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

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Most children in South Africa are *exposed* to high levels of adversity including poverty, violence and systemic discrimination on the grounds of their race, gender, ability, age as well as the long-lasting effects of colonialism and apartheid.[1] The 2015 National Integrated Early Childhood Development Policy (NIECD Policy) identifies equity as critical concern with children living in historically underserved rural and informal settlements experiencing the highest levels of deprivation.

Additional risk factors that compromise children's development include malnutrition, maternal depression, violence and neglect. These early exposures to adversity tend to be mutually reinforcing and have a cumulative impact that serves to widen inequalities over time. It is therefore most effective – and cost effective – to intervene early in life to reduce inequalities and optimise the development of young children. Investments in early childhood development have the potential to serve as a great equaliser helping to level the playing field and improve outcomes across the life course.

This chapter identifies a range of risk factors that pose a threat to young children's development and potential strategies to address these challenges. It then examines the multiple forms of adversity experienced by children in the South African setting and considers how best to provide a system of support that is better attuned and responsive to their needs in order to ensure that no child is left behind.

What are the potential risks to children's development?

Children move back and forth along a continuum from well-being to vulnerability in response to changing circumstances over time. For example, a sudden illness such as diarrhoea has an immediate impact on children's dietary intake causing their growth to falter, but with top-up feeds, they should be able to regain the weight they lost and rebuild their immunity so that they are better able to cope with future illnesses. But many young children in South Africa are exposed to persistent challenges that have a cumulative and adverse impact across multiple domains of health and development. These are often referred to as risk factors.

In relation to child development, the term 'risk factors' refers to biological, environmental, socio-cultural and psychosocial factors that can compromise outcomes across any of the developmental domains.[2] There is significant overlap between the major risk factors that influence whether a child survives, and how a child thrives. Risk exposure often starts before birth, and early risk exposure can have lasting effects on health and development across the life course. Exposure to stunting, extreme poverty and severe psychosocial deprivation, have been shown to compromise short and long-term child health and development outcomes.[2]

A single risk factor does not necessarily lead to developmental impairments; however, children exposed to one risk factor are at increased risk of exposure to others. Risks, particularly in adverse conditions, often co-occur and persist, with multiple risks having a cumulative impact as they interact and reinforce one another. Many of the same risks that compromise child health also place children at risk of poor developmental outcomes.

Cumulative risk exposure is usually more detrimental to children as it can result in adaptive physiological and stress responses which can have long-term effects on an individuals' health and wellbeing, and their ability to cope with stress throughout the life course.

Children do not grow up in isolation, nor in vacuums. Interactions (relationships and processes) between children and their environments can support, sustain or hinder child development. Applying an ecological framework helps us to understand how interactions between factors in a child's biology, immediate family/community environment, and broader

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society steers and shapes their development over time. It also recognises the bidirectional relationship between children and their environments and illustrates the various levels at which children's development can be influenced both positively and negatively.[3]

Young children grow and thrive in environments of responsive and secure relationships with their caregivers. Children who have secure relationships with their caregivers show more controlled stress hormone responses when they are upset or experience fear. In contrast, children who have insecure relationships with their caregivers display higher stress hormone levels even when experiencing mild fear. Thus, having safe, responsive caregiving environments can serve as an important buffer or mediator against elevated stress hormone levels and responses, even among children living in adverse conditions who are particularly vulnerable to stress-system activation.

It is therefore essential to identify key risk and protective factors at each level of the socio-ecological system to ensure that children and families receive the required support and intervention to protect them from harm and optimise their health and development.

Individual

Some risks factors are intrinsic to the child. For example, preterm infants and those born low birth weight are more vulnerable to infection, undernutrition, and developmental delay. It is equally important to intervene even earlier in the antenatal period, as maternal risk factors such as teen pregnancy, obesity, diabetes and maternal depression may compromise the health and nutritional status of the developing foetus, and the mother's capacity to care for her newborn child.

Family and home

Other risks play out within the context of the home and immediate family where children's living conditions (e.g. overcrowding or poor access to water and sanitation) may increase their risk of illness, or where their nutrition is compromised due to poverty and unemployment, or where domestic violence threatens their physical and psychological safety and increases the risk of abuse and/or neglect.

Community

These household dynamics are shaped by wider political and economic forces. Persistent spatial and racial inequalities rooted in the colonial and apartheid era continue to compromise the development of children living on farms, in informal settlements and in the former homelands which are characterised by widespread poverty and unemployment, and limited access to health care, early learning programmes and child protection services. And it is children in these communities and households who are most likely to experience multiple forms of adversity, exclusion, and deprivation.

How can we counter some of these risks?

Based on the current evidence base, the 2020 WHO Guidelines on Improving Early Childhood Development,[4] recommends the following key areas to intervene.

Promote responsive care and early learning

The guideline stipulates that all children should receive responsive care during the first three years of life and that parents and other caregivers should be supported to provide responsive care. Responsive care refers to care that is prompt, consistent, contingent, and appropriate to the child's cues, signals, behaviours and needs.[4] In doing so, parents create a stable, engaged and nurturing environment in which their children will develop, learn and thrive. Responsive caregiving has been shown to improve responsive feeding, stimulation and health care seeking behaviour with benefits for both parents (parental mental health) and children (cognitive, social, and language).[5, 6]

The second guideline recommendation is that all infants and children should have opportunities for stimulation and learning from birth with their parents and other caregivers during the first three years of life; and that parents and other caregivers should be supported to engage in this early learning with their infants and children. It goes further to recommend that support for responsive care and early learning should be included as part of interventions for optimal nutrition of infants and young children.

Support maternal mental health

The final recommendation is that psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services. Maternal depressive symptoms have an adverse effect on parenting and child health and development. However, if mothers are assisted with caregiving, and their mental health is treated, children are protected.[5]

Further to these recommendations, it is important to note that children growing up in poverty are more likely to be exposed to environmental risks, household stresses and violence, in addition to receiving suboptimal healthcare, nutrition, and education. Thus, additional interventions such as social protection (e.g. financial support) have the potential to

ameliorate the effects of the multiple risks that co-occur when children live in 'poor households' or 'poverty'. (Box 5).[5, 7]

What is the situation of children in South Africa?

In 2022, just over 70% of young children lived below the upper-bound poverty line.[11,12] These children are more likely to experience multiple forms of deprivation that further compromise their health and development, including overcrowding, inadequate water and sanitation, increased risk of illness and injury, and barriers to accessing quality healthcare. Many of these risk factors are a direct result of limited access to services in poor communities where children and families are in greatest need, and this 'inverse care law'[13] further entrenches inequities across domains of health, education, protection and wellbeing. For example, in 2016, almost half of the children in lower income quintiles did not attend any educational programme.[14] These inequities have their roots in colonial and apartheid era discriminatory policies which restricted employment and educational opportunities for generations of Black South Africans, giving rise to persistent racial and spatial disparities in socioeconomic status which have proved difficult to uproot.

