Africa and other countries.

A critical issue for area targeting is the level at which data for targeting purposes is available. For example, the information such as that presented in this report is at provincial level, but risk factors are frequently uneven – even within social development and health districts there may be distinct variations. For example, while there is a relatively low overall HIV prevalence in the Western Cape, a study by Shaikh *et al.* (2006) confirms that HIV prevalence is very uneven across the province, with various sub-epidemics depending on a number of factors operating in different areas. Some of these might include migration, rapid urbanisation, unemployment, high population density and sexual behaviours. Understanding of local variations is very important for planning for several services – in this example PMTCT, HAART and VCT. Similarly, provincial grant take-up figures mask lower take-up in certain municipalities and in the bottom two income quintiles.

5.2 Recommended approach and implications for data management

As well as the challenge of defining poor children, there is the issue that while the designated vulnerable categories are risk indicators they may not, depending on circumstances, necessarily be direct risk indicators for example, living in child-headed households (Donald & Clacherty, 2005 and Bray & Brandt, 2007), child outcomes are not necessarily compromised by having a teen or single parent etc.

In this regard, screening within risk groups using a risk index would be more efficient and allow for a determination of which of the NIP programmes are needed. However, the more specifically targeted a service is, the higher the administrative cost and as has been raised above, there may be social costs as well as political costs.

The DoH's primary, secondary and tertiary service model and the DoSD's levels of intervention for service delivery (Department of Social Development, 2006c) – from prevention through early intervention (non-statutory) to statutory interventions and reintegration – suggest a framework for differentiating service delivery. Figure 5 shows how particular aspects of the NIP service package are universal and others specifically targeted. Service intensity and specialisation increase from one level to the next. The universal level would include services available on a routine basis to all children. At the next two levels, the concept of multiple risk factors as discussed in Section 3 above is helpful in terms of targeting. Figure 6 summarises risk factors requiring different intensities of intervention.

Figure 5 – Hierarchy of ECD interventions to improve outcomes for children 0-4 years (with reference to the National Integrated Plan)

