



Mauritius

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2012

Policy Goals

Status

1. Establishing an Enabling Environment

Laws to promote the health and nutrition of women and children in Mauritius are generally strong but there are clear areas for improvement. The GoM has a strategy and implementation plan for preprimary education, and mechanisms for multi-sectoral cooperation between the essential sectors of education, social protection, health, and nutrition.

Established



2. Implementing Widely

There is wide scope and coverage of ECD services in Mauritius. Access to health and education is generally high and equitable, although more data are needed to fully assess this.

Advanced



3. Monitoring and Assuring Quality

Mauritius collects many administrative data relevant to ECD, but could expand the survey data it collects. Standards for ECCE teacher qualifications, service delivery and facilities are established, though these standards are not always met and enforced, particularly in private childcare centers.

Established



This report presents an analysis of the Early Childhood Development (ECD) programs and policies that affect young children in Mauritius. This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework¹ and includes analysis of early learning, health, nutrition and social and child protection policies and interventions in Mauritius, along with regional and international comparisons.

Mauritius is a small island nation in the Indian Ocean situated approximately 2,000 kilometers east of the African continent. It has a population of 1.25 million, including 173,000 children below the age of 7. The Ibrahim Index of African Governance ranked Mauritius first overall in 2012, and second in human development. Its GDP per capita in 2010 was USD 13,671. The country has near universal enrollment in preschool. The Government of Mauritius (GoM) runs free public preschools, and gives cash transfers to private schools for every child enrolled. The GoM offers free public healthcare, including essential health and nutrition services for pregnant women and young children. The Ministry of Gender, Family Welfare and Child Development is responsible for coordinating ECD policies and programs for pregnant women and children from birth to age 2 across several government ministries, while the Early Childhood Care and

Education Authority is responsible for coordinating policies and programs affecting children age 3-5. While the GoM has implemented important ECD policies and programs, some aspects of the legal framework and systems to monitor and assure quality could be improved.

SABER – Early Childhood Development

SABER – ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multisectoral 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.

| Snapshot of ECD Indicators in Mauritius with Regional Comparison | Mauritius | Kenya | Seychelles | Tanzania | Uganda |
|--|-----------|-------|------------|----------|--------|
| Infant Mortality (deaths per 1,000 live births) | 13 | 55 | 12 | 50 | 63 |
| Under-5 Mortality (deaths per 1,000 live births) | 15 | 85 | 14 | 76 | 99 |
| Maternal Mortality Ratio (deaths per 100,000 births) | 22 | 490 | 57 | 450 | 440 |
| Gross Preprimary Enrollment Rate (36-59 months, 2010) | 96% | 52% | 102% | 33% | 14% |
| Birth registration 2000-2010 | 100% | 60% | N/A | 16% | 21% |

Source: UNICEF Country Statistics, 2010

¹SABER-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.

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? | |
|--|--|
| Healthcare | |
| <ul style="list-style-type: none"> • Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits | |
| Nutrition | |
| <ul style="list-style-type: none"> • Breastfeeding promotion • Salt iodization • Iron fortification | |
| Early Learning | |
| <ul style="list-style-type: none"> • Parenting programs (during pregnancy, after delivery and throughout early childhood) • High-quality childcare, especially for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms) | |
| Social Protection | |
| <ul style="list-style-type: none"> • Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation and 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 | |
| <ul style="list-style-type: none"> • 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 | |

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

As presented in Figure 1, SABER-ECD presents three core policy goals that countries should address to

ensure optimal ECD outcomes: *Establishing an Enabling Environment, Implementing Widely and Monitoring and Assuring Quality*. For each policy goal, a series of policy levers, upon which decision-makers can act in order to strengthen ECD are identified.² Improving ECD requires an integrated approach to address all three goals.

Strengthening ECD policies can be viewed as a continuum; as described in Table 1, countries can range from a latent to advanced level of development within the different policy levers and goals.

²These policy goals were identified based on evidence from impact evaluations, institutional analyses, and a benchmarking exercise of top-performing systems. For further information see “Investing Early: What Policies Matter” (forthcoming).

Figure 1: Three core ECD policy goals

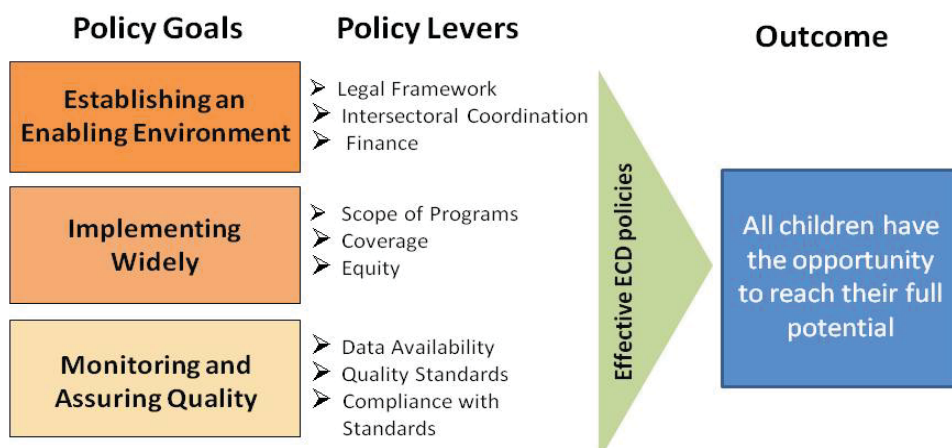


Table 1: ECD Policy Goals and Levels of Development

| ECD Policy Goal | 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.³ 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



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 and parents and caregivers.

Mauritius has not adopted sufficient national laws and regulations to promote appropriate dietary consumption by pregnant women and young children.

Mauritius does not have a policy to fortify cereals or staples with iron or other nutrients in accordance with World Health Organization guidelines.⁴ The country also lacks a policy to encourage salt iodization. An estimated 14 percent of pregnant women in Mauritius have anemia. According to the WHO, this level of prevalence constitutes a mild public health problem. Anemia can have adverse health effects: mild anemia may impair work productivity, and severe cases can increase risk of maternal and child mortality. While the GoM provides iron and folic acid supplements to pregnant women, more could be done to ensure that populations at risk of anemia are receiving adequate iron. Iron and other nutrient consumption will likely be higher among women, girls, and young children if these nutrients are added to food staples so that they are

regularly consumed without having to alter diets or take supplements.

Mauritius could adopt policies to encourage exclusive breastfeeding during a baby's first six months.

Mauritius has not enshrined in law the International Code of Marketing of Breast Milk Substitutes, an international health policy framework for breastfeeding promotion adopted by the WHO. According to UNICEF, as of April 2011, the GoM had formed a committee to study the feasibility of implementing the Code. The percentage of infants in Mauritius who are exclusively breastfed the first six months of life is not known. Breast milk provides nutrients and antibodies essential for babies' development that are not found in milk substitutes. Breastfeeding confers a number of near term and long term health benefits, and the GoM could more actively promote the practice. In addition to implementing the International Code of Marketing of Breast Milk Substitutes, the Government could take measures such as extending maternity leave and expanding parental education and public awareness on the importance of breastfeeding.

The Government of Mauritius does not currently mandate preschool, but according to official speeches and documents, is considering doing so.

Mauritius has managed to achieve near universal enrollment in preschool through a combination of capitation grants to private preschools and provision of public preschools. The GoM is considering mandating preschool attendance for children starting at age 3. Several government strategy documents articulate a desire for mandatory preschool, and the Government is weighing a number of legal and practical issues as it considers when and/or how to implement such a policy.

National laws mandate the provision of healthcare for pregnant women and young children.

According to the Ministry of Health and Quality of Life (MoH), the Government mandates that young children receive a full course of immunizations and attend regular well-child visits. As an incentive, the Government deposits a cash voucher worth Rs 200 (approximately USD 6) at a post office savings account on a child's first, second, and third birthdays upon completing the visits. Pregnant women are required to be screened for HIV/AIDS and sexually transmitted diseases, and referrals for services are made for women in need. Healthcare is free for all citizens at public providers. Some middle and upper income Mauritians pay for private healthcare through

³Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005.

⁴The WHO Recommendations on Wheat and Maize Flour Fortification include fortification with iron, folic acid, zinc, Vitamin B12, and Vitamin A.

insurance plans, as there is a perception that the quality is better than the public health system.

