Swaziland

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report 2013

Policy Goals	Status
1. Establishing an Enabling Environment Swaziland has comprehensive policies and strategies in place for the provision of ECD services. The National Children's Policy (2008) and the National Early Childhood Care and Education (ECCE) Guidelines lay the foundation for programs and policies to support children and mothers. Due to the recent free primary education initiative, the National Children's Coordination Unit is investing more time and resources into promoting ECCE initiatives. Nonetheless, ECD budget allocations remain a major constraint for the development of the sector.	Emerging
2. Implementing Widely The Government of Swaziland (GoS) has essential social and child protection programs in place, but the health, nutrition, and education sectors are lacking in both service provision and scope of programs. Availability of HIV/AIDS services and programs, including Antiretroviral Therapy and Prevention of Mother to Child Transmission, has increased since 2000, but program coverage rates remain low throughout the country. The GoS is making targeted efforts to increase the provision of programs in poor and rural areas.	Emerging
3. Monitoring and Assuring Quality Aside from MISC, the GoS collects little to no data on ECD indicators. Recently, relevant government ministries have shown support for the development of guidelines and standards for ECD programs in order to effectively monitor progress. Although registration and accreditation procedures for ECCE centers are in place, there are no data to indicate whether centers are complying with the protocols as described in the Ministry of Education and Training's ECCE Guidelines.	Emerging

As of January 31, 2017, in-country validation of this report had not taken place. Information on Swaziland's ECD system was collected in 2013. Consequently, potential policy options may have diminished or varying relevance depending on current circumstances in Swaziland and in the sector.

This report presents an analysis of the Early Childhood Development (ECD) programs and policies that affect young children in Swaziland and recommendations to move forward. This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework [1] and includes analysis of early learning, health, nutrition, and social and child protection policies and interventions in Swaziland, along with regional and international comparisons.

Swaziland and Early Childhood Development

Swaziland is a lower middle-income country with a population of 1.23 million inhabitants. The country is ranked 141st in the UNDP Human Development Index. The country has a Gross National Income of $2,860 per person, with 63% of the population living below the poverty line.

Approximately 50% of the population in Swaziland is below the age of 18, with more than 158,000 of the population between the ages of 0 and 5. The country struggles with high poverty rate for young children, high under-5 mortality rate, and low preprimary school enrollment rate. Table 1 presents a snapshot of ECD indicators in Swaziland with regional comparisons.

In 2010, the Government of Swaziland (GoS) began enforcing the country's new constitutional mandate to ensure that a child's first two years of schooling are free. Soon after, Early Childhood Care and Education (ECCE) advocates, including the National Children's Coordination Unit (NCCU) within the Ministry of Education and Training (MoET), began strategizing for increased federal support for ECD, in particular ECCE.

Swaziland's Education Policy (2011) includes an ECCE subsector that lays the foundation for ECCE objectives and strategies. The goal of this policy is to prioritize the expansion of equitable access to early learning in order to accommodate every young child in Swaziland from 3 to 6 years old. Standardization of curriculum and enforcement of registration and accreditation procedures for ECCE have also developed in recent years. The National Children's Policy (2008) aims to provide policy guidelines to ensure adequate care and protection for children, especially orphaned and vulnerable children (OVC). The policy describes detailed strategies for addressing pressing issues and meeting objectives as they relate to children.

The GoS has put in place ECD policies that support the development of children and mothers. The ECD sector still lacks strong inter-sectoral coordination between government ministries. Appropriate budget allocations are lacking to equitably meet the needs of all children and mothers. Further support is necessary to develop ECCE standards and ensure compliance.

Table 1: Snapshot of ECD indicators in Swaziland with regional comparisons

	Swaziland	The Gambia	Liberia	Ghana	Sierra Leone
Infant Mortality (deaths per 1,000 live births, 2010)	69	58	58	52	119
Below 5 Mortality (deaths per 1,000 live births, 2010)	104	101	78	78	185
Moderate & Severe Stunting (Below 5, 2006-2010)	31%	24%	42%	28%	44%
Net Preprimary Enrollment Rate (3-6 years, 2010)	23%	30%	N/A	114%	7%
Birth registration (2010)	50%	53%	4%	63%	78%

Source: UNICEF, 2011

[1] SABER-ECD is one domain within the World Bank initiative, Systems Approach for Better Education Results (SABER), which is designed to provide comparable and comprehensive assessments of country policies.

Systems Approach to Better Education Results – Early Childhood Development (SABER-ECD)

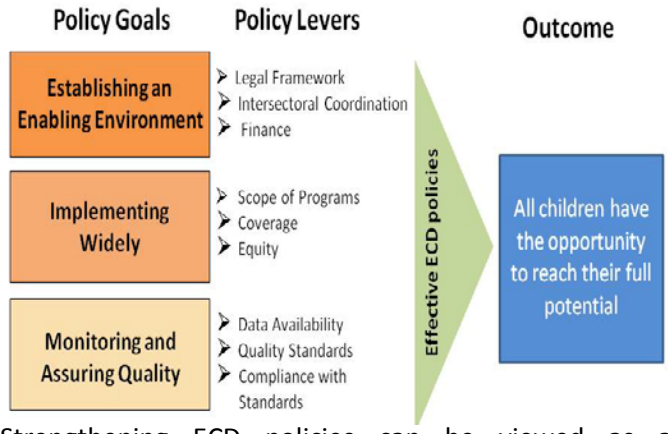
SABER – ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multi-sectoral information is collected on ECD policies and programs through a desk review of available government documents, data and literature, and interviews with a range of ECD stakeholders, including government officials, service providers, civil society, development partners and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies for young children and their families.

Box 1 presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive, but is meant to provide an initial checklist for countries to consider the key policies and interventions needed across sectors.

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: Establishing an Enabling Environment, Implementing Widely and Monitoring and Assuring Quality. Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of policy levers are identified, through which decision-makers can strengthen ECD.

Figure 1: Three core ECD policy goals



Strengthening ECD policies can be viewed as a continuum; as described in Table 2 on the following page, countries can range from a latent to advanced level of development within the different policy levers and goals.

Box 1: A checklist to consider how well ECD is promoted at the country level

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families?
Health care
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early Learning
• Parenting programs (during pregnancy, after delivery and throughout early childhood) • High quality childcare for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social Protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation/ access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc.)

Child Protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially for young children) • Training for law enforcement officers in regards to the particular needs of young children

Table 2 ECD policy goals and levels of development

	Level of Development			
	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●
Establishing an Enabling Environment	Non-existent legal framework; ad-hoc financing; low inter-sectoral coordination.	Minimal legal framework; some programs with sustained financing; some inter-sectoral coordination.	Regulations in some sectors; functioning inter-sectoral coordination; sustained financing.	Developed legal framework; robust inter-institutional coordination; sustained financing.
Implementing Widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes.	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes.	Near-universal coverage in some sectors; established programs in most sectors; low inequality in access.	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted.
Monitoring and Assuring Quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement.	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance.	Information on outcomes at national, regional and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance.	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance.

Policy Goal 1: Establishing an Enabling Environment

➢Policy Levers: Legal Framework • Intersectoral Coordination • Finance

An Enabling Environment is the foundation for the design and implementation of effective ECD policies[2]*. An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD; coordination within sectors and across institutions to deliver services effectively; and, sufficient fiscal resources with transparent and efficient allocation mechanisms.*

Policy Lever 1.1: Legal Framework

Emerging ●●○○

The legal framework comprises all of the laws and regulations which can affect the development of young children in a country. The laws and regulations which impact ECD are diverse due to the array of sectors which influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young children, parents, and caregivers.