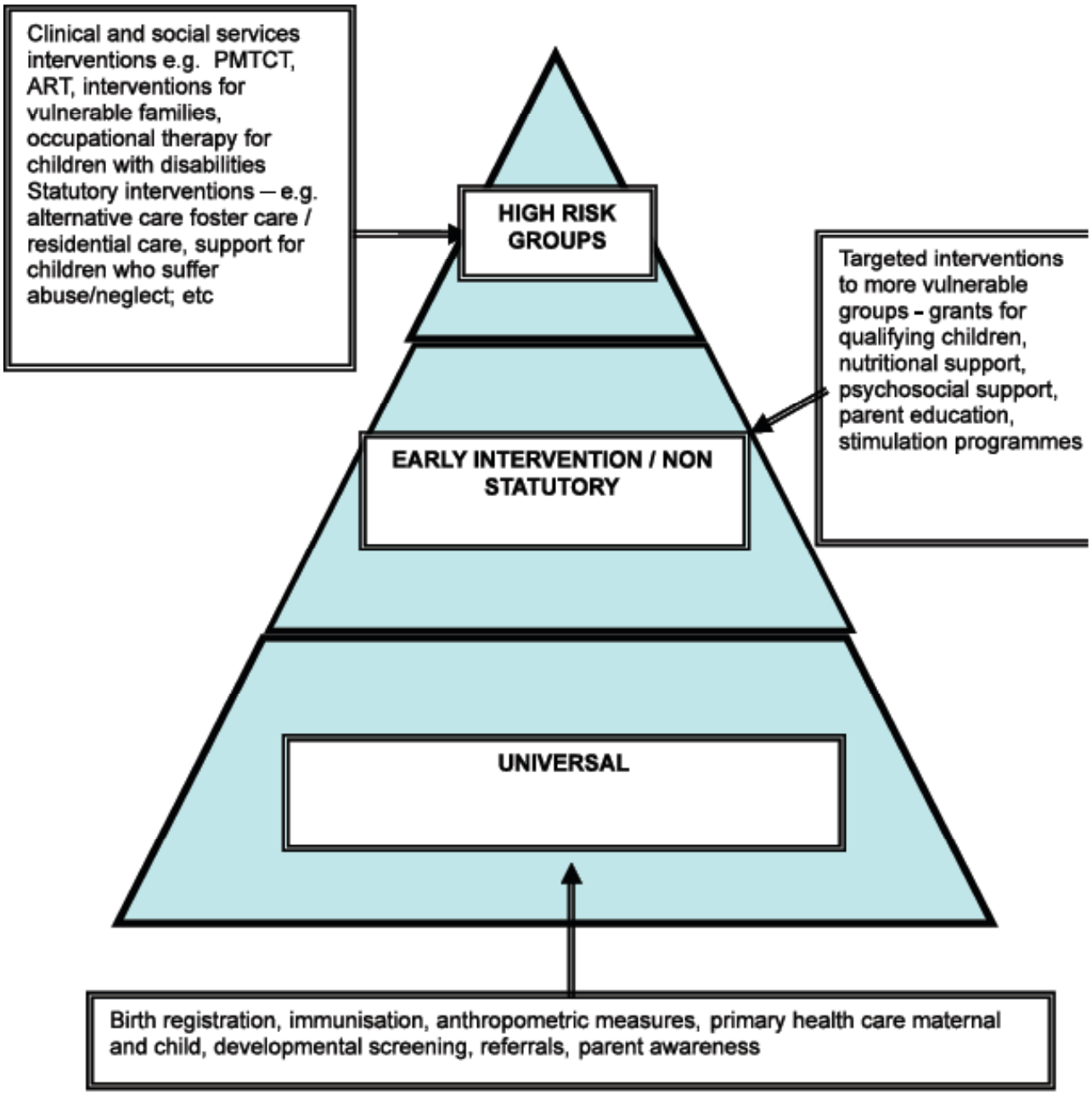


Table 7 – Risk factors requiring different levels of intervention

Early intervention	More intensive interventions for high-risk groups	
Factors which put young child development at risk	**Factors which can seriously compromise caregiving capacity**	**Children who have extra needs**
Poverty	HIV	Disability and chronic illness
Low caregiver literacy	Domestic violence	
Compromised food security	Substance abuse	Abused and neglected children
Lack of access to primary healthcare	Caregiver illness, depression	
Little environmental stimulation	High dependency ratios	Children with no caregivers
Lack of support systems	Very young or old caregivers	

5.2.1 Children needing formal, community and home-based ECD services

The NIP has provided an estimation of the percentages of children requiring different forms of services delivered at different sites. This is that 16% to 20% of children should be reached through services delivered at formal sites (such as crèches, ECD centres, child and youth care centres); 30% through community based services (including parent education programmes, IMCI, primary health care, accessing grants, playgroups, PMTCT) and 50% by services aimed directly at households (psychosocial care and support, birth registration, play, stimulation, protection, hygiene etc). This is a significant feature of the NIP, as it clearly signals that there will be no attempt to move towards universal formal provision for young children but instead that government will recognise a wide range of services.

Estimating how many children need a **formal** ECD service is almost impossible. The NIP proportion is based on the number of children thought to be in such provision already. The General Household Survey 2006 (Statistics South Africa, 2007a) provision estimate of 16.6% meets the NIP parameters. It is based on a question about attendance at an educational institution and it is not clear whether this refers to daycare programmes including child minders. Whether or not it is an accurate reflection, there is neither an indication whether this is an adequate service supply nor whether the children most likely to require daycare are those accessing the services. These would include children whose primary caregivers were working, or were unable to care for them due to age (grandparents and child headed households), illness or vulnerable (dysfunctional) family circumstances. It would also include children requiring early intervention due to disability. Data on all these categories is urgently needed so that the adequacy of 16% to 20% for formal services can be ascertained.

According to anecdotal evidence, many working parents make use of daycare services, but children from poor, very stressed family circumstances are less likely to do so because they cannot afford the fees (for example, Biersteker & Dawes, 2008; Biersteker, 2006; and Streak & Norushe, 2008). While we have no recent statistics, a low 1% of children with disabilities were accessing ECD services at the time of the

nationwide audit (Department of Education, 2001b). Only a third of these were under five years old (Biersteker & Dawes, 2008). While the numbers of children in children's homes are relatively low, we know that this is an increasing form of provision.

Estimations of the need for community and household services are equally difficult. Our understanding is that while all children require birth registration, stimulation, etc. as outlined in Table 6, only a proportion of households need assistance in accessing these. Whether or not 50% of children under five need such support is difficult to say. What is clear is that the NIP aims to put in a safety net for vulnerable families at this level, which is essential in helping the realisation of young children's rights and in avoiding costly tertiary interventions. However, in order to provide resources where they are most urgently needed, our recommendation is to:

- Improve data availability on both the status and needs of young children and families and service access and quality so that there is very disaggregated information to help pinpoint areas with particular risk factors and to help service planning; and
- Screen target groups within these communities using simple measures.