While the poorest children are prioritized in national policy frameworks – such as the NIECD Policy, subsidisation of ECD centres, and the pro-poor Grade R funding formula – access to quality services remains a challenge for African children living in rural areas and informal settlements. Early learning programmes in the poorest communities in South Africa are frequently characterised by overcrowding, poor infrastructure and an informal, poorly paid and under-qualified workforce.[15]

Only half of three- to four-year-olds attending an early learning programme, attend programmes of sufficient quality to improve learning – with wide disparities in enrolment and attendance across provinces, and the most disadvantaged children in rural and poorer areas.[14] Many community-based ECD programmes in rural areas and informal settlements fail to meet the registration requirements for assimilation into the national ECD system, and this prevents them from accessing government funding, further disadvantaging children from those communities.[16]

Poverty in South Africa is also notably gendered, with half of female-headed households living below the upper bound poverty line.[17] Women's disproportionate responsibility for unpaid care work in the home and in society contributes substantially to these gender inequalities by restricting their participation in income generation activities. Once again, the NIECD Policy prioritizes support for caregivers, but in practice, there is limited state investment in adequate and affordable childcare,[18] which would enable women to engage in the labour market and improve their capacity to care for and support their children's development.

Children with disabilities face additional barriers in accessing services and are more likely to experience multiple forms of deprivation. The UNICEF report – Seen, Counted, Included – describes how children are more likely to be stunted or underweight, less likely to have had their birth registered; less likely to have received basic vaccinations; more likely to have poorer access to drinking water, basic sanitation and hygiene services; less likely to receive early stimulation and responsive care, less likely to receive adequate supervision; less likely to have access to books and toys; and more likely to be exposed to violent discipline at home.[19]

Historically, social services have focused attention on 'orphaned and vulnerable children', yet orphaning rates in South Africa have declined steadily following the introduction of antiretroviral treatment, and in 2022 just under 50,000 young children (0.5%) were double orphans (who had lost both their mother and father). Most orphans remain in the care of extended family the with poorest households carrying the greatest burden of care, but they are not necessarily more at risk than other children living in poverty.

Even fewer young children (0.05%) are estimated to live in child-only households. These are often temporary arrangements and most of these children have a parent living elsewhere. While the numbers may be relatively small (under 3,000 children), these children are concentrated in the poorest households and in the absence of adult care and protection they may struggle to access services and be especially vulnerable.[20]

Strict conditions for granting nationality mean that many children are undocumented or remain without birth registration for long periods of time. Access to documentation such as birth certificates is a challenge for children of both South African and migrant parents and can compromise their access to a range of services. For example, the majority of formal ECD centres require a birth certificate for registration since centres are not able to claim government subsidies for children without birth certificates.

In addition, children and families of migrants are exposed to xenophobic violence and attacks by members of the public, and efforts by government officials to exclude foreigners from basic government services.[21]

Some measures are in place to protect children against discrimination based on nationality or documentation status. For example, the recent SECTION 27 case in the Gauteng High Court[22] has affirmed that all pregnant and lactating women and children under six are entitled to free health care regardless of their nationality or documentation status. Regulation 13 (1)

Box 5: Strengthening social protection for children and families

Social protection consists of a range of programmes aimed at supporting families in need financially or in-kind. The package includes social grants, free basic education, free health care for pregnant and breastfeeding women and children under six, free basic water and electricity and subsidised ECD facilities.

The Child Support Grant (CSG) is a proven effective mechanism in alleviating child poverty. It is well targeted at children living in the poorest households and is reaching over 13 million children and seven million caregivers, primarily women.

However, the grant amount valued at R530 in 2024 is 30% below the food poverty line (R760 in 2023) and is insufficient to meet a child's daily nutritional needs, let alone other essentials such as transport, clothing, shelter and energy. While originally set at enough money to feed a child, the value has been eroded over time because the annual increases each year have not kept pace with food price inflation.[8] This may explain why South Africa has seen a decline in child hunger following the rollout of the CSG, but little change in the high rates of child stunting. So, a strategy to address the impacts of poverty on the health, growth and development of young children would be to restore the value of the CSG to the food poverty line, and to prioritise young children under six as the first phase.

Grant beneficiaries are automatically entitled to free health care and free basic education or school fee exemptions, but these fee waivers do not cover the costs of childcare and early learning programmes. The state supports family's costs of childcare and early learning in a different way by providing a subsidy to NPO-run ECD centres that are registered. However, very few ECD centres receive the subsidy and therefore have to charge fees to survive. Those that do receive subsidies often still charge fees because the subsidy is too low to cover the basic costs of running an ECD centre (R19/child/day) and has not been increased with inflation for the past five years. The recent ECD audit showed that, among children attending ECD facilities, the poorest caregivers spent almost half the value of the CSG on ECD fees.[9]

A strategy to address this gap would be to remove barriers to registration for ECD programmes, actively support ECD programmes in poor and disadvantaged communities to register and recognise the full range of ECD programmes. Recent proposed amendments to the Children's Act aim to simplify the registration process and broaden the types of ECD programmes that qualify for funding (see p. 22). The subsidy should also be increased to ensure it covers the full operational costs of an ECD programme and enables programmes to feed children nutritious meals without having to charge fees. It is also vital to address gaps in coverage to ensure that the most vulnerable children are not excluded from social grants.

Take up of the CSG is at its lowest level during the first year of life - a time when children are most in need of nutritional support. In 2020, only 48% of eligible infants were receiving the CSG.[10] The rate of exclusion for infants in 2024 is not yet available, but there are almost 200,000 less infants accessing the CSG in 2024 than there were in 2020, and child poverty rates have risen since 2020, therefore the exclusion rate is likely to be significantly higher.

Most eligible children without birth certificates and young mothers without IDs are not receiving social grants, despite the law allowing SASSA to accept applications and pay grants to unregistered children and caregivers.

Children with disabilities and long-term health conditions – in particular very young children and those with 'invisible' disabilities – are particularly vulnerable and often encounter significant barriers in accessing the care dependency grant which is intended to contribute to the costs of caring for children with severe disabilities who need permanent care.

In addition, there is no income support for pregnant women who are unemployed, informally employed or precariously employed. Only women in formal employment have some form of income support for the maternity period. While the COVID-19 Social Relief of Distress Grant provides R370 to some unemployed pregnant women, it is too low to meet the nutritional needs of a pregnant woman, only available to those with less than R624/month in their bank accounts, and not guaranteed every month.