National laws promote opportunities for parents to provide care to newborns and infants in their first year of life, but could be strengthened. Under the Labour Act of 1975, women are entitled to 12 weeks of paid maternity leave, provided they have been working continuously at their current place of employment for at least one year. Fathers receive five days of paid paternity leave. These provisions apply to both public and private sector employers. Employers must provide nursing mothers with breaks for breastfeeding. The Equal Opportunities Bill of 2005 prohibits discrimination based on pregnancy or family responsibility.

Table 2 presents information on parental leave policies in select countries in East Africa and the Indian Ocean region. Other countries in the region offer longer paid maternity leave than Mauritius. Kenya leads the region, offering 90 days of maternity leave and five days of paternity leave. Due to the large informal economies in many countries in the region, these policies may not

actually apply in practice to the many parents working in the informal sector. Table 3 summarizes parental leave policies in several countries classified by the World Bank as upper middle income, a category that includes Mauritius. These countries offer substantially longer maternity leave than Mauritius.

Mauritius could consider increasing the amount of maternity and paternity leave to allow parents adequate time to care for their newborns and infants and to ease the transition back to the workplace. Sweden's policy (described in Box 2) is often viewed as model due to the amount of leave, flexibility, and financial support for both mothers and fathers. While it may be unrealistic for Mauritius to extend its parental leave policy to the scope of that offered in Sweden, it could draw on Sweden's model by taking measures such as extending the amount of leave offered to mothers, offering more paternity leave to fathers, offering the option to divide family leave between mothers and fathers, and granting leave to parents of young children with illness or disability.

Table 2: Regional Comparison of Parental Leave Policies

| Mauritius | Kenya | Seychelles | Tanzania |
|--|---|---|---|
| 60 days paid maternity leave at 100% wage, paid by employer; 5 days paid paternity leave, paid by employer | 90 days paid maternity leave at 100% wage, paid by employer; five days paid paternity leave, paid by employer | 70 days paid maternity leave at 100% wage, up to 4 weeks of unpaid leave; no paid or unpaid paternity leave | 84 days of paid maternity leave at 100% wage, paid by employer; three days of paternity leave, paid by employer |

Table 3: Comparison of Parental Leave Policies in Several Upper Middle Income Countries

| Mauritius | Chile | Latvia | Turkey |
|--|--|---|---|
| 60 days paid maternity leave at 100% wage, paid by employer; 5 days paid paternity leave, paid by employer | 126 days paid maternity leave at 100% wage, paid by the government; 5 days paid paternity leave at 100% wage, paid by the employer | 112 days of maternity leave at 80% wage, paid by the government; 10 days of paternity leave at 80% wage, paid by the government | 112 days of maternity leave at 66% of wage, paid by the government; plus 180 days of unpaid maternity leave; no paid or unpaid paternal leave |

Box 2: Relevant lessons from Sweden's Parental Leave Policy

Summary: The *Swedish Parental Insurance Benefit* is the international exemplar for parental leave policy. Parental Insurance in Sweden is designed to benefit both men and women. In total, the leave includes 480 days of paid leave, 60 days of which are earmarked for the mother, 60 days for the father, and the remainder to be divided as the couple chooses. It commences up to seven weeks prior to the expected birth, and also is available for parents adopting a child. The compensation rate can vary; as a minimum, however, 80 percent of the employee's salary is provided during leave. In addition, each parent is legally entitled to take unpaid leave until a child is 18 months old. Additional benefits include: temporary parental leave, which entitles a parent 120 days of parental leave annually to care for children below the age of 12 with illness or delay (child requires a doctor's certificate); a pregnancy benefit, payable for a maximum of 50 days to expectant mothers who are unable to work because of the physically demanding nature of their jobs; and, pension rights for childcare years, which partially compensate the loss of future income during the period when the parent is at home with the child.

Key considerations for Mauritius:

- ✓ Mandated paternity leave recognizes the crucial role fathers play in young children's development
- ✓ Adequate, sustainable financial support to support families during early stage of child's life
- ✓ Additional benefits for families with children who have special needs

(Source: Information on Swedish parental leave: www.forsakringskassan.se)

National laws promote child protection and care for vulnerable children. The Civil Status Act of 1981 established procedures for the registration of all births in Mauritius. The Civil Status Office gives a unique identification number to each citizen upon birth registration. Mauritius has universal birth registration so these procedures are clearly working effectively – given very low levels of birth registration in most countries in the region, this success is particularly notable.

Children with disabilities have legal rights to ECD services in education, health, and social protection. A legal right to nutrition services is not specified. Additional details about the status of children with special needs and disabilities are included in this report in section Policy Lever 2.3: Equity.

Mauritius has numerous policies in place to provide services to orphans and vulnerable children. The Ministry of Social Security (MoSS) offers monthly cash assistance to poor families with children below the age of ten. Through the National Empowerment Foundation, the Ministry of Social Integration and Economic Empowerment (MoSIEE) operates free childcare centers for families below a certain income level. The Child and Family Development Program, formerly called the Eradication of Absolute Poverty Program, provides food, clothing and other materials to preprimary age children; job training for their parents;

and psychological support and counseling for children and parents. Orphans and abandoned children often live in residential care institutions if they cannot be placed with foster families. According to the Ombudsperson for children, the conditions at these institutions are poor and need urgent attention.

Within the Ministry of Gender, Child Development and Family Welfare (MoGCDFW), the Child Development Unit (CDU) is responsible for a number of child protection services and ECD programs. In accordance with the Child Protection Act of 1995, the CDU works with the police to investigate incidents of abuse, provides shelter for abused children, and offers therapy and family counseling.

An Ombudsperson for Children monitors conditions in the country for compliance with the UN Convention on the Rights of the Child. The Ombudsperson issues an annual report to the President of Mauritius. Mauritius could improve the judicial system's capacity to handle child protection cases by offering training for judges, lawyers, and law enforcement officers on interacting with children; establishing special courts for children; and creating a child advocacy body.

Box 3. Key Laws and Regulations Governing ECD in Mauritius

- Mauritius ratified the UN Convention on the Rights of the Child in 1990.
- Mauritius ratified the African Charter on the Rights and Welfare of the Child (1999).
- The Child Protection Act (2000) created laws, mechanisms and services to protect children from abuse.
- The Institution for Welfare and Protection of Children, Regulations 2000, regulates standards at day care centers.
- The Early Childhood Care and Education Authority Act (2008) established the body responsible for designing and coordinating ECD policy for 3-5 year olds.

Policy Lever 1.2: Intersectoral Coordination

Established



Development in early childhood is a multi-dimensional process.⁵ 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.

Mauritius has multi-sectoral ECD policies, but could clarify its strategies and plans. Mauritius's ECD policies were primarily established in the Child Protection Act of 2000 and the Early Childhood Care and Education Authority Act of 2008. These pieces of legislation cover the essential ECD sectors of education, social protection, health and nutrition. The Government laid out an early childhood care and education (ECCE) strategy and plan in the Education and Human Resources Strategy Plan 2008-2020, building off of the National ECD Plan presented in 1998. This strategy document takes a multi-sectoral approach, and includes health and social protection elements, but its main emphasis is on education in preprimary schools. It is recommended that there is a current, detailed ECD