5.2.2 Data availability

The primary health data system generally operates efficiently, capturing valuable information at a localised level. However, the social sector data systems are extremely weak and there is no comprehensive data collection. Further, different risk factors are not integrated in a single database and data on key services are not easily available (for example, up-to-date data on the numbers of ECD services). For effective administration of the NIP service package, better data systems are needed, ideally with links to a single database. This would have to be at local level. For example, the Massification Concept proposes a five-year phasing in of a process of linking families with services using existing ECD centres as the point of convergence, starting with the identified target municipalities in Project Consolidate. These municipalities have been prioritised through a process of targeting according to demographic indicators (including housing, water and sanitation, electricity, indigent population, unemployment and income)[11], but for NIP purposes we need to draw in information on percentages of children immunised, who have a Road to Health Card, anthropometric measures, eligible children receiving grants, children receiving ART, attending ECD centres, receiving household services, etc. (see Dawes, 2008a and 2008b).

5.2.3 Screening

Tools for screening need to be extremely simple, easy to administer and should focus on key risk factors. They should be simple enough that outreach workers with low educational levels can be trained to administer them. The more complex the screening process, the more of a barrier it becomes to quick identification of those who need

[11] Information on indicators used for profiling from Project Consolidate Booklet accessed at www.projectconsolidate.gov.za on September 10, 2007.

the service. For many of the risk factors, especially in relation to high-risk groups, delays can cause death or permanent damage.

A variety of vulnerability screens exist and could provide a starting point. Examples include the Academy for Educational Development's Speak for the Child Household Vulnerability Screen (Academy for Educational Development (AED), 2002) trialled in rural Kenya, the REPSSI Information and Action Tool (HSRC, 2006) and the UNICEF OVC and Vulnerable Children Screen (UNICEF, 2005).

5.3 Recommendations and inferences for design of ECD (0-4 years) demonstration project

In exploring the question of how the NIP services to vulnerable groups could be more specifically **targeted**, the following is proposed:

- The NIP service components are viewed as being delivered on a continuum basis, from universal (such as birth registration, primary health care, parent awareness messages), to early interventions to more vulnerable groups (such as grants, IMCI, psychosocial support, parent education groups) to specialised interventions including statutory interventions for children who are more seriously at risk (such as HIV positive children, children 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 collection and management to enable more directed service planning and delivery at local level, so that high-risk areas and groups can be targeted. Included in this proposal is that research and consultation be pursued to enhance understanding about the appropriate poverty line to be used in developing poor child targets in ECD budgeting and service delivery;
- A simple risk screen is developed and administered to determine the service components required by different children and their caregivers.

On the basis of this review of policy, demographics, child outcomes, service provision and targeting, the key inferences for the design of the Demonstration Projects could include:

- Testing ways of achieving delivery of the integrated NIP service package through formal, community and home based ECD services. 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.
- Trialling mechanisms for improving quality in the delivery of the NIP service package and ways of measuring and monitoring this.
- Exploring a two phase targeting process, firstly general targeting to particular areas on the basis of how the basic NIP service package has been delivered (for example, health status, birth registration, immunisation status, access to ECD stimulation programmes) and secondly risk screening within the community in

order to carefully target very high risk caregivers and children requiring intensive interventions. This will involve adapting or developing screening tools for this purpose and validating them.

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Appendix 1 – ECD centres as resources of care and support for poor and vulnerable children and their families (including OVCs): concept document

This document from the Departments of Social Development and Education provides an illustration of how the proposal in the Massification of ECD document of the ECD centre as a node for broader integrated ECD service delivery, at a household and community level, might be operationalised. The rationale is to use existing ECD resources as a means of extending services to up to three or four times more young children, than are currently reached.

Interventions will aim to ensure that young children's basic rights in terms of health, nutrition, care, protection and support are addressed in the context of the child's family and will also benefit older children and caregivers as an essential part of the intervention.

As with the NIP for ECD, interventions for young children affected by poverty, HIV and AIDS within the context of other interventions for OVCs in communities will be prioritised.

An ECD centre as a Resource for the Care and Support for Poor and Vulnerable Young Children and their Families (including OVCs) will provide day care for children in the community, but in addition to that is seen as providing other services to the surrounding community. Examples are given of such services and link closely to the priority target groups and programmes of the NIP. The table below indicates these linkages.