DSD's draft Maternal Support Policy proposes a maternal support grant starting in the second trimester of pregnancy that would provide much needed income support and reduce the risk of poor mental health and poor nutrition during pregnancy and the incidence of low birth weight babies.

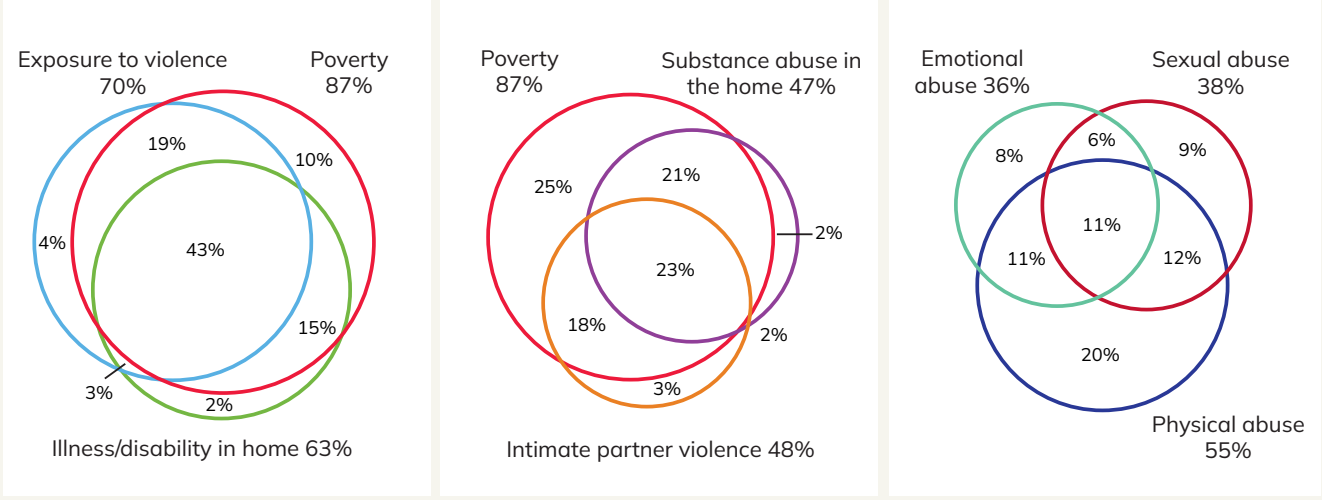
Case 9: Children exposed to concurrent adversities in the Birth to Thirty cohort study

Data from the Birth to Thirty cohort study[28] indicate that most children in Soweto were exposed to multiple concurrent adversities. For example, in Figure 14, 87% of children were reported to be living in households experiencing poverty, yet only 10% of these children experienced poverty outside of the context of violence and severe illness or disability in their homes over the same period. Nearly half the children in the cohort (43%) experienced all three adversities simultaneously.

Similarly, poverty, substance abuse and intimate partner violence often co-occurred within the same households, affecting one in four children. Only 2% of households affected by substance abuse and 3% of households affected by intimate partner violence, existed outside the context of poverty. Forms of direct abuse also tend to co-occur; across their childhoods, one in 10 children had been exposed to physical, sexual, and emotional abuse.

These three examples show how three types of abuse and adversity occur at a time. The data show that 45% of the cohort reported six or more forms of adversity across their childhood and these multiple exposures exponentially increases the likelihood that they will experience negative health and well-being across their life course.

Figure 14: Multiple, mutually reinforcing risk factors affecting children in Soweto



Source: Birth to Thirty cohort study. Analysis by Sara Naicker.

of the Social Assistance Act allows for alternative forms of identification to ensure that this doesn't compromise children's access to the Child Support Grant,[23] and the recent *Phakamisa* judgment compels government to establish an alternative, less discriminatory, means of managing admissions and resource distribution within the education system.[24]

Violence against children continues to be pervasive, with 42% of children in South Africa experiencing child abuse, violence or neglect in the Optimus national prevalence study.[25] While there is limited data on the extent to which young children are exposed to violence, a national study on child homicide found that more than three-quarters of murders of children under five took place in the context of child abuse and neglect.[26] Infants and young children are at high risk of abuse and neglect, often in their own families, because their developmental stage and dependence on those around them means they are unable to avoid – or defend themselves against – harm. Exposure to violence at an early age, particularly in the absence of responsive caregiving, can result in insecure attachment, impair brain development and impact other parts of the nervous system, negatively affecting cognitive development and resulting in poor schooling outcomes, possible conduct disorders, and a greater likelihood of engaging in risky health behaviours.[27]

Data from the Birth to Thirty cohort study (Case 9) illustrate how children in South Africa are exposed to multiple, mutually reinforcing risks that may leave them trapped in a lifelong, intergenerational cycle of poverty, violence, and ill-health. For example, early exposure to domestic violence and/or harsh physical punishment has been found to increase the risk of children becoming either victims or perpetrators of violence later in life and increases the risk that they will use harsh physical punishment to discipline their own children.[29]

Understanding how these risks co-occur can help those who care for children and families understand how to better target prevention and support efforts. For this to work effectively, a trauma-informed workforce is necessary. Comprehensive, integrated family- and community-centred approaches that cut across sectors in government and civil society are essential to addressing the multiple intersecting forms of adversity. Given the high prevalence of adversities in our context, it is critical that we find ways to deliver extra support at scale for the large proportion of children who consistently experience high levels of adversity over long periods of time.

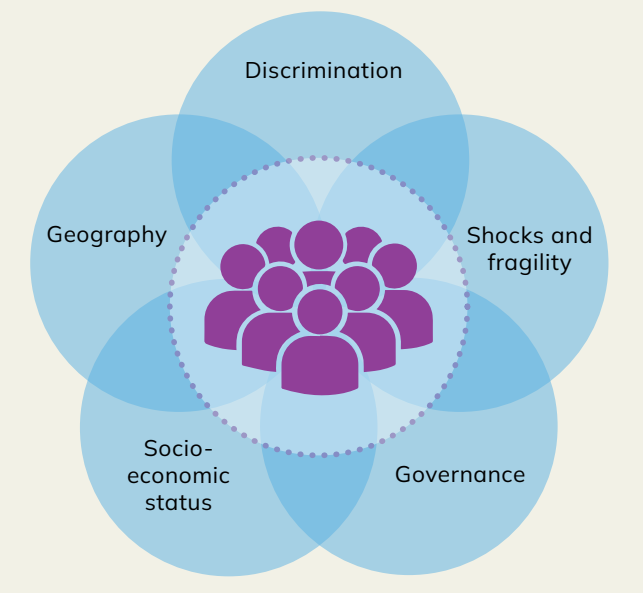
The United Nations Development Programme's discussion paper on 'leaving no-one behind' in the quest to achieve the Sustainable Development Goals, captures how these many dimensions of deprivation and exclusion intersect – with those children at the intersection of the circles in Figure 15 most likely to be deprived, excluded, silenced, and left behind. The framework highlights the ways in which income inequality is shaped by history, geography, and the play of power and discrimination on multiple grounds, and the ways in which these patterns of deprivation may be reinforced by poor governance and fragile systems or amplified during periods of shock and strain.