The GoS has yet to develop a multi-sectoral ECD policy. The Ministry of Education and Training (MoET) is primarily responsible for the rollout of the ECD policy. Planification for an ECD policy is ongoing at the National level and covers the education, health, and nutrition sectors. No costed implementation plan or resource mobilization plan for the development of an implementation plan exists. There is no expected date for the finalization of the ECD policy.

Although no multi-sectoral policy has been developed, the government does provide a menu of integrated ECD services for young children. Many of these services, described in various policies, are of strategic importance for the development of the ECD multi-sectoral policy. Box 2 presents key laws governing ECD in Swaziland. The Early Childhood Care and Development (ECCD) section of Swaziland's Education Policy (2011), for example, includes: policy objectives ensuring that all children ages 3 to 6 years have equal opportunity to access ECCE services; registration and accreditation procedures critical for ECCE centers and providers; and strategies for the provision of parental education programs.

Swaziland's National Children's Policy (SNCP) has established policy guidelines that ensure appropriate interventions for the care and protection of children**.** The

[2] Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005

policy is comprehensive and includes a wide range of services for children in the education, health, and nutrition sectors. The SNCP is the product of the multi-sectoral collaboration between the Prime Minister's office, various ministerial bodies, and civil society and international partners. Born out of a response to international and regional human rights legislation, including the UN Convention on the Rights of the Child (1990) and the African Charter on the Rights and Welfare of the Child (1990), the SNCP serves as an expression of the government's intention to address children's issues and protect and promote their welfare, as set by international standards.

Box 2: Key laws governing ECD in Swaziland

ECD Laws in Swaziland

- National Children's Policy (2008)
- Education Policy (2011)
- Disability Policy (2013)
- Fortification Standards (2010)
- Salt Iodization Policy (1997)
- National Guidelines on Infant and Young Child Feeding (2010)
- Nutrition and HIV Guidelines (2007)
- National Guidelines on Integrated Management of Acute Malnutrition (2008)
- Employment Act (1980)

The focus of the SNCP is on children between the ages of 0 and 18, but special emphasis is placed on the vulnerable populations, including children with HIV/AIDS, children with special needs, and children who have suffered any kind of abuse. Swaziland is a country categorized by high income inequality (GINI index, 51.5), with 69% of its citizens under the poverty line, and an HIV/AIDs epidemic that is on the rise. Therefore, the focus of the programs and prevention strategies within SNCP has been on marginalized groups. The SNCP begins with the rights of the child and includes relevant existing international and national legislation that also supports the development of the child. The strategies include food and nutrition issues, education, care and support, psychosocial support, socio-economic security, health, disabilities, and child protection and legal support. Through strategic interventions implemented by different ministerial bodies, the policy established a comprehensive platform for the healthy development of children, especially the OVC population. In addition, the National Plan of Action for Orphans and Vulnerable Children (NPAOVC) and the Social Protection for Orphans and Vulnerable Children (SPOVC) also serve as precursors to this policy and include additional strategies for providing tailored services for the community.

National laws and regulations promote the appropriate dietary consumption of pregnant women and children. Salt iodization and food fortification policies are established in Swaziland. The Salt Iodization Policy (1997) mandates salt iodization. Since the policy's inception, consumption of iodized salt has increased, with consumption currently at 52%. The food fortification policy, Wheat and Maize Flour Fortification (2010), encourages iron fortification of staples like wheat, maize, and rice.

National laws in Swaziland offer inadequate workplace security and benefits for pregnant women. Swaziland's Employment Act (1980) mandates the provision of a 12-week maternity leave to expectant mothers, only 2 weeks of which are paid. In order to be eligible for maternity leave, women must have been employed by the employer for a minimum of 12 months. The Act allows for an unpaid extension of 6 weeks in the event that further medical attention or rest is required. Female employees who return from maternity leave are allotted a one-hour nursing break for 3 months following maternity leave. Any employee who has requested maternity leave within the last 24 months will not be authorized for a second maternity leave before 24 months have passed. Table 3 presents a regional comparison of maternity and paternity leave policies in Swaziland and select African countries.

Table 3 Regional comparison of maternity and paternity leave policies

Swaziland	The Gambia	Liberia	Ghana
12 weeks with 2 weeks paid for women; no leave for fathers	24 weeks maternity leave for women; 10 days of paternity leave for fathers	90 days paid maternity leave at 100% salary for women; no leave for fathers	84 days paid maternity leave at 100% salary for women; no leave for fathers

Source: ILO, 2013

Policy Lever 1.2: Intersectoral Coordination

Emerging

Development in early childhood is a multi-dimensional process.[3] In order to meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, non-state actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with non-state actors are also essential.

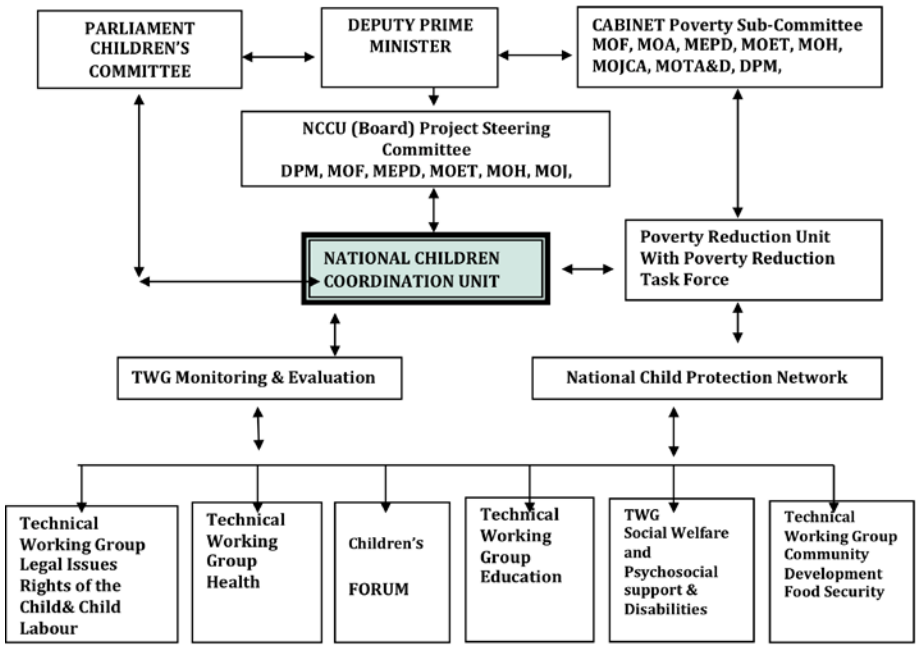
An institutional anchor has been established to coordinate ECD across sectors. Swaziland's National Children's Coordinating Unit (NCCU) was established in 2009. As principal coordinator of ECD programming, the NCCU plays a critical role in the development of Swaziland's comprehensive ECD policy. Figure 2 shows the relationship between the NCCU and the ministerial bodies. This framework has been used to coordinate overall activities and services for children between the ages of 0 and 18.

The overall purpose of the NCCU is as follows:

1. Coordinate ECD programming
2. Foster collaboration and information sharing between ECD partners
3. Develop legal framework to regulate the ECCD sector in Swaziland
4. Regulate ECD training
5. Review and make recommendations for the National ECD policy
6. Develop framework for ECD advocacy at all levels
7. Mobilize resources for ECD
8. Lobby for ECCD policy finalization

Coordination meetings between the various implementing partners at the subnational level are held semi-annually. The NCCU coordinates the ECD Forum on a bi-monthly basis while the Ministry of Tinkhundla Administration and Development coordinates meetings with the National Center for Children in Poverty (NCCP) and implementing partners on a monthly basis. Through forums and meetings, the various stakeholders and ministerial bodies have developed a menu of ECD services in the education, health, nutrition, and social and child protection sectors. Table 4 portrays the roles of respective ECCD stakeholders. Within each of the sectors, the relevant ministry has an ECD specialist in the unit whose mandate is the overall coordination of ECD programs.

