Southern Africa Food Lab & Western Cape Government

Food and Nutrition Security Strategy Design Lab I Final Input Note

Early Childhood Development (ECD) support services in the Western Cape as sites of opportunity for food and nutrition security

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1. Pursuing zero stunting in the Western Cape

Introduction

Why is investing in (zero) stunting so imperative?

Scientific research has established conclusively that a healthy start to life is essential not only for individuals to reach their potential, but also to provide the human capital development necessary to enable sustainable economic development and to reduce the burden of chronic disease. Health, in the earliest years, starts with the future mothers' wellbeing before they become pregnant. The first 1000 days of life offer a unique opportunity to lay the foundations for optimum health, growth and neurodevelopment for children across the lifespan. Food and nutrition play a key role in ensuring this healthy start to life.

Stunting can have life-long implications for individuals including compromised motor and cognitive functioning and development. Impaired cognitive development has an effect on educational outcomes later in life, with studies showing reading, non-verbal cognitive skills and years of schooling to be affected. The outcomes of stunting further include lower earning potential as adults and less productive contributions to the workforce due to compromised intellect, slighter build and an increased proneness to disease. In general, undernutrition is associated with significant loss of GDP, yet return on investment is competitive in relation to other public spending.

The intensity to which these deficits develop is strongly correlated to the age when undernutrition is experienced. The impact of nutrition early in life reaches far into the future and evidence has shown that children who are well-nourished in the first 1000 days are 10 times more likely to overcome life threatening childhood diseases, complete 4.6 times more grades in school, earn 21% more wages as adults and are more likely as adults to have healthier families (www.thousanddays.org).

By improving the nutrition of pregnant women and young children and promoting their linear growth, substantial improvements in human capital and economic productivity are evidenced. Stunting in early life is associated with a higher risk of obesity and non-communicable diseases when that infant becomes a child and later an adult. This places a high burden on the individual, his or her community and ultimately the healthcare system providing services to affected persons. [i]

The impact of poor nutrition is particularly pronounced in the first two years of life. Even if children catch up on height, the impact of stunting on brain development may well endure. Based on the evidence-based arguments presented in this input paper, it is thus critically important to prevent stunting, respond proactively to early signs of stunting and provide additional stimulation and support for children who are stunted.

In the Western Cape, stunting prevalence at 20.7% is a particular challenge though underweight and wasting of 5.6% and 1.2% are also a concern.[ii]

Early in life, the developing brain is highly responsive to environmental and risk and resilience factors, which can either promote or limit a child developmentally. According to the National Integrated Early Childhood Development Policy 2015[iii], protective factors include: good health and nutrition of the mother, infant and child; clean environments free of pollutants such as alcohol and drugs; nurturing, caring, protective and stimulating relationships with parents and other primary care givers; and access to safe, quality education early in life. Risk factors include: poverty; malnutrition; stunting; low birth weight; infectious diseases in pregnant women, infants and children; environmental toxins; toxic stress; exposure to violence; psychosocial risks; disrupted caregiving and absent parents; ill parents, non-parent caregivers or abandonment and disabilities. Health (including mental health) and nutrition services during pregnancy and the first few years of a child's life play a critical role with respect to risk and resilience surveillance and response.

The National Integrated ECD Policy highlights food and nutritional support as a gap in current service provision. In particular, it notes that "current programmes do not make adequate provision of food for children with growth failure, for effective prevention of malnutrition through targeted prevention interventions aimed at pregnant women and infants or broader public prevention communication".[iv]

Nutrition Services for Children Under 5 mandated in the National Integrated ECD Policy

- Promotion of exclusive breast feeding for the first 6 months after birth
- Counselling to support appropriate and responsive complementary feeding or alternatives to breastfeeding where this is not possible, including prevention of obesity
- Home, community and facility-based growth monitoring, early identification of growth faltering and referral for follow up of all children aged birth to two years
- Micronutrient supplementation and food supplementation for underweight pregnant women and children who fail to thrive for reasons of poverty and associated social problems
- Provision of food and nutritional support to pregnant women and young children by community outreach workers including the DoH Community Health Workers