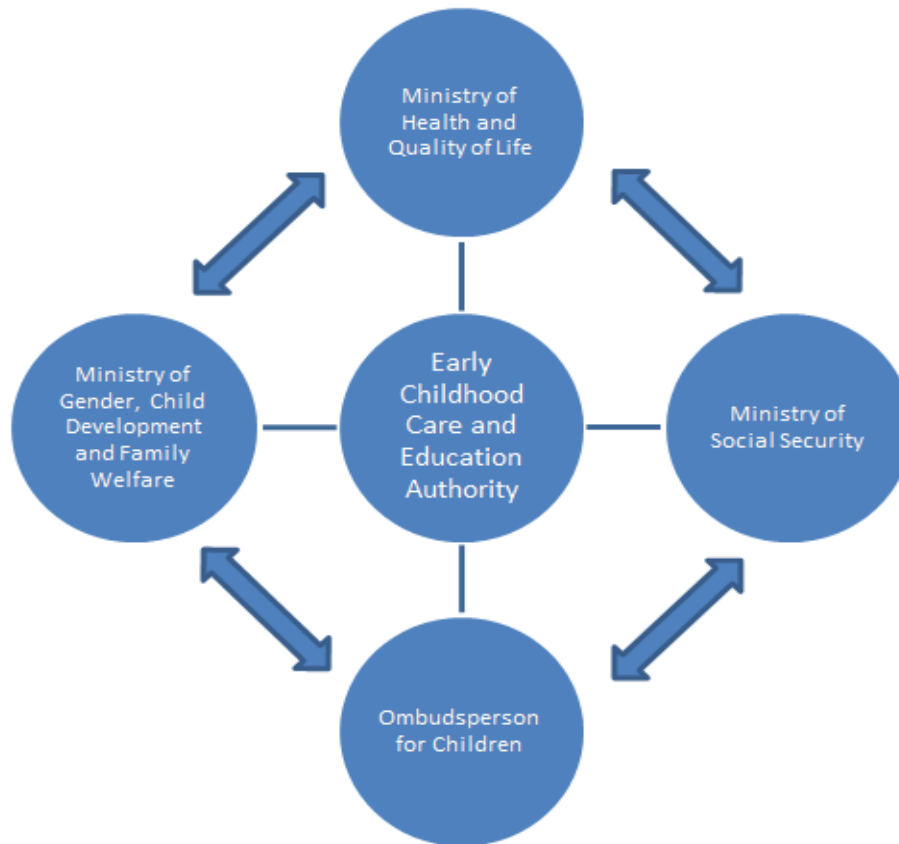
strategy plan incorporating education, health, nutrition, and social protection, giving adequate consideration to each sector. The Government could strengthen the impact of its many ECD programs by making the strategy and implementation more explicitly multi-sectoral. Box 3 describes the development and implementation of a successful multi-sectoral ECD policy in Chile. The policy development process involved all stakeholders, which promoted buy-in, clarified each stakeholder's responsibilities, and ensured coordination.

Mauritius has established institutional anchors to coordinate ECD across sectors. The Early Childhood Care and Education Authority (ECCEA) coordinates early childhood care and education policies and programs for children age 3-5 in Mauritius. The ECCEA was established under the ECCEA Act of 2008, and replaced the Pre-School Trust Fund as the country's lead body on ECD. It is lodged within the MoGCDFW. The ECCEA is responsible for registration and supervision of ECCE facilities for children age 3-5, setting standards, and administering grants to ECCE institutions. It also operates 186 public preschools and implements a number of other ECD programs.

Through monthly meetings with representatives from other ministries and bodies, the ECCEA coordinates on issues related to education, health, nutrition, and social protection. Responsibility for implementing ECD services lies across several ministries and government bodies, including the MoH, the MoSS, the MoGCDFW, and the Ombudsperson for Children. Figure 2 illustrates the ECCEA's coordinating role between these bodies.

The Child Development Unit (CDU), also within the MoGCDFW, is responsible for coordinating issues related to pregnant women and children below 3 years old. The CDU also runs many of the country's social protection programs, and sets standards and registration procedures for childcare centers. It is unclear the extent to which the CDU coordinates regularly with all of the institutions concerned with ECD policies and programs for pregnant women and children below age 3 and information pertaining to violence, abuse, and maltreatment of children in the 3-5 age group are shared and discussed with the ECCEA. Improved coordination between the CDU and ECCEA could help to ensure seamless coverage for children. Coordination between the CDU, the ECCEA, and all other bodies in the GoM relevant to ECD is crucial to

⁵Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005.

Figure 2: Intersectoral coordination for ECD policies and programs for children age 3 to 5

ensure integrated services and the most efficient use of resources.

There are mechanisms to support collaboration between state and non-state ECD stakeholders. According to the ECCEA charter, non-state stakeholders must be represented on the ECCEA board. The board must include two representatives of parents' organizations or NGOs involved in promoting services for young children and one representative of managers of private registered educational institutions. Other board members include state officials and one government-appointed ECD expert. It is not clear if non-state stakeholders consult regularly with the CDU, which is responsible for policies concerning pregnant women and children below the age of 3.

ECD interventions are coordinated at the point of service delivery. Sub-national governments and local municipalities are also responsible for implementing ECD services. There is an established menu of ECD services, and procedures in place for referrals to additional interventions for parents, pregnant women and children who need them. For example, children not reaching development milestones are referred to specialists for support services, and parents identified as at-risk are referred for participation in parenting programs.

Box 4: The Chilean Experience: Benefits of Multisectoral Policy Design and Implementation

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 can be 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 percent of households 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 multisectoral, 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 the Mauritius:

- Multisectoral policy that articulates responsibilities for each government entity
- Highly synergistic approach to service delivery
- Policy developed with input from all levels of government

Policy Lever 1.3: Finance

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.⁶ 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

The budget allocation process for ECD uses explicit criteria, but not a clear formula. ECD spending is

tracked in education and social protection, but not in nutrition or health. The Mauritian State Budget is determined according to performance based budgeting, which ties funding to specific programs that are closely monitored in order to reach target outcomes. Budget allocations to ECD are determined by the central government, and are allotted to the various government bodies associated with the sector, including the ECCEA, the MoGCDFW, the MoH, the Ministry of Social Security (MoSS), the Ministry of Social Integration and Economic Empowerment (MoSIEE), and the National Empowerment Foundation. The ECCEA coordinates across ministries on ECD plans and policies, but does not have the authority to coordinate budgets across ministries. There does not seem to be any legislation that guarantees a minimum level of funding for ECD.

ECCE allocations are determined taking into account criteria such as the number of teaching positions, geographic location, construction of new schools, and renovation of existing schools. However, there is no clear formula to determine how funding is allocated.

⁶Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek & Luque, 2013.

Education allocations take into account children's characteristics, such as socioeconomic status and special needs. In order to ensure adequate resources for schools that may serve large numbers of children requiring extra support, the budget process could take into account the background characteristics of the children at each institution. In social protection, early childhood allocations are informed by the number of children covered and the characteristics of those children. There are clear criteria to determine early childhood allocations in health and nutrition. In all sectors, the GoM uses explicit criteria to determine both national budgets and sub-national allocations. This promotes transparency and efficient use of resources, increasing the likelihood of funding going to where it is most needed.

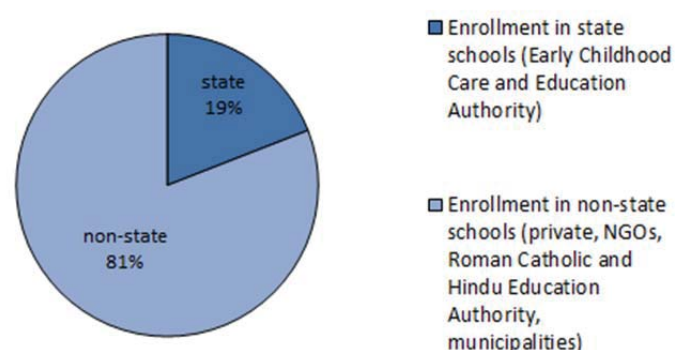
Information on ECD expenditure on education and social protection is available, but there is currently no way to disaggregate health and nutrition spending on ECD within sector spending as a whole. The GoM could put in place budgeting and information systems to allow for identification of ECD-specific spending within health and nutrition budgets.

The burden of finance for ECD services is distributed equitably across society. Nearly all childcare centers for children below age 3 in Mauritius are private. Low income families receive monthly allowances to pay for childcare services.