Figure 2: Institutional anchor-National Children's Coordination Unit



[3] Naudeau et al., 2011; UNESCO-OREALC, 2004; Neuman, 2007

Table 4: Roles of ECCD Stakeholders

Year	2009	2010	2011	2012
Total public expenditure on education	1,512,093,139 SZL 145,379,290 USD	456,747,467 SZL 43,493,662 USD	NA	1,960,000,126 SZL 188,583,691 USD
Total public expenditure on education as a percentage of government expenditures	NA	NA	NA	NA
Total public expenditure on ECCE	627,474 SZL 60,328 USD	745,653 SZL 71,690 USD	NA	3,463,573 SZL 333,003 USD
Total public expenditure on ECCE as a percentage of government expenditures	0.04%	0.16%	NA	0.18%

Policy Lever 1.3: Finance

Latent

While legal frameworks and intersectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensure that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns, but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits 4 *. Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.*

ECD budget allocations are not coordinated between the various government ministries and the sectors lack transparent budget processes. Criteria to determine ECD spending levels is used in only one sector- education. The GoS uses poverty levels to determine the level of ECCE spending in poorer regions. To date, an allotment of approximately $6,000 USD is reserved for the procurement of teaching and learning materials in the poorer areas. The GoS has no coordination mechanisms in place to determine ECD budgets with the other ministries that support ECD efforts.

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The GoS has very limited budget information on ECD spending. Limited data on public expenditure for ECCE and education spending are presented in Table 5. Also included in Table 6 is limited information on the amount of donor financing available for education and ECD related projects and programs from 2006 to 2013.

Table 5: Public expenditure on Education/ECCE

ECCD Stakeholder	Role
MoET (Ministry of Education and Training)	Regulate education component of ECCD through the preparation and implementation of rules, regulations, and structures as well as the provision of supporting guidelines that will facilitate stronger control over ECCD centers
MoHSW (Ministry of Health and Social Welfare)	Address health and nutrition needs of children through policy and program development
MoTinkhundla and Regional Development	Community Development Department – develop community based ECCD programs especially at Neighborhood Care Points (NCPs)
DPMs Office/ Dept. of Social Welfare	Ensure welfare of children through policy and program development
NGOs	Develop ECCD programming that complements government programs (mainly at NCPs)
NCCU (National Children's Coordination Unit)	ECCD sector coordinating unit

[4] Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek & Luque, 2003

Table 6: Donor financial support for all education and ECD related projects

Name of External Donor	Financial Contribution
UNICEF (2013)	585,000 USD for all Education and 237,000 USD for ECD
EU (2006 to 2013)	602,370 USD for all Education and ECD

The level of finance for ECD services is inadequate to meet the needs of children of Swaziland. The GoS utilizes less than 1% of the education budget on ECCE- a level of finance that is considered inadequate to meet the needs of Swaziland's children. Government spending in ECCE is matched by parent fees for education materials and salaries. Parents are required to pay fees in both public and private ECCE centers for tuition, matriculation, uniform, meals, assessment, desks, teacher salary, parent teacher association, and transportation. Other ECD sectors are also affected by limited government financing.

Parents are responsible for essential health and nutrition services. Compared to other countries in the region, Swaziland's out-of-pocket expenditure as a percentage of all private health expenditure is low, still fees levied on citizens are an impediment to greater access to health services. Table 7 presents a regional comparison of select health expenditure indicators. Parents are charged for labor and delivery, emergency services for young children, and insecticide-treated bed nets for pregnant women and children, malaria treatment, and PMTCT and ART services.

Table 7: Regional comparison of select health expenditure indicators[5]

	Swaziland	The Gambia	Sierra Leone	Ethiopia	Mali
Out-of-pocket expenditure as a percentage of all private health expenditure	43%	48%	90%	80%	99%
Out-of-pocket expenditure as a percentage of total health expenditures	15%	21%	79%	37%	53%
Government expenditure on health as a percentage of GDP	10 %	2%	13%	5%	5%
Routine EPI vaccines financed by government, 2010	No data	100%	No data	5%	20%

Source: WHO Global Health Expenditure Database, 2012

Policy Options to Strengthen the Enabling Environment for ECD in Swaziland

Legal framework:

- **The GoS, together with relevant ministries, could develop and implement the multi-sectoral ECD policy**. Swaziland has a long history of battling inadequacies and inequity in service provision. The country has also struggled with resource mobilization for ECCE. The development and adoption of a multi-sectoral policy would help to support resource mobilization through the inclusion of sector-specific strategies and objectives. Implementation of the policy would help in accomplishing some of the goals and objectives as set forth by various policies, including Swaziland's Education Policy, which recognizes the high returns for investment in the formative years of a child's life. The GoS could consider further developing and implementing their multi-sectoral ECD policy in order to meet its objectives related to child development. The policy should clearly articulate the roles and responsibilities of the relevant ministerial bodies.

- **Swaziland's National Children's Policy is an example of a multi-sectoral, comprehensive policy that addresses the rights of the child.** The Policy has initiated the full implementation of programs and interventions included in the policy. The policy is an example of a document that was developed with the support and funding of different levels of government and stakeholders. It is a culmination of 5 years of collaboration with many stakeholders, and reviewed by the Child Protection Network, a committee of more than 300 organizations. The process by which this policy was created and the commitment of such a large network serves as an example to the ECD committee responsible for drafting and implementing the ECD policy.

Intersectoral Coordination:

- **The GoS may consider strengthening the roles and responsibilities of the ECD coordinating body- the NCCU.** . As it stands, the role of the NCCU is to coordinate ECD at the National level. Meetings for the NCCU are organized with National-level representatives from each

of the relevant governing bodies. In order for more adequate planning and effective implementation of the ECD policy, it is important that subnational and local or regional representatives be involved in the planning process. Without input from more than National level government representatives, the NCCU risks developing an ill-informed ECD policy, inadequate for the needs of children. The GoS also risks lack of buy-in from local governments who will ultimately be responsible for the successful implementation of ECD services in their respective regions. The NCCU should consider scaling up the frequency of meetings as well as assigning a specific ECD representative from each of the relevant government organizations. Designation of a specific ECD representative instead of a more general representative will assist in ensuring that the focus of the ECD policy planning remains on young children and mothers as opposed to a broader population, e.g., children of all ages. Box 3 is an example of a multi-sectoral ECD policy that has been informed by various levels of government and focuses on the early stages of a child's life.

Finance:

- **The GoS could consider increasing ECD budget allocations in order to more adequately meet the needs of children and mothers**. The level of finance available for ECD services is inadequate for adequate ECD service provision. In recent years, budget allocations for ECD services have decreased due to tightened ministerial budgets and the necessity to increase budget allocations in other areas of priority. This has hindered access to services in poorer communities. It is critical that the NCCU prioritize budget allocations during policy development meetings. Budget allocations should be indicative of the needs of children and mothers, and special attention should be paid to subgroups in most need, including those in poorer, rural areas and children with special needs. It is also advised that the GoS revise the way ECD expenditures are reported by ministerial bodies. Only a few sectors are able to report accurate ECD expenditures and budget appropriations remain an autonomous decision by each ministerial body. It is critical that budget appropriations become a coordinated effort across ministries.

Box 3: Example of a comprehensive multi-sectoral strategy

Chile's Crece Contigo, a Multi-sectoral Policy

Summary: A multi-sectoral ECD policy is a comprehensive document that articulates the services provided to children and key stakeholders involved, including responsibilities of service providers and policy makers. The policy should also present the legal and regulatory framework in a country and address any possible gaps. Typically, a policy can include a set of goals or objectives and an implementation plan that outlines how they will be achieved. The benefits of doing so are manifold. The preparation process requires all stakeholders to contribute, which in turn promotes a more holistic, synergetic approach to ECD and identifies possible duplication of objectives by individual stakeholders. Another benefit is that the policy framework clarifies the boundaries within which all stakeholders are to operate and can create accountability mechanisms.