The National Integrated ECD Policy recognises the critical window of opportunity afforded by the first 1000 days of life (conception to 2 years) and is explicit about the need for health, nutrition, social support and parenting support services to commence during pregnancy and continue through the first two years and be sustained beyond that time until the child reaches school entry age. Investments made in the first 1000 days of life yield the most return as this is the most sensitive period with respect to infant growth and brain development and is the period in which nutrition interventions have the strongest impact on growth trajectories, including protection against stunting. Country models (such as the Chile Crèche Contigo) have demonstrated the effectiveness of using prenatal care in health care services as entry points for optimising ECD.[v]

The two pillars of the **Draft Western Cape Household Food Security and Nutrition Strategy** (WCHFSNS) most immediately related to the prevention of stunting and early childhood development programmes and services are

- Effective food assistance strategies and improved nutritional safety nets involving both government and NGO agencies to ensure better access to, and utilisation of food. Activities to address this include nutritional interventions for children at risk of malnutrition, promotion of exclusive breastfeeding and appropriate complementary feeding and the use of schools (The National School Nutrition Strategy currently feeds

60% of learners in identified Quintile 4 schools and will extend to all children in priority schools by 2019) and ECD centres as sites of opportunity.

- Improved nutrition education and awareness including district level nutrition services to assist households and communities monitoring their nutritional status. A key programme for the ECD sector is WASH, currently implemented in schools, but which is planned to extend to registered ECD centres to ensure hygiene education and a high quality WASH environment.

Defining ECD

ECD services as defined in the current national policy are services or support provided to infants and young children, or to the child's parent or caregiver by a government department or civil society organisation with the intention to promote the child's early emotional, cognitive, sensory, spiritual, moral, physical,[vi] social and communication development.

Currently, the draft Western Cape Household Food Security and Nutrition Strategy has identified the use of ECDs as sites of opportunity as a key strategy for supporting food security and nutrition for young children. The term *ECDs* is used in the strategy document to refer to ECD centres rather than the full range of ECD Programmes (in and out of centres) and services and excludes after school care programmes. Furthermore, the draft strategy focuses on registered and funded ECD centres, while at least 43% of centres are not yet registered. We elaborate on this below but note that the majority of young children unreached by ECD centres and programmes are likely to be the most vulnerable – those either too young to be in an ECD programme, or whose parents are too poor to pay the fees. They are not easy to identify or to reach with consistent, appropriate ECD services as they are in homes and communities. **It is critical to expand the focus from reaching children in ECD centres to reaching nutritionally vulnerable young children in all care settings**. The focus should be on delivering ECD services and utilising services as opportunities to improve and address issues of food and nutrition security.

ECD Programmes

ECD centres where more than 6 children are cared for on a regular basis by someone other than their parent are but one kind of ECD programme. The Children's Act (38 of 2005) and National Integrated ECD policy recognise a range of types of programme that provide care, development, support and early learning for children from birth until entry to formal schooling. These include:

- Community-based playgroups
- Outreach and support programmes for young children and their families at household level
- Parenting support and enrichment programmes
- ECD programmes provided at partial care facilities (centres)[vii]

In addition, many young children are cared for in the community by day mothers. These are often the youngest children and linking with networks of day mothers provides another opportunity for supporting the provincial food security strategy. Many more infants and young children are in the care of parents and family members and do not receive any ECD programme or service.

ECD and Partial Care Services and Programmes in the Western Cape

Table 1 indicates the extent and distribution of ECD and After Care centre programmes across different districts in the province. The provincial database is under construction, not all facilities are listed and enrolment data is not yet available for many of the unregistered facilities. The summary data in Table 1 simply gives a **minimum indication of the extent of coverage** that is around 134 615 children pre-Grade R and 6 233 of school going (mostly primary school) age.