These shocks to the system, such as the COVID-19 pandemic, inflation and austerity, socio-political unrest, and extreme weather events driven byclimate change also intersect to form what UNICEF describes as a "polycrisis" that is intensifying these existing inequalities on a global scale in ways that leave infants and young children particularly exposed to harm.[30] Yet despite these risks, South Africa's disaster mitigation and climate change adaptation and mitigation plans tend to be centred on adult concerns and rarely contain any concrete measures to safeguard children.[31]

The 2015 NIECD Policy stipulated that Government should prioritise the development, funding and implementation of ECD programmes that target the poorest 64% of children, as these comprise the most vulnerable children as well as the group that will benefit most from ECD services.[32] This estimate was based on the proportion of children living below the upper-bound poverty line[v] at the time. The latest estimates show that this has increased further to 70% in 2022 – with nearly five million children under six years old not having their basic needs met.[11]

This places children at risk of increased developmental and learning delays and compromises nurturing care – including young children's mental and physical health, growth and nutrition, safety and protection, learning, and their caregivers' ability to provide responsive care. These in turn negatively

Figure 15: What does it mean to leave no-one behind?



Source: United Nations Development Programme. What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation. New York: UNDP. 2018.

impact individuals' short- and long-term health and well-being, educational attainment, economic potential and, ultimately, result in greater exclusion and inequity.

These high and pervasive levels of adversity mean that most children in South Africa are starting with a deficit and need a boost at baseline. Therefore, it may be more productive to move beyond targeted support for those 'at risk' and to start providing some form of extra care and support to all young children and families.

How can we provide a system of support that is responsive to the needs of all children and families?

Despite policy intentions, current efforts are largely focused on improving coverage of universal services with limited progress in the provision of indicated and targeted support for those children and families most in need. Thus, the question of how we can create a system that identifies and provides additional support to vulnerable children and families, in a way that helps level the playing field and promote more equitable outcomes, remains.

At a minimum, all families require information, encouragement when things are going well, and support when they need help to overcome specific challenges. A small proportion of children and families may require more intensive, often longer-term, sustained support – such as children with a disability or other long-term health conditions. These different

v Statistics South Africa determines the national poverty lines, and the upper-bound line represents the minimum income required to provide just enough for basic food, clothing, and other essentials.

levels of support are typically described as universal, targeted and indicated support (Figure 16).

Universal services are available for all children and their families e.g. birth registration, immunisation or deworming programmes. These services are for everyone, and provided through the platforms that young children and their families engage with the most. Services are designed to benefit all families, caregivers and children and ideally, information and resources are tailored to the child's age and developmental stage, as well as family circumstances. When there are challenges, children should be identified early through these universal services and refer caregivers for further assessment and care. These services should also provide anticipatory guidance and additional support to help families navigate times of change or heightened vulnerability, such as when mothers return to work, or when children transition to care arrangements outside the home.

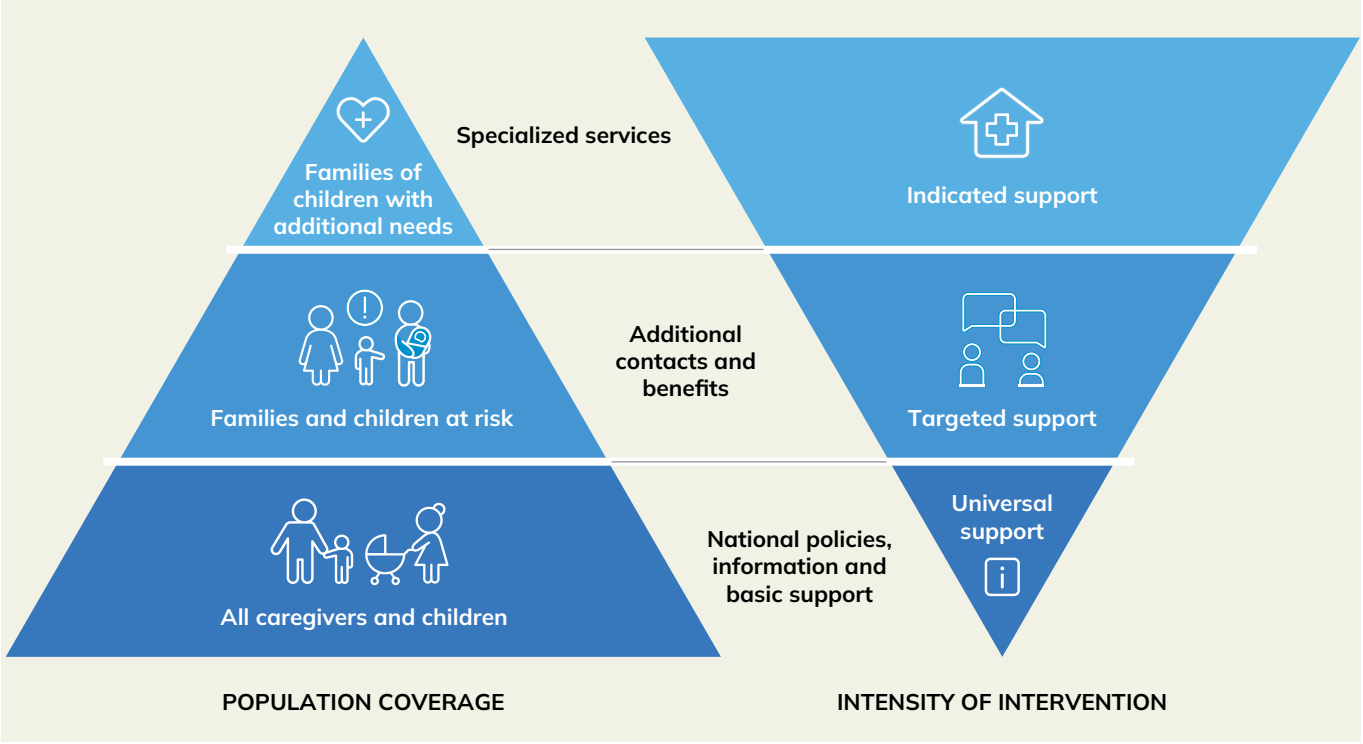
Beyond the provision of basic universal support services, children, families or entire communities may need **targeted support** when children's development is compromised, i.e. children and families deemed 'at risk'. Examples of risk factors may include children experiencing a developmental delay or disability, violence in the community or at home, or other adversities at a household or community level. In addition, the WHO Nurturing Care Handbook identifies children at risk of malnutrition, children in humanitarian settings, children affected by HIV, families living in poverty, and young mothers as groups who may benefit from targeted services. This targeted support can be provided at facility, household or community/societal levels, e.g. social grants for children living in poverty, or home visits from community health workers for premature and low birthweight infants.

Some children, and their caregivers, may need indicated support in addition to universal and targeted support. These **specialised services** are for children with more serious challenges who need higher intensity, usually more complex care and support, e.g. rehabilitation services for children with disabilities or complex long term health conditions.

Strengthening extra care and support services for children and families

The single, most sustainable, method of achieving equitable early childhood development is to effect change at a systems level – by scaling up systemic actions to promote, protect, and support early childhood development, and ensuring that the most vulnerable children and families are prioritised. The integration of ECD interventions into existing platforms for service delivery is an effective and efficient way to reach large numbers of families and children. For a start, using existing platforms to create a more integrated response and early access

Figure 16: Levels of support for children and their families



Source: World Health Organization, United Nations Children's Fund, World Bank Group. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential.* Geneva: WHO; 2018. P. 22.

Box 6: Chile Crece Contigo's suite of universal and targeted services

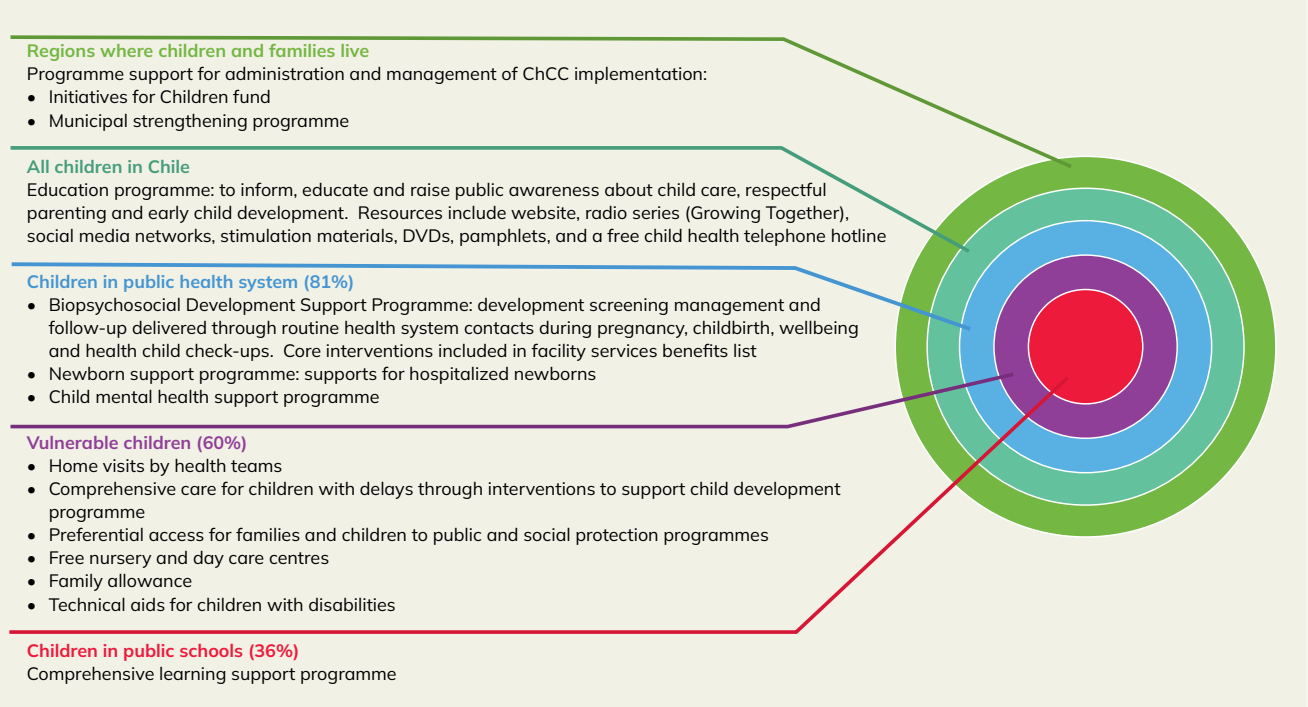
In 2006, Chile Grows with You (Chile Crece Contigo, CCC) introduced and expanded a new model of practice aimed at fostering child development through political will, evidence-informed advocacy, consensus-based policy development, and use of existing functional systems.[33, 34] Health, social care and education teams are coordinated by the municipality, and responsible for monitoring the development of children and coordinating the provision of services that are targeted to meet the needs of each child and their family.

CCC was institutionalised by law in 2009, guaranteeing consistent and increasing budget allocations, systematic collection and use of data for programme management, and coordination of health, education, and social care services.

CCC developed a range of screening tools to identify mothers and infants at risk. These are applied during routine health visits starting in the antenatal period. This includes screening for psychosocial risks in pregnant women (such as late booking (after 20 weeks), adolescent pregnancy, depression, substance use, gender-based violence, unintended pregnancy, and insufficient family support). Further screening continues after birth with a focus on identifying post-partum depression, delays in psychomotor development, safety risks in the home and infants at risk of pneumonia and malnutrition. CCC then provides a range of universal and targeted services, where:

- Universal services include education to sensitize families about infant care, respectful parenting, and stimulation.
- Universal and specialised support is offered through the public health system with a focus on newborn care, biopsychosocial development which includes a comprehensive package of care for children in vulnerable situations or with developmental delays.
- Targeted services for children from the most vulnerable 60% of the population include free early childhood education and free technical assistance for children with disabilities.
- Families and children from the most vulnerable 40% of the population are offered additional targeted services including preferential access to public programmes and services such as work placement, mental health care, prevention of domestic violence and infant abuse, and improvements in homes and living conditions, and social assistance.

Figure 17: A continuum of services from universal services to targeted support for vulnerable children and families



Adapted from: Milman HM, Castillo CA, Sansotta AT, Delpiano PV, Murray J. *Scaling up an early childhood development programme through a national multisectoral approach to social protection. Lessons from Chile Crece Contigo. BMJ.* 2018, 363(k4513).