One such example is *Chile Crece Contigo* ("Chile Grows With You", CCC), an intersectoral policy introduced in 2005. The multi-disciplinary approach is designed to achieve high quality ECD by protecting children from conception with relevant and timely services that provide opportunities for early stimulation and development. A core element of the system is that it provides differentiated support and guarantees children from the poorest 40% of household's key services, including free access to preprimary school. Furthermore, the CCC mandates provision of services for orphans and vulnerable children and children with special needs. The creation and implementation of the CCC has been accomplished through a multi-sectoral, highly synergistic approach at all levels of government. At the central level, the Presidential Council is responsible for the development, planning, and budgeting of the program. At each of the national, regional, provincial, and local levels there are institutional bodies tasked with supervision and support, operative action, as well as development, planning and budgeting for each respective level. The *Chile Crece Contigo* Law (No. 20.379) was created in 2009.

Key considerations for Swaziland:

1. Multi-sectoral policy that articulates responsibilities for each level of government
2. Differentiated support likely informed by different levels of government

Policy Goal 2: Implementing Widely

➢ Policy Levers: Scope of Programs • Coverage •Equity

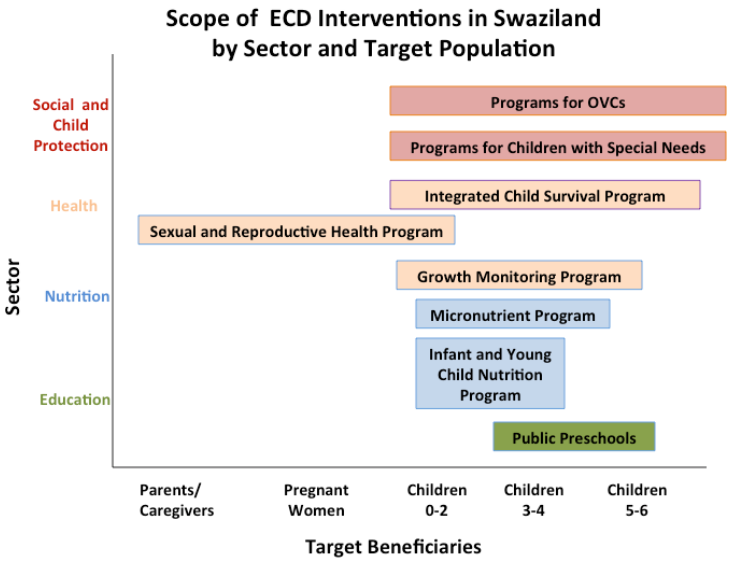
Implementing Widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population) and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, and social and child protection, and should target pregnant women, young children and their parents and caregivers. A robust ECD policy should include programs in all essential sectors; provide comparable coverage and equitable access across regions and socioeconomic status – especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

Emerging

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 3 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

Figure 3: Essential interventions during different periods of young children's development



The health and nutrition sectors have a limited scope of basic programs designed to target mothers and children. The antenatal healthcare program for expecting mothers is one of the more developed health programs provided throughout Swaziland. The program includes antenatal care plus PMTCT services for approximately 33,000 mothers. Little information exists on the programs provided for children in the country. The MoHSW is responsible for the country's immunization program that provides vaccinations for babies who are up to 14 weeks of age throughout the country. Data indicates that in the month of March (2013) alone, 6,364 babies were vaccinated. Vaccinations included in the program are DPT, HEPB, and HIB3.

The MoHSW has implemented the Growth Monitoring Program; a program designed to be administered throughout Swaziland. The Growth Monitoring Program ensures that growth is monitored monthly and plotted against the ages on the Child Health Card, issued to parents to ensure development standards are being met. Mothers and caretakers are offered nutritional counseling for their children at every health appointment completed by a health worker, irrespective of the growth status of the child. If growth failure is detected, the mother or caretaker is immediately advised and the child is attended to accordingly. The program ensures that children who are considered even moderately malnourished be referred to the nearest therapeutic feeding center to participate in the Child Supplementary Feeding Program.

Swaziland has developed essential child and social protection programs to target children with disabilities. In 1990, a Community-Based Rehabilitation Program was established to support services for children with disabilities.

Based on feedback and increased need, this program was upgraded to a National Disability Unit housed within the MoHSW. Since then, the program has continued growing and the unit is now part of the Deputy Prime Minister's office. In the past 15 years, other programs to target parents and children with disabilities have been developed, leading to a wider variety of programs in the country that ensure diverse needs are being met. Figure 4 shows the scope of ECD interventions in Swaziland by sector and target population.

Figure 4: Scope of ECD interventions in Swaziland by Sector and Target Population

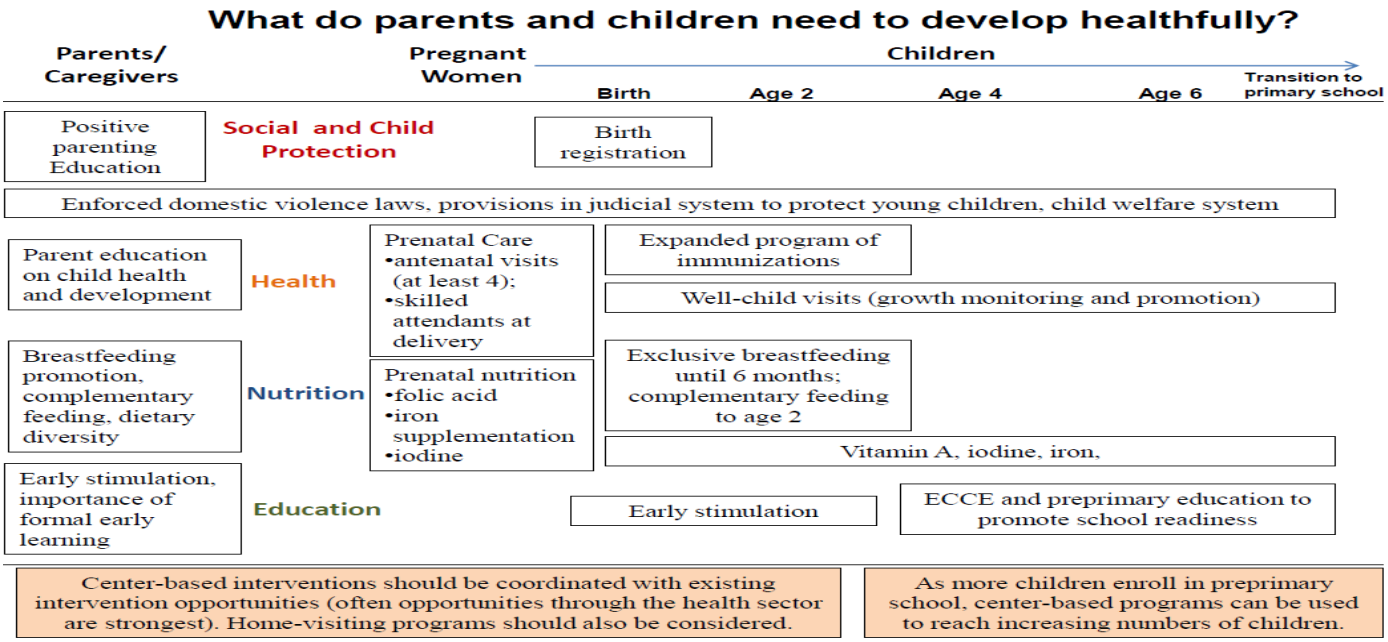


Table 8: ECD programs and coverage in Swaziland

ECD Intervention	Scale	
	Number of Regions Covered	Coverage
Education		
Preschool (excluding Grade 0)	4	24,139
Childcare or Daycare	4	17,097
Health		
Antenatal and newborn care (2011)	4	32,434
Integrated management of childhood illnesses and care for development	N/A	N/A
Childhood wellness and growth monitoring	4	2322
National immunization program	4	6364
Nutrition		
Micronutrient support for pregnant women	4	N/A
Food supplements for pregnant women	4	N/A
Micronutrient support for young children	4	N/A
Food supplements for young children	4	N/A
Food fortification	N/A	N/A
Breastfeeding promotion programs	4	N/A
Anti-obesity programs encouraging healthy eating/exercise	N/A	N/A
Feeding programs in preprimary/kindergarten schools	4	N/A
Parenting		
Parenting integrated into health/community programs	N/A	N/A
Home visiting programs to provide parenting messages	N/A	N/A
Special Needs		
Programs for OVCs (*Boarding schools & children's homes*)	4	190,000
Interventions for children with special (*emotional and physical*) needs	N/A	N/A
Anti-poverty		
Cash transfers conditional on ECD services or enrollment	N/A	N/A
Comprehensive		
A comprehensive system that tracks individual children's needs	4	N/A