Table 1: ECD and After Care Facilities in the Western Cape

Region	Number of ECD facilities	Children in ECD facilities	Registered facilities (full/ conditional)	DSD Funded facilities	Number of After care Facilities	Children in after care facilities	Registered After care (full/ conditional)	DSD Funded After care
Metro South	973	38753	347	138	3	65	1	1
Metro East	707	32582	310	126	8	375	2	-
Metro North [a]	251	15863	251	44	13	756	13	
West Coast	159	7823	111	53	14	154	5	4
Winelands	709	15130	524	199	65	3660	31	28
Eden Karoo	436	24464	307	168	20	1223	14	14
TOTAL	3235	134615	1850	728	123	6233	66	47

(Source: DSD administrative data)

[a] Registered facilities only

ECD centres as sites of opportunity

- Approximately 25% of young children under school going age/Grade R (i.e. 0 – 5 years) attend 3 235 ECD centres, registered and unregistered. These children are unlikely to be the most vulnerable as almost all centres (even if subsidised by DSD) require parents to pay fees. The national trend also is that ECD enrolment by older children (from 3 years) is more common while the period 0 – 2 years is when children are most vulnerable in terms of nutritional requirements and brain development.
- Around 60 000 children in 728 ECD centres (or 45% of the total ECD enrolment) and 47 after care facilities receive the poverty targeted provincial per child subsidy of which 40% is intended for feeding.[1] However, many non-profit centres serving poor children do not receive a subsidy, either because they are not registered, or because departmental budgets are limited.
- Feedback from ECD practitioners tells us just how important the food provided at ECD centres is for the children who attend, especially in poor communities where children may receive little additional food at home. This means that it is imperative that centres provide good nutrition. A study indicated that centres in the poorest areas spend about a quarter of their income on food,[viii] but that this is less than centres in more affluent areas.
- Many ECD centres rely on parents to send some (snacks) or all of the food. Parents may not send appropriate food for their children and centre staff need to provide guidelines as to acceptable snacks to send.

Out of Centre Programmes

A range of out-of-centre ECD programmes also serve young children and their families in the Western Cape, several of which are supported by DSD. In relation to the numbers of children accommodated in ECD centres, numbers are low (See Table 2, which is based on available though not exhaustive information). However, these tend to serve more vulnerable young children whose families cannot afford to send them to ECD centres and who are likely to be more at risk nutritionally than other children. Some programmes provide some food as part of their service offering, however programmes do not necessarily meet on a daily basis and food supplied, while an incentive to attendance, is insufficient to meet a significant part of children's nutritional requirements.

[1] [1]DSD personal communication: many rural ECD centres receive food donations

[2] Promoting breastfeeding through workplace interventions is another of the Southern Africa Food Lab and Western Cape Government Design Lab concept areas to assist with implementing the WCFNS.

- ECD parenting and home visiting programmes that target families provide an opportunity to interface with pregnant women and infants.
- Home visiting programmes tend to assist families with referrals to needed services including child support grants, social relief of distress, and clinic referrals.
- Programmes involving parents usually offer health and nutrition education opportunities
- Some programmes include income-generating activities and food gardening