Case 10: The Gauteng Early Child Intervention project[i]

In 2010, the rehabilitation sub-directorate of the Gauteng Department of Health established a multi-disciplinary early childhood intervention (ECI) workgroup in response to concerns over the late identification of children with developmental difficulties and disabilities and the fragmented and variable quality of services in the province. The key objectives of the workgroup are to:

- Raise the profile of ECI in the province.
- Provide provincial guidance and leadership around ECI.
- Improve coordination and standardisation of ECI service delivery at all levels of care.
- Link with partners in the field of early childhood development, education, social development, affiliate health directorates and other relevant partners to address issues with ECI service delivery.

The workgroup prioritised a few key areas to initiate change in the province, i.e. building the capacity of health professionals, providing strategic guidance on ECI, developing resources, engaging with stakeholders, and promoting service-level research and innovative approaches to ECI service delivery.

Since its inception, the workgroup has been hosting at least two workshops a year. The first workshop helps strengthen the ECI knowledge and skills of health professionals (therapists, psychologists, social workers, dietitians, podiatrists, among others) who are new to the province. The second workshop provides a platform for health professionals to share their ECI practices to promote benchmarking, shared learning and innovation. These have included a focus on workshops on child development and ECI for caregivers, educators, early learning practitioners and health care providers; workshops on making toys from waste; transdisciplinary screening and intervention services; and specialised interdisciplinary clinics for children with autistic spectrum disorders.

Regular stakeholder meetings with relevant government departments, non-profit organisations and academic partners have been used to address current gaps and challenges and to improve collaboration and the coordination of services for young children and their families.

Strategic inputs include the development of a provincial ECI policy; guidelines on "How to get started with ECI in your workplace"; integrating key ECI indicators into routine provincial data monitoring systems; and including key tenets of ECI service delivery into the provincial facility audit process.

The workgroup hosts an annual conference which attracts academics and service providers from across the country; publishes a bi-annual newsletter; and produces caregiver education materials on the development of young children for health (and other) professionals.

This investment in strategic guidance, tools and support has led to a growing interest in ECI and ECD within Gauteng and is helping to shift practice from a deficit- to strengths-based approach; place families at the centre at all levels of care; strengthen referral systems and networks; and increase the use of community resources outside the health system.

i Westwood A, Slemming W. Long term health conditions in children: Towards comprehensive care. In: Shung-King M, Lake L, Sanders D, Hendricks M, editors. *South African Child Gauge 2019*. Cape Town: Children's Institute, University of Cape Town; 2019

to support services. For example, by linking birth registration to birthing centres; ensuring CSG beneficiaries have access to free or subsidised early learning programmes (in the same way they are entitled to a fee waiver for health and education); and integrating services across various departmental systems for a comprehensive and holistic approach. While the NIECD Policy calls for an integrated approach to ECD provision, a detailed roadmap on how to achieve this practically is still absent, and a strong, capable leadership structure and funding model are yet to be established to address the equity gap.

Guiding principles

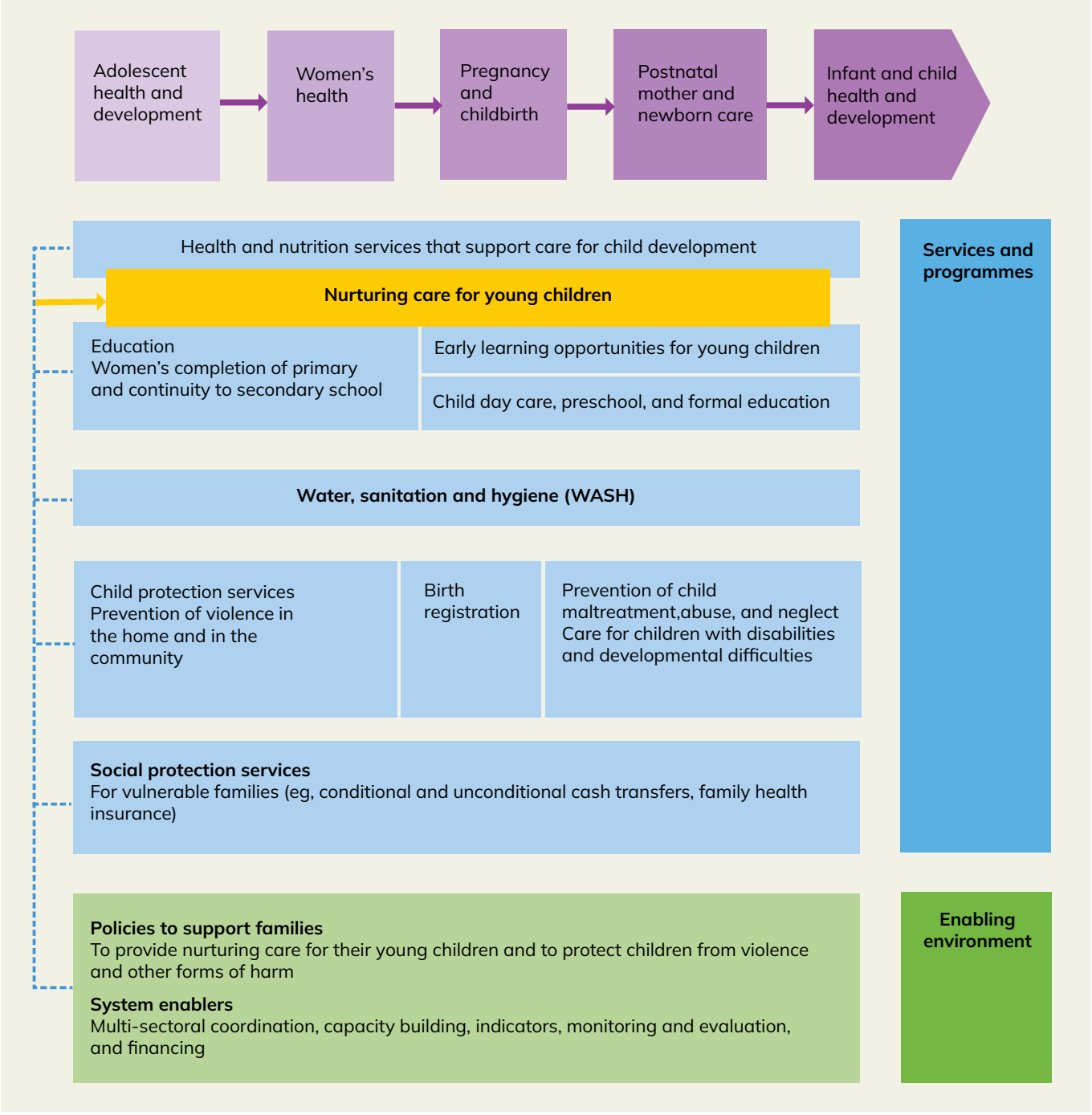
There are a set of essential guiding principles that need to underpin the design and implementation of an essential package of care and support for early childhood development to ensure that no child is left behind. In the following section, we aim to outline some of these key principles and provide some insights on how these can be implemented in practice.