The Ministry of Labor and Social Security provides vocational training geared towards self-employment and income generation for people with disabilities. The purpose of the training program is to empower people with disabilities and provide them with relevant entrepreneurial skills necessary for self-employment and income generation. Vocational training is provided in 3 rehabilitations centers throughout the country. The program targets poorer parents and caretakers with the objective to equip them with the skills they need to successfully find employment and provide for their children. In order to address the education needs of children with disabilities, the Special Education Unit within the MoET leads the provision of special and inclusive education beginning in primary schools. The education program addresses the needs of learners with any type of disability and the program lasts from preprimary to tertiary level schooling.

Policy Lever 2.2: Coverage

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage and reach the entire population equitably–especially the most disadvantaged young children–so that every child and expecting mother have guaranteed access to essential ECD services.

Due to the devastating effects of the HIV/AIDS pandemic in Swaziland, the government has developed and enhanced programs such as ART and PMTCT. To date, program coverage still remains an issue, with access and awareness being principal constraints. The HIV/AIDS prevalence amongst 2 to 4 year olds is 5%, and 3% amongst those ages 10 to 14. The NCCU has called for the scaling up of programs in order to best meet the needs of young children. Among children eligible for ART, only 35% are accessing the services. The situation is most dire for pregnant women between the ages of 15 and 49; this age range has an HIV positive prevalence rate of more than 40%.

Limited access to programs has been further exasperated by low birth registration. Although birth registration is mandated, Swaziland has one of the lowest rates in the region. Communities affected by lack of access or inability to cover registration fees are those in poorer communities and the OVC population. Table 9 presents a regional comparison of level of access to birth registration. Access to other essential health services, including Swaziland's Oral Rehydration Program have also been impacted by low birth registration rates. Table 9 and 10 present a regional comparison of level of access to essential health and nutrition services for young children and pregnant women. The rates for infants and pregnant mothers who receive the services are slightly higher, showing increasing government support and progress since the program started.

Table 9: Regional comparison of level of access to birth registration

	Swaziland	The Gambia	Sierra Leone	Ghana	Mali
Birth registration	50%	53%	78%	63%	81%

Source: UNICEF Country Statistics, 2010

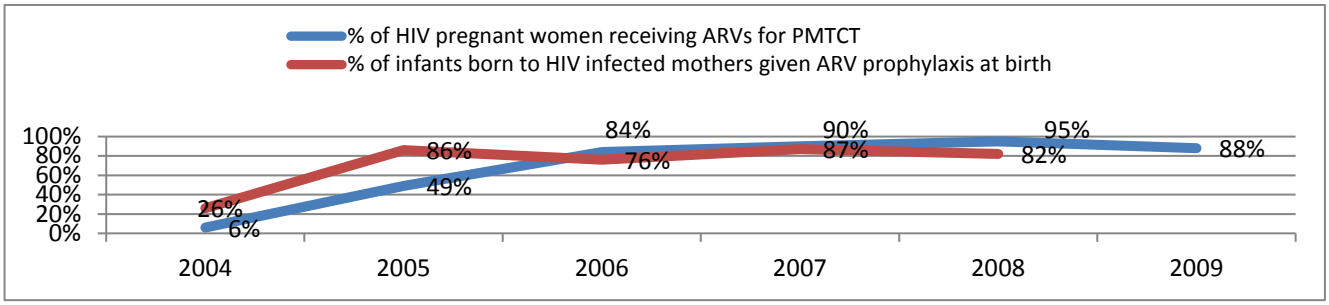
Table 10: Regional comparison of level of access to essential health services for young children and women

	Swaziland	The Gambia	Sierra Leone	Ghana	Mali
1-year-old children immunized against DPT (corresponding vaccines: DPT3ß)	91%	96%	84%	91%	72%
Children below 5 with diarrhea receive oral rehydration/ continued feeding (2010)	57%	39%	73%	35%	14%
Children below 5 with suspected pneumonia taken to healthcare provider (2010)	58%	70%	74%	41%	38%
Pregnant women receiving antenatal care (at least four times)	77%	72%	75%	87%	35%

Source: UNICEF Country Statistics, 2010

Most recently, the GoS began imposing additional screenings for HIV/AIDS and since then many more pregnant women and infants have been receiving ARVs for PMTCT. Figure 5 shows the percentage of women with HIV and HIV-exposed infants receiving ARVs for PMTCT. There is potential for the trajectory to continue upward, increasing provision of services for HIV positive women and HIV exposed infants, but the GoS must continue funding HIV/AIDS initiatives. With continued funding and support, GoS' National. Targets for 2014 are certainly within reach. Box 4 summarizes some key National targets for Swaziland.

Figure 5: Percentage of women with HIV and HIV-exposed infants receiving ARVs for PMTCT



Box 4: Swaziland's national targets by 2014

- Reduce HIV infections among infants to 5%
- Reduce HIV infections among pregnant women, ages 15 to 24, to 35%
- Provide ARV prophylaxis for PMTCT to at least 90% of women with HIV
- Reduce proportion of women, ages 15 to 49, who do not want any more children when they become pregnant to 20%

Table 11: Regional comparison of level of access to essential nutrition services for young children and pregnant women

	Swaziland	The Gambia	Sierra Leone	Liberia	Mali
Children below 5 with moderate/severe stunting (2006-10)	31%	24%	44%	42%	38%
Infants exclusively breastfed until 6 months of age (2010)	44%	34%	32%	34%	38%
Infants with low birth weight	9%	10%	11%	14%	19%
Prevalence of anemia in pregnant women (2010)	24%	75%	60%	62%	73%
Prevalence of anemia in preschool-aged children	47%	79%	83%	87%	83%

Source: UNICEF Country Statistics, 2010; WHO Global Database on Anemia

Policy Lever 2.3: Equity

Emerging

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services[6]. One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

In an effort to address inequities in service provision for constituents with disabilities, the GoS recently developed the National Disability Policy. A study informing the Deputy Prime Minister's Office of the inequities in service provision for those with disabilities, has paved the way for the development of the National Disability Policy. In Swaziland, there are obvious gender and geographical inequities in the population with disabilities. Approximately 58% of those with disabilities are female. In terms of geographical inequity, 82% of people with disabilities live in rural areas. Regionally,

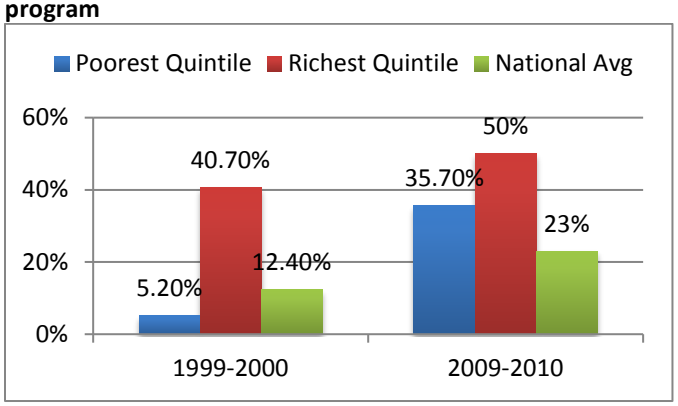
Manzini has the highest population with disabilities (29%), followed by Hhohho (27%), Lubombo (25%), and Shishelweni (19%). The leading cause of disabilities in Swaziland is disease or illness (59%), followed by congenital (25%), and injury (16%). The majority of the population with disabilities in Swaziland is also less educated, with 25% never having attended any school and only 2.3% of the population having attended preprimary. In Swaziland, access to services is often hampered by geographical locations, especially in rural areas.