Table 2: Out of centre ECD Programmes in the Western Cape

Programme	Type	Numbers served	Areas	DSD funded
Family and Community Motivator programme (ELRU)	Home visiting to pregnant women, caregivers and children 0 – 2 years	198 families 179 children	Langa Vredendberg: Saldanha/Louwville	☆
Hlumisa (ELRU)	Community based Playgroups 3 – 5 years (Nutrition support component)	240 children 106 children	Langa Louwville	☆
Playgroups (ELRU/SmartStart)	Community based Playgroups 3 – 5 years (Nutritional support component)	850 children (350 more to be recruited)	Khayelitsha	
Family in Focus (FCW)	Home visiting	9612 children	Cape Metro Atlantis Paarl, Worcester Caledon Beaufort West Oudtshoorn	☆
Family outreach (CECD)	Home visits plus parenting sessions and playgroups (food parcels)	60	Guguletu	
Playgroups (Grassroots)	Playgroups	1360	Cape Metro Winelands, West Coast , Eden /Karoo	☆
Playgroups (Cotlands)	Playgroups	505	Macassar	
Toy Library (Cotlands)	Toy library programme	82	Macassar	
FCM (Sikhule Sonke)	Home visiting	250	Khayelitsha	☆
FCM (Valley Development	Home visiting	220	Ocean View/Masiphumelele	☆
Emthonjeni Playgroups (Sikhule Sonke)	Public space playgroups (nutritional support component)	269	Khayelitsha: Monwabisi Park	☆
Parent infant home visiting (Parent Centre)	Home visiting to mothers from pregnancy to 6 months	599	Philippi Gugulethu Greater Retreat Heideveld Imizamu Yethu Hangberg Khayelitsha Mitchells Plain	
Home- and Community Based programme (Flower Valley)	Home visits	80	Gansbaai and surrounds	☆
Early years	Toy library and parenting workshops	1200	Grabouw, Caledon, Bredasdorp and Suurbraak/Barrydale	☆
NACCW - Isibindi (0 – 6 years)	Variety of services (141 CYCW)	1761	Cross Roads Grabouw Hout Bay Saldanha Bay St Helena Bay	☆

Programme	Type	Numbers served	Areas	DSD funded
			Hopefield Murraysburg Mitchell's Plain	
TOTAL		17133		

Source: Administrative data from NPOs and DSD

2. Current Interventions in Support of Food Security and Nutrition for Young Children

The Department of Health provides comprehensive health services across the care continuum. The following services are provided: primary health care (PHC), acute hospital, specialised hospital and other specialised services e.g. emergency medical services.

The PHC service component of the health system is the most critical component as it serves as the entry point into the care continuum and caters for the vast majority of patient contacts. It comprises three distinct but inter-related service delivery platforms:

- Home and community-based care (HCBC);
- Primary care services (PCS) at health facilities; and
- Intermediate care.

Collectively, these settings provide a comprehensive array of preventive, promotive, curative, rehabilitative and palliative interventions.

This includes the Road to Health Booklet as well as Infant and Young Child Nutrition programs, primary amongst which is the promotion and protection of breastfeeding[2].

ECD Component of the Nutrition Assessment, Counselling and Support Capacity Building Project (NASCAP)

In 2013, under the lead of Department of Health, *Nutritional support to and rehabilitation of malnourished children (<3 years) in ECD Centres, Out of Centre and Community-Based Programmes* was established. Outcome areas related to young children included:

- Quality nutrition provision in facilities (adequate, appropriate meals, menu planning, food preparation, safety and hygiene): To achieve this, an *Operational manual for provision of food in care facilities for younger children* was developed, piloted and revised. Twenty nine trainers/social workers received training on this manual which would be used to train ECD practitioners/cooks. Health aspects including the use of MUAC tapes for identification of children with severe acute malnutrition, growth monitoring, micronutrient supplementation, identification of danger signs, management of minor ailments and use of the Road to Health Booklet by ECD practitioners were covered in the training.
- Improved identification and management of malnourished children: A package of care for children under five was developed to strengthen the community-based service component and for ECD centres to identify and help with rehabilitation of children diagnosed with Severe Acute Malnutrition.
- Increased food security in ECDs: The Department of Agriculture has targeted ECD centres as sites for a food security initiative, in which food gardens would be established at ECD centres. ECD centres are prioritised when proposals for funding are received.

First 1000 days Initiative

[2] Promoting breastfeeding through workplace interventions is another of the Southern Africa Food Lab and Western Cape Government Design Lab concept areas to assist with implementing the WCFNS.