Early means early

It is well-established that it is most effective and cost-effective to intervene as early as possible in the life course – to minimise risks and strengthen protective factors – starting in the antenatal period or even preconception.[7] Services must also be geared to early identification of children and families requiring additional care and support, whether for a health, psychosocial or other concern. At that point (even before a formal assessment or diagnosis), it is imperative that there

is a systemic early intervention response to prevent the initial situation from escalating or deteriorating. These early identification mechanisms and intervention responses should be embedded in existing services, such as integrating targeted interventions for children with developmental disabilities into health, early learning and social development services. These approaches include primary prevention (or actions to protect children from harm and prevent problems from arising), secondary prevention (or early identification and intervention services that detect and respond to emerging problems before they cause serious harm), and tertiary prevention efforts (or rapid response systems for children and families in a crisis or emergency situation, as well as interventions designed to soften the impact of an illness, disability or traumatic event and prevent further harm). For example, preventing violence against children could include a continuum of interventions at different

Figure 18: Framework to promote young children's development through a multisectoral approach



Source: Richter L, Daelmans B, Lombardi J, Heymann J, FL. B, Behrman JR, . . . Paper 3 Working Group and the Lancet Early Childhood Development Series Steering Committee. Investing in the foundation of sustainable development: Pathways to scale up for early childhood development. *Lancet*. 2017, 389(10064):103-118.

points in the life course including: parenting programmes with a focus on non-violent forms of discipline (primary prevention), screening for intimate partner violence during antenatal care to identify and support women at risk before the baby is born (secondary prevention), and reporting incidents of abuse and neglect to trigger a social work investigation and ensure the child's safety (tertiary prevention).

Early child intervention (ECI) services are designed to support families with young children who are at risk of or have identified developmental delays or disabilities. These services strive to provide a multisectoral, integrated and trans- or interdisciplinary response and to provide individualised care to improve child development, promote resilience and strengthen family competencies and skills to facilitate children's development. ECI services can be delivered through health clinics, early intervention, rehabilitation or community centres, homes and schools. There are longstanding local efforts to strengthen ECI services for young children in South Africa, including the Gauteng Early Child Intervention project (Case 10).

Integrated approaches across sectors

Many young children and their families are exposed to multiple forms of adversity, so it is important to adopt holistic approaches looking beyond the immediate presenting complaint to consider the interplay of different risk and protective factors. For example, there is a strong association between food insecurity, domestic violence and maternal depression,[35, 36] and maternal depression can, in turn, compromise a mother's capacity to care for their children in ways that may impact on children's health, nutritional status and early learning.[4]

Thus, we need to bring together different sectors and services to address multiple adversities. This includes strong referral systems and/or integration of services at the point of delivery to enable pregnant women, young children and families to access health care, nutrition support, social assistance, developmental and mental health screening and access to social services.[7]

For this reason, the WHO Guideline for Improving Early Childhood Development recommends integrating support for maternal mental health into early childhood health and development services. In addition, it encourages extending these interventions to expectant fathers to promote the involvement of fathers in childcare and to address other potential risk factors (such as intimate partner violence). Similarly, integrating elements of responsive care and early learning into interventions to promote the optimal nutrition of infants and young children has been found to more effective at improving ECD outcomes, than investments in nutrition alone.[4]

Family-centred and child-focused care

It is also important to recognise the central role that families play in the development of young children, and provide them with the information, resources, care and support they need to provide nurturing care for their children. Family-centred care has long been a best practice for supportive services working with families of children with developmental disabilities.[37] This approach recognises parents and caregivers (and the child) as equal partners in decision making in their child's care, honours the cultural and contextual diversity of families, and upholds the values of respect and honesty in communicating and working with families. In family-centred approaches, parents and caregivers (and children) work with and guide those supporting them as to the priorities for their care, including their specific needs, preferences and choices. These approaches take into consideration each child and family's unique circumstances and are tailored to their individual strengths and capacities.

The Road to Health Book (RTHB) and the national Side-by-Side Campaign aim to ensure that young children have access to the full range of nurturing care services at health facility and household levels. Side-by-side aims to convey the concept of partnership and togetherness and speaks to the shared child-rearing journey that caregivers embark on with their children, and all those who help and support them. The demand side of the campaign speaks to caregivers with its central message that 'You are central to your child's nurturing, care, and protection – and their lifelong health outcomes. Your health worker is there to support you.'[38]

This orientation of health services to place children and families at the centre of care, is an important paradigm shift. There is consistent evidence, across contexts, to show that parent reports of developmental concerns are generally accurate. Thus, the RTHB includes a focus on eliciting parental concerns of child development and this alone, where there are concerns, may prompt referral for further assessment. It also recognises that parents/caregivers and families are equal partners in the planning and implementation of any supportive and promotive intervention and thus these should be co-produced around their needs and priorities. In short, families should always be equal partners and at the centre of decision making around their child's care.

It is equally important to recognise that families and caregivers are often in need of extra care and support themselves. Yet support services for adults and children are often delivered in silos in ways that compromise the health and safety of children. For example, children of parents with mental illness are particularly at risk, so it is vital for adult mental health services to put protective measures in place to support

Box 7: A continuum of parenting support from universal to specialised care

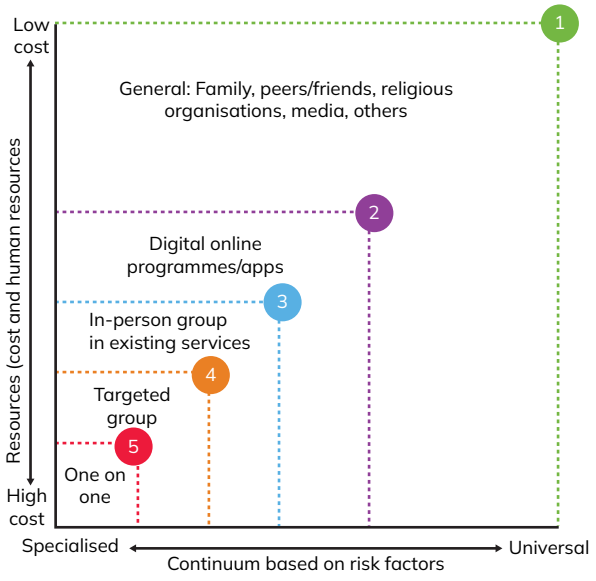
Andre Viviers[i]

Parent support exists on a continuum from the general support parents receive from families and friends to highly specialized services as illustrated in Figure 19.