Table 8 – Links between the NIP for ECD programme components and services proposed for ECD Centres in support of poor and vulnerable children

NIP programme components	Examples of services to be offered by ECD Centres as supports for poor and vulnerable children
Universal registration of births	Assisting children to obtain birth certificates.
Integrated Management of Childhood Illnesses (IMCI)	Integrating the Key Family Practices of the Community Component of Integrated Management of Child Illnesses into the centre programmes as well as the household programmes.
Promoting healthy pregnancy, birth and infancy	Health promotion of the children in the centre as well as young children in the community.
Immunisation	Ensuring that all young children have a Road to Health Card and assist parents/ caregivers to monitor the immunisation, growth and general health of the child
Nutrition	Development of food gardens Assisting households to obtain food parcels while they await social grants
Development and implementation of psychosocial programmes	Support groups for parents Have support groups and respite day-care programmes for grandparents who look after young children Support groups for child or adolescent households with young children Support to HIV+ caregivers and their children, especially on their psychosocial needs and ART adherence.
Referral services for health and social services	Outreach programmes through volunteers to poor and vulnerable households to assess need for and provide support. Assisting young children and their families to obtain grants where they qualify. Assisting foster parents with young children through application of foster child grants and foster parent support groups
Early learning stimulation	Parenting capacity development and training programmes for all parents in the community. Running Family Literacy Classes that will enhance the literacy skills of caregivers and further early childhood stimulation. Toymaking Workshops for parents and other care providers

This type of ECD service, introduces a new ECD job category in the form of a Family Support Worker (FSW), who will visit households in the catchment area of the

ECD centre. Skills training rather than an ECD qualification is proposed including early childhood care and development, C-IMCI Key Family Practices and an understanding of the basic Social Services available (for example, application for birth certificates, grants and how to link with other government and NGO resources in the community). The Concept document notes a number of requirements for such a service approach to be successful including

- ECD practitioners responsible for the operation of the ECD centre would have to be trained both in FSW skills and management and facilitation of the programme
- ECD policies and guidelines would need to be adjusted to shift from the current centre based approach to a more community based approach in alignment with NIP
- DoSD norms for funding ECD centres would need to move from the per capita formula to a programme based integrated formula.
- Tools to assess the needs at a household level and indicators to monitor the impact of the programme.

Appendix 2 – List of ECD policy and related documents with implications for the delivery of services to 0-4 year-olds

Table 9 – ECD policy and related documents with implications for the delivery of services to 0-4 year-olds

Sector	Document name	Source
	International	
All	Convention on the Rights of the Child (1989)	http://www.ohchr.org/english/law/crc.htm
All	Committee on the Rights of the Child General Comment No 7 Implementing Child Rights in Early Childhood (2005)	http://www.ohchr.org/english/bodies/crc/docs/discussion/earlychildhood.pdf
All	African Charter on the Rights of the Child (1999)	http://www.africa-union.org/official_documents/Treaties_%20Conventions_%20Protocols/A.%20C.%20ON%20THE%20RIGHT%20AND%20WELF%20OF%20CHILD.pdf
All	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	http://www.unhchr.ch/html/menu3/b/e1cedaw.htm
All	Millennium Development Goals	http://www.un.org/millenniumgoals/
Education	Education For All Goals	http://portal.unesco.org/education/en/ev.php-URL_ID=43811&URL_DO=DO_TOPIC&URL_SECTION=201.html UNESCO (2000) Dakar Framework for Action: Education for All; Meeting our Collective Commitments. UNESCO; Paris
Social Development	Malta Statement on the Family	http://www.un.org/ga/children/maltaE.htm
	South African legislation	
All	Constitution of RSA (Act 108 of 1996)	http://www.acts.co.za/constitution/index.htm
Social Development	Children's Amendment Act 2007	http://www.ci.org.za/depts/ci/plr/pdf/bills/ChildrensAmendmentBill25Aug.pdf
	National policy and related documents	
Social Cluster	National Integrated Plan for Early Childhood Development in South Africa 2005-2010, Departments of Education, Health and Social Development (NIP)	Departmental Document
Social Cluster	Expanded Public Works Programme Social Sector Plan 2004/5 – 2008/9	http://search.freefind.com/siteindex.html?id=94481444&ltr=19456&fwr=320&pid=i&ics=1 Departmental Document
	Massification of ECD	Draft Departmental Document
DoE/SAQA/DoL	FETC in ECD Level 4 (Draft 3, August 2006)	Draft SAQA Unit Standard available for public comment