As a response to the interrelated challenges the Western Cape faces, provincial strategic goals (PSGs) and several game changers have been prioritised for implementation to bring about change. A transversal management system is in place for government departments and partners to work with communities to bring about change. The Health Department is leading the Provincial Strategic Goal 3 that focusses on increasing wellness and tackling social ills.

The Provincial First 1000 Days initiative was launched in February 2016 as one of the projects under PSG3 to improve wellness and tackle social ills. Key concepts (www.developingchild.harvard.edu) have been adapted into the context of the province to work towards what is needed for lifelong health.

The First Thousand Days highlights the interdisciplinary nature of early childhood development and the interactions of nutrition, health, care and stimulation. These are represented by a unique identifier i.e. the Bowl - Indicative of the nutrition and health elements; Heart - representing the Nurture, Care and Support; and Alphabet blocks representing the Safety, Protection and Stimulation elements. In short - GROW, LOVE & PLAY.

The Department of Health has, in its strategy, identified the first 1000 days as a key priority to improve maternal, neonatal and child health outcomes and have adopted the SURVIVE, THRIVE AND TRANSFORM framework as per the Global Strategy for Women's, Children's and Adolescent's health (2016-2030).

All three core elements of the first 1000 days are essential for ECD. ECD centres and programmes could be seen as key entry points for implementation of the First 1000 Days Initiative.

Provincial government recognises the role of family interventions during the critical first 1000 days period, as the safety and health of children cannot be promoted in isolation from the family.[ix] There need to be much stronger links between the First Thousand Days Initiative and ECD programmes, in particular home visiting and parenting interventions (out of centre programmes) focused on pregnant women and younger children.

Food Provision through ECD Programmes

ECD programmes targeting children are required to provide at least one meal a day in safe and hygienic circumstances and 40% of the R15 per qualifying child per day DSD subsidy is intended for this purpose. The provincial health department training and guidelines referred to above are aimed at ensuring that meals and snacks are nutritious, sufficiently diverse, portions are adequate and that high standards of hygiene are maintained. This was in response to inadequate menus, incorrect cooking practices and poor hygiene.

Local authority environmental health practitioners monitor ECD facilities for hygiene and safety.

The Child Support Grant (CSG)

337 168 (51.5 %) of 0 – 5 year old children in the Western Cape received the CSG in 2016[x] and 13.5% of all children live in households where there is reported child hunger[xi]. There is convincing evidence that the Child Support Grant contributes to improving food security and nutrition and receipt of the grant during the first two years of life significantly increases child height, especially for girls. If the grant is available for less than half this period, no gains in child height are seen, showing the importance of early and continued access to the grant. However, take up by infants under one year is lower than for other age groups with only two out of three eligible infants under 1 year of age accessing the CSG nationally[xii]. Studies have also shown the effects of receiving a grant on child hunger, stronger in poorer households.[xiii]

3. Proposed Change Initiative

The challenge

To prevent stunting and malnutrition in young children, respond proactively to early signs of stunting and provide additional stimulation and support for children who are stunted, we need to identify children who are growth faltering and link them to services.

The Draft WCFNS Strategy has an important focus on using ECD programmes as opportunities in this context, however only 25% of children 0 – 5 in the Western Cape attend the 3 235 currently identified registered and unregistered centres. The Department of Social Development subsidises about 60 000 children in 728 of these centres and 40% of the subsidy is earmarked for food and nutrition. **Thus, only about 12% of children in the birth to school going age group receive any kind of nutritional support.** The approximately 75% of young children unreached are likely to be the most vulnerable – those either too young to be in an ECD programme or whose parents are too poor to pay the fees and those in informal care arrangements. They are not easy to identify or to reach with consistent, appropriate services as they are in homes and communities. While the Department of Health is a key contact point, the most vulnerable do not always seek health services. Furthermore, stunting is not easily picked up in the health system and children are often lost to follow up between 9 and 18 months. We urgently need to find more effective ways of identifying and referring vulnerable children early to improve nutritional status and avoid loss of human development potential. This is in line with the National Integrated ECD Policy definition of ECD services.