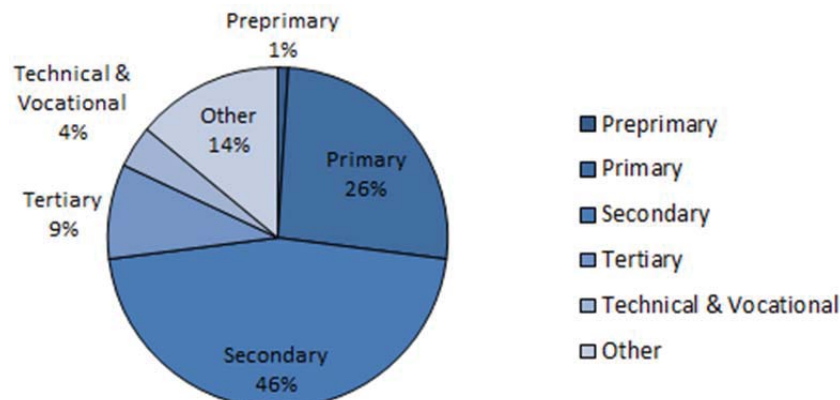
Currently, 76 percent of preschool institutions (for children age 3-5) are private, 24 percent are public and run by the ECCEA, and the remainder are run by religious institutions or municipalities. Figure 3 shows the proportion of children attending state and non-state preschools. The GoM makes a monthly payment of Rs 200 (approximately USD 6) to private preschools for each child enrolled at the school. The payment is sufficient to cover the tuition at the most inexpensive private preschools, and goes directly to the preschool manager. Monthly private preschool tuition ranges from roughly USD 6 to more than USD 100, with most schools charging between USD 20-30. Families who send their children to more expensive preschools must pay any fees above Rs 200 per month from their personal funds. The GoM gives families below a certain income level additional financial support to cover transportation, clothing, materials, and other costs associated with preschool attendance. The ECCEA also operates public preschools around the country, which

are physically attached to public primary schools. These schools do not charge fees. Families choose which school to send their children to based on proximity to their workplaces and homes and ability to pay fees. Due to the provision of public preschools and government financial support to private preschools, cost is not a barrier to access to preschool in Mauritius. Primary education begins at age 5 or 6, at which point most children attend free public primary schools. The NCF Framework Preprimary is mandatory in all preprimary schools in Mauritius, for which all educators have been trained by the MIE.

Figure 3: Enrollment in state and non-state preschools



The GoM provides free public healthcare to all citizens. This includes a range of health services for pregnant women and young children. Many Mauritians, who can afford to pay from their personal funds, use private providers for much of their healthcare. Private healthcare is viewed as higher quality than public healthcare. The level of out-of-pocket expenditures as a percentage of total health expenditures was 52 percent in 2010, which is quite high for a country with accessible, free public healthcare. Table 4 shows a regional comparison of health expenditure indicators.

Figure 4: Distribution of government expenditure on education by level**Table 4: Regional comparison of health expenditure indicators**

| | Mauritius | Kenya | Seychelles | Tanzania | Uganda |
|---|-----------|--------|------------|----------|---------|
| Out-of-pocket expenditure as percentage of all private health expenditure | 89% | 77% | 68% | 42% | 64% |
| Out of pocket expenditure as percentage of total health expenditures | 52% | 43% | 6% | 14% | 50% |
| General government expenditure on health as a percentage of GDP | 6% | 5% | 3% | 6% | 9% |
| Total expenditure on health per capita (2010, adjusted for purchasing power parity) | USD 803 | USD 78 | USD 785 | USD 83 | USD 125 |
| Percentage of routine EPI vaccines financed by government | 100% | 5% | 100% | 18% | 36% |

The level of ECD finance appears to be adequate in health, but may be inadequate in education to ensure universal high quality. Nearly 14 percent of total government expenditure in Mauritius goes towards education. Figure 4 shows the distribution of government expenditure on education. Only 1 percent of the country's education budget is allocated towards preprimary education. Almost 2 percent of Mauritius's education budget goes towards special education programs, which may include some children of preprimary age. Current funding levels are sufficient to promote near universal access, but quality remains a concern in some private preschools. Given that ECD spending within the education budget is a smaller proportion than in other sectors, the GoM could consider spending more in the sector in order to strengthen quality. As demonstrated in Table 4, government finance of early childhood health is adequate, with free universal coverage of immunizations and well-child visits.

The level of remuneration for ECCE service providers is difficult to assess and may vary widely, though official wages for qualified teachers are reasonable. The pay scale for preprimary teachers in Mauritius is between Rs 8,800 (USD 380) and Rs 17,200 (USD 535) per month for teachers without a diploma, and up to Rs 26,400 (USD 820) per month for teachers with a diploma. GNI per capita, Atlas method, in 2011 was USD 8,240. The wage for teachers with a diploma is, thus, competitive and should provide an incentive for talented individuals to enter the ECCE field and contribute to the professionalization of the sector. Many preprimary teachers at private schools do not have diplomas and are paid substantially less (starting salary is equivalent to roughly USD 4,560). Pay scales at institutions caring for children below the age of 3 are at the discretion of the employer and may be quite low.

Policy Options to Strengthen the Enabling Environment for ECD in Mauritius

Legal framework

- The GoM could consider adopting a policy to fortify staples with iron and other nutrients, and encourage salt iodization. Additionally, adopting and implementing the International Code on Marketing Breast Milk Substitutes could better promote breastfeeding in the country.
- The GoM could move forward to adopt a mandatory preschool attendance policy.
- The Government could consider extending maternity and paternity leave to promote labor participation and proper caregiving for infants. Mauritius is wealthier than other countries in the region but has shorter parental leave. A baby's need for caregiving, breastfeeding and nurturing are greatest in the early months of life. Extending parental leave could improve babies' health and development outcomes, as well as the well-being of mothers (which in turn has a strong impact on their children's well-being). The country's current length of leave is not adequate for parents to devote the time and energy to caregiving that is their necessary for children's healthy development.
- Mauritius could improve the capacity of its judicial system to protect children by offering training for judges, lawyers, and law enforcement officers on interacting with children; establishing special courts for children; and creating a child advocacy body.

Intersectoral Coordination

- Mauritius could develop a detailed ECD strategy and implementation plan that incorporates the education, health, nutrition, and social protection sectors. The current strategy guiding the country's ECD policies and programs focuses mainly on education. A multisectoral strategy can reduce duplication of efforts across sectors and maximize financial, human, and material resources.
- The institutional anchors for ECD could develop mechanisms to ensure that their policies and programs are aligned. This could help ensure program coverage and improve efficiency.

Finance

- Government budgets—particularly the MoH budget—could consider establishing systems to track ECD spending in all sectors. The current system does not distinguish ECD spending from the overall budgets for health and nutrition. The various government bodies with ECD programs could coordinate in developing their ECD budgets. This will promote coordination in service delivery, and reduce duplication of efforts.
- In order to ensure that all children attend high quality preprimary schools, the GoM could consider allocating a higher percentage of its education budget to preprimary education. The National Curriculum Framework Preprimary is mandatory in all preprimary schools and to ensure equity, all teachers are trained by the MIE. The Government could consider funding a study to examine how funding could be used more efficiently, looking at issues such as current gaps in coverage, duplication of efforts, integration of services, and coordination at the point of service delivery.

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

Established

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 5 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.

ECD programs are established to target all relevant groups of beneficiaries in Mauritius. Mauritius has a range of ECD programs established in all of the relevant sectors: education, health, nutrition, and social and child protection. Interventions are established that serve pregnant women, young children, and parents and caregivers.

The scope of programs is generally adequate but there are gaps in nutrition programs. The GoM does not seem to provide food supplements to pregnant women or young children, and lacks a food fortification policy. Despite the fact that the International Code of Marketing of Breast Milk Substitute is not enshrined in law, there are breastfeeding promotion programs with high coverage levels.

The scope of programs targeting parents and caregivers could be expanded to cover more parents of young children. Mauritius’s National Parental Empowerment Program offers several programs primarily targeted to disadvantaged families. The Parenting Education Unit launched the École des Parents (Parents’ School) in 2010. The program targets families deemed at-risk for child abuse, and teaches parenting techniques, health, nutrition, and child development. The Parents’ School is expanding at community centers and social welfare centers around the country. Mauritius may be able to expand parental education and support services for the broader parent population, in addition to its support for disadvantaged parents. This could include increased parental education on health, nutrition, and child development. The GoM could also consider adding maternal mental health screening and services into its healthcare system. Maternal depression can impede bonding between babies and their mothers, which can have far-reaching consequences on children’s development. Depression screening could be conducted during mothers’ visits to healthcare clinics for well-child visits or for their own medical care.

Figure 5: Essential interventions during different periods of young children's development

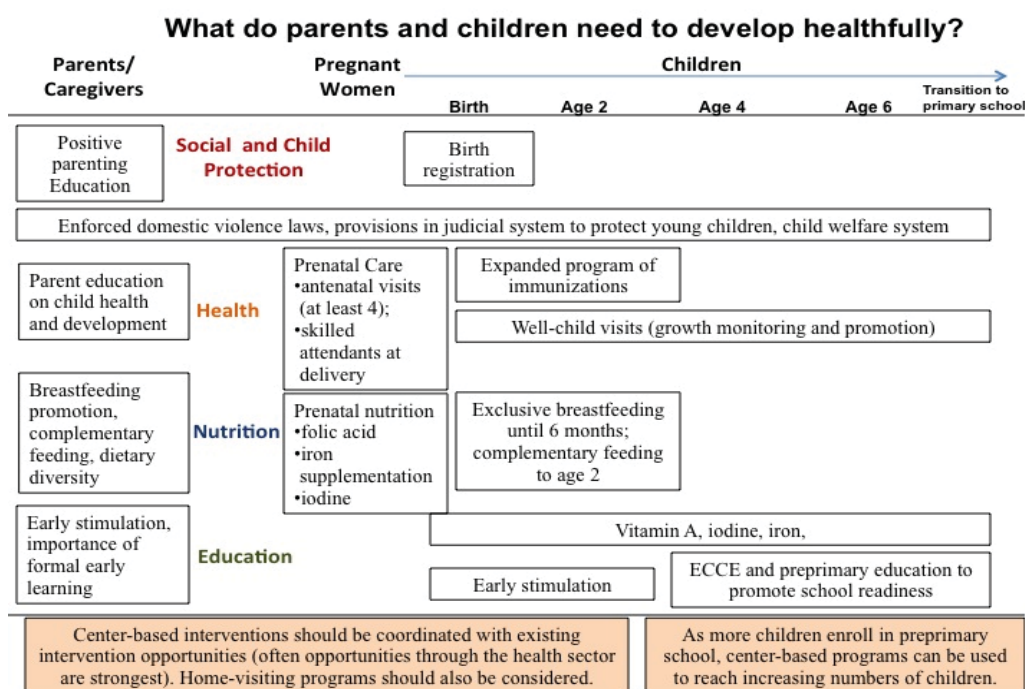
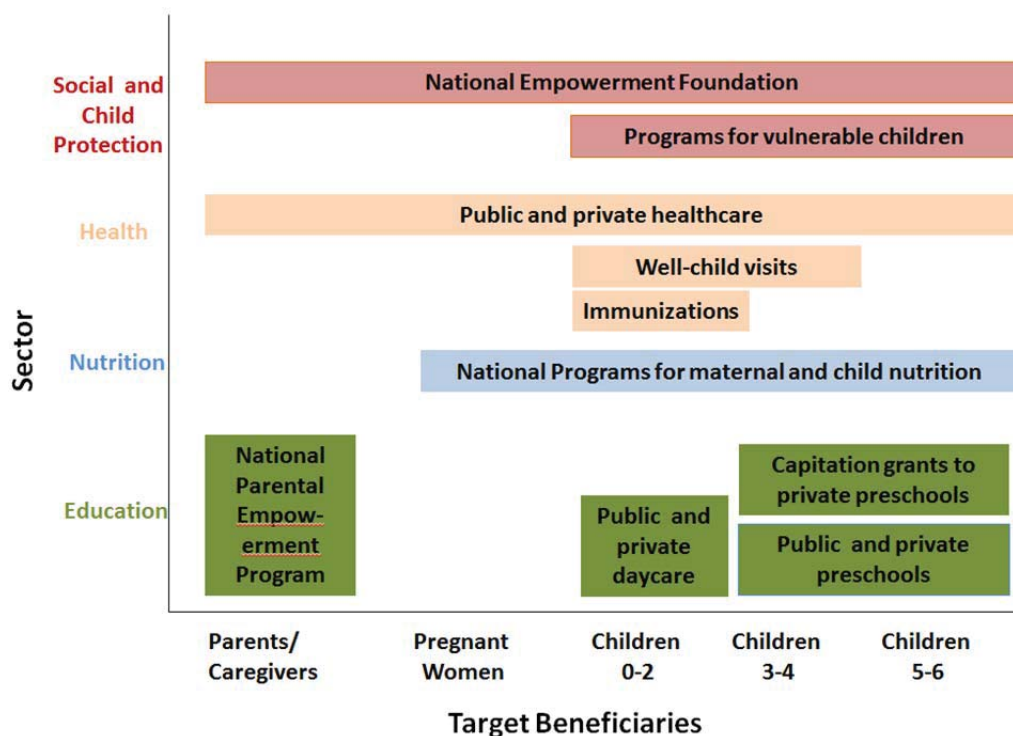


Figure 6: Scope of ECD Interventions in Mauritius by Sector and Target Population



ECD programs are established in all essential areas of focus. A variety of interventions are established in all essential areas of ECD service provision, including in health, nutrition, education, and social and child protection.

Key programs are summarized in Table 5. The table indicates that while a range of ECD interventions exist, coverage is not always universal.

Table 5: ECD Programs and Coverage in Mauritius

| ECD Intervention | Scale | |
|--|---------------------|--------------------|
| | Service is provided | Universal coverage |
| EDUCATION (stimulation and early learning) | | |
| Government-provided early childhood care and education | Yes | No |
| Privately-provided for profit early childhood care and education | Yes | No |
| Privately-provided not-for-profit early childhood care and education | Yes | No |
| Community-based early childhood education | Yes | No |
| Capacity building interventions for ECCE caregivers and teachers | Yes | Yes |
| HEALTH | | |
| Prenatal healthcare | Yes | Yes |
| Labor and delivery | Yes | Yes |
| Comprehensive immunizations for infants | Yes | Yes |
| Childhood wellness and growth monitoring | Yes | Yes |
| Capacity building intervention on quality of child health services | Yes | No |
| Maternal depression screening or services | No | No |
| NUTRITION | | |
| Micronutrient support for pregnant women | Yes | Yes |
| Food supplements for pregnant women | No | No |
| Micronutrient support for young children | Yes | Yes |
| Food supplements for young children | No | No |
| Food fortification | No | No |
| Breastfeeding promotion programs | Yes | Yes |
| Anti-obesity programs encouraging healthy eating/exercise | Yes | No |
| Feeding programs in preprimary schools | Yes | No |
| PARENTING | | |
| Parenting integrated into health/community programs | Yes | No |
| Home visiting programs to provide parenting messages | No | No |
| ANTI-POVERTY | | |
| Cash transfers conditional on ECD services or enrollment | Yes | Yes |
| SOCIAL AND CHILD PROTECTION | | |
| Programs for OVCs | Yes | Yes |
| Interventions for children with special needs | Yes | No |
| Advocacy and capacity building intervention for provision of care to children with special needs | Yes | No |
| MULTI-SECTORAL OR COMPREHENSIVE | | |
| A comprehensive system that tracks individual children's needs and intervenes, as necessary | No | No |

Source: SABER-ECD Policy Data Collection Instrument and SABER-ECD Program Data Collection Instrument

*Note: Nearly universal coverage signifies coverage rates over 95 percent

Policy Lever 2.2: Coverage⁷

Advanced



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.

Access to essential health interventions for young children seems to be high, but more data are needed to assess this fully. Access to essential healthcare interventions for young children seems to be high in Mauritius, but it is difficult to assess fully because commonly used indicators are not available. There are no data available on the percentage of children below 5 with diarrhea who receive oral rehydration and continued feeding or the percentage of children below 5 with suspected pneumonia who receive antibiotics. Though malaria has been a serious health concern in the past, the GoM has worked with international partners to successfully eradicate malaria. Data are available on the rate of DPT immunization coverage.

Pregnant women have access to essential ECD health interventions. Access to essential healthcare interventions for pregnant women seems to be high, but it is difficult to assess fully given that commonly used indicators are not available. The rates of births attended by skilled attendants and the percentage of pregnant women receiving at least four antenatal health visits are very high in Mauritius. The percentage of HIV-positive pregnant women who receive anti-retrovirals for the prevention of mother to children transmission is not available, but the HIV prevalence rate is below 1 percent, with a largely localized epidemic. Given the high level of coverage of antenatal care, it is likely that most women do receive counseling and medical care to test for HIV and prevent mother-to-child transmission. Table 6 shows available data on access to health services for young children and pregnant women in Mauritius and several other countries in the region. The table makes clear the gaps

in data collection in Mauritius. Section 3.1 of this report discusses data collection in more detail.

The level of access to essential ECD nutrition interventions for young children and pregnant women is unclear; more data are needed to assess this fully. Several indicators used in the SABER-ECD analysis to gauge access to essential ECD nutrition interventions for young children and pregnant women are unavailable, including the percentage of children who are exclusively breastfed below the age of six months, the percentage of the population that consumes iodized salt, childhood stunting and anemia rates, and the vitamin A supplementation coverage rate for young children. According to policy, nutrition supplements are offered to all pregnant women, and to children identified as nutritionally deficient through regular growth monitoring and well-child visits. The percentage of pregnant women who have anemia is 14 percent, which is considered by the WHO to constitute a minor public health problem. Table 7 shows the available data for nutrition indicators in Mauritius and several other countries in the region. Kenya, Tanzania and Uganda have more data available than Mauritius and Seychelles.