The preprimary enrollment rate in Swaziland is currently at 23%, with large variations by region and type of service provision. Preschool is encouraged but not mandated by the GoS. Discrepancies in type of service provision, public versus nonstate, vary by region. There exist large variations in preprimary enrollment rates by region as well. The Manzini region has the highest number of children attending preprimary schools- approximately 10,000 (14.3%), whereas the Lubombo region has less than 4,000 (10%) children attending preprimary school. The enrollment rate in the richest quintile in Swaziland is approximately 50%, while the poorest quintile has an enrollment rate of 35.7%.

[6] Engle et al, 2011; Naudeau et al., 2011

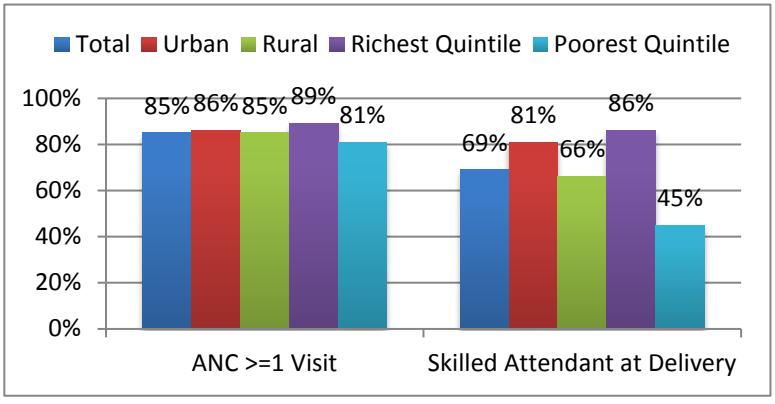
Since the initial administration of MICS, the MoET has worked to further advance the ECCE agenda, leading to a doubling in preprimary enrollment rates in the country. Figure 6 illustrates the number of children ages 35 to 59 months attending an ECCE program by wealth quintile.

Figure 6: Children ages 35 to 59 months attending an ECCE program



Access to antenatal services is limited for women living in poor and rural areas. Most women in Swaziland are able to access and receive skilled care during pregnancy, but many living in rural and poorer areas are not able to benefit from such services. Although access to antenatal care is widespread, more than 70% of women do not receive antenatal care until after their third month of pregnancy. Inability to access antenatal services at the onset of a pregnancy has given rise to the popularity of at home births. Although comfortable and high accessible, at home births come at a cost. Most at home births account for the low percentage of skilled attendants at delivery in the poorest and rural areas. Figure 7 illustrates the percentage of women who attended at least one ANC visit during pregnant and the percentage of births attended by skilled physicians.

Figure 7: Percentage of women who attended at least one antenatal care visit during pregnancy and percentage of births attended by skilled physicians



Policy Options to Implement ECD Widely in Swaziland

Scope of Programs

- **The GoS could support and further promote early education initiatives in the country**. Support for early education programs are sparsely mentioned in policies, including the National Children's Policy, ECCE guidelines, National ECCD Coordination Committee guidelines, among others. The recent introduction of free primary education from the GoS has spurred interest in also advancing preprimary. Recently, the MoET developed Swaziland Early Learning Development Standards (SELDS). SELDS is a compilation of comprehensive learning standards for children between the ages of 0 and 60 months. The purpose of SELDS is to encourage standardization of learning standards across different providers of preprimary education. Further support for early childhood education programs will ensure higher and timely primary school enrollment, and prepare children with the cognitive, emotional, and physical stimulation they need to grow. Box 5 describes an example of a strategy developed by the Australian government in order to increase support for provision of ECCE services.

Coverage

- **The GoS could continue to scale up programs such as the ART and PMTCT in order to provide access to services for more families in need**. Currently, HIV prevalence among children between the ages of 2 and 4 is 5% and 3% for children between the ages of 10 and 14. Only 35% of eligible HIV infected children are on ART. The GoS should consider enhancing their monitoring program to ensure that health visits are being tracked and services are being more closely monitored. This will ensure that services are reaching those most in need and that necessary and adequate follow up is being provided. The scaling up of services will be most successful with the enhancement of the quality of ART and PMTCT services. Increasing support for ANC visits is an excellent opportunity for early diagnosis and prevention treatments. Capacity building for local health workers for ANC services could also help ensure that women and children are receiving appropriate services. Health workers could use ANC visits as an opportunity to promote access to family planning services among women living with HIV.

- **The GoS should consider scaling up maternal health services and programs**. According to a health survey implemented by the MoHSW, the maternal mortality rate was over 500 per 100,000 live births in 2008. Although policies mandate the provision of health services to all women, over 25% of women do not or cannot access maternal health services. Lack of maternal health services further exacerbates low infant and child access to health services. Increasing access to services for maternal and antenatal health could also help in boosting immunization amongst children. Monitoring and ensuring compliance with routine health visits, including ANC visits, has the potential to increase immunization rates and overall health visits.

Equity

- **The Deputy Prime Minister's Office, together with relevant ministries, should consider enhancing their single education system so that it is more inclusive of the needs of all learners by addressing disparities in provision of educational services for children with disabilities.** The GoS could revamp the monitoring and evaluation system that is part of their single education system, so that it more accurately tracks the needs of children and gaps in service provision as they occur. Data collected from the monitoring and evaluation system can be used to inform relevant policy, helping provide increased and more equitable services to all children in need, especially those living in rural and poorer areas.

- **In order to improve outcomes for women and children during labor, the GoS could consider increasing the number of skilled physicians in rural and poorer neighborhoods as well as enhancing their monitoring and evaluation system.** The increase in skilled physicians could help in ensuring accurate and speedy diagnosis and treatment of complications that may arise during labor and ensure that physicians are administering technically appropriate procedures. Although more than 70% of births are attended by skilled physicians in Swaziland, the rate varies widely between rural, poorer areas and urban areas. The rate also varies depending on the level of education of women. Less educated women have been known to have less access to skilled physicians than more educated women. Swaziland's monitoring and evaluation system also needs to be revamped so that it collects accurate data on access to health services more routinely. Enhancement of the monitoring and evaluation system will allow for service provision to be more receptive to the needs of mothers and children, as indicated by the data.

Policy Goal 3: Monitoring and Assuring Quality

Policy Levers: Data Availability • Quality Standards • Compliance with Standards

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children, standards for ECD services and systems to monitor and enforce compliance with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible, or even detrimental.

Policy Lever 3.1: Data Availability

Accurate, comprehensive and timely data collection can promote more effective policy-making. Well-developed information systems can improve decision-making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards and efforts to target children most in need.

Limited data are collected in the health sector in Swaziland. The GoS collects little to no data on ECD indicators besides what is included in the Multiple-Indicator Cluster Survey (MICS). In 2010, the Central Statistics Office (CSO) of Swaziland, in collaboration with and funding from UNICEF and UNFPA carried out MICS. MICS is an international household survey developed by UNICEF that provides up to date information on the situation of women and children. The first time MICS was administered in Swaziland was in 2000. According to the World Health Organization (WHO), data in Swaziland's health sector are collected semi-routinely, but quality is seldom high. According to the organization, this is most likely due to the poor design of data collection tools, incompleteness of data collection, inexperienced data collectors and untimely reporting of data. Essential data on health indicators is analyzed in Swaziland's Ministry of Home Affairs. Table 12 presents the availability of data to monitor ECD in the country.

Table 12: Availability of data to monitor ECD in Swaziland

Administrative Data:	
Indicator	**Tracked**
ECCE enrollment rates by region	✓
Special needs children enrolled in ECCE (number of)	X
Children attending well-child visits (number of)	X
Children benefitting from public nutrition interventions (number of)	X
Women receiving prenatal nutrition interventions (number of)	X
Children enrolled in ECCE by sub-national region (number of)	✓
Average per student-to-teacher ratio in public ECCE	X
Is ECCE spending in education sector differentiated within education budget?	✓
Is ECD spending in health sector differentiated within health budget?	✓
Survey Data	
Indicator (MICS data, 2010)	**Tracked**
Population consuming iodized salt (%)	✓
Vitamin A Supplementation rate for children 6 -59 months (%)	✓
Anemia prevalence amongst pregnant women (%)	X
Children below the age of 5 registered at birth (%)	✓
Children immunized against DPT3 at age 12 months (%)	✓
Pregnant women who attend four antenatal visits (%)	✓
Children enrolled in ECCE by socioeconomic status (%)	✓

The GoS has taken measures to support the overhaul and scale up of country data collection system. In the Education Policy (2011), the MoET stresses the importance of more up-to-date data in order to more easily share data across ministries and work multi-sectorally in addressing education needs. The MoET also puts forth short and medium term strategies to address these challenges. The policy describes as one of its strategies the assurance of an accurate and readily available database of teacher appointments and assignments in order to better manage supply and demand of teachers and ensure an equitable distribution of teachers throughout Swaziland. Also included in the Policy is an entire section outlining the challenges and strategies for the Education Management Information System (EMIS). The MoET has put in place strategies to ensure that EMIS collects timely and accurate data, as well as to ensure enhanced training for the data technical team responsible for data collection.

Other government ministries also describe the need for enhanced data collection systems. The Deputy Prime Minister's Office, through the National Disability Policy, also seeks to enhance data collection systems in order to ensure more timely and accurate data. The National Guidelines on Infant and Young Child Feeding includes a chapter on the importance of monitoring and evaluation for appropriate implementation of the guidelines. In order to assess the effectiveness of the dissemination strategies, the MoHSW proposes a data collection method that will collect and review indicators and assist in informing the future of programs currently in place.

Policy Lever 3.2: Quality Standards

Established

Ensuring quality ECD service provision is essential. A focus on access – without a commensurate focus on ensuring quality – jeopardizes the very benefits that policymakers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children[7].

Registration and accreditation procedures for ECCE centers are established in Swaziland. The MoET's ECCE Guidelines are a compilation of information regarding the registration procedures and standards for operating ECCE centers. The document describes the registration procedures and application requirements for the various types of ECCE centers, including: daycare centers, preschools, grade 0, and aftercare programs. The guidelines list the required standards for ECCE centers to operate on either one of two levels with the requirements to obtain a level 2 (more established) permit. Table 13 presents operating guidelines for ECCE center by level. ECCE center requirements include a PTR (pupil-teacher ratio) of 15:1 for 3 to 4 year olds; qualifications for ECCE providers including ECCD training, referral and previous ECCD training; recommended use

[7] Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et al, 2011V; Victoria et al, 2003

of MoET ECCD Unit curriculum; and creation of ECCD center committee and participation of parents in committee.

If after one year of provisional registration, the ECCE center is deemed by an inspector to have met all standards and guidelines, the center will be offered a certificate of official registration. It is mandatory that teachers be recruited from the center's surrounding community and undergo in-service training if they have no prior training. Eventually the MoET plans to phase out in-service training and replace with more accessible pre-service training for new teachers.

Table 13: Operating guidelines for ECCE centers

Requirements	Level 1	Level 2
Classrooms	Enclosed room, minimum size of 6x8 meters (1) floor, roof, windows; (2) clean; (3) well ventilated; (4) some appropriate furniture	Building with classrooms (1) floor (with mat), roof, windows, doors; (2) minimum 8x6 meters for 25 children; (3) clean; (4) well ventilated structure; (5) child-size chairs and tables; (6) accessible to children with special needs (e.g., ramps, rails)
Toilets/ Latrines	More than one toilet- at least one for girls and one for boys, and one for teachers (1) safe; (2) clean; (3) latrines minimum 2 meters deep and 10 meters away from source of water. Clear path to toilets	Age appropriate toilets (1) preferably flush toilets; (2) safe; (3) clean; (4) at least one to cater for children with special needs; (5) toilets for boys and others for girls, and one for teacher
Feeding	One balanced meal per day in centers that operate half day, and an additional snack for centers that operate a full day (1) high standards of cleanliness and hygiene	One balanced meal per day in centers that operate half day, and an additional snack for centers that operate a full day (1) high standards of cleanliness and hygiene

Policy Lever 3.3: Compliance with Standards

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

The MoET has developed mechanisms to ensure compliance with standards for ECCE centers and their managing member(s), but has yet to implement the mechanisms. Included in the ECCE guidelines is a list of strategies used by the MoET, other government ministries, and local governments and councils to evaluate ECCE centers and ensure their compliance with standards. Strategies include:

- Relevant ministries will carry out a baseline survey before any ECCE news programs are launched.
- All ECCE Centers and training institutions shall be assessed for quality assurance at least once a year by the governing board.
- ECCE regional Inspectors & trainers will monitor activities in all ECCE and day care centers in their regions.
- ECCE personnel, in collaboration with the Steering committee, will periodically evaluate the ECCE program in the regions in order to identify main strengths, challenges, and emerging issues.

Both state and non-state ECCE centers are required to comply with standards. Yet to date, information on ECCE center compliance with standards are not tracked. National and local officials have not collected the necessary information. To date, no data are available to indicate whether ECCE teachers are being trained, or whether they are going through the required pre or in-service trainings.

Policy Options to Monitor and Assure ECD Quality in Swaziland

Data Availability:

- **The GoS could consider enhancing local capacity building initiatives.** Swaziland has long struggled with both availability and quality of data. The MoHSW has in the past, successfully employed grassroots initiatives to address data collection issues for the AIDS epidemic. Box 5 describes a grassroots initiative that was successful in improving data collection techniques. The GoS should mobilize local efforts to assist with the data collection processes. Such efforts can include capacity building workshops for training of data collection and analysis officers. Each government agency should tailor efforts based on data needs.

Quality Standards

- **The MoET could enhance infrastructure and service delivery standards for ECCE facilities in Swaziland.** Current standards for ECCE facilities, including PTR, required minimum number of hours of preprimary per week, and infrastructure standards have been developed but could be further enhanced to optimize quality of services. For example the required PTR should be capped at 15 to 1 (preferably less) to allow for more effective student-teacher interaction and attention. Infrastructure standards are also limited and should be expanded to include access to a potable water source and functional hygienic facilities.

Compliance with Standards

- **The GoS could consider developing an appropriate monitoring mechanism to ensure ECCE centers are complying with set standards**. Swaziland has established registration and accreditation procedures for all types of ECCE service providers. It would be useful to also develop a standardized monitoring and evaluation system for ECCE centers that can be administered by auditing officials. This will ease both tracking and transfer of data and assist in disbursing information to the appropriate office. Status of ECCE provision as well as gaps in provision will be more readily available, ensuring that the MoET can address needs and issues as they arise. Box 6 describes examples from different countries on innovative ways to monitor and assure quality in ECCE services.