Sector	Document name	Source
DoE/DoSD	Draft Concept Document: ECD Centres as resources of care and support for poor and vulnerable children and their families (including OVCs) July 2006	Departmental Document
Social Cluster	National Integrated Plan for Children Infected and Affected by HIV/AIDS (2000)	Departmental Document
Departmental policies and related programme documents		
Education	White Paper on Education and Training (1995)	http://www.info.gov.za/whitepapers/1995/education1.htm
Education	White Paper 5: Early Childhood Education (2001)	http://www.info.gov.za/whitepapers/1995/education1.htm
Education	White paper 6: Special Needs Education (2001)	http://www.info.gov.za/whitepapers/2001/educ6.pdf
Education	Draft National Strategy on Screening, Identification, Assessment and Support (May 2005)	http://www.education.gov.za/content/documents/784.pdf
Social Development	White Paper for Social Welfare (1997)	http://www.welfare.gov.za/Documents/1997/wp.htm
Social Development	Guidelines for Early Childhood Development Services (May 2006)	http://www.info.gov.za/otherdocs/2006/DSD_childhoodDevlpmentservices.pdf
Social Development	National Department of Social Development Strategic Plan 2002/2003 & 2005/2005-2009/10	www.welfare.gov.za/Documents/2002/March/SPLAN.PDF www.socdev.gov.za/documents/2006/stratplan.pdf
Social Development	Integrated Service Delivery Model (Department of Social Development, 2006)	www.socdev.gov.za/documents/2006/sdm.doc
Social Development	National Family Policy (Final Draft June 2006)	Draft Departmental Document
Social Development	Plan of Action for Families (Department of Social Development, 2004)	www.welfare.gov.za/documents/famplan.doc
Social Development	Five year HIV/AIDS Strategic Plan for Social Development 2003- 2008	Departmental Document
Social Development	National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, Department of Social Development, (undated)	Departmental Document
Social Development	Policy Framework for Orphans and Other Children made Vulnerable by HIV/AIDS (South Africa) Department of Social Development 2005.	http://www.cindi.org.za/publications/Policy-Framework-for-OVC-Final.pdf
Health	White Paper on the Transformation of Health in South Africa (1997)	http://www.info.gov.za/whitepapers/1997/health.htm
Health	National Health Act of 2003	www.info.gov.za/gazette/acts/2003/a61-03.pdf
Health	Strategic Priorities for the National Health System 2004-2009	http://www.doh.gov.za/docs/index.html
Health	Integrated Management of Childhood Illnesses (IMCI): Primary Health Care Package for SA – a set of norms and standards	www.doh.gov.za/docs/policy/norms/part1f.html
Health	HIV, AIDS and STI Strategic Plan for South Africa 2007 - 2011	http://www.doh.gov.za/docs/misc/stratplan-f.html

Appendix 3 – Overview of child poverty measurement studies in South Africa

Table 10 – Overview of child poverty measurement studies in South Africa (using indirect monetary indicator*)

Study and data used	Poverty definition	Child poverty rate (%)
Study: 1. Budlender reported in Monson *et al.* (2006*) South African Child Gauge 2006*. Cape Town: Children's Institute, University of Cape Town. Data used: 2005 General Household Survey.	One absolute definition: 1. Child (age 0-17) poor if he/she lives in a household with reported expenditure of less than R1,200 per month.	South Africa 66.2 Eastern Cape 80.2 Free State 65.5 Gauteng 43.0 KwaZulu-Natal 69.0 Limpopo 83.0 Mpumalanga 69.5 Northern Cape 59.6 North West 72.3 Western Cape 36.1
Study: 2. Budlender (2007) conducted for HSRC for NIP ECD project. Data used: 2005 General Household Survey.	One absolute definition: 1. Child (age 0-4) poor if he/she lives in a household with reported expenditure of less than R1,200 per month.	South Africa 66.0 Eastern Cape 79.0 Free State 71.0 Gauteng 68.0 KwaZulu-Natal 74.0 Limpopo 66.0 Mpumalanga 81.0 Northern Cape 59.0 North West 43.0 Western Cape 40.0
Study: 3. Budlender 2006 reported in Monson *et.al.* (2006*) South African Child Gauge 2006*. Cape Town: Children's Institute, University of Cape Town. Data used: 2005 General Household Survey.	Two absolute definitions: 1. Child (age 0-17) poor if he/she resides in a household with reported income of less than R800 per month.	South Africa 55 Eastern Cape 73 Free State 60 Gauteng 29 KwaZulu-Natal 60 Limpopo 74 Mpumalanga 57 Northern Cape 49 North West 58 Western Cape 18
	2. Child (age 0-17) poor if he/she resides in household that reported less than R1,200 income per month.	South Africa 60 Eastern Cape 78 Free State 66 Gauteng 35 KwaZulu-Natal 65 Limpopo 78 Mpumalanga 66 Northern Cape 57 North West 63 Western Cape 23

Study and data used	Poverty definition	Child poverty rate (%)
Study: 4. Woolard 2003 reported in Streak Chapter 1 in (Coetzee & Streak, 2004)Monitoring Child Socio-economic rights in South Africa: Achievements and Challenges. Data used: 2000 Income & Expenditure Survey.	Two absolute definitions: 1. Child (age 0-17) poor if she/he resides in a household calculated to have less than R430 per capita per month	South Africa 74.8 Eastern Cape 85.6 Free State 77.7 Gauteng 54.8 KwaZulu-Natal 78.9 Limpopo 86.7 Mpumalanga 77.7 Northern Cape 70.8 North West 76.2 Western Cape 46.9
	2. Child (age 0-17) poor if she/he resides in a household calculated to have less than R215 per capita per month	South Africa 54.3 Eastern Cape 72.2 Free State 57.6 Gauteng 28.0 KwaZulu-Natal 59.8 Limpopo 69.2 Mpumalanga 52.0 Northern Cape 47.9 North West 53.1 Western Cape 19.6
Study: 5. Woolard 2001 cited in(Streak, 2002). Idasa Budget Information Service Child Poverty Monitor 1. Data used: October Household Survey 1995.	Two absolute definitions: 1. Child (age 0-17) poor if she/he resides in a household calculated to have less than R400 per capita per month	South Africa 64.7 Eastern Cape 81.7 Free State 76.0 Gauteng 27.0 KwaZulu-Natal 66.9 Limpopo 69.6 Mpumalanga 72.4 Northern Cape 69.4 North West 73.2 Western Cape 44.5
	2. Child (age 0-17) poor if she/he resides in a household calculated to have less than R200 per capita per month	South Africa 38.9 Eastern Cape 58.7 Free State 53.7 Gauteng 7.7 KwaZulu-Natal 36.7 Limpopo 43.4 Mpumalanga 44.0 Northern Cape 35.7 North West 48.9 Western Cape 14.7

Study and data used	Poverty definition	Child poverty rate (%)
Study: 6. Woolard 2001 cited in Streak 2002. Idasa Budget Information Service Child Poverty Monitor 1. Data used: October Household Survey 1999.	Two absolute definitions: 1. Child (age 0-17) poor if he/she lives in a household calculated to have income per capita of less than R400 per month.	South Africa 75.8 Eastern Cape 88.4 Free State 77.2 Gauteng 55.4 KwaZulu-Natal 80.0 Limpopo 84.3 Mpumalanga 78.7 Northern Cape 72.9 North West 78.7 Western Cape 46.8
	2. Child (age 0-17) poor if he/she lives in a household calculated to have less than R200 per capita per month.	South Africa 58.1 Eastern Cape 74.0 Free State 59.5 Gauteng 37.2 KwaZulu-Natal 62.9 Limpopo 67.5 Mpumalanga 59.1 Northern Cape 48.2 North West 59.1 Western Cape 24.2
Study: 7. Dieden & Gustafson, 2003 Child Poverty in South Africa: An assessment based on microdata for 1995 in *International Journal of Social Welfare* Vol.12. Data used: October Household Survey 1995.	Absolute (World Bank) informed definition: Child (age 0-17) poor if he/she resides in a household calculated to have an income of less than R122.56 per capita per month. Develop to be equivalent to World Bank line (also used for monitoring MDGs) of US1$ per day.	South Africa 28.4 Eastern Cape 47 Free State 39.7 Gauteng 4.3 KwaZulu-Natal 25.7 Limpopo 33.0 Mpumalanga 26.8 Northern Cape 24.2 North West 37.4 Western Cape 8.3
Study: 8. Barnes, Wright, Noble, & Dawes, 2006 The South African Index of Multiple Deprivation for Children 2001. Data used: Census 2001	Relative definition: Child (age 0-17) poor if he/she lives in household that has annual per adult equivalent household income (need adjusted using OECD equivalence scale) of less than 40 of the mean adult equivalent household income. (Works out to R10,189 per annum or R849 per adult equivalent/child per month).	South Africa 81 Eastern Cape 89 Free State 83 Gauteng 58 KwaZulu-Natal 83 Limpopo 89 Mpumalanga 84 Northern Cape 76 North West 82 Western Cape 55

Study and data used	Poverty definition	Child poverty rate (%)
Study: 9. Barnes et.al. (2006) The South African Index of Multiple Deprivation for Children 2001. Data used: Census 2001	Relative definition: Child (age 0-4) poor if he/she lives in household that has annual per adult equivalent household income (need adjusted using OECD equivalence scale) of less than 40 of the mean adult equivalent household income. (Works out to R10,189 per annum or R849 per adult equivalent/child per month).	South Africa 82 Eastern Cape 88 Free State 83 Gauteng 61 KwaZulu-Natal 84 Limpopo 89 Mpumalanga 84 Northern Cape 77 North West 82 Western Cape 57
Study: 10. National Institute of Economic Policy (NIEP), 1996 *Children, Poverty and Disparity Reduction.* Johannesburg, NIEP. Data used: 1993 Project for Statistics on Living Standards and Development.	Relative definition: Child (age 0-4) poor if he/she lives in household that lies in the bottom 40% of adult equivalent household income distribution.[12]	South Africa 60

Source: Streak, J. (forthcoming) "Taking stock of the evidence base on child poverty and the child support grant in South Africa".
** Income or expenditure*

[12] Simple (World Bank informed) equivalence scale used to adjust household income for economies of scale.

Appendix 4 – Detailed information on selected service deliverables in the NIP package

In this section, further information is given on key deliverables referred to in Table 6 in Section 4 of the report.

Birth registrations

Birth registration is important because it enables government planning and monitoring; access to social services such as health care, social grants and education; identifies sections of the population for special interventions; and allows for monitoring against international and national commitments such as the Millennium Development and EFA goals. It is also related to the right to a name and nationality from birth.

The analysis by Dobbie, Masebe and Nhlapo (2007) shows that generally there has been a great improvement in the completeness of birth registrations, from 25% of current registrations in 1998 to 72% in 2005 for which this has been tracked. Late registration, defined by the authors as births not registered in the first year (although the official definition is after 30 days post-birth), remains a problem, with about a quarter of all births unregistered even after five years. A relatively large percentage of births are registered between the first and third years of birth.

As can be seen, provinces differ in the completeness of registration, with urbanised provinces having greater completeness and rural and poorer provinces such as the Eastern Cape, KZN and North West and Limpopo having lower completeness levels.

Note: The slight discrepancy between the completeness estimate and percentage current registration/estimated births is due to an adjustment factor.

Table 11 – Birth registrations by province, 2005

Province	Estimated n of births	Current registration	Completeness estimate (%)
Eastern Cape	170,929	112,662	65.9
Free State	64,258	48,009	74.7
Gauteng	193,454	157,508	81.4
KwaZulu Natal	243,315	151,838	62.4
Limpopo	146,521	98,758	67.4
Mpumalanga	80,568	56,648	79.3
Northern Cape	19,731	16,224	82.2
North West	92,508	62,353	67.4
Western Cape	90,817	87,850	96.7
All provinces	**1,102,099**	**793,788**	**72.0**

Source: Dobbie et al. (2007)

Social security for children aged 0-4 years

In July 2007 grants paid out to children included the child support grant, foster grant and care dependency grants for children with disabilities.

Table 12 – Social grants paid out for 0-4 year-olds by Province in July 2007

Grant	E Cape	Free State	Gauteng	KZN	Limpopo	Mpuma-langa	N Cape	North West	W Cape	South Africa
CSG by age										
0-1	57,118	23,770	40,880	79,314	68,588	27,598	7,875	22,467	17,951	345,561
1-2	110,462	37,520	74,576	146,046	104,930	48,887	13,189	46,781	32,747	615,138
2-3	119,130	39,668	82,119	153,812	104,341	53,856	14,150	52,839	36,758	656,673
3-4	110,825	35,941	81,375	144,541	91,427	49,941	14,126	50,708	37,755	616,639
4-5	108,678	35,227	80,840	155,548	90,704	49,492	14,276	50,474	38,090	623,329
Total	506,213	172,126	359,790	679,261	459,990	229,774	63,616	223,269	163,301	2,857,340
CDG	1,860	544	1,804	3,681	1,419	685	532	910	1,436	12,871
Foster	3,359	1,908	3,086	3,928	1,829	788	579	1,045	2,316	18,838

It is not possible to estimate the take-up of the care dependency and foster grants for young children aged 0-4 years relative to need due to lack of data available to calculate eligibility numbers. Below is an estimation of the uptake of the Child Support Grant based on the numbers of children who received the grant in July 2007 and the provincial child poverty estimates presented in Section 2 of the report. It needs to be stressed that the estimates are rough because the numbers of children living in

households that reported to have expenditure of less than R1,200 per month in the GHS 2005 is used as a proxy for the number that would pass the means test.

Table 13 – Estimated provincial percentage uptake of the CSG by eligible children

Province	CSG beneficiaries aged 0-4, July 2007	Poor children aged 0-4	Implied CSG uptake (%)
Eastern Cape	506,213	643,148	79
Free State	172,126	213,248	81
Gauteng	359,790	369,937	97
KwaZulu-Natal	679,261	712,353	95
Limpopo	459,990	556,669	83
Mpumalanga	229,774	262,289	88
North West	223,269	317,506	70
Northern Cape	63,616	55,574	114
Western Cape	163,301	187,823	87
All provinces	2,857,340	3,318,547	86

A critical issue to note is that the aggregate take-up at national and provincial level high but this masks the finding from research conducted by the Department of Social Policy at Oxford University for the Department of Social Development, that amongst the poorest two quintiles, where need is greatest, take-up is still low in many municipalities.

Access to ECD services

As is recognised in the National Integrated Plan for ECD and previous policy documents (DoSD, DoE), there should be a range of ECD services depending on the needs of particular families and children. More formal ECD services, most commonly ECD centres, but including programmes at hospitals, prisons, child and youth care centres, etc. are one form of provision. Historically this type of programme has tended to be viewed as the only ECD service, and because of registration requirements for any programme with more than six children cared for on a regular basis (Child Care Act of 1983 as amended and Children's Amendment Act of 2007), it is the service about which most is known. However, it is recognised that in the South African context it is not necessary or even desirable for every child to access a facility which offers a full-day programme.

Children in ECD centre provision

Provincial audits to update the 2000 Nationwide Audit of ECD Provisioning are currently underway. So, as yet there is no accurate data on the numbers of children in this age group in organised ECD provision. The number of registered and subsidised ECD centres, given as an indication of provision by the Department of Social Development (UNICEF, 2007) is far lower than the numbers that do exist, and while

the General Household Survey indicates an increase, it is not clear how households have understood the question. Table 14 is based on the numbers identified in the 2000 audit (Department of Education, 2001b) which found 406,917 or 9% of children under five, differentiated by age into 5% of children less than three years and 15% of children aged three and four years.

Table 14 – Percentage of children under five years attending ECD sites by age and province in 2000

Province	Population <3	% in ECD	3-<5 population	% in ECD
Eastern Cape	405,474	4	339,566	13
Free State	141,458	7	106,961	18
Gauteng	380,778	7	252,841	28
KwaZulu-Natal	532,090	4	429,639	12
Mpumalanga	186,492	3	139,934	10
Northern Cape	53,819	2	36,346	15
Limpopo	367,637	3	280,434	10
North West	222,316	2	149,970	10
Western Cape	222,314	10	162,274	25
Total	2,512,378	**5**	1,897,965	**15**

Calculated from: Statistics South Africa (1999): population statistics and Department of Education (2001)

Registration and subsidisation of ECD centres

More recent figures have been provided by provincial departments of social development on the numbers of registered and subsidised ECD facilities in their provinces and numbers awaiting registration. Registration requires the meeting of minimum standards in terms of the physical aspects of the facility, staffing and programme. Only registered community ECD facilities which have children who qualify in terms of a means test are eligible to apply for subsidies, which are a key factor in making the service sustainable and improving its quality. In Table 15 we give the latest information we have been able to access on the number of sites receiving a subsidy, subsidised children and subsidy amount. We also attempted to gather good data from provincial social development departments on the number of unregistered and registered sites not receiving subsidies. However, the data provided in this regard was sketchy and of questionable quality. The data relating to unregistered sites will improve once the process of auditing in the provinces is complete.

Table 15 – Provincial data on ECD sites: registered, receiving subsidy, children subsidised and subsidy amount, 2006 and 2007

Province	Sites receiving subsidy (N)	Children receiving subsidy (N)	Value of per child subsidy (R)
Eastern Cape	1,124	59,940	9.00
Free State	434	28,558	5.20
KwaZulu-Natal	1,800	59,000	11.00
Gauteng	281	21,117	9.00
Limpopo	1,221	56,223	7.50
Mpumalanga	450	35,095	6.00
North West	210	15,165	9.00
Northen Cape	254	12,600	9.00
Western Cape	808	44,655	7.50
South Africa	6,582	332,353	

Source: Supplied by Provincial Social Development Department Officials August to October 2007. Data relates therefore to current (2007/8) subsidy levels and numbers of children and sites registered as receiving subsidies.

Numbers of children receiving the subsidy are below provincial targets. According to the Costing of the Implementation of the Children's Bill (Barberton, 2006), provinces had substantial progress to make in order to reach their targets for the number of the 0-4 population that should be subsidised. There were also large differences in the subsidy allocated, the national costing norm being R9 per child per day (see Table 16). As can be seen comparing the values below for the previous years, the subsidies have generally risen.

Table 16 – Provincial per capita subsidies, child population subsidised and targets

Province	Partial care/ECD subsidy 2005/6	% 0-4 population subsidised 2005/6	Target % to be subsidised 2010/11
Eastern Cape	4.30	8	14
Free State	4.50	9	14
Gauteng	6.00	2	25
KwaZulu-Natal	9.00	5	11
Limpopo	6.00	8	17
Mpumalanga	4.40	4	14
Northern Cape	7.00	13	25
North West	4.50	3	10
Western Cape	5.00	13	22

Source: Barberton (2006)