Low and middle income countries which have reduced stunting (Chile, Jamaica, Rwanda, Ethiopia, Thailand, Vietnam, India) commonly have good community population coverage through community health workers. With support, community level workers with relatively little formal education can work with the child's carer in the home and community setting to identify and facilitate improvements in children's nutritional status. It is recognised in policy as a strategy for improving child outcomes and should be actioned in the Western Cape.

The proposed innovation

The proposed innovation builds on the provincial strategic goals which give priority to early childhood development by Western Cape Health and Social Development Departments and the First 1000 Days Initiative (PSG 02 and PSG 03). It is aligned with the National Integrated ECD Policy goal of nutritional support for vulnerable children and delivery of ECD services.

Goal: To reduce the prevalence of stunting in the Western Cape in pursuit of zero stunting by working at district level in collaborative multi-sectoral partnerships in order to coordinate the use of the varied community level workforce to identify and refer vulnerable pregnant women and young children to appropriate ECD services (mainly nutrition support, including social grants, and WASH) at ward level.

As well as identifying those in need of services, there needs to be comprehensive mapping of appropriate referral channels and resources in each ward and at district level.

Nutrition, including breastfeeding, appropriate complementary feeding, and adequate and diverse food intake, is part of the necessary initiatives to address stunting and poor growth in young children. Other key issues that need attention are access to health services, clean water, safe sanitation and responsive care. The complexity of issues demands an inter-departmental and inter-sectoral response. Given the existence of the First Thousand Days Initiative, Hilary Goeiman is best positioned, with support and/or convening function from The Office of the Premier, to provide the necessary leadership for a public/private collaborative partnership approach to address the challenge and to give it the political and bureaucratic priority it requires.

This innovation makes efficient use of existing channels, networks and human resources and requires strong coordination, but minimal additional resources.

1) It would require putting in place an operational governance structure with a project leader supported by the Department of the Premier. Presentations should be made to the MECs and DGs of Health and Social Development to get political and administrative 'buy in'.

Roles and responsibilities would need to be clarified in terms of what should be done at provincial level (e.g. standardisation and design of intervention, monitoring and evaluation) and local implementation roles. A team who work with a technical group could develop this, based on reviewing what is in the system and building on that where feasible.

2) Pilot the innovation in one or two **wards**, targeted on the basis of a high prevalence of nutritional vulnerability in the young child population as well as gathering energy, commitment and innovation already displayed by some key stakeholders. Existing data for this process can be sourced from DoH administrative data, WCDSD poverty data and population coverage by services (DSD Research and Knowledge Management) and municipal data.

3) Building on existing initiatives, convene key stakeholders to jointly vision, plan and work together towards achievement of the goal including drawing up a register of community workers of all kinds working in the area. These could include Community Health Workers, Home Based Carers, Community Development Workers, Social Workers and Social Auxiliary workers, Community Works and Expanded Public Works Programme, NPO fieldworkers (including health, Isibindi etc.), Department of Agriculture Extension workers etc.

For roll out of the innovation, a clear picture of the full range of community workers in the province would be needed including the number of community workers, where they are deployed and by whom, their roles and responsibilities, caseloads etc. This would involve key departmentally funded programmes as a start and those in the NPO sector.

4) To enable referrals of those identified as being in need of services, develop a map of all the resources operating in the area and broader district. This would include public services, but also NPOs and CSI stakeholders involved in nutrition support and education and food security initiatives in the area. It would also include formal and informal ECD and social support services, community hubs, day mothers, income generating projects, community food gardens etc.

5) Develop a simple screening tool based on clearly defined vulnerability criteria and a referral protocol with local referral directory for the ward. A central referral register and systems for tracking and recording these would need to be set up. A digitised referral tool or phone app would greatly improve efficiency and be more likely to be used.

6) Promote the innovation and build buy in and interest from community cadres for assisting the initiative. Western Cape Government support is needed to enable this. Community workers often have strenuous duties and it must be stressed that identification and referral of pregnant women and young children at risk would not be onerous, but something done in the course of ongoing household and community support duties. (For many community projects, referrals form a key service so this is a matter of ensuring that there is an eye on young children and pregnant women).

7) Coordinate, support and train community cadres to use the screen. This would include the household level, informal care services such as day mothers and ECD and other social support programmes, including Mom Connect, and clinic registers of those lost to follow up.

8) Monitor referrals and collect follow up data on nutritional indicators for the pilot areas.

9) Reflect on process at each stage through a Multi-stakeholder Forum including community representation. Adapt as necessary.

Deliverables and timing

	Proposed Deliverables	Requirements	Proposed timing
1	Buy in from all relevant government departments for the innovation	Hilary Goeiman supported by the Premier's Office to champion, coordinate & get 'buy in' from all relevant departments (especially DoH, DSD, COGTA, municipality, DoA) Advocacy and communication	TBC
2	Identify pilot communities	DoH nutrition stats; DSD data; SASSA data, municipal data	TBC
3	Establish operational governance structure and technical working group	Convene technical group to determine roles and responsibilities at provincial, district and site level	TBC
4	Develop register of community cadres in area	Information from NPOs, DSD, DoH, DoA, Municipality	TBC
5	Map services (clinics, day mothers, ECD programmes, social support initiatives, community gardens etc) including current CSI and NPO supports, stakeholders & useful structures	Departmental and ward data, on the ground key informants	TBC
6	Develop guidelines to identify vulnerable pregnant women & children – short scale of vulnerability.	Refer to existing protocols and evidence base for simple scales Focus on nutrition and WASH	TBC
7	Develop referral pathways and data collection system	Clarify roles & responsibilities Adapt existing protocols and data register	TBC
8	Develop training package for identification and referral	Print materials	TBC
9	Train trainers who will cascade to community cadres	Print materials Venues	TBC
10	Monitor and support	Multi-sectoral stakeholder forums to give input at each step and to include community representation	Continuous
11	Reflect on learnings and adjust (action-reflection cycle)	Stakeholder forum including beneficiaries	Continuous

4. Additional Possibilities for ECD Programmes as Supports for Child Nutrition

ECD programmes and particularly community-based ECD centres could be an important resource in any strategy or programme to address food security and nutrition in the Western Cape. However, one would have to recognise the constraints under which they operate their battle for financial survival and general lack of capacity to take on additional responsibilities beyond what is expected within their current programmes. Any additional services would need to come with strong managerial input, capacity building, mentoring and support, clear measurable outcomes and incentives.

Most provincial programmes have targeted registered ECD facilities and programmes, but around 40% of known facilities are not registered and should be considered for inclusion in any ECD Nutrition strategy.

The following are possible ways in which ECD facilities and programmes could assist with the nutrition and food security of young children in the province:

Referrals/Information Sharing

Assisting children/families with applications for emergency grants, child support grants and referring them to primary health services. This is not widely practiced, should be strengthened and a simple register kept of referrals (and those resolved or not) should be submitted to the DSD service office for aggregation and follow up if necessary.

