

Western Cape Government
Investing in the Early Years

**INTEGRATED PROVINCIAL
EARLY CHILDHOOD DEVELOPMENT
STRATEGY**



2011-2016

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Chapter 1: The case for early childhood development

1.1 Introduction

Young children demand and deserve special attention. The first five years of their lives are the most important because vital development takes place in all domains (sensory-motor, cognitive, socio-emotional), and their earliest experiences have the potential to influence them positively or negatively, their families and their communities in later life. The period between birth and 5 years is thus an important and transient window of opportunity as brain development after this period occurs at a significantly slower pace and builds on the base achieved in early childhood such that competencies acquired here become cumulative. Similarly, lack of optimal cognitive and psychological development in this critical period becomes increasingly difficult and costly to address as children get older. Thus, without intervention, gaps between better and worse-off children widen over time; the earlier the intervention, the less it costs and the narrower the gap (Grantham-McGregor et al., 2007; Heckman, 2006).

There is a substantive body of evidence on early childhood development, the findings of which provide a call to action. The findings in a recent Lancet series of reviews on child development in developing countries suggest that an estimated one third of more than 200 million children under 5 years, 61% of whom live in Sub Saharan Africa, are not developing to their full potential because they are exposed to multiple risks including poverty, poor health and nutrition – all of which impact negatively on development. This compromises their readiness for school and their future as productive members of society. The evidence suggests that the economic implications of poor child development are dire:

- the loss of human potential is associated with a 20% deficit in adult income;
- children who fail properly to develop physically, emotionally, intellectually and socially are less likely to be well educated and economically productive adults;
- as parents they tend to raise children who are disadvantaged, thereby transferring poverty to the next generation;
- when large numbers of children are involved, national development could be at stake.

The pathways between poverty and childhood development and the potential for interventions are illustrated in Figure 1 below.

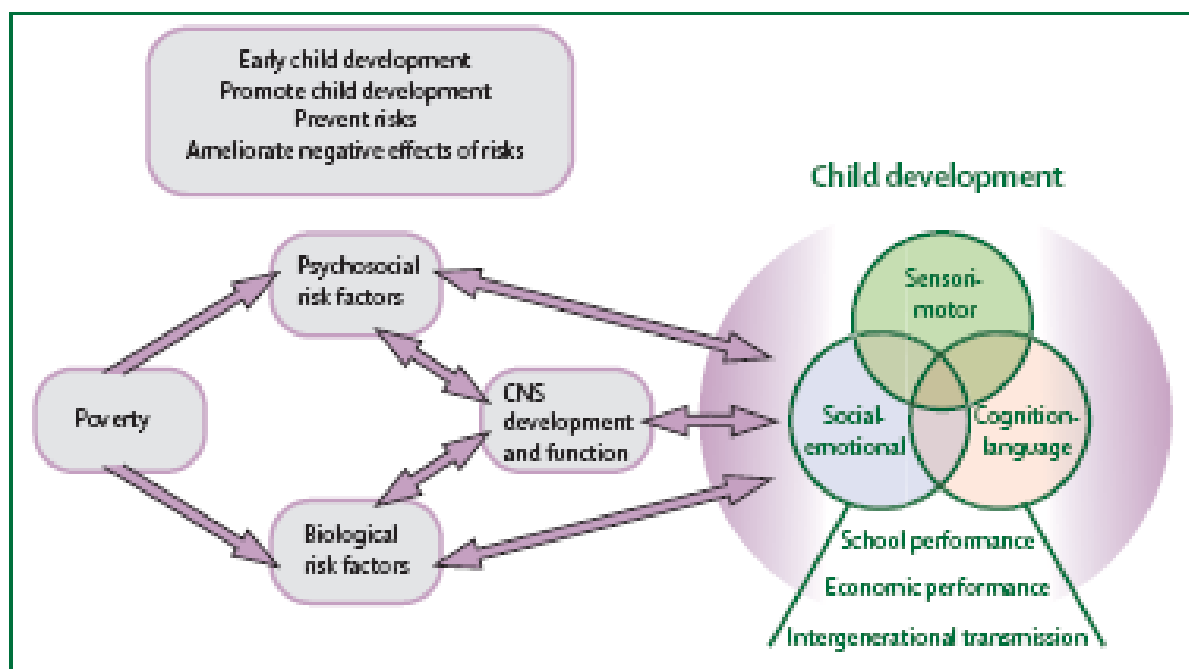


Figure 1: Pathways from poverty to poor child development

Source: Engle et al., 2007, p.230.

The historical legacy for the majority of children in the Western Cape in the ECD age cohort has largely been negative as it has been one of exclusion, inequality and fragmentation, with the majority of children who need ECD provision most, not having access to it. Statistics indicate that 5 years ago only about 22% of children in the province had access to ECD provision and that the burden of this provision fell disproportionately on families and communities. Even where children had access, the quality was variable and literacy and numeracy testing of grade 3 learners done by WCED in 2003 and again in 2010 indicated that children are poorly prepared for school and that the school system was not able to redress the effects of early deprivation. (Source)

However, as the evidence suggests that substantial interventions in the form of integrated programmes during a child's early years can help to prevent the loss of potential in affected children, the Western Cape Government has prioritised investment in Early Childhood Development as:

- a vehicle for early intervention and child protection;
- the basis for improving school outcomes and laying the foundation for lifelong learning;
- a means to reduce childhood poverty;
- an opportunity to develop the skills and competencies required for economic opportunities in later life.

1.2 Background to early childhood development

Early childhood is a critical period in human development with the bulk of brain development occurring before 5 years of age. Indeed, recent research on cognitive skills and socio-economic status (SES) has found that children living in poverty perform significantly worse in all five neurocognitive systems (Noble, Norman, & Farah, 2005). The largest disparity was observed in the language and executive function systems and smaller disparities were apparent in visual cognition, visio-spatial skills and memory. The language system is a core part of developing reading skills and as such suboptimal language development is a major setback to a child's development.

On examining reading-related brain activity, researchers have demonstrated that the observed differences in reading skills across SES are strongly linked with differences in the development of neural pathways across SES¹(Noble et al., 2006). Furthermore, differences in language performance were determined by the amount of cognitive stimulation children received from their home and school environment and pre-school programmes, itself related to SES (Noble, McCandliss, & Farah, 2007).

Brain and biological development in the early years is experience-based, leading to neurophysiological pathways being laid down in synaptic formations in the brain. These establish the foundation for emotional, language, motor and cognitive competencies. The quality of sensitivity provided in early relationships with carers is integral to this process. The developmental sensitivity of this period provides both opportunities for laying a positive foundation for the child's future emotional and intellectual development, as well as being a time during which insults can have a long lasting impact on development. As Figure 2 illustrates different functions develop sequentially and pre-birth to three years are especially critical.

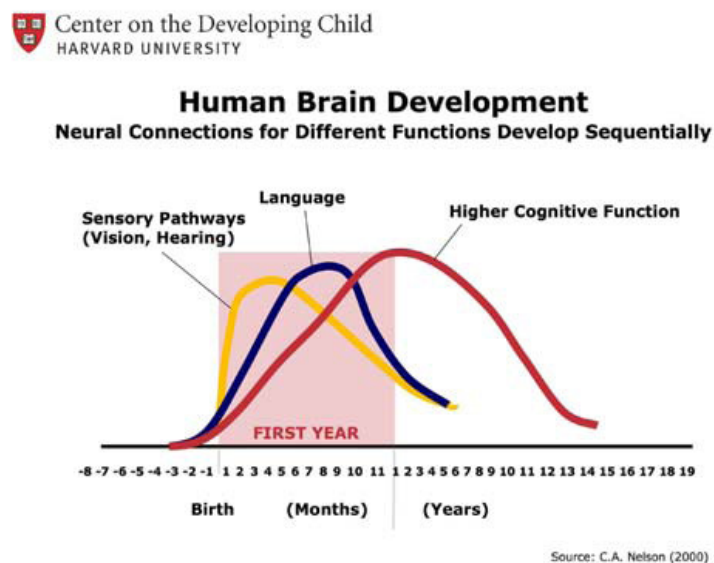


Figure 2: Human brain development

Source: *Center on the Developing child at Harvard University (2007).*

¹For children with weaker innate phonological skills to acquire average reading skills, they must receive sufficient or additional cognitive stimulation in order to develop compensatory neural pathways. The amount of stimulation received in the home or school is directly related to SES, and as such, children with a low SES and a lower level of phonological ability will not “catch up” to their peers unlike similar children of high SES (Noble, Wolmetz, Ochs, Farah, & McCandliss, 2006).