Access to early childhood care and education (ECCE) in Mauritius is high. The country's gross enrollment rate in preprimary education in 2010 was 96 percent. Gross enrollment is defined as the total enrollment in a specific level of education, regardless of age, expressed as a percentage of the official school-age population corresponding to the same level of education in a given school year. It is widely used to show the general level of participation in a given level of education. The net enrollment rate in preprimary education in 2010 was 89 percent. Net enrollment is the number of students in the theoretical age group for a given level of education enrolled in that level, expressed as a percentage of the total population in that age group. Net enrollment indicates the extent of coverage in a given level of education of children belonging to the official age group corresponding to that level of education. The GoM has achieved this high enrollment rate through a combination of provision of public preschools and capitation grants to private preschools.

The Ministry of Education's Education and Human Resources Strategy Plan 2008-2020 lays out the strategic objective of making preschool compulsory for children age 3 and older from January 2013 onwards. The Government is working to identify communities

⁷In a typical SABER-ECD Country Report, this section presents administrative data collected through the Multiple Indicator Cluster Survey (MICS) which is carried out in countries, with support from UNICEF. Mauritius does not participate in MICS and alternative sources of administrative data are not available. This section presents an analysis with available data, but it is possible the level of "Coverage" in Mauritius may have been classified differently if more data were available.

Table 6: Access to essential health services for young children/pregnant women in Indian Ocean and East Africa

| | Mauritius | Kenya | Seychelles | Tanzania | Uganda |
|---|----------------|-------|------------|----------|--------|
| 1-year-old children immunized against DPT (corresponding vaccines: DPT3B) | 99% | 83% | 99% | 91% | 60% |
| Children below 5 with diarrhea receive oral rehydration/continued feeding (2006-10) | N/A | 43% | N/A | 50% | 39% |
| Children below 5 with suspected pneumonia receive antibiotics (2006-10) | N/A | 50% | N/A | N/A | 47% |
| Children below 5 sleeping under insecticide-treated net (2006-10) | Not applicable | 47% | N/A | 64% | 33% |
| Children below 5 with fever, receive anti-malarial drugs (2006-10) | Not applicable | 23% | N/A | 59% | 60% |
| Births attended by skilled attendants | 98% | 44% | N/A | 49% | 42% |
| Pregnant women receiving antenatal care (at least once) | 99% | 92% | N/A | 88% | 94% |
| HIV+ pregnant women/exposed infants receive ARVs for PMTCT | N/A | N/A | N/A | 83% | 65% |

Source: UNICEF Country Statistics, 2010

Table 7: Level of access to essential nutrition interventions for young children and pregnant women in Indian Ocean and East Africa

| | Mauritius | Kenya | Seychelles | Tanzania | Uganda |
|--|-----------|-------|------------|----------|--------|
| Children below 5 with moderate/severe stunting (2006-10) | N/A | 35% | N/A | 42% | 38% |
| Vitamin A supplementation coverage (6-59 months) (2010) | N/A | 62% | N/A | 99% | N/A |
| Infants exclusively breastfed until 6 months of age (2010) | N/A | 32% | N/A | 50% | 60% |
| Infants with low birth weight | 14% | 8% | N/A | 10% | 14% |
| Prevalence of anemia in pregnant women (2010) | 14% | 55% | 25% | 58% | 41% |
| Under-5 children with anemia | N/A | 69% | 24% | 71.8% | 64.1% |
| Population that consumes iodized salt (2006-10) | N/A | 98% | N/A | 59% | 96% |

Source: UNICEF Country Statistics, WHO Global Database on Anemia

with limited access to state preprimary facilities, construct new preprimary schools, and set up special education units in priority areas. It is not clear what legal framework will underpin mandatory preschool attendance, nor how the GoM will identify children who are not attending school.

Policy Lever 2.3: Equity

Advanced



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.⁸ One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

Boys and girls are enrolled in equal numbers in preprimary schools. Enrollment rates for boys and girls in preprimary school are nearly equivalent (97 percent and 96 percent, respectively). While the GoM reports on the number of children enrolled in preschool in each district, it does not report on the number of school-age children in each district, thus comparing enrollment rates across districts is not possible. With near universal enrollment, any differences between districts would likely be minor, yet the data could still be collected. While enrollment rates are very high, government documents suggest that those few children not enrolled in preprimary school are likely to be from the poorest families.

All of the more than 1,000 preschools in Mauritius must adhere to basic standards regulating facilities and personnel, but there may be variations in quality, particularly in private schools. While it is difficult to find quality indicators for these schools, anecdotal evidence suggests that there is a wide range in fees, facilities and

⁸Engle et al, 2011; Naudeau et al., 2011.

teacher qualifications. Tuition ranges from approximately USD 6 per month to more than USD 100 per month, with most private schools charging monthly fees of USD 20-30. Tuition is offset by the payment of capitation grants. More expensive preschools may offer expanded curriculum offerings and better facilities.

Access to ECD services is equitable between socio-economic levels and rural and urban areas. Mauritian children have equitable access to ECD services, regardless of where they live or their socio-economic background. With universal birth registration, skilled attendants at birth, and improved sanitation facilities, all children have similar access to essential health services and infrastructure. It is difficult to assess if the quality of services is consistent across urban and rural areas, and across institutions that tend to serve children from poorer or wealthier families.

Access to ECD services for special needs children may not be fully equitable but is improving. The Government of Mauritius has, in recent years, placed an emphasis on improving services for children with special needs. Currently, most young children with special needs who do attend preschool attend at specialized schools run by NGOs. However, the Government is moving towards more inclusive education practices. It is gradually making facilities accessible and including special needs education components in teacher training programs. The Mauritius Institute of Education now offers a diploma in Early Childhood Education Special Needs Education.

Policy Options to Implement ECD Widely in Mauritius

Scope of Programs

- The GoM could expand parental education programs on children's health and development. Maternal depression can have serious consequences for children's development. The GoM could consider offering maternal depression screening and services, perhaps through integrating screening into existing healthcare services attended by mothers.

Coverage

- Access to education is high, but it is difficult to fully assess the coverage of ECD programs and services in health and nutrition. The anemia rate among

pregnant women is 14 percent, which may indicate a need for more access to nutrition programs. One way to address the anemia problem is through fortification of food staples.

Equity

- Access to ECD services is generally equitable. The country could now focus on ensuring that all children have access to high quality education and health services. Children from lower income households are more likely to live in home environments that do not promote learning, making high quality preschool that much more important for poor children. The GoM could continue working to ensure that special needs children can attend preschools with the necessary facilities and staff to provide them with a quality education. In addition to being an equity issue, this is necessary to facilitate compliance with any future mandatory preschool attendance policy, if one is enacted.

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

Established



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.

Data availability on ECD access and outcomes is mixed. Table 8 presents some of the types of indicators a

Table 8: Availability of data to monitor ECD in Mauritius

| Administrative Data | |
|--|---------|
| Indicator | Tracked |
| Special needs children enrolled in ECCE (number of) | ✓ |
| Children attending well-child visits (number of) | ✓ |
| Children benefitting from public nutrition interventions (number of) | ✓ |
| Women receiving prenatal nutrition interventions (number of) | ✓ |
| Children enrolled in ECCE by sub-national region (number of) | ✓ |
| Average per student-to-teacher ratio in public ECCE | ✓ |
| Is ECCE spending in education sector differentiated within education budget? | ✓ |
| Is ECD spending in health sector differentiated within health budget? | X |
| Survey Data | |
| Indicator | Tracked |
| Population consuming iodized salt (%) | X |
| Vitamin A Supplementation rate for children 6 -59 months (%) | X |
| Anemia prevalence amongst pregnant women (%) | ✓ |
| 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 (%) | ✓ |

country can collect to assess access to ECD services and outcomes. Many important administrative data for Mauritius are available; these figures reflect total uptake of services and are gathered through a census.

The country could collect and/or make available survey data, which are based on sampling a specific population. Several important health and nutrition indicators are not available, including the percentage of the population consuming iodized salt, and the Vitamin A supplementation rate for young children. The Vitamin A supplementation rate, for example, could be determined through a survey of a representative sample of the country's young children.