1. Parents draw on the support and advice of their family, peers and religious communities, coupled with information from books, magazines and the internet on childrearing and parenting. These types of support are universal and come at low cost to parents and society (green line).
2. Online programmes and applications such as MomConnect and ECDmobi are designed to provide dedicated and developmentally appropriate support to parents of young children with a focus on child development, prevention and early intervention. But not all parents have access to these due to internet access and data costs.
3. Social services, health services or early learning programmes often run parent support groups as part of their broader package of services – for example, information sessions at clinics or ECD centres.
4. Parents who find themselves in difficult circumstances may require more dedicated time and resources in the form of a targeted support programme, such as the *National Parental/Primary Caregiver Capacity-Building Training Programme (Children Birth to Five Years).*
5. A small number of parents of young children may require individualized support and specialised services, for example, consultations with pediatricians; psychological or social work services to parents with post-natal depression; interventions by occupational therapists to support young children with developmental delays and their parents; nutrition interventions by dietitians / nutritionist in cases of malnutrition, amongst others. But the specialised staff and dedicated resources to provide these critical and often life-saving interventions is extremely limited.

It is also important to recognize that parents move back and forth along this continuum in response to changing circumstances, and how these different layers of support need to be integrated in order to enable timely referrals and continuity of care.

Figure 19: A continuum of parenting support



i UNICEF South Africa

young children when treating parents with mental illness.[39] Similarly, we need to safeguard and provide counselling for children who witness domestic violence and provide support for mothers whose own trauma may be retriggered when their child is sexually abused.[40] We must, therefore, place the family at the centre of all care and support services and programmes, ensuring that families are equipped with what they need to provide and care for their children in sustainable ways.

Strengths-based approaches to care and support

It is essential to shift away from a problem-centred approach towards more appreciative forms of enquiry, in which we look beyond the immediate risks and deficits to seek out and build on the assets that exist within the child, family and broader community. A strengths-based approach to supporting children and families is about 'how', and not 'what' support we provide. It focuses on inherent knowledge, abilities and capacities rather than deficits, or things that are 'lacking'. The approach does not seek to avoid or minimise problems, challenges or risks within the family, but to identify the assets or strengths that can be built upon and used to support the family to overcome or manage these challenges.

When the child, parents/caregivers or family are regarded as the experts in their own lives, the supportive relationship becomes about partnership and facilitation rather than solving or 'fixing'.

Inclusion and participation

It is also crucial to transform mainstream services and put in place specific supports and reasonable accommodations to enable the inclusion, participation, health and wellbeing of all children including those with disabilities and other challenges. Twin-track approaches, that promote system-level changes that enable all children to be included, along with tailored and differentiated strategies to meet the needs of individual children with specific challenges or impairments should be promoted. This includes capacity development to ensure staff working in a range of settings are able to provide appropriate care and support to children and families.

This twin-track approach is a helpful way of thinking about how the different levels of care can work together in practice, when approaching children with identified needs. Should these children be supported by mainstream (universal services available to the general population) or specialised services (targeted or indicated)? The answer is "both". Linking back to the differentiated levels of support available to children and families illustrated in Figure 16, it is important to note that universal services are also provided to children with additional needs. There is no clear distinction between children who use universal services and children who require additional support. Trained frontline workers (across sectors) should be able to recognise what type of support is required by every family and child. Thus, frontline workers will provide care for all children, and should be able to identify when children and families require specialised (targeted or indicated) services and help these families to get the support they need. This includes coordination with other service providers to ensure that children with additional needs can access all the services and support they require to promote their health and wellbeing, and enable their inclusion and participation in learning and social activities.

Providing a continuum of care

A continuum of care approach is simply having "the right person, at the right time, in the right place, providing the right care" for children and families.[41] This expression has two interpretations. First, care is necessary throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and second, there should be continuity of care between places of caregiving (including households and communities, outreach services, and clinical and other care settings for young children).[41, 42]

The objective should be to build a continuum of services that can support all families of young children, and that can identify and intervene early for those children and families who require additional support. This requires strengthening primary care services, capacitating frontline workers and caregivers, and establishing transdisciplinary and intersectoral teams to provide individualised and contextually relevant extra care for children and families.[37, 38]

It is important to take a systems approach to making such improvements. Often, we focus attention on the resources, content, and skills required to effect the envisioned changes without thinking of the broader programmatic support required to effectively expand and sustain services. For example, improvements at one level of the system may require corresponding improvements at other levels, to ensure that referral pathways and the quality and continuity of care are not compromised. Even when planning for universal support, it is important to consider children and families with additional needs and how systems can be strengthened to respond appropriately, as well as how different sectors providing nurturing care services – such as health and social services – collaborate and coordinate to provide this support for families.

An important challenge is to overcome the 'silos' that often exist between disciplines within and across sectors. To realise an effective continuum of care for children and families, intersectoral collaboration and coordination must be assured between and within government departments, as well as between government and the non-profit and private sectors. Services need to be organised around supporting the child's functioning and participation in daily life and employ place-based approaches[vi] to strengthen extra care and support for children and families who need it in their communities and close to home.

Conclusion

The case for investing in early childhood development as a strategy to dismantle inequalities in child outcomes is clear, with the potential to reap substantial developmental and economic returns for society at large.[43, 44] The nature and extent of adversity and risk that many, if not most, children in South Africa face, and their cumulative effect, undermines our efforts to promote their development. We must ensure that all children receive the essential components of nurturing care and that all families receive the support they need to nurture their children's optimal development.

Delivering this support to both young children and their caregivers, through high-quality, inclusive and equitable strategies, is the crucial pathway to reducing inequalities

vi A place-based community approach addresses the needs and problems of families and communities by building on strengths at the local level, starting from the caregivers to the relevant ECD systems around them, even to the natural environment. The geographic focus of such an approach can be a neighbourhood, municipality, district, county, province, or other sub-national area.

and leveraging early childhood development as an equalizer for all children. Achieving universal, equitable early childhood development for all children and fast-tracking those furthest behind is only possible in the South African landscape through strong partnerships between civil society, private sector and government. At the same time, parents, caregivers and communities have a crucial role to play in demanding greater investment in early childhood development.

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