Box 5: Example of local community response to data unavailability

In 2003, responding to the widespread and ever-increasing AIDS epidemic and the inaction on behalf of the MoHSW, local communities took it upon themselves to mobilize. Local officials formed the Total Community Mobilization Program, a grassroots initiative with the goal to support donors and support groups by collecting as much information as possible on households coping with relatives who have HIV/AIDS. Local community officials were responding to lack of AIDS containment efforts that had been hindered by lack of reliable data. Data collectors were trained on data collection methods and working with families.

Box 6: Relevant lessons from international experiences in monitoring and assuring quality

Example from Mexico: The Government of Mexico created the Quality Schools Program (*Programa Escuelas de Calidad)* in 2001 to promote community participation in schools and allow local stakeholders to address the needs of the schools. The national government provides school grants to local committees to improve school quality. Committees are also provided technical assistance in designing, implementing, and monitoring their quality improvement plans. Parents increased their participation and supervision of the schools and teachers after participating in this program.

Example from Indonesia: Introduced in 2007 by the Indonesia Ministry of Home Affairs, the National Community Empowerment Program in Rural Areas (PNPM) provides community planning and block grants to increase demand for maternal and child health services and preprimary education. Communities are mobilized to expand ECED services, including parental education, nutrition counseling, and access to preprimary education. The Indonesian program has positively impacted health and education outcomes for young children and could serve as an exemplary first step in Vanuatu in strengthening and coordinating quality ECD services across sectors.

Source: *Decentralized Decision-Making in Schools,* Barrera-Osorio et al., 2009;
Indonesia's PNPM Generasi Program, Olken et al., 2011

Comparing Official Policies with Outcomes

The existence of laws and policies alone do not always guarantee a correlation with desired ECD outcomes. In many countries, policies on paper and the reality of access and service delivery on the ground are not aligned. Table 14 compares ECD policies in Swaziland with ECD outcomes.

Table 14: Comparing ECD policies with outcomes in Swaziland

ECD Policies	Outcomes
Law complies with some provisions of the International Code of Marketing of Breast Milk Substitutes →	Exclusive breastfeeding rate (> 6 mo): **44%**
Swaziland has national policy to encourage the iodization of salt →	Household iodized salt consumption **52% %**
Preprimary school is not free or compulsory in Swaziland →	Preprimary school enrollment: **23 %**
Young children are required to receive a complete course of childhood immunizations →	Children with DPT (12-23 months): **91 %**
Policy mandates the registration of children at birth in Swaziland →	Completeness of birth registration: **50%**

Preliminary Benchmarking and International Comparison of ECD in Swaziland

Table 15 presents the classification of ECD policy in Swaziland within each of the nine policy levers and three policy goals. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges.

On the following page, Table 16 presents the status of ECD policy development in Swaziland alongside a selection of countries worldwide.

Table 15: Benchmarking Early Childhood Development Policy in Swaziland

ECD Policy Goal	Level of Development	Policy Lever	Level of Development
Establishing an Enabling Environment	●●○○	Legal Framework	●●○○
		Inter-sectoral Coordination	●●○○
		Finance	●○○○
Implementing Widely	●●○○	Scope of Programs	●●○○
		Coverage	●●○○
		Equity	●●○○
Monitoring and Assuring Quality	●●○○	Data Availability	●○○○
		Quality Standards	●●●○
		Compliance with Standards	●○○○
Legend:	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●

Table 16: International Classification and Comparison of ECD Systems

ECD Policy Goal	Policy Lever	Level of Development				
		Swaziland	Chile	Liberia	Turkey	Uganda
Establishing an Enabling Environment	Legal Framework	●●○○	●●●●	●○○○	●●●●	●●○○
	Coordination	●●○○	●●●●	●●○○	●●○○	●●○○
	Finance	●○○○	●●●●	●○○○	●●○○	●○○○
Implementing Widely	Scope of Programs	●●○○	●●●●	●●○○	●●●○	●●○○
	Coverage	●●○○	●●●○	●●○○	●●○○	●●○○
	Equity	●●○○	●●○○	●○○○	●●○○	●○○○
Monitoring and Assuring Quality	Data Availability	●○○○	●●●○	●○○○	●●○○	●●○○
	Quality Standards	●●●○	●●●○	●○○○	●●●○	●●○○
	Compliance with Standards	●○○○	●●●○	●○○○	●●○○	●○○○
Legend:	Latent ●○○○	Emerging ●●○○		Established ●●●○		Advanced ●●●●

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities for further development of effective ECD systems. This Country Report presents a framework to compare Swaziland's ECD system with other countries in the region and internationally. Each of the nine policy levers are examined in detail and some policy options are identified to strengthen ECD are offered.

Table 17 summarizes the key policy options identified to inform policy dialogue and improve the provision of essential ECD services in Swaziland.

Table 17: Summary of policy options to improve ECD in Swaziland

Policy Dimension	Policy Options and Recommendations
Establishing an Enabling Environment	• Development and implementation of an ECD multi-sectoral policy. • Definition of the roles and responsibilities of the ECD coordinating body, NCCU. • Consideration of increased ECD budget allocations in order to better meet the services of children and mothers.
Implementing Widely	• The GoS could support and effectively promote early learning initiatives in the country. • The GoS could continue to scale up programs such as the ART and PMTCT in order to provide services for more families in need. • The GoS could consider scaling up maternal health services and programs • The GoS could consider enhancing services in rural and poorer neighborhoods. • The Deputy Prime Minister's Office, together with relevant ministries, could consider enhancing their single education system that is supposed to be inclusive of the needs of all learners in order to address the wide disparities in educational provision for children with disabilities
Monitoring and Assuring Quality	• The GoS could consider revamping the data collection units housed within respective government ministries as well as support mobilization of local communities. • The GoS could consider formalizing the registration and accreditation procedures by monitoring standards to evaluate whether ECCE centers are complying with the standards. • The MoET, along with the relevant government National and local government ministries, should ensure compliance with standards.

Acknowledgements

This Country Report was prepared by the SABER-ECD team at the World Bank headquarters in Washington, DC. The report presents country data collected using the SABER-ECD policy and program data collection instruments and data from external sources. The report was prepared in consultation with the World Bank Human Development Swaziland team and the Government of Swaziland. For technical questions or comments about this report, please contact the SABER-ECD team (helpdesk@worldbank.org)

Acronyms

ANC Antenatal Care
ART Antiretroviral Therapy
ECD Early Childhood Development
ECCD Early Childhood Care and Development
ECCE Early Childhood Care and Education
EMIS Education Management Information System
GoS Government of Swaziland
HIV Human Immunodeficiency Virus
MICS Multiple Indicator Cluster Survey
MoET Ministry of Education and Training
Mohs Ministry of Health and Social Welfare
NCCP National Center for Children in Poverty
NCCU National Children's Coordination Unit
NPAOVC Social Protection for Orphans and Vulnerable Children
OVC Orphans and Vulnerable Children
PMTCT Preventing Mother to Child Transmission
PTR Pupil-Teacher Ratio
SELDS Swaziland Early Learning Development Standards
SPOVC Social Protection for Orphans and Vulnerable Children
SNCP Swaziland National Children's Policy
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
WHO World Health Organization

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The **Systems Approach for Better Education Results (SABER)** initiative produces comparative data and knowledge on education policies and institutions, with the aim of helping countries systematically strengthen their education systems. SABER evaluates the quality of education policies against evidence-based global standards, using new diagnostic tools and detailed policy data. The SABER country reports give all parties with a stake in educational results—from administrators, teachers, and parents to policymakers and business people—an accessible, objective snapshot showing how well the policies of their country's education system are oriented toward ensuring that all children and youth learn.

This report focuses specifically on policies in the area of Early Childhood Development.

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