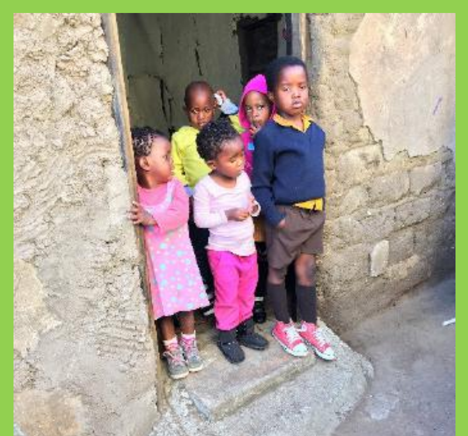
Research Report

Informal Early Childhood Development Centres -a new area-based approach for improved and up-scaled ECD services for the urban poor.
(Amaoti Informal Settlement, eThekwini Municipality)



Submitted by: Project Preparation Trust of KZN

In collaboration with:

University of KwaZulu Natal and SARChI/DST Research Chair

and Training & Resources for Early Childhood Education

Executive Summary

This Research Report provides valuable learning, evidence, and methods which can be utilised to programmatically address the prevailing crisis of access to acceptable Early Childhood Development (ECD) services by millions of young children in informal settlements and other low-income, underserviced communities in South Africa. A new and scalable ECD Response Model was successfully piloted and refined which can achieve substantial population coverage whilst at the same time optimising limited fiscal resources. The primary focus is on identifying and supporting, in a structured fashion, large numbers of de-facto, under-resourced ECD centres which have the potential to improve and provide acceptable ECD services. These centres form the backbone of the ECD services provided to young children in under-serviced communities, but are currently substantially outside of the system of state support. Given the success and value of the Response Model, a logical next step is to develop a user-friendly operational manual to assist government and non-governmental stakeholders with implementing it.

Context and rationale

"The current system of provision is blind to the majority of young children who are outside the system. It only 'sees' the children who are in registered ECD facilities. Despite an increase in the number of subsidies to early childhood development (ECD) centres, still only a third of young children are exposed to formal child care or education outside of the home. Among the poorest 40% of our population, that proportion drops to one fifth" – David Harrison, CEO DG Murray Trust, 2012.

Early childhood development (ECD) in South Africa is in a state of crisis, especially within low-income, under-serviced communities such as urban and peri-urban informal settlements. KwaZulu Natal is one of the worst affected Provinces. A paradigm shift and new programmatic approach are urgently required to create hope for young children from poor households and to break long-term cycles of poverty. Whilst ECD is a high priority for Government and whilst there is acceptance of the importance of ECD for poverty and inequality reduction and human development, there are currently no adequate programmes of support which reach large numbers of children within these unregistered, under-resourced centres. There is also a lack of information about these centres and no structured programme in South Africa to address the problem. Within this context, this research initiative has a critical role to play in respect of obtaining new information and evidence, testing new methods and enabling improved policy development.

There are estimated to be at least 2 million children in underserviced communities in South Africa who lack access to adequate ECD care and education. Most ECD centres are not registered with the Department of Social Development (DSD) and/or do not receive state support and are consequently heavily under-resourced. Children often face a range of health and safety threats. Infrastructure deficiencies are a common barrier to achieving registration, without which centres are unable to receive state support (including DSD operational subsidies and training) and remain outside the system and off the 'radar' of government. Providing support to all centres so they can improve and become registered is therefore critical.

Improving access to adequate ECD services in low income, underserviced communities, is recognized as a national priority within the National Development Plan and by key Departments such as Social Development. It forms part of both National and Provincial Social Development strategies aimed at 'massification' of ECD services. These strategies include more effectively supporting large numbers of de-facto, under-resourced ECD centres within low-income communities such as informal settlements. The challenge remains one of implementation.

Informal settlements are a particular area of need. A significant proportion of vulnerable children reside within these settlements, most of which are located within Metropolitan Municipalities such as eThekwini. There are at least 1.2 million households within informal settlements in South Africa - approximately 4.2 million people of which an estimated 600,000 are young children (5 years and below). Access to adequate ECD services within

informal settlements is however severely constrained. There is often a paralysis of developmental responses by government for informal settlements due to policy, funding, capacity, regulatory and other constraints. Informal settlements tend to remain on a 'developmental back-burner', despite the good intentions of government to mainstream incremental, city-wide upgrading. Yet given continuing urban expansion and the key role of Cities in the economy, such settlements offer a strategic opportunity to address poverty through better inclusion of the urban poor in the opportunities which Cities can provide.

Research focus

This research initiative responds to these critical issues, it being recognised that there is currently a gap in respect of organisations and spheres of government responding proactively to address them. The Initiative responds by testing in a real-world situation a new and programmatic ECD response model which can potentially be scaled up to achieve maximum population coverage.

The particular focus on informal settlements is due to the high concentration of ECD vulnerabilities within these settlements, the strategic importance of Cities as rapidly expanding centres of employment and economic growth, and the opportunity to leverage off synergies with parallel informal settlement upgrading initiatives underway in South Africa.

Concurrent ECD work

This research initiative takes place in parallel with closely related work being undertaken by PPT, working in close collaboration with other support organisations (such as Ilifa Labantwana, Network Action Group and Assupol Community Trust) within five rural municipalities in KZN as well as an additional informal settlement area within Umlazi in eThekwini. The experience, tools and learning from this parallel ECD work have significantly assisted and enriched this research initiative. The parallel learning has been referred to and assimilated where possible and relevant.

Research objectives and method

The primary research objective was to test and refine an evidence-based and scale-able ECD response model for the support of unregistered ECD centres in underserviced, informal settlement communities, which enables inclusion, flexibility and incremental improvement, and which thereby achieves maximum population coverage of young children and maximum impact on various aspects of poverty affecting such children and their families.

Specific research objectives of the Action relate to:

1) **Generating new information and knowledge** about ECD centres – status, potentials and challenges.
2) **Developing and testing a categorisation framework** which can accommodate all centres and support population-based ECD response planning.
3) **Developing and testing methods for assessing centres** and planning for improvements which have a favourable cost-benefit.
4) **Testing infrastructure-funding solutions** via securing funding to implement infrastructure improvements at six pilot sites.
5) **Implementing operational and infrastructural improvements** at six pilot sites.
6) **Refining the ECD Response Model** for potential upscaling and replication.
7) **Strengthening quantitative research skills** within PPT and its partners.
8) **Supporting improved ECD policies and practices by government through improved use of evidence** (derived from quantitative and qualitative studies) by eThekwini Municipality and the Department of Social Development (DSD).

The initiative was an applied, action-research project with a mix of quantitative and qualitative methods. It is emphasised that action research is a flexible, iterative research process with methodological refinements made during the research process as a result of project learning and inputs (e.g. stakeholder feedback, unanticipated environmental factors encountered). The research activities, methods and processes consisted of both those which form part of the ECD response model being tested and those which were necessary in order to assess its efficacy.

The research initiative consisted of four main phases:
1. Phase 1: Scoping and setup.
2. Phase 2: Area-level rapid assessment & baseline.
3. Phase 3: Pilot interventions at six centres.
4. Phase 4: Quantitative research study, dissemination and policy feedback.

Research timeframes

This Research Initiative took place over a period of 20 months between 23 May 2015 and 31 January 2017, although it is noted that the commencement of project activities was delayed due to the contract transfer to DPME from the Presidency and the associated delay with the payment of the first funding tranche. Substantial work was only underway by August 2015.

ECD Response Model tested

As per the Research Method, the response model consists of two main elements:
1) An **ECD Rapid Assessment and Categorisation** (RAC) method (including a field survey).
2) **Incremental ECD development plans** and related response packages (for both infrastructural and operational improvements).

The four main constituent sub-elements of the response model are as follows:
1) a systematic method for **rapidly assessing and categorising all ECD centres** at area or municipal level (and on this basis, extending structured funding and support to enable improved care, learning and infrastructure);
2) greater **flexibility** in respect of current minimum standards and registration requirements;
3) the development and implementation of comprehensive **centre development plans**;
4) **infrastructural improvements**/investments in order to address infrastructural deficiencies and unlock centre improvements, registration and inclusion within the current system of ECD

Research team

The research team comprised of Project Preparation Trust (PPT), University of Kwazulu Natal (UKZN) with involvement of the SARCHi Research Chair for Applied Poverty Reduction Assessment and Training and Resources for Early Childhood Education (TREE). PPT held the contract with the DPME, managed and co-ordinated the team, and undertook the bulk of the action research work. UKZN provided research advice and undertook a literature review, focus group work and compiled a research paper. TREE undertook operational assessments and training at pilot sites.

Key stakeholder involvement

It was critical that various key stakeholders were effectively involved and engaged during the action research process, particularly given the regulatory and funding role of government in respect of ECD centres, the intention of state funding and support, and various parallel ECD initiatives and policy developments which were directly relevant.

An eThekwini ECD Project Steering Committee was established which functioned as a reference group in order to obtain input and feedback from key stakeholders. The collaborating organisations (PPT, UKZN, TREE) also formed part of this Committee. Bilateral engagement with these stakeholders occurred as and when the need arose. The following stakeholders were represented on the Project Steering Committee: eThekwini Metro (Human Settlements, Health, Social Cluster, Engineering Services); KZN Dept. Social Development (Service, District and Provincial Offices); Ilifa Labantwana; Network Action Group.

Research implementation

Most aspects of the research plan were successfully implemented including:

- Extensive **stakeholder engagement, participation and buy-in** at Metro, provincial and national levels.
- Development of a **dedicated ECD survey tool** (Android tablet, cloud-based, 149 key questions) and successfully utilised in the field.
- **Specialist field survey team's** capacity was trained and mobilised.
- An **ECD field survey** was successfully implemented. Many unknown centres were identified and significant new information about ECD in informal settlements was obtained.
- **Data management tools** were developed to capture, process and analyse survey information.
- The **ECD Categorisation Framework** was developed along with additional, refined and successfully implemented (general categories of A, B1, B2, C1, C2 using 52 marker questions plus additional measures for ECD potential, infrastructure adequacy and investment potential).
- A **two-stage method for filtering, shortlisting and selecting centres** (prioritising) was developed and successfully implemented.
- **Parameters for flexibility for ECD in informal settlements** and other underserviced communities were determined in consultation with key stakeholders (pertaining to DSD registration, building norms etc.)
- **Tools and methods for ECD infrastructure response planning** were developed and successfully utilised (methods for operational planning already existed).
- **ECD improvement plans** were successfully developed (operational and infrastructure).
- **Infrastructure delivery models** were developed (for minor improvements, extensions and new builds).
- **Funding options for ECD infrastructure** were successfully evaluated, viable sources identified for pilots, and substantial progress made in finding long-term solutions (post pilots).

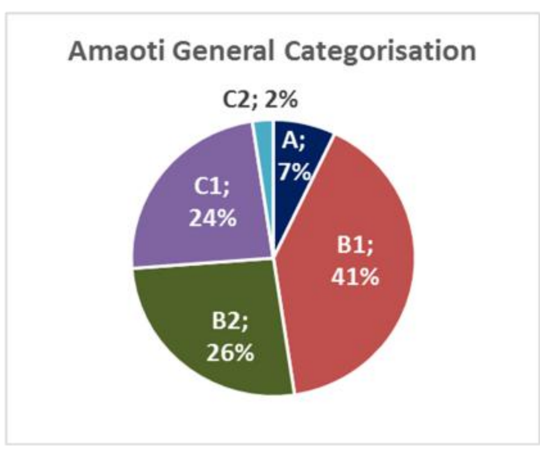
Overview of surveys done in KZN

Target areas	ECD Centres surveyed	NPO Registered	DSD Registered	DSD subsidized	Infrastructure deficits	Children in centres	Children subsidised
eThekwini Informal Settlements (81 centres, 3,917 children)							
Amaoti	**42**	**21**	**11**	**6**	**41**	**2 542**	**361**
Umlazi	39	30	9	6	27	1 367	266
Rural Municipalities (435 centres, 15,686 children)							
Vulamehlo	52	45	44	25	47	1 615	1 012
Umzumbe	102	84	71	43	98	3 700	2 001
Msinga	111	74	61	26	103	*4 038*	1 217
Umvoti	72	40	36	23	60	2 395	1 220
Nquthu	98	95	68	59	86	3 938	2 845
TOTAL	**516**	**389**	**300**	**188**	**462**	**19 595**	**8 922**

Categories and Scoring ranges

Category	Scoring	
A: Well-functioning, high potential and already providing 'acceptable ECD services'	80%	100%
B1: Basic-functioning with good potential to provide 'acceptable ECD services'	60%	79%
B2: Low-functioning with moderate potential to eventually provide 'acceptable ECD services'	40%	59%
C1: Low-functioning with limited/ no potential to provide 'acceptable ECD services'(basic 'child-minding' only)	25%	39%
C2: High risk and dysfunctional, need to be rapidly closed down (no potential / hazardous)	0%	24%

Amaoti Categorisation Results



Key findings and learning

The action research initiative provided significant new information and learning pertaining to ECD in informal settlements as well as the efficacy of the new Response Model and preconditions for its replication and upscaling.

- **The need for a new ECD response model was clearly demonstrated:**
  - **Most centres are outside of the current DSD system of oversight, funding and support** – 75% of the informal settlement centres are not registered (69% at Amaoti and 82% at Umlazi versus 36% for the five rural municipalities and 42% overall). An even higher percentage (85%) do not benefit from DSD ECD subsidies (since many registered centres don't get the subsidy) (86% at Amaoti and 85% at Umlazi versus 60% rural, 54% overall*)*
  - **There are large numbers of children who are excluded from state support in under-resourced, unregistered or unfunded centres:** There were 3,286 children centres not registered or receiving the DSD subsidy in the two informal settlements study areas in eThekwini (84% of all the children in centres - 86%/2,185 at Amaoti and 81%/1,101 at Umlazi). This is significantly higher than the average in the five rural municipalities surveyed where it was 47% (7,392 children).
  - **Infrastructure deficiencies pose the most significant barrier to centre improvement and registration.** Most of the informal settlement centres (84%/69 centres) require infrastructure improvements due to various deficiencies (basic services, building, accommodation or site) (98%/41 centres at Amaoti, 69%/27 Umlazi versus 91% rural, 90% overall average). These deficiencies typically pose problems in respect of the health and safety of children as well as meeting norms and standards for DSD registration.
  - **Most centres have potential to improve and are viable for support.** Despite their limited resources, most centres show commitment under difficult circumstances and have potential to improve, provided they receive support. 73% of centres surveyed at Amaoti have potential (31 out of 42 were in categories A, B1, B2) and 48% (20) have good potential (A, B1). The trend was significantly higher in Umlazi informal settlements and the five rural municipalities surveyed.
  - **Absence of any alternative programmatic response model:** No alternative programmatic ECD response model which can achieve population coverage was identified. Current ECD responses by government are ad hoc and reactive. Only a small number of centres are assisted.

- **The efficacy of the new ECD Response Model was proven:**
  - **It effectively identifies existing centres at area-level for the first time:** The Model collects and collates existing lists of ECD centres and in addition, identifies significant numbers of centres not previously known. For the first time it provides a comprehensive and detailed list of all (or most) existing centres in targeted under-serviced areas. This can be done at area or municipal level. At Amaoti, only 11 out of 42 centres (26%) were covered by the 2014 National ECD Audit. Existing lists of centres are systematically collected from various sources (DSD, Municipality, support NGOs). Even after this was done at Amaoti, an additional 10 centres were identified which were not on any pre-existing lists. This trend is consistent with other areas surveyed where, after consolidating all existing lists, significant numbers of additional centres not previously known were identified (34% of all centres surveyed in areas outside of Amaoti). Globally, in all areas surveyed by PPT, the 2014 National ECD Audit only identified 40% of the number of centres identified and surveyed and 30% of the children.
  - **It provides new and essential information about existing centres:** The Model provides significant new information pertaining to the status quo, needs and potentials at existing centres (making use of 149 survey questions). This includes information about the number of children, DSD and NPO registration status, centre and ownership, capacity and governance, infrastructure status, health and safety threats, and status of early learning programmes. It is noted that on the pre-existing lists of government, the information on those centres listed was typically limited (typically just the name of the centre, number of children enrolled, NPO and registration status, and sometimes an address and contact details). Information on EHP's lists tended to be more detailed than that on DSD lists (including some

information pertaining to infrastructure and ECD qualifications). In rural municipalities, such additional information was not accessible from EHPs.

- **It establishes a comprehensive ECD database for the first time:** The area/municipal-level databases can readily be rolled up and consolidated into a provincial database and potentially a national ECD database. The historical absence of a comprehensive ECD database has posed a major limitation on population-based response planning, budgeting and support.
- **It enables population based ECD response planning using data:** The comprehensive data collected enables effective population-based ECD response planning to take place for the first time. The Categorisation Framework is a key tool in this regard along with the other ratings for ECD potential, infrastructure adequacy and investment potential. Centres can easily be grouped according to their function and potential and ranking or filtering of centres can be done for various purposes. The overall ECD capacity within a particular area/municipality can quickly be gaged.
- **The Categorisation Framework is effective and 'fit-for-purpose':** The categorisation (A,B1,B2,C1,C2) was shown to be a good predictor of ECD functioning and potential. It is therefore an effective tool for population based ECD planning, including gaging existing local ECD capacity at area-level, shortlisting centres for ECD support and determining local ECD capacity and potential.
- **The Model enables prioritisation of those centres with the greatest potential and highest numbers of children for support:** The data and categorisation enable funding and other resources to be allocated so as to achieve maximum benefit and population coverage. Centre profiles with photographs assist with selection. All of this enables more transparent, evidence-based and accountable decision making on resource allocation for ECD improvements and support.
- **The Model provides a more transparent, accountable and depoliticised basis for the selection of ECD centres** for state support, instead of support flowing only or mainly to those centres which are already known or enjoy local political support.
- **Improving existing centres is cost effective and is therefore the infrastructure investment priority** if population coverage and 'massification' are to be achieved. The Model is premised on supporting and improving centres as the primary focus. Almost seven times more children can be assisted when improving centres than constructing new builds for an equivalent budget. The costs of building new centres for all under-serviced children is unaffordable to the fiscus, costing more than almost seven times per child relative to improving existing centres. The average planned cost per centre is R108,798 at R2,086 per child (for a mix of basic services and minor building improvements at 91 centres in six municipalities). By contrast, new builds cost between R14,000 and R29,000 per child (depending on whether they are built at basic/NPO or higher/state facility specification). New builds should only be undertaken where necessary and even then should preferably also function as 'hubs' which support surrounding, less-resourced ECD centres
- **De-facto 'community-based' ECD centres respond uniquely to the particular needs of parents in informal settlements** in various ways: they play an important role in supporting families to cope with everyday pressures; there is often a personal, flexible and supportive relationship with parents and rendering extra assistance in times of stress; they are typically nearby and accessible; there is often flexibility in respect of drop-off and collecting times; there is often flexibility in respect of payment.
- **Overall, it provides the only viable, programmatic and scale-able response model:** Given the absence of any programmatic response and the prevailing fiscal and other constraints, the new ECD Response Model provides the only viable method for addressing the prevailing ECD crisis in informal settlements and other under-serviced communities.

- **There are several key preconditions for scaling the Model up:** If these are not addressed then the new Model cannot be successfully implemented. The key pre-requisites relate to:
  - **Effective ECD co-ordination and institutional relationships (especially at municipal-level).**
    - **Adequate funding instruments and budgeting (for infrastructural and operational improvements at centres).**
    - **Procurement, partnerships and delivery models for scaling up planning and delivery.**
    - **Flexibility in respect of ECD registration, norms and standards, tenure and centre ownership.**

- **A greater fiscal allocation for ECD is necessary:** The global fiscal allocation to ECD (both operational and infrastructural) is clearly insufficient as evidenced by the fact that many registered centres do not yet receive an operational grant due to provincial budget shortages and the absence of any dedicated fiscal allocation for ECD infrastructure. Given the strategic importance of ECD for South Africa (e.g. from an economic and educational point of view) and the special rights of children under the Constitution, reprioritising certain other budget votes so as to increase the allocation to ECD is surely appropriate. Based on a rough estimate, it would require approximately R11 billion to address the entire ECD infrastructure backlogs in South Africa assuming a model of improvement with new builds only where necessary and appropriate. On the operational side, it would cost approximately R8.5billion per annum in ECD grants, once all children in South Africa enjoy access to the subsidy. Without infrastructural improvements and ECD subsidies, under-resourced centres cannot be expected to improve. The typical fees paid by poor parents (R50-R150 per month) are inadequate. Such centres will otherwise remain outside of the system and will be unable to provide acceptable ECD services to millions of young children.

- **State funding instruments for ECD infrastructure need strengthening:** There is not yet an adequate solution for state ECD infrastructure funding and this requires urgent attention. The main source of funding is currently municipal infrastructure funding (MIG/ICDG). Such usage is common and envisaged in the Division of Revenue Act. However, it is problematic for ECD to have to compete with other infrastructure funding demands in municipalities. Requiring municipalities to make firm ECD allocations (e.g. on their BEPPs and MTEFs[1]) or ring-fencing some of this funding for ECD would greatly assist. The other funding instrument, the DSD's conditional ECD maintenance infrastructure grant which is being piloted on a limited basis over a three year period, is highly constrained: at this stage it is still very small in fund value; there is a R100,000 ceiling per centre; is only being utilised for those centres which have conditional registration (excluding all other centres with potential); and Provincial DSDs do not have the necessary infrastructure experience to effectively manage the funding. Expanding it and making it more flexible would greatly assist, along with either allocating it to municipalities or else putting in place an effective, special purpose delivery vehicle. In the case of both instruments, there needs to be prescribed flexibility for government to invest in infrastructural improvements for centres which do not own the underlying land provided they meet DSD and EHP approval (with prescribed flexibility as to norms and standards).

- **More effective institutional co-ordination and funding mandates are necessary:**
  - **Municipal-DSD relationship and IGR:** ECD is currently a shared function (Schedule 4B of the Constitution) and an unfunded mandate. The roles, responsibilities and funding mandates of the municipality versus the provincial DSD need to be clearly agreed, preferably via dedicated high-level meetings and a resultant MOA.
  - **Responsible Metro Department for ECD support:** A Metro Department needs to be assigned to deal with ECD from a development (as opposed to regulatory) point of view. In eThekwini, no Department has been assigned (currently dealt with jointly by Human Settlements and Social Cluster).
  - **Municipal-level ECD co-ordination structure:** Strong municipal-level ECD co-ordination for response planning, budgeting and stakeholder co-ordination involving the Municipality, DSD, ECD forums and support NGOs is critical. This needs to be a high level structure with decision-making authority involving senior officials.
  - **Municipal-level ECD strategy:** A Metro-level strategy for ECD support is a necessary part of the Response Model if it is to be effectively scaled up. In eThekwini such a Strategy has not yet been developed although it is understood that certain other Cities may have such strategies.
  - **Support NGOs:** The involvement of specialist support NGOs with ECD skills and capacities (pertaining to both infrastructure and operational dimensions) is regarded as a key element of a successful ECD Response Model.

[1] BEPP = Built Environment Performance Plan; MTEF = Medium Term Expenditure Framework

- **Appropriate flexibility is necessary to include ECD centres with potential in the system of state support:** The current registration and other ECD requirements are out of reach for most centres due principally to low levels of income at centres and prevailing building types and underlying land use. Examples of areas where flexibility is required are: zoning, building plans, DSD minimum floor area requirements, ratios of trained practitioners per child, separating age groups, and age-appropriate programmes. Substantial flexibility is already applied by many EHPs and social workers, however this will vary and there is no official basis or standard for this de-facto flexibility (which is usually applied so that much-needed support can be extended to needy and worthy centres).
  - **DSD Partial Care Facility Registration:** Significant flexibility is already envisaged in the DSD's draft gold-silver-bronze incremental registration framework currently being finalised by the National DSD in close consultation with various other stakeholders. Once implemented, under-resourced centres will be able to attain bronze level conditional registration and be included in the system. However, the current framework is premised on centres being able to transition rapidly from bronze to silver levels, even though some centres will in reality struggle to do so, principally due to insufficient operational funding (income) and infrastructural deficits. Further refinements may be necessary.
  - **Municipal bylaws for ECD and building regulations:** The required flexibilities need to be agreed upon, documented and implemented. The National DSD is currently investigating the possibility of a 'universal bylaws' for ECD.
  - **State infrastructure investment (land and centre ownership):** Centres cannot be expected to own the underlying land in order to be eligible for state-funded improvements (however not for new builds or major extensions). Privately owned centres which are considered as 'community based centres' by the DSD should also be eligible for minor improvements since they provide an essential service and operators themselves are typically low income and operating on a subsistence basis, typically having invested significant personal resources into their centres.
  - **DSD Programme Registration:** Whilst this was not specifically assessed as part of the research initiative, it is recommended that the DSD further assess this to determine how under-resourced ECD centres can be included and supported in achieving acceptable standards within their prevailing financial and other limitations.

Refined ECD Response Model

The proposed new Response Model thus offers significant potential to be scaled-up and mainstreamed, thereby transforming the access to improved ECD services for children within underserviced, informal settlement communities and resulting in inclusion within the current system of state support. The Model was substantially refined and strengthened through the PSPPD-funded action research initiative as outlined in the diagram on the following page.

The model is premised on supporting and improving de-facto, under-resourced ECD centres wherever possible. This is not only for reasons of cost-efficiency and achieving population coverage, but also because such 'community-based centres' can respond uniquely and flexibly to particular local needs, often helping parents/families to cope in various ways with prevailing pressures and stresses. The level of state investment in infrastructural improvements will vary, but will most often focus on minor improvements to address key infrastructural deficiencies. New builds are only appropriate where there are no other options and then should preferably also serve as 'hubs' to support surrounding, less-resourced centres. The Model provides a rational basis upon which to make these determinations as part of population-based ECD planning.

