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**The Sobambisana ECD Evaluation: Lessons learnt
from home visiting, playgroups and Centre-based
support in poor communities.**

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Abstract

The Sobambisana project was supported by Ilifa Labantwana grant-makers. Over four years, we tested integrated ECD interventions in five rural and informal communities in four provinces. A central goal was to provide evidence for programming and scaling up. Interventions included community playgroups, family home visiting, and ECD site-based practitioner training. A further goal was to assess the quality of programme implementation and derive lessons for effective programming in low resource community contexts. Effects of the interventions on parental care and stimulation, child development, and the quality of ECD site programming were measured at baseline and follow-up. In some instances quasi-experimental designs were employed using wait-list controls. Sobambisana children were followed into Grade R and compared with children from the same communities who had not been exposed to any ECD programme. Child outcome measures included cognitive and language development, numeracy and readiness to learn.

Findings: The effects of home visiting programmes on caregiver affectional care, responsiveness, academic stimulation, and safety and hygiene practices were assessed. Home visiting improved caregiver coping, affectional care, child stimulation, and safety and hygiene. The cognitive development of children in community playgroups improved if the inputs were aligned with skills required in school, and if attendance was high. Home visiting did not improve outcomes on these measures, but had a significant impact on access to health and social services and parenting. In all cases, significant gains in the quality of the daily programme for children in ECD sites were observed following training and enrichment. In Grade R, Children who had attended an ECD site where there had been training and support performed better than children who had other Sobambisana interventions or who had not had any ECD intervention. High levels of malnutrition were found and this reduced the ability of the interventions to improve child outcomes. Home visiting provided the most effective way to reach vulnerable children. Parent education workshops tended to be poorly attended and required high attendance to make a difference to parenting behaviours.

Background

Sobambisana is one of seven components of the Ilifa Labantwana Project. Full documentation of the evaluation will be available on the website by end September 2012 (<http://www.ilifalabantwana.co.za/>).

The objective of Sobambisana was to develop, implement and evaluate models of ECD provision that would increase access to, and improve the quality of ECD for children in under-served communities in five areas and four provinces.

ECD Policy and Sobambisana

Early childhood development service provision has increasingly become a development priority in South Africa since the change to democratic government. Government seeks to rapidly massify and scale up of services aimed at young children. The National Integrated Plan (NIP) for ECD 2005–2010¹ and the Children's Act No 38 of 2005 (as amended) provide the framework for delivery of a comprehensive range of ECD programmes and services for children under school-going age. Integration in the NIP is defined as:

An approach where services and programmes are provided in a comprehensive and interwoven manner, with the aim of ensuring the holistic development of children.

This requires the development of relationships and links between government departments, NGOs and communities in order to provide comprehensive ECD programmes to the children of South Africa.

The NIP service package includes:

- Universal registration of births;
- Integrated Management of Childhood Illnesses (IMCI);
- Promoting healthy pregnancy, birth and infancy;
- Immunisation;
- Nutrition;
- Referral services for health and social services;
- Early learning stimulation;
- Development and implementation of psychosocial programmes.

¹ Departments of Education, Health, and Social Development, 2005.

As only 30% of children are in formal ECD centre programmes, the NIP for ECD recognises multiple approaches to developing young children, including

- Direct services to children;
- Training caregivers and educating parents;
- Promoting community development;
- Building public awareness.

The NIP had a phased approach, with an initial focus on increasing centre access and quality. Phase 3, which is not yet operational, was intended to work on the establishment of a 'mother-child programme', which included home visits to provide support for parents in vulnerable contexts, deliver early stimulation programmes, and provide a route for referral to appropriate services.

Phase 3 programming has not previously been a focus for government. Even though there are many examples that have been developed by NGOs, these have not been rigorously evaluated. The need for rapid scale up of these programmes makes it essential that scaling up be done using the best available evidence and that all interventions are done at sufficient quality to deliver the intended outcomes.

The Sobambisana Initiative therefore sought to explore the policy, service and delivery priorities of the National Integrated Plan. Participating partners were asked to submit proposals for interventions which:

- Dramatically increase access to developmental opportunities for children under the age of 6 years;
- Are of a high standard and address the very real issue of quality of implementation;
- Ensure the seamless transitions between home, ECD sites and school;
- Define the relationship between participating NGOs and the State (including service integration).

The five ECD NGOs that partnered with Sobambisana addressed these issues in various ways in comprehensive site- based interventions.

The Evidence-base for early interventions

Risks to sound early childhood development

Early childhood outcomes are a function of several key factors. They include the child's genetic make-up and the environmental influences that are present from before birth. The nature and quality of the early home care environment has a critical

impact on development². Of key importance are the cultural expectations for development and methods of child-rearing which influence the manner in which all aspects of early child development unfold³.

Poverty levels in South Africa are very high. Many South African children arrive at school significantly compromised by its effects and especially growth compromised due to food insecurity. Early stunting and undernutrition compromise neurological development and hinder the ability of the child to benefit from education⁴. The manner in which risks to early development operate is illustrated in Figure 1 below which is adapted from Walker and colleagues (2007)⁵. We have added caregiver health and well being which is of critical importance in early development. Maternal depression has been identified as a threat to development in their most recent paper⁶. As a consequence of high prevalence of HIV and AIDS and infectious diseases such as tuberculosis, early child care is compromised as carers labour under the burdens of long term poverty and illness as they struggle to provide care for the young⁷.

² Richter, L. M. (2003). Poverty, underdevelopment and infant mental health. *Journal of Paediatrics and Child Health*, 39, 243-248. Richter, L. M. (2004). Early child development in resource poor settings: Balancing children's material and mental needs.

http://www.who.int/child-adolescent/health/publications/CHILD_HEALTH/ISBN_92_4_159134_X.htm

³ Miller, P. J. & Goodnow, J. J. (1995). Cultural practices: Toward an integration of culture and development. In J.J.Goodnow, P. J. Miller, & F. Kessel (Eds.), *Cultural practices as contexts for development* (pp. 5-16). San Francisco: Jossey-Bass Publishers.

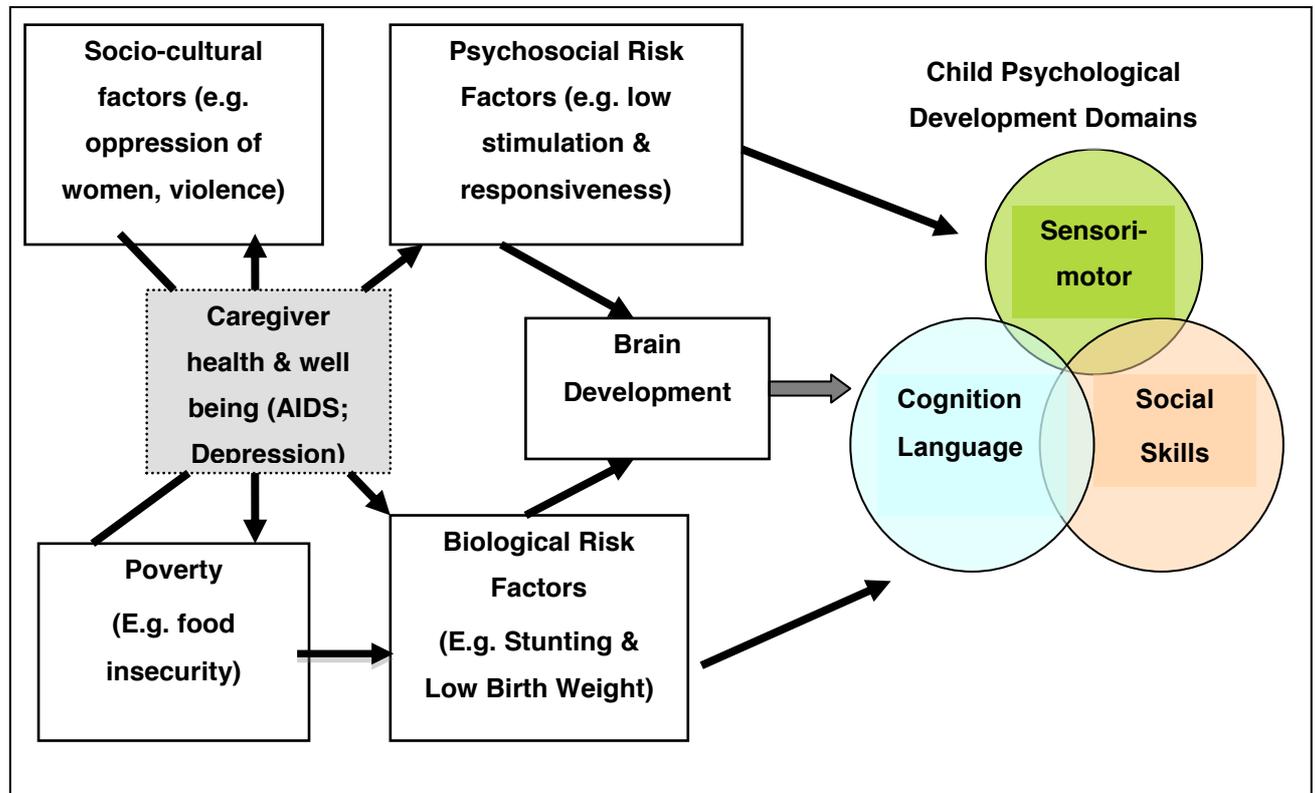
⁴ Walker, S. P., Wachs, T. D., Meeks Gardner, J., Lozoff, B., Wasserman, G. A., Pollitt, E. et al. (2007). Child development: risk factors for adverse outcomes in developing countries. *The Lancet*, 369, 145-157.

⁵ Walker, S. P., Wachs, T. D., Meeks Gardner, J., Lozoff, B., Wasserman, G. A., Pollitt, E. et al. (2007). Child development: risk factors for adverse outcomes in developing countries. *The Lancet*, 369, 145-157.

⁶ Walker, S. P., Wachs, T. D., Grantham-McGregor, S., Black M. M., Nelson C. A., et al (2011) Inequality in early childhood: risk and protective factors for early child development. *The Lancet*. www.thelancet.com Published online September 23, 2011 DOI:10.1016/S0140-6736(11)60555-2

⁷ Brandt, R. (2007). Does HIV matter when you are poor and how? The impact of HIV/AIDS on the psychological adjustment of South African mothers in the era of HAART. PhD University of Cape Town. Richter, L. M., Manegold, J., & Pather, R. (2004). *Family and community interventions for children affected by AIDS*. Cape Town: Human Sciences Research Council.

Figure 1: A Conceptual Model of How Risk Factors Affect Early Childhood Psychological Development



Interventions designed to reduce risks and promote development in the years prior to school need to appreciate each element of this complex chain of relationships.

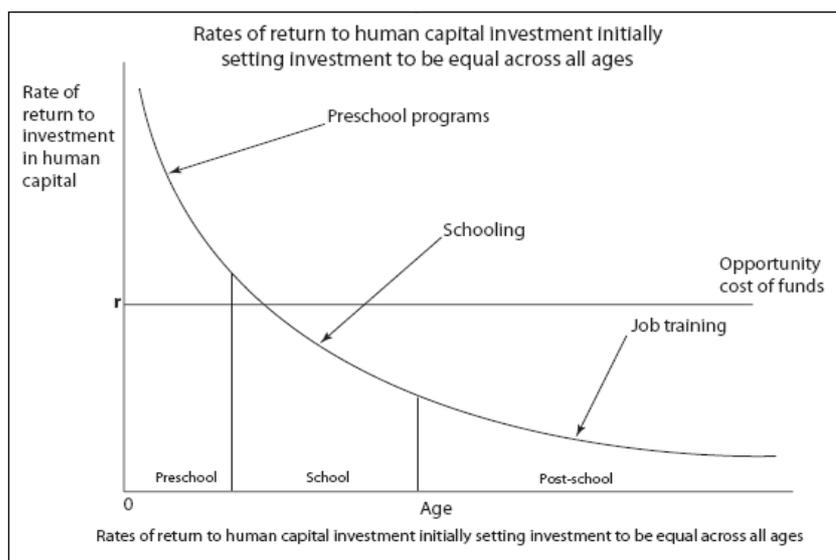
Interventions to ameliorate risk

Evidence for the effectiveness of interventions in early childhood is robust, and derived from meta-analyses, systematic reviews of randomised controlled trials, and longitudinal studies mainly from high income but also from poorer regions of the world. 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 also reducing later-life problems that will burden not only the mental and physical health systems, but also other areas of society⁸.

⁸ Anderson, L, Shinn, C, Fullilove, M et al(2003) *American Journal of Preventive Medicine*, 24(3S), 32–46. Engle, P. L., Black, M. M., Behrman, J. R., Cabral de Mello, M., Gertler, P. J., Kapiriri, L. et al. (2007). Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *The Lancet*, 369, 229-242. Reynolds, A. J. and Temple, J.A. (2008). Cost-Effective Early Childhood Development Programs from Preschool to Third Grade. *Annual Review of Clinical Psychology*, 4, 109–39. Walker, S. P., Wachs, T. D., Meeks Gardner, J., Lozoff, B., Wasserman, G. A., Pollitt, E. et al. (2007). Child development: risk factors for adverse outcomes in developing countries. *The Lancet*, 369, 145-157.

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 time⁹. 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 2).

Figure 2: Economic Benefits of Interventions Early in Life



(Source: Heckman & Krueger, 2003)

South African policies and programmes focusing on ECD need to take account of the evidence that programmes with long term effects are well resourced to achieve quality and high cost benefits.

For formal centre based ECD interventions, the evidence of key inputs associated with positive child outcomes is well established. In particular this includes trained caregivers/teachers who are able to scaffold children’s learning, a set curriculum, availability of learning materials and play equipment, ECD centre management and financial sustainability, programmes that attend to children’s physical, social, and emotional needs, as well as cognitive needs, parent and community involvement¹⁰.

Yoshikawa, H. (1995). Long term effects of early childhood programs on social outcomes and delinquency. *The Future of Children: Long Term Outcomes of Early Childhood Programs*, 6, 51-75.

⁹ Heckman J.(2006). Skill formation and the economics of investing in disadvantaged children. *Science* 312, 5782, 1900 – 1902. Heckman, J. & Kreuger, A.B. (2003). *Inequality in America. What role for human capital policies*. Boston: MIT Press.

¹⁰ Biersteker. L. & Kvalsvig, J. (2007) Early childhood development and the home-care environment in the pre-school years. In A. Dawes, R. Bray, & A. Van der Merwe (Eds.),

It is reasonable to expect that the same factors would apply in respect of community playgroups, which are also a group experience. These may be offered part time and the frequency of sessions would be an additional factor. Using less qualified community volunteers could affect outcomes but there is evidence that this type of intervention can have positive effects on child outcomes¹¹.

The evidence in respect of home- and community-based interventions is less clear-cut because programmes target children of different ages and have different goals and approaches making them difficult to compare. Nevertheless, evidence of the positive impact of community-based interventions is emerging from the health, social development and education sectors. Furthermore such interventions have been shown to stimulate demand for services¹². Home visiting in general is emerging as a promising strategy for helping parents and promoting the growth and development of young children indicates positive outcomes^{13, 14}. Facilitating effective links with a range of other local services is another important aspect of home and community ECD services¹⁵. 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. Programming parameters that have been shown to be improve parenting and early stimulation include: ¹⁶

- Parental participation needs to be active, engaged and regular, normally over extended periods.

Monitoring child wellbeing. A South African rights-based approach (pp. 159-190). Cape Town: HSRC Press.

¹¹ Rao, N.; Sun, J.; Pearson, V.; Pearson, E.; Liu, H; Conostas, M.A & Engle, P.L (forthcoming). Is Something Better than Nothing? An Evaluation of Early Childhood Programs in Cambodia. To appear in *Child Development*.

¹² Manandhar D.S., et al. (2004). Effect of a participatory intervention with women's groups on birth outcomes in Nepal: a cluster-randomised controlled trial. *The Lancet*, 364(9438), 970-979.

¹³ Weiss, H. & Klein, L.G. (2006) Changing the conversation about home visiting: scaling up with quality. Harvard Family Research Project. Accessible at www.hfrp.org.

¹⁴ Paulsell, D., Avellar, S., Sama Martin, E., & Del Grosso, P. (2010). *Home Visiting Evidence of Effectiveness Review: Executive Summary*. Washington, DC.: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

¹⁵ UK Government (2010). Paper 5: Evidence on Interventions to Improve Parenting, the Home Learning Environment and Early Years Attainment. Background report to Field, F (2010), *The Foundation Years: preventing poor children becoming poor adults: The report of the Independent Review on Poverty and Life Chances* accessible at <http://webarchives.nationalarchives.gov.uk/20110120091228/ht>.

¹⁶ Dawes, A., Biersteker, L. & Irvine, M. (2008) What makes a difference to child outcomes in the period 0 – 4? Inputs for quality ECD interventions. Scaling up ECD 0 – 4 years in South Africa HSRC.

- Home visiting needs to be *frequent* – weekly visits have the best chance of success. In terms of duration and contact (home visits and group meetings over at least a year is desirable).
- For good outcomes to occur, the relationship between participant and programme staff needs to be stable, warm, supportive and uncritical. Also, the practitioner skill in work with parents is a key determinant of success.
- *Joint interventions* to improve child development (e.g. language and cognition) that involve direct activities with the child *and* training with the parent, plus joint activity with both, work best to improve cognitive and language development.

The Sobambisana evaluation provides the opportunity to assess whether and to what extent the international evidence of quality parameters for different ECD programmes and services applies in different South African contexts.

The Sobambisana Interventions

Only the central interventions for each implementing partner are reported here including training for centre-based ECD practitioners based training, home visiting and playgroups. Detailed discussion of partner interventions is covered in each report (see the website).

Centre-based training and enrichment to improve ECD site quality

The ELRU School Enrichment Intervention

Capacity building workshops were offered to teachers in Foundation Phase classes and community preschools to improve the quality of these services. Workshops and site support were offered during ELRU visits to the area (initially 4 times and later 7 times per year). Community preschool committees were involved in training to help get these established and become eligible for the Department of Social Development subsidy.

The Ntataise Enrichment Programme (NEP)

The intervention aimed to assist practitioners who have received formal training (preferably Level 4) with practical implementation of a quality learning programme for 3 – 5 year olds in their classes, and to prepare them for school. The intervention included provision of suitable learning materials, monthly theme workshops and on-site modelling of good practice twice per term.

CECD ECD Practitioner Training

In 2009/10 a Level 4 training programme was offered. In 2010 a Skills programme consisting of 15 workshops and on-site support focused on improving the teaching and learning environment was provided.

Khululeka Preschool Enrichment Programme

A Level 4 (FETC in ECD) Training programme was delivered at Khululeka in Queenstown over a period of two years (each session was two weeks in duration). Theory sessions alternated with skills workshops in which trainees were exposed to methods of making equipment. On-site visits provided individual support for practical implementation.

TREE ECD Site Training and Support Programme

The intervention was a multipronged strategy including practitioner training at Levels 1 and 4, management training, as well as capacitating the local ECD Forum. The outcome and impact of practitioner training was evaluated.

Advocacy with government structures to improve services to young children

CECD Advocacy

This intervention was implemented to improve coordination and efficiency of services at local level. CECD engaged with different departments and especially the Municipality.

ELRU Wakh' Umtwana Wakh' Isizwe

This intervention aimed to raise community awareness of the importance of early childhood development and to develop local and provincial government officials' understanding of the need for integrated service provision for young children in order to create the necessary supports for vulnerable young children. The intervention involved information sharing and discussion at imbizos of community members, NPOs and government officials. These were held 3 or 4 times each year and were also used to provide feedback on progress. In addition ELRU followed up with individual meetings to different stakeholders during their visits to the area. It was also intended to establish a Local Monitoring and Action Structure to improve service delivery to vulnerable families and young children.

TREE Advocacy to Provincial and Local Government

TREE had aimed at facilitating the development of a Municipal Children's Forum of stakeholders involved in children's programmes including government officials, political and traditional leadership and service organisations. This was to develop

support for young children and the different interventions for them in the area. A component of the intervention was to get ECD included in the Integrated Development Plan of the Municipality.

Home-based interventions to improve health, nutrition and early learning environments of children not in formal ECD

The CECD Family Outreach Programme

In this programme vulnerable young children and their carers received 18 home visits of about one and a half hours and one group workshop a month at which toys were made from waste materials, and information about child development was provided along with a food parcel. During the visits the visitor supported the caregiver, provided knowledge to help them provide good care and demonstrated early stimulation activities with the child.

The ELRU Family and Community Motivator (FCM) Home Visiting Programme

In the FCM programme vulnerable households with young children received two 2-hour home visits a month and a monthly cluster workshop with other caregivers and an informal playgroup for children. Caregivers were provided with emotional support exposed to key messages about providing a safe, healthy and stimulating environment for young children, and linked the family to services grants and services. Each visit included a session where the FCM and caregiver are engaged in play activities with the children using locally available materials and a toy kit.

Khululeka Family Home Visiting Programme (FHV)

The FHV programme targeted very vulnerable children who were not attending ECD services. Visits were conducted by trained and supervised Community Development Practitioners (CDPs) and lasted up to two hours. In the first year the programme content included service referrals, health, nutrition, caregiver support and child stimulation. Because child stimulation was not a priority for very vulnerable caregivers, the programme was adjusted in 2010 to focus on basic needs such as grant access, health and nutrition inputs and caregiver support. Children were provided with a toy bag but there was no focused educational input in year two.

Community Playgroups to provide ECD education for parents and stimulation for children not in formal ECD

Ntataise Mosupatsela Playgroup Programme.

A weekly two hour playgroup programme was offered for parents and children aged 3 – 5 years in different outdoor locations, with a focus on school readiness activities. The target was children who were not able to attend preschools, mostly because their parents could not afford fees. Parents were expected to attend with children so that they could learn to support the learning of both the playgroup children and others in their homes but parent attendance was poor and inconsistent in both years.

TREE Structured Playgroup Programme

This programme provided developmentally appropriate experiences, with accompanying resources, and targeted young children aged 3 - 5 years who did not have access to preschools. The original approach in 2009 was that play facilitators (PFs) chosen by the community and trained and supported by TREE, were each responsible for 10 playgroups for 10 – 15 children. Play facilitators in turn trained parents of participating children to run these groups on a rotating basis. While large numbers of children were reached, the programme was not delivered as designed with several playgroups becoming more like ECD centres and enrolling too many children. Quality controls could not be maintained.

In 2010 the programme was revised to improve oversight and quality. Play facilitators were responsible for 4 playgroups each and facilitated a session once per week. Volunteer parents hosted the groups and offered them on days when the PF was not present. Refresher training on the programme was provided to play facilitators once per month.

Parent education programmes

The Khululeka Infant and Toddler Support Programme (I&T)

The I&T programme targeted caregivers of children from birth to six years who were not receiving any form of ECD service. Caregivers attended weekly group sessions lasting 2 – 3 hours accompanied by their children. They received information about child development and stimulation and practical sessions in which they made early stimulation and play resources while the children participated in informal play activities. In the first programme cycle thirty-five sessions were offered. Due to poor attendance, this was cut to between 16 and 19 in the second cycle.

The Ntataise Parent Support Programme (PSP)

PSP was a series of workshops aimed at parents of children enrolled in preschools. Matrons (preschool supervisors) were trained to deliver the workshops each of which included a listening and sharing time to support the parent, inputs on early brain development, knowledge building modules or bookmaking sessions, and a learning game (activities to be done with the child at home).

Evaluation Questions

A key goal of the Sobambisana initiative was to improve access to ECD among children currently excluded. A further goal was to test the effectiveness of approaches to improving the early development environments of the home and the ECD site so as to provide better quality of care and early stimulation to children. A final goal was to engage stakeholders in supporting provision of integrated holistic services to vulnerable young children and their families.

If these goals were to be realised, the quality of implementation needed to be sound and to follow the programme manuals and design. Implementation evaluation was used to assess the nature and quality programme delivery.

These goals informed the evaluation questions which together with data sources are presented in Table 1.

Table 1: Evaluation Questions and Primary Data Sources

Implementation Evaluation	
Questions	Data Sources
<i>1: Were partner interventions delivered as intended?</i>	<ul style="list-style-type: none"> • Partner Project Proposals submitted to the donor (Projections of reach). • Partner annual M&E narrative reports (2010 and 2011). • Partner programme descriptions, implementation manuals and plans, and their theories of change for each intervention. • Minutes of meetings and consultations with partners. • Interviews with programme staff and beneficiaries. • Site visits by the M&E team.
<i>2: What were the perceived benefits of beneficiary participation and barriers thereto?</i>	<ul style="list-style-type: none"> • Partner annual M&E narrative reports (2010 and 2011). • Minutes of meetings and consultations with partners. • Interviews with programme staff and beneficiaries conducted by both M&E team and independent interviewers.
Outcome Evaluation 1: Reach	
<i>1: Did the interventions reach their intended targets?</i>	<ul style="list-style-type: none"> • Annual reports to the donors. • Partner quarterly M&E reports. • Partner annual M&E narrative reports (2010 and 2011). • Interviews with programme staff.
<i>2: Did the interventions increase ECD opportunities for vulnerable children?</i>	<ul style="list-style-type: none"> • Partner Project Proposals submitted to the donor (Projections of reach). • Enrolment and participation data captured in the Common Data Entry Tool. • Partner quarterly M&E reports. • Interviews with programme staff.
Outcome Evaluation 2: Adult outcomes	
<i>Did the interventions improve the capacity of caregivers to provide safe, hygienic and stimulating environments for children who are not in formal ECD?</i>	<ul style="list-style-type: none"> • The Common Data Entry Tool: Scores on the H.O.M.E inventory and the Hygiene and Safety Checklist.
Outcome Evaluation 3: Child outcomes	
<i>Did the interventions improve cognitive and language abilities, and to improved access to services?</i>	<ul style="list-style-type: none"> • The Common Data Entry Tool: at baseline and follow-up on tests of: <ol style="list-style-type: none"> 1. Cognitive and Language development. 2. Growth. 3. Referrals for services.
Outcome Evaluation 4: ECD site outcomes	
<i>Did site enrichment interventions (practitioner training) improve the quality of early care and learning environments?</i>	<ul style="list-style-type: none"> • The Common Data Entry Tool: Scores at baseline and follow-up on the Early Childhood Environment Rating Scale – R. • Partner annual M&E narrative reports (2010 and 2011). • Minutes of meetings and consultations with partners.

	<ul style="list-style-type: none"> • Interviews with programme staff and beneficiaries.
Outcome Evaluation 5: Effects of Advocacy Initiatives	
<i>Do advocacy initiatives lead to changes in the responsiveness of stakeholders to the needs of vulnerable families and young children?</i>	<ul style="list-style-type: none"> • Partner annual M&E narrative reports (2011). • Interviews with programme staff.
Impact Evaluation	
<i>Do children in Grade R who have experienced Sobambisana interventions perform better on assessments of cognitive, language, numeracy and academic readiness than those who have not received an ECD programme prior to Grade R?</i>	<p>The Common Data Entry Tool: Scores on tests of:</p> <ul style="list-style-type: none"> • Cognitive development; • Language; • Numeracy; • Emotional development. • Growth.

Evaluation Methods

Recommendations for planning, implementing and evaluating interventions such as those implemented by Sobambisana partners are evident from the literature referred to previously and in the programme evaluation literature¹⁷. They apply to home-based early stimulation programmes, ECD site enrichment programmes, playgroup programmes and many others:

1. The intervention goals, design, delivery and outcome measures must be realistic, and informed by a knowledge of the risks to positive early development outcomes.
2. The frequency (similar to a dose) and duration of the intervention must be likely to be sufficient to make the desired difference. This is normally determined with reference to research findings or to the prior experience of the implementing organisation.
3. The intervention must be underpinned by a strong theory of change - why it is expected to make a difference. .
4. It is best that this account is informed by evidence regarding the effectiveness of interventions for producing specific outcomes
5. It is essential to provide a clear description of the intervention, including target participants, activities, goals and outcomes. The activities must be clearly

¹⁷ Engel, P. L., Black, M. M., Behrman, J. R., Cabral de Mello, M., Gertler, P. J., Kapiriri, L. et al. (2007). Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *The Lancet*, 369, 229-242; Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A systematic approach*. Newbury Park CA: Sage. Donaldson, S.I., Christie, C.A. & Mark, M. (2009). *What Counts as Credible Evidence in Applied Research Evaluation Practice?* Los Angeles: Sage.

linked to the objectives, and clear, measurable indicators for the assessment of progress and outcome must be included.

6. The intervention needs to target those characteristics of participants and their circumstances that, when changed, are likely to lead to an improvement in outcomes. This applies to both direct interventions with children and adults who care for them, and whose changed behaviour is believed to have an indirect positive effect on child outcomes.
7. The intervention itself must be implemented as designed, and the implementation of the programme must be logged by the implementing agency. Known as programme fidelity, this aspect is often not sufficiently considered. Failure to implement the programme as designed will commonly lead to its failure.
8. Measures of outcomes need to be valid and reliable, and must be aligned to the programme inputs and goals. If measures of programme success are not appropriate, one could have a good intervention, but not see the positive results because the measures of success were not appropriate.
9. New interventions (those that are not based on established tested programmes), should be evaluated before any claims to their effectiveness are made.

The Sobambisana project evaluation sought to take all these points into account when supporting the partners to develop sound designs and programme implementation, and when formulating the evaluation questions.

The evaluation methodology was informed by a number of sources that provided guidelines for a multi-faceted evaluation such as that used for Sobambisana. In particular it was important that the evaluation provided *actionable evidence* as far as possible¹⁸. The evaluation can be conceptualised in four stages as depicted in Table 2.

¹⁸ Julnes, G. & Rog, D. (2009). Evaluation methods for producing actionable evidence. In S.I. Donaldson, C.A. Christie, & M. Mark (2009). *What Counts as Credible Evidence in Applied Research Evaluation Practice* (pp. 96-131). Thousand Oaks CA.: Sage. Rossi, P. H., Lipsey, Rossi, P.H., Lipsey, M.W. & Freeman, H. E. (2004). *Evaluation: A Systematic Approach*. Newbury Park CA: Sage.

Table 2: Sobambisana Project Phases 2008-211

Participatory Evaluation Throughout					
2008	2009-2010		2010-2011		
1. Start Up	2. Outcome Evaluations		3. Outcome Evaluations		4. Impact Evaluation
1. Develop relationship with partners. 2. Develop Evaluation Designs & Tools.	Partner Interventions Enrol First cohorts*		Partner Interventions Enrol Second Cohorts		Grade R Child Testing
	Monitoring Implementation				
	Child, Adult and ECD Site Assessments				
	Baseline	Follow-up	Baseline	Follow-up	

(* In some instances interventions commenced in the latter half of 2008.)

The impact evaluation had been planned for two points in time, 2010 (after the first cycle), and in 2011. The National Department of Basic Education failed to respond to repeated requests for permission to test children in Grade R in 2010. Relevant provincial departments were approached for the 2011 session, and permission was granted by the Free State, Eastern and Western Cape, and KwaZulu-Natal.

Design issues

The gold standard for rigorous effectiveness studies is the Randomised Controlled Trial¹⁹. Where this is not feasible (as was the case here), a quasi-experimental approach with suitable controls is acceptable. This was the approach initially chosen for the Sobambisana evaluation.

- Efforts were made to establish quasi-experimental designs (using appropriate comparison groups) for the testing of programme effects on adults and children and on the classroom environment following teacher training and enrichment. The objective was to enrol wait list comparison groups of adults and children and comparison classrooms were possible.
- An effort was made to secure sufficient statistical power by ensuring that the evaluation would cover child and adult beneficiaries enrolled over two years and at least 60 adults and children would be in each intervention and waitlist group for comparison at baseline and follow-up.

¹⁹ Rossi, P.H., Lipsey, M.W. & Freeman, H. E. (2004). Evaluation: A Systematic Approach. Newbury Park CA: Sage.

For reasons that differed across partners quasi-experimental designs could only be realised in a few instances:

- **Home visiting:** Intervention and Wait List comparison groups were enrolled and measured at both baseline and follow-up in the ELRU Family Community Motivator programme, and the CECD Family Outreach Programme.
- **Playgroups:** Ntataise playgroup children were divided into two groups following the intervention – those who had attended less or more than 50% of the sessions. The former acted as a comparison group, and dose-response could be tested.

In all other cases, the outcome evaluation was only able to undertake comparisons between baseline and follow-up in those who had received the intervention. This applies to interventions that sought to change adult, child and practitioner outcomes. It is not an optimal approach because no controls are in place against which changes in the intervention groups can be judged. Nonetheless such an approach can yield findings that are promising and which can be tested under more rigorous conditions.

Ethics

Ethical clearance was obtained from the University of Cape Town Department of Psychology and Faculty of Humanities Research Ethics Committee. Partners obtained consent for child testing from parents. Permission to conduct the impact evaluation was obtained from the Departments of Basic Education in the Free State, Kwazulu-Natal, Eastern Cape, and Western Cape. Permission to test children was obtained from the principals of each school.

Outcome measures

A key element in the evaluation was to ensure common measures across partners. A summary is presented in the two tables that follow.

Table 3: Outcome Measures for Adults

Domain	Indicator	Tool
Care and early stimulation	Quality of caregiver responsiveness to her child	The H.O.M.E. ²⁰ Inventory Responsivity subscale
	Quality of caregiver stimulation of the child's language	The H.O.M.E. Inventory Language Stimulation subscale
	Quality of caregiver stimulation of academic competencies	The H.O.M.E. Inventory Academic Stimulation subscale
	Quality of caregiver parenting and her relationship with the child	The H.O.M.E. Inventory Acceptance subscale
Hygiene and safety	A safe and hygienic environment in the home	The Hygiene and Safety Checklist*

(Designed by the partners and the M&E team)

Table 4: Outcome measures for children

Domain	Indicator	Assessment Tool
Access to services	<i>Successful referrals: Number of children referred for services have attained them at follow-up.</i>	Checklist* 1: Road to Health Booklets 2: Social Grants: <ul style="list-style-type: none"> • Child Support • Care Dependency (Disability) • Foster
Cognitive Development	<i>Improved levels of Cognitive Development {controlling for maturation (age)}. Increased numbers of children are within the norm for their age on the test.</i>	The Grover Counter Scale ²¹
Language Development	<i>Improved levels of Language Development {controlling for maturation (age)}.</i>	The Sobambisana Language Development Standards Assessment** ²²

(*In addition to these cross-partner common outcomes, where children required referral for other services, these were also captured (e.g. Identity Documents; Emergency Food Parcels.

²⁰ Caldwell, B. M. & Bradley R.H. (2001). HOME Inventory Administration Manual. Little Rock: University of Arkansas at Little Rock.

²¹ Sebate, M. (2000). Report on the standardisation of the Grover-Counter Scale of Cognitive Development. Pretoria, South Africa: Human Sciences Research Council. Unit for Assessment Research and Technology, Education and Training; Grover, V.M. (2000). Revised manual for the Grover-Counter Scale of cognitive development (GCS). (With the Unit for Assessment Research and Technology (UART).

²² Department of Basic Education (2009). National Early Learning and Development Standards (NELDS) for Children Birth to Four Years. Pretoria: Department of Basic Education; Kvalsvig, J.D., Govender K. and Taylor, M. (2009). Research on the age validation of NELDS related to the cognitive development of children between 0-4 years. Durban: Child Development Research Unit; Shipley, K. and McAfee, J.G. (1992) Assessment in speech-language pathology. San Diego: Singular Publishing.

**Developed for the Sobambisana initiative and subsequently used in the National Early Learning Standards language validation assessment).

Child Growth Status:

While improvement in growth status was not a goal of the Sobambisana initiative, the growth status of children in all programmes was assessed for *underweight* (weight for age) and *stunting* (height for age) using WHO Anthropometric standards. This data was collected for two reasons:

- Because it is an important indicator of the Sobambisana children's well-being, and,
- The effect of growth status on the outcomes of interest (cognition and language development) was examined. Growth status could have moderated the effects of the Sobambisana interventions as malnutrition in the early years is known to impact neurological development, and as a consequence, cognitive and related functions.

Limitations of the outcome evaluation

There are clearly limitations of pre-post outcome evaluations without controls. A number of sources of bias will be evident. The most important would be:

- That one cannot be sure that external sources of influence could be responsible for the observed change (contamination);
- Lack of randomisation to the treatment is a source of bias in that participants in intervention and wait list groups may have particular characteristics that would have favoured one or other outcome;
- Unknown selection effects are another potential source of bias. For example, caregivers chose to enrol might have been different in some important respect to those who did not. Certainly those who attended diligently are very likely to be different to those who did not.
- It is well known that the effects of conditions in the home play a key role in children's developmental outcomes. It was not possible to control for the potential confounding effects of such differences in participants.

Testing young children is affected by both child and tester variables. All children were tested in the morning so as to avoid the effects of fatigue, which is more likely later in the day

The performance of young children on tests such as the Grover Counter Scales does vary depending on their condition on the day of assessment. For example a child

might not be well, or be tired or hungry (where children were obviously not well they were not tested). Beyond the exclusion of disabled and obviously ill children, and while testing was discontinued if the child was not cooperative, it was not possible to control for the child's orientation to the testing situation.

Assessor variation may also affect findings. While those testing children were trained and supervised, as several assessors were involved, it is possible that there was variation in their approach to testing. For example, they may have been more or less able to set young children at ease – thus affecting their engagement with the task. They may also have been more or less strict. When large numbers of children are tested, this variation is not so critical. As sample sizes were relatively small, variations in children and assessors on testing day would have affected the internal validity of the evaluation.

Impact evaluation in Grade R April- June 2011

As there was no baseline data for certain groups compared at Grade R, impact was measured in a post-hoc design²³. The performance of children who had participated in one or other of the Sobambisana interventions was compared with children who had had no exposure to an ECD programme (with early stimulation components) once they had reached Grade R.

Group comparisons

Comparisons varied across partners depending on their interventions as displayed in Table 5.

Table 5: Post Hoc Comparisons at Grade R.

Comparison Groups at Grade R	Partner				
	CECD	Khululeka	ELRU	Ntataise	TREE
Group 1: Children whose teachers had participated in practitioner training.	X	X		X	X
Group 2: Children who had participated in a home visiting programme.	X		X		
Group 3: Children who had participated in a playgroup programme.				X	X
Group 4: Children with no exposure to an ECD programme.	X	X	X	X	X

²³ Campbell, D. & Stanley, J.C. (1963). *Experimental and Quasi-Experimental Designs for Research*. Boston: Houghton Mifflin.

Measures used to assess children in Grade R are presented in Table 6.

Table 6: Assessment of Child Outcomes: Cognition and Language

Domain	Assessment Tool
Disability Screen**	WHO 10 Point Disability Screen
Growth Status**	WHO Anthropometry Growth Standards
Cognitive Development	The Grover Counter Scale
Language Development	The Peabody Picture Vocabulary Test (PPVT-4) ²⁴
Numeracy ²⁵	Counting Concepts and Number Concepts
	Numerical Concepts
Academic Adjustment ²⁶	SACAS*: <i>Academic Readiness</i> subscale
	SACAS*: <i>Resilience</i> subscale

(* South African Child Assessment Scales; ** Children were screened for disability)

Children's growth status was measured so as to test for its moderating effects on child development measures.

The Grover counter test was used to assess cognitive development in both the child outcome and impact evaluations

The Peabody Picture Vocabulary Test (PPVT-4) was translated into Afrikaans, SeSotho, isiXhosa, SeSotho, and isiZulu, piloted, and adjusted for use within these ethnolinguistic groups.

Children's emotional maturity affects their adjustment to school. Ability to work constructively with peers, to regular emotions and behaviour, confidence and an ability to work independently are all indicators. These characteristics were assessed on two of the South African Child Assessment Scales, namely *Academic Readiness* (Readiness to Learn) and *Resilience*. The SACAS was developed for the assessment of young children in the Birth to Twenty cohort study and has been used

²⁴<http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/enus/Productdetail.htm?Pid=PAa30700>

²⁵ Herbst, I. and Huysamen, G. K., (2000). The construction and validation of developmental scales for environmentally disadvantaged pre-school children. *South African Journal of Psychology*, 30 (3). 19-24.

²⁶ Used in the Birth to Twenty cohort study (www.wits.ac.za/birthto20)²⁶; Barbarin, O. and Richter, L. (2001). *Mandela's children: Growing up in post-apartheid South Africa*. New York: Routledge.

in other studies²⁷. The child's teacher rates the child on a set of items using a three-point scale.

Testing took place during the morning at the children's schools either in a classroom or under a gazebo erected for the purpose in the schoolyard.

Limitations of the impact evaluation

Because post-hoc designs are cross-sectional, one has to be cautious when attributing causality where children perform better on one or other intervention. This is because other uncontrolled sources of such differences may be affecting the findings. For example, if children who were in preschools prior to Grade R perform better than other groups, this may be due to the fact that their families are better off (and can afford the fees) or they may provide a more stimulation environment at home. These are known as selection effects and could not be fully controlled in the Sobambisana study. However, as all the children compared lived in the same economically deprived circumstances, it is likely they did not differ substantially on economic grounds. Controls for age variation were employed in statistical analyses.

Further investigation using longitudinal designs and controls for other likely variables is required to address selection effects.

As is the case of the outcome evaluation, and discussed above, both variation in the child's approach to the testing situation and variation in assessors constitute threats to the internal validity of the evaluation.

FINDINGS

For this paper we summarise the main findings in Table 7. Those for each partner may be accessed from the Ilifa labantwana website. Findings are rated by symbols in terms of their alignment with the international evidence summarised above. More detail is provided after the Table.

²⁷ Van der Merwe, A. & Dawes, A. (2000). Prosocial and antisocial tendencies in children exposed to community violence. *Southern African Journal of Child and Adolescent Mental Health*, 12(1), 19-37.

Table 7: Summary of Sobambisana Findings

Sobambisana Intervention	International Evidence²⁸	Sobambisana Evidence
Home Visiting	Parent / Caregiver education (safety, hygiene, early stimulation and nutrition)	++
	Service access(eg.grants, health)	+
	Caregiver support	++
	School readiness	-
Community Playgroups	Parent / Caregiver education (safety, hygiene, early stimulation and nutrition)	-
	School readiness	+/-
	Link to services	+
Parent Education Workshops	Parent / Caregiver education (safety, hygiene, early stimulation and nutrition)	-
	School Readiness	-
Training for ECD Centre Practitioners (Accredited and Support Workshops)	Classroom quality	++
	School readiness	++
Advocacy for integrated service delivery	Community awareness	+/-
	Local and provincial authorities, NGOs	+/-

(Sobambisana Evaluation Findings: ++ = strong evidence of effectiveness in line with the international evidence; + = fairly positive results; +/- = mixed results; - = no evidence of effectiveness.)

1: Outcomes for Home Visiting

The three home visiting interventions varied somewhat in their delivery but had in common parent/caregiver education on health, hygiene, nutrition and stimulation, caregiver support and linking the household with services.

Two programmes followed the two generational approach of working with parents and children (ELRU and CECD) while the third focused directly on the needs of caregivers but provided play materials to children (Khululeka). Khululeka included demonstrations of food gardens while CECD provided food parcels.

- Home visiting programmes were able to reach significant numbers of caregivers and children and provide support, enable service access and involve them in

²⁸ See the discussion in the introduction.

activities, which stimulate their development and improve the health and safety of the home environment.

- In total 794 caregivers and 1513 children were reached by home visiting programmes between 2009 and 2011.
- These programmes reached children who would not otherwise have had access to developmental opportunities, and they were able to capacitate caregivers to support young children.

In the case of Khululeka and ELRU, home visiting programmes improved hygiene and safety in the home and produced positive changes in parenting behaviours including academic and language stimulation and affectional care. There were no significant changes in parenting in the CECD programme.

Khululeka assessed caregiver coping which improved significantly indicating that the support provided made a difference to caregiver well-being and efforts to take control of their situation.

Assessments of child outcomes showed no improvements in language and cognition for ELRU (the only home visiting programme where this was assessed).

Service access (social grants, road to health charts and other documents and services) improved in interventions where baseline service access was limited.

Impact at Grade R:

When impact was assessed in Grade R, there was no difference in cognitive, language, numeracy or emotional maturity between home visited children and those who had not received an ECD intervention.

Lessons from the evaluation of Home visiting programmes

- A home visiting approach is able to reach very vulnerable families and secure high participation with few visits missed by caregivers though retention in the programme was affected in two communities by in- and out- migration and short term work opportunities.
- Less vulnerable families were better able to gain from the intervention by being ready and involved during the visits but results were achieved even with certain dysfunctional families.
- The interest and support shown by the home visitors was important in helping build caregivers' own motivation to improve their and their children's circumstances.

Evidence from home visiting in the Sobambisana Interventions accords with the international picture in the following ways:

- It is a successful approach for reaching very vulnerable households and securing the participation of caregivers whose young children would not otherwise have had access to developmental opportunities and who were linked to other local services.
- Support improved caregiver coping and agency, hygiene and safety in the home and parenting became more responsive and affectionate and conscious of children's stimulation needs.

Child cognitive and language outcomes did not improve beyond that expected due to maturation.

A number of factors might have contributed to this including the very compromised nutritional status of the children. For example, in the case of ELRU, which was working in the Lusikisiki area, **38%** of the 94 children measured for growth were stunted (>2 Standard Deviations below the median weight for height for their age). In addition, at baseline, an average of **84%** of the children were below the norm for their age on the Grover Counter Test. There was no difference at follow-up and it is probable that compromised growth status and associated neurological deficits contributed to this outcome.

Given the compromised nature of the children and their poor home circumstances, Programme factors were likely to struggle to make a difference. In particular, the stimulation components may not have been sufficiently aligned to school readiness skills (and the outcome measures), and the home visitors, who were all selected from the local communities, insufficiently trained in ECD to facilitate the transfer of these skills to the caregivers.

2: Outcomes for Community Playgroups

Two community playgroup interventions that use structured curricula and which are delivered weekly (for different periods of time) were evaluated. Key differences were that Mosupatsela (Ntataise) had a very strong school readiness activity focus and was offered once a week by a formally trained ECD facilitator, and TREE playgroups provided a broader developmental programme facilitated by a trained locally chosen playgroup facilitator once a week and offered by volunteer caregivers on other days.

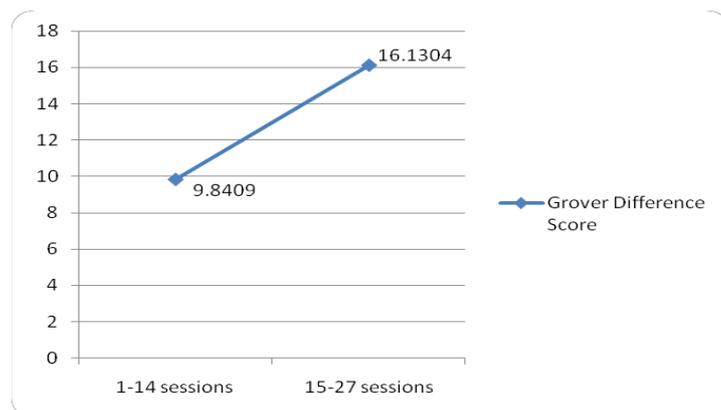
Parent participation was a key element of the programme theory of the former with the intention that stimulation would continue at home. Both were targeted at 3 – 5

year olds who do not have access to preschools. The recommended size for both groups was about 15 children.

Mosupatsela:

- Mosupatsela had a limited reach of 116 children in 2009 and 2010 and low parent participation rates (33%).
- Children who attended 15 or more sessions of Mosupatsela showed significant improvements in cognition compared with children who attended fewer sessions. Calculation of an Odds Ratio indicated that these children were **1.5 times** more likely to be within the norm for their age after the programme, than those who attended less than 15 sessions. Change scores (controlling for age) are displayed in Figure 3. No change was evident for language.

Figure 3: Effects of Mosupatsela playgroup attendance on cognitive development.



- Hierarchical Regression of Mosupatsela playgroup data showed that Age, Stunting and Underweight were significant predictors of cognitive scores at follow-up: ($F(4,34) = 5.73, R^2 = .333, p < .01$). Here there is evidence that older children do better in this playgroup programme, but growth status moderates programme effects.

TREE

- In the case of TREE, 10 Play facilitators reached 1175 children in 2009 and 2010 providing an ECD experience for large number of children who would not otherwise have had one.
- Children in TREE playgroups were referred for documents, clinic cards and social grants and some were successfully resolved (but data is limited). No children were tested on cognitive and language development in this programme.

Impact at Grade R:

- At Grade R, playgroup children had no advantage on cognitive, language, numeracy and academic readiness scores than those who had not had ECD when compared with children who had been in preschools. However, for Mosupatsela, outcomes for Readiness to Learn and cognition were close to statistical significance indicating the potential to promote readiness for school.

Lessons from the evaluation of playgroup programmes:

- A highly structured programme provided by well trained staff and with suitable equipment can have positive effects with relatively light exposure. The parent component was not very successful and may not be a critical element.
- Efforts need to be made to secure more regular child attendance to ensure a higher dose of inputs, as the low dose may be insufficient to change cognitive and language outcomes. Attendance in both models was, on average, much lower than the level expected to make a difference.
- Sustainability of playgroups using volunteer parents and for which many venues are community homes is likely to be challenging in the longer term.
- Mosupatsela delivered promising child outcomes, but numbers reached were low and per child cost is something to be considered as a scaling issue.
- In the playgroups run by volunteer caregivers with weekly support from playgroup facilitators many younger children enrolled in the playgroups. This may have been because they accompanied the volunteers or because feeding was an incentive in these groups.

Outcomes for the Playgroup interventions largely support the international evidence that group experiences are effective in developing the cognitive and learning readiness requirements for school. In the Khululeka I&T programme children participating in an informal play experiences had improved cognitive outcomes even when parents did not attend frequently. However, children attending playgroups run by volunteers with weekly oversight by trained play facilitators did not show better outcomes at Grade R than children who had not been exposed to organised ECD stimulation.

3: Outcomes for Parent Education Workshops

The Ntataise Parent Support Programme was a workshop series delivered to interested parents of children attending 14 preschools by the preschool supervisors approximately once a month. Khululeka's Infant and Toddler Support Programme was delivered in two to three hour weekly support group sessions targeting

caregivers of children (birth to six years who were not receiving an ECD service). Children participated in unstructured play activities during the session. The Ntataise Parent Support Programme enrolled 230 caregivers from 14 ECD centres in 2009 and 2010. However, the programme was not delivered satisfactorily and attendance was very poor.

- In the Khululeka programme, 76 of 92 parents enrolled from 2008 to 2010 attended more than two support group sessions. Attendance was 66% in 2010-2011; Over the course of the evaluation, 146 children attended.
- The Khululeka programme was less successful in reaching parents whose children were not receiving another ECD experience. Only a third of families who had completed the home visiting programme enrolled and many parents of children in the local preschools joined up.
- Attendance at group programmes of all kinds tended to be inconsistent.

Child and Caregiver outcome data is only available for Khululeka²⁹

- Caregiver coping: Scores significantly improved indicating that the support provided made a difference to their well-being
- Caregiver parenting and early stimulation: carers were more accepting and responsive to their children and provided improved academic and language stimulation.
- Referrals for services: most children were already connected to grants and services but 62% of referrals for grants were resolved by the end of the evaluation period.
- Child cognitive and language development *improved* over the course of the intervention (the effects of age were controlled). *Higher rates of child and caregiver attendance* were associated with greater gains.
- The Ntataise PSP enrolled the targeted group but was unable to deliver the inputs to more than a small proportion (less than one third of those who enrolled) due to significant attendance challenges.

Lessons from the evaluation of Parent Education workshops

- Parent education programmes must sustain sufficient attendance to be worth offering and this is challenging when parents have other duties.

²⁹ No Grade R follow up was possible because no cohort had completed the parent support programme at the time of testing.

- It is essential that programme implementers are appropriately trained, motivated to implement the programme and receive regular support.

In the case of Ntataise's programme, the preschool supervisors offering the parent education programme had many other duties and the lack of an incentive made it difficult for them to implement the intervention.

- In both interventions practical workshops to make items to take home were valued as was the social support and the fun of the group setting.

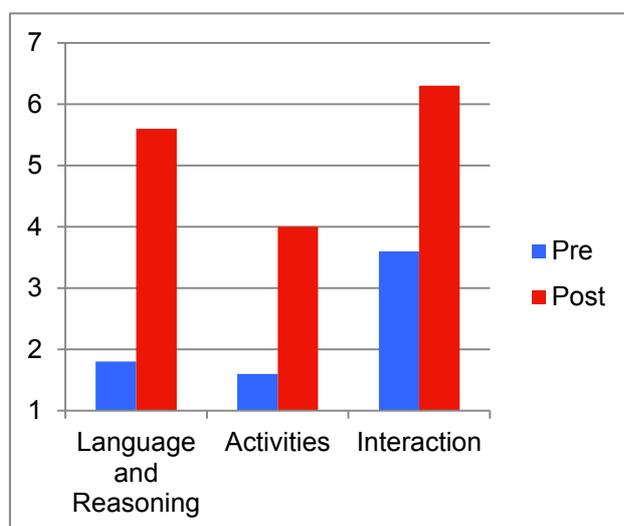
The Khululeka programme attracted a number of parents of children attending preschool as well as those whose children had no ECD service exposure.

- Take-up by some of the targeted caregivers was disappointing. This programme format which requires getting to a venue at a regular time for a group meeting is not suited to caregivers who live at a distance, are sickly or have many pressing household responsibilities. It also does not attract caregivers who are not coping well, or who feel shy or burdened.

4: Training for ECD centre practitioners (Accredited or Capacity building workshops): Outcomes for ECD Sites and Public Schools

- Accredited training programmes reached relatively small numbers of practitioners with three Level 4 courses reaching 38 practitioners.
- Three shorter workshop programmes were offered reaching 138 practitioners.
- Attrition is a problem especially with the longer accredited programmes where there were drop outs as a result of illness, death, leaving employment or in one peri-urban setting transferring to EPWP learnerships with stipends.
- Three subscales of the Early Childhood Rating Scale (Revised) were used to assess classes prior to and following teacher training. They included advances on measures of teacher mediation of language and reasoning, the quality of the learning programme (activities) and the quality of the interaction between the teacher and the child. Regardless of the type of intervention, in the community preschools classroom quality improved in almost every case - sometimes substantially. Findings are displayed in Figure 4.

Figure 4: Effects of interventions to improve Preschool Quality in 17 classrooms.



Impact at Grade R

- Impact evaluation in Grade R showed that children who had attended preschools where teachers had been trained performed better on assessments of cognition, language, numeracy and school readiness than children who had not been exposed to an ECD programme, or who had been in a home-based programme, a playgroup, or a parent education programme³⁰.

Figures 4 and 5.1 and 5.2 show the findings for the comparison between children who had not had exposure to an ECD programme and those who had attended a preschool where the teacher had been trained by one of the partner organisations. All differences displayed were statistically significant (age was controlled).

Figure 4: Impact Differences: Children who attended an ECD site with practitioner training and those who had no ECD exposure: Cognition and Language

³⁰ Statistical Summary: ANCOVAs: Counting: $F(2,268) = 9.13, p = .003$; Number Concept: $F(2,268) = 12.85, p = .001$; Academic Readiness: $F(2,210) = 4.45, p = .036$; Cognition: $F(2,268) = 8.22, p = 0.004$; Language: $F(2,268) = 3.61, p = 0.058$.

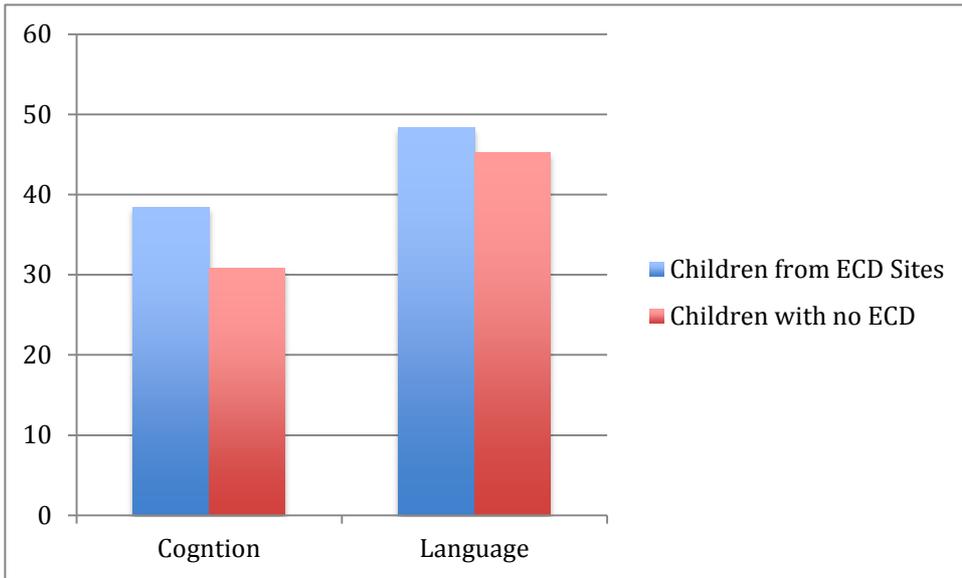


Figure 5.1: Impact Differences: Children who attended an ECD site with practitioner training and those who had no ECD exposure: Numeracy

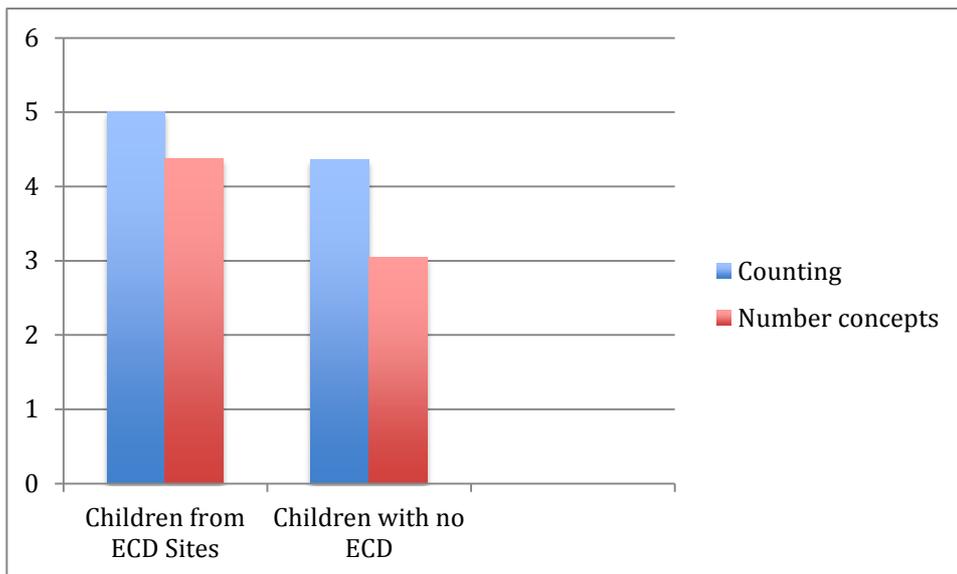
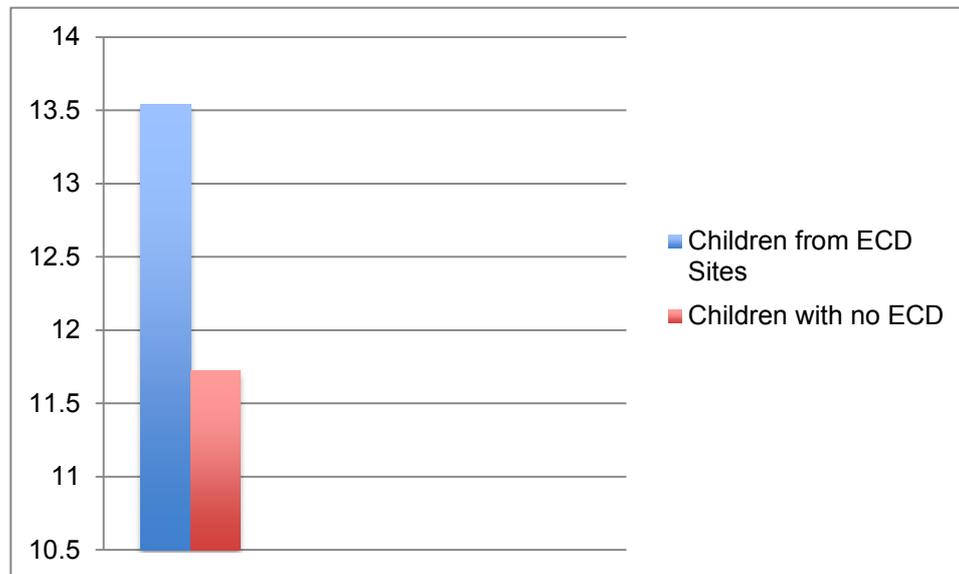


Figure 5.2: Impact Differences: Children who attended an ECD site with practitioner training and those who had no ECD exposure: Readiness to Learn



Lessons from the evaluation of programmes for ECD Sites and Public Schools

- Implementation is strengthened when the management committee, principal or Head of Department supports the practitioner.
- Practical on-site support where appropriate teaching practice is modelled and practitioners assisted with particular capacity building needs, together with the provision of appropriate equipment (improvised or bought) are key to the success in improving programme quality.
- Short practical courses focused on activities, and a planned programme can effect improvements in ECD classroom quality in quite a short time.
- Maintaining participation in learnerships and skills programmes, which do not have the incentive of a stipend or qualification, is challenging in certain contexts.
- Personal support through the trainer and group training experience is very motivating for practitioners and can encourage them to improve their classes and to consider further professional development. Evidence from the training programmes in the Sobambisana Intervention supports the international experience in that the involvement of management, training and equipment enhance practitioners' ability to offer a quality programme, including a range of activities, improved interaction and language and reasoning mediation. .

5: Outcomes for Advocacy and Community Awareness interventions for integrated service delivery

Four of the five partners working in new areas included some focus on advocacy. The fifth worked in an area where services for young children were reasonably well established.

Those participating partners (RTOs) with a community development rather than a service delivery orientation invested more in community processes.

Two worked at facilitating the development of some sort of local structure to support young children's access to services in the area. Both found that it is very challenging to build new structures in communities where existing leadership is already stretched and where there are no incentives and instead built ECD elements into existing community forums and structures.

- Regular community report backs and imbizos were found to be invaluable in creating interest and demand for young child services.

In one approach the local community development facilitator became the contact point for links to government services, in the other, the RTO included public and NGO service providers in imbizos and follow up individual meetings to strengthen the service network.

- Through these processes the community committee, home visitors and preschools came to know the government officials and other resources and to work together for young children in the community.

The local municipality was the advocacy target of the other two RTOs.

The outcomes of advocacy initiatives were mixed. Strengthening responsiveness of government stakeholders met with very limited success in two of four advocacy interventions. In two other cases it was much more successful and there is evidence both of community interest in ECD and more responsiveness from government services.

Lessons from the Advocacy interventions

- A key learning is that advocacy was most successful when it was a regular and sustained initiative with a clear purpose and guiding framework, was public and brought together both community members and officials and service providers to discuss needs and what could be offered. The imbizo or community report back format was a powerful culturally appropriate medium for this.

- While ECD organisations may seek to influence provincial and local government processes for the benefit of young children, and it is desirable outcome, there are many processes over which they have no control and which may thwart the realisation of programme goals.
- Consideration should be given to the considerable investment of time needed for advocacy in relation to time and resources available for managing and implementing the intervention as a whole and its primacy as a goal.
- Rather setting up new community structures building on existing structures is more likely to have traction and be sustainable
- Where there is broad community involvement in awareness and advocacy processes of different kinds, service demand and uptake and service responsiveness has been strengthened. There is also evidence of increased social cohesion and support by caregivers for each other and more broadly in the community.

Narrative reports and interviews suggest that raising community awareness can lead to service uptake and demand, a finding that concurs with international evidence from the health sector.

Overall Programme Implementation Lessons

Proximity vs. distance

Most of the RTOs worked at a distance from the programme implementation sites.

This is inevitable when the majority of very deprived areas lack local resource organisations. It adds to the expense of interventions and poses a number of other challenges. Resource organisations unknown to the community require sufficient time for a careful entry process and it is less easy to monitor implementation by local field workers. Two RTOs increased the time they had budgeted to be on site because local field staff needed more supervision than they had originally planned. However, distance was also enabling for leadership transfer in that the local staff and stakeholders had to take the work forward in the RTOs' absence and this enhanced their independence and ownership of the work.

Protocols, manuals and quality assurance mechanisms

Protocols, manuals and quality assurance mechanisms help to standardise implementation across different fieldworkers and sites. While some partners did not have these in place at the outset, all were established by 2010.

Regular quality assurance procedures, monitoring protocols, step by step implementation guidelines and manualised materials helped standardise implementation across different households and villages. Not all partners had allocated sufficient time for development and management of M&E systems. Several partners used their systems to review how programme delivery was working and made adaptations along the way including varying the content and amount of input and delivery mode. However there were instances when needed adaptations were not made with the same difficulties for the second cohort.

Theories of change and programme adaptations

When formulating their interventions, few of the partners had articulated the underlying theory of change for each programme. In some cases implicit assumptions were not soundly based and as a result elements of the programmes were not successful. For example, assumptions were made that a cascade model of training using relatively new and low skilled play facilitators would be effective. While it rapidly increased access it proved ineffective in controlling implementation quality. Some partners assumed that parents would attend group programmes on a regular and sustained basis. In fact attendance at groups was generally challenging.

Several interventions were adapted for the second cohort. The cascade approach for expanding playgroups was abandoned in favour of a model with more regular oversight and input from trained facilitators. One home visiting programme decided to focus on basic needs and caregiver support and leave the stimulation messages for another intervention, as families in need did not focus on the early childhood education messages. Another increased the number of home visits in order to have a greater chance of changing child and parent outcomes and introduced food parcels as an incentive to attendance and to provide some basic necessities.

Staffing

All partners used well-qualified and experienced staff and/or outside experts in the design and oversight of the interventions. In two RTOs multiple staffing changes at management and oversight level and insufficient time in the field, compromised implementation for several months.

Most partners employed local field staff that needed to be trained from scratch. This is important from the point of view of community buy-in and local capacity development but it took time and support for them to become experienced.

Well-supervised fieldworkers with low qualification levels were able to deliver services that improved the care and education environment for young children and

supported their caregivers. In one programme child outcomes also improved. This accords with international evidence.

However, there are questions about how much can be expected of such workers, and it needs to be stressed that they were working with a limited number of households and had a focused set of deliverables.

It would not be reasonable to expect that a generalist health worker or Community Development worker could deliver this full package as well as other duties at whole community level.

A community development versus a service approach

There were differences in approach to the site based interventions among the partners, with two operating from a service delivery perspective (Ntataise and CECD), and three working within a community development framework (TREE, ELRU and Khululeka).

In the former the service provider has more control over programme implementation especially if experienced existing staff are used, and can start up more quickly as there is no negotiation about the deliverables. In an ECD approach which emphasises community development and is dependent in large part on volunteers, it is difficult for the service provider to ensure that the programme is implemented as designed. Community choices may need to be taken account of in selecting programme elements and local staff. The advantage of a community development approach is that if it is successful programme ownership shifts to the community and there is a greater chance of sustainability. For example in two sites local structures are in the process of setting up NPOs to take aspects of the work forward.

When partners have a simple service delivery orientation, the RTO alone determines whether the service continues or not (and in one case the programmes were all withdrawn quite suddenly, leaving nothing behind).

CONCLUSION

There are several promising findings emerging from the outcome and impact evaluations of the Sobambisana Initiative. The different interventions demonstrated that in relation to the overall goals:

- It was possible to significantly increase access to developmental opportunities through home visiting and playgroup models.

- However, the benefit of scale was uneven. Participation was greater for home visiting and participation by both parents and children in group programmes was frequently low. In programmes where access increased very rapidly, the quality of delivery was a challenge.
- ECD centre quality was improved through various training and support initiatives. Quality of delivery for other programmes was variable and depended on strong oversight, staff capacity building and having clear guidelines for programme implementation.
- The impact of programmes on children's readiness for the transition to Grade R (measured by cognitive and language, numeracy and academic readiness outcomes) was mixed. Group programmes at ECD centres with content well aligned to these capacities had the best results,
- Delivering integrated and holistic services through coordinated efforts of the NGO and the State was a challenge. In some cases NGO and local field staff were able to enhance service access by simultaneously raising community awareness and demand and advocating for better public service delivery. This required a community development approach with sustained effort over several years.

These findings provide helpful pointers for implementing the National Integrated Plan for ECD

In the drive to develop sound models of early childhood programming, sight must not be lost of the fact that in addition to the quality of the programme content, the quality of the implementation makes a critical difference to the achievement of the desired outcomes.

It is also necessary to recognise that regardless of the efforts put into community and site-based formal ECD programming, factors within the child and her home environment will play a significant role in moderating the influence of the programme. For example, in this evaluation, children's growth and cognitive status were seriously compromised, which reduced the probability of securing successful developmental outcomes.

Vulnerable young children and their caregivers require a range of services to address their needs and programmes that use a holistic approach are most effective in this regard. While programmes to improve children's readiness for school are necessary, for the best outcomes, they need to be nested in an holistic approach.

The evaluation provides us with a number of important findings and lessons. However, given the methodological limitations of the current evaluation, opportunities should be found to further assess the outcomes and impacts of community-based programmes more rigorously and on a wider scale. More rigorous designs with sufficient sample sizes to achieve statistical power are recommended.