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

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

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

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

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

Table 3: Child population, 2016 – 2022

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

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

Child population

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

What happened during lockdown?

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

Basic services

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

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

Table 4: Access to basic services, 2016 – 2022

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

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

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

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

Health

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

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

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

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

What happened during lockdown?

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

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

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

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

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

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

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

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

Nutrition

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

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

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

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

Sources:

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

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

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

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

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

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

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

What happened during lockdown?

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

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

Social protection

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

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

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

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

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

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

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

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

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

What happened during lockdown?

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

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

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

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

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

Care and learning

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

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

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

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

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

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

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

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

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

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

What happened in during lockdown?

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

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

Reflections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Good Average Poor

Coverage of programmes

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

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

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

Service gaps and equity concerns

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

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

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

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

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

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

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

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

The Plan promotes improved:

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

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

Coverage of the NFNSP

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

Policy gaps and equity concerns

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

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

Priority 3: Provision of universal early learning opportunities from birth

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

Scope of programmes

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

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

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

Good Average Poor

Table 14: Provision of universal early learning opportunities from birth

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

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

Coverage of programmes

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

Programme gaps and equity concerns

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

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

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

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

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

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

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

Good Average Poor

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

Scope of existing policy and programmes

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

The White Paper provides the following directives:

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

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

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

Coverage of existing policy and programmes, gaps and equity concerns

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

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

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

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

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

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

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

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

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

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

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

Good Average Poor

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

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

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

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

Scope of existing programmes

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

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

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

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

Gaps in coverage and equity concerns and equity concerns

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

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

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

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

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

What systemic factors require priority attention?

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

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

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

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

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

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