The GoM could consider expanding the types of data it collects relevant to the health of young children and pregnant women as this is an essential component of informed ECD policymaking. Information can be used to modify existing ECD programs or to develop new ones in response to needs identified by data analysis. Monitoring the provision and quality of health services and outcomes will help improve and assess programs. The GoM could consider participating in UNICEF's Multiple Indicator Cluster Survey (MICS). The Survey gathers numerous data on health, education, child protection and HIV/AIDS. It allows for comparisons between citizens based on income level and geographic

location, making it an important tool for assessing equity in a country.

Mauritius monitors several domains of child development, but individual child development outcomes are not tracked. Mauritius has child development monitoring systems in place to collect and track children's physical development. Indicators of children's cognitive, linguistic and social development are also tracked. Children identified as not meeting developmental milestones are referred for support services. It is not clear that all of these outcomes are collected in a way such that all data for an individual child are accessible in one file for monitoring the holistic development of the child. Mauritius could strengthen its ability to identify children in need of support services by compiling children's development outcomes in all domains over time.

Mauritius will soon begin issuing each newborn a Child Health Passport document. The document will be updated throughout childhood with the child's health outcomes, and is intended to promote early identification and intervention for any developmental difficulties. The Health Passport system could be expanded to include cognitive, linguistic and social development outcomes. This could provide a mechanism to track individual child development from

birth into childhood, provided the data are appropriately collected and monitored.

Data are collected to differentiate outcomes by some groups, but additional data on language and ethnicity could be helpful for research and improving programs.

Mauritius collects data to differentiate access and outcomes by special populations, including by gender, special needs status, geographic area, and socio-economic background. Data are not collected on children's ethnicity or children's home language environment. Most Mauritian children do not speak English or French as their mother tongue, although these are the main languages of instruction in primary school. The language spoken in homes may include one (or more) of the following: Mauritian Creole, Hindi, Urdu, several other South Asian languages, and several Chinese languages. Given the diversity of languages spoken in the country, it could be useful to collect data on children's mother tongue to see if outcomes differ by home language.

There is speculation among some in Mauritius that poor academic achievement by some children in primary school may be linked to children not understanding the language of instruction in preprimary school and the early grades of primary school. Currently there is little research on this issue, and collecting information on children's home language environment could help determine if children from different language backgrounds need additional support. For this reason, language of instruction is an area that deserves more research. Depending on research findings, Mauritius could consider developing small scale pilot programs using mother tongue based multilingual instruction in preprimary and early primary school.

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.⁹

ECCE curricula and standards are established. The MoGCDFW issued the Early Childhood Development Programme Guidelines Handbook (0 -3 years) in 2003 to provide childcare centers with standards and guidance. The handbook emphasizes the importance of play in development, and is intended to help caregivers plan, implement and evaluate daily activities. The ECCEA established the National Curriculum Framework Pre-Primary in 2009. The curriculum aims to develop pre-literacy and numeracy skills; and promote children's cognitive, emotional, social, spiritual and moral development. It is based on the basic principles of the UN Convention on the Rights of the Child, and reflects the diversity of Mauritian society. These curricula could be updated periodically to reflect the growing research base on ECCE and incorporate best practices in the field.

There are training and certification requirements for ECCE caregivers and educators. The CDU and the ECCEA set minimum standards for ECCE teacher qualifications. Caregivers for children below age 3 and preprimary teachers for children age 3-5 must have completed upper secondary school and a specialized training course in ECCE. Primary school teachers for children age 5-7 must fulfill similar requirements, plus complete a supervised internship. ECCE centers are required to offer regular in-service training to their staff.

The Mauritius Institute for Education offers a number of courses and certificates for early childhood professionals. These include a foundation course for caregivers of children age 0-3 years, a foundation course for early childhood education, a certificate of proficiency in early childhood education for pre-primary school educators, a teacher's certificate in early childhood education for preprimary educators, a teacher's diploma in early childhood education, and a certificate in educational management for managers of preprimary schools. The teacher's diploma in ECCE is a two year, part-time program for practicing preprimary educators. Several other private institutions offer certifications and courses for ECCE professionals. While these institutions are registered with the Mauritius Qualification Authority, the quality of their programs may be lower than those offered at the Mauritius Institute of Education. Despite the government

⁹Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et al, 2011V; Victoria et al, 2003

Table 9: Requirements for preprimary teachers in Indian Ocean and East Africa

| | Mauritius | Tanzania | Seychelles |
|---------------------|---|--|--|
| Pre-Service | All preprimary teachers must complete secondary school and a specialized ECD course. Every ECCE center is required to have at least one staff member with a full teacher's diploma. | State pre-primary teachers must complete 2 years of pre-service training after completing secondary school; standards for non-state pre-primary teachers are less stringent. | Caregivers for children below age 3 receive ECD training. Preprimary and primary teachers must complete an ISCED 4A equivalent of tertiary education and a certificate in ECD. |
| In-Service | Mandatory regular in-service training | Mandatory 40 hours of in-service training per year for educators for children age 2 and older | Mandatory regular in-service training |
| Institutions | Mauritius Institute for Education, Mauritius College of the Air, private institutions | Agha Khan University, Teacher Resource Centres, teachers colleges | University of Seychelles, Ministry of Education |

requirements for minimum ECCE staff qualifications, some private facilities do not adhere to these standards and hire staff without the required training. Table 9 shows requirements for preprimary teachers in countries in the Indian Ocean and East Africa region.

There are established infrastructure and service delivery standards for ECCE in Mauritius. ECCE facilities must adhere to infrastructure standards regulating the roof, floor, structural soundness, building materials and windows. Schools are required to have access to potable water and hygienic facilities, but are not required to have a connection to electricity.

The required teacher-to-pupil ratio for childcare centers for children below age 3 is 1:20, and the required teacher-to-pupil ratio in preprimary schools is 1:25. These ratios are somewhat higher than the required ratios in many other countries with strong ECCE systems, where best practice is often viewed as less than 15 children per teacher. Preprimary schools must be open a minimum of five hours per day, five days per week.

There are established registration and accreditation procedures for ECCE facilities. Public and private ECCE facilities must register with the CDU (for childcare centers for children below age 3) or the ECCEA (for preschools for children age 3-5). Facilities are subject to monthly inspections. Table 9 lists requirements for preprimary teachers in Mauritius and in comparison with countries in the Indian Ocean and East Africa region.

Policy Lever 3.3:

Compliance with Standards

Established



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.

ECCE educators in public schools meet qualifications standards; not all educators in private childcare centers and schools meet standards. The number of early childhood caregivers and educators who have received in-service training, coursework, degrees or no training at all is not available. Anecdotally, all staff in public institutions possess the required credentials, and many staff in private facilities do as well. There are, however, some private childcare centers and preschools that employ staff without the requisite training, as it is easier and less expensive than hiring trained staff. The Mauritius Institute of Education has more spaces available in its ECD programs than there are enrolled students, so the problem does not seem to be inadequate training capacity. Only 10 percent of ECCE professionals have completed a teacher's diploma course in ECCE. While the diploma level is not a requirement, it is desirable to increase the number of staff holding more advanced training.

Preschools largely comply with established service delivery and infrastructure standards, but most childcare centers do not comply with infrastructure standards. Public and private daycare centers, preschools and schools largely adhere to required teacher-to-pupil ratios per classroom and with the

Table 10: Comparing ECD policies with outcomes in Mauritius

| Policy | Outcomes |
|--|---|
| National Immunization Policy mandates a complete course of childhood immunizations | Children with DPT (12-23 months): 100% |
| Civil Status Act mandates birth registration | Birth registration rate: 100% |
| GoM makes monthly payments to private preschools for each student they enroll; ECCEA offers public preschools | Gross preprimary school enrollment (3-5 years): 96% |
| CDU and ECCEA mandate minimum pre-service training standards for ECCE caregivers and teachers | Percentage of ECCE caregivers and teachers holding required qualifications: unknown |
| CDU mandates childcare facilities for children below age 3 to meet standards in order to officially register and operate | Percentage of registered childcare facilities for children below age 3: 12% |

minimum number of opening hours. (In fact, the average teacher-to-pupil ratio in ECCEA preschools is 1:14, well below the requirement of 1:25.) Eighty percent of preschools meet service delivery and infrastructure standards. As of May 2012, only 12 percent of childcare centers met the standards necessary to be registered with the MoGCDFW. This means that there are only 37 registered childcare centers out of the 299 centers in the country. The unregistered centers have submitted applications to the Ministry but do not meet the infrastructure requirements. The Ministry is aware of these deficiencies and allows the centers to remain open so as not to cause a massive shortage of childcare. To address this problem, the GoM is beginning to offer small grants to daycare centers to upgrade their facilities so that they can meet registration requirements. The Ministry could intensify its efforts to support and/or pressure childcare centers to meet standards to ensure children's safety.

Policy Options to Monitor and Assure ECD Quality in Mauritius

Data Availability

- Data collection and monitoring are important features of a strong ECD system, and are necessary for identifying needs and assessing programs. Mauritius could expand the survey data it collects to include important indicators such as rates of childhood anemia and stunting, and the percentage of the population consuming iodized salt. The GoM could consider participating in the Multiple

Indicator Cluster Survey, which helps gauge access to and equity in health and education.

- Mauritius could track individual child development from birth into childhood, perhaps expanding upon the new Child Health Passport document to incorporate children's physical, cognitive, linguistic, and social development in one accessible file. It could collect data on children's mother tongue to ascertain if there are differences in outcomes for children with different home language environments.

Quality Standards

- Mauritius has established quality standards in ECCE. It could consider adding a connection to electricity to the infrastructure requirements.
- The GoM could consider lowering the required teacher-to-student ratio in preschools to 1:15. This would help ensure safety and development. It could also lower the required ratios in childcare centers. International best practice recommends a ratio of 1:10/12 for children age 3-5, 1:4/6 for children age 2-3, 1:3/4 for children age 1-2, and 1:2/3 for age birth-1.

Compliance with Standards

- The Government could work to ensure that private childcare centers and preschools employ staff with the required qualifications. Policies to address this may include expanded monitoring, or financial incentives for centers that comply. The failure of most childcare centers to meet standards for registration is cause for concern. The GoM could identify what the main barriers to meeting

Table 11: Comparing policy intent with ECD outcomes in Indian Ocean and East Africa

| | Mauritius | Kenya | Seychelles | Tanzania |
|---|---|--|--|---|
| Salt Iodization | | | | |
| Salt Iodization Policy | No law or policy | Mandatory | No law or policy | Mandatory |
| Population Consuming Iodized Salt | Data not available | 98% | Data not available | 59% |
| Appropriate Infant Feeding and Breastfeeding Promotion | | | | |
| Compliance, Code of Marketing of Breast Milk Substitutes | Not law | Some provisions law | Law | Law |
| Exclusive Breastfeeding until 6 Months | Data not available | 32% | Data not available | 60% |
| Preprimary Education | | | | |
| Preprimary School Policy | Not compulsory; state and non-state provision; government finances some costs | Not compulsory; government finances some costs | Not compulsory; free 2 years state provision | Not compulsory; free 2 years state provision but user fees are common |
| Preprimary School Enrollment Rate | 96% | 42% | 102% | 33% |
| Birth Registration | | | | |
| Birth Registration Policy | Mandatory | Mandatory | Mandatory | Mandatory |
| Birth Registration Rate | 100% | 60% | Data not available | 22% |

standards are, and design or adjust policies to help and/or pressure centers to meet standards. This may include grants to upgrade facilities, financial incentives for compliance, or working with parents and the public to pressure the centers to improve.

Comparing Official Policies with Outcomes

The existence of laws and policies alone do not always guarantee a given 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 10 compares several ECD policies with outcomes in Mauritius. The Government has been very successful in implementing its policies mandating immunizations and birth registration, resulting in full coverage throughout the country. Despite the lack of a policy mandating attendance, Mauritius has achieved universal preschool enrollment through a combination of public preschools and capitation grants to private preschools. Its policy on

ECCE standards has been less successful. The ECCEA and CDU mandate minimum pre-service training standards for ECCE caregivers and teachers. The percentage of teachers who comply is not clear, but compliance does not seem to be universal. Most childcare centers do not meet the standards necessary for registration, yet they continue to operate. Given the discrepancy between the policy intent and outcome, the policy itself and its implementation warrant examination.

Table 11 summarizes key policy provisions in the Indian Ocean region and East Africa, along with related outcomes. All countries have mandatory birth registration policies, but Kenya and Seychelles struggle to implement the policy. None of these countries mandates preprimary school, but Mauritius and Seychelles have universal enrollment. Data for Mauritius and Seychelles on the population consuming iodized salt and exclusive breastfeeding until 6 months are not available.

Table 12: Benchmarking Early Childhood Development Policy in Mauritius


















































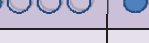



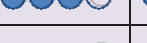

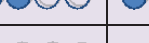












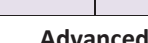





| ECD Policy Goal | Level of Development | Policy Lever | Level of Development | |
|--------------------------------------|--|--|--|--|
| Establishing an Enabling Environment |  | Legal Framework |  | |
| | | Inter-sectoral Coordination |  | |
| | | Finance |  | |
| Implementing Widely |  | Scope of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

Table 13: International Classification and Comparison of ECD Systems

| ECD Policy Goal | Policy Lever | Level of Development | | | | | |
|--------------------------------------|---------------------------|---|---|---|---|---|---|
| | | Mauritius | Australia | Sweden | Tanzania | 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  | | |

Preliminary Benchmarking and International Comparison of ECD in Mauritius

Table 12 presents the classification of ECD policy in Mauritius within each of the nine policy levers and three policy goals. For the Establishing an Enabling

Environment policy goal, Mauritius's level of development is classified as "Established." For the Implementing Widely policy goal, Mauritius's level of development is classified as "Advanced" (although there were several pieces of data typically used in the calculation that were unavailable). For the Monitoring and Assuring Quality policy goal, Mauritius's level of development is classified as "Established."

Table 14: Summary of policy options to improve ECD in Mauritius

| Policy Dimension | Policy Options and Recommendations |
|---|--|
| Establishing an Enabling Environment | <ul style="list-style-type: none"> • Adopt a policy to fortify staples with iron and other nutrients, and a policy to iodize salt. Adopt and implement the International Code on the Marketing of Breast Milk Substitutes • Adopt a mandatory preschool attendance policy • Extend paid and unpaid maternity leave and paternity leave • Expand on the Ministry of Education's Education and Human Resource Strategy 2008-2020 to incorporate social protection, health and nutrition into the country's ECD strategy and plan • Ensure that the CDU and ECCEA coordinate closely on programs • Establish systems to identify and track government spending on ECD within the country's health and nutrition budgets • Consider studying how current ECD funding could be used more efficiently |
| Implementing Widely | <ul style="list-style-type: none"> • Add maternal depression screening and services to programs targeting parents • Continue efforts to make preschools accessible to special needs children, through staff training and facilities improvements |
| Monitoring and Assuring Quality | <ul style="list-style-type: none"> • Increase the types of survey data collected to include important ECD indicators such as: stunting and anemia rates in children, percentage of the population consuming iodized salt, and percentage of children receiving antibiotics for suspected pneumonia. Consider participating in the Multiple Indicator Cluster Survey (MICS) • Develop a system to track and monitor individual children's development outcomes, possibly through the new Child Health Passport document • Consider lowering the required teacher to pupil and caregiver to child ratios in preschools and childcare centers to promote children's safety and development • Examine the reasons for the failure to implement childcare center registration standards and consider ways increase implementation, such as grants for facilities improvements, financial incentives for compliance, and public awareness and pressure |

Table 13 presents the status of ECD policy development in Mauritius alongside a selection of other countries. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers. Additional regional comparisons of ECD policy goals and levers are forthcoming.

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. 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. This Country Report presents a framework to compare Mauritius'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.

Mauritius has implemented many important programs and policies in the area of early childhood development, including universal preschool enrollment and access to essential health and nutrition programs. The Government can build on these achievements by implementing policies to strengthen its legal framework, financing, and data availability and monitoring. While access to programs is high in the country, there may be variations in quality. The country has established standards for ECCE, and could work to improve compliance with these standards. Table 14 offers policy recommendations and options that the Government could consider to strengthen ECD.

The Systems Approach for Better Education Results (SABER) initiative collects data on the policies and institutions of education systems around the world and benchmarks them against practices associated with student learning. SABER aims to give all parties with a stake in educational results—from students, administrators, teachers, and parents to policymakers and business people—an accessible, detailed, objective snapshot of 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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