Scale-able ECD Response Model for Rapidly Improving ECD Centres in Underserviced Communities in South Africa

Stakeholder engagement

mainly via Municipal level ECD Co-ordination Structure involving **EHPs, DSD ECD Forums support NGOs**

Step 1: Rapid Assessment and categorisation

(Once off)

Preparation

- Procure/partner for RAC & year 1 planning
- Define target area
- Desktop study
- ID existing & new centres

Field Survey

- Familiarise team wth survey tool
- Recruit & train field workers
- Field Survey Data Processing , analysis
- Survey report

Categorisation

- General categoires (A, B1, B2, C1, C2)
- ECD potential
- Infrastructure adequacy
- Investment potentials

Optional focus group discussions Individual In-depth interviews (IDIs)

Step 2: ECD Response Plans

(ongoing, multi year)

Shortlisting & selection of centres for support

in current year/MTEF period

Assessments & response planning

including cost estimates for delivery:

1) **Inftrastructure**

2) Operational

Procurement / partnerships for response planning

(2nd year onwards until all viable centres completed)

Step 3: Implementation

(ongoing, multi year)

Infrastructure improvement procurement & delivery

(*Year 1)*

Infrastructure Improvement procurement and delivery

(*Subsequent years until all viable centres completes)*

Operational improvement & delivery

(*Year 1)*

Operational Improvement procurement & delivery

(*Subsequent years until all viable centres completed)*

Key Preconditions for Response Model

Stakeholder and institutional co-ordination.

Funding instruments and budgeting (infrastructure and operational).

***Procurement/partnership** model* for survey, planning and delivery.

*Clarity on **ECD flexibilities*** (e.g. gold-silver-bronze) and including clarity on tenure, land and centre ownership.

Challenges and limitations

- The nature of the Action determined that the PPT team needed to work closely and alongside government (principally eThekwini Municipality and KZN DSD). This largely determined the 'pace' at which the Action could be undertaken. It was both unviable and contrary to the purpose and methods of the project to undertake work in isolation from government. The timeframes for securing the support necessary from eThekwini to proceed with the implementation of pilots took far longer than expected. This was due to many factors beyond the control of the team and these are addressed in some detail in the main report (e.g. lack of a clearly assigned municipal Department to deal with ECD and the flux created by the 2016 local government elections). However, one key factor was the desire of the Municipality to move forward programmatically with ECD and ensure that various internal institutional issues, IGR alignments and high level political support were all in place. This is now close to resolution.
- As a result of the above, implementation of pilots was not possible within the project timeframe, although it is expected to occur during 2017.
- The budget for the research initiative was tight relative to the scale and complexity of work involved. This placed pressures on the project team (additional to those outlined above).
- So far, there have been only two informal settlement study areas. The survey of additional informal settlement areas would be highly beneficial to increase the sample size of data.
- The scale and scope of the research exceeded expectation. ECD is a complex field and it is even more complex in the environment of under-resourced centres and informal settlement communities. The range of issues which came to bear was very diverse ranging from the statutory and regulatory environment and ECD norms to laws and regulations affecting state investment and issues of intra government co-ordination.
- The Action did not set out to develop a comprehensive operational manual for the operationalisation and scaling up of the model. However, having successfully demonstrated the efficacy and need for the model, such a manual is now considered necessary. Amongst other things, this would distil key knowledge and information into an accessible and user-friendly format for both governmental and non-governmental stakeholders. It would need to address a range of key issues pertaining both to the model itself as well as a range of key related issues and pre-requisites (e.g. tenure, state procurement, norms and standards etc.)

Policy implications – summary

- **Greater fiscal allocation for under-resourced ECD centres**, both in respect of infrastructure and operating costs (DSD subsidies). Most children currently do not benefit. Their families cannot afford to pay enough for centres to provide acceptable care. Substantially increased state funding is a necessity.
- **NDSD to finalise the new gold-silver-bronze registration guidelines,** which confer important and necessary registration flexibility and will enable inclusion of many centres currently outside the system.
- **National Treasury to facilitate ECD priority within municipal infrastructure grants** (MIG, ICDG) including: requiring firm allocations on BEPPs/MTEFs and/or ring-fencing for ECD; greater flexibility including with respect to centre and land ownership. This will help empower Municipalities to play a more developmental ECD role (noting that ECD is a concurrent function).

- **DSD to optimise ECD conditional maintenance grant** during its two-year pilot phase, via improved co-ordination at Provincial and District level and better co-ordination with municipal IDPs. If scaled up, significant refinement would be necessary e.g. increased threshold per centre and inclusion of centres which are not conditionally registered but which have potential.
- **Undertake ECD surveys in all municipalities** to determine the status and category of existing ECD centres and provide the data necessary for effective, population-based ECD planning. Funding for is required. This could be provincially driven to enable consolidated data-bases and rapid delivery.
- **ECD centre improvement planning & delivery support** is necessary (provincial/local level) to develop viable and 'bankable' ECD project pipelines. Efficient provincial or municipal delivery models and partnerships are needed. Leveraging the capacity ECD support organisations will be beneficial.
- **Structured DSD-Municipal collaboration / clear IGR** (e.g. via MOAs) in order to clarify intra-governmental responsibilities and ECD infrastructure funding streams. This must include Metros who have large, concentrated, underserviced populations.
- **Municipal level co-ordination structures** are necessary for response planning, budgeting and stakeholder co-ordination and involving Municipality, DSD, ECD forums and support NGOs.
- **Long-term settlement plans should not block ECD response planning** as it will negatively affect access and quality of ECD for thousands of children that will adversely affect children's school readiness and the rest of their educational development.
- **Include ECD in informal settlements as a priority within the national upgrading agenda** of all spheres of government. ECD in an important part of upgrading and Cities such as eThekwini are moving to include ECD as part of their upgrading programmes.

Contents

PART 1: MAIN RESEARCH REPORT 18
1 Introduction 18
1.1 Problem statement and context........ 18
1.2 Related ECD work 19
1.2.1 Prior work 19
1.2.2 Concurrent ECD work 19
2 Research Team........ 20
3 Literature Review........ 21
4 Research objectives 21
4.1 Overview........ 21
4.2 Primary and secondary research questions 22
4.3 Overall Objective of the Action 22
5 Overview of ECD Model to be tested 23
5.1 Functional requirements of a programmatic response model 23
5.2 Main elements of the response model 23
5.2.1 An ECD Rapid Assessment and Categorisation (RAC) method. 24
5.2.2 Incremental ECD development plans and related response packages. 25
6 Action Research Methodology and Process 25
6.1 Research overview........ 25
6.2 Project design documents 26
6.3 Activity flow (summary work plan)........ 26
6.4 Refinements to action research method........ 27
6.5 Research Methods........ 28
6.6 Stakeholders 29
6.7 Research area 30
6.8 Sample 33
6.8.1 Field survey........ 33
6.8.2 Pilot sites for improvements 33
6.8.3 Centres to participate in focus groups and in depth interviews 34
6.9 Timelines........ 34
6.10 Limitations and challenges 35
7 Evaluation against research objectives........ 37
7.1 Overall objective........ 37
7.2 Application of RAC method in study area 38
7.3 ECD response planning........ 39
7.4 Scaling up the response model........ 41
8 ECD Response Model – efficacy and refinements made 42
8.1 Rapid Assessment & Categorisation........ 43
8.1.1 Field Survey........ 43
8.1.2 Categorisation........ 44
8.2 ECD response plans 46
8.2.1 Prioritisation & selection of centres........ 46

8.3 Response planning for infrastructure improvements ... 47
8.3.1 Response planning for operational improvements ... 48
8.4 Delivering improvements - infrastructure ... 48
8.4.1 Infrastructure improvements ... 48
8.4.2 Operational improvements ... 49
8.5 Key pre-requisites of the Response Model ... 49
8.5.1 Co-ordination and institutional relationships ... 49
8.5.2 Funding instruments and budgeting ... 50
8.5.3 Procurement and delivery models for scaling up ... 51
8.5.4 Tenure, land and centre ownership ... 52
8.5.5 NPO registration and private ownership ... 53
9 Refined ECD Response Model ... 53
9.1 Overview ... 53
9.2 Process ... 54
9.3 Preconditions ... 55
9.4 Diagram: Scale-able ECD Response Model for Rapidly Improving ECD Centres in Underserviced Communities in South Africa ... 56
10 Policy engagements ... 57
11 Summary of key learning ... 59
11.1 New Response Model proven ... 59
11.2 Preconditions for scaling up Response Model ... 61
11.3 Flexibility is critical ... 62
11.4 Fiscal allocation for ECD ... 63
11.5 State infrastructure funding instruments ... 63
11.6 Effective ECD institutional co-ordination and funding mandates ... 64
11.7 New key learning from ECD survey data ... 65
11.8 Other learning from assessments, focus group discussions, consultations, etc. ... 65
12 Recommendations and policy implications ... 66
PART 2: IMPLEMENTATION OF MODEL, SPECIFIC FINDINGS AND REFERENCES ... 67
13 Implementation of model with key findings ... 67
13.1 Stakeholder engagement and buy-in ... 67
13.2 Desktop study ... 69
13.3 Field survey of ECD centres ... 70
13.4 Categorisation Framework ... 77
13.5 Categorisation of ECD centres ... 79
13.6 Selection of pilot centres ... 91
13.7 Flexibility necessary for registration and infrastructure ... 94
13.8 Minimum infrastructure norms (flexibility) ... 96
13.9 Response planning - ECD infrastructure improvements ... 99
13.9.1 Infrastructure response packages ... 100
13.9.2 Infrastructure assessments & improvement plans ... 103
13.9.3 State infrastructure investment criteria ... 106
13.9.4 Cost estimates for ECD infrastructure improvements ... 112

13.9.5 Cost-benefit of the infrastructure improvement model 114
13.9.6 Capital funding for infrastructure improvements 115
13.10 Response planning - operational improvements 118
13.11 Implementation of ECD infrastructure improvements 120
13.12 Implementation of ECD operational improvements 120
13.13 Post implementation: score card assessment & structured interviews........ 123
13.14 Partial Care Registration by DSD 123
13.15 Individual In-depth Interviews and Focus Group Discussions 124
13.15.1 Qualitative Research Objectives........ 124
13.15.2 Qualitative research methods used 125
13.15.3 Selection of Centres........ 125
13.15.4 Limitations 125
13.15.5 Individual in-depth interviews (IIDIs) 126
13.15.6 Focus Group Discussions 129
13.16 Community-based ECD Centres........ 134
14 References 135

Annexures:

A. Summary Learning Brief (Policy Brief)
B. Literature review (UKZN)
C. Research Methodology
D. Report on Stakeholder Engagement
E. Survey Report (Amaoti) – including survey questionnaire
F. ECD Summary Profiles (all 42 Centres at Amaoti)
G. ECD Categorisation Framework Evolution and Refinement
H. ECD infrastructure improvement costs (22 sites including 8 pilot sites)
I. ECD pilot site summary and improvement plans (8 pilot sites)
J. Amaoti ECD Practitioner Baseline Report, December 2016 (TREE)
K. January 2017 Final Report - ECD training report (TREE)
L. Qualitative Research Report March 2017 (UKZN)
M. ECD multi-stakeholder workshop report (Jan 2017)
N. Categorisation Framework for ECD (PPT base document 2015)
O. ECD Funding Model (PPT base document 2015)
P. ECD Norms and Standards (PPT base document 2015)

List of Tables

Table 1: Research Team........ 20
Table 2: Activity flow(summary work plan)........ 27
Table 3: initial planning vs actual 35
Table 4: Informal settlement data vs comparable rural dataset........ 35
Table 5: Stakeholder roles and responsibilities........ 68
Table 6: Summary of marker questions for categorisation........ 80
Table 7:Marker questions & weighting 83

Table 8: Percentages assigned to categories ... 83
Table 9: Categories and scoring ranges ... 84
Table 10 Categorisation Results Amaoti ... 84
Table 11: Combined categorisation: informal settlements vs rural vs overall scores ... 85
Table 12: General categorisation scores & calculation of potential ... 86
Table 13:Breakdown of initial computer site selection results for Amaoti and Umlazi ... 93
Table 14: Minimum space norms for extensions and new builds ... 98
Table 15: Summary of improvements required at pilot centres- informal settlements vs rural vs overall .. 104
Table 16: Summary of investments required ... 113
Table 17: Costing of improvements and new builds ... 114
Table 18: Training modules provided by TREE ... 121
Table 19: Further training courses recommended for practitioners ... 122

List of Figures

Figure 1: ECD Rapid Assessment and Categorisation flow chart ... 24
Figure 2: Infrastructure assessment and implementation flow chart ... 25
Figure 3: Categorisation Results Amaoti ... 84
Figure 4: Categorisation results for informal settlements, rural areas and overall results ... 85
Figure 5: No of centres per investment level ... 110
Figure 6: Amount per investment level ... 113
Figure 7: Ranking of most important features by parents ... 132

List of Maps

Map 1: Location of Amaoti in relation to Durban ... 31
Map 2: Amaoti survey area ... 32
Map 3: Centres surveyed ... 71

Abbreviations

ACT	Assupol Community Trust
BEPP	Built Environment Performance Plan
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development
DPME	Department of Planning, Monitoring and Evaluation
ECD	Early Childhood Development
EHP	Environmental Health Practitioner
EU	European Union
HDA	Housing Development Agency
IGR	Intergovernmental Relations
KZN	KwaZulu-Natal
NDP	National Development Plan
NDSD	National Department of Social Development
MTEF	Medium Term Expenditure Framework
NPO	Non-Profit Organisation
NQF	National Qualifications Framework
PSPPD	Programme to Support Pro-Poor Policy Development in South Africa

PPT	Project Preparation Trust of KZN
SARChI[2]	South African Research Chairs Initiative
TREE	Training and Resources for Early Childhood Education
UKZN	University of KwaZulu Natal

Authors

This report was compiled principally by PPT's Mark Misselhorn (CEO) and Liesel du Plessis (Senior Project Manager), but inputs made by Ndumiso Mzobe (ECD Intern) and Inbavelli Govender (Finance Manager). Reports submitted by TREE (Bertha Magogo, Teressa Ngobese) and UKZN (Prof. Sarah Bracking, Kathleen Diga, Nhlanhla Nkwanyana) were assimilated and in some respects summarised.

Acknowledgements

This Research Report is the result of joint efforts by many organisations, funders, researchers and government officials. The authors wish to acknowledge valuable inputs by:

- Our funders and fund managers:
    - European Union for funding
    - The Department of Planning, Monitoring and Evaluation
    - PSPPD programme staff
- Our stakeholders
    - eThekwini Metropolitan Municipality
    - Department of Social Development
    - Ilifa Labantwana
- ECD Centre staff and parents
- Our project team
    - UKZN's Prof S Bracking, Heidi Attwood, Kathleen Diga and Research Assistants Mbali Mthembu, Nduta Mbarathi, Nhlanhla Nkawanyana, Sibongile Buthelezi and Duduzile Khumalo
    - TREE's Betha Magoga, Teressa Ngobese, Sibongisile Blose and Nomvula Zungu
    - PPT's Mark Misselhorn, Nana Ndlovu, Robert Mann, Inba Govender, Nqabenhle Hadebe, Ndumiso Mzobe and Sindi Chauke

---

Disclaimer

This document has been produced with the financial assistance of the Programme to Support Pro-Poor Policy Development (PSPPD), a partnership programme of the Department of Planning, Monitoring and Evaluation (DPME) and the European Union. The contents of this report can in no way be taken to reflect the views of the Department of Planning, Monitoring and Evaluation and the European Union.

[2] South African Research Chairs Initiative under the auspices of the National Research Foundation

PART 1: MAIN RESEARCH REPORT

1 Introduction

1.1 Problem statement and context

Early childhood development (ECD) in South Africa is in a state of crisis, especially within low-income, under-serviced communities such as urban and peri-urban informal settlements. KwaZulu Natal is one of the worst affected Provinces. A paradigm shift and new programmatic approach are urgently required to create hope for young children from poor households and to break long-term cycles of poverty. Whilst ECD is a high priority for Government and whilst there is acceptance of the importance of ECD for poverty and inequality reduction and human development, there are currently no adequate programmes of support which reach large numbers of children within these unregistered, under-resourced centres. There is also a lack of information about these centres and no structured programme in South Africa to address the problem. Within this context, the Project has a critical role to play in respect of obtaining new information and evidence, testing new methods and enabling improved policy development.

Most young children (at least 2 million[3]) utilise informal, unregistered ECD centres or are unable to access ECD services. According to the DSD, KZN is one of three provinces with the highest number of young children with only 38% receiving access to recognized ECD services (DSD, 2012). TREE estimates the figure to be significant lower than this. However, there is no structured programme of incremental assistance and support for such centres which provide the backbone of ECD services for the poor. The significant resources of the state are not being effectively mobilised. "The current system of provision is blind to the majority of young children who are outside the system. It only 'sees' the children who are in registered ECD facilities" (Harrison, 2012). Most informal ECD centres can't qualify for assistance because they can't formally register with the Department of Social Development (DSD) and meet its high prescribed standards. Large numbers of young children therefore receive no state assistance and endure a range of significant challenges.

The Project is a direct and practical response to this prevailing crisis. Within urban and peri-urban informal settlements, there is a high prevalence of unsupported, unregistered, and under-resourced ECD centres and a large unmet demand for improved ECD services. There are at least 1.2 million households residing within informal settlements in SA (over 13% of the population of which 55% are located in the 8 main metropolitan areas). Preliminary PPT research into informal ECD in collaboration with the Housing Development Agency during 2014 has confirmed the problem and proposed a systematic, programmatic and inclusive approach to informal ECD centres. Other initiatives underway validate this new ECD approach (e.g. work by Ilifa Labantwana outlined later). Large numbers of children within informal settlements hence lack access to acceptable early childhood development (ECD) care and services. In addition, they often face a range of health and safety threats. Most ECD centres in these settlements are as yet not registered and thus fall outside of the current system of registration and related support. The challenges are both in terms of 'access' (i.e. enabling more children to access centres which are within the system) and 'quality' (e.g. in terms of quality of programmes, skills of practitioners and infrastructural adequacy).

[3] The actual figure is expected to be significantly higher than this. Although Harrison estimates the figure as being at least 1.5million (DG Murray Trust, 2011), based on Census 2011 and Wazimap data, there are appear to be at least 3.5million vulnerable children who are not enrolled (703,073 children enrolled out of a total of 6.7million young children giving 6.0million not enrolled of which at 59% are in dire poverty). It is also noted that: There are approximately 3.8million children (59%) live in dire poverty in South Africa (Attmore, Ashley-Cooper, 2012) with the bottom 40-50% of the population of children receiving inadequate education (Atmore, 2012, SA Centre of ECD). There are approximately 1.76 million children living in informal dwellings (STATS SA, 2011). Less than 1/5th of the poor (40% of the population) have formal ECD access (Harrison, 2012).

Improving access to adequate ECD services is recognized by Government as a national priority (e.g. within the National Development Plan (NDP) and by key Departments such as Social Development). The NDP prioritises ECD indicating that it needs to be made a 'top priority among the measures to improve the quality of education and long term prospects of future generations' and that 'dedicated resources should be channelled towards ensuring that all children are well cared for' and that innovation should be encouraged. It indicates that the approach should be to: "Encourage innovation in the way early childhood development services are delivered. Home and community-based early childhood development interventions should be piloted in selected districts. Financing for this initiative could involve working closely with foreign donors and private sector funders." (NDP, 2012, p. 301).

There is a strong relationship between ECD and poverty reduction and human development. "American studies have shown that for every dollar spent on preschool education, between four to eight dollars is saved in later social service costs to society. As an investment in human development, spending money on the first six years of a child's education yields the highest return over the course of a person's life" (Harrison, 2012). Within the current framework, change cannot be realised at scale, given the pre-occupation with a purely formal ECD paradigm. By contrast, the new model proposed will realise massive impacts and changes within relatively short time periods by focussing funding and other resources on informal ECD where the greatest numbers of children are in care. As a direct result of the innovation: A) Large numbers of children will eventually be included in state ECD support programmes with associated access to funding, nutrition, training, improved infrastructure etc. B) A new paradigm of inclusion and incremental support will be adopted by government towards informal ECD centres to achieve close to full population coverage.

1.2 Related ECD work

1.2.1 Prior work

Prior work on this issue can be found in the "Informal Settlement Upgrading Guidelines: Informal Early Childhood Development Centres in Informal Settlements in South Africa" developed by PPT in collaboration with the Housing Development Agency (HDA) in 2014, which included the initial development of the model, which PPT wanted to test by means of this research initiative.

The ECD support framework and method (i.e. response model) has been informed by substantial prior work and research by PPT and other organisations such as Ilifa Labantwana, TREE, NAG, DG Murray Trust and others as well as by government priorities and strategies (e.g. NDP, recent strategies of the DSD).

There is already an emerging consensus on a range of key issues (e.g. the need for 'universal ECD access'; greater flexibility in registration; the need for infrastructural improvements in order to address constraints which currently block unregistered or conditionally registered centres from inclusion within the current system of state support). There has, however, not yet been any systematic research which tests the utilisation of such a response model.

1.2.2 Concurrent ECD work

PPT is working with Ilifa Labantwana on rolling out the Strategic ECD Infrastructure Support ("SEIS") model in the Kwazulu-Natal province as a mechanism for increasing access to Early Childhood Development ("ECD") services for young children.

This project is implemented in the **four rural municipalities of Umzumbe, Vulamehlo, Umvoti and Msinga as well as in the Umlazi infill informal settlement areas in eThekwini**. PPT prepared three base documents namely a) ECD Centre Categorisation Framework, b) ECD Centre Infrastructure Norms and Standards and c) ECD Centre Infrastructure Delivery and Funding Model. This was followed by the surveying and categorisation of 376 centres; the shortlisting and selection of 86 pilot projects, development and costing of 86 improvement plans and feasibility of new build centres; the submission and presentation of ECD funding reports to municipalities; the development of minimum norms and standards, the design and costing of new builds in close cooperation with LIMA, the provision of input on matters relating to policy and procedures via Ilifa Labantwana or directly to the National DSD and the development of learning briefs.

PPT was also appointed by **Assupol Community Trust (ACT) for the development of a supplement survey and the roll out of the supplementary survey in Msinga and the enhanced survey in Nquthu,** the categorisation and technical assessment of centres and the submission of pilot project funding requests to the Assupol Community Trust that approved almost R11 million for the improvement of 40 ECD Centres (which include infrastructure improvement, nutrition, first aid training etc.) The survey database was used extensively in planning programmes for funding

Data and findings on both these projects is reported on in this research report to show rural urban differences or to confirm trends identified in informal settlements.

2 Research Team

The research team comprises Project Preparation Trust (PPT) (Coordinator), University of Kwazulu Natal (UKZN) and Training and Resources for Early Childhood Education (TREE).

Research team (20)

PPT - 8 Project Preparation Trust	UKZN - 8 University of Kwa Zulu Natal	TREE - 4 Training and Resources for Early Childhood Education
Mark Misselhorn	**Prof Sarah Bracking**	**Bertha Magoge**
CEO, process design, M&E, strategic relationships	SARChI Chair, research advice, publications oversight	Director: TREE, advisory support
Liesel du Plessis	**Heidi Attwood**	**Teressa Ngobese**
Project management, strategic relationships	Senior Researcher: research advice, guidance, training & mentoring	Assessments, improvement plans, training
Inba Govender (finance) **Robert Mann**	**Kathleen Diga, Nduta Mbarathi** **Mbali Mtembu**	**Sibongiseni Blose**
Technical Assessments, improvement plans & costing	Literature review	Representative at PSC
Nana Ndlovu		**Nomvula Zungu**
Survey planning, logistics, training		ECD Training
Fieldworkers / interns: (Nqabenhle Hadabe, Sindy Chauke, Ndumiso Mzobe	**Research Assistants: Nhlanhla Nkwanyana, Mbali Mthembu, Sibongile Buthelezi, Duduzile Khumalo**	
Centre ID, Field survey, centre profiles, focus groups etc	Focus Group discussions & report	

Table 1: Research Team

Note: Professor Sarah Bracking (UKZN) is also the SARChI (SA Research Chairs Initiative) Research Chair for Applied Poverty Reduction Assessment.

3 Literature Review

A literature review was undertaken by UKZN and the following extract is provided as an overview. Please refer to **Annexure B** for the full Literature Review report.

Early Childhood Development (ECD) has become a priority sector within South Africa, particularly in respect to ensuring equity and high quality of care for the youngest members (ages 0 to 5 years old) of the population. South Africa is also burdened with high levels of poverty, inequality and unemployment as well as unequal levels of service delivery and public provision of infrastructure. Given the recent development and request for feedback on the provisional ECD policy, there would be a benefit to examine the current state of this draft policy, its respective white papers, and its national and international mandates as well as to understand their relationship to South Africa's context of poverty.

Furthermore, child poverty remains a major concern in the country, particularly in respect to the geographical and living conditions where children live, study and play. The literature review wishes to bring to light literature on poverty and, from a multi-dimensional lens, understand how early childhood development provision, whether it be through its programming or the physical centres themselves, are affecting the lives of children, particularly those within households living in urban poverty. ECD centres are intended to provide children with a safe facility to stay and with some standards of conditions which would allow children to learn and improve their skills. ECD centres lso provides parents with the ability to leave their children in safe places so that they can work or learn. The proximity of ECD centres, their costs, the staffing and their physical conditions influence the choices of parents to leave their children at an ECD centre. The ECD centres within informal settlements were also explored in this review, given the need for further understanding of such physical infrastructures within a municipality's planning.

Planning for ECD centres within the 'grey areas', such as informal settlements or those located in traditional land, can be problematic, especially for ECD managers or principals in gaining access to much needed ECD resources through the appropriate departments. Those parents who have limited and erratic income stream are provided with inadequate choices which may put a mother and/or father in difficult situations of child care. The ECD policy would benefit poor households, particularly those living within informal settlements, through understanding the conditions of the poor and their limitation of choices in ECD centres. In understanding their limitation, government could help provide a more meaningful policy which caters to their needs.

4 Research objectives

4.1 Overview

The primary research objective is to **test and refine an evidence-based and scale-able ECD response model** for the support of unregistered ECD centres in underserviced, informal settlement communities, which enables inclusion, flexibility and incremental improvement, and which thereby achieves maximum population coverage of young children and maximum impact on various aspects of poverty affecting such children and their families.

4.2 Primary and secondary research questions

The Research Method (**Annexure C**) identified the following primary and secondary research questions.

Primary Research Question

To what extent can the proposed new ECD framework and method facilitate access to improved ECD services for children within underserviced, informal settlement communities and inclusion within the current system of state support?

Secondary Research Questions

1. To what extent can the RAC method be successfully applied within the study area?
    a. What new information does the RAC process reveal in respect of the prevalence, characteristics and trends of ECD sites in the target study area?
    b. To what extent can all centres within the study area be accommodated within the proposed categorisation framework?

2. To what extent can ECD response plans and related response packages be successfully provided at six representative pilot sites within the study area:
    a. What ECD service improvements can be achieved at the six pilot centres as a result of ECD response plans and packages (including infrastructural investments and programme support), what is the cost-benefit and which categories of centres benefit (or not)?
    b. What state support including funding can be secured for the six pilot centres?

3. What is the potential for the response model to be scaled up so as to achieve greater inclusion, flexibility and population coverage of children?
    a. What proportion of children in ECD centres in the study area could potentially benefit from improved ECD services if similar response packages were extended to all centres in the same categories?
    b. To what extent might the new ECD framework and method (response model) be accepted and/or utilised by government decision makers (noting that the model is expected to be refined during and as a result of the research).

These research questions are consistent with and provide a refinement (from a research method point of view) of the overall objectives and specific objectives outlined in the Description of the Action (original proposal to the EU).

4.3 Overall Objective of the Action

Short term: Initiation and rollout of a new ECD support programme in eThekwini Municipality for less formal, unregistered ECD centres (with related research, learning and evidence-based policy feedback).

Medium term: Acceptance and mainstreaming (at provincial and national levels) of: a) A new evidence-based, systematic framework and method for rapidly assessing and categorising all ECD centres at area or municipal level and on this basis, extending structured funding and support to enable improved care, learning and infrastructure. b) A new standard of basic, acceptable but less-formal ECD care (and associated

new incremental model of ECD support which together will result in significantly expanded access to improved ECD services, state support and inclusion into the state's ECD system in KZN and South Africa).

Specific Objectives of the Action

a) Test and refine the new ECD framework and method, including the ECD rapid and categorisation (RAC) method.
b) Generate new knowledge about ECD activities, potentials, challenges, and effective and scalable responses.
c) Provide improved ECD care and infrastructure at six pilot unregistered ECD centres.
d) Further develop quantitative research skills within PPT and its partners.
e) Improved use of evidence (derived from quantitative and qualitative studies) by eThekwini Municipality and the Department of Social Development (DSD) in policy-making and policy implementation with respect to informal ECD centres.

5 Overview of ECD Model to be tested

5.1 Functional requirements of a programmatic response model

At the outset of the research initiative, the following were regarded as the essential performance requirements for a ECD scale-able response model. The ECD Response Model which was developed and which was tested through the Action is designed to address these both directly and indirectly in various ways.

- Achieving universal ECD access / maximum population coverage of children especially those in low income, underserviced communities such as urban informal settlements and rural settlements. This has a range of practical implications. In the first instance it means that the initial, area-level ECD field survey needs to cover all sites and that the amount of information collected needs to be realistic and achieve-able yet sufficient for initial categorisation and response planning.
- Proactively assisting as many centres as possible to achieve incremental improvement, it being recognised that most children are within centres which are not (yet) registered and within the formal system. Such assistance will significantly improve ACCESS to acceptable ECD services by as many children as possible and may take the form of infrastructural investments, practitioner training, facilitating improved access to state clinic services, or other support. At the same time, QUALITY of ECD services will also be incrementally improved.
- Strengthening government capacity and systems, in particular within the DSD Service and District Office levels (e.g. in bringing unregistered centres into the system) as well as Municipal Environmental Health Departments.

5.2 Main elements of the response model

As per the Research Method, the response model consists of two main elements:

1) An ECD Rapid Assessment and Categorisation (RAC) method.
2) Incremental ECD development plans and related response packages.

The four the main constituent sub-elements of the response model are as follows:

a) a systematic method for rapidly assessing and categorising all ECD centres at area or municipal level (and on this basis, extending structured funding and support to enable improved care, learning and infrastructure);
b) greater flexibility in respect of current minimum standards and registration requirements;
c) the development and implementation of comprehensive centre development plans;
d) infrastructural improvements/investments in order to address infrastructural deficiencies and unlock centre improvements, registration and inclusion within the current system of ECD support.

5.2.1 An ECD Rapid Assessment and Categorisation (RAC) method.

This is a systematic framework in terms of which all ECD centres in a particular area (including unregistered, less formal centres) are identified and assessed by means of **a rapid field survey and then categorised** in respect of their operational capacity and potentials so as to determine the appropriate types of support which may be appropriate.

A detailed field survey is undertaken in order to obtain key information on all ECD centres within a particular target area. A database of ECD centres is established, the data analysed and a survey report compiled. Coordinates are also collected for all ECD Centres to enable mapping to gain a clear understanding of the distribution of sites within a neighbourhood and per ward. *Refer to Part 2: Section 13.3* as to how this was implemented in practice.

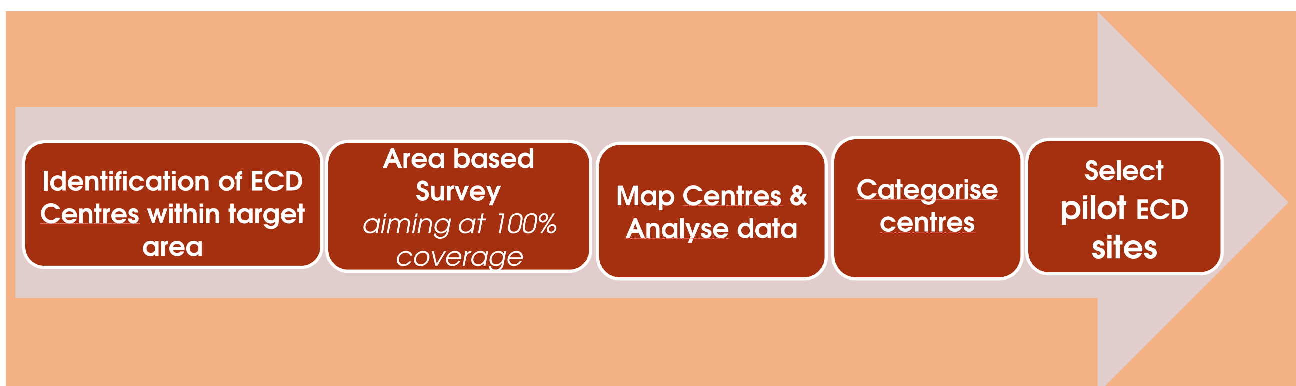


Figure 1: ECD Rapid Assessment and Categorisation flow chart

Using the data collected, all centres are then categorised according to the following framework[4]:

- CATEGORY A: Well-functioning, high potential and already providing 'acceptable ECD services':
- CATEGORY B1: Basic-functioning with good potential to provide 'acceptable ECD services':
- CATEGORY B2: Low-functioning with moderate potential to eventually provide 'acceptable ECD services':
- CATEGORY C1: Low-functioning with limited/no potential to provide 'acceptable ECD services' (basic childminding only):
- CATEGORY C2: High risk and dysfunctional - need to be rapidly closed-down (no potential/ hazardous).

Refer to *Part 2: Section 13.4 – 13.5* as to how this was implemented in practice including the refined and detailed categorisation framework and marker questions.

[4] These are the refined categories developed at the end of the Action which are substantially along the lines of the original framework – refer to *Part 2: Section 13.4* and Annexure G.

Once categorised, a site selection process is followed to prioritise sites for improvements This is an important step as there is insufficient funding and resources to assist all centres at the same time. There must be a process to determine priorities for investment purposes. Refer to *Part 2: Section 13.5* as to how this was implemented in practice.

5.2.2 Incremental ECD development plans and related response packages.

Infrastructure and operational assessments are undertaken at the selected priority centres by suitable qualified entities preferably in close cooperation with the Social Worker responsible for ECD Centres in the area and the Environmental Health Practitioner.

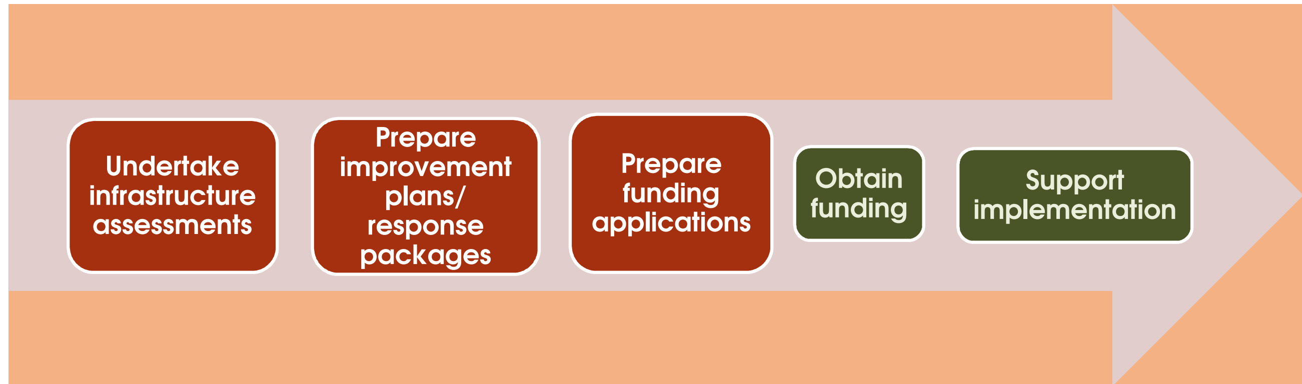


Figure 2: Infrastructure assessment and implementation flow chart

Improvement plans are compiled and funding applications are submitted to municipalities, DSD and / or donors. The extent and type of investment will be affected by factors such as the potential of the centre to improve and achieve DSD registration (with appropriate flexibility) and the types of needs or deficits at the centre. Implementation will follow once funding approval is obtained.

6 Action Research Methodology and Process

6.1 Research overview

The project is an applied, action-research project with a mix of quantitative and qualitative methods. It is noted that action research is a flexible, iterative research process with methodological refinements made during the research process as a result of project learning and inputs (e.g. stakeholder feedback, unanticipated environmental factors encountered).

The research method is outlined in more detail in the table contained in *Section 6.3* including the specific methods and data sources as well as the alignment with project phasing.

The Project/Action consists of two main elements from a research point of view: a) the method/framework to be tested through practical, real-world application; b) research and assessment of the method/framework as it is applied in order to test and refine it (e.g. efficacy, stakeholder receptiveness, replicability etc.).

It is important to distinguish between research methods (and processes) that form part of the ECD model being tested, and research methods (and process) that are aimed at investigating the application of the ECD

model. TREE and PPT are involved in both, because they are implementing an ECD model and at the same time reflecting on their implementation in order to improve and finalise the model. UKZN are not involved in the implementation of the ECD model and therefore only apply research methods which aim to gather information to assist PPT to refine their ECD model.

Accordingly, the activity workflow in *section 6.3* makes this distinction via two columns which identify the responsible organisations for particular parts of the Action.

6.2 Project design documents

The design framework utilised in this Research Report and associated evaluation of the Action, is the Research Methodology which was developed during the Inception phase and which is attached as **Annexure C**. This Research Methodology was developed taking into consideration the 'Description of the Action' contained in the original PPT Proposal to the EU as well as the detailed Logical Framework which also formed part of the Proposal. Whilst the Research Method is the main basis for evaluation, reference is also made to the Logical Framework in some instances, since this contains certain additional design elements.

6.3 Activity flow (summary work plan)

The following work plan indicates the aspects relating to the testing of the model and the aspects relating to the research

Project Activities		**ECD Model for up-scaling**	**Research to test/ refine the model**
1	**Phase 1: Scoping and setup**		
1.1	Establish Project Steering Committee (PSC) and convene PSC #1 including contacting and informing stakeholders	PPT	PPT
1.2	Review and refine research method and log-frame		PPT/UKZN/TREE
1.3	Contextual desktop literature review		UKZN
1.4	Review and refine categorisation framework		PPT
1.5	Develop research tools and data management process		UKZN/ PPT
1.6	Decide study boundary		PPT(PSC)
1.7	Collect existing data on ECD centres, as well as broad socio-economic data on the study area	PPT (TREE)	
2	**Phase 2: Area-level rapid assessment & baseline**		
2.1	Identify and train survey fieldworkers	PPT	
2.2	Field survey of all ECD centres resulting in database of all centres including preliminary baseline data	PPT (TREE)	
2.3	Qualitative semi-structured interviews with survey FWs and with selected local stakeholders (ECD forum)		UKZN
2.4	Project Steering Committee meeting #2	PPT	PPT
2.5	Process and analyse survey data	PPT	
2.6	Apply categorisation criteria and categorise all centres	PPT	
2.7	Produce research report including key trends from survey		PPT/UKZN
2.8	Refinement of ECD response model/categorisation framework	PPT	PPT

3	Phase 3: Pilot interventions at six centres		
3.1	Select six representative centres in terms of defined criteria	PPT/TREE	
3.2	Detailed survey and updated baseline at six centres	PPT/TREE	
3.3	Develop a practical improvement plan for each of the six centres	PPT(TREE)	
3.4	Secure capital funding for infrastructure delivery at 6 pilot sites	PPT	
3.5	Project Steering Committee meeting # 3	PPT	PPT
3.6	Deliver skills training and programme enhancements	TREE	
3.7	Deliver rapid equipment/material improvements at 6 pilot sites	PPT	
3.8	Support infrastructure delivery at 6 pilot sites	PPT	
3.9	Project Steering Committee meeting # 4 (after completion of improvements at the six centres)	PPT	PPT
4	**Phase 4: Quantitative research study, dissemination and policy feedback**		
4.1	Undertake focus group discussions with parents and individual in-depth interviews with principals/owners at 7 centres		UKZN
4.2	Survey assessment against baseline at 6 pilot sites (quantitative)	PPT	
4.3	Scorecard assessment against improvement plans at 6 pilot sites (quantitative) including on-site inspections	PPT/TREE	
4.4	Semi-structured interviews for 6 pilot sites (qualitative)		PPT/TREE
4.5	Further review and refine the delivery response model and categorisation framework including feasibility of upscaling		PPT(TREE/UKZN)
4.6	Final research report and description of refined model	PPT	(UKZN)
4.7	Summary Synthesis Report for stakeholder briefing and dissemination		PPT(UKZN)
4.8	Dissemination of Synthesis Report and Research Report	PPT/ TREE	UKZN
4.9	Multi-stakeholder workshop (disseminate & share learning)	PPT(TREE)	PPT(UKZN)
4.10	Project Steering Committee meeting # 5	PPT	PPT
4.11	Assessment of potential for replication and upscaling (and plan)		PPT/UKZN/TREE

Table 2: Activity flow(summary work plan)

Note that, as per discussions with UKZN and PSPPD, the focus group discussions were moved to the Phase 4 of the process outlined above due to various challenges experienced in Phase 2.

6.4 Refinements to action research method

The following changes were effected during the research period.

a) Focus groups were moved to later in the process due to various problems e.g. political instability due to elections and internal dynamics between different personalities

b) Slight refinement to survey questions and or omissions relative to original log frame based on stakeholder input. The following specific questions were not addressed: i) health and safety threats pertaining to extreme temperature, poor air quality, traffic hazards; ii) certain institutional arrangements e.g. prevalence of a business plan; iii) Infrastructure questions regarding prevalence of hot water, uninsulated roofs ; iv) Equipment- prevalence of chairs for all children, prevalence of tables for children, average % children with chairs , average % children with tables, prevalence of paper and

writing equipment, v) nutrition - meals provided to children, vi) tenure and zoning - prevalence of sites zones for special residential use vii) ECD hubs & play groups: prevalence of first time play group access, prevalence of first time ECD hub access with trained practitioners, prevalence of access to improved play groups and prevalence of access to improved ECD hubs.

In addition, due to the fact that infrastructure improvements at pilot ECD sites could not be implemented within the timeframe of the Action, certain methods were not utilised:

a) Scorecard (quantitative) assessment at six pilot sites against ECD centre improvement plans: On-site quantitative assessment of change (e.g. improved water or sanitation infrastructure or a separate food preparation area).
b) Structured interviews at six pilot sites to gage impact (qualitative): Qualitative information (in addition to the quantitative scorecard) to evaluate impact (e.g. the presence of improved infrastructure may not necessarily translate into impact if it is not being utilised for some reason or is not fit for purpose or does not perform as expected within the local environment).

6.5 Research Methods

The following research methods, as outlined in the Research Method, were utilised. The various methods utilised (e.g. surveys, focus groups, pilot interventions, project steering committees) are appropriate and typical for an applied, action-research Project such as this. There is a mix of quantitative and qualitative methods. ECD in informal settlements is a complex issue which requires multiple methods and the practical testing of possible solutions in a real world situation in order to obtain useful learning. More detail on these methods is contained in the detailed table in *section 4.4* of the Research Method (**Annexure C**).

a) **Desktop literature study**: A literature study was done to gain more knowledge of ECD in informal settlements in respect of policy trends, related research, related interventions etc.
b) **Project Steering Committee (PSC):** An eThekwini ECD Project Steering Committee was established in September 2015 involving key stakeholders to gain stakeholder buy-in, understand the impact on policies, obtain data, resource allocation for pilots, etc.
c) **Field surveys of all sites:** There was limited information on existing ECD centres in the study area. The survey data was also used for categorisation and response formulation.
d) **Collection of existing data on target study area:** This was quite important to understand the local context, including existing data on local ECD centres.
e) **Semi-structured interviews with survey team**: These were thought necessary to understand the local context in which the survey was carried out, as well as to collate fieldworkers' perceptions of the survey tool and their insights into the nature of the fieldwork process (for future refinement).
f) **Qualitative research (FGDs and IIDIs) at approximately seven sites:** These discussions were necessary in order to obtain qualitative data which cannot be obtained via the field survey as well as to better understand any data gaps or specific trends arising from the survey. NOTE: since the selection of sites for a focus group discussion were done after the pilot sites were identified, it could not influence its selection or non-selection as a subsequent pilot site for interventions.
g) **Selection of six[5] representative sites for pilot interventions:** The pilot sites needed to be selected in a structured, replicable and transparent fashion. Whilst the objective was to select centres which span the different categories within the response model, specific local factors affected selection e.g. the

[5] It should be noted that the PSC decided that all 23 ECD sites initially shortlisted should be assessed. A list of 8 centres were there after identified for centre investment by the eThekwini Council. TREE assessed 6 centres as originally planned.

municipality indicated that they do not want to consider risky ECD Centres for municipal funding during the pilot phase.

h) **Field surveys (detailed assessments) of six pilot sites**: More detailed follow-up assessments were undertaken by PPT on infrastructure and by TREE on institutional, operational and programme matters at pilot sites in order to obtain more detailed and specific information to enable the development of infrastructure and institutional improvement plans.
i) **ECD response (improvement) plans for six pilot sites:** Response plans are a key part of the model to be tested and are also a necessary action research method since they determine the nature of the intervention to be made. The plans are based on the assessment by means of observation and discussions with centre owners/operators
j) **Assessment of potential for upscaling via an extrapolation assessment of potential benefits to all ECD sites**: The potential for upscaling is the most important aspect which needed to be tested and an assessment by means of extrapolation is the only viable means of doing so within the limited resources of the Project. All assumptions and limitations will be clearly stated.
k) **Review and refinement of the ECD response model:** It is necessary to refine the response model. A review of it is therefore essential based on its application within the applied, action research project and including the feedback and input from key stakeholders via the PSC.

More details on the implementation of these activities are provided in *Part 2: Section 13* below

6.6 Stakeholders

It was critical that various key stakeholders be effectively engaged during the research process, particularly given the regulatory and funding role of government in respect of ECD centres, the intention of the research to determine the potential to increase access by centres to state funding and support, and current initiatives and policy trends which are directly relevant.

An eThekwini ECD Project Steering Committee was established which functioned as a reference group in order to obtain input and feedback from these key stakeholders. The collaborating organisations (PPT, UKZN, TREE) also formed part of this Committee. Bilateral engagement with these stakeholders occurred as and when the need arose. The following stakeholders were represented on the Project Steering Committee:

- **The eThekwini Metro i**s a key stakeholder. PPT, UKZN and TREE all have close working relationships with the City. UKZN has an MOA with the City. PPT has held numerous service provider contracts with the City since 1993 and has assisted it in developing various development programmes which include work on the upgrading of informal settlements.
  Role: eThekwini's role includes the provision of infrastructure funding, urban settlement planning for ECD, setting aside land where necessary, and assisting in liaising with the KZN DSD and National Spheres of Government including Treasury.
  Represented by: its Strategy, Infrastructure and Environmental Health Departments. It should be noted that the HOD of eThekwini Health withdrew from the project from March 2016 which means that senior Environmental Health officials did not attend any further meetings after March 2016. PPT kept the officials informed via emails and DSD communicated with them via the normal channels. An official from this office did attend the dissemination workshop on 27 January 2017.

- **KZN Department of Social Development (KZN** DSD) its Provincial, District and Service Offices are key stakeholders as the responsible party for development, delivery, regulation, registration, quality monitoring, improvement and evaluation of early childhood development programmes.
  Role: The DSD's role is to assist in aligning the new proposed method and framework with current DSD initiatives including the mooted gold, silver and bronze standard and ECD Infrastructure Improvement Programme. They also assist in providing guidance on key requirements for an 'basic or minimum yet acceptable standard of ECD services. DSD is also ultimately responsible for registering and monitoring all ECD centres and the provision of per-child subsidies
  Represented by: a senior official nominated by the KZN provincial DSD office and two ECD Coordinators of the eThekwini District Offices – one from the Amaoti area and one from the Umlazi area.

- **Ilifa Labantwana** is a valuable resource for this project. Ilifa is working in close and formal collaboration with the KZN Social Cluster to improve access to Early Childhood Development (ECD) services for young children in underserviced communities. The collaboration is via a Memorandum of Agreement (MOA) with Departments of Social Development, Health Sport and Recreation, Agriculture etc. This research project is directly aligned with the Government's ECD 'Massification' Strategy. Ilifa supports a similar parallel ECD programme in another informal settlement area in Ethekwini and in 4 of the poorer rural municipalities in KZN with special emphasis on registration and infrastructure improvements.
  Role: Ilifa's role is to advise on matters relating to ECD services and to report to provincial and the national ECD forums on policy related issues.
  Represented by: KZN Coordinator and the Acting Executive Director.

- **Network Action Group (NAG)** is an important role-player in systemizing the registration process and are also working on various policy aspects e.g. gold, silver, bronze registration levels and their input though not directly involved in eThekwini, is most valuable.
  Role: Advising on various aspects of ECD service delivery, registration, etc.
  Represented by: NAG Director

National Department of Social Development (NDSD): Though not initially identified as a key stakeholder and though not represented on the eThekwini ECD Project Steering Committee, the NDSD proved to be a very important stakeholder. NDSD is responsible for a) the development, delivery, regulation, registration, quality monitoring, improvement and evaluation of early childhood development programmes; b) the development and registration of programmes in collaboration with Department of Basic of Education and c) ensuring the universal availability and adequate quality of, and equitable access to, inclusive learning opportunities for children aged birth to until the year before they enter formal school.

Refer to *Part 2: Section 13.1* for information pertaining to stakeholder engagement activities and outcomes.

6.7 Research area

The initial PSPPD proposal identified the broader INK (Inanda Ntuzuma, KwaMashu) area and within this, one particular precinct, Amaoti (portions of ward 53, 57 and 59) which was thought to be representative and which includes a substantial informal settlement population, and which is also abutting formal township and / or peri-urban precincts. The eThekwini ECD Project Steering Committee reviewed and approved the proposed area. The following criteria was taken into account

- Size of area: preferably an area with between 2000 – 5000 households
- Well established - e.g. exist for at least 10 years
- Area not earmarked for relocation
- Area free of political problems and /or high levels of crime
- Supportive local structures
- Area may include an area in process of being formalised (e.g. pegged, serviced or RDP houses under construction)
- Preferably within the Dense Urban Integration Zone (ICDG zone) identified by the Metro
- Study area supported by Environmental Health and DSD and:
- Area that Tree and PPT are familiar with

M*ap 1: Location of Amaoti in relation to Durban*

"Amaoti is located in the extreme east of the wider Inanda area. Amaoti represents one of the major informal settlement areas of eThekwini. Much of the development within Amaoti is of informal nature with few local supporting facilities and amenities, few formal services and, with the exception of the D403, mostly informal and unsurfaced access roads. With the exception of the flatter bottom areas of the Ohlange River valley, much of the remainder of the Amaoti area exhibits steep and fragmented topographic conditions." "Amaoti consists of a great number of individual communities with their individual background and character grown into the present state over decades. In addition, the population has a variety of backgrounds and consequent aims and approaches. Any future formalisation or redevelopment needs to take account of this by on the one hand "tailor make" a range of housing opportunities and associated services to the needs of the communities, while on the other hand build on the unique physical conditions of the area." [6]

The Golder Associates' Report on Social Vulnerability of Amaoti 2009 [7]summarises Amaoti as follows

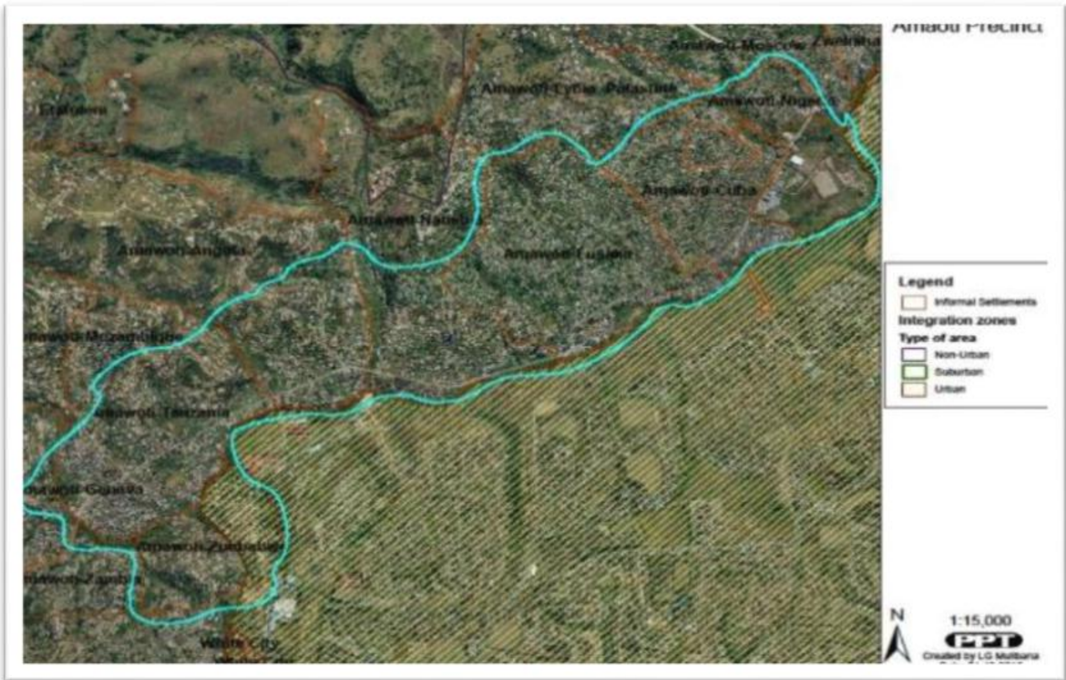
- Amaoti is one of the largest informal settlements in Durban with a hilly area covering approximately 700ha.

---

[6] eThekwini Metro: Human Settlements: planning progress at Greater Amaoti Area (wards 53, 56, 57,59) Monthly progress report, October 2015

[7] Golder Associates (Pty) Ltd: January 2009. *Report on Social Vulnerability of Amaoti (*Report No: 10612), Durban.

- Amaoti means “more wood”- remnants of a time when the area was densely forested.
- Amaoti is not clearly represented on a map- it falls across 4 different Municipal wards.
- There are 14 different communities within Amaoti of various ethnic groupings.
- A single main road leads into the area.
- The area is ‘littered’ with poor housing, sanitation and infrastructure.
- A portion of the community works in neighbouring suburban areas, very few are professionally unemployed, and the vast majority is unemployed.



Map 2: Amaoti survey area

“<u>One of the main reason for the comparative lack of formal development of Amaoti lies in the underlying land ownership</u>. Emanating from the original “released area”, smallholdings and subdivisions were allocated to private individuals who ultimately allowed “shack farming” to take place on their land. The transfer of the privately held land to the municipality has been a torturous and time consuming process. <u>The land acquisition exercise has been concluded</u>.” [8]

“The proposed Amaoti Greater is an informal settlements upgrade development comprising of 15 different areas, which are Nigeria, Cuba, Palestine, Moscow, Namibia, Lusaka, Libya, Zambia, Angola, Mozambique, Tanzania, Brooksfarm, Zimbabwe, Geneva and Amaotana. The proposed development will be one of the largest sustainable Integrated Human Settlements Initiatives by KwaZulu-Natal National, Provincial Department of Human Settlements and the Ethekwini Municipality. The whole development will be laid on approximately 600 hectares of land and will provides for mixed income residents and housing opportunities incorporating commercial, social amenities and residential sites. The beneficiaries will receive freehold tenure.”[9]

---

[8] eThekwini Metro: Human Settlements: planning progress at Greater Amaoti Area (wards 53, 56, 57,59) Monthly progress report, October 2015

[9] Report on the Amaoti Greater Housing Project dated 10 July 2016 Prepared by: Busi Buthelezi from the Human Settlements Unit

6.8 Sample

6.8.1 Field survey

During the initial survey phase, all identifiable sites (or as many centres as possible) were surveyed. There was thus no sampling. Any and all sites which qualify as ECD sites in terms of the prevailing DSD's definition (i.e. more than six children) were surveyed. 42 ECD centres were surveyed. These centres were attended by a total of 2,542 children

6.8.2 Pilot sites for improvements

Though the initial intention was that the selection of the six pilot sites will be based mainly on representivity across the different categories in the model (A, B1, B2, C1, C2), this was changed as a result of stakeholder inputs (noting that this is consistent with the Action Research method employed).

Ultimately, 23 pilot sites were shortlisted and of these eight were selected for selected as pilots for infrastructure improvements (funding to be provided from eThekwini Municipality) and operational and capacity support (provided by TREE). *[An additional two were selected for submission to a private donor (Victor Daitz Foundation) for infrastructure improvements only.]*

<u>Reasons for selecting eight pilot sites:</u> Eight pilot sites were selected due to there being sufficient infrastructure funding reserved by eThekwini Metro.

<u>Reasons for avoiding high risk (C1 & C2) pilots</u>: Both eThekwini Municipality and Department of Social Development representatives on the PSC were averse to supporting pilot centres which pose a risk in respect of their capacity, sustainability and potential to achieve DSD registration. From an infrastructure investment point of view, eThekwini indicated that it would be challenging to present to Council centres which have severe capacity and other limitations, limited prospects for improvement and DSD registration, and where the extent of flexibility required in respect of norms and standards are regarded by them to be excessive. – i.e. typically category C1 and C2 Centres. These government preferences are understandable because: a) it is important to demonstrate positive outcome when a pilot is done - a negative experience may create a negative response and compromise further rollout; b) government funding is used and the Metro must be able to demonstrate that investments are not subjected to unnecessary risk that may result in fruitless or wasteful expenditure; c) there were only a few centres within the C1 and C2 categories and these should be addressed together with DSD once the programme is established and proven.

<u>Shortlisting and selection approach</u>: A two-phased approach was followed for the shortlisting and selection of pilot centres:

- *Shortlisting*: Centres were filtered using the database and agreed criteria (e.g. categorisation, years of operation, number of children, DSD registration and funding status) – reducing the 42 centres to 23.
- *Selection*: eThekwini and DSD PSC representatives (working with PPT) selected eight centres from this shortlist in a working session taking into account the afore-mentioned risk aversion and the DSD's experience in visiting all the shortlisted centres.

More details about the selection of the sites is provided in *Part 2: Section 13.6.*

6.8.3 Centres to participate in focus groups and in depth interviews

It was important for the **selection of the six sites for qualitative research (focus group discussion and in depth interviews)** to achieve a spread of centres in terms of quality (based on initial indications from survey data of the quality of care provided). The guidelines for the selection of centres for qualitative research in January 2017 differed from the guidelines used to select centres in February 2016 (for fieldwork in February and March that had to be postponed). This is because by the end of 2016, PPT had already selected centres as pilots for upgrading (as well as identifying another four centres in need of some form of emergency assistance). A sample for qualitative research had to consider the stage the project was at and linked to that, the aspects of differentiation between the centres in Amaoti that should be recognised in a diverse sample. The guidelines used to select the qualitative research sample in December 2016/ January 2017 were:

- half the sample should be those selected as pilots for upgrade or for emergency assistance
- all 5 of PPT's categories ranking categories (A, B1, B2, C1, and C2) should be included and;
- at least one centre should to be included in the sample where the fieldworkers' qualitative ranking and PPT's quantitative ranking differed substantially

The following site selection process was followed:

- Step 1: UKZN analysed the ranking of ECD centres by PPT in terms of survey data collected and the field workers ranking based on their experience of visiting the centres and doing the survey. Centres were tabled according to agreement on categorisation and difference in categorisation by the 2 entities.
- Step 2: centres were then selected based on the geographical spread in an attempt to include at least one centre from each suburb in Amaoti surveyed.
- Step 3: Where there was still a choice between two centres in the same group, in the same area, random selection was applied. There was one centre selected that refused to participate (as they felt that researchers were wasting their time) and another centre was randomly selected. It is important to note that the selection of centres was not linked in any way to the selection of centres earmarked for upgrades.

6.9 Timelines

The research was undertaken in four phases as set out in the Research Method attached (**Annexure C**). The funding agreement was signed on 22 May 2015 with the Presidency for a period of 18 months until November 2016. No tranches were paid until after an amended agreement was signed on 2 December 2015 with DPME, the new contracting authority that took over the PSPPD programme. The first tranche was only paid on 30 December 2015. This caused some delays as UKZN was unable to enter into any contracts with their research staff which in turn delayed some of PPT's work e.g. refinement of research methodology.

Phases and Initial planning		Actual completion	Comments
Phase 1: Scoping & set up	**June '15 – November '15** I. Establish PSC II. Literature review III. Refine research methodology IV. Review & refine categorisation framework V. Develop research tools	**June'15 – March '16** I. Sept '15 II. Final: January '16 III. Finalised March '16 IV. March '16 V. Nov '15	Late payment of 1st tranche delayed research staff appointment

Phase 2: Area level rapid assessment	**November '15 - April '16** I. ID & train fieldworkers II. Field survey III. Analyse survey data & report IV. Categorise centres	**November '15 – Sept '16** I. Oct '15 II. Nov – February '16 III. Analysis & final report: Sept'16 IV. July '16	
Phase 3: Pilot interventions at 6 centres	**April '16 – October '16** I. Select centres for pilots II. Assessment at 6 centres III. Improvement plans IV. Secure funding for infrastructure development V. Skills training VI. Equipment and material improvement VII. Support infrastructure delivery VIII. Focus group discussions	**July '15 – Jan '16** I. July (1st round=23) Sept 2016 2nd round = 8) II. July – Aug '16 @ 23 centres instead of 6 III. Sept– Nov '16 (submitted 8 to eThekwini & 2 to Victor Daitz Foundation IV. Jan '16 by TREE for 14 practitioners V. Jan'16 VI. Not done - funding not yet approved VII. Jan '16	2 phased approach To gain better understanding of infrastructure conditions Funding not yet approved for implementation of pilots.
Phase 4: Dissemination and policy feedback	**October - November '16** Extension till end January '17 for completion of the action	Dissemination - Jan– April '17 Final report & audit - end April '17	

Table 3: initial planning vs actual

6.10 Limitations and challenges

Limitations due to the methodology:

Adequacy of sample: Although a relative small data sample of 42 ECD Centres may have limited usefulness in terms of identifying trends, it provided important new data no previously collected that is very useful for planning, prioritising of centres for programmatic support and that offers some cost saving possibilities. To improve the sample size, we consolidated data from parallel a project (Ilifa Labantwana) in the informal settlement of Umlazi (39 centres), eThekwini that provided us with a combined total of 81 centres. We also referenced findings from surveying 435 centres in 5 rural municipalities since it is relevant to overall trends.

Overview of surveys done in KZN

Target areas	ECD Centres surveyed	NPO Registered	DSD Registered	DSD subsidized	Infrastructure deficits	Children in centres	Children subsidised
eThekwini Informal Settlements (81 centres, 3,917 children)							
Amaoti	**42**	**21**	**11**	**6**	**41**	**2 542**	**361**
Umlazi	39	30	9	6	27	1 367	266
Rural Municipalities (435 centres, 15,686 children)							
Vulamehlo	52	45	44	25	47	1 615	1 012
Umzumbe	102	84	71	43	98	3 700	2 001
Msinga	111	74	61	26	103	*4 038*	1 217
Umvoti	72	40	36	23	60	2 395	1 220
Nquthu	98	95	68	59	86	3 938	2 845
TOTAL	**516**	**389**	**300**	**188**	**462**	**19 595**	**8 922**

Table 4: Informal settlement data vs comparable rural dataset

- Clash between the implementation of a project, the methodology as flexible and unfolding and funder prerequisites i.e. fixed timeframe and budget.
- Survey data and categorisation does not substitute for DSD SW and EHP visits and statutory/regulatory professional determination

Limitations and challenges with regard to implementation due to factors beyond control:

- The 'withdrawal' of the eThekwini Health Department in March 2016 due to some internal dynamics and political issues required the identification of a new champion Department within eThekwini for the ECD programme. This resulted in a series of meetings and inputs from top management until it was agreed that the Department of Human Settlements would step in to progress the Action. Health's withdrawal also resulted in the withdrawal of the senior manager representing Health on the Steering Committee and prevented normal interaction with the EHPs at grass roots level
- ECD being a shared function/unfunded mandate – this issue created some uncertainty on roles and responsibilities and resulted in some hesitance on the part of the eThekwini Metro. The NDSD consulted with national departments on roles and responsibilities but did not consult the Metro and other municipalities on their role, responsibilities, funding streams, and future collaboration.
- The 2016 Elections created an unfavorable political environment in wards prior to elections; caused huge administrative delays with council meetings for approximately 5 months - no council meetings prior and during election month while council meetings were limited soon after elections to the selection of portfolio committees and orientation. Failure to submit the items / report to Council Committees in Nov '16 & Feb '17 resulted in
  - Infrastructure improvements at the pilot projects not being implemented as the capital reserved and earmarked for ECD in informal settlement for the next 3 years, was not approved by the new Council in time. This also prevented the planned post scorecard assessment (both quantitative and qualitative)
  - Delayed centre operational assessment & training as Council was also expected to approve the selection of the pilot projects. It was eventually decided to continue with the operational assessment of the proposed pilot projects and the training of ECD practitioners and;
  - Delayed Focus Groups discussions due to the political environment prior and during elections and the non-availability of human resources e.g. Senior Researcher that designed and trained field workers in February 2016 entering a crunch time on a new research project towards the end of 2016.

Problems with Kandu survey tool:

- PPT experienced some teething problems with the tool as the survey questionnaire is quite long and the technical requirements quite complex. Kandu employed an elaborate system of "in line" questions which was not previously well tested. PPT lost important information when the information could not be properly retrieved. This problem has since been addressed for other survey projects.
- Incorrect programming of the Kandu tool and resultant incorrect recording of GIS coordinates: PPT had to revisit a large number of sites to recollect the GIS Coordinates which caused unnecessary delays.

7 Evaluation against research objectives

7.1 Overall objective

Primary research question: To what extent can the proposed new ECD framework and method facilitate access to improved ECD services for children within underserviced, informal settlement communities and inclusion within the current system of state support?

The proposed new ECD framework and method offers significant potential to transform the access to improved ECD services for children within underserviced, informal settlement communities and inclusion within the current system of state support.

The model has been significantly refined and strengthened through the PSPPD-funded Initiative (as outlined in more detail in *section 9*).

Evidence:
The main evidence for this assertion are as follows:

- The need for a new and improved response model within informal settlements has been clearly demonstrated:
  - There is clearly a significant deficit of adequate ECD services and inadequate support to existing centres:
    - Most centres are not registered with the DSD and/or are not receiving DSD funding and related support.
    - Most centres have infrastructural deficiencies.
    - Most centres are indeed outside the current system of state support.
  - Most existing centres have the potential to improve if provided with support.
- All key elements of the new Model have demonstrated their efficacy even though the implementation of pilots did not occur within the project timeframe:
  - Field survey
  - Categorisation
  - Response planning: infrastructure and operational
  - Infrastructure improvements (await funding approval)
  - Operational improvements.
- The cost-benefits of improving existing centres versus a new-build model are compelling. Even though new builds will be required in some instances, improvements to existing centres are far more cost effective – improvements at an estimated six ECD Centres and almost seven times the number of children will benefit from an equivalent amount of capital funding.

Pre-requisites for implementation:
The key pre-requisites for the successful implementation/rollout of the model are as follows (also refer to *section 11.2*):

- Consensus between municipalities and provincial DSDs w.r.t:
  - Roles and responsibilities municipality versus DSD (e.g. with respect to ECD planning and co-ordination and providing support to existing ECDs).
  - Statutory and regulatory flexibility and norms and standards (i.e. municipal ECD health bylaws utilised by EHPs and ECD norms and standards utilised by DSD social workers).

- Funding mandates/arrangements municipality versus DSD, specifically with respect to ECD infrastructure funding.
- Preferably structured co-operation (DSD / Municipal MOA)

- Strong municipal-level ECD co-ordination planning, monitoring and delivery of support. This related closely to the above-mentioned consensus. It will be beneficial if Metros (and other municipalities) have clearly defined ECD strategies. Given the important role that ECD infrastructure plays in the ECD response model, it is challenging for provincial DSD's to be the main 'drivers'[10]. Municipalities are probably better positioned to play this role, working closely with Provincial DSDs.
- Adequate state funding for ECD: a) for operational purposes (ECD subsidy from DSD); b) for ECD infrastructure (improvements and, where appropriate, new builds); c) training for ECD operators and practitioners; d) up-front ECD surveys, infrastructure and operational assessments and improvement plans (in order to provide the necessary capacity to undertake these key elements of the response model).
- Adequate capacity for ECD survey, response planning and delivery support. Whilst having the necessary funding in place is necessary, it is not, in itself, a sufficient condition for success. ECD requires specialised experience and capacity which is not always readily available. Securing collaborations with and involvement of support NGOs is regarded as a key success factor given that these skills appear to be in short supply within both government and the private sector.
- Appropriate delivery mechanism(s) for ECD infrastructure (improvements to existing centres and new builds where appropriate), noting that this is different to conventional municipal infrastructure and that dedicated solutions will be required which are efficient. ECD infrastructure delivery will need to be 'batched' to enable cost efficiency.
- Preferably an enabling national policy framework which supports the above key elements. There is already significant progress in this regard in terms of the ECD 'massification' strategy, a flexible framework for registration (gold-silver-bronze) and an ECD infrastructure (conditional) grant.

7.2 Application of RAC method in study area

Secondary research question:

1. To what extent can the **RAC method** be successfully applied within the study area?
    a. What **new information** does the RAC process reveal in respect of the prevalence, characteristics and trends of ECD sites in the target study area?
    b. To what extent can **all centres within the study area be accommodated** within the proposed categorisation framework?

The RAC method was successfully applied within the study area of Amaoti (portions of Wards 53, 57 and 59), eThekwini. The data on the 42 surveyed centres was successfully captured, processed and analysed. 52 key categorisation marker questions were identified (with stakeholder input) and utilised to calculate the category for each centre. The marker questions covered three main categories: institutional capacity and governance; infrastructure and health and safety; ECD programmes. There was a good correlation between

[10] DSD does not deal with infrastructure. Whilst it typically makes use of the Department of Public Works for infrastructure purposes, the kind of infrastructure which Public Works deals with is very different in nature to ECD infrastructure in informal settlements and other under-serviced low income communities and in particular given that the primary infrastructure response consists of relatively minor improvements to large numbers of existing ECD centres and given that, even ECD new builds, will need to be at NPO specification rather than usual government specification for reasons of cost and the need to achieve population coverage within limited fiscal resources.

the categories calculated and the status of the surveyed centres as well as with DSD registration[11]. Two additional categories were developed for state investment potential and infrastructure adequacy given that the overall categorisation is a three-way matrix. These two additional categories assisted with the selection and screening of centres for infrastructure improvement planning.

Significant new information was identified in respect of ECD sites in the target study area. In addition, 10(24%) of the centres identified and surveyed were not yet on the DSD or municipality's radar. Of the centres which the municipality and DSD were aware there was minimal information available on their lists (typically name of centre, contact number and ward number). The National ECD Audit of 2014 only covered 11 (26%) of the 42 centres surveyed by PPT. Centre profiles based on survey data and photos were used to communicate the findings visually to stakeholders. Refer to **Annexure F.**

All centres within the study area could be accommodated within the categorisation framework. The key question however is whether or not the accommodation is 'reasonable' and 'useful'. The experience has been that this is indeed the case. First of all, the categorisation achieved, correlates well the description of the specific category for each centre. Secondly, and as previously indicated, there was a positive correlation between DSD registration status and categories achieved. And thirdly, the categorisation scoring was useful in filtering and pre-selecting centres with good potential for ECD support (infrastructure improvements and operational support) and which enjoyed support from the DSD.

7.3 ECD response planning

Secondary research question:

2. To what extent can **ECD response plans** and related response packages be successfully provided at six representative pilot sites within the study area:
    a. What **ECD service improvements can be achieved** at the six pilot centres as a result of ECD response plans and packages (including infrastructural investments and programme support), what is the cost-benefit and which categories of centres benefit (or not)?
    b. What **state support** including funding can be secured for the six pilot centres?

Even though infrastructure response packages could not be delivered within the project timeframes, there is nonetheless strong evidence to suggest that this will be possible, both based on experience within eThekwini and other municipalities in which PPT is working. Within eThekwini, there is a high level of support from key Departments. ICDG funding to the value of R9 million (R2 million for 2016/17, R3 million for 2017/18 and R4 million for 2018/19) was approved for the next MTEF in May 2016 to be utilised for ECD infrastructure improvements and related ECD survey work.[12] A draft committee report has been compiled and is ready for tabling to the two standing committees namely the Human Settlements and Infrastructure as well as Health, Safety and Social Services Committees. On the operational side, DSD co-operation and assistance was relatively easy to secure. They visited shortlisted centres and were willing to proceed with conditionally registering centres in the knowledge that state funding is to be made available to effect infrastructural improvements needed. TREE provided operational support in the form of training to 14 ECD

[11] Of the 11 centres which were already registered or conditionally registered with the DSD, 2 of these were category A, 8 were category B1 and 1 was category B2 (i.e. all centres with some level of registration achieved a categorisation with a positive 'potential'). There were no C1s or C2s which were registered. In Umlazi of the 9 centres with registration status, 8 were category A and 1 was B1.

[12] eThekwini Vote number BU 25300, item 44739 for Project P5471

practitioners. This was financed by the project budget. If funding is available, such operational support can also be extended to other ECD centres requiring operational strengthening and capacitation.

The services improvements which can be realistically achieved utilising ICDG include:

- Basic services (water, sanitation, hand wash facilities, storm water management, electricity, fencing, outdoor equipment)
- Minor / major building improvements (floor, wall, window, door, roof repairs, etc.)
- Extensions (playrooms, kitchen, office, sickbay)
- New builds

The following state support can be reasonably expected at not only the pilot sites, but other sites as the programme is rolled out and gains traction:

- Infrastructure improvements and new builds using ICDG conditional grant funding available to the Municipality as an interim (pilot) arrangement and with the DSD's new conditional infrastructure maintenance grant for rollout.
- DSD ECD operational subsidy for those centres which achieve registration.
- ECD NQF Level 4 Training for practitioners nominated from registered ECD Centres by DSD social workers for financing by Department of Education

There are however some significant constraints pertaining to the forms of state support which will be achieved – especially for upscaling and rollout:

- DSD operational subsidy funding limitations. This is clearly demonstrated by the number of registered centre in Amaoti and centres in other areas surveyed that do not receive subsidies. Some of these centres have been operational and registered for many years and are still not subsidised.
- Municipal infrastructure funding limitations – ECD has to compete with sport and other community needs for the 5% funding allowed for social facilities in terms of MIG and 10% in terms of ICDG funding. It is unviable to roll out an ECD infrastructure improvement programme at scale with such limited / "left over" funding.
- DSD Infrastructure Maintenance Grant – This fund only provides funding to Conditionally Registered Centres and excludes high potential unregistered centres and registered centres with infrastructure problems. The funding quantum is small - capped on R100 000 with an additional R30 000 available subject to special motivation. This fund thus cannot be utilised for larger centres requiring significant improvements, major improvements, extensions and new builds.
- Department of Human Settlements Social Economic facility funding can be utilised for the construction of a new ECD Centre provided it is linked to a community hall. This is a rather restrictive condition and a revision on this stipulation should be requested by NDSD.
- State owned facilities funded by DSD (built by Public Works) could potentially be utilised but given the very high costs, these should be only provided where they can function effectively as ECD hubs which can provide effective support to under-resourced ECD centres in surrounding communities. Such state-owned facilities should not be seen as a mass delivery solution.
- Department of Education funding for NQF[13] level 4 training is limited to practitioners of registered centres (with Grade 10 -12). Practitioners of all unregistered centres are thus excluded and cannot receive formal training. This leaves an even bigger need for short courses that should also include practitioners that do not meet the set criteria (e.g. Grade 12) for NQF level 4 training.
- Donor funding will have to be found for Educational equipment and toys

[13] Further Education and Training Certificate: Early Childhood Development (SAQA US 58761 *NQF Level 4*)

7.4 Scaling up the response model

Secondary research question:

3. What is the potential for the **response model to be scaled up** so as to achieve greater inclusion, flexibility and population coverage of children?
   c. What **proportion of children in ECD centres in the study area could potentially benefit** from improved ECD services if similar response packages were extended to all centres in the same categories?
   d. To what extent might the new ECD framework and method (response model) be **accepted and/or utilised by government** decision makers (noting that the model is expected to be refined during and as a result of the research).

There is significant potential to scale up the response model with significant traction already achieved (e.g. National DSD now starting to support infrastructure improvements programmatically, eThekwini budgetary allocations, take up in several rural municipalities, take up by Assupol Community Trust. However, there are a number of pre-requisites that need to be *in* place in order to do so (see *sections 7.1 and 11.2)*. Of all of the pre-requisites (constraints) listed, funding is perhaps the most critical. ECD will need to receive a higher fiscal priority than it currently enjoys. This will require political will and trade-offs with other state-funded programmes.

On the operational side, it is estimated that, in the near term, approximately an additional 1.43 billion in DSD subsidies would be required per annum to service all existing centres[14] and in the longer term, approximately R8.4billion[15] (once all children in underserviced communities such as informal settlements have access to the grant and there is full population coverage of young children by ECD centres).

On the capital side, it is estimated that approximately R11 billion would be required to address all ECD infrastructure in under-serviced communities (mix of improvements, extensions and new builds[16]).

Whilst a significant number of children at Amaoti could benefit from the implementation of the model (2,256 children[17]), the major constraint is that many young children are most likely not yet receiving services in ECD centres (registered or unregistered). The percentage of children attending ECD centres in the surveyed portion of Amaoti[18] is estimated at 32%[19]. [It is noted that this is significantly higher than the average in other municipalities surveyed where the average was approximately 12%]. This does not factor in children in 'basic childminding' centres which do not qualify as acceptable ECD services (typically 6 or fewer children and no ECD programme etc.). In addition, there are constraints in providing support to high risk, low potential centres in categories C1 and C2[20]. There are 11 centres and 286 children in these categories. Nonetheless, if all centres with potential at Amaoti were to receive support, then 2,256 children could receive acceptable ECD services with modest state investment.

[14] Assuming 17% of children are in centres (registered and unregistered) – 17% of R9.1billion. The figure of 32% access Amaoti has been reduced taking into consideration that the average in rural municipalities is closer to 12%.

[15] Assuming 2million children outside the system, R16 per child per day, and 264 ECD school days per annum.

[16] Assuming 2 million children outside the system and/or underserviced, 85% improvements/extensions (at an average cost per centre of R200,000) and 15% new builds (at an average cost per centre of R800,000), average centre size of 50 children.

[17] All children in centres categorised A, B1 or B2.

[18] 2,542 children out of 7,901 children attends the 42 centres surveyed which constitutes 32 % of the 0-5year old population

[19] Total population of young children (0-5yrs) in the informal settlements at Amaoti was calculated at 7,901 calculated as follows: a) the number of households at Amaoti provided by eThekwini; b) the average number of children per household of 0.5 at Amaoti taken from 2011 Census data and Wazimap data (based on 2011 Census data). The total number of children in surveyed centres was 2,542.

[20] E.g. risk of fruitless state expenditure on centres which cannot achieve DSD registration and/or which may have a limited lifespan and/or which may be unwilling or unable to improve.

Based on work undertaken, there are good prospects for the model to be utilised and implemented by government and decision makers (refer to preceding sections). However, the pre-requisites and constraints previously outlined are again noted. Taking these into account, it is likely that, in the near term, implementation of the model can occur, but at a relatively slow rate due to these prevailing constraints.

It is noted that, in the rural municipalities in which PPT is working, there currently appears to be a higher appetite for allocating municipal infrastructure funding for ECD improvements (e.g. at UMzumbe the Municipality intends to address the full backlog of 102 centres over a period of 5 years with an annual ECD infrastructure budget allocation of approximately R6.3million.) Ethekwini seems keen to follow this model and has as mentioned above, reserved R9 million for this purpose over a period of 3 years. The same model is also adopted by the Assupol Community Trust for the identification, categorisation, selection of 40 ECD pilot centres in Nqutu and Msinga for infrastructure and operational improvements in Year 1 with an approved budget of almost R11 million - they will be repeating the process for another 2 years which means they could potentially attend to 120 centres over a 3-year period.

8 ECD Response Model – efficacy and refinements made

The ECD Response Model was refined in various ways during the course of the Action based on stakeholder feedback, action research experience (practical experience implementing the model), experience on parallel ECD work in other municipalities, and concurrent ECD policy developments.

The Model proved to be effective and relevant in providing a programmatic and scale-able method for addressing the challenge of ECD in informal settlements (and other underserviced communities) in various ways. For example:

- <u>Identification of centres</u>: The Model enables the identification of all (or most) de facto ECD centres within a specific target area including numerous previously unknown, unregistered, under resourced and unsupported ECD centres utilising an area based approach.
- <u>New information on centres</u>: The survey provides significant new information (in the form of a comprehensive database) not previously available on ECD centres (both those previously known and unknown). This information pertains to the capacity, governance, infrastructure, status of ECD programmes, DSD and NPO registration, and numbers of children amongst others (based on 149 survey questions).
- <u>Categorisation framework</u>: The categorisation of centres (using collected data) is valuable in various ways:
  - it enables *population-based ECD planning* (by municipalities and DSD),
  - it provides a *quick and accessible overview* of the status quo, needs and potential of centres,
  - it assists greatly in *prioritising centres for response planning* and particular types of support (e.g. infrastructure) on a more rational and equitable basis than would otherwise be possible.
- <u>Response planning</u>: Structured ECD response planning is necessary in order to ensure that the potential of existing centres are optimised, their greatest needs (including barriers to registration) addressed and limited state resources are optimised.

8.1 Rapid Assessment & Categorisation

8.1.1 Field Survey

Efficacy:

It is evident from the action research work undertaken that it is indeed viable and necessary for ECD field surveys to occur as a key element of the ECD Response Model. The survey identified large numbers of centres not previously on government lists and for the first time provided a detailed data set on all (or most) existing centres within the targeted area.

The National DSD, eThekwini and other stakeholders expressed significant interest in PPT's ECD survey data and they indicated that such data had not previously been available. Nonetheless, certain officials within the National DSD have expressed concerns that doing ECD surveys nation-wide in all under-serviced communities will be too expensive, it is difficult to envisage how population based coverage and massification of ECD services can be achieved unless all (or most) existing ECD centres are identified and their key characteristics, needs and potentials understood. It is again emphasised that many of the ECD centres identified and surveyed by PPT were not previously known to the DSD or Municipality (10 new centres identified) nor covered in the National ECD Audit of 2014 (only 11 out of 42 were identified in the Audit). Alternative approaches to on-the-ground field surveys will not be effective in identifying and understanding centres (e.g. using Stats SA data or aerial photography or existing DSD and Municipal data bases). Field survey is therefore regarded as an essential and necessary first step in achieving population based ECD response planning and 'massification' of ECD services (as per the DSD's strategic plans). The use of the National ECD Audit of 2014(which clearly did not identify many ECD centres in under-serviced communities[21]) for national population planning purposes can result in a serious under estimation of existing centres

It is noted that the ECD survey developed by PPT was detailed and comprehensive taking into account the desire for information on ECDs by key stakeholders (Municipal officials including EHPs, DSD, NGOs) and partners (TREE and UKZN). The survey was successful in being able to capture most of this information, although it is noted that the data arising from the surveys is indicative and does not substitute for the professional assessments by DSD social workers and EHPs.

Area-based ECD field survey is relatively cost effective (approximately R2,250 per centre surveyed using the PPT model – this includes all personnel costs, disbursements and data processing).

Refinements and comments:

- The up-front identification of existing ECD centres is a key activity in its own right and requires: a) dedicated work in order to source this information from the DSD and Municipalities and support NGOs; b) on the ground visits including engaging with local residents.
- It is much more cost-efficient to undertake ECD field surveys in Metro/informal settlement environments (compared to rural communities) due to the denser settlement patterns and associated reduction in logistical costs.

[21] Of the 516 centres surveyed by PPT in six municipalities in KZN, only 212 (41% of the number identified and surveyed by PPT) had been identified in the National ECD audit. Significant work was necessary in order to obtain up to date lists of existing ECD centres from the DSD and Municipalities (i.e. the data was not immediately available) and even then, PPT identified an additional 113 centres in its survey. It also determined that some centres were no longer in existence or facilities were not being utilised (more than 80). This clearly demonstrates the need for field survey to be a core part of the model.

- Supplementary survey data can be obtained telephonically to fill data gaps (e.g. in case where an operator was not present at the time of survey and the interviewee was not able to provide registration of management information).
- ECD survey team training needs to cover technical (ECD and infrastructure) issues in order to adequately empower the survey team (given the specialist nature of the survey). E.g. in respect of ECD registration and norms and standards.
- Involving DSD social workers and EHPs in the field survey may not be viable (due to time and logistical constraints). It is however valuable to involve them in the training of field workers.
- Timing is important - some centres close early (e.g. just after lunch) and centres are often closed during school holidays.
- Since it takes significant effort to establish a survey system, tools and capacitated survey team (noting the specialised demands and complexities of an ECD survey), it is cost-effective to batch survey work and, where possible, keep survey teams working for sustained periods (instead of stopping and restarting). The survey teams get better and more efficient the longer they survey and work together as a team.

8.1.2 Categorisation

Efficacy:

The categorisation method functioned effectively having been significantly developed and refined during the course of the action research initiative. Over and above the main categorisation (A, B1, B2, C1, C2), three additional ratings were developed using the survey data (ECD potential, investment potential and infrastructure adequacy). Overall there was a good correlation between the categorisation determinations made using the survey data and the actual status and potentials of surveyed centres (Refer *to Part 2: Section 13.5*). This means that, on the whole, the categorisation framework is a good predictor of ECD functioning and potentials and is therefore an effective tool for population based ECD planning, including gaging existing local ECD capacity at area-level and shortlisting centres for ECD support.

Refinements and comments:

- Overall, the key categories, elements and logic of the categorisation framework have been retained, though significant refinements have been achieved. Refer to **Annexure G**.
- The method for calculating the general categorisation was developed using a three-way scoring matrix which aligns with the most critical parameters of the categorisation (capacity and governance; health and safety; ECD programme). 52 marker questions with a weighting method were introduced to calculate the general categorisation[22.] A scoring range was determined for each of the general categories (A, B1, B2, C1 and C2). All centres were thus categorised according to their aggregated scores.
- It became apparent from the general categorisation scoring that more specific guidance on ECD potential, investment and infrastructure adequacy were necessary. The general categorisation, whilst very useful, was a broad aggregate score. For example, some centres scored high in capacity and governance and ECD Programming but poorly in infrastructure due to a lack of funding to improve and maintain the infrastructure. Such centres should not necessarily be prejudiced in respect of receiving support.
- Three additional ratings were therefore developed using the data and marker questions - refer to *Part 2: Section 13.5* for more detail:

[22] The 52 marker questions were weighted. Each field was scored separately to get a clear idea of the level of competency/ deficiency within a particular field. An aggregated score was determined by adding the scores of the three fields and obtaining an average score.

- A rating to determine the potential of the centre based on the capacity & governance and the ECD programme scores. This percentage score was primarily considered for selecting centres viable for support.
- An overall infrastructure adequacy rating taking into consideration status of services, building, functional space, and site issues. This provides a quick indication of infrastructure adequacy and was used to determine where infrastructure problems lie. However, a specific infrastructure adequacy score is used for shortlisting centres based only on the status of services (e.g. water, sanitation) and building (e.g. walls, roof, floor). This helped select centres requiring infrastructural improvements (a score below 60% was used to screen).

- An investment potential rating taking into consideration general categorisation, NPO registration, ownership issues, etc. to indicate to what extent a centre may be viable for investment.
- None of the above scoring systems were in place prior to the implementation of the Action.
- Aside from conditionally or fully registered centres, category C1 and C2 centres were not shortlisted as part of the Action, due to risk aversion by DSD and Municipality. However, for purposes of the Response Model, Category C1 and C2 centres should be further assessed and considered for basic mitigations (i.e. of imminent health and safety threats) or else, if closure is necessary, for the provision of alternative ECD solutions (e.g. establishment of a new centre or provision of non-centre based services).
- Based on stakeholder feedback, there was a shift away from a separate, alternative standard of 'less formal' ECD care (as envisaged in the original funding proposal) towards flexibility within the existing registration framework. This has had implications for the categorisation framework as well as other aspects of the ECD model[23].
- Function and potential were retained as the key defining elements of categorisation. The initial design in this regard was sound.
- Greater consistency in respect of the key descriptive parameters for categorisation was established.
- Programme registration was introduced as a descriptive parameter for the different categories.
- The omission of a C3 category (already noted as being unviable for support in the original funding proposal) has been removed and has effectively become category C2. C1 and C2 as initially envisaged have been collapsed into C1 given that there was no enough difference between these initial categories and no functional advantage in retaining them.
- Hence, the overall framework has been simplified so that there are five categories instead of 6 - and only two categories of C (C1 and C2).
- ECD Correlation: Overall, the correlation was good (Refer to *Part 2: Section 13.5*). For registered centres, the correlation was particularly high. Score for investment potential were lower than expected due mainly to informal settlement constraints such as centre and land ownership, tenure, NPO registration. It is also noted that some centres with high function and potential (e.g. A and B1) were not be registered whilst others with constrained function and potential (e.g. B2) had achieved registration as a partial care facility. DSD seems to be registering centres with limited infrastructural problems despite a relatively low level of capacity and poor ECD programme.

[23] NOTE: A key assumption of the new response model at the time of developing the proposal to PSPPD was to test the potential for acceptance of a "new standard of basic but acceptable less-formal ECD care". Since submission of the PSPPD proposal, government released the Draft National Early Childhood Development Policy (released for comment in March 2015) which reflects a shift towards significant flexibility in terms of registration requirements and new 'gold', 'silver' and 'bronze' standards have subsequently been mooted by the Department. It is therefore apparent that the framework for greater inclusion may require greater flexibility in respect of registration rather than an alternative standard of 'less-formal' ECD care as initially envisaged in the initial PSPPD Proposal. This also has direct implications for the RAC framework and validates it. Defining the specific nature of the flexibility which may be appropriate (e.g. in respect of infrastructure norms and standards) is an important part of the Project.

- The categorisation model requires a good command of Excel. A more user friendly tool would potentially have developed for other user groups but this would require a purpose-made tool which would be costly.

8.2 ECD response plans

8.2.1 Prioritisation & selection of centres

Efficacy

ECD data (database derived from the survey) and related categorisations were used to screen, shortlist and select centres for further assessment, response planning and support. This provided an effective method which is more evidence-based and equitable. It also removed possible bias in selecting centres and ensures that all existing centres are considered (and not only those on existing, limited databases of government). This fosters a more fair and accountable selection process.

Refinements and comments

- Centre selection emerged as a critical component of the model.
- A two-phase selection process emerged (also refer to preceding section):
    - Phase 1 - shortlisting by filtering the database according to five pre agreed criteria which proved very effective and useful[24]. The following method emerged as optimal:
        - *For centres with potential* (i.e. already with or with potential to achieve DSD registration (with flexibility) and provide acceptable ECD services – A, B1, B2):
            - Filter (group) all centres into fully registered, conditionally registered and unregistered categories (DSD partial care facility registration).
            - For unregistered ECD Centres – group them into A, B1, B2 and for each group, select those centres that afford a favourable risk and return on investment based on:
                - Potential (recommend potential score >60%).
                - Centre size (recommend 20 children or more).
                - Years of operation (recommend 5 years or more).
            - For conditionally registered ECD Centres: as above
            - For fully registered ECD Centres and not receiving DSD operational subsidy, select based on:
                - Centre size (recommend 20 children or more).
            - For fully registered ECD Centres and receiving the subsidy, select based on:
                - Infrastructure problems (recommend infrastructure adequacy score 60% or less).
                - Centre size (recommend 20 children or more)

[24] In respect of the method utilised during the Action, the centres were first grouped (filtered) into registration status groups (unregistered, conditionally registered and fully registered). Unregistered centres were grouped into the three main categories with potential (A, B1, B2). These three main groups were in turn filtered based on: Potential rating >50%, at least 5 years of operation, at least 20 children. Those centres conditionally registered were automatically shortlisted for further assessment. Those fully registered centres without DSD operational subsidies and with at least 20 children were shortlisted as well as those with subsidies and at least 20 children but having significant infrastructure problems (infrastructure adequacy score 60% or less). It is noted that this was influenced by: a) governments desire to focus on those centres with greatest potential and lowest risk; b) the DSD's conditional infrastructure grant which is intended only for conditionally registered centres.

- *For all other centres which may require mitigation of imminent and material health and safety threats or require alternative ECD measures*
  - Filter all C1, C2 centres along with the A, B1,B2 centres which fell below the threshold size, years of operation and potential rating:
  - Select all centres with a low specific infrastructure adequacy score (basic services and building) or low score on the health and safety sub-score under the general classification – recommend below 40% on either of these.

- Phase 2 - selection of centres from the shortlist for further assessment, response planning and improvements. This is usually done by means of a workshop-type meeting including: DSD personnel (social workers and service office managers); municipal personnel (environmental health practitioners (EHPs) and potentially those involved in social cluster/human settlements/IDP budgeting) and project team (who undertook the survey). Those centres which have potential may require different modes of response relative to those requiring only mitigation of imminent health and safety threats. New builds may need to be considered where centres need to be closed down and/or where there is an obvious problem in respect of the supply of ECD services relative to demand or in cases where existing centres cannot cost effectively address this problem.

- Shortlisting and selection enables population based ECD response planning and associated budgeting: Support to ECD centres would typically be done on a phased basis depending on available budget and other resources. Typically, those centres with the greatest potential and return on investment (using criteria such as those utilised) would be selected first. This method would be used in order to achieve population based ECD response planning and the development of 'bankable' ECD improvement pipelines with associated budgets linked to Municipal and/or DSD MTEF or BEPP budgets.
- The specific filtering criteria utilised and threshold levels applied can be varied depending on local conditions, stakeholder preference, available funding etc. For example, increasing the screening size from 20 to 40 children in a centre, increasing or decreasing the threshold score for centre potential or infrastructure adequacy.
- It is noted that, even though the above method provides are more rational, evidence-based, depoliticised, and accountable way of selecting ECD centres for state support, there is always the risk of reversion into previous 'modes' (e.g. selecting centres best known to government officials, selecting centres preferred by the Ward Councillor). These risks should be borne in mind.

8.3 Response planning for infrastructure improvements

Efficacy

Structured ECD infrastructure response planning is necessary in order to ensure that the potential of existing centres is optimised, their greatest needs (including barriers to registration) addressed and limited state resources are optimised. The assessment and infrastructure planning methods and tools developed and employed through the action research initiative proved effective. Even though the field survey provides an overview of the status quo of infrastructure, it is indicative and is not based on an assessment by an infrastructure/built environmental specialist. An on-site infrastructure assessment, by a suitably experienced built environmental specialist is therefore imperative - not only to assess infrastructure, but also to prioritise and quantify infrastructural interventions and develop cost estimates. A standard/uniform 'one-size fits all' infrastructure 'package' is not considered viable for various reasons (e.g. diversity of centre characteristics and need to achieve maximum cost-benefit).

Refinements and comments

- An ECD infrastructure assessment tool was developed (tool (form) for use on site with a guideline).
- Photos and short video clips of the infrastructure should be utilised for assessment (post visit) and communication purposes.
- Minimum space requirements and general guidelines were drafted to address issues of flexibility and to facilitate clarity on how flexibility is applied.
- It is imperative that EHPs participate in the on-site infrastructural assessments undertaken by the infrastructure service provider and the DSD.

8.3.1 Response planning for operational improvements

Efficacy

Operational assessments (separate to infrastructure) by suitable skilled specialists is necessary in order to develop effective operational improvement plans, which consist mainly of the provision of specific types of training (e.g. for operators pertaining to management and administrative issues and for ECD practitioners pertaining to early learning programmes). TREE's operational assessments (as part of the action research initiative) utilised their well-developed Baseline Assessment Tools to collect the necessary information for the improvement plans. This was indeed important for the study; but also a key learning in respect of conducting thorough assessments for tailored interventions and support to ECD centres and practitioners.

Refinements and comments

No refinements are deemed necessary to the assessment tools. For any intervention to have meaningful impact however; it must have mentoring aspects in order to facilitate understanding from theory to practice. From TREE's 32 years of experience in the sector; this goes a long way into sustaining interventions and giving practitioners the skills to better engage with children and support superior ECD provisioning in rural and marginalized communities.

It is noted that the DSD also provides some training (e.g. pertaining to management – e.g. HR, policies, finances etc.) and that social workers nominate eligible ECD practitioners of registered ECD Centres for financial assistance by the Department of Education for formal NQF Level 4 Training at a registered Training Service Provider.

8.4 Delivering improvements - infrastructure

8.4.1 Infrastructure improvements

Efficacy

Even though infrastructure improvements could not be delivered within the timeframe of the Action, it is evident from action research work undertaken, that it is indeed viable for infrastructure delivery to occur as a primary outcome of the ECD Response Model[25]. The delivery of ECD infrastructure (improvements and, where appropriate, extensions and new builds) requires appropriate and efficient delivery mechanisms given the nature of the works involved (i.e. largely non-standard municipal infrastructure). Effective delivery depends in large measure on effective state procurement models and/or effective collaborations with support NGOs and other organisations with the necessary specialised expertise. Refer to *section 8.5*.3

[25] This assertion is based on the support from key eThekwini Departments, development of a report to key Committees for approval of systematic ECD response in informal settlements and the existing budget vote. Refer also to sections 7.3 and7.4.

for more detail. Work undertaken (survey, infrastructure assessments, DSD feedback etc.) also confirmed that improving infrastructure at centres is a key factor for overall ECD improvement and registration with the DSD. In fact, ECD infrastructure deficits emerged as the primary barrier to DSD registration.

Refinements and comments
The principal refinements required relate to the aforementioned enabling partnerships and/or state procurement solutions (refer to *Section 8.5.3).* Other refinements/adjustments include the realisation that basic services such as sanitation and handwashing cannot easily be addressed separately from building improvements (especially in dense, well-established informal settlements) as a rapid 'stand-alone' response (although this might be possible in different informal settlement settings – especially those which are more peri-urban and lower density in nature).

8.4.2 Operational improvements

Efficacy
It is evident from action research work undertaken that it is indeed viable for beneficial operational support to occur as a primary outcome of the ECD Response Model[26]. The provision of training to under-resourced ECD centres aimed at increasing both management capacity as well as ECD practitioner skill levels is well established. Organisations such as TREE specialise in this work. Work undertaken (survey, practitioner feedback, focus groups etc.) also confirmed that strengthening capacity at centres is a key factor for ECD improvement and registration with the DSD.

Refinements and comments
Follow-through mentoring for ECD operators/management and ECD practitioners at centres (post training) would be very beneficial. In order to scale up this kind of support, the aforementioned enabling partnerships and/or state procurement solutions are necessary (*refer to Section 8.5).* This work needs to be adequately funded and budgeted. Support NGOs such as TREE cannot fund this (especially at scale) using limited donor funding sources available (noting that operators and practitioners in under-resourced ECD centres typically cannot afford to pay for such training).

8.5 Key pre-requisites of the Response Model

8.5.1 Co-ordination and institutional relationships

Efficacy
It is evident from action research work undertaken that effective stakeholder co-ordination and functional institutional relationships are indeed a key pre-requisite for the ECD Response Model. However, these relationships are typically not yet in place or fully functional. There were substantial challenges experienced in this area during the course of the Action. These relationships are thus regarded as substantially ineffective, even if substantial progress was achieved by means of the Action in achieving a programmatic shift in these relationships in eThekwini.

[26] This assertion is based on successful delivery by TREE of well-established training and support to pilot centres. Refer also to *Part 2: Section 13.10.*

Refinements and comments

- *Responsible Metro Department for ECD support*: A Metro Department needs to be assigned to deal with ECD from a development (as opposed to regulatory) point of view. In eThekwini, no Department has been assigned. The issues are currently being jointly dealt with by Human Settlements and the Social Cluster.
- *Municipal-level ECD co-ordination*: Strong municipal-level ECD co-ordination for response planning, budgeting and stakeholder co-ordination is critical. The Integrated ECD Forums established by DSD for different areas in eThekwini (North, South and West) are attended by multiple stakeholders (representatives from various departments, NPOs, communities, etc.), but no high level decisions are taken or policy issues are addressed at these Forums. Whilst on the Action, a project steering committee was utilised, this is clearly not an ideal solution for upscaling and replication. In addition, there were challenges in securing sufficient participation from senior officials at times in the PSC.
- *eThekwini-DSD relationship and IGR*: ECD is currently a shared function (Schedule 4B of the Constitution) and an unfunded mandate. The roles, responsibilities and funding mandates of the municipality versus the provincial DSD need to be clearly agreed upon, preferably via dedicated high-level meetings and a resultant MOA.
- *Municipal-level ECD strategy*: A Metro-level strategy for ECD support is a necessary part of the Response Model if it is to be effectively scaled up. In eThekwini such a Strategy has not yet been developed, although it is understood that certain other Cities may have such strategies.
- *Support NGOs*: The involvement of specialist support NGOs with ECD skills and capacities (pertaining both to infrastructure and operational dimensions) is regarded as a key element of a successful ECD Response Model.

8.5.2 Funding instruments and budgeting

Infrastructure Funding

- There is not yet a solution for state ECD infrastructure funding.
- Municipal infrastructure funding is the current (default) funding model. ICDG funding has been allocated by eThekwini for use on the pilot ECD sites in eThekwini. In other municipalities, MIG funding has been allocated. The use of municipal infrastructure funding for ECD is envisaged in the 2016 / 2017 Submission for the Division of Revenue[27] as part of investments in public facilities, including those that are NPO owned and operated[28]. The use of municipal infrastructure funding for purposes of ECD is well established in KZN with more than R750 million spent between 2009 and 2014[29].
- The DSD has developed a conditional ECD maintenance infrastructure grant which is being piloted on a limited basis over a three-year period (refer to *Part 2: Section 13.9.6*). The future of this grant will depend on efficacy in the three-year pilot phase. One challenge is that the DSD does not have the capacity and expertise to manage infrastructure funding. In addition, the value of the grant in the three-year pilot phase is limited. The grant is also deficient in that it prioritises centres that have a conditional registration (omitting unregistered centres with potential and registered ones which have dilapidated infrastructure). The funding formula is also rigid with a low ceiling of R100,000 (in terms of the budgetary allocation per centre).

---

[27] Submission for the Division of Revenue 2016/2017 29 May 2015 by the Financial and Fiscal Commission (ISBN: 978-0-621-43719-5 RP173/2015)

[28] Finance and Fiscal Services Commission DORA Submission FY2016/7 page 14: "Government provides a full or partial capital subsidy for constructing and/or upgrading community-and NPO-based ECD facilities, through the municipal infrastructure conditional grant. The funding will facilitate compliance with the required infrastructure norms and standards, ensure that capital expenditure for ECD is carried out through municipalities and minimise inequities in quality standards and service levels".

[29] FFC 2016 DORA Submission.

- Clarity on state funding instruments and greater budget allocation is necessary.[30] It is problematic for ECD to have to compete with the broader basket of municipal infrastructure priorities whilst the DSD conditional infrastructure maintenance grant is too small and is poorly positioned within the DSD, unless it can be allocated to municipalities for utilisation.
- Based on a rough estimate, it would require approximately R13.2 billion to address the entire ECD infrastructure backlogs of in South Africa assuming a mixed improvement and new build model (refer to *Section 7.4* for details).
- The above requires further consideration by all spheres of government.

Operational funding

- There is insufficient fiscal allocation for ECD operational subsidies, as evidenced by the fact that many registered centres to do not receive the grant and the KZN DSD having indicated that it can has insufficient budget and can only approve operational subsidies up to the available budget. Many centres are left out. Without the subsidy, centres cannot be expected to improve or function adequately, noting the low level of fees which parents can afford (typically R50-R150 per month).
- Even with the DSD ECD operational subsidy, centres still face budgetary pressure. Half of the subsidy is utilised for food alone. This is one of the reasons flexibility in the application of ECD norms and standards is necessary (e.g. in respect of trained practitioner to child ratios).
- Based on a rough estimate, it would require an additional approximately R1.5 billion per annum in the near term and R8.8 billion in the longer term to provide operational subsidies to all children currently outside the system (once there are sufficient centres which can meet DSD minimum requirements which would obviously take many years). Refer to *Section 8.4* for more detail.
- The above requires further consideration by all spheres of government.

8.5.3 Procurement and delivery models for scaling up

Efficacy

The procurement and delivery models utilised in the action research initiative are, in general, not regarded as efficient and viable for a scale-able and programmatic ECD Response Model. However, putting in place the necessary specialist skills and capacities for ECD survey, planning and co-ordination, and efficiently delivering ECD infrastructure improvements, are key success factors and form a critical part of the Model. For example: a) It took PPT several years to secure the donor funding from the EU via PSPPD (and from other donors for parallel work in several rural municipalities) in order to undertake the work which has taken place so far. This is not replicable or scale-able going forward. b) The type of municipal infrastructure procurement which is utilised for the pilot in eThekwini (most likely several small separate sub-contracts), whilst adequate for a small pilot, is not regarded as an efficient, long-term infrastructure delivery solution.

Refinements and comments

- Procurement and delivery methods were not specifically posited as part of the Response Model to be tested, even if it was implicit that they are a pre-requisite when it comes to rollout and scaling up. I.e. This dimension needs to be added to the model if it is to be successfully transitioned from pilots to mainstream rollout.
- The experience of PPT and partner organisations working in other municipalities provides useful precedent which can potentially be drawn on with regard to EDC in informal settlement and Metro environments.

[30] PPT prepared an ECD Funding Model for Ilifa Labantwana in September 2015 (**Annexure O**). This project confirmed only willingness of eThekwini to avail funds from the ICDG for the purpose of ECD improvements.

- For up front ECD survey, assessments and response planning: This requires special expertise and municipalities and the DSD will not have the necessary skills and expertise in house. The following options are considered viable:
  - Municipal or DSD procurement at either municipal or even provincial level (open to private sector and support NGOs).
  - Special delivery vehicle, most likely at provincial or else Metro level – e.g. partnership between state and support NGOs.
- For minor improvements to existing centres and minor extensions: The bulk of these improvements is expected to relate to the building itself. *Refer also to Part 2: Section 13.9.2.* Given the small nature of the works, it is unviable to procure this work as separate, stand-alone contracts. The works need to be batched for reasons of cost efficiency and quality control. The following options have emerged as being viable:
  - Municipal procurement via a framework contract or panel of service providers.
  - Special delivery vehicle, most likely at provincial or else Metro level – e.g. partnership between state and support NGOs.
  - Turnkey Implementing Agent organisations (private sector and NGOs)[31].
  - Batched contracts for each phase of delivery (the least efficient model).
  - Inclusion of certain components in other annual service delivery programmes (e.g. fencing, water, sanitation, outdoor equipment) – (this will typically only address certain components of the required delivery but not all given the high prevalence of the need for building improvements).
- For new builds (where appropriate and necessary): Noting that these need to be at NPO and not conventional government specification.
  - Batched contracts for each phase of delivery (e.g. five centres at a time with a similar basic, modular specification – standard designs, low cost housing type specification e.g. steel frame etc.).
  - Turnkey Implementing Agent organisations (private sector and NGOs).
  - Special delivery vehicle, most likely at provincial or Metro level – e.g. partnership between state and support NGOs.

8.5.4 Tenure, land and centre ownership

The underlying land ownership and tenure patterns in informal settlements are complex and challenging to resolve. At Amaoti, most centres do not have formal tenure (title deeds, PTOs, Deeds of Grant or lease agreement). This is typical in informal settlements in eThekwini and other cities. This is in contrast to rural centres, where it is easier for centres to obtain a traditional PTO or lease agreement from the Traditional Authority.

In addition, many centres are privately owned. Some are also registered NPOs and are typically regarded by the DSD as 'community based centres', since they provide an essential service in underserviced communities, the operators themselves are typically low income and operating on a subsistence basis and because of the kind of relationship with parents that helps poor families to cope in various ways. Such owners have typically invested significant personal resources into their centres over the years.

---

[31] E.g. Along the lines of the Community Resource Organisations (CROs) utilised by the Department of Human Settlements on People's Housing Process (PHP) projects which comply with the government's procurement regulations which makes provision for the registration of such accredited organisations on the municipal or provincial database. Selected ECD centres could then select a preferred Implementing Agents from the list. This process could involve prospective Implementing Agents presenting their implementation capacity to the ECD centres who could then select their preferred candidate and with government input.

For the reasons outlined above, it is therefore necessary that government is flexible and realistic in respect of making infrastructure investments. In particular, it is recommended that:

- Centres cannot be expected to own the underlying land in order to be eligible for state-funded improvements (not for new builds or major extensions however).
- Privately owned centres which are considered as 'community based centres' by the DSD should also be eligible for minor improvements.

For more information, refer also *to Part 2: Section 13.9.3* for more detail on the types of tenure and ownership scenarios which may be encountered.

8.5.5 NPO registration and private ownership

As indicated above, many privately owned centres are also registered as NPOs in which case they are often regarded by the DSD as 'community based centres' (refer to *Section 4.4* for their attributes) and thus nonetheless eligible for registration and DSD operating subsidies. Given the essential service these centres provide in under-serviced communities, their subsistence nature, the low income levels of the owners, and the difficulties in transferring the ownership of private assets to the NPO, it is therefore considered appropriate that such centres be regarded as eligible for minor state infrastructure investments (subject to the usual DSD and EHP approvals – with flexibility), but not for major extensions or new builds. This is necessary in order to extend and enhance much-needed ECD services to vulnerable young children, including mitigating health and safety threats, it being noted that that:

- The size of the investments for minor improvements is typically between R75,000 and R125,000 (averaging approximately R2,086 per child).
- The selection criteria for centres for infrastructural support, using survey data, typically includes such risk-mitigating factors as: centres which have been operational for 5 years or more, the achievement of a good potential score and accommodation of at least 20 children. This is over and above securing DSD and EHP approval.

9 Refined ECD Response Model

9.1 Overview

The proposed new Response Model offers *significant potential to be scaled-up and mainstreamed*, thereby transforming the access to improved ECD services for children within underserviced, informal settlement communities and resulting in inclusion within the current system of state support.

As previously indicated, the *Model was substantially refined and strengthened*.

No alternative model was identified which can achieve the key strategic ECD objectives of population coverage ('massification' of ECD services) for millions of young children in underserviced communities such as informal settlements.

The model is *premised on supporting and improving de-facto, under-resourced ECD centres wherever possible*. This is not only for reasons of cost-efficiency and achieving population coverage, but also because such 'community-based centres' can respond uniquely and flexibly to particular local needs, often helping

parents/families to cope in various ways with prevailing pressures and stresses. Refer also to *Part 2 Section 13.16.*

The *level of state investment in infrastructural improvements will vary*, but will most often focus on minor improvements to address key infrastructural deficiencies. In the case of certain high-potential centres, larger investments in expanding/extending centres may be appropriate. Costly new-builds (including state-owned facilities) are only appropriate where there are no other options and then should preferably also serve as 'hubs' to support surrounding, less-resourced centres.

In all cases, *all centres with potential should be included within the state's current ECD system* (i.e. registration as partial care facilities with appropriate flexibility e.g. at 'bronze' level).

This means that all such centres (with potential) should *receive DSD subsidies as well as appropriate training* (both for ECD practitioners in respect of programmes and early learning as well as for operators in respect of management and administration).

Even *centres with high constraints* and limited potential may warrant basic levels of support (e.g. to address imminent health and safety threats when children have no other options available). It is accepted that some centres may be so dysfunctional that they may need to be closed down and other solutions found for children, but this should be considered as a last resort.

The Model provides a ratio*nal basis upon which to make these determinations as part of population-based ECD planning*. This provision is made principally through the key methods and tools which constitute the model, such as area-based ECD survey, categorisation, and structured ECD assessments and response planning.

9.2 Process

The refined ECD Response Model is outlined below in summary. Not all detailed elements and content have been included since these are provided in other parts of this Research Report or in Annexures to it, in which case these have been referenced. The development of a full, user-friendly operational manual to assist government and non-governmental stakeholders with implementing the Response Model is a logical next step.

Step 1 - Rapid Assessment and Categorisation (once off)

- *Preparation/setup*:
  - Procurement for RAC and 1st year of response planning
  - Establish municipal-level ECD co-ordination structure (if not in place).
  - Target area definition.
  - Desktop study – demographic data (population of young children, household sizes, incomes, etc.).
  - Identification of existing (de-facto) centres (DSD and municipal lists, national ECD audit, site visits). *Refer to Part 2: Section 13.3 (a)*
- *Field survey:*
  - Review survey tool (familiarise team).
  - Recruit and train field workers. *Refer to Part 2: Section 13.3 (c)*
  - Undertake field survey (data collection). *Refer to Part 2 Section 13.3 (e)*
  - Data processing, analysis. *Refer to Part 2: Section 13.3 (f & g)*
  - Survey Report. **Refer Annexure E.**

- *Categorisation*: Including general categorisation (A, B1, B2, C1, C2), ECD potential rating, infrastructure investment potential, infrastructure adequacy (overall and specific). *Refer to 5.2.1, Part 2 Sections 13.4, 13.5.*

Step 2 - ECD Response Plans (ongoing, multi-year)

- *Shortlisting and selection* of centres for support in current year/MTEF. *Refer to Sections* 5.2.1, *Section 8.2.1.and Part 2: Section 13.6*
- *Assessments & response planning*:
  - o Infrastructure assessments, plans, cost estimates. *Refer to Part 2: Section 13.9.*
  - o Operational assessments, plans, cost estimates. *Refer to part 2: Section 13.10.*
- *Procurement* for response planning 2nd year onwards until all viable centres completed.

Step 3 - ECD Improvement Implementation (ongoing, multi-year)

- *Infrastructure improvement* procurement and delivery year 1. *Refer to Part 2: Section 13.11.*
- *Operational improvement* procurement and delivery year 1. *Refer to Part 2: Section 13.12.*
- *Infrastructure and improvement* procurement and delivery subsequent years until complete.
- *Operational improvement* procurement and delivery subsequent years until complete.

9.3 Preconditions

The following are the key preconditions for the successful implementation of the Response Model. These have already been articulated in more detail in *section 8.5*.

- *Effective stakeholder and institutional co-ordination*.
- *Adequate funding instruments and budgeting* (infrastructure and operational).
- *Effective and enabling procurement/partnership models* for survey, planning and delivery.
- *Clarity on ECD flexibilities (e.g. gold-silver-bronze) and including clarity on tenure, land and centre ownership.*

9.4 Diagram: Scale-able ECD Response Model for Rapidly Improving ECD Centres in Underserviced Communities in South Africa

Stakeholder engagement

mainly via Municipal level ECD Co-ordination Structure involving **EHPs, DSD ECD Forums support NGOs**

Step 1: Rapid Assessment and categorisation

(Once off)

Preparation

- Procure/partner for RAC & year 1 planning
- Define target area
- Desktop study
- ID existing & new centres

Field Survey

- Familiarise team wth survey tool
- Recruit & train field workers
- Field Survey Data Processing , analysis
- Survey report

Categorisation

- General categoires (A, B1, B2, C1, C2)
- ECD potential
- Infrastructure adequacy
- Investment potentials

Optional focus group discussions Individual In-depth interviews (IDIs)

Step 2: ECD Response Plans

(ongoing, multi year)

Shortlisting & selection of centres for support

in current year/MTEF period

Assessments & response planning

including cost estimates for delivery:

1) **Inftrastructure**

2) Operational

Procurement / partnerships for response planning

(2nd year onwards until all viable centres completed)

Step 3: Implementation

(ongoing, multi year)

Infrastructure improvement procurement & delivery

(year 1)

Infrastructure Improvement procurement and delivery

(subsequent years until all viable centres completes)

Operational improvement & delivery

(year 1)

Operational Improvement procurement & delivery

(subsequent years until all viable centres completes)

Key Preconditions for Response Model

Stakeholder and institutional co-ordination.

Funding instruments and budgeting (infrastructure and operational).

Procurement/partnership model for survey, planning and delivery.

Clarity on ECD flexibilities (e.g. gold-silver-bronze) and including clarity on tenure, land and centre ownership.

10 Policy engagements

Good progress was made in respect of policy engagements and feedback. This is regarded as a particular success of the research initiative. Significant levels of engagement occurred at Metro, Provincial and National levels, with positive results at all levels, notwithstanding the previously mentioned delays with eThekwini Municipality. There was a high level of interest in the new Response Model and it was evident that there is a gap which it effectively addresses. Particular parts of the Model which received positive feedback included the ECD database and related categorisation enabled by the field surveys, the cost-benefit of an ECD improvement model (as opposed to new build), and infrastructure response planning and related models and cost norms.

The testing of a model for possible upscaling requires active stakeholder involvement and the communication of progress and findings on a regular basis to those directly and indirectly affected (refer also to a short overview of stakeholder engagement in *section 8.5.1*). Given the extent of the stakeholder engagement which occurred and the associated wide range of issues and complexities, a dedicated report is provided in **Annexure D**. PPT's policy engagements were informed by the policy engagement plan, presented at the PSPPD Grantee Policy Engagement Workshop 17 – 18 March 2016. A successful multi-stakeholder ECD Workshop for policy feedback and engagement purposes was held in Durban for policy feedback and engagement purposes in January 2017. Feedback on policy implications and recommendations were presented at the latest PSPPD II Research Conference on Research Findings and Potential Policy Implications on 14 and 15 March 2017 which was attended by various important policy makers. A policy brief was also made available at this event (Refer to **Annexure A)**. Policy matters were addressed via engagements with the following stakeholders:

a) eThekwini ECD Project Steering Committee

The following stakeholders were represented on the PSC: eThekwini Municipality (representatives of Planning, Human Settlements, Environmental Health); Provincial DSD; District DSD (North and South Offices); Ilifa Labantwana; Network Action Group (NAG); TREE; UKZN. The PSC advised on various matters e.g. study area, participated in the refinement of the model (e.g., survey and categorisation) and the implementation of the Action e.g. survey, selection of pilot sites, etc. Three formal PSC meetings were held as well as three PSC workshops on various matters – e.g. norms and standards, refinement of categorisation, survey feedback, categorisation results and shortlisting of sites.

b) EThekwini Municipality

Despite some challenges, substantial headway was made in respect of eThekwini Municipality starting to move positively and programmatically in respect of ECD in informal settlements. The process took longer than expected for reasons previously mentioned, but to a significant degree, this reflects the City's desire to move in a programmatic fashion and a desire to only proceed with pilots once key issues such as institutional alignments, funding mandates and high-level political support have been secured. The following are examples of the clear evidence of the progress made: a) a budget vote of R9million for ECD infrastructure pilots, b) numerous high-level meetings with senior officials including various Heads of Department and the City Manager, c) the development of a detailed report to be tabled to the Committees of both Human Settlements and Social Cluster in the near future, which has had detailed inputs form multiple Departments and which addresses more than only the proposed pilot sites in that it establishes the key principles for an ECD programme in the City.

Additional notes: *As indicated previously, eThekwini Municipality is regarded as the primary stakeholder whose involvement and buy-in is necessary for achieving a new and more inclusive approach to ECD*

within informal settlements. Extensive high level engagements were undertaken throughout the project period to ensure buy-in. In general, City Departments were very supportive of the initiative and recognised its developmental importance. However, the lack of a clear institutional 'home' in the City posed constraints and there were also questions raised over the respective responsibilities and funding mandates of the City versus the Department of Social Development in respect of ECD. PPT engaged with various City departments e.g. City Health, Human Settlements, City Manager, Social Cluster Portfolio Chair, Safer Cities, Planning and building plans, Architectural Department on various matters ranging from buy-in, institutional home for ECD within the City development approach, status of NPOs, use and development of land for ECD Centres, zoning, procurement channels for contractor services, reservation and approval of ICDG funding for pilot projects, additional surveys, establishment of a pipeline of viable bankable ECD improvement projects, etc. Most of these issues have policy implications. Various challenges had to be addresses, e.g. the unexpected withdrawal of the Health department as lead department, the finding of a replacement Municipal lead department, very long delays caused by elections, high level staff turn-over e.g. City manager and the readdressing of issues with a new council and confirmation of support, the approval of ICDG funds, etc.

c) KZN DSD

PPT introduced the project to the HOD of the provincial DSD (Ms Sophazi), upon commencement. PPT were invited to do a presentation to the Provincial Integrated ECD Committee on 14 June 2016 on the ECD response model and progress to date (including the results of the field survey). The invitation was facilitated by Ilifa Labantwana who had a signed MOA with the Social Cluster Departments on the roll out of an ECD programme focussing on registration and infrastructure improvements for ECD Centres. There was also positive and wide-ranging engagement with and involvement of the Deputy Director: ECD (KZN) (Mr Timla) – with regard to: provincial representations to the PSC; ECD centre identification; ECD registration status (provincial records); the sharing of the PPT survey database; categorisation and shortlisted sites; identification of centres for the Conditional Maintenance Grant; a presentation at the Dissemination Workshop in January 2017; sharing of the Policy Brief arising from the Action, etc.

d) NDSD

PPT had regular and ongoing interaction with the NDSD since the start of the research initiative. A positive relationship was established and significant positive policy feedback achievements were realised including: a) extensive input into the cost norms of the DSD's new conditional infrastructure maintenance grant; b) significant input into the DSD's new flexible, incremental gold-silver –bronze registration framework; c) invitation to participate in National ECD Infrastructure Spatial Plan Task Team. The NDSD expressed particular interest in elements of the Model such as the database and categorisation arising from the survey, the centre profiles which were developed, and infrastructure response planning and related infrastructure models, cost norms and delivery models. It was evident that PPT is one of only a few organisations involved in ECD support who has significant infrastructure expertise.

<u>Additional notes</u>*: At the outset of the initiative, there was engagement with the NDSD's Musa Mbere, Chief Director: ECD and her team including Anita Samaad, responsible for infrastructure development at the inception of the project. Most of interaction was on issues pertaining to the model (e.g. survey, categorisation, technical assessments of centres); infrastructure investment planning, types and extent of flexibilities required, ownership issues, costing of technical assessments in order to budget for such service for the Conditional Infrastructure Maintenance Grant; proposed high-level meeting with eThekwini top management regarding roles and responsibilities and possible MOA. Mark (PPT CEO) attended a national stakeholder meeting (NDSD, National Treasury and the National Infrastructure and Registration subcommittee) to finalise framework for incremental, flexible Gold Silver Bronze*

registration framework at Hollard Foundation in Johannesburg. PPT (Liesel du Plessis) was also invited to serve on the National ECD Infrastructure Spatial Plan Task Team (first meeting in Pretoria on 13 March 2017) that addresses issues pertaining to progress on policy implementation, national stakeholder coordination, population based planning & spatial planning, Infrastructure norms and standards, etc. A further four meetings have been scheduled for the next 12 months.

e) Ilifa Labantwana

A parallel ECD project was undertaken in close collaboration with Ilifa Labantwana in parts of Umlazi (informal settlement areas) and four rural municipalities (Umzumbe, Vulamehlo, Umvori and Msinga) PPT prepared three base documents (pertaining to categorisation, norms and standards, infrastructure delivery and funding models) which also helped lay the platform for the PSPPD research. Ilifa Labantwana has a signed MOA with KZN Social Cluster for roll out of ECD programme in KZN and is also serving on the National, Inter-Sectoral Forum for ECD's Infrastructure and Registration Sub Committee. PPT commented on various policy matters via Ilifa Labantwana (e.g. with regard to cost estimates for the conditional Infrastructure maintenance grant, conditional grant assessment tool, guidelines for the maintenance grant, service level agreements for the conditional grant, ECD centre designs, norms and standards, bylaws, gold silver bronze registration levels, etc.)

f) Multi Stakeholder ECD dissemination workshop - 27 January 2017

The workshop was attended by 58 representatives of Provincial, District and Metropolitan government officials, Donors, EU representatives, DPME / PSPPD, support NGOs and other role players such as practitioners and some parents of pilot sites in Amaoti. The main speakers were Mr Timla (KZN DSD) Prof Sarah Bracking (UKZN), Mark Misselhorn and PPT colleagues, TREE and Thuthukile Mhlungu (an ECD Practitioner from the Inkhanyezi ECD Centre in Amaoti). Feedback confirmed the need for funding for infrastructure improvements and support, more flexibility on norms and standards, the need for training, and structured stakeholder co-operation and coordination (e.g. DSD Metro Memorandum of Agreement) Refer to **Annexure M** for the Multi Stakeholder ECD Dissemination Workshop Report.

11 Summary of key learning

11.1 New Response Model proven

- **The need for a new Response Model was proven based on research undertaken.** For example: No other programmatic response model is yet in place; many centres are not yet known to government and are thus off the DSD's radar; there is weak area level data on local demand for ECD services (neither the Municipality nor the DSD has area based data on all ECD centres and no concerted effort is made to identify centres on an area basis); there is no clear idea of the condition of ECD infrastructure within service areas although it is recognised that infrastructure deficiencies are a major barrier to registration. Without addressing issues such as those outlined above, effective population based ECD planning is impossible. It is imperative that these issues be addressed systematically.
  - **Most centres are outside of the current DSD system of oversight, funding and support** – 75% of the informal settlement centres were not registered (69% at Amaoti and 82% at Umlazi versus 36% for the five rural municipalities and 42% overall). An even higher percentage (85%) do not benefit from DSD ECD subsidies (since many registered centres don't get the subsidy) (86% at Amaoti and 85% at Umlazi versus 60% rural, 54% overall)
  - **There are large numbers of children who are excluded from state support in under-resourced, unregistered or unfunded centres:** There were 3,286 children centres not registered or not

receiving the DSD subsidy in the two informal settlements study areas in eThekwini (84% of all the children in centres - 86%/2,185 at Amaoti and 81%/1,101 at Umlazi). This is significantly higher than the average in the five rural municipalities surveyed where it was 47% (7,392 children).

- **Infrastructure deficiencies pose the most significant barrier to centre improvement and registration.** Most of the informal settlement centres (84%/69 centres) require infrastructure improvements due to various deficiencies (basic services, building, accommodation or site) (98%/41 centres at Amaoti, 69%/27 Umlazi versus 91% rural, 90% overall average). These deficiencies typically pose problems in respect of the health and safety of children as well as meeting norms and standards for DSD registration.
- **Most centres have potential to improve and are viable for support.** Despite their limited resources, most centres show commitment under difficult circumstances and have potential to improve, provided they receive greater support. 73% of centres surveyed at Amaoti have potential (31 out of 42 were in categories A,B1,B2) and 48% (20) have good potential (A,B1). The trend was significantly higher in Umlazi informal settlements and the five rural municipalities surveyed.
- **Absence of any alternative programmatic response model:** No alternative programmatic ECD response model which can achieve population coverage was identified. Current ECD responses by government are ad hoc and reactive. Only a small number of all centres are assisted.

- **New Response Model is effective: The Model was tested, refined and proven to be effective.**
    - **It effectively identifies existing centres at area-level for the first time:** The Model collects and collates existing lists of ECD centres and in addition, identifies significant numbers of centres not previously known. For the first time it provides a comprehensive and detailed list of all (or most) existing centres in targeted areas. This can be done at area or municipal level. At Amaoti, only 11 out of 42 centres (26%) were covered by the 2014 National ECD Audit. Systematic identification collects and collates existing lists of centres from various sources (DSD, Municipality, support NGOs). Even after this was done at Amaoti, an additional 10 centres were identified which were not on any pre-existing lists. This trend is consistent with other areas surveyed[32] where, after consolidating all existing lists, significant numbers of additional centres not previously known were identified (34% of all centres surveyed in areas outside of Amaoti). Globally, in all areas surveyed by PPT, the 2014 National ECD Audit only identified 40% of the number of centres identified and surveyed and 30% of the children.
    - **It provides new and essential information about existing centres:** The Model provides significant new information pertaining to the status quo, needs and potentials at existing centres (making use of 149 survey questions). This includes information about the number of children, DSD and NPO registration status, centre and ownership, capacity and governance, infrastructure status, health and safety threats, and status of early learning programmes. It is noted that on the pre-existing lists of government, the information on those centres listed was typically limited (typically just the name of the centre, number of children enrolled, NPO and registration status, and sometimes an address and contact details). Information on EHP's lists tended to be more detailed than that on DSD lists (including some information pertaining to infrastructure and ECD qualifications). In rural municipalities, such additional information was not accessible from EHPs.
    - **It establishes a comprehensive ECD database for the first time:** The area/municipal-level databases can readily be rolled up and consolidated into a provincial database and potentially a national ECD database. The historical absence of a comprehensive ECD database has posed a major limitation on population-based response planning, budgeting and support.
    - **It enables population based ECD response planning using data:** The comprehensive data collected enables effective population-based ECD response planning to take place for the first time. The

[32] Parts of Umlazi and five other rural municipalities in KZN (Umzumbe, Vulamehlo, Umvoti, Msinga and Nquthu).

Categorisation Framework is a key tool in this regard along with the other ratings for ECD potential, infrastructure adequacy and investment potential. Centres can easily be grouped according to their function and potential and ranking or filtering of centres can be done for various purposes. The overall ECD capacity within a particular area/municipality can quickly be gaged.

- **The Categorisation Framework is effective and 'fit-for-purpose':** The categorisation (A,B1,B2,C1,C2) was shown to be a good predictor of ECD functioning and potential. It is therefore an effective tool for population based ECD planning, including gaging existing local ECD capacity at area-level, shortlisting centres for ECD support and determining local ECD capacity and potential. (Refer to *Part 2: Sections 13.4 and 13.5* for details.)
- **The model enables prioritisation of those centres with the greatest potential and highest numbers of children for support:** The data and categorisation enable funding and other resources to be allocated so as to achieve maximum benefit and population coverage. Centre profiles with photographs assist with selection. All of this enables more transparent, evidence-based and accountable decision making on resource allocation for ECD improvements and support. *Refer to Part 2: Section 13.6*
- **The model provides for a fair and transparent site selection system to ensure accountability, and 'de-politicisation'** of the' selection of centres but there is always the risk of some contestation. *Refer to Part 2: Section 13.6*
- **Improving existing centres is cost effective, can be done fairly quickly, and is therefore the infrastructure investment priority** if population coverage and 'massification' are to be achieved. The Model is premised on supporting and improving centres as the primary focus. Almost 7 times more children can be assisted in improving centres than in constructing new builds. *Refer to Part 2: Sections 13.9.4 – 13.9.5.* The cost of building new centres for all under-serviced children is unaffordable to the fiscus, costing more than six times per child relative to improving existing centres. The average planned cost per centre is R108,798 at R2,086 per child (for a mix of basic services and minor building improvements at 91 centres). By contrast, new builds cost between R14,000 and R29,000 per child (depending on whether they are built at basic/NPO or higher/state facility specification).
- **A simple multi-year process is enabled by applying the model** - Survey once off and yearly assessments and implementation until all centres have been improved. *Refer to Section 9.*
- **Overall, it provides the only viable, programmatic and scale-able response model:** Given the absence of any programmatic response and the prevailing fiscal and other constraints, the new ECD Response Model provides the only viable method for addressing the prevailing ECD crisis in informal settlements and other under-serviced communities.

11.2 Preconditions for scaling up Response Model

The Response model works and can be scaled up subject to certain conditions being met:

- **Sufficient fiscal allocation for under resourced ECD Centres both in respect of infrastructure and operating costs (DSD subsidies).** There is simply not enough funding available for ECD. *Refer to Section 11.4*
- **More and dedicated funding instruments for infrastructure and operational improvements.** The ECD agenda will not be progressed as long as it has to compete with other priorities for a fraction of a budget (e.g. 5% of the MIG budget) *Refer to Sections 11.4 and 11.5*
- **Funding for ECD surveys and technical assessments in all municipalities** in order to determine the status and category of all ECD centres and to provide the data necessary for effective, population-based ECD planning and to ensure a pipeline of viable infrastructure improvement projects. Surveys should

Ideally be provincially-driven to enable consolidated data-bases, while technical assessments and implementation should be done on a municipal basis. *Refer to Part 2: Section 13.3*

- **Effective municipal level ECD co-ordination and institutional relationships are imperative** – internally among municipal departments, but also with government departments and NGOs. *Refer to Section 11.6*
- **Efficient procurement / partnership arrangements and ECD infrastructure delivery model/vehicle,** which meets the particular requirements of ECD infrastructure and take into account economies of scale, is an important success factor. The investments are typically relatively small, but in multiple localities, which are often geographically dispersed. A programmatic roll out is thus required. Such a model/vehicle needs to be 'tuned' to ECD norms and standards and related flexibilities. *Refer to Section 8.5.3* and Part 2: *Section 13.9.2.*
- **Flexibility in respect of ECD registration, norms and standard, tenure and centre ownership –** *see following section***.**

11.3 Flexibility is critical

- **Appropriate flexibility is a critical pre-requisite:**
  Appropriate flexibility is necessary to include ECD centres with potential in the system of state support: The current registration and other ECD requirements are out of reach for most centres due principally to low levels of income at centres, prevailing building types and underlying land use. Requirements where flexibility is required include: zoning, building plans, DSD minimum floor area requirements, ratios of trained practitioners per child, separating age groups, and age-appropriate programmes amongst others. Refer to PPT base document on Norms and Standards – **Annexure P.** Substantial flexibility is already applied by many EHPs and social workers, however this will vary between areas and there is no official basis or standard for this de-facto flexibility (which is usually applied so that much-needed support can be extended to needy and worthy centres).
    - **Flexible DSD Partial Care Facility Registration:** Significant flexibility is already envisaged in the DSD's draft gold-silver-bronze incremental registration framework currently being finalised by the National DSD in close consultation with various other stakeholders. Once implemented, under-resourced centres will be able to attain bronze level conditional registration. However, the current framework is premised on centres being able to transition rapidly from bronze to silver levels. Some centres will in reality struggle to do so, principally due to insufficient operational funding (income) and infrastructural deficits. Further refinements may be necessary[33]
    - **Municipal bylaws for ECD and building regulations:** It is expected that many of the required flexibilities will be documented and addressed by the proposed gold, silver bronze framework which take into consideration the National Environmental Health Norms and Standards that is also found in municipal bylaws. The National DSD is currently investigating the possibility of a 'universal bylaw' for ECD.
    - **State infrastructure investment (land and centre ownership)**: Centres cannot be expected to own the underlying land in order to be eligible for state-funded improvements (however not for new builds or major extensions). Privately owned centres which are considered as 'community based centres' by the DSD should also be eligible for minor improvements. They are regarded as such because they provide an essential service in underserviced communities, the operators themselves

[33] Some centres are unlikely to achieve registration, even with flexibility (such as that proposed at the bronze and silver levels). Such centres typically offer only basic childminding and are often the centres with least resources to improve infrastructure. Such centres are typically at the C1 or C2 levels. They are thus likely to remain outside the system, yet there may not yet be any other alternative care options for children and it may be difficult to close them down.

are typically low income and operating on a subsistence basis and the kind of relationship with parents helps poor families cope in various ways. The owners typically invest significant personal resources into their centres. Refer also to section 13.16.

- **DSD Programme Registration:** Whilst this was not specifically assessed as part of the research initiative, it is recommended that the DSD further assess this to determine how under-resourced ECD centres can be included and supported in achieving acceptable standards within their prevailing financial and other limitations. One of the biggest problems for unregistered centres in achieving acceptable standards is the lack of training and support and urgent flexibility is required - e.g. with regard to the current arrangement that only practitioners from registered centres may receive NQF Level 4 training with DoE financial support. NQF Level 4 training is also only available for persons with grade 10 to 12. It is imperative that provision be made for appropriate funded training / short courses for staff with lesser school qualifications at accredited training service providers.
- **Privately-owned centres[34] may be regarded as acceptable by the DSD and may viable for state funding** (operational subsidies and/or minor infrastructure investments) in certain instances – i.e. when the centre is a dedicated centre on a separate site or when it is fenced off and separate from the household. Such centres may be regarded by the DSD as a 'community-based ECD centre'. However, centres where children share household space and facilities (e.g. toilets) are not acceptable to the DSD. *Refer to section 13.9.3 (f).*

11.4 Fiscal allocation for ECD

- **A greater fiscal allocation for ECD is necessary:** The global fiscal allocation to ECD (both operational and infrastructural) is clearly insufficient as evidenced by the fact that many registered centres do not yet receive an operational grant due to provincial budget shortages and the absence of any dedicated fiscal allocation for ECD infrastructure. Given the strategic importance of ECD for South Africa (e.g. from an economic and educational point of view) and the special rights of children under the Constitution, reprioritising certain other budget votes so as to increase the allocation to ECD is surely appropriate. Based on a rough estimate, it would require approximately R11 billion to address the entire ECD infrastructure backlogs of in South Africa assuming a model of improvement with new builds only where necessary and appropriate. On the operational side, it would cost approximately R8.5billion per annum in ECD grants, once all children in South Africa enjoy access to the subsidy. Without infrastructural improvements and ECD subsidies, under-resourced centres cannot be expected to improve. The typical fees paid by poor parents (R50-R150 per month) are inadequate. They will remain outside of the system and will be unable to provide acceptable ECD services to millions of young children. This is a key challenge to 'massification'. *Refer to Section 8.5.2.*

11.5 State infrastructure funding instruments

- **State funding instruments for ECD Infrastructure funding need strengthening:** There is not yet an adequate solution for state ECD infrastructure funding and this requires urgent attention. Major barriers with regard to the allocation of existing MIG/ICDG and the DSD conditional grant. *Refer to Part 2: Section 13.9.6*

[34] Either a private individual or a Faith Based Organisation (FBO) or a Community Based Organisation (CBO).

- The main source of funding is currently municipal infrastructure funding (MIG/ICDG). Such usage is common and envisaged in in the Division of Revenue Act. However, it is problematic for ECD to have to compete with other infrastructure funding demands in municipalities. The portion that can be allocated for planning and technical work is insufficient in the ECD context (e.g. capped at 10% for ICDG capped and 5% for MIG). The ECD agenda cannot be progressed with “left over” funding. Requiring municipalities to make firm ECD allocations (e.g. on their BEPPs and MTEFs) or ring-fencing some of this funding for ECD would greatly assist. *Refer to Section 8.5.2.*
- The other funding instrument, the DSD’s conditional ECD maintenance infrastructure grant which is being piloted on a limited basis over a three year period, is highly constrained: at this stage it is still very small in fund value; there is a R100,000 ceiling per centre; is only being utilised for those centres which have conditional registration thus excluding all other centres with potential i.e. well established centres not registered or registered but with infrastructure problems; and Provincial DSDs do not have the necessary infrastructure experience to effectively manage the funding. Expanding it and making it more flexible would greatly assist, along with either allocating it to municipalities or else putting in place an effective, special purpose delivery vehicle.

  In the case of both instruments, there needs to be prescribed flexibility to for government to invest in infrastructural improvements for centres which do not own the underlying land provided they meet DSD and EHP approval (with prescribed flexibility as to norms and standards).

- **There is a need for funding for survey (once off) and response planning (annually).**
- **ECD centre improvement planning & delivery support** is necessary (provincial/local level) to develop ‘viable and bankable’ ECD project pipelines. Efficient provincial delivery models are needed. Leveraging the capacity ECD support organisations will be beneficial. *Refer to Part 2: Section 13.9.6*

11.6 Effective ECD institutional co-ordination and funding mandates

- **eThekwini-DSD relationship and IGR:** ECD is currently a shared function (Schedule 4B of the Constitution) and an unfunded mandate. The roles, responsibilities and funding mandates of the municipality versus the provincial DSD need to be clearly agreed, preferably via dedicated high-level meetings and a resultant MOA to ensure sstructured DSD-Municipal collaboration. Municipalities (including Metros who are regarded as key stakeholders) need to be adequately engaged by DSD (provincial or national) on new ECD policy. Currently the main engagement is with the provincial spheres of government e.g. provincial DSDs and COGTA. Such engagement would need to involve officials of similar seniority from both sides.
- **Responsible Metro Department for ECD support:** A Metro Department needs to be assigned to deal with ECD from a development (as opposed to regulatory) point of view. In eThekwini, no Department has been assigned. The issues is currently being jointly dealt with by Human Settlements and the Social Cluster.
- **A legitimate high level Municipal ECD co-ordination structure:** Strong municipal-level ECD co-ordination for response planning, budgeting and stakeholder co-ordination is critical involving the Municipality, DSD, ECD forums and support NGOs. This needs to be a high level structure with decision-making authority involving senior officials that can drive the strategies for ECD to meet the objectives set by the National Development Plan for 2030
- **Municipal-level ECD strategy:** A Metro-level strategy for ECD support is a necessary part of the Response Model if it to be effectively scale up. In eThekwini such a Strategy has not yet been developed although it is understood that certain other Cities may have such strategies.
- **Support NGOs:** The involvement of specialist support NGOs with ECD skills and capacities (pertaining

both to infrastructure and operational dimensions) is regarded as a key element of a successful ECD Response Model.

- **Escalating the priority of ECD in informal settlements within the national informal settlement upgrading agenda** of all spheres of government. ECD in an important part of upgrading and Cities such as eThekwini are moving to include ECD as part of their upgrading programmes.

11.7 New key learning from ECD survey data[35]

- **Most centres are outside of the current DSD system of oversight, funding and support.** *Refer to Part 2: Section 13.3 (b)*
- **There are large numbers of children in under-resourced, unregistered centres.** *Refer to Part 2: Section 13.3(b)*
- **The vast majority (68%) of the children 0-5 years old in these informal settlements are not attending ECD centres** *Refer to Part 2. Section 13.3(b)*
- **Infrastructure deficiencies pose the most significant barrier to centre improvement and registration.** *Refer to part 2: Section 13.3.(b)*
- **Most centres surveyed are relatively small** - The average size was 48. Centres at Amaoti were atypical in being significantly larger (average of 60 children) *(vs rural average of 36, overall average of 38 children—significantly less than the national median of 53 for fully registered centres).*
- **Low-income levels are a key constraint:** Most parents in low-income communities can only afford to pay between R50 and R150 per child per month. This places centres under extreme financial pressure. Even if the DSD ECD grant is provided, funding is still insufficient to meet all requirements. Fee levels were slightly higher at Umlazi where most parents (66%) were paying R151 to R250.
- **Significant deficiencies in ECD practitioner skills and capacity -** 23 % of principals and 38% of practitioners had no ECD training *(vs 28% and 48% rural and 27% and 46% overall)*
- **Most centres do their best and many have potential.** *Refer to Part 2: Section 13.3(b)*

11.8 Other learning from assessments, focus group discussions, consultations, etc.

- **Micro-location of ECD centres and cost are key factors for parents** – Centres need to be easily accessible for parents (e.g. dropping children early on route to public transport for work and collecting them late on the way home - sometimes outside normal ECD operating hours). Parents' put a high value on convenience and accessible location (75% expressed this). Affordability of ECD services is also a key factor for parents **-** (60% expressed this). Other priorities were the provision of food (58%) and other family members or friends using the same centre (56%). *Refer to Part 2: Section 13.15.6*
- **Parents values good trained teachers and a high level of care (64%)**
- **Parents maintain close relations with the principals and staff** that enables them to negotiate some flexibility of hours (33%) and payments.
- **Parents identified Infrastructure improvements as a high priority** e.g. improvement of water and

[35] *NOTE: Although the EU-funded PSPPD research focused on informal settlements, (Amaoti study area - 42 centres), findings from an Umlazi informal settlement study area (39 centres) are also factored in and the data on both areas consolidated to improve the sample size and settlement representivity (giving a combined total of 81 centres). Findings from five rural municipalities in KZN (435 centres) have also been referenced since this is relevant to overall ECD trends and national policy. The additional areas were funded by various donors via Ilifa Labantwana and Nqutu was funded by Assupol Community Development Trust. Because the Umlazi informal settlements are 'infills', most centres were located in adjacent township neighbourhoods. Separate data is provided for Amaoti versus Umlazi and for urban versus rural municipalities where significant differences in trends were detected.*

sanitation, electricity (94%), buildings (80%), health and safety (67%) security threats from outside (32%).

- **Infrastructure deficiencies are the main obstacle to partial care registration.** Centres with weak or no programme are registered if they do not have any fundamental problems with infrastructure. There was some confusion at centres as to whether or not their programmes are registered. It is expected that this issue has been addressed with the latest registration drive undertaken in Amaoti and other areas.
- **Long-term settlement plans should not block ECD response planning** – Long-term settlement plans (e.g. for formal town planning and township establishment and formal housing provision) are typically very slow processes taking many years, and often decades. They are also subject to available implementation funding (e.g. housing subsidies). Unless the implementation of such settlement plans is already underway and funding is available for implementation, ECD response planning and support should go ahead, even if a greater emphasis is on major investments such as new builds or major extensions.
- **Formal population based planning needs to be undertaken jointly by all stakeholders for each area surveyed** to ensure the incorporation of children not yet benefitting from any ECD services. The Municipality and stakeholders should develop a strategy for 'massification'.
- **Many low capacity centres may be ineligible for state support** - A sizable number (15%) of the low capacity centres (C1, C2) (Amaoti26%, Umlazi 3%) representing a combined total of 298 children are excluded from infrastructure improvement opportunities as per the categorisation framework (vs rural 6%). The model highlights these centres for further investigation and special interventions by DSD.

12 Recommendations and policy implications

- **Greater fiscal priority for under-resourced ECD centres,** both in respect of infrastructure and operating costs (DSD subsidies). Most children currently do not benefit. Their families cannot afford to pay enough for centres to provide acceptable care. There is simply not enough funding available for ECD.
- **NDSD to finalise the new gold-silver-bronze registration guidelines**, which confer important and necessary registration flexibility.
- **DSD to ensure effective utilisation of the ECD conditional maintenance grant** during its two-year pilot phase, especially at Provincial and District level where implementation occurs and including better co-ordination with municipal IDPs.
- **National Treasury to consider flexibility in existing municipal infrastructure grants** (MIG, ICDG/USDG) so Municipalities can fund ECD infrastructure and planning and play a more proactive role, noting that ECD is a concurrent function and largely an unfunded mandate and that the DSD's conditional infrastructure grant currently has limited budget.
- **ECD surveys are required in all municipalities** in order to determine the status and category of all ECD centres and to provide the data necessary for effective, population-based ECD planning. Funding for this is required. Ideally this should be provincially-driven to enable consolidated data-bases.
- **ECD centre improvement planning & delivery support** is necessary (provincial/local level) to develop 'viable and bankable' ECD project pipelines. Efficient provincial delivery models are needed. Leveraging the capacity ECD support organisations will be beneficial.
- **Structured DSD-Municipal collaboration** (e.g. via MOAs) in order to clarify intra-governmental responsibilities and ECD infrastructure funding streams. This must include Metros who have large, concentrated, underserviced populations.
- **Include ECD in informal settlements as a priority within the national upgrading agenda** of all spheres of government. ECD in an important part of upgrading and Cities such as eThekwini are moving to include ECD as part of their upgrading programmes.

PART 2: IMPLEMENTATION OF MODEL, SPECIFIC FINDINGS AND REFERENCES

13 Implementation of model with key findings

13.1 Stakeholder engagement and buy-in

WORK UNDERTAKEN

Given the nature of the Action, it was vital to secure participation and buy-in from the key stakeholders - the eThekwini Municipality and the Department of Social Development. Some of the most valuable learning derived from the Action, pertains to stakeholders' understanding of their respective roles, functions and funding mandates. The process of securing political buy-in from eThekwini proved significantly slower than anticipated, but also yielded valuable learning and helped lay a stronger platform for embedding ECD firmly within City policies and programmes.

Given the extent of the stakeholder engagement which occurred, and the associated wide range of issues and complexities, a dedicated report is provided in **Annexure D.**

The roles of key stakeholders (excluding the project team) and the key issues which emerged can be summarised as follow:

Stakeholder	Role – intended and actual	Key issues and comments
eThekwini Health Dept.	The initial intention was that this would be the lead department for the initiative within the City (over and above its normal regulatory role in ECD). It retracted from playing this role early in 2016 due to perceived risk and lack of mandate. It did however participate in Project Steering Committee up until March 2016.	• The Dept. was initially supportive but did not follow-through effectively. • There is a lack of a clear institutional home for ECD in eThekwini. • Pre-election dynamics created some tension within the municipality • Strained relations between Departmental Head and oversight Committee. • Absence of Municipal ECD policy (from a developmental as opposed to regulatory perspective).
eThekwini Human Settlements Dept.	Supports ECD as a key element of informal settlement upgrading. Participated in the Project Steering Committee.	• The Dept. is supportive • Committee approval was delayed due to elections and induction of new councillors; some caution over introducing a new programme (funding, roles) and human resource constraints
eThekwini Engineering Services Dept.	Supports ECD infrastructure pilots from a strategic budget allocation point of view. Participated in the Project Steering Committee.	• The Dept. is supportive.
KZN Dept. Social Development District/Service Offices.	Participated in the Project Steering Committee Assisted in developing methods and tools.	• The District and service offices are supportive. • Social Workers Understand the need for flexibility w.r.t partial care registration

	Assessed pilot ECD Centres Embarked on registration of unregistered centres & work closely with the EHPs in this regard	• Challenge over how to support highly constrained centres with limited potential (lack of DSD mandate). • Tendency to focus on existing ECD project delivery/priorities.
KZN Dept. Social Development Provincial Office.	Engage with feedback from pilot sites (one meeting held). The expected policy, funding and IGR engagement with eThekwini did not occur.	• Dept. supportive only in principle with very limited direct participation. • Some communication difficulties. • Still adjusting to implementation of new ECD 'massification' policy and to the new approach.
National Dept. Social Development	PPT engaged with NDSD from project inception. As the project unfolded, there was significant and productive interaction.	• NDSD supportive of PPT ECD Model. • Significant PPT input into DSD conditional infrastructure grant and new flexible registration framework made.
Support NGOs (outside of project team) Ilifa Labantwana NAG LIMA	Planned for in policy engagement plan (March 2016). Ilifa Labantwana played a significant supportive role especially in respect of national and provincial DSD policy feedback. Network Action Group and LIMA also played supportive roles (e.g. in respect of categorisation and infrastructure planning respectively).	• Peer NGO collaboration is important. • A strong collaboration between support NGOs has been established and can be potentially leveraged going forward.

Table 5: Stakeholder roles and responsibilities

LEARNING AND KEY FINDINGS

- **There is a high level of consensus** amongst key stakeholders in various respects:
  - ECD is clearly recognised as a priority by all key stakeholders.
  - PPT's ECD support model in all of its key facets is likewise supported.
  - There is consensus over the importance of addressing ECD in informal settlements and recognition that it is currently substantially neglected.
  - There is consensus in respect of the need for flexibility in respect of norms and standards pertaining to ECD.
- **eThekwini prefers to move forward programmatically** with ECD and is reticent to commence with pilot projects before addressing key issues (e.g. funding mandates and roles and responsibilities of the Municipality versus the DSD).
- There is currently **no institutional home for ECD support in municipalities** such as eThekwini (over and above the regulatory function played by EHPs).
- **The eThekwini Municipality has not yet compiled an ECD policy or strategy** although they recognise that ECD is a key issue (e.g. in their draft Social Development strategy). It is noted that other Metros (e.g. Cape Town and Johannesburg) already have some strategies in place.
- **Municipalities (including Metros who are regarded as key stakeholders) are not being adequately engaged by DSD (provincial or national) on new ECD policy**. The main engagement is with the provincial spheres of government e.g. provincial DSDs and COGTA. Such engagement would need to involve officials of similar seniority from both sides.
- **There is no MOA or similar arrangement which defines municipal versus DSD roles.**

- There is an **unclear and overlapping ECD mandate between Municipalities and DSD** (ECD is a shared function and unfunded mandate).
- **It is difficult to secure and retain high-level stakeholder representation in a PSC** (e.g. by officials at a senior, decision-making level). This constrains the effectiveness of a PSC.

13.2 Desktop study

WORK UNDERTAKEN

PPT consulted various documents for the desktop study, namely statistics from Stats SA, Wazimap, the National ECD Audit report 2014, eThekwini Informal Settlement data and the PPT field survey. The total population of the three wards amounted to 116,833 and the number of households to 32 791 according to the 2011 Census of which translates in a household size of 5.9 people. Of the 116 833 people in these three wards, 16 343 were children aged 0 – 5 years old. **PPT did not survey entire wards. The survey only explored the informal settlements closest to the Dense Urban Integration Zone as well as a few centres lying directly adjacent to the informal settlements as these centres service the informal settlement community.**

Ethekwini estimated the number of households within the informal settlement areas at 15 801 households.[36] The Census 2011 based Wazimap[37] indicates an average of 0,5 children aged 0-5 years per household which amounts to 7 901 children in the informal settlements and 48% of the children in the three wards[38]. Of the 7 901 children aged 0 to 5 in Informal Settlements 2 542 (32%) are attending the 42 ECD centres surveyed by PPT. The National Audit (2014) however only surveyed 11 centres with 971 children (5,9% of the total number of children,16 343, aged 0-5 years) in the greater Amaoti. PPT surveying only a portion of each ward, found 2.5x more centres and children than the National ECD Audit[39] which emphasises the need and value of an area based approach. The same finding was made with the area based survey in 5 rural municipalities of Vulamehlo (now Umdoni), Umzumbe, Umvoti, Msinga and Nqutu, which suggests that National DSD may be working on grossly understated figures if using the National ECD Audit statistics as baseline.

When looking at the children's living conditions the following was found:

- Approximately two fifths of the centres have women as head of the households.
- Almost a third of the population has matric and higher and almost a third is employed.
- Households are generally poor. The average monthly / annual income is low and is the same across all three wards - i.e. R1200 per month or R14 600 per annum.
- The majority of households have water, electricity and refuse disposal services but less than half (45%) of the households had access to acceptable toilets.

More detailed information can be obtained from the Survey Report (**Annexure E**).

[36] eThekwini internal document: Informal Settlement Project List
[37] Available online at: https://wazimap-ecd.code4sa.org/profiles/ward-59500053-ethekwini-ward-53-59500053/
[38] PPT did not extrapolate the Census figures which means that the figures may be conservative.
[39] Audit of Early Childhood Development (ECD) Centres: National Report: Date 31 July 2014

LEARNING AND KEY FINDINGS

- **The number of ECD centres in Amaoti is grossly understated in the National ECD Audit of 2014.** They found 11 centres with 971 children in the whole of the area while the PPT's survey covering only a portion of the three wards in Amaoti identified 42 centres with 2 542 children. The same trend is found in most of the 5 rural municipalities surveyed.
- **The vast majority (68%) of the children 0-5 years old in these informal settlements are not attending ECD centres.** However, the number of children attending child minding services is unknown

13.3 Field survey of ECD centres

Note: Please refer to section 6.7 for the processes followed for deciding the study area boundary.

WORK UNDERTAKEN

a) Pre-identification of ECD Centres (existing, new, unknown centres, registered or unregistered)

PPT consulted the following people / entities / resources prior to the fieldwork with regard to the compilation of a preliminary list of ECD Centres:

- National Audit: Database of Early Childhood Development (ECD) Centres, KwaZulu Natal Province, 30 September 2014.
- EThekwini Municipality: Environmental Health Practitioners
- Department of Social Development (DSD): Social Workers /ECD Coordinators at the eThekwini District Office.
- 'Training and Resources in Early Education (TREE) – project partner

An initial list comprising 52 ECD sites was drafted. Upon closer scrutiny it was found that 20 Centres fell outside the target area. Initial attempts made to identify more and previously unknown ECD sites with the assistance of Municipal EHPs were unsuccessful. PPT decided not to involve the local ECD Forum due to the political involvement of some of its members and the possibility of creating expectations that may have been fuelled by the then upcoming elections. PPT's field workers eventually had to revert to walking the area by foot which yielded better results. Field workers covered the area by car and by foot and surveyed all centres found to be in the target area. Ten (10) new sites were identified and 42 centres were eventually surveyed.

b) The survey tool

PPT made use of handheld Android Tablets with a customised, locally developed and supported "Kandu" software which is 'cloud' based. The Kandu DMP tool provided an Excel database as its primary data output. Centre profiles are automatically available online along with an aerial map showing the locality of all centres surveyed and with the facility to zoom in on particular centres to examine their micro-locality in aerial view.

c) Recruitment and training of field workers

PPT made use of its own staff - a survey manager and 2 graduate interns and a contracted graduate field worker. eThekwini EHP were included in the fieldwork for the purpose of skills transfer. It also gave eThekwini Municipality the opportunity to experience the value of the survey method first hand. A fieldworker training manual was compiled. Fieldworker training also ensured that the survey team are familiar with the Android survey device; key ethical research principles; and the need for data accuracy

and objectivity. Nine EHPs attended the training sessions. Training and briefing sessions were held in November and December 2015.

d) Structuring of the survey team

PPT's survey team comprised of a survey manager and three field workers that were linked with Municipal EHPs in an effort to get the municipality involved and excited about the advantages of sites surveys using tablets. EHPs assisted the field workers in locating the centres and introducing them. This arrangement proved not to be ideal as EHPs still have to attend to their normal duties. Although the survey manager interacted with field workers on a daily basis, the presence of an on-site team leader would have been beneficial.

e) Survey

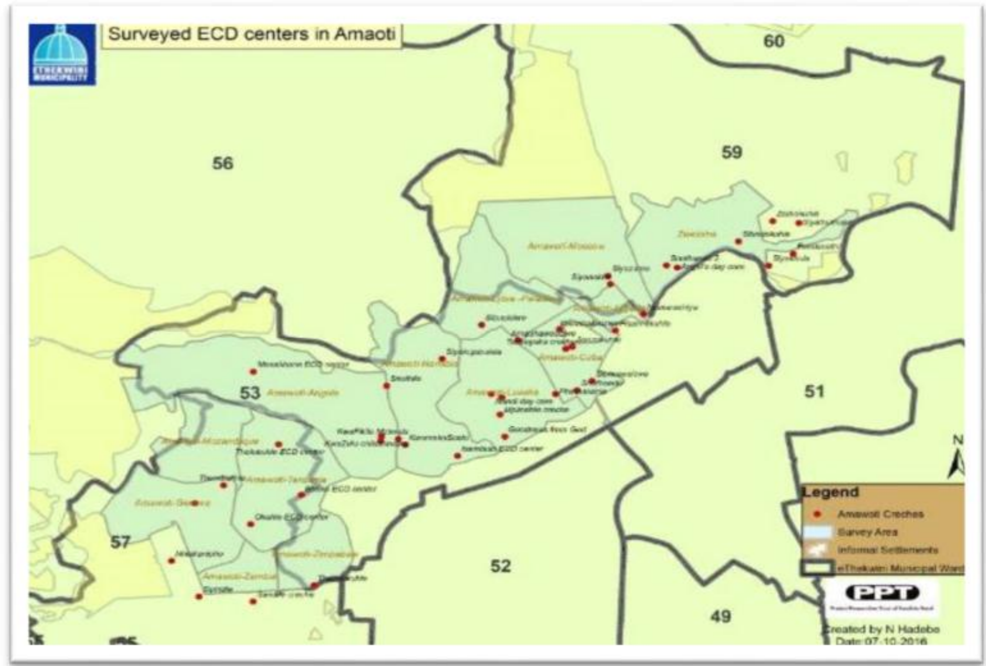
PPT conducted a quantitative survey of child care centres and aimed to include all centres with more than 6 children. The Amaoti survey areas included the following informal settlements: Angola, Cuba, Libya, Lusaka, Mozambique, Namibia, Nigeria, Ohlange, Tanzania, Thabo Plaza, White City, Zimbabwe, and Zwelisha.

Respondents:

Owners (28.6%), principals (28.6%) of ECD sites accounted for more than half of the respondents, while 33.3% and supervisors (9.5%) of the remaining respondents were child-care practitioners. A data limitation was identified in terms of the ability of practitioners and supervisors to respond to some questions (e.g. ownership, registration). Telephonic follow ups had to be done with owners / principals where possible. This did not adversely affect the research findings.

Number of field surveys done

The survey commenced on 10 November 2015 and was interrupted yearend holidays. Most ECD centres closed early December (4th- 11th) and reopened between the 5th and 12th of January 2016. The survey resumed and was completed by the end of January 2016. A total of 42 centres were surveyed. Refer to **Annexure E** for a copy of the **Amaoti Survey Report.** The centres are indicated on the map below



Map 3: Centres surveyed

Geographical spread

More than half (55%) of the 42 centers were located in Ward 53, with almost a quarter (24%) in Ward 59 and 21% of the centres in ward 57 or immediately adjacent. The centres surveyed were spread across 14 sub-areas or suburbs. The highest number of centres per suburb (6 or 7) were found in Cuba, Lusaka and Zwelisha.

Children

In total, 2,542 children (730 babies and 1812 toddlers) were attending the 42 ECD centres surveyed in Amaoti. The number of children per centre ranged from 6 to 255 children, with an average of 61 children per centre. There are only a few centres (14,3%) with less than 20 children. Two thirds of centres (66,7%) had between 21 and 80 children, with five centres having over 100 children (of which only one had over 200 children).

Principals and practitioners

There were 42 principals, of which 10 had no schooling, and 126 practitioners of which 77 (76.2%) reported to have some ECD training. 46% of the ECD centres had adequate number of caregivers, while 10 (23,8%) of the ECD centres had no trained practitioners.

f) Survey analysis and report

The survey data was made available in various predetermined formats by the Kandu tool – e.g. in Excel, CSV, Word or PDF formats.

PPT initially utilised the data in Excel format to analyse the data and produce tables and graphs for illustration purposes. UKZN's senior researcher Ms Heidi Attwood offered to assist with the running of data on SPSS to assist with statistical analysis which was very useful especially for frequency tables, cross tabulation and creating multi mention tables. A detailed survey report was compiled (Refer to **Annexure E)**

g) Data collection

Most of the data collected was derived from survey participants and were not independently verified (e.g. NPO registration, DSD subsidy support, practitioner qualifications etc.).

Some of the data, e.g. pertaining to land ownership and tenure, was not easily understood participants and may reflect perception more than reality (e.g. land in informal settlements may be perceived to belong to the ECD centre when in fact the underlying land belongs to the Metro

Other data (e.g. pertaining to infrastructure) was based on observations of the survey teams. It should also be noted that the survey was not undertaken by ECD specialists such as social workers or environmental health practitioners.

Data was checked by PPT using Excel to identify any missing information. Information gaps were addressed primarily through telephonic follow-ups. It should be noted that PPT did not verify data except for DSD registration status.

Data and limitations: The survey data provides a broad picture of current ECD sites but cannot be utilised for decision making (e.g. whether full or conditional registration) and resource allocation (e.g. infrastructural improvements) without follow-up work and assessments.

Data storage, synthesis and analysis: All data is kept in electronic format in PPT's offices.[40] After an initial data cleaning process by PPT using Excel, the data was converted into SPSS for further analysis by UKZN. The data was checked by UKZN 's senior research for internal consistency. Initial quantitative description and analysis of survey data was done by UKZN, with additional analysis by PPT.

h) Sharing of data

PPT compiled and presented centre profiles to stakeholders as a way of communicating what was found in a more visual and practical manner.

PPT shared the database with the DSD and other stakeholders on request. The large size of database requires a high level of skill to utilise. It was found that some stakeholders are not skilled enough to engage efficiently with the database.

PPT continue to filter data for various purposes and interventions upon request - e.g. to determine the need for first aid kits, first aid training, fire extinguishers or the need for outdoor equipment, fencing, nutrition, training for management committees, etc. Important information can be extracted for various calculations e.g. to determine practitioner / child ratios or indoor and / or outdoor space adequacy. PPT remains the main custodian of the database, which means that the data is not adequately accessible. Going forward, it would be ideal if a more accessible, central database could be developed (e.g. in the format of Wazimap)

LEARNING AND KEY FINDINGS

a) General findings and processes followed

i. Identification of ECD Centres

- **ECD Centres in informal settlements are not actively being identified- hence the limited information available on ECD Centres in informal settlements.** Neither DSD nor the Municipal EHPS have time or the resources to undertake regular walks through huge informal settlement areas to identify ECD Centres. DSD attends to ECD centres which take the initiative to register. However, most of the centres know that they will not meet the norms and standards and seem to be reluctant to take the chance of being closed down if they do not meet the requirements. EHPs may stumble upon and inspect some ECD centres in informal settlements, but they do not seem too keen to follow-up as they indicate that many centres are 'here today and nowhere to be found tomorrow' due to the fluid circumstances in informal settlements. This would be particularly true of home based centres attending to limited numbers of children.
- **Lack of a co-ordinated and proactive approach for identifying and registering ECD Centres.** EHPs will refer unregistered centres to DSD for registration if they come across these centres. DSD will wait for centres to approach them. EHPs will in turn wait for DSD to request an inspection.
- **Identification of ECD centres is resource intensive and time consuming:** All centres with more than 6 children are required to register as partial care facilities. There are difficulties in distinguishing between child minding and ECD Centres (e.g. a woman may have 3 of her own

[40] All data is stored in a safe and confidential place (electronic files on PPT's server to which only staff have access and hard files in the office of the relevant Project Manager). PPT retains all data and records for a minimum period of 5 years after the end of the Project, but usually retains such data and records permanently, disposing only of information such as draft documents and background information.

children while looking after 6 other children). This means that some interviews are required before determining a centre for survey.

- **The best way to identify ECD centres in informal settlements might be to employ different methods**
  - Obtain a list of all known ECD Centres (registered and unregistered) from the DSD, EHPs and ECD Training Service providers in the area
  - Consult the national Audit list
  - Obtain a list of member centres from local ECD Forums
  - Request a list of centres from each Ward committee
  - Request a list of centres known to the ward based community health care workers.
  - Use local "scouts" familiar with the area to identify all centres caring for more than 6 children in the area. This would be cheaper than to use field workers to attend to both the scouting and the interviews.

ii. Survey questionnaire

- **Wide consultation resulted in a lengthy survey questionnaire which took longer to complete and it necessitated more training.** Both DSD and EHP inspection forms were used as basis for the questionnaire. All stakeholders e.g. DSD, eThekwini Environmental Health Practitioners, TREE, NAG, UKZN and Ilifa Labantwana were consulted during compilation of the survey. There are pros and cons to this approach. Pros - consultation ensures that all parties take ownership of the questionnaire and since surveys are expensive, it affords stakeholders the opportunity to get some valuable information which can be used for planning purposes (health and safety issues, training, nutrition, infrastructure etc.) The questionnaire can sufficiently be used to obtain a clear picture of all types of centres surveyed. Cons – since the stakeholders each represented different interests, they automatically wanted to see those interests emphasised which resulted in a rather lengthy questionnaire (149 questions) which required better trained and supported fieldworkers and took additional time to complete. Refer to **Annexure E** for a hard copy of the Survey questionnaire as annexed to the Amaoti Survey Report.
- **The lack of information and the cost of surveys justify a more comprehensive survey**. If the survey is to be used as a tool to be used primarily for the assessment of infrastructure (basic services, site and building) it can be significantly reduced. If, however, one acknowledges that there is very little data available on ECD Centres in general, but more particularly in informal settlements, it is understandable that a more comprehensive survey is required

iii. Survey Tool

- **The use of new technology requires more time for real world testing**

  PPT experienced some teething problems with the Kandu tool as the survey questionnaire is quite long, and the technical requirements quite complex. New functionality was introduced for the first time and it resulted in some loss of information. Although it seemed to work well with the initial tests, PPT only discovered much later that there was a problem with an underlying formula which resulted in inaccurate GPS readings which meant that PPT had to return to the field to recollect the GPS coordinates. Some amendments also had to be made to the reporting structure. *This tool was subsequently also utilised for two other projects that PPT has undertaken in partnership with Ilifa Labantwana and the Assupol Community Trust.*

iv. Recruitment, training and safety of field workers

- **Graduate fieldworkers required more technical (ECD and infrastructure) training**

  Although PPT recruited graduates as field workers, provided training, and teamed them up with EHPs that are responsible for the inspection of ECD centres for compliance, it became clear that the

initial training was not enough and that more technical training was required both in terms of ECD and infrastructure. Follow up training sessions were scheduled. PPT also gained some valuable input and guidance from UKZN's senior researcher. At least a week's training that should include surveys, is required for this type of survey with follow up sessions based on data collected over set periods.

- **It became clear that safety is an issue especially in areas where it is not possible to travel by car.** Municipal EHPs and DSD staff insist on traveling together when entering informal settlement areas. Field workers thus worked in pairs. This was not a big problem as the field workers subdivided the work - e.g. while one is interviewing the other one is taking photographs.

v. Area based survey

- **The area based survey provided a comprehensive database with new information,** useful for variety of stakeholders. It put previously unknown and identified unregistered centres on the DSD's radar.
- **Area-based field survey provided valuable information** w.r.t the prevalence, status, needs, potentials of ECD Centres, and spatial spread of centres.
- **The survey and mapping of these centres provided a clear picture of the number of children attending centres and the distribution of ECD Centres** which are essential for population based planning. David Harrison stated that "*The starting point in planning for service delivery should be to assess the numbers and educational needs of all the young children in a defined geographical area; and the aim should be to achieve universal coverage of all eligible children, starting with the poorest municipal wards in each province. In response, programmes should be developed to ensure that the necessary human, physical and financial resources are in place to support and monitor implementation.*"[41]

vi. Data collection

- **The use of numeric codes would have worked better for Excel data analysis** for all close ended questions.
- **The need for follow-ups emphasised the challenges of owners / principals often not present at ECD Centres**. Ideally contact details should be collected upon a separate site identification process to enable fieldworkers to make appointments with principals. (this is also not a full proof option as principals may still not keep appointments, their phone numbers may change, etc.) The need for follow ups also highlighted the need for additional technical training on ECD and infrastructure.
- **The use of a computerised statistical analysis programme proved to be much more time and cost efficient** than using Microsoft Excel- especially for running cross tables. Excel still proved useful for calculations and provided better quality graphs. It can also handle more complicated graphs.
- The availability of **a data specialist with SPSS experience proved to be valuable**.
- **Providing a huge database to stakeholders did not prove to be useful** - the database information should be provided in the form of short/ manageable reports. Officials are often not sufficiently proficient in Excel to interrogate the database on their own. It is recommended that agreement must also be reached on the most useful reports and it should be clear upfront what purpose each report will serve, what should be covered in the report and who will be using the data. These reports must be printable on an A4 format.
- **The database should be made centrally available to all stakeholders in a user friendly way e.g. similar to Wazimap** which should be centrally managed - e.g. adding of new / changed information.

---

[41] David Harrison, Chief Executive Officer, DG Murray Trust: "The state of provision of early childhood development services in South Africa"

vii. **Sharing of data**

- One of the most effective ways of sharing the data on infrastructure related matters was by compiling and presenting profiles of the centres surveyed.
- The data collected should be centrally accessible by stakeholders in a user friendly way or else it will be of no real use

b) Findings on ECD Centres in Informal settlements of Amaoti and Umlazi (a parallel project)

Differences in findings between the two informal settlements are highlighted and where applicable reference is also made to findings in 5 rural municipalities using the same questionnaire to highlight differences in findings between informal and rural ECD centres. Overall figures are also provided to highlight overall trends.

- **"The current system only sees children in registered ECD facilities"**[42]**. 75% of the informal settlement centres in Amaoti and Umlazi were not registered** *(vs 36% rural, 42% overall)*
- **Most centres (85%) and children do not benefit from DSD ECD subsidies** (since many un-registered centres don't get subsidies) *(vs 60% rural, 54% overall)*
- **More than half of the children in these two Informal Settlements are in under-resourced, unregistered centres** - 51% and 2,002 children in the informal settlements centres *(vs 25% and 3,862 rural, 30% and 5,864 overall).*
- **A large number of ECD Centers were not known by government (DSD or Municipality) – 31% and 25 centres in the informal settlements** (vs rural 33% and 33% and 113 centres overall). The centres in the informal settlements are now in the process of registration.
- **Most centres are NPO registered (63%)** *(vs rural 78% and overall 75% NPO).*
- **The responsibility for the establishment/ provision of ECD Centres has for decades been taken up by individuals or community based organizations as there was no or very limited assistance from government and the private sector.** Very few (7%) of the ECD centres in informal settlements are making use of Government, school or the Municipal buildings in Amaoti (4 centres) and Umlazi (1 centre)
- **Most centres are long-standing, dedicated ECD sites.** More than half the centres (56%) in the informal settlements were dedicated ECD centres (64% Amaoti vs 46% Umlazi) *(vs rural 69%, overall 67%)*
- **Almost half the centres (48%) in informal settlements have been operational for > 10 years and 22% for between 5 and 10 years.** *(vs rural 48% >10yrs, 20% >5rs, overall trend, 48% >10yrs and 20% >5yrs).*
- **Most centres surveyed are relatively small -** The average size was 48. Centres at Amaoti were atypical in being significantly larger (average of 60 children) *(vs rural average of 36, overall average of 38 children*—significantly less than the national median of 53 for fully registered centres).
- **There are significant deficiencies in ECD practitioner skills and capacity** - 23 % of principals and 38% of practitioners had no ECD training (*vs 28% and 48% rural and 27% and 46% overall)*
- **Most centres operate in formal buildings (78%) (***vs 87% rural, 86% overall)*
- **Infrastructure deficiencies pose the most significant barrier to centre improvement and registration.** Most centres 84% (98% Amaoti, 69% Umlazi) require infrastructure improvements due to various deficiencies in services, building, accommodation or site. *(vs 91% rural, 90% overall)* Deficiencies in adequate accommodation (54%) scored highest in informal settlements while basic services (81%) scored highest in rural areas
- **Low-income levels are a key constraint: Most parents in Amaoti (93%) can only afford to pay between R50 and R150 per child per month.** This places the centres under extreme financial pressure.

[42] David Harrison, Chief Executive Officer, DG Murray Trust: " The state of provision of early childhood development services in South Africa"[42]

Even if the DSD ECD grant is provided, funding is still insufficient to meet bylaw requirements e.g. more toilets, fencing, extension to buildings, etc. Fee levels were slightly **higher at Umlazi where most parents (56%) were paying R151 to R250. (***vs 69% paying R0 – R50 in rural areas*). Dave Harrison explained*: "At present, the poorest communities get locked into a vicious cycle of exclusion. They don't have the finances to improve their buildings, so they can't meet infrastructural standards for registration. Most of the fees paid by parents are then spent on food for the children. That means less money for teachers and fewer teaching materials, and little chance of meeting the quality standards for learning that are required for registration. It's a domino-effect that significantly limits a poor child's prospects of early education."*

- **General observation: Most centres do their best and many have potential.** Despite their limited resources, most centres show commitment under difficult circumstances and have potential to improve, provided they receive greater support. Government should recognise the work the community has begun and join them in their efforts to provide ECD services of an acceptable standard.

Ownership issues[43]

- **Most centres are NPO registered (63%) of which 23% are privately owned ECD centres** (*vs rural 78% NPO, 8% privately owned and overall 75% NPO, 10% privately owned) –* It is suspected that the NPOs in "private ownership" will turn out to be a much bigger problem than shown in figures as it is clear that both owners and Social Workers do not understand the implications of registering a private centre as an NPO. The registration of private centres as NPOs should be stopped as it causes much confusion for all parties
- **Most centres are privately owned/managed -** (60%) Amaoti, 86% & Umlazi, 33%. *(vs 19% rural, 25% overall)* – which can be a constraint for state investment. Such centres will in all probability only be able to be assisted with basic services (e.g. water, sanitation, storm water management, fencing and outdoor equipment)
- **Land ownership issues are complicated -** most sites (69%) in Informal Settlements are deemed to be "privately owned" usually by mere fact that the site has been occupied for a long time and / or improved by the "owner". Yet the underlying land belongs to the Municipality. This situation may change with the formalisation of Amaoti as the land can then be registered in the NPOs name. *(Privately owned site in rural areas, 26%, overall 33*%)

13.4 Categorisation Framework

Significant refinements to the categorisation framework were made with inputs from key stakeholders including the KZN DSD, eThekwini Municipality, and other ECD support organisations such as Ilifa Labantwana and Network Action Group.

In respect of the evolution of the framework, key issues and main refinements were made as follows:

- Overall, the key categories, elements and logic of the categorisation framework have been retained, though significant refinements have been achieved.
- Function and potential have been retained as the key defining elements of categorisation. The initial design in this regard was sound.
- Based on stakeholder feedback, there was a shift away from a separate, alternative standard of less formal ECD care (as envisaged in the original funding proposal) towards flexibility within the existing

[43] Shown separately as it is a major factor determining investment potential

registration framework. This has had implications for the categorisation framework as well as other aspects of the ECD model.

- Greater consistency in respect of the key descriptive parameters for categorisation has been established.
- A three-way scoring matrix base has been introduced which aligns with the most critical descriptive parameters (capacity and governance; health and safety; ECD programme).
- Registration does not necessarily correlate with categories, for example some centres with high function and potential (e.g. A and B1) may not be registered whilst others with constrained function and potential (e.g. B2 and C1) may often have achieved registration as a partial care facility.
- Programme registration has been introduced as a descriptive parameter.
- The C3 category (already noted as being unviable for support in the original funding proposal) has been removed and effectively become category C2. C1 and C2 as initially envisaged have been collapsed into C1 given that there was not enough difference between these initial categories and no functional advantage in retaining them.
- Hence the overall framework has been simplified so that there are five categories instead of 6 - and only two categories of C (C1 and C2).

CATEGORY A: Well-functioning, high potential and already providing 'acceptable ECD services':

1) Good governance and capacity.
2) Structured and acceptable ECD programmes.
3) No significant health or safety threats – any infrastructural deficiencies can be easily mitigated and typically are the main barrier to registration (where it is not already in place).
4) Often registered[44] or else registerable as a partial care facility (sometimes with flexibility) easily and quickly (typically well within a year[45]).
5) Often have DSD-registered ECD programme or can achieve this quickly (well within a year).
6) Thus viable for investment and support (e.g. to address minor infrastructure deficits, extend buildings to cater for more children).
   [Small proportion of centres in underserviced, low income communities are expected to fall into this category.] [May or may not receive ECD operational grants; May or may not be NPO registered].

CATEGORY B1: Basic-functioning with good potential to provide 'acceptable ECD services':

1) Basic governance and capacity with potential to improve (with support).
2) Basic ECD programmes with potential to improve (with support).
3) Infrastructural, health and safety problems (often present) can easily be mitigated - any infrastructural deficiencies can be easily mitigated and typically are the main barrier to registration (where it is not already in place).
4) Quite often registered or else registerable as a partial care facility (usually with flexibility) relatively easily and quickly (typically within 2 years).
5) May have DSD-registered ECD programme or can achieve this relatively quickly (within 2 years).
6) Thus viable for investment and support (e.g. to address minor infrastructure deficits, extend buildings to cater for more children, training).
   [Significant proportion of centres in underserviced, low income communities are expