Community Early Childhood Development Network: Model Description

A collaborative project of
South Africa Partners and
Masibumbane Development Organisation

Conceptual Approach

Introduction

A key response to South Africa's challenge in meeting its goal of ensuring that every child in South Africa has access to a comprehensive package of early childhood development (ECD) services by 2030 is to address the quality of services provided by community-based ECD centers in low-resource areas. We know that centers in these settings that are not formally registered with the Department of Social Development are worse off than their conditionally and fully registered counterparts in all respects including staffing, materials, equipment , quality of instruction, and child nutrition, health, safety, all of which have a direct impact on growth, learning and development outcomes for children. Critically, non-registered centers cannot access per-child government subsidies to support the care they deliver. We recognize that such centers, the women who run them, and the women employed in them make valuable contributions to their communities; these centers have arisen as a necessary response to an urgent need. As such, they are existing community assets deserving of support. Our program objective, therefore, is to partner with these centers and identify and supply the short-term help they require to elevate them from marginal places of care to sites delivering quality early education, enabling them to operate as financially stable, sustainable, registered enterprises. When existing centers develop the capacity to deliver quality early care and education, the children who attend these centers can start Grade R ready to learn and ready to thrive.

Origins

Our Community ECD Network program model was developed between 2013 and 2018 to serve low-resource ECD centers in the Eastern Cape.

The Community ECD Network originated with our outreach to eight unregistered, under-resourced care centers operating in close proximity to one another in the Duncan Village area of the Buffalo City Municipality. Initially identified for us by the Department of Social Development, each of the unregistered centers expressed interest in improving the quality of care and early learning they provided through a partnership with Masibumbane Development Organisation, our sister organization, and South Africa Partners.

We engaged with these eight centers as a cohort, bringing leadership and staff together for purposes of training, capacity-building, and mutual support. By connecting the centers within a geographic cluster to one another to achieve a common goal, we both created efficiencies in our delivery of support services but laid the ground work for these centers to develop into a community of practice, knit together through relationships that developed across the several years of working together.

The centers that comprised our original Network were not identical: they varied in size from serving as few as 20 children to as many as 70 (in a typical year, Network centers served 450-500 children across eight sites). None, however, were comprised entirely of formal structures, none were formally registered, and at most centers the educational level of staff did not go beyond Grade 12, or matric. Many staff members had not advanced beyond Grade 8. Levels of English and home language literacy (isiXhosa or Afrikaans) were low, with a few exceptions.

Center practitioners were, generally, young women who had entered the ECD work force casually and out of necessity, and the wage they earned was both small and often erratic given the financial instability of the centers. As a result, staff attrition was, and remains, a constant challenge for centers. We have seen that formal training is a powerful motivator for these young women to stay on a path to becoming long term ECD professionals. At the other end of the age range, there were practitioners, and some Principal/owners, who had been child-minders for many years without the benefit of formal training or acknowledgement of the value of their informal experience. Many in this group had no wish to enroll in formal coursework. A benefit of the network approach we used, however, was the opportunity these women had to listen to and learn from one another. At every step, our goal was to recognize and build upon existing strengths, knowing that in this challenging environment there is no "one size fits all" approach and that all experience is valuable when shared as part of a learning community.

With this context in mind, we sought to develop a model that:

- Is short term, cost-effective and replicable
- Delivers sustainable results
- Respects and leverages existing community assets and strengths
- Takes a holistic approach to ECD, including child health and family outreach

During a multi-year period of relationship-building, program development, and implementation, we engaged in a process of continuous learning guided by the following questions:

1. Which inputs are most effective and most cost effective in achieving the desired outcomes?
2. Are we making best use of existing local and community resources and partnerships in the NGO, tertiary and public sector?
3. Are we drawing upon best practices in ECD programs and pedagogy both from within South Africa and internationally?
4. Are we identifying and responding to challenges, opportunities and learning year to year, and adjusting in response?

We have achieved measurable success with the current network of centers. As of the end of 2018:

- Seven centers in the Community ECD Network have acquired Non-Profit Organisation certificates, a prerequisite for formal registration as partial care facilities
- Five of seven have achieved "bronze level" conditional registration with the Department of Social Development and are accessing government subsidies for the ECD services they deliver
- 20 practitioners have completed formal Level 1 or Level 4 training
- Centers have shown improvement, as measured by the ECERS-R and ITERS[1], classroom practice and availability and use of materials for learning and play (see Evidence of Impact in Appendix C)

[1] The ECERS-R and ITERS scales are designed to assess process quality in an early childhood or school age care group. Process quality consists of the various interactions that go on in a classroom between staff and children, staff, parents, and other adults, among the children themselves, and the interactions children have with the many materials and activities in the environment, as well as those features, such as space, schedule and materials that support these interactions. Process quality is assessed primarily through observation and has been found to be more predictive of child outcomes than structural indicators such as staff to child ratio, group size, cost of care, and even type of care, for example child care center or family child care home (Whitebook, Howes & Phillips, 1995).

- Children served by the centers are scoring above the median for school readiness as measured by the Early Learning Outcomes Measure (ELOM)[2]
- Principals and practitioners report benefitting from mentoring and coaching and have developed peer to peer relationships that will continue after the anticipated end of the coaching
- Eight non-governmental organisations (NGOs), government, or tertiary sector partners have established partnerships with and provided services to the network, lowering costs and further increasing the visibility of the Network centers within the ECD sector in the area

As a result of South Africa Partners and Masibumbane Development Organisation's investment of time and resources over five years, we have established the Theory of Change, specific objectives, general methodological approach and "four pillar" model that we present in this document. The approach is well-suited to low-resource environments and enables us to helpfully engage with local centers and then exit, leaving behind a stronger ECD delivery system within the communities we have reached.

[2] The Early Learning Outcomes Measure (ELOM) is an easy to administer South African pre-school child assessment that indicates whether an Early Childhood Development (ECD) program is effective in preparing children for Grade R and identifies areas for programmatic improvement. This innovative tool has been developed for government, funders, program developers, ECD providers and monitoring and evaluation specialists, who need valid evidence of program effectiveness.

Community ECD Network
Theory of Change

Problem	Methodology	Outcomes	Impact
78% of children under 6 in the Eastern Cape live in poverty, most lack access to an early learning program Community-based preschools operate in high poverty areas but often do not meet minimal standards	Assess needs and current capacity Activate local resources and partners Provide key supports: training, mentoring, materials Build a Community of Practice	Preschools are sustainable enterprises and safe environments Educational program is responsive and age appropriate Nutrition and growth and monitored and supported Parents are engaged in early learning Early learning outcomes improve	Low-resource, based prescho quality progra services to chi their families

Objective of the Model

Our overall objective is to enable existing unregistered, low-resource, community-based ECD centers to delivery better quality early care and education to children and their families and operate as successful, sustainable enterprises. To succeed in reaching that objective, four specific objectives must be achieved:

Specific Objective 1: Network centers are financially sustainable, registered enterprises, and safe environments

Specific Objective 2: Centers measurably improve delivery of quality, age-appropriate learning and play

Specific Objective 3: Growth and nutrition of children served by centers is monitored and supported; children identified as at risk are referred to the primary health care system

Specific Objective 4: Caregiver and parent engagement in children's early learning, care and development is measurably increased

Time Frame

Our model aims to achieve its objectives through an 18-month engagement with a cluster of 8-10 under-resourced, previously unregistered ECD centers. The full-time frame is two years, including project startup, implementation, evaluation and exit.

Methodological Overview

We embrace a partnership approach, working collaboratively with center-based providers and the communities they serve to improve quality and achieve sustainability through four key steps:

1. Assess need and scan for strengths. Before planning for implementation, we conduct an audit of Network centers, recognizing that they do not all start from the same point. We undertake an inventory of materials, gather information on training and educational background of staff, learn about the history of the center and its leadership, and gather information on the building and land from a health and safety and legal perspective. In collaboration with the Principals, we then plan for implementation with a clearer picture of what is achievable and what should be prioritized. When Principals are part of the planning process, and that process begins with an acknowledgement of their strengths and is responsive to their expressed needs, there is stronger initial buy-in, which contributes to greater success during the implementation period and an increased likelihood that improvements in quality will be sustained after it.
2. Identify, consult with, and activate community, local, national and international resources and partners. The ECD sector in South Africa is both very active and highly decentralized. Because to date the delivery of ECD services has largely fallen to the non-profit sector and is often carried out at the local level, there is a high risk of duplication of efforts and of "recreating the wheel". With so much need, this is a risk that must be avoided, and so a key piece of our methodology is to play a coordinating role, identifying and activating existing resources where feasible rather than providing all needed supporting directly. When we began working in the geographic area around East London, we first familiarized ourselves with: the range, scope and capacity of organizations active in the ECD space; government policy, government action, and the gap the remains between them in working toward the nation's goals; expertise and research in early care and early learning that resides within South African universities

and in other countries, and finally, as mentioned above, the knowledge and experience that already exists within the communities we aim to support. For example, we enroll Network practitioners in high quality training courses delivered by partner NGOs rather than designing, accrediting and delivering our own. With our first cohort, we accepted an offer from the Cape Town-based Center for Early Childhood Development to deliver their management training workshops. Over the period of our first implementation of the Network model, we secured in-kind and financial contributions or drew upon the resources and experience of the University of Fort Hare, Wheelock College in Boston, Cotlands, ITEC, JAM and Loaves and Fishes (NGOs active in the area). Recognizing and deploying existing knowledge, expertise and resources eliminates duplication of effort, increases impact, and decreases costs.

3. Build local capacity and establish a community of practice. Our approach is not to enter an unoccupied space and build a new institution, rather it is to elevate those that are already there, operating as small businesses. That local capacity just needs a period of support to become sustainable and successful. As importantly, our Network approach brings Principals and practitioners together in a spirit of learning and mutual support, creating ties and a professional community that will endure after the end of the project period.
4. Provide key supports. Given the very challenge context in which they are located, centers cannot elevate themselves through hard work and commitment alone. The provision of essential training, support, and materials are the fuel needed to launch under-resourced centers on a trajectory toward long-term quality and sustainability.

We understand the importance of taking a holistic approach to providing ECD as called for in the National ECD Policy and Programme, for that reason a last key piece of our methodology is the integration of nutrition, health and parent engagement components. The nutrition and health component is a necessary foundation for all development, cognitive as well as physical. Parent engagement is just as essential for children to thrive. We also seek to empower parents to advocate for ECD and understand the role they also play as their children's teachers. Additionally, we have learned from our experience to date in the ECD sector that consultation and coordination with other area NGOs and with the Departments of Health, Social Development and, as of 2019, Basic Education are key to good program design and successful delivery. We have also learned that while formal training of practitioners is desirable, practice-based coaching is just as important; similarly, mentorship of Principals must accompany workshops. Because sustainability is a key objective, our model prioritizes a strong mentorship and coaching component in order to bridge the gap between theory and practice, using coach/mentors with appropriate linguistic and cultural competency who are recruited from the local area. Finally, we have seen the power a network has to cultivate a spirit of mutual learning, sharing of ideas, and problem solving.

Staffing

Locally based staff lead on project start-up, program activities, and monitoring and evaluation of the program. For a Network cohort of 8-10 centers, the model requires the following staff:

- Program Director - responsible for day-to-day management of program activities per the work plan; supervision of Program Assistant, Teaching Practice Coach, Health Mentor; responsible for meeting with and securing government, NGO and university partners; responsible for leading needs assessment activities; staff lead on activities under the management and infrastructure pillar; represent the project in ECD sector meetings and conferences at the local and national level. Required skills: project management (including

managing evaluation), report writing, fluency in isiXhosa, knowledge of local community's geography, culture and history; experience working with local government, experience in ECD, understanding of basics of business and financial management.

- Program Assistant - Responsible for logistics, including scheduling, transportation and communications. Required skills: strong verbal and written communication skills, fluency in isiXhosa, knowledge of local community's geography, culture, and history.
- Teaching Practice Coach - responsible for monitoring accredited practitioner training, implementing practice-based coaching, and promoting peer to peer relationships and support amongst staff in Network centers; primary responsibility for all activities for practitioners related to learning and play. Required skills: qualification in ECD at NQF Level 5 or equivalent and classroom experience as an ECD practitioner; fluency in isiXhosa, knowledge of local community's geography, culture and history; strong verbal communication skills, problem solving
- Health and Nutrition Mentor - responsible for overseeing activities for center-based monitoring of child growth and nutrition, referrals for follow-up care, and parent education and communication around health and nutrition. Required skills: qualification as a registered nurse; understanding of local primary care health delivery system; knowledge of local community's geography, culture and history; strong verbal communication skills; experience in gathering and managing health-related data

Project Work Plan

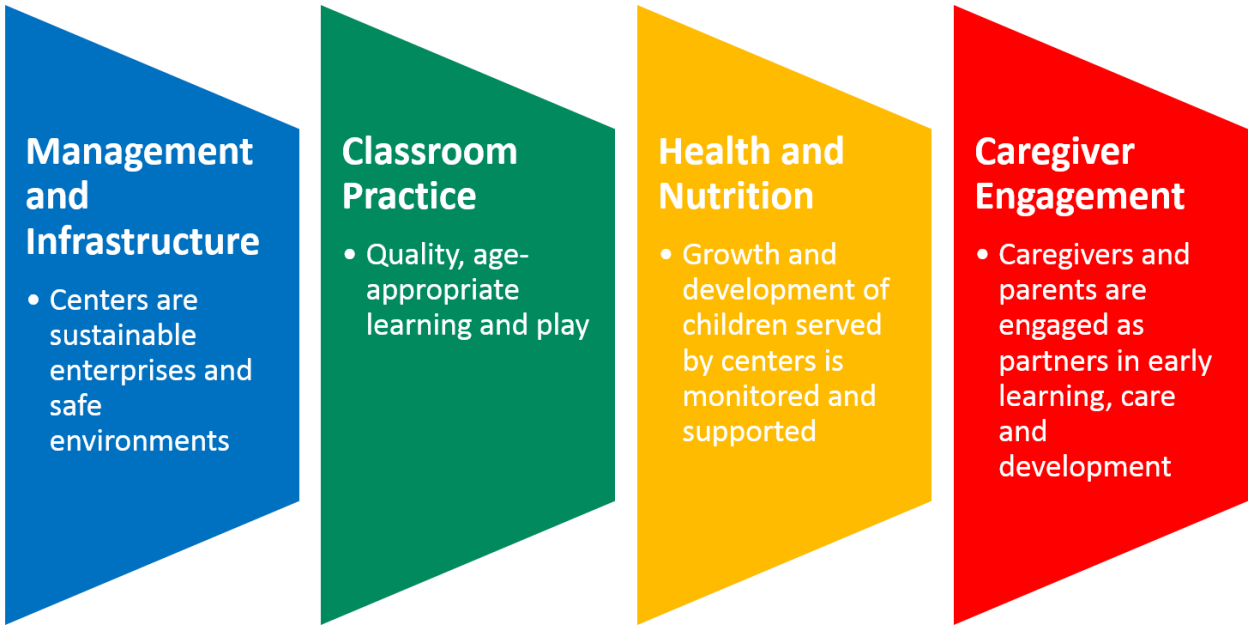
Activity	Expected Result	Y1		Y2				Y3	
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Project Start Up									
Project Staff Up: Director, Assistant, practitioner coach, health mentor	Project Staff recruited and inducted								
Situational analysis: catchment area defined	target community selected								
Candidate center identification by local Department of Social Development	List of unsupported centers								
Initial outreach to and visits to candidate centers by Project Director and staff	List of proposed Network centers								
Stakeholder consultations: Project Director meetings with Department of Social Development, Health District officials, community leadership, other ECD NGOs active in the same catchment area	Buy-ins, contributions secured								
Supporting partners identified: ECD training organizations, NGOs offering relevant services, tertiary institutions	Contributions of time of resources secured, scheduled								
Finalize list of participating centers that will form the Network									
Institutional Agreements: MOUs with each center or supporting partner detailing roles and responsibilities of the partnership	MoA/contracts signed with centers and partners								
Baseline needs assessments: materials inventory, management, health and safety, infrastructure, staff skills and educational level audit	Baseline report on center status and needs: materials, training, infrastructure								
Baseline data collected on child health: Road to Health Cards									
Preparation of training materials, reporting templates, scheduling of meeting and workshops	Implementation year activities planned; venues secured; materials prepared for distribution								

Program Period Activities	Expected Result	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Principal capacity building, goal setting, training and mentoring	Management Capacity of center principals improved; registration secured; develop relationships across the Network								
1. Sharing of results of needs analysis. Collaborative planning for practitioner training enrollments, setting of individual center goals, feedback on needs analysis and plan for engagement									
2. Monthly meetings to build management capacity, guide on steps toward registration; quarterly revisiting of center goals and progress									
Provision of materials for learning and play in coordination with training	Centers adequately supplied with materials								
Practitioner training: Level 1 and Level 4 enrollments in local training programs; participation in app-based training	ECD Practitioners trained in ECD								
Practice-Based Coaching	Practitioners supported through site visits in putting training into practice								
Preparation for exit	Centers are prepared to continue the Network without direct support								
Nutrition provision, monitoring, support	All children receive two nutritious meals per day of attendance								
Routine Health and Growth Monitoring and Screening, Referrals	Growth of children in the centers monitored and routine screening, referrals taking place								
Parental engagement activities	Increased parent awareness around early learning, nutrition, and development								

Advocacy to promote ECD awareness	**Expected Result**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Intersectoral meetings, meetings with NGOs and municipalities	Project visibility, advocacy on policy and funding, partnership development, sharing of lessons learned								
Monitoring and Evaluation									
ECERS-R and ITERS: baseline, midpoint, final									
ELOM: baseline, final									
routine monitoring and reporting: monthly staff reports, review of progress against objectives, activities and indicators (referencing midpoint ECERS-R and ITERS)									
Self-Assessments by Principals and practitioners in conjunction with monthly meetings and practice-based coaching cycles									
Survey evaluations of specialized workshops, parent meetings									
Monitoring of progress of centers toward individual goals in conjunction with monthly Network meetings									
Qualitative summative surveys: Principals and practitioners, parents									
Sharing of evaluation results with Network Principals									
Final Summative Report									

Components: The Community ECD Network Program Pillars

Our holistic support model's long-term goals and key activities are represented by four "program pillars" that align with our specific objectives:



Management and Infrastructure

As noted above, a typical center begins as a small enterprise arising in response to an urgent community need. The facility is often below the standards required to ensure the health and safety of children. Principals often lack the experience needed to operate the business as a sustainable enterprise and comply with standards and reporting requirements. Registration, full or conditional, with the Department of Social Development as a partial-care center is a prerequisite for government funding of ECD through the early learning subsidy.

After establishing a Community ECD Network cluster by identifying centers in need of support and signing participation agreements, we convene **monthly meetings** for Network Principals that focus on management processes and procedures. Principals are guided through the steps required to progress toward registration. As part of this process, most Principals must ensure they are compliant with health and safety standards and require assistance in understanding how to remediate their environments. A second challenge for many is learning how to set up and keep records and registers and establish proper governance for the center. Project staff are well-versed in these procedures, and as needed can bring in local experts to assist. Another key step when the Network is established is to share with Principals the results of the needs

assessment that project staff have conducted[3] and share results of the baseline ECERS-R and ITERS. Before the new school year begins, Principals will set goals and priorities for the year ahead in collaboration with program staff. Over the period of engagement, Principals continue to meet monthly for **group problem-solving and discussion**. As needed, program staff arrange for speakers or **specialized workshops** to address specific areas of interest and need. In addition, program staff serve as a bridge between Principals and government officials as they move through the several paper submissions and the through on-site inspection required for registration.[4] In this work, Ilifa Labantwana, a national ECD support organization, is a key partner. Their Bhalisa Inkulisa project, now active in the Eastern Cape, works with local NGOs and ECD centers to smooth the path of under-resourced centers toward formal registration. Project staff are available to deliver workshops on registration processes to Network Principals and their print resources are invaluable (see Appendix G). Our own program staff also provide one to one mentoring to Principals, helping them respond to challenges as they arise. While a priority is placed on steps required to move toward the formal registration that is needed to access the critical government subsidy, areas of focus for workshops and coaching may also include:

- Understanding the Needs Assessment
- Health and Safety Standards
- Nutrition and Growth Monitoring
- Certificate and Registration Processes
- Financial Management
- Human Resource Development
- Data and Reporting Management
- Infrastructure improvement
- Fundraising
- Family engagement

Ilifa Labantwana is a South African early childhood development program founded in 2009. Through research, advocacy, and outreach, they help coordinate and lead the ECD sector in building the financial, administrative, and human resource systems to support ECD service delivery at scale.

As needed, the Network will provide **materials or technology needed to operate the center as a successful enterprise**, including tools for financial and data management and reporting, which include paper registers and/or tablets and specialized software.

Classroom Practice

Many of the practitioners working in center classrooms have little or no formal training in early care or early education. In our work with the first cohort of centers, our assessment revealed that practitioners demonstrated great interpersonal skills with children but did not know how to stimulate and educate children in a way that promoted early learning and development and adequately prepared them to enter formal schooling. Materials for age-appropriate learning and play were in short supply, and when present practitioners often did not use materials effectively, or at all. Three components make up the Classroom Practice Pillar: supply of essential materials, formal training in the theory and practice of early care, and practice-based coaching in the application of theory to practice in the classroom setting. In our work to date, these capacity-building inputs yielded measurable returns.

[3] The needs assessment activities include: an inventory of existing resources for learning and play, a survey of health, safety and infrastructure conditions, a staff skills and educational level audit (see Appendix D), examination of current record keeping systems, inspection certificates, land and building deeds

[4] Required documents include: a business plan, police clearance certificates, a daily care plan, non-profit registration and constitution, emergency plans, a discipline policy, building plans, zoning approval, daily care plan and daily menu

Supply of essential materials - The provision of materials for learning and play begins with an inventory of existing resources and materials during the needs assessment stage and comparing that inventory to a list of basic, **developmentally appropriate materials for learning and play** (see Appendix E). In collaboration with center Principals, program staff purchase or source from donor organizations the additional materials needed as appropriate for the space, number of children, and as dictated by funding available. Individualized for program size, space, and need, each center will receive a set of basic materials to support critical domains for example books in both home languages and English, blocks, manipulatives, gross motor play equipment, early math materials, dolls, animals, or vehicles for creative play. Limited supplies of consumables (crayons, markers, paint, and paper) may also be supplied with the intention of centers budgeting forward for resupply.

Formal training - Training delivery is tailored to meet the needs and interests of practitioners; our approach is to identify the mix of methods to deliver training that will work best in each community context or for each practitioner. Some practitioners welcome the opportunity to engage in **formal, accredited training**[5]; others wish to learn through **ECD training apps.**[6] A practitioner's formal educational level and the English proficiency requirements of some courses are practical and psychological barriers to entry for some practitioners. Therefore, all practitioners are supported by **on-site modeling of best practices** and the cultivation of peer to peer group learning on site. In all forms of training, there is an emphasis on **storytelling, games, and songs in home languages**, all of which are rich, culturally indigenous sources for early learning and development that practitioners bring to the classroom. Our methodology recognizes the teaching capacity that practitioners already have, and explicitly values and activates that capacity within a preschool classroom regardless of the practitioner's level of formal educational achievement. Additionally, practitioner training in child development and classroom practice will be accompanied by the delivery of **customized workshops** in response to identified needs. Examples include: infant massage and stimulation; using personal dolls to help children develop empathy and express their own feelings; and producing classroom materials from recyclables.

Practice-Based Coaching - Finally, and critically, the classroom pillar focuses on the successful translation of training and theory into classroom practice under real conditions and uses both **practice-based coaching** (see detailed description in Appendix A) and **peer-to-peer suppor**t to achieve that goal.

As needed, practitioners are provided with print materials to support curriculum and instruction aligned with NELDS standards, including a year's worth of theme-centered lesson planning materials produced by the Loaves and Fishes Network, a national ECD resource and training organization that offers a well-targeted and high-quality Level I course.

Health and Nutrition

According to the recent South African Demographic and Health Survey,[7] 27% of children under five suffer from stunting in the country. Their growth is delayed, and their brains aren't

[5] NQF Level 1, NQF Level 4 through local ECD Resource and Training Organizations (RTOs)
[6] For an example of a training app go to PlaySA's Play to Learn at https://playsa.org
[7] National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. 2017. *South Africa Demographic and Health Survey 2016: Key Indicators*. Pretoria, South Africa and Rockville, Maryland, USA; NdoH, Stats SA, SAMRC, and ICF.

developing as they should, and yet stunting often goes overlooked.[8] As is increasingly common in middle-and-low-income countries, South Africa faces a double burden of under-nutrition and obesity. The science is clear: malnourishment impairs physical, cognitive and motor development. Childhood stunting and obesity are precursors of adult type II diabetes, reduced quality of life, lower educational achievement, lower earning, and shortened life expectancy.

Network centers will contribute to reducing stunting and malnutrition by directly **monitoring, through simple methods, the growth of the children** who attend them. In addition, centers will help to address malnutrition by ensuring that **all children receive two nutritious meals per day** while in their care. In collaboration with the local Health District, staff will be trained to measure and record child height, weight and middle upper-arm circumference (MUAC) on a monthly basis. The program staff member with primary responsibility for this pillar is the Growth and Health Monitoring Mentor. The Mentor works with center staff to reinforce the training (including the use of "how to" videos viewed on site visits), review the growth data gathered and, if a problem is identified, liaise with families and the Health District to **refer children who are under-height or underweight for further assessment through the primary care system** (see detailed description in Appendix B).

Activities to support this pillar include:

- Engagement of area stakeholders such a JAM[9] that can provide daily nutrition assistance to centers,
- Guidance to center staff, as needed, in establishment of center vegetable and fruit gardening and daily food preparation
- Equipment and training of staff in growth monitoring
- Liaising with local Department of Health to open channels for referrals
- Management support to ensure adequate budgeting for nutritious meals
- Outreach to parents on child nutrition, encouraging packing of appropriate snacks or lunches

Caregiver Engagement

Through this program pillar, ECD center staff increase their outreach to and engagement with families around the children's learning and progress. Through quarterly meetings or workshops facilitated by program staff during the project period, **parents will learn about the importance of early stimulation and early education,** giving them confidence and tools to support their children's development and encouraging them to **advocate for ECD within their communities**. Workshop and meeting topics may include:

- Nutrition, growth and development
- Learning at home, reading at home
- Physical development, cognitive development
- School readiness
- Being a partner in your child's learning
- Stress management, stress reduction

[8] Mqudi, Sinikiwe. "Stunting, the silent killer of South Africa's potential." *Opportunity 5: Reflection and Analysis, Strategy 2017*, DGMT, 22 Nov. 2017, dgmt.co.za/stunting-the-silent-killer-of-south-africas-potential/

[9] For a description of JAM Nutritional Early Childhood Development School Feeding program go to https://jamsa.co.za/programmes-and-campaigns/nutritional-school-feeding/

Sustainability

As visualized in the Work Plan above, active engagement with the Network of centers is of limited duration and is designed to build capacity within each center such that they quickly achieve partial or full registration, access training, and have the required skills to conduct ECD. At the end of the two-year engagement, the goal is for centers to be operating as quality, sustainable enterprises with a plan for continued improvement going forward. Furthermore, to ensure that quality is maintained, promising practitioners or Principals are identified and encouraged to continue as peer-to-peer mentors in area centers. Along with providing a dependable wage as a result of improved financial stability, the ability of Principals to position practitioners for leadership and professional visibility is critical to sustainability, as it may help mitigate against the historically high attrition rate of ECD practitioners.

Specifically, the activities and outcomes in our model lead to sustainability by:

- Providing formal training complemented by practice-based coaching to facilitate the successful translation of training into practice; establishing working relationships between center Principals and local ECD Resource and Training Organizations (such as Loaves and Fishes)
- Helping principals establish and follow sound small business management practices: record keeping, financial planning, reporting, investing in materials and infrastructure
- Gaining access to subsidies that provide a reliable stream of revenue to complement fees by achieving formal DSD registration as partial care facilities
- Establishing a culture of peer support and a community of practice that capacitates practitioners and principals to continue assisting one another after project end
- Initiating and nurturing cooperation amongst community partners
- Raising visibility of ECD and advocating for its expansion and support through outreach to families and community partners
- Preparing for exit by: sharing final evaluation results with Principals; supporting goal-setting for upcoming year; facilitating Principal or practitioner-initiated Network meetings or peer to peer support meetings during final three months of project time frame;

Monitoring and Evaluation

Monitoring and evaluation are the cut-across activities that guide and inform implementation; we collect the data necessary to monitor delivery, track targeted outcomes, measure impact of the model and document lessons learned. Our plan is visualized in the M&E Framework below, outlining activities, outputs, outcomes and impact indicators as well as means of verification. The framework helps to monitor the project, ensure that specific targets are reached, and ensure that the project is always guided by its key objectives. Referencing the Work Plan and the Logical Framework, Network staff review project data every month to ensure that activities are being implemented according to the set schedule within the set budgetary constraints.

Armed with tools that capture both quantitative and qualitative data from implementation, the model provides for baseline, midterm and final evaluation of impact. Baseline assessment paints a picture the situation before implementation begins and guides allocation of resources and the setting of individual center goals and priorities. Midterm evaluation indicates if the project is on course, is still relevant and needed and is on track to demonstrate impact, creating an opportunity for course correction if the implementation is not meeting specific targets and beneficiaries' expectations. A final evaluation will look at the impact and effectiveness of the

intervention and whether the target indicators and gains have been achieved. At each stage, evaluation data is shared with Principals as part of the process of goal setting, helping them understand their progress and charting next steps. When budgets permit, the environmental level and individual child level assessments named below will be administered by external evaluators rather than by program staff.

We use several instruments across the course of the project to evaluate a range of indicators of quality and impact:

1. Environment-level evaluation: ECERS-R (ages 3-5), ITERS (infant and toddler) instruments, baseline, midline, final. These tools measure a range of factors observable in the classroom environment – from available materials to classroom practice - that impact child outcomes and are therefore targets for project impact including: room arrangement for play, books and pictures, encouraging children to communicate, using language to develop reasoning skills, music and movement, math and numbers, gross motor equipment and activities, schedule, group time, free play
2. Child-level evaluation: ELOM: baseline, final. The ELOM measures children's level of skill and development in domains related to school readiness: gross motor development, find motor coordination, visual motor integration, emergent numeracy and mathematics, cognition and executive functioning, emergent literacy and language
3. Surveys: Surveys conducted with Principals, practitioners and parents to evaluate the program activities, gathering both formative and summative information to help assess the program from the point of view of its beneficiaries and to measure the impact of meetings, workshops, and other program activities against goals (see Appendix G).
4. The Road to Health Card (RTH), a booklet issued to children at birth and held by parents that serves as a summary record of a child's health in the first five years. Copies held at each center will be used to record routine growth monitoring and any generated referrals.

Goal	**Enable existing unregistered low resourced community based ECD centers to deliver better quality early care and education**						
Objective	**Activity**	**Sub activities**	**Outputs**	**Outcomes**	**Impact**	**Timeline**	**Means of Verification**
Network centers are financially sustainable, registered enterprises and safe environments	Identify and enroll target centers	Consultation meetings with DSD, Community Stakeholders, Center Principals. Baseline needs assessments: materials inventory, management, health and safety, infrastructure, staff skills inventory, ECERS-R, ITERS, ELOM	# of Meetings held with DSD, Center Principals and other Stakeholders in the community; Baseline needs assessments	Community ECD Network established	Centers are committed to improvement goals	3 mos.	MOUs signed with centers to join Network; Centers goals documentation
	Support principals in improving management and achieving formal registration	Conduct Monthly Principals' Meetings: goal-setting and peer relationship development; provide resources according to identified priorities; provide capacity building-training on management and registration processes; identify and plan for infrastructure improvements	# of Principal's Meetings held; # of capacity building workshops; lists of resources provided; submission of documents needed to progress toward registration	Centers are registered with the DSD and receive subsidies; Center principals improve skills and knowledge on managing centers and center resources	Centers are sustainable and operated according to the quality norms and standards. Well run ECD centers offer quality ECD	18 mos.	Registration certificates: resource inventories; attendance registers; evaluation surveys; budgets

Centers measurably improve delivery of quality age-appropriate learning and play	Provision of formal training, specialized workshops, practice-based coaching	Practitioner enrollment in formal training; provision of age appropriate materials, toys and curricula; practice-based coaching	# of practitioners trained; # of workshops held; # of coaching cycles completed; list of age appropriate materials and toys provided; # of ECD centers provided with age appropriate materials and toys.	Practitioners acquire skill, knowledge and qualification in ECD; centers adequately resourced with age appropriate materials and toys	Improved classroom practice; improved ECD provisioning	18 mos.	ECERS/ETERS; ELOM assessments; surveys
Growth and nutrition of children served by centers is monitored and supported; children identified as at risk are referred to the primary health care system	Routine Growth Monitoring	Baseline measurements of children in the centers; center staff trained in growth monitoring; provision of growth monitoring equipment; opening and support of referral channels between centers and health facilities	# of practitioners and principals trained; # of centers provided with growth monitoring equipment; # of centers successfully linked with health facilities; # of children whose growth is routinely monitored; number of referrals made to health facilities	Center principals and practitioners acquire skill and knowledge in monitoring and on the importance of nutrition; # of cases of malnutrition and stunting identified and resolved; improved nutrition status of all children in centers	Reduction in malnutrition and stunting against baseline; Increased case identification	18 mos.	Road to Health Cards, referral slips, reports
	Nutrition Provisioning	Training of centers on the importance of nutrition and balanced daily meal provision; center food gardening; commitments from stakeholders to provide assistance with nutrition	# of centers with food gardens; # of practitioners and principals trained on nutrition; agreement for supply of nutrition from area NGO				
Caregiver and parent engagement in children's early learning, care and development is measurably increased	Parent engagement	Parents' workshops on early stimulation, early learning, health and nutrition; one-on-one consultations and counseling accompanying referrals for health or development-related intervention	# of parents reached through workshops and information sessions; # of families counseled and referred for further interventions	Increased parent engagement in child's learning; increase in understanding of ECD	Improvement in home-based support of ECD; improved health outcomes	18 mos.	Attendance registers; parent evaluation surveys; referral data

A Case Study from the Community ECD Network: Ikhwezi Child Care Center

Background

In February 2013, Ikhwezi Day Care center, an unregistered, home based care center in the Eziphuzana area of Duncan Village, East London was referred to use for support by the Department of Social Development. South Africa Partners and Masibumbane Development Organisation reached out to the Principal, Noloyisa Madlanga, who accepted the offer to become part of the first cohort of Community ECD Network centers.

Applying the Theory of Change

Assess needs and current capacity

When we conducted an initial assessment of the eight centers who comprised our initial network, Ikhwezi was one of two centers we saw as most urgently in need of support. On an initial survey, we learned that the Principal was caring for as many as 40 children in an informal structure, or shack, that served as both her home and her day care business. She had no formal training in early education, no education past Grade 7. Her younger assistant, Mhimhi Lugebu,

completed schooling through Grade 11 but also lacked formal training in ECD. She expressed her strong interest in developing her professional skills as a practitioner. At the point of entry, Ikhwezi had no access to resources to support the center other than an inconsistent income from fees, no safe outdoor play space, few materials, and inadequate sanitation facilities for children. While it was clear that Ms. Madlanga provided loving care to the children in her care, Ikhwezi was far below the standard that she wished to meet, that government required to achieve formal registration, and that the children of the community needed and deserved.

In July 2013, a trained U.S./South African assessment team lead by faculty from Wheelock College, Boston, conducted a formal, observation-based assessment of Ikhwezi using the ECERS-R and ITERS. The evaluations instrument documented Ikhwezi's strengths: positive interactions with children, a well-defined daily schedule, and good communications with parents and families. The weaknesses that needed to be addressed, however, were just as visible: overcrowding, few resources to support early literacy and numeracy, inadequate training in age-appropriate learning activities, inconsistent management routines, and significant problems with safety and sanitation both indoors and outdoors (see photos below):

Ikhwezi agreed to join the inaugural Community ECD Network, and our partnership began.

Activate local resources and partners

Applying our methodology, we took steps to meet four of Ikhwezi's critical needs by tapping into local resources and partners.

Practitioner Training: At the start of 2014, Mhimhi Lugebu was enrolled in a Level I course, Delivering an Effective ECD Programme, through Loaves and Fishes Network, a national training organization with active in the East London area. As part of an initial cohort from the Network, Mhimhi attending training part time for one year. After successful completion of the Level I course, in 2017 she completed the Level 4 course in ECD offered by ITEC, another local ECD training organization. Mhimhi now leads the center's educational program and assists in the daily management of the center.

Nutrition: Mrs. Madlanga provided the children with a cooked lunch daily but noted that many children arrived in the morning without having eaten. MDO negotiated a partnership, at no cost to the center, with JAM, arranging for the weekly delivery of breakfast porridge. Ikhwezi is now in its third year of supplying all children with breakfast and lunch daily. In late 2018, they began active monitoring of children's growth by routinely measuring height, weight and middle-upper-arm circumference to screen for stunting and malnutrition.

Children with special needs: Through our relationship with the University of Fort Hare and the local Health District, Ikhwezi benefitted from a series of visits from students completing their studies in social work at UFH to help identify children with special needs. In 2016 a 5-year-old girl was identified as in need of remediation. She did not speak when she was at the center and did not want to participate in activities. An Occupational Therapist from UFH paid a series of visits to the center, working with the child and with staff to encourage and support her in communicating and participating. The child and her mother were successfully referred to Frere Hospital, a local public hospital, where she was thoroughly examined and provided with additional specialist support. In 2017, Mhimhi assisted the child's mother in applying for placement at Parklands Special School, a local primary school that can provide the services and support the child needs as she enters formal schooling. She enrolled in 2018. MDO Programme Assistant Aletta Ngangani recently saw the now 7-year-old at Parklands and reports "she can now speak and play with other children. This was a highlight for me, since I met her when she had just started at Ikhwezi."

Formal registration: Ikhwezi benefited from our engagement with Ilifa Labantwana's Bhalisa Inkulisa project designed to smooth the path toward formal registration for centers like Ikhwezi. Through the Network's partnership with Bhalisa Inkulisa, which delivered workshops to Network Principals and supplied step-by-step instructions and materials, Ikhwezi achieved "Bronze Level" conditional registration in 2018. This conditional registration gives Ikhwezi access to the much-needed per child government subsidy for a 5-year period and makes Ikhwezi eligible for government investment in is infrastructure, an area where further improvement is still needed.

Provide key supports

Management support: Over a five-year period, the Principal, often accompanied by Mhimhi, regularly attended Network Principal meetings designed to develop stronger management processes and practices. Principals also participated in workshops on topics in early education delivered by program staff and outside specialists. With her practitioners, the Principal participated in over 80% of the workshops. It was noted that the Principal was, at first, tentative about speaking up in these meetings, but that she became more vocal and more engaged over time, perhaps a measure of her growing confidence and of the value of using a cohort model in which Principals develop peer to peer relationships.

Provision of materials for learning and play: Ikhwezi was outfitted with a "literacy corner" library, blocks, infant toys, and a range of additional basic materials to support fine and gross motor development, early numeracy, and imaginative play.

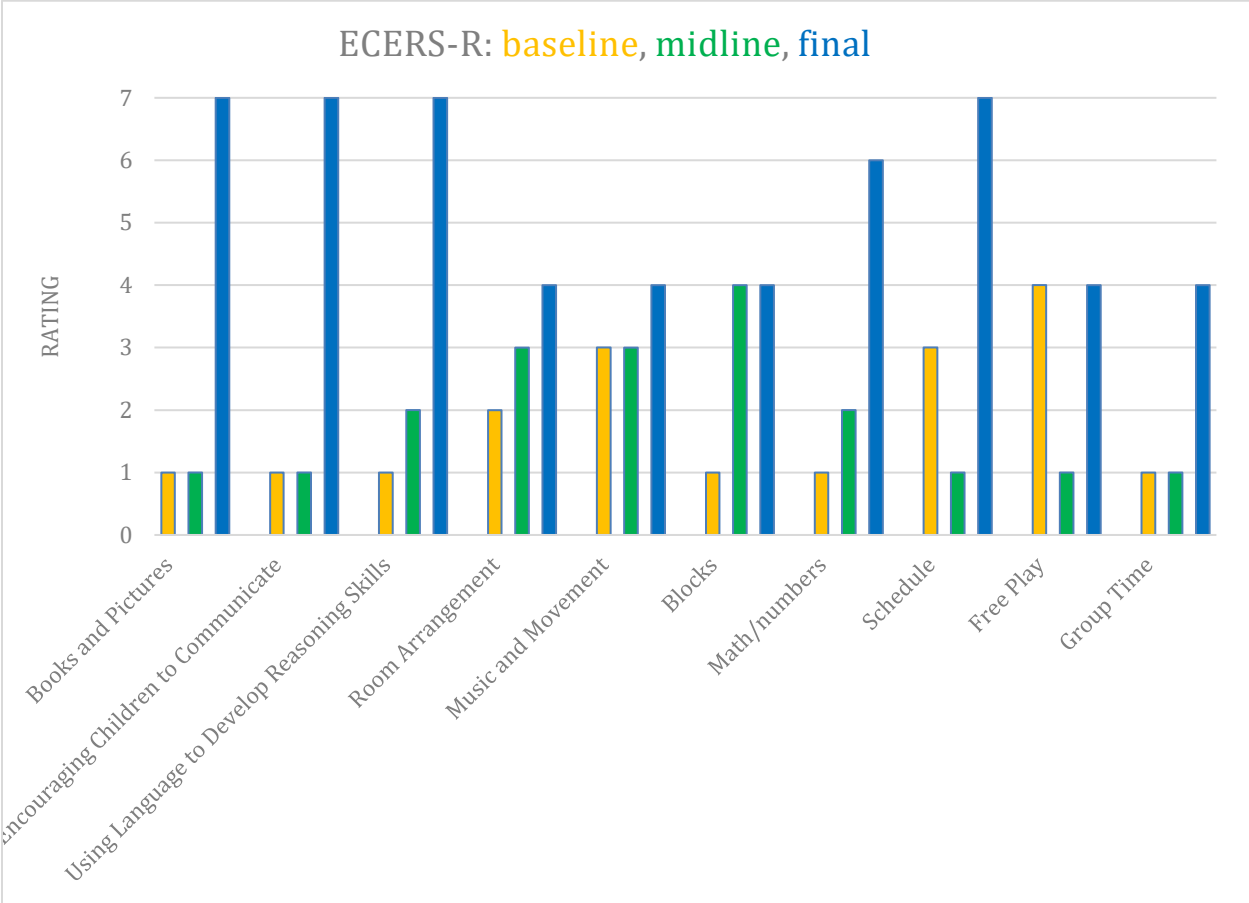
Practitioner support: as noted above, the lead practitioner enrolled in and successfully completed two levels of formal training. An additional staff member who did not wish to enroll in formal training benefited from on-site teaching practice workshops and site-based coaching, a key element of our model.

Infrastructure improvements: with the encouragement of program staff, the Principal was able, over time, to improve the physical space and physical safety of her site (see table below). Renovation of the structure helped Ikhwezi meet norms and standards required for “Bronze Level” registration. The facility now has running water, two plumbed toilets with hand basins, and a paved outdoor area.

Build a Community of Practice: As noted above, Noloyiso Madlanga has been a part of the Network group of Principals now for five years. While her formal educational level and her proficiency in English are the lowest of the group of participating Principals, she has steadily increased her level of engagement and participation with the group. Her membership in this community of practice has raised her profile in her own geographic area and appears to have increased her level of confidence as an owner of a small, now more stable, small business. She and Mhimhi have been happy to host a succession of visitors, from donors to the leaders of South African and U.S. universities. They are proud of the progress they have made, proud of the way they have expanded and upgraded the facility.

Measures of progress

Classroom environment and instructional practice: Ikhwezi has made remarkable progress during the period of its membership in the Community ECD Network. As measured by scales on the ECERS-R selected for their relevance, Ikhwezi has shown marked improvement in classroom practice and instruction in all areas, most strikingly in early literacy and numeracy and in encouraging language use. Higher ratings on these scales have been reliably correlated to improved school readiness. The ECERS-R ratings below reflect both the materials available for learning and play and how they are used in practice:



Formal registration: As noted above, as a result of hard work by the Principal and support provided through the Network, Ikhwezi has been awarded “Bronze Level” conditional registration as a partial care facility by the Department of Social Development despite its infrastructure challenges. Ikwezi has 5 years to advance toward Silver and Gold level registration. Administrative and financial systems are now in place, and access to the government subsidy will stabilize the center’s financial condition. A larger financial investment will be required to elevate the infrastructure to meet the next level standard, but Ikhwezi now has a path to access additional funds, as conditional Bronze Level registration is a pre-requisite for accessing public funding allocated to the Eastern Cape Department of Social Development for this purpose.

Infrastructure improvements: During the period of engagement, at the initiative of the Principal and without direct funding by the Network, Ikhwezi’s indoor space has been extended, a fully-plumbed working toilet has been added for use by older children, and the outdoor space has been leveled, cleaned, fenced, and provisioned with a climbing structure.

The table below illustrates where Ikhwezi began in 2013 and the point to which it has advanced by the end of 2018.

Infrastructure	Assessment in 2013	Assessment in 2018
Indoor Space	Sufficient space but inadequate lighting and ventilation, building in poor repair; reasonably clean and well-maintained	Sufficient space, building renovated and extended with enough windows, clean and maintained
Furniture: L&P	Long table with chairs, good repair; nothing else; no cribs or changing table	They have bought tables and chairs, 2 cribs, and set up a nappy changing area
Furniture: Comfort	Carpeted floor, some soft furnishings	Carpeted floor, but need more cushions
Room arrangement	No centers, sufficient space	Literacy corners installed and are in daily use
Privacy	Some spaces for supervised privacy	They have an office to discuss issues privately and store management records
Child-related display	Some materials displayed, no children's work	Walls are displayed with children's paintings
Gross Motor Space	Outdoor space not safe, not fenced, uneven and rocky	Outdoor space paved, safe with outdoor resources
Gross Motor Equip.	Rocking toys indoors, little else	They have some outdoor equipment like ladder for climbing, balls, hoola hoops; still need equipment with wheels
Greeting/departing	Good interactions	Good interactions with parents and children

Infrastructure	Assessment in 2013	Assessment in 2018
Meals/Snacks	Sanitation not good; well-balanced meals, good atmosphere	Hygiene has improved, they provide nutritious meals every day, children are well taken off
Nap/Rest	Physical provisions not adequate; schedule and supervision are good	Mattresses for toddlers, cribs for babies
Toilet/diaper	Sanitation not good; basic provisions with buckets	Toilets were built for the children; washing basins in use; bin for diapers
Health practices	Needs improvement re: spread of germs	The center has running water; hand wash routines in place
Safety practices	Needs improvement; supervision good but environment hazardous; nails, unfenced outdoors, tripping hazards	Outdoor area now fenced, leveled, and paved
Books and Pictures	Very few books, no reading observed; appropriate wall posters	Lots of books and the book corner is used every day, children know when its story time. Practitioners are reading for children in IsiXhosa and English, variety of books
Language communication, reasoning, informal comms.	Few activities supporting communication and logical reasoning; many staff-child conversations	Practitioners communicate with children, encourage them to talk and reason
Fine Motor	Very few materials; poor repair	More materials still needed, but they improvise
Art	Very few materials	Since practitioners attended trainings and workshops, they understand importance of doing art activities in their program. They use dough, paints and brushes
Music and Movement	Teacher-initiated music activity; no materials	They have no music instruments, but they sing and dance to their own songs
Blocks; Sand and Water	No blocks, no sand and water	Blocks in good repair, sand and water area
Dramatic Play	Some materials available and accessible	“Fantasy Corner” installed that children enjoy

Infrastructure	Assessment in 2013	Assessment in 2018
Nature/Science; Math/numbers	No materials; one match chart on the wall	Puzzles are used for maths, sorting and matching materials in use
General Supervision; discipline; interaction/child interaction	Positive and adequate supervision; very positive interactions	Space is larger, making it easier to supervise children effectively
Schedule/structures	Basic schedule in place/mostly free play; no small group or individual activities	Follow daily program, children understand activities, know the routine
Parents and Staff	Some sharing of information; interactions respectful and positive; staff interaction positive	Parent involvement has improved, sharing information around various topics e.g. nutrition and health

Noloyiso Madlanga, Principal, at Ikhwezi, Duncan Village, East London, 2018

Appendices (A and B included in this document, B – H are separate attachments)

A: Detailed Description: Practice-Based Coaching

B: Detailed Description: Health and Nutrition Monitoring

C: Evidence of Impact: ECERS-R and ITERS results for first cohort

D: Initial Needs Assessment Forms

E: Materials for Learning and Play: Checklist

F: Sample MOU with Network Centers

G: Practitioner and Principal Survey Forms

H: Bhalisa Inkulisa Registration Materials

Appendix A: Practice-Based Coaching

The Classroom Practice Pillar: Practice-Based Coaching

A specific objective of the Community Early Childhood Development (ECD) Network model is to measurably improve the delivery of quality, age-appropriate learning and play in low-resource ECD centers. The model uses a two-pronged approach to professional development of Network practitioners in support of this key objective.

The first is the voluntary enrollment of classroom practitioners in **formal, accredited ECD training** at National Qualifications Framework (NQF) Level 1 or Level 4 offered by local ECD Resource and Training Organizations. Enrollment fees of R3500 for Level 1 and R6500 for Level 4 are covered out of the Network budget or, when possible, covered through the enrollment of practitioners in learning cohorts funded by government or corporate sponsors. However, facilitating enrollment in formal training is not sufficient. Not all practitioners will elect to enroll in formal training for a variety of reasons, including insufficient levels of education and personal circumstances. In addition, those who do enroll benefit from support during and after the formal training period. The support assists them in translating theory into practice, consolidating their learning, and adapting what they have learned to suit the context of their workplace and the individual needs of children in their care.

The second is **Practice-based Coaching (PBC).** Our model pairs formal training with 24 months of site-based support provided by a qualified ECD Mentor, a professional with experience in the field and with a formal qualification at NQF Level 5 or higher. We adapted the **Practice-Based Coaching** strategy developed and extensively evaluated in the United States. (PBC). Practice-based Coaching is a cyclical approach for supporting effective teaching practices that leads to positive outcomes for children. It occurs within the context of a collaborative partnership between a coach and a classroom practitioner. The coaching cycle involves planning goals and action steps, engaging in focused observations, and reflecting on and sharing feedback about teaching practices. [10]

At the heart of PBC is the establishment of a trusting, collaborative, one-on-one partnership between the ECD Mentor, as coach, and the practitioner. For this reason, it is critical that the coach not only have formal qualifications but also possess the local knowledge, experience, and cultural and linguistic competencies that allow the coach to work effectively with individuals in high-poverty, historically disadvantaged communities. The capacity allows the coach to meet practitioners where they are and developing relationships with them as fellow professionals. The role of the coach is not to judge the practitioner, but to support her. The Mentor provides focused, targeted feedback so that the practitioner takes ownership of a set of effective classroom practices and implements them with fidelity. Secondly, as developed and implemented through the Community ECD Network, PBC goes beyond collaboration between the ECD Mentor and an individual practitioner. Their work together lays the foundation for the establishment of peer-to-peer support within and between staff at Network centers and the development of an informal Community of Practice (CoP) amongst practitioners that will outlast the formal 24-month delivery of PBC. Using a cohort model, the coaching process as

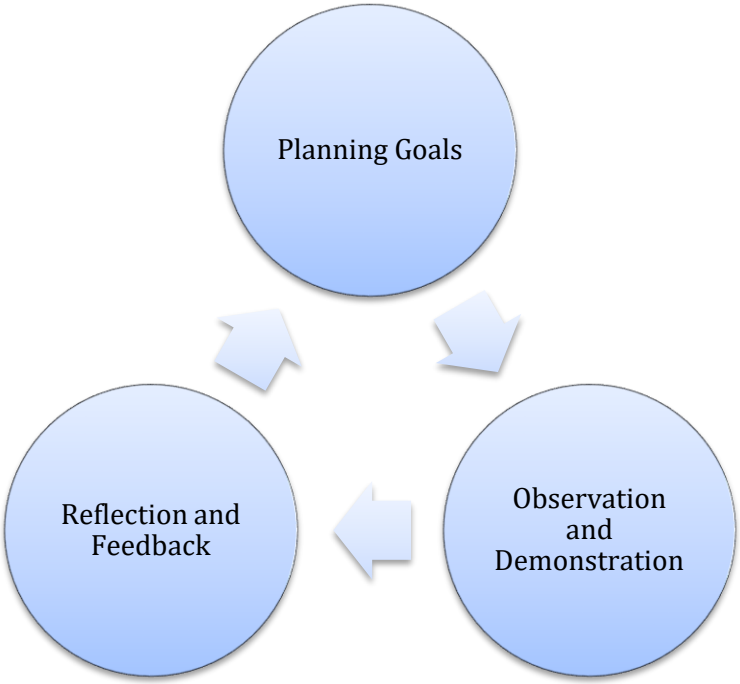
[10] Practice-Based Coaching: The National Center on Quality Teaching and Learning https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/pbc-handout.pdf

implemented below helps develop a climate of collaboration and cooperation across centers that helps establish a self-sustaining professional network of support and advice.

Practice-Based Coaching in the Community ECD Network

Our approach is based on the U.S.-developed strategy that we adapted over a two-year period of implementation to meet the needs and conditions, assets and challenges of a low-resource, South African context. To be sustainable, we have kept costs low and sought to build upon the strengths and nurture the leadership potential to be found within the ECD workforce. As noted above, we have threaded PBC into our Network cohort model. As such, coaching focuses on the same area or topic across centers to promote collaboration, build peer to peer support, and make the most efficient use of the financial and human resources available.

The Coaching Cycle: 4-6 Weeks



Stage One: Planning Goals

- The ECD Mentor reviews assessments of current practice in centers[11] and identifies areas of common need for support across centers (for example: daily program,

[11] A baseline evaluation of classroom environments and classroom practice is carried out as a first stage in implementation. Instruments used are selected items from the Environment Rating Scales ECERS-R (ages 3-5) and ITERS (Infant and Toddler) environment rating scales. Numerous research projects in the United States and abroad had used the ECERS to assess global quality and have discovered significant relationships between ECERS scores and child outcome measures. We employ the sub-scales that are both appropriate to the South African context and address program objectives.

numeracy, gross motor activities). The Mentor also liaises with partner training organizations and references training curricula to align with the concepts practitioners are currently learning in formal coursework and working to implement in their classrooms.

- The ECD Mentor visits sites and consults with Principals and practitioners, discusses needs and concerns, elicits feedback on possible areas of focus for the PBC cycle. In this way the practitioners "own their own growth" by identifying areas where they need additional professional development.
- Based on all input above, the ECD Mentor identifies a focus area for the PBC cycle and shares activity plans with Network Principals and practitioners.

Stage Two: Observation and Demonstration

- The ECD Mentor supports practitioners in a selected focus area:
    - ECD Mentor makes individual site visits to observe focus area practice, discuss challenges with individuals and center staff, assess staff strengths and weaknesses, and identify practitioners who may provide peer to peer support and leadership.
    - Group training workshop/demonstration models best practice *onsite in a selected center or centers*; session facilitated by the ECD Mentor but may feature demonstration by an identified practitioner.
    - Individuals practice new skills and methods in their own classrooms.
    - Exchange visits of practitioners take place, as feasible, between classrooms or centers after demonstration.
    - ECD Mentor makes follow-up visit to individual sites to observe new efforts, note and share observed changes in practice; individual practitioner reflection and feedback gathered in preparation for stage three.

Stage Three: Reflection and Feedback

- Group meeting(s) are held to reflect on successes and challenges in improving practice in the focus area. The ECD Mentor facilitates meetings through paired or group discussions. Practitioners share reflections, exchange tips and ideas as a Community of Practice. Questions may include:
    - What did practitioners do differently, and why?
    - What went well? What methods or activities were successful, and what were the indicators of success?
    - What still needs attention or improvement?
    - How did children respond to the change in practice?
- ECD Mentor elicits feedback on the process.
- Group discusses and agrees upon next area of focus; cycle begins again.

Additional operational specifics

- One part-time ECD Mentor (.5 FTE) serves 6-8 ECD centers. With our current Duncan Village, East London cohort, the Mentor supports 24 practitioners
- ECD Mentor visits, on average, individual centers one day per month

- In addition to activities designed for the full Network cohort, centers are clustered geographically for some activities to
    - Reduce transportation costs
    - Encourage and increase ease of frequent, even spontaneous, peer to peer support
- Demonstration workshops are hosted onsite in working classrooms. Onsite demonstrations a) help ensure that practice is embedded in real classroom conditions, b) contribute to higher rates of attendance, and c) reduce time out of the classroom for practitioners, particularly when delivered in geographic clusters

Evidence of Impact

We implemented our PBC model within the Community ECD Network in 2018. As part of our program evaluation, we evaluated classrooms and classroom practices at the environmental, or classroom, level in late 2017 and again in late 2018/early 2019 using selected items from the ECERS-R and ITERS instruments. As noted above, ECERS-R and ITERS ratings have been shown to have a strong relationship to individual child outcomes, which were not measured due to resource constraints. Observations were carried out by internal staff trained on administering the instruments. Items selected for use were those relevant to overall program objectives or aligned with specific focus areas addressed in the coaching cycle. Sub-scales used included:

- Room arrangement
- Gross motor equipment, gross motor area for play
- Books and pictures
- Math/numbers
- Encouraging children to communicate
- Using language to develop reasoning skills
- Music/movement
- Blocks
- Schedule
- Free Play
- Group Time

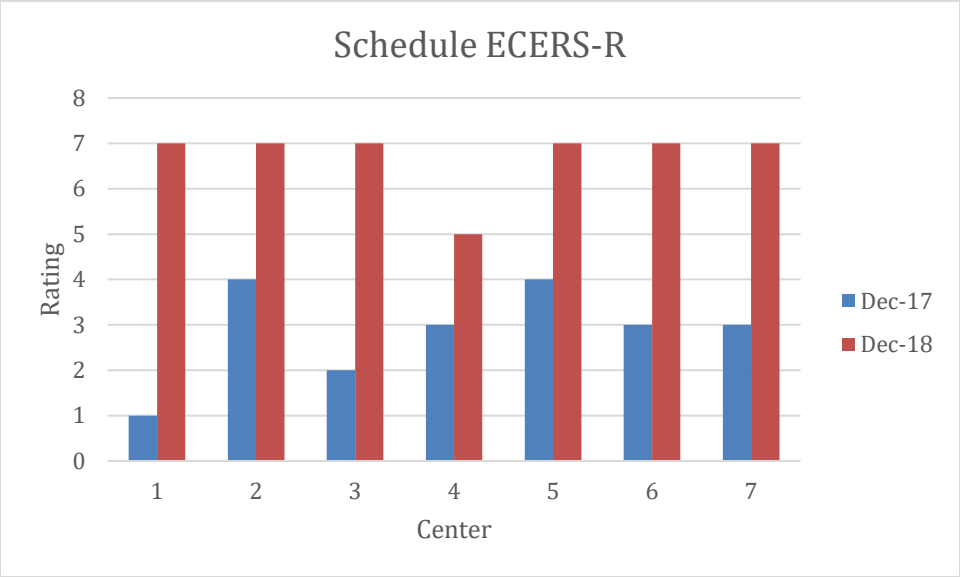
Two of the domains measured – **schedule and room arrangement** - were focus areas targeted in PBC cycles. The quantitative results offer initial evidence of impact of PBC as part of the Community ECD Network model. In addition, the ECD Mentor made her own qualitative observations and gathered and shared direct, qualitative feedback from practitioners. Did participation in a PBC cycle change practice for the better?

Example 1: Schedule

In formal training, practitioners are taught the importance of designing, posting, and following a daily program that provides structure for both children and practitioners. In December 2017, the assessors observed that while all centers had a written schedule posted in the room, many practitioners did not follow the program. In discussion, Principals and practitioners acknowledged that there was a clear gap between theory (posting and following the generic schedule provided with the training materials) and practice (following either an inconsistent daily program or a program that did not correspond to the written schedule). They sought support from the ECD Mentor and from one another to close the gap. The ECD Mentor guided practitioners through a workshop on how to construct a daily program that was tailored to the conditions at each particular center, taking into account the ages and number of children, the space and materials available, and other variables.

As shown in the graph below, as measured by the ECERS-R instrument, there was a dramatic change in the rating for program structure comparing the scores before and after the classroom schedule was an area of focus of PBC. Six of the seven centers achieved a top rating of 7. To do so, the observer had to verify that the schedule provided:

- A balance of structure and flexibility
- A variety of play activities, some teacher-directed and some child-initiated
- A substantial portion of the day used for play activities
- Both gross motor and less active play daily
- At least one indoor and one outdoor play period daily (weather permitting)
- Smooth transitions between daily events
- Variations made in schedule to meet individual needs



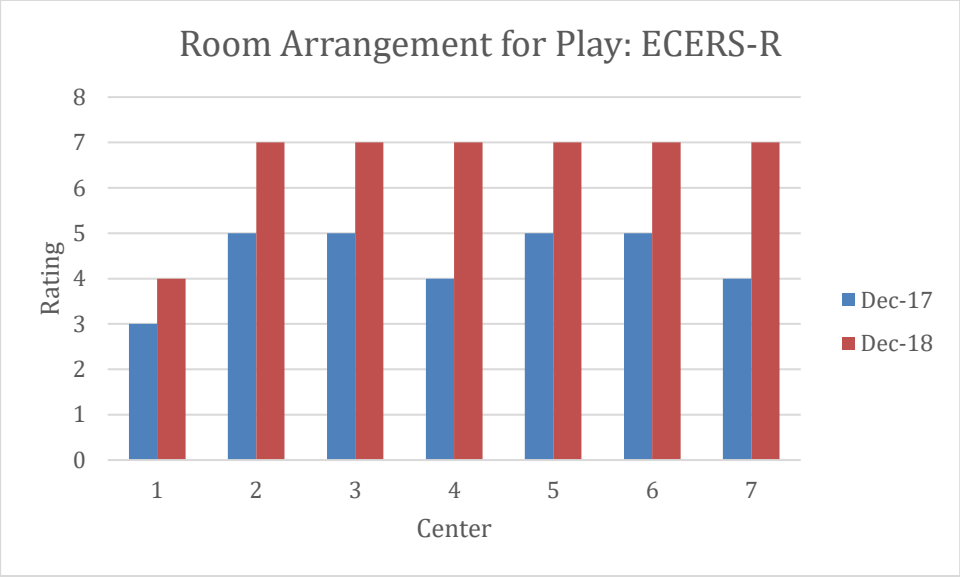
During the coaching cycle focused on schedule, the ECD Mentor observed and reported that at each center, practitioners made adjustments to suit their populations of children, and during follow-up visits they were able to offer explanations of why they had made changes and to describe the resulting positive outcomes for children and practitioners.

Example 2: Room Arrangement

Room arrangement has two aspects: safety and learning experiences. During training, practitioners work in a demonstration space that may or may not be replicable in their centers. This challenge is particularly acute in low-resource centers where space and materials constraints and high practitioner/child ratios are a large factor. Network centers were eager to learn how to maximize their space and how to best arrange their materials for learning and play. Here, onsite workshops were critical, in which the ECD Mentor and practitioners worked together to rearrange spaces and set up activity centers.

As seen in the ECERS-R (ages 3-5) and ITERS (infant and toddler) graphs below, by the end of 2018 Network centers demonstrated significant improvement in room arrangement. For children ages 3 to 5 years, a top rating of 7 is achieved when the assessor observes all of the following:

- At least five different interest centers with a variety of learning experiences
- Centers organized for independent use by children
- Visual supervision of play is not difficult
- Space is arranged so most activities are not interrupted.

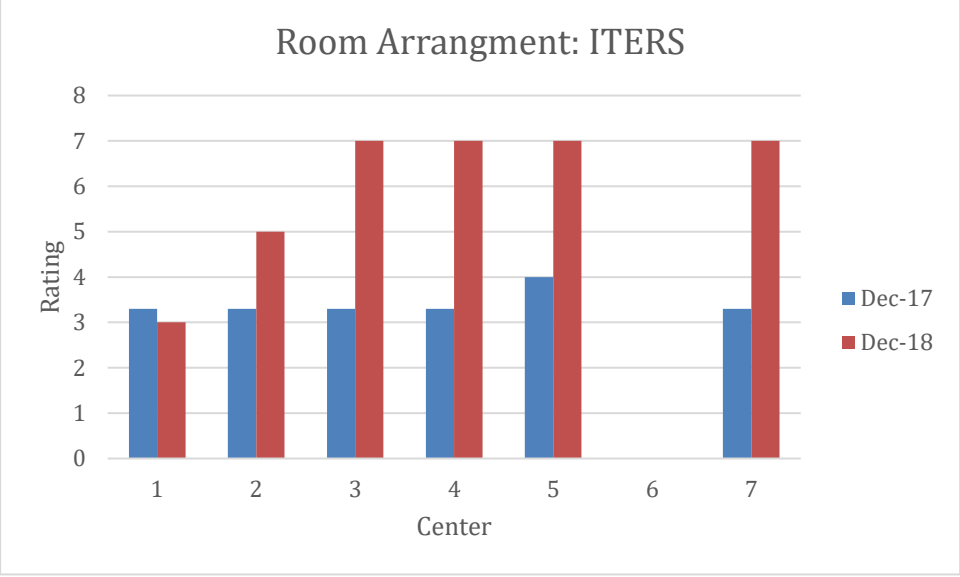


For centers that serve infants and toddlers, an ITERS score of 5 indicates that:

- Routine care areas are conveniently arranged
- Staff can see all children at a glance
- Areas for quiet and active play are separated
- Toys are stored for easy access by children

To achieve a score of 7, the following must also be observable:

- Suitable space for different kinds of experiences
- Materials with similar use are placed together to make interest areas
- Traffic patterns do not interfere with activities



[12]

[12] Center # 6 does not have a separate infant/toddler room

What the Principals and practitioners say:

In a survey of practitioners, respondents rated in-class support as “extremely helpful.” They reported that through their work with the ECD Mentor they have changed their teaching methods in general, the way they organize their classrooms, and the way they organize and carry out a daily program.
Combined with formal training, this model of Practice-Based Coaching is an effective method of professional development for practitioners in low-resource ECD settings.

Appendix B: Health and Nutrition

The Health and Nutrition Pillar: Monitoring and Support Child Growth, Health and Nutrition through Center-based Care

A specific objective of the Community Early Childhood Development (ECD) Network is to monitor and support the growth and nutrition of children served by centers and facilitate the referral of children identified as at risk back to the primary health care system.

In the final year of the development of our Network model, South Africa Partners and Masibumbane Development Organisation have begun implementing a strategy that positions Network centers to serve as screening and referral hubs. This strategy recognizes that to be effective, early care and development must be holistic. It builds upon the existing trusted relationship between ECD center staff and parents to support the health of children in these learning centers.

Background: In 2017, South Africa Partners and MDO initiated a partnership with the Buffalo City Metro Municipality (BCMM) Health District to better understand the scale of child malnutrition and stunting in local communities. The most recent South Africa Demographic and Health Survey places the rate of child stunting of children ages 5 or younger in South Africa at about 27%[13]. In areas like Duncan Village where poverty is rife, stunting and malnutrition rates are likely even higher. As is increasingly common in middle-and-low-income countries, South Africa faces a double burden of under-nutrition and obesity. The science is clear: malnourishment impairs physical, cognitive and motor development. Childhood stunting and obesity are precursors of adult type II diabetes, reduced quality of life, lower educational achievement, lower earning, and shortened life expectancy.

Our Approach

The work carried out through this pillar is designed to address several challenges to improving child health and nutrition in the community in which we work.

The first area of focus for our activities is identification. Many children within the Duncan Village community become effectively invisible to the primary care system between the ages of 18 months, the end of the infant immunization schedule, and six years, when their next immunization is due. Children who are not taken for well child visits may not receive routine Vitamin A supplements or de-worming medication. In addition, are not routinely screened for stunting, malnutrition, hearing and vision problems, or not evaluated against critical developmental milestones. Our strategy to address this challenge is to work with the local Health District to train early childhood practitioners - those who see the children in their

[13] National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. 2018. South Africa Demographic and Health Survey 2016 Key Findings. Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF.

community on a daily basis and interact with parents - to carry out routine growth and nutrition monitoring and to position the centers in our Network as training sites for students from the University of Fort Hare studying for degrees in nursing. As a result of this training and screening activity, children with growth and health problems are identified and referred back to the primary care health system.

First, ECD center staff are trained by health professionals from the BCCM Health District in measuring and recording height, weight and middle-upper-arm circumference (MUAC) on a monthly basis. The Community ECD Network provides the necessary equipment to conduct the screening and monitoring. As a routine practice, ECD centers retain a copy of each child's Road to Health Card (RTH), a booklet issued to children at birth and held by parents that serves as a summary record of a child's health in the first five years. Center staff are familiarized with the booklet through training by the BCCM Health District and then review RTH cards for compliance with immunization schedules, alerting parents if the recommended schedule has not been followed.

Secondly, a partnership with the Faculty of Nursing Sciences at the University of Fort Hare brings nurses-in-training and their supervisors to the centers once per quarter to screen children for additional health issues and assess them for developmental delays. Our initial experience to date shows that ECD center staff, having watched these screening services be delivered at the centers, have become more proactive in alerting visiting professionals and parents to children's ailments or possible developmental delays.

The Community ECD Network employs a Health Mentor, a part time staff member with a nursing qualification, to coordinate and monitor these activities. The Health Mentor supports ECD center staff as they learn to carry out, record and track monthly measurements post-training and plans with UFH for their quarterly screening visits, providing feedback to the BCCM Health District and to UFH on their respective activities. Critically, she serves as the liaison between the center, children and their families, and the local health facilities to which identified cases are referred for care and follow-up. She visits each network center at least once a month.

A second area of focus is community education. In under-resourced communities, it is critical to educate caregivers, parents and children about the importance of good nutrition and physical activity early in life to prevent the early onset of chronic diseases that are difficult to manage and add a high burden of cost to the state. In addition to communicating with and referring families when problems are identified in a child, MDO, with support from UFH and the Department of Health, organizes workshops for parents and caregivers. Delivered by our expert partners at UFH and from the BCCM Health District, topics covered include child nutrition, early stimulation, recognizing developmental milestones, and the importance of physical activity for children. Parent workshops are delivered on site in Network centers or in a local community center at an hour designed to maximize attendance; child care is provided in central venues.

Finally, we focus on promoting healthy physical activity. Through another arm of our partnership with UFH, students and faculty from the University of Fort Hare Health Sciences Department of

Human Movement visit the centers and work with center staff, coaching them on playful ways to incorporate physical activities into the daily program, promoting health and the development of gross motor skills. Each center receives a set of equipment to promote active, healthy outdoor play.

Our approach draws together families, ECD centers, local government, and the local university in a coordinated program of outreach and education, one that links back to the primary care system.

Objectives and Activities

Objective 1: Enable and promote monthly growth and weight monitoring and referral in ECD centers and promote daily nutrition

Activity 1: BCCM Health District trains principals and practitioners in measuring height, weight and middle-upper arm circumference (MUAC); following initial training, program staff support ECD center staff in accurate recording of measurement and how to recognize the need for referral for stunting, underweight or overweight based on age and measurement results; second phase of training by BCCM as follow-up, including training in nutrition and how to provide or ensure two healthy meals/day for children

Activity 2: Provide equipment necessary for growth and nutrition monitoring

- Infant weight scale, one per center
- Child weight scale, one per center
- Height measurement poster to affix to wall
- Middle-Upper-Arm Circumference (MUAC) tapes, 20 per center (reusable)

Activity 3: In partnership with UFH Nursing Faculty and Department of Health, review monitoring data and facilitate referral of children identified as possibly stunted, underweight or overweight to primary health care locations in close proximity to the ECD center for follow-up.

Activity 4: Engage JAM (Joint Action Management) to supply and deliver breakfast porridge to all centers.

Objective 2: Facilitate quarterly health screening and referral by nursing students on site in Network centers

Activity 1: UFH Student Nurses and Supervisor visit each center; screen individual children for ailments and development delays; monitor Road to Health (RTH) cards for compliance with immunization, Vitamin A supplement and de-worming schedules; screen for hearing and vision problems

Activity 2: UFH Supervisor collects and records baseline data

Activity 3: Refer children as needed to a local primary health care facility for follow-up

Objective 3: Improve physical activity of children in Network centers through play and exercise

Activity 1: Equip centers with hoola hoops, skipping ropes, buckets, balls, and other gross motor skill development and outdoor equipment
Activity 2: Facilitate quarterly visits of by faculty and students from UFH Health Sciences Department of Human Movement to Network centers for purposes of demonstration of methods for encouraging physical movement and using supplies resources effectively
Activity 3: Two workshops for Principals and Practitioners delivered by UFH on the need for play and exercise and how to facilitate it in the daily and weekly program

Objective 4: Promote parent awareness and understanding of child health
Activity 1: Quarterly workshops for parents delivered by partners (UFH, BCMM, JAM) in or near Network centers with a focus on nutrition, developmental milestones, monitoring of growth through Road to Health cards, compliance with immunization and supplement schedules

Sustainability

Our hypothesis is that capacity building in the form of workshops and mentorship provided to the leaders of Network centers will result in centers continuing to use the materials supplied to monitor child height, weight, and MUAC and to continue the relationship established with both the Health District and UFH after the Community ECD Network implementation period ends. In light of the strong interest in this approach expressed by the Department of Health, we are confident that the relationship established between the centers, the Department of Health and local health facilities will endure, particularly if we are able to document success in referrals. Since we began these activities, we have been encouraged by the enthusiastic manner in which the Principals and practitioners have implemented monitoring, and they have reported that they have begun, independently, the counselling of parents on good nutrition. The University of Fort Hare has also been an enthusiastic participant, as they welcome the opportunity for their students to train directly in community settings. UFH has already collected and recorded in a dedicated database baseline data on children attending the centers and will track referrals. Having created the platform for this partnership between government, an academic institution, and community-based ECD centers, preliminary indications are that the engagement may endure after the eighteen-month engagement that the Community ECD Network model provides.