Provision of information to parents of children in the programme but also awareness campaigns for the local community. This might be done by health and nutrition experts/personnel or alternatively ECD programme staff would require training and curriculum/materials would have to be assessed for appropriateness. Community radio broadcasts and articles in local newspapers are another avenue for this (e.g. the Ilifa Love, Play, talk radio programmes[xiv]). Mom Connect is another existing channel; this is the National Department of Health free messaging service that creates awareness among pregnant women about available health services for their infants and advice for new mothers on caring for the baby (e.g. exclusive breastfeeding, immunisation, family planning for the mother, oral rehydration during diarrhoea, check-up periods at the clinic).[xv] Finally, the Western Cape Department of Social Development has piloted Care-up with promising reports of sustained parent and ECD practitioner interest. This uses mobile phones to deliver coordinated messages and content to teachers and caregivers of young children aged 2-6. So far this has focused on early language and literacy content, but could be used to deliver nutritional messaging.

Although there is limited evidence regarding the value of broader communication campaigns on early childhood development as a stand-alone strategy, behaviour change communication (BCC) strategies can be an important tool for supporting programming for young children, when it is used in a specific and relevant way. Crucial in the effectiveness of BCC is knowing the target audience, involving them in the design of interventions, incorporating feedback loops to determine what is and is not working, and revising messaging accordingly and frequently. Studies have shown that efficacy grows with multiple channels and increasing dosages of BCC.[xvi] Specifically, greater effectiveness is correlated to utilisation of the following categories of messaging: behavioural level (performance techniques); social level (social support, interpersonal media); sensory level (materials, media); and cognitive level (problem solving, information).[xvii xviii]

The Ugandan Nutrition and Child Development Project provides a good example of the use of multiple channels including print (press and brochures); audio; radio; road shows; and reinforcement through personal communication. A significant feature of this was that it targeted these messages at multiple stakeholders including politicians; local leaders; and parents. Evaluations over a two year period indicate that this campaign improved nutrition practices; having an impact on practices such as breastfeeding; dietary variety; supplementary feeding; deworming; hygiene; and sanitation. The communication campaign also changed the perception of parents' towards the importance of playing with and talking to children.[xix]

Relevant topics: first 1000 days, nutrition for pregnant and breastfeeding mothers, breastfeeding, complementary feeding, responsive feeding, appropriate meals using locally sourced foods, household hygiene and safety, visiting clinics for micronutrient supplementation and growth monitoring, the importance of early stimulation for health growth and development. There should be a focus on WASH in the home in all awareness campaigns.

ECD Centres

- Roll out training of principals and cooks on nutrition guidelines
- Campaign to ensure ECD centres are WASH compliant (already in the strategy)
- ECD centres and programmes to provide a hub for primary health service campaigns on deworming and growth monitoring. They should develop strong links to Community Health Workers or Home Based carers
- Inclusion in curriculum of information for children on healthy foods and hygiene practices
- Rehabilitation of malnourished children

This type of information and support should be extended to day mothers who care for up to 6 children in their homes. These tend to include babies and toddlers who are most nutritionally vulnerable. DSD is currently funding training of day mothers through Badisa. Support and regulation of day mothers is an area in which local authorities have an important role to play which should be strengthened.

Food Provision

Demonstration food gardens

- Demonstration food gardens for training and observation (and as a learning opportunity for children).

Distribution of nutritious foods

- While the State spends R5.3 billion on the National Schools Feeding Programme School targeting vulnerable children in schools, there is no feeding scheme for the youngest children in their most critical developmental stage of life. The goal should be to develop a feeding scheme that targets vulnerable pregnant women and young children using every point of contact with state and other services – DoH, DSD, SASSA, churches, ECD programmes. The cost and complexity of this is recognised, but the opportunity to support early development should not be missed. Meanwhile;
    - All ECD centres should provide nutritious food to children attending them in line with dietary guidelines for registered, subsidized centres.
    - Nutritious snacks should also be distributed from approved NPOs and other sites to playgroups and for home visits. A constraint to be noted for food distribution for home visits is that the home visitors travel from family to family and are not able to carry a lot of food stuff with them. Some programmes have provided food parcels to families at monthly workshops.

[i] Adair LS, Fall CHD, Osmond C, Stein AD, Martorell R, Ramirez-Zea M et al.; COHORTS Group.

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