Formal training in the mother tongue is an important factor in the development of global language proficiency in multicultural children. Therefore it is recommended that formal training in ECD facilities is provided in the child's mother tongue as it is the means for children in developing countries to access basic literacy and numeracy as well as other skills that will improve their lives. Mother tongue-based bilingual (L1 = Mother tongue and L2 = English) education not only increases access to skills but also raises the quality of basic education by facilitating classroom interaction and integration of prior knowledge and experiences with new learning (Benson, C. 2004).

In relation to children's access to pre-school programmes in developing countries, the gross enrolment ratio for pre-school in developing countries is 34.3%, compared to 81.1% in developed countries. The lowest pre-school enrolment rates are to be found in the poorest regions; in Sub-Saharan Africa, for example, only 5.6% of young children attend pre-school programmes (Engle et al., 2007).

1.2.1 Return on investment

Evidence for the effectiveness of interventions in early childhood is robust, coming from meta-analyses, systematic reviews of randomised controlled trials, and longitudinal studies. The evidence indicates that investment in early child development is both highly effective and cost-effective, in terms of short term cognitive and mental health benefits and reducing later-life problems that will burden not only the mental and physical health systems, but also other areas of society (for instance, in terms of costs of incarceration, substance abuse programmes, and poor employment records).

Anderson et al (2003) in their excellent systematic review of randomised controlled trials of early childhood programs for low socio-economic status children ('children at risk') took 57 intervention studies, and examined them for cognitive, social child health and family outcomes. The review found strong evidence for the effect of ECD programmes on cognitive outcomes which included increased IQ scores, increased school-readiness, lower retention rates (failing a grade), improved academic performance and reductions in the need for special education placements. More than 70% of the effects reported were in the cognitive domain with very limited evidence available in the other domains. However, the authors point out that cognitive ability and school-readiness are themselves predictors of behavioral problems and delinquency, both of which are predictors for later life mental illness.

Yoshikawa's (1995) systematic review found positive effects of early childhood programmes on both cognitive and verbal abilities which in turn decreased the negative impact of low socio-economic status on the likelihood of developing childhood behavioral disorders.

While most of the studies in the review were conducted in the United States, a recent Lancet review of early childhood interventions in developing countries has shown that study findings in developing settings concur with those in developed countries. Based on 20 studies that met the study criteria, the review found that pre-school programmes consistently improved children's cognitive development. In terms of socio-emotional development, the majority of the studies reported improvements in children's social skills, self-confidence, relationships with adults and motivation. Longitudinal studies found improvements in school enrolment rates, age of school entry, retention and academic performance (Engle et al., 2007; Walker et al., 2007).

The Lancet series identifies the following major risk factors impeding child development in developing countries: inadequate cognitive stimulation, malnutrition, maternal depression and violence (Walker et al., 2007).

There is also evidence that there are numerous long-term benefits to pre-school programmes. Multiple positive effects of pre-school interventions have been documented well into adulthood and are therefore a major investment opportunity for development.

Yoshikawa (1995), for example, found that children attending pre-school programmes with a family support component showed declines in long-term antisocial behaviour or delinquency. The longitudinal results of the Chicago Child-Parent Centre (CPC) Preschool Program showed that preschool participation “was significantly associated with more years of education ... a higher rate of high school completion ... and a higher rate of college attendance” (Ou & Reynolds, 2006). “Findings demonstrate that large-scale school-based programs can have enduring effects into early adulthood” (Ou & Reynolds, 2006). A recent study of the same programme found that, relative to the comparison group receiving the usual services, program participation was independently linked to higher educational attainment, income, socioeconomic status (SES), and health insurance coverage, as well as lower rates of justice-system involvement and substance abuse (Reynolds, 2011).

The persistence of effects of ECD interventions into adulthood is also powerfully demonstrated by the High/Scope Perry Preschool Project. Outcomes for a half-day preschool intervention for at-risk children from impoverished backgrounds in the U.S, combined with weekly home visits, was associated with short-term benefits as described above. Further long-term benefits were found with follow up to age 27. These included 40% reduction in arrests and 40% increase in employment and literacy rates. Adults were less likely to be dependent on welfare and displayed improved social responsibility (Schweinhart & Weikart, 1998). A cost analysis of this intervention showed that for the \$1000 spent per child on the preschool intervention, over \$7000-\$8000 benefits were returned in terms of taxes paid and lower crime, justice and welfare system costs (Schweinhart & Weikart, 1998). The evidence from developing countries concurs with these findings with the effects of early cognitive stimulation documented up to 17 years after the intervention (Walker et al., 2007).

The 2000 Nobel prize winner for Economic Sciences, economist James Heckman, demonstrated that interventions early in childhood yield economic returns far higher than interventions at any other time (Heckman & Krueger, 2003; Heckman, 2006). In specific terms, their work found that early interventions for disadvantaged children were more effective (in terms of outcome) and cost less, than later educational interventions, such as reducing pupil-teacher ratios, or adult interventions, such as job training (Figure 3).

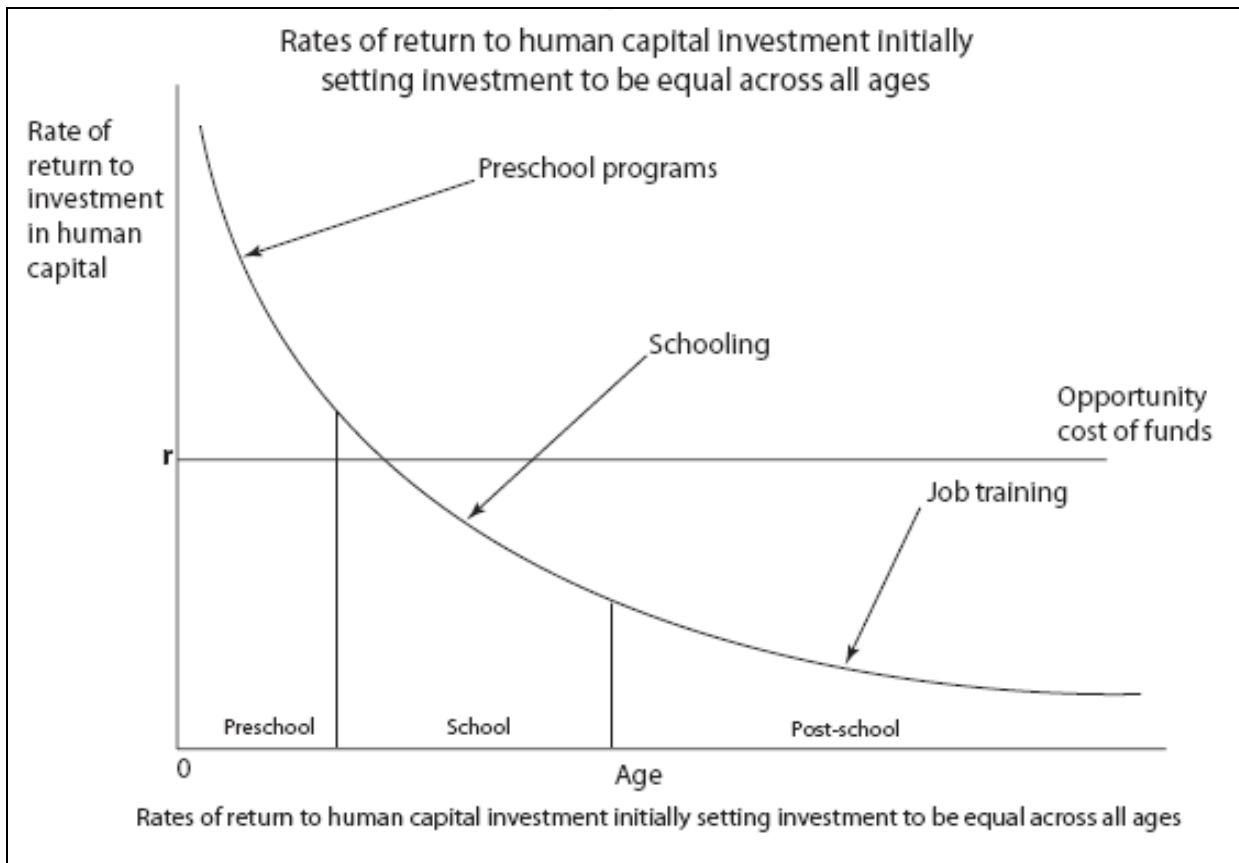


Figure 3: Economic benefits of interventions early in life

Source: Heckman & Krueger, 2003

The mechanism through which pre-school programmes may impact on educational and behavioral outcomes is illustrated in Figure 4 below. While few of these reviews directly examine mental disorder outcomes other than behavioral ones, it should be noted that behavioral problems in children are typically associated with common mental disorders in adulthood, such as depression (American Psychiatric Association, 1994).

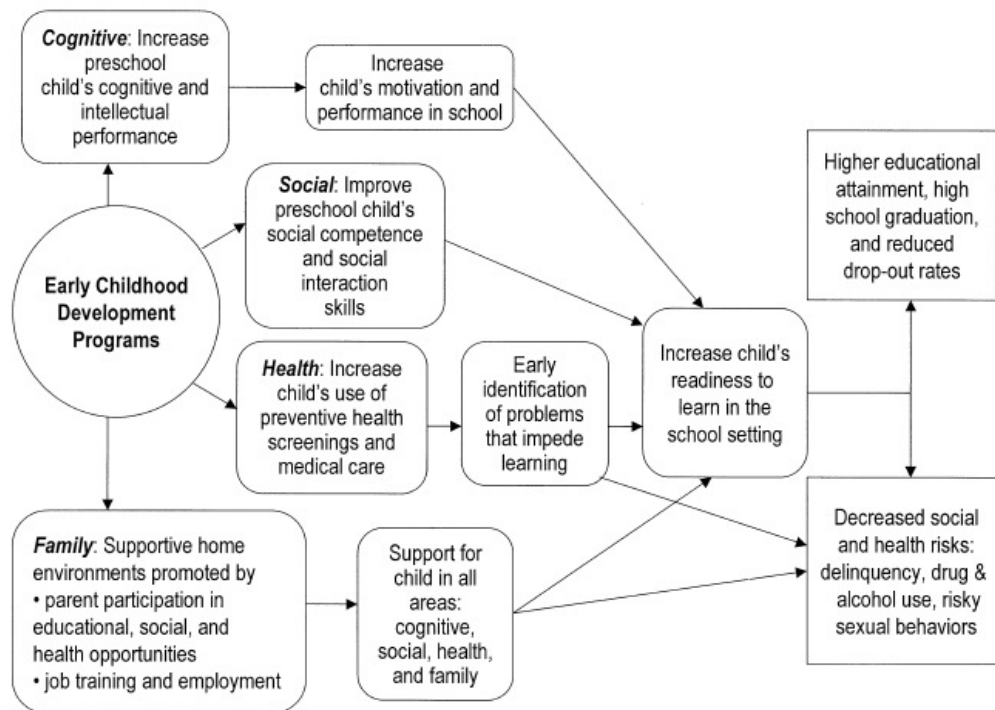


Figure 4: The postulated mechanisms through which access to high quality pre-school improves educational, social and health outcomes.

Source: (Anderson et al., 2003) p.36

There is robust evidence that access to quality pre-school programmes improves cognitive, verbal and social development resulting in improved educational outcomes and long term reductions in mental health problems, crime and unemployment up to 27 years later.

The impact of access to pre-school on maternal mental health should also be borne in mind. The literature on the availability of child care is instructive in this instance; both ecological and cross-sectional studies have demonstrated that access to child care is associated with increased maternal employment and enrolment in educational activities (Crawford, 2006; Ficano, Gennetian, & Morris, 2006; Herman & Jane-Lopis, 2005; Hofferth & Collins, 2000). In the context of this evidence, Doherty et al (1995) (Doherty, Rose, Friendly, Lero, & Irwin, 1995) argue that the provision of high quality child care is a fundamental part of enabling parents to enter and remain in employment. Publicly funded or subsidised child care programs promote women's economic and social equality, enable families to become economically self-reliant and as such represent an opportunity to reduce poverty and inequality. While none of these studies evaluated mental health outcomes, there is some evidence of the association between child care and mental health: in a cross-sectional study of low-income working mothers living in poor urban neighborhoods in Philadelphia (USA), Press et al (2006) (Press, Fagan, & Bernd, 2006) found that mothers who had problems with child care were significantly more likely to report depressive symptoms (after adjusting for confounders).

In conclusion, there is strong evidence that access to early child development programmes improves cognitive abilities, which in turn affects a child's achievements and successes in the school environment and beyond, into adult life. The long-term impact of the benefits of preschool interventions is seen in reduced burden of societal cost, both in terms of positive mental health outcomes and economic gain.

1.2.2 Characteristics of successful ECD intervention

UNICEF, in an abridged article on child development which appeared in the Lancet in 2007, identifies the following characteristics of ECD programmes that deliver positive results:

- a focus on disadvantaged children and families;
- programmes for disadvantaged children are introduced at an earlier rather than a later stage in childhood;
- sufficient intensity, duration and quality of programmes that are integrated with health, nutrition, education, economic development and social services;
- services provided directly to children which include an active parenting and skills building component;
- children are given opportunities to initiate and instigate their own learning and exploration of their surroundings with age-appropriate activities;
- traditional child rearing practices and cultural beliefs blended with evidence-based approaches;
- ECD staff provided with systematic in-service training, supportive and continuous supervision, observational methods to monitor children's development, practice and good theoretical and learning material;
- Collaboration and coordination between stakeholders in government, civil society and other sectors.

This is in line with World Health guidelines published in 1999 on programmes that have the greatest impact on child growth and development. These include but are not limited to programmes that:

- Commence prenatally and extend into infancy and early childhood as a continuous chain of support;
- Combine interventions that utilize several simultaneous "delivery channels" (eg home visits, group counseling, child-care centres, and mass media). Combined interventions include a package of (for example) child nutrition, parental education on diet and feeding practices, supplementary foods or micronutrient supplements, and parenting and child development education: they are more efficient and cost effective, they avoid duplication and families access an integrated package of services which reduces their service access costs.

The importance of adopting an integrated approach that takes account of biological factors that may moderate the effects of pre-school on early childhood development is highlighted. For developing countries, it is essential that a broad range of risk and protective factors are concurrently addressed as part of comprehensive pre-school programmes.

Chapter 2: An overview of ECD in the Western Cape

2.1 Problem statement

In the Western Cape the legacy of provision of early childhood development is characterised by inequality with more advantaged children having access to high quality services, a large group of less advantaged children having access to poor quality replicas, and many children having no access at all. The main model of provision is centre-based. Evidence has shown that if this model is replicated under current conditions and challenges in poor communities, it will result in poor quality services with large numbers of children in the care of too few adults, with inadequate space and equipment to provide opportunities for exploration and development.

According to Community Survey 2007, there are 956, 528 children between the ages 0-9 years in the province. Those between the ages 0-4 years are primarily the responsibility of the Department of Social Development insofar as ECD provision is concerned, whilst those between the ages 5-9 years are the responsibility of the Department of Education. Table 1 below provides a breakdown of this age cohort by age and gender.

Age	Male	Female	Total of this age	Grand Total
0 – 4	249 360	245 991	495 351	495 351
5- 9	232 516	228 662	461 178	461 178
Grand Total	481 876	474 653	956 528	956 528

Table 1: ECD population by age and gender

In the Western Cape as in other parts of South Africa, ECD audit data indicate that access to ECD services, and in particular to those of good quality, is skewed towards older children and to those who come from families with more resources. About 60% (or 333,600) of children from birth to four years do not have access to ECD services and programmes. The majority of these are the most disadvantaged children in the province for whom good quality early services are likely to have the most impact in terms of survival, nutrition, cognitive development, subsequent schooling performance and later employability. It is these children and their families who are prioritised in the Children's Act and are the target of the National Integrated Plan for ECD. The National Integrated Plan has stated that the majority of young children will be reached at household and community level, as formal centre-based ECD services are both too few and not necessarily able to reach these children and families.

2.2 Access to quality ECD

Currently there are 896 ECD facilities registered with and subsidised by the Department of Social Development which can accommodate 64,249 children between the ages 0-4 years. The actual number of children who are enrolled is higher as DSD only subsidises children where the joint parental income does not exceed R3,000 per month. In addition, a recent audit revealed that there are approximately 1,

700 unregistered, unfunded facilities which accommodate about 55,000 children, 70% of this total is in the metropolitan area. A further 30,000 children are at registered at unfunded ECDcentres, and about 9, 800 children access community-based ECD services. What is not known is the number of children who access ECD services provided by the corporate sector.

In total therefore the DSD provides access to ECD provision for approximately 159,000 children or 40.12 % of children between the ages 0 – 4 years. This figure is up from the approximately 22% of children who accessed ECD provision five years ago. The quality of provision is unknown, although it is estimated that quality provision is lacking in about 50% of the sites. What is known and is being reconfirmed by the audit of unregistered facilities which is currently underway, is that the historical neglect of this sector has resulted in parents and communities taking responsibility for much of the ECD provision, and as a result many facilities are in community buildings (53%) or based at home in backyard structures (28%).

Whilst ECD provision is generally low for children under 3 years, not all children in this age category require full-day programmes in a centre or in alternative provision. The Western Cape is also the only province to subsidise out-of-centre or community-based ECD provision. What is encouraging is that government policies note the need for a variety of programming options.

Children with disabilities need particular support for development in the early years. For this reason it is important to detect their problems early on, and ensure that they receive the necessary services and stimulation that will mitigate their disability and assist them to develop to their fullest potential (Schneider &Salogee, 2007). Such early detection is currently hampered by lack of professionals. As a consequence, few of these children access early childhood development provision. Similarly, provision directed at children and families affected by HIV and AIDS, isalso important.

In terms of gender equality, just over 49,5 % of ECD enrollments are female and 50,5% are male, indicating almost equal access to ECD provision.

The Department of Education is mandated to provide education for five to nine year olds. The Institutional Management and Governance Planning Directorate is responsible for the establishment and provisioning of Grade R classes for the five to six year olds in both public ordinary schools as well as ECD Independent schools (formerly referred to as privately owned community crèches).

Currently 885 public ordinary schools and 411 ECD Independent schools offer Grade R with a total of 2,500 Grade R classes; 233 qualified Grade R teachers are paid by the Department, and the remaining 2,263 are Grade R practitioners who are school governing body employees. There are 67, 000 children enrolled in Grade R.

In terms of the *South African Schools Act (SASA)* Section 3(1), school education is compulsory for all learners from the first day in which the child turns seven, until the last school day of the year in which a learner reaches the age of fifteen years or the ninth grade, whichever occurs first. The state and the WCED have a Constitutional obligation to provide basic education to all learners.

Therefore, all children between the ages of seven and nine years are of compulsory school-going age and schools are provided with a Norms and Standards allocation for each learner accommodated in Grades 1 to 3.

2.3 ECD and nutrition

Malnutrition is associated with serious short and long term consequences. A significant proportion of children under 5 years of age are found to be undernourished in the Western Cape. The stunting prevalence is particularly high in the province and increases in the prevalence of over-nutrition are also observed (Duraio et al., 2011). Poor nutrition in children under the age of two can lead to irreversible physical and cognitive damage which impacts adversely not only their future health, but also their economic well-being and welfare.

Given a disturbing level of under-nutrition in children and their developmental vulnerability during early childhood, providing adequate nutrition is a key aspect of a quality ECD programme. The majority of facilities operate for between 5 and 10 hours per day and provision of meals are therefore essential. The current funding model is one of subsidisation and as a consequence, many children, especially in unsubsidised facilities, have to bring a snack or one of their meals from home. The nutritional quality of this arrangement is of concern and in facilities where children have to bring their own food, some go hungry.

Schools that are in impoverished areas are part of the National Schools Nutrition Programme (NSNP), which provides daily nutritious meals to learners in the most disadvantaged areas and the Grades R to 3 learners who are at these public ordinary schools benefit from this programme.

2.4 Community-based ECD provision

Evidence of the positive impact of community-based interventions is emerging from the health, social development and education sectors. Home visiting programmes target children of different ages and have different goals making them difficult to compare. However the evidence supports home visiting in general as a promising strategy for helping parents and promoting the growth and development of young children (Weiss, 2006).

Community-based health workers (CHWs) can play a major role in identifying serious health problems in families and in some cases they can successfully administer treatment for common conditions. They can also be equipped to provide care during pregnancy and support immediately post-delivery, as well as nutrition interventions. With support, community-based healthworkers with relatively little formal education can work with the child's carer in the home setting to facilitate improvements in the child's nutritional status. A systematic review (Lewin et al, 2010) indicates promising benefits in promoting immunisation uptake and breastfeeding, improving TB treatment outcomes, reducing child morbidity and mortality when compared to usual care.

A review of impact studies of seven large United States-based home visiting focusing on pregnant women and families with children from birth to 5 years (Paulsell et al;2010) indicates positive outcomes. These outcomes varied across the different programmes, but favourable outcomes were demonstrated in child development and school readiness, parenting practices, maternal health, reduction of child maltreatment, and family economic self-sufficiency. An earlier review (Gomby, 2003) found the strongest evidence for home visiting programmes in the domains of parenting behaviours, child safety and the prevention of child abuse and neglect. In South Africa, preliminary results of

research on home visiting programmes in three sites in vulnerable communities (the Sobambisanaproject) indicate significant changes in parenting behaviours, successful linking of families to social grants and other services and improvement in parental coping.

The Children’s Act prescribes the following staff norms for ECD facilities and programmes:

- 1 – 18 months 1:6
- 18 months – 3 years 1:12
- 3 – 4 years 1:20
- 5 – 6 years 1:30

Facilitating demand for services is a critical element in ensuring that women and young children access necessary services. Community-based workers have been effective in mobilising communities to take up services but also to make demands for greater government accountability in provision of services and factors affecting their accessibility. This has been demonstrated in Nepal where local women facilitated support groups discussing issues around maternal and newborn health problems and together with community members, formulated strategies to address them. This intervention reduced neonatal mortality by 30% with changes in care seeking practices and hygiene, formation of transport schemes and child health funds.

Similarly, a number of South African integrated community based ECD interventions use community workers to raise awareness, and bring together local and district government and other service providers to facilitate access to services by young children and their caregivers (Biersteker, 2007).

Currently, community-based early learning workers may be state funded health workers or they may work in the NGO sector (with donor or public funding). There is commonly a two-tier model with an employed supervisory worker and semi-employed volunteers. Average ratios of a community based worker to a family/household vary according to distances and the kinds of interventions. In health the average ratios across many national CHW programmes is 1 full-time CHW: 500 households, and 1 CHW:10-20 volunteers. For ECD interventions a worker may work with between 20 and 40 families.

2.5 Resourcing ECD provision

The paucity of financial resources for many ECD facilities, together with other factors, can place serious constraints on the quality of the programming. Facilities serving poor communities who cannot afford to pay high fees or any fees at all, are most affected by this. Lack of funding can also mean poor nutrition offered to children, lack of educational equipment, and an inability to maintain infrastructure. Insufficient funding also seriously impacts on the wages earned by practitioners, which leads to high attrition rates from the sector, and often low motivation and morale.

The Department of Education pays the salaries of the 233 Grade R educators (pre-primary teachers) and transfers a per capita learner subsidy to the rest of the public and ECD Independent schools that have Grade R classes. 80% of the subsidy goes towards the Grade R practitioner’s salary and 20% must be utilized for the purchasing of learning and teaching support materials (LTSM) for the Grade R classes.

Personnel costs must be between 65% to 85% of the total Grade R allocation (Par. 226 of the NSF-Grade R) and the remaining percentage should be utilized for non-personnel costs. The School Governing

Bodies are required to “top up” the Grade R practitioners’ salaries. The minimum salary is currently R5,000 per month.

The national norms and standards for Grade R funding propose that a pro-poor approach be adopted in the calculation of the Grade R learner subsidy; therefore learners in the most disadvantaged communities are subsidized on a higher tariff than learners in the least poor communities. Grade R learners who are at schools in national quintiles 1, 2 and 3 are subsidized at R18,00, R17,00 & R14,00, respectively, while learners, who are at schools in national quintiles 4 & 5 are subsidized at R12,00 & R10,00 per learner for 200 school days.

In accordance with the National Norms and Standards for Grade R funding (Government Notice No. 30679 of 18 January 2008), all public and independent schools offering Grade R must be registered on the Education Management Information System (EMIS) and be in possession of a current registration certificate. All the Grade R learners either at public ordinary, independent or ECD independent schools must be registered on the Central Education Management Information System (CEMIS).

In addition, the Department of Education also provides infrastructure and LTSM to selected schools and provides accredited training and qualifications for the ECD practitioners.

DSD subsidises ECD facilities at a unit cost of R12,00 per child per day for 264 days per year. The DSD is unable to afford the recommended unit cost of R18,00. However, none of the provinces are paying and in fact, only three provinces are paying R15,00 per child per day. This subsidy must cover food, salaries, materials and equipment as well as other overhead costs. The ECD budget for DSD is R215 m per year and that of the Department of Education is R378m per year.

The human resource capacity to manage a portfolio of such scope and complexity needs urgent attention both within the ECD sector and within government departments. Within DSD this portfolio is managed in a sub-directorate consisting of a deputy director and three assistant directors. Similarly, within the Department of Education, Grade R classes are managed by a sub-directorate, with a chief education specialist, one deputy chief education specialist and one senior education specialist. The Curriculum for ECD is managed by the curriculum sub-directorate, with a chief education specialist and two deputy chief education specialists as permanent staff. It is worth noting that in both these departments, the sub-directorates also have EPWP responsibilities.

2.6 Challenges

The ECD sector is a vibrant but complex one, characterised by multiple role players, differing policy approaches and co-dependencies, to name but a few. Notwithstanding the undeniable benefits of investing in quality ECD provision, this sector faces a number of challenges, some of which can be attributed to the historical legacy of how the sector developed. Currently the ECD sector experiences the following key challenges:

- under provisioning or skewed provisioning in relation to need and where children find themselves;
- variable quality of programmes because they have never had to be accredited;
- lack of or inadequate practitioner/teacher training and supervision and low morale of staff who are trained but have limited career path opportunities;

- inadequate or poor infrastructure that compromises safety and learning;
- lack of institutional capacity in community-based organizations for good governance and management;
- inadequate departmental institutional capacity to manage the size and scope of responsibility;
- lack of finance;
- lack of compliance with norms and standards and the legislative requirements of the new Children’s Act;
- lack of coordination and fragmentation in the sector and between spheres of government e.g. different interpretations of the role of local government;
- inadequate systems and resources to monitor a sector where there is a high turnover of organizations;
- barriers to access for children with special needs and a concomitant shortage of allied professionals who can do early identification and render specialist services.

This strategy needs to address the above challenges in order to improve access to quality early childhood development for children in the Western Cape.

If we are to achieve the outcomes of a number of the provincial strategic objectives, in particular that of promoting social inclusion and reducing poverty, intervention needs to occur prior to children starting school, and an investment in quality, measurable ECD programmes makes good economic sense.

2.7 Legislative and policy context

ECD service provision falls within the legal and policy mandates of several government departments, with major responsibility residing with the Departments of Social Development, Education and Health. In addition, the South African government has ratified various international treaties, protocols and conventions, some of which have been taken into account in its law reform process and have been incorporated into legislation such as the Children’s Act 38 of 2005, with the Constitution (in particular Section 28) being the overarching legal instrument.

The Children’s Act has particularly far reaching consequences for ECD in that it prescribes norms and standards, the registration of facilities, the registration of programmes, the need for a provisioning plan, the need to keep and maintain records of all registered programmes and centres, the conditions for granting registration, the need to prioritise poor communities if money has been appropriated for ECD, the assignment of functions to municipalities, and the monitoring of facilities and services.

A comprehensive list of policies has been included below. The following is a brief synopsis of some of the key legal and policy instruments that guide service provision:

- Children’s Act 38 of 2005
- White Paper for Social Welfare (1997)
- National ECD guidelines
- National Integrated Plan for ECD in South Africa (NIP)

While children between the ages 5 – 9 years are within the foundation phase, this strategy document focuses on the education of 0-6 year olds as 7-9 years old are governed by compulsory schooling as outlined in the *SASA*.

Chapter 3: The Strategy

3.1 Scope of applicability

This strategy applies to all individuals, entities, government departments, municipalities, and organizations that provide ECD services and programmes, or support functions.

3.2 Vision

In a world fit for children, every child should have:

“...A nurturing, caring and safe environment to survive, be physically healthy, mentally alert, emotionally secure, socially competent and be able to learn.” (United Nations, *A World Fit for Children* 2002)

3.3 Mission

To facilitate, measure and monitor the provision of a range of ECD services and programmes that include a developmentally appropriate curriculum, knowledgeable and trained staff and educators, and support the health, nutrition, physical and social wellbeing of children.

3.4 Goal

To ensure that children have opportunities to access a range of quality, developmentally appropriate ECD programmes that promote their care, protection and development.

3.5 Strategic objectives

1. To develop a range of quality, developmentally appropriate ECD programmes that promote the care, protection and development of children.
2. To offer comprehensive services to children that support their health, nutrition and social well-being.
3. To encourage ECD programmes which build on the strengths, traditions and resourcefulness of families and communities.
4. To promote the development of the English language in ECD programmes and services.
5. To promote the development of healthy physical environments for children in ECD programmes.
6. To promote quality services through the implementation of norms and standards and ongoing research.

7. To train of ECD service providers as well as parents and caregivers.
8. To develop and implement mechanisms for integration, co-ordination and inter-sectorial collaboration.
9. To promote the implementation of an integrated management information system.

The strategic objectives constitute the framework for intervention and resonate with the five approaches to developing children as proposed by the World Bank:

- delivery of quality services to children;
- training of caregivers and educating parents;
- promoting community development;
- strengthening institutional resources and capacity;
- building public awareness.

3.6 Principles

How we intervene to achieve the desired outcomes for ECD in the province must be underpinned by the following principles:

- children have a right to ECD provision and for it to be provided in a holistic, integrated way;
- access for children to attend and families to participate in ECD programmes and services should not be limited by such barriers as costs, disabilities, health status or any other eligibility criteria;
- the principle of equity must receive priority to ensure that the most disadvantaged and those with the fewest resources have the same opportunities as all other children;
- programmes must reflect diversity and respect the cultural backgrounds of the children being served whilst also preparing them to participate with confidence in the broader society;
- all partners must be accountable for achieving the objectives and outcomes of this strategy.

3.7 ECD provisioning strategy

The primary purpose of the ECD Strategy is to ensure that as many children as possible have access to quality, affordable ECD provision. To achieve this within the context of the historical legacy of provision, coupled with the sheer volume of children that require access, places a challenge on policy makers to make policy decisions that are equitable, developmental, innovative and cost effective to replicate.

This strategy is based on the premise that about 25 % of people are able to pay for ECD provision of their choice and that government will have to subsidise provision to the remaining 75 %. Full coverage for 0-4 in centre-based ECD is also not envisaged, however full enrollment in Grade R by 2014 is envisaged, as well as incremental access to ECD services for all within the next five years.

The various elements of this strategy will be implemented by the Departments of Agriculture, Education, Health and Social Development, in ECD centres, as well as out of centres for children between the ages of 0 and 9, as of the 2012/13 financial year.

The Department of Agriculture will:

- Provide technical advice and support for the establishment and maintenance of food gardens for ECD centres and programmes.

The Department of Education will:

- Provide public and ECD independent schools with a per capita learner subsidy for each Grade R learner (Four and half to six years of age);
- Provide compulsory schooling for all children from ages 7 to 9 i.e. Grades 1-3;
- Provide nutritious meals for Grades R – 3 learners at public schools within disadvantaged communities;
- Provide accredited training at FET Colleges on ECD Levels 1, 4 & 5 for unqualified or under-qualified ECD practitioners (EPWP funding);
- Design, develop and facilitate the Pre-Grade R curriculum (Site-based learning programme for three to four year olds).

The Department of Health will:

- Provide child health, nutrition, health promotion, and environmental health services in and out of ECD centres.

The Department Social Development will:

- Register ECD centres;
- Conduct accreditation of ECD programmes;
- Develop alternative models of ECD provision;
- Develop an ECD Provisioning Plan that can inform planning and budgeting;
- Manage the ECD budget and payment of subsidies;
- Provide training and capacity building of practitioners, service providers and boards of management;
- Develop procedures and operational guidelines;
- Monitor compliance with norms and standards;
- Manage of stakeholder relationships;
- Participate in national policy processes;
- Conduct public awareness, education and advocacy.

3.7.1 Substantially increase out-of-centre or home and community based programmes by setting a target of 30%

The scope of the current need for provision points strongly to the fact that a significant expansion of quality centre-based ECD provision is currently not a financially viable option and neither will it provide the desired coverage in either the medium or longer term. Therefore, out-of-centre programmes will be increased on a larger scale, in order to cover those children in need, in a cost-effective manner. Out of centre programmes also have the advantage of being able to target vulnerable children, working directly with the parent or caregiver, providing support to teenage parents and parents of special needs children, monitoring progress in subsequent visits and being able to identify risk or problems early on, and referring these for appropriate interventions.

To accelerate development in the province it is urgent that our ECD interventions are better targeted to address the needs of these most vulnerable young children in the context of their families and communities. To reach them there needs to be a much greater emphasis on community coverage through outreach to caregivers through community based workers specifically trained to deal with younger children. This is a strategy that the Western Cape DSD has increasingly supported over the last six years. Such interventions are also well-placed to provide an integrated approach to supporting the health, nutrition and stimulation needs of young children and to reach them as early as possible.

Community-based workers must be in sufficient concentration in order to have significant reach. For them to be fully effective they require a supportive and functioning health and social services system in which supervision of community workers is critical.

Successful outcomes of home- and community-based interventions are dependent upon a number of conditions. The common feature of Malawi, Bangladesh and Brazil where maternal and child health interventions have been scaled up is the training and deployment of large numbers of community-based health workers equipped with a “package” of core interventions who enjoy regular and appropriate support from the health services at sub-district and district levels, and who are catalysts for, or empowered by, enhanced community engagement.

Similarly, the effectiveness of home-visiting programmes aiming at child protection and development has been associated with training and support to programme sites. Key requirements are the frequency of home visits, supervision of implementation, and clear and specified content/activities for the home visit. In the South African context strong linking to other services is needed to form a safety net for young children.

The lack of consistent funding has been a significant challenge in retaining trained and experienced workers. This needs to be addressed if the programme is to be effective. Possible sources that might be looked to in the startup stages of such a programme include the Community Works Programme and EPWP.

A number of promising models of community based provision of ECD services are implemented by NGOs in the Western Cape and elsewhere in South Africa (Biersteker, 2007) but these are relatively small scale. Pilots which scale such services to district level should be established in representative districts (peri-urban and rural) and thoroughly evaluated to inform later roll out in districts across the province.

3.7.2 Invest in provision of quality, developmentally appropriate centre-based ECD programmes that promote care, protection and development

a. Limited centre –based expansion with focus on quality for next 2 years

Some five or six years ago there was rapid expansion of centre-based ECD through the presidential massification programme. This intervention regarded ECD primarily as a vehicle to address childhood poverty and its goal was to expand coverage as rapidly as possible so as to ensure that no child goes hungry. Although this intervention demonstrated that with political will and financial resources it is possible to reach targets, it also demonstrated that quality is compromised when only quantitative goals are set for a programme which equally demands quality in order to facilitate long-term development and poverty reduction. Certainly in this province the evidence showed that with limited institutional capacity within the department of Social Development, quantity of provision outweighed quality.

The findings of various research studies on ECD provisioning make it clear that only substantial investments in *quality* programmes will achieve the child development outcomes needed to help children develop to their full potential. Coupled with this, the introduction of the Children’s Act now places a statutory obligation on quality with its focus on governance and management of centres, accreditation of programmes, and monitoring of the implementation of norms and standards. If we are to achieve the desired child development outcomes, there will have to be a focus on quality.

Quality is multi-dimensional and refers to, amongst others:

- the quality of the programme, the quality of the teacher training, the supervision and mentoring given to teachers and practitioners;
- the teacher: child ratio;
- materials available;
- the degree of involvement of, and support for, parents and caregivers;
- infrastructure;
- the physical and social environments of the children;
- governance arrangements;
- funding; and
- nutritional support.

It is therefore proposed that the focus be placed on improving quality for the next two years and that during this period, funding for centre-based programmes only be considered in respect of those that fully comply with norms and standards and are located in high priority areas. Conditional registration and support is the route in high priority poor areas, to being able to comply with norms and standards. This focus on quality should include pilot projects that will provide insights into models to be replicated. To achieve this objective, a number of ECD enrichment centres have and will continue to be established. A range of services aimed at improving the quality of service provisioning will be piloted at the enrichment centres.

b. Stratified funding

There will be two funding scales for ECD centres: those which comply with norms and standards being paid at a scale of R15 per child per day as per the national formula; and retaining the scale of R12 per child per day for those which are already in our payment system but do not yet comply. This is a mechanism for incentivising crèches to improve quality and comply with norms and standards. Additional support for those that do not yet comply can be garnered from private donors and other sources to assist in reaching compliance levels. Provincial government, in partnership with local municipalities, could also provide once-off grants for centre development and improvement.

c. No funding to centres with fewer than 20 children

This new strategy provides us with an opportunity to make a distinction between private care arrangements between a parent and a caregiver, and a community service by a registered non-profit organization with a functional board of governance, to a number of children.

The preliminary findings of the audit of almost 2000 unregistered facilities indicate that about 7,7 % of them are small centres with fewer than 20 children, started by individuals in their homes or backyards and are often in quite close proximity to each other. They generally do not comply with the norms and standards as set out in the Children's Act and often exist because of the entrepreneurial spirit of the owner/founder rather than because of the need to render a community service. Although even this is better than leaving a child unattended or unsupervised and provides some sort of service to working families, the cost of administering and monitoring them is overly burdensome for both the service provider and the government. Such centres should be given the option of operating privately without financial support from the Department. Alternatively, they can be encouraged to consolidate into one centre which, if they comply with requirements, could apply to the department for financial assistance.

The only exception to this would be in instances (especially in rural areas) where a facility with fewer than 20 children is the only facility within a 5 kilometer serving a community.

d. Increasing access to Grade R- Models of provisioning

In Education White Paper 5, access to Grade R would be available at three different sites.

- Reception Year programmes within the public primary school system.
- Reception Year programmes within community-based sites, and
- Independent provision of Reception Year programmes.

Furthermore, it was envisaged that universal access to Grade R would be achieved by 2010, but this strategic objective has now been shifted to 2014. In the quest to universalise access to Grade R by 2014, the first priority would be that all public ordinary schools should become the sites for the provision of accredited Reception Year programmes for approximately 85 per cent of all 5 year olds and the remaining percentage would be accommodated within independent schools and selected ECD independent schools (formerly referred to as community-based sites).

In 2008 it was proposed that community-based sites, which were offering a reception year programme and complied with the specific criteria, should register as ECD Independent school.

As will be the case with public primary school-based Reception Year provision, these ECD Independent schools would also be required to fulfill national policy and norms and standards on the provision of Reception Year programmes

In the Department of Basic Education's Strategic Plan for 2011-2014 (9 March 2011), the first outcome dealing with the improvement of quality of basic education, one of the key outputs would be the improvement of early childhood development through the universalization of access to Grade R and the improvement of the quality of early childhood development programmes.

Part of improving the quality of Grade R would include capacity-building directed at practitioners and a gradual improvement in the formal levels of qualifications of teachers.

Chapter 4: Implementing the Strategy

4.1 Implementation plan

As noted above, a number of departments have responsibility for the provision of ECD services and programmes. The matrix below is a synopsis of the roles and responsibilities of key departments in achieving each of the key strategic objectives of this strategy:

ACTION	RESPONSIBLE DEPARTMENT	INDICATOR
1. To develop a range of quality, developmentally appropriate ECD programmes that promote their care, protection and development.		
Design and accreditation of programmes Development of alternative models of ECD provision Put ECD provisioning plan in place Manage research projects Advocacy/ awareness creation/communication with communities Registration of ECD facilities and funding of poor children Development of alternative models (Enrichment Centres, playgroups, home based care, outreach programmes for children on farms in rural areas) Implementation of legislation Development of Partial Care and ECD strategy Inspection of partial care facilities Development of norms & standards Funding Medium to long term Manage research projects	DSD	No of registered ECD sites that are implementing the registered pre-grade R Early Stimulation Programme Services/programmes meeting registration requirements Registered ECD appropriate subsidy cover Access to non centre ECD provision Participation of parents and caregivers in support programmes Public policies in support of ECD are monitored against departmental plans, programmes, budgets and delivery Annual provincial budget

Plan and manage expansion of out-of-center or community based ECD services Facilitate birth registration drive Development of cost effective models of funding ECD provision		allocation for ECD
Ensure universal birth registration	Department of Home Affairs	100% coverage
Provision of child support grants to eligible children and caregivers	South African Social Security Agency	100% coverage
2. To offer comprehensive services to children that support their health, nutrition and social well-being.		
Health Screening of children including; Nutrition, Immunization, growth and development <ul style="list-style-type: none"> Provision of appropriate supplements as required. Assistive devices as well as seating assessment and the provision of buggies as needed. 	DoH	Immunization coverage < 1 year; Vitamin A coverage < 1 year; Vitamin A coverage 12 – 59 months of age Developmental screening under 1 year Health screening of grade 1 learners
Provision of quality nutrition in facilities i.e. adequate, appropriate meals, menu planning, food preparation, safety and hygiene.	DoH DSD DoA	# crèches meeting norms and standards
Nutrition support/rehabilitation of malnourished children in crèches	DoH DSD	# children placed in crèches for nutrition rehabilitation
3. To encourage ECD outreach programmes which build on the strengths, traditions and resourcefulness of families and communities.		
Awareness Campaigns on child health, growth, development, TB HIV and nutrition. Ongoing interventions at Crèches, schools and community forums.	DoH(Health Promotion, ACSM, Community health workers)	# crèches covered during outreach campaigns
Ongoing interventions including workshops at crèches, schools and other community forums	DoH DSD	# workshops at creches
4. To promote the development of the English language in ECD programmes and services.		
In accordance with the Language Policy, instruction in	DoE	Number of ECD centres and

<p>the Foundation Phase would preferably and largely be in the Mother-tongue.</p> <p>Using the additive bi-lingual approach, English would also be introduced within the Foundation Phase</p> <p>A stimulating, text-rich environment would further develop the acquisition of English in the formative years</p>		<p>services that provide instruction in English</p>
<p>5. To promote the development of healthy physical environments for children in ECD programmes.</p>		
<p>Provisioning of land</p> <p>Alignment of bi-laws with norms & standards and the Children's Act</p> <p>Make buildings available for partial care services and for children with special needs</p> <p>Maintenance of buildings/infrastructure</p>	<p>Municipalities</p>	<p>No of sites made available</p> <p>By-laws aligned with Children's Act</p> <p>#creches meeting norms and standards</p>
<p>Facilitate infrastructure improvement</p>	<p>DSD</p>	
<p>6. To promote quality services through the implementation of norms and standards and ongoing research.</p>		
<p>Provision of quality nutrition in facilities i.e. adequate, appropriate meals, menu planning, food preparation, safety and hygiene.</p>	<p>DoH DSD</p>	<p># crèches meeting norms and standards</p>
<p>Development of the curriculum and stimulation programmes for ECD</p> <p>Universal access to all Grade R children by 2014</p> <p>Advocacy and promotion of Grade R</p> <p>Improving the Quality of Learning and Teaching</p>	<p>DoE/DSD</p>	<p>Number of sites that offer quality Pre-Grade R stimulation programmes for 3-4 year olds</p> <p>No of Grade R learners</p>
<p>7. Training of ECD service providers as well as parents and caregivers.</p>		
<p>Comprehensive accredited training for care givers/parents that includes the following;</p> <ul style="list-style-type: none"> • Basic child health, growth and development aspects. • Warning/Danger signs in terms of health, growth development and use of road to health book/chart. • How to stimulate the child with developmental delays, Neuro – Developmental Therapy techniques (passive movement, positioning etc.) including the provision of home programmes. • Provision of appropriate, adequate, and safe meals 	<p>Training service providers</p> <p>DoH, DoE & DSD</p>	<p>No of care-givers/parents trained</p>

to infants and young children.		
Training curricula to be comprehensive, including aspects of child health, growth, development and nutrition.	Training service providers NGO's	Review of qualifications and standards
Development of the capacity of parents/primary caregivers (parenting programmes)/boards of management Identification of practitioners for training by WCED Comprehensive Training Manual audit and update	DSD/DoH/DoE	Participation of parents/caregivers and boards of management in support programmes
Provide education related training to ECD practitioners. Providing learnerships.	DoE	Number of trained and competent ECD practitioners – level 4 accredited qualification Number of trained and competent ECD practitioners – level 5 accredited qualification Number of trained and competent ECD practitioner assistants – Level 1 skills programme Number of trained and competent ECD practitioners – Full level 1 accredited qualification
8. To develop and implement mechanisms for integration, co-ordination and inter-sectorial collaboration.		
Capacity of cooks/caregivers in preparing appropriate, adequate and safe meals provided to infants and young children in facilities.	Training service providers NGO's DoH/Municipalities	% crèches meeting norms and standards
Comprehensive monitoring of services provided and adherence to polices and standards.	DSD DoE DoH	Public policies in support of ECD are monitored against departmental plans, programmes, budgets and delivery
Prioritise children's issues in their IDP's Implement effective granting system Active participation in the inter-sectorial collaboration	Municipalities	Provision for ECD in IDps at local level
Inter-sectorial collaboration Enhancement of DSD and WCED institutional capacity to manage the ECD portfolio and fulfill legislative	DSD, DSD, WCED	WG meetings, ECD Strategy, structure and budget in place

requirements such as monitoring the implementation of norms and standards		
9. To promote the implementation of an integrated management information system.		
Registration of partial care facilities	DSD	Services / programmes meeting registration requirements
Registration of ECD programmes	DoE	No of registered ECD sites that are implementing the registered pre-grade R Early Stimulation programme
Monitoring and evaluation of partial care facilities	DoH	
MIS		
Monitoring norms & standards to ensure best possible care and protection		Services/programmes meeting registration requirements

4.2 ALTERNATIVE REVENUE STREAMS

The primary revenue streams for ECD at present are those provided by different government departments and municipalities either as direct financial transfers or as infrastructure or training investments, as well as fees paid by parents or donor funding mobilised by NPOs. International financial support such as that between the Department of Social Development and the Principality of Monaco happens on a small scale and tends to be of limited duration. The extent of private sector investment in ECD through corporate social investment programmes is not fully known but presents an opportunity for further development and could become a valuable alternative revenue stream. Some of the support can be ongoing whilst others can be time-bound, thus enabling as many corporates as possible to contribute in ways that work for them.

The private sector could contribute to quality ECD provision through some of the following:

- “Adopting” a center for a period of time and in this time ensure that the centre is developed so that it complies with norms and standards, before moving on to the next one. This would represent the full package.
- Alternatively, the private sector could invest in elements of the full package such as:
 - fencing of the property to ensure safety
 - provision of baby products (nappies) and/or food
 - provision of playground equipment and equipment for programme use
 - provision of toys
 - equipping the library with books
 - purchasing of major items eg stove, freezer, microwave, television, fire extinguisher
 - governance training to the board of management
 - training of staff eg in first aid, toy making, management of donations

- donating paper and used magazines
- paying the salary of the principal or another staff member such as a handyman/gardener
- purchasing a vehicle
- ongoing maintenance of the center
- covering the costs of insurance of assets
- covering the costs of educational outings for the children
- Donating their 67 minutes on Mandela Day or another occasion, to repairing or renovating an ECD centre.
- Establishing a corporate fund to be used for the express purpose of scaling up quality ECD provision.

ECD centres themselves can become more self-reliant and at the same time reduce their carbon footprint by recycling and, where they have space, starting their own food gardens or making and selling toys.

4.3 MEASURING HOW WE DO: MONITORING AND EVALUATION FRAMEWORK

In order to know if we are reaching our goals and making a difference, we need to measure what we do. Indicators help us to do so. Indicators also help us to set targets, allocate resources, monitor progress and ensure accountability. Furthermore, indicator systems which are embedded in the administrative practices of the relevant government departments and service providers enable us to track how we are doing with respect to the desired outcomes for early childhood.

Although there are many aspects of child development that can be measured, decisions will have to be made about a minimum set of outcomes to be achieved. In their research report published in 2006 on indicators for ECD, the Human Sciences Research Council (HSRC) found that there are no uniform, globally accepted indicators for child development. Based on their research findings, the HSRC proposed a comprehensive indicator set relevant to the South African context and the legal and policy mandates it has to meet. The indicators cover, amongst others, access, quality, policy, family and home environment.

The research report did however caution that an indicator system should be regarded as 'live' rather than fixed and should be flexible enough to be adjusted to the changing environment. Given that comprehensive measurement is time consuming and costly and dependent on the quality of data collection and management systems, this strategy adopts a phased-in approach to, or progressive realization, of indicators. We will thus start with what we have and can measure, and add or adjust as our systems improve or changed circumstances warrant.

In this regard the following 24 indicators will initially be used although it should be noted that some of these such as under 5 mortality rate are cross cutting to other provincial strategic objectives and also measure child wellbeing more broadly:

- Under 5 mortality rate

- Immunization coverage under 1 year
- Developmental screening under 1 year
- Screening of grade 1 learners
- Improved nutritional status in children under 5 years.
 - * vitamin A coverage 6 – 11 months
 - * vitamin A coverage 12 – 59 months
 - * prevalence of underweight children under 5 years
- Enrolment in ECDcentres
- Services / programmes meeting registration requirements.
- Participation of parents and caregivers in support programmes
- Access to non-centreECD provision
- Registered ECD appropriate subsidy cover
- Training of ECD practitioners – level 4
- Training of ECD practitioners – level 5
- Training of ECD practitioner assistants – skills programme
- Training of ECD practitioner assistants – level 1
- No of registered ECD sites that are implementing the registered pre-grade R Early Stimulation programme
- No of grade R learners
- No of ECDcentres and services that include English as part of their curriculum
- Provision for ECD in IDPs at local level
- Public policies in support of ECD are monitored against departmental plans, programmes, budgets and delivery
- Birth registrations in children 0-9 years
- Social grant uptake by eligible children and caregivers
- Annual provincial budget allocation for ECD
- Access for learners with special education needs
- Increased access to screening and referral services

Monitoring and evaluation will be conducted on a continuous basis to ensure that quality and effective interventions and services are being rendered to children and those who care for them.

Monitoring is ongoing and concerned with the collection and analysis of information as a project progresses. Evaluation in turn provides factual information about the comparison between what was intended and what has been accomplished, as well as how it has been accomplished. Both are necessary as they help you learn from what you are doing and how you are doing it because you can:

- Review progress
- Identify risks or problems early on
- Take corrective action that can improve the likelihood of achieving objectives

Monitoring and evaluation in respect of the strategy will be conducted on three levels.

- Internal: relevant departments must monitor and evaluate their own progress in respect of their own plans.
- External: relevant departments will monitor the programs and progress of service providers who receive transfer money, as well as monitor for compliance with minimum norms and standards.
- A joint, representative mechanism will be put in place, with overall responsibility for reporting on progress regarding the successful implementation of the strategy.

In terms of reporting requirements there will, at minimum, be dual accountability and progress reports will have to be submitted as determined by departmental prescripts as well as to the Steering Groups of Strategic Objective 8 and Human Development Strategic Sector Committee.

4.4 RESEARCH

The following areas require investigation and research:

- **Mapping** the coverage of ECD service provisioning and gap analysis: The DSD is currently mapping all social service delivery points and service delivery areas. For ECD this means that point data for all known ECDs, and the service delivery areas of all ECD service providers, outreach programmes and out of centre programmes, are being captured. This will allow the DSD to do a gap analysis between current service delivery and areas of highest need/priority. Furthermore, it will provide the base for the Department's ECD provisioning plan, which is a statutory obligation. In short, it will assist the DSD to do proper and informed spatial targeting, including matching service delivery to areas with the highest rates of child poverty. An attempt will be made to link these to the after-school care programmes being piloted in disadvantaged areas. This way we try to support the continuum of development from ECD through primary and then high school.
- **Costing** the provisioning of minimum quality ECD services in the province, community and centre-based.
- **Improving ECD Quality:** The piloted programmes as well as the enrichment centres will be closely monitored and evaluated in order to learn from these experiences to develop knowledge for use in up-scaling an improved quality of ECD across the province.

- **Social Impact Analysis** of Outreach Programmes: This is a new study that has not been undertaken in the province before. The purpose will be to determine the following: a) how successful ECD outreach and out of centre programmes are in reaching ECD objectives (as determined by the strategy); b) how cost effective this ECD service is given that site based ECDs will never be able to accommodate all children in the province; c) how outreach and out of centre services can contribute to the development of a continuum of ECD service provisioning in the province.
- **Improvement of literacy and numeracy results:** Longitudinal research should be conducted to investigate the impact of quality Pre-Grade R and Grade R programmes on the improvement of the Grades 3 and 6 literacy and numeracy assessment results. This study should include both qualitative and quantitative data and the sample should be a cross-cultural representative of the population of the province.

4.4 COMMUNICATION STRATEGY

A joint communication strategy will be developed and implemented. This will include, but not be limited to:

- Ensuring that all staff in all departments know and understand the strategy and, commit to achieving its goals and objectives.
- Presenting the strategy to the relevant cabinet committee and the applicable standing committees.
- Obtaining cabinet approval for the strategy.
- Ensuring that communities, service delivery partners and other relevant stakeholders are aware of the strategy, contribute to it and support it.
- Widespread dissemination of the finalised strategy.
- Communication must be language and literacy sensitive.

4.5 MANAGING RISK

A portfolio of this size, scope and complexity is invariably associated with a degree of risk. The risks to the Western Cape of *not* increasing the current investment in ECD provision include, but are not necessarily limited to, the following:

- partial achievement of outcomes of the Western Cape Government's provincial strategic objectives, and its broader development agenda;
- continued transmission of inter-generational poverty;
- delays in achieving desired education outcomes /academic performance;
- compromised wellbeing of children ;
- possible increase in anti-social behavior and crime.

Conversely, there are also risks associated with too much investment, too soon. These risks include:

- it may crowd out the budget for other services;
- the institutional capacity and systems may not be in place to support too big and rapid a growth in this sector.

In order to reduce or mitigate the risks associated with this sizeable portfolio, the following measures should be implemented:

- implement a comprehensive communication plan which focuses on securing support for the Strategy at intra, and inter-governmental level, as well as with key external stakeholders;
- recognize that expanding access to quality ECD provision in the most cost-effective manner is part of the longer term developmental agenda of the provincial government and therefore the implementation plan can at best be incrementally phased in;
- address and right-size the institutional capacity of the two key delivery departments namely Social Development and Education, to give effect to the ECD Strategy and in so doing, also their policy and legal mandates;
- measure and report on progress or constraints thereto (with corrective actions), at regular, predetermined intervals.

4.6 GOVERNANCE AND INSTITUTIONAL ARRANGEMENTS

Given the transversal nature of ECD, successful implementation will depend both on the nature and quality of the intra- and inter-governmental collaboration and the partnership with the NPO sector which has historically carried most of the responsibility for ECD provision. In addition, the key Departments must be appropriately resourced so that they have the institutional capacity to deal with the size and scope of their portfolios and also the statutory requirements of the Children's Act. In this regard the Departments of Social Development and Education in particular should have their current capacity upgraded to the level of a Directorate in order to give focused attention to achieving the objectives and outcomes of the ECD strategy. The implementation plan as well as the more detailed operational plans must be designed to ensure that this materialises.

The following structural arrangements will be in place:

- regular meetings of the ECD work stream to ensure that the strategy is implemented, objectives are met, co-ordination and integration is promoted, and challenges timeously identified and resolved;
- reporting to the Human Development Social Sector Committee (HDSS) when required to report on progress, get buy-in for policy positions;

- the Department of Social Development as the major funder of NPOs involved in the ECD sector, as well as the Department of Education as provider of Grade R and the Foundation Phase, will have their own institutional arrangements with this sector and other partners to ensure that the strategy is communicated, understood, supported, implemented, and that there is compliance with norms and standards;
- logistical and administrative support will be provided by the Department of Social Development who will also be primarily responsible for reporting to the Human Development Strategic Sector Committee;
- community-based approaches need to be linked with intersectoral structures at district and sub district levels. Health, Social Development and Education are the key departments, though others should be drawn in as needed. This will involve Local Integrated ECD Committees, as envisaged in the National Integrated Plan for ECD. A mechanism for linking with intermediaries such as NGO and CBO service providers, who will continue to play a delivery role for community services, needs to be established.

GLOSSARY & ACRONYMS

CAPS – Curriculum Assessment Policy Statement.

CEMIS – Central Education Management Information System.

DSD- Department of Social Development

DoH – Department of Health

ECD - Early Childhood Development – Period from birth to nine years

ECD practitioner- An adult working with young children (Birth to four years of age) at a community crèche or an ECD independent site.

Grade R class – The class for children aged five to six years of age , the year before they start compulsory schooling in Grade 1. The Grade R class could be offered at a public school, an independent school or an ECD Independent school (formerly known as a community crèche).

Grade R practitioner – An adult working with children aged four and a half to six years of age.

ECD Level 4 certificate– A SAQA accredited qualification with 140 credits obtained over a period of 18 months. Certificate is on the same NQF Level as matric.

ECD Level 5 certificate – A SAQA accredited qualification with 140 credits obtained over a period of 18 months. Certificate is on the same NQF Level as matric plus one year.

EPWP – Expanded Public Works Programme – A governmental strategy / initiative in creating job opportunities for unemployed persons by offering them training in order to acquire a qualification. This training opportunity is via a learnership which means that 30% of the learner’s time is spent at a training institution and 70% is spent with on-site training.

ETDP - Education and Training Developmental Practices

NQF - National Qualifications Framework

SASA - South African Schools Act

SAQA - South African Qualifications Authority

SETA - Sectoral Education and Training Authority

SGB - School Governing Body

WCED - Western Cape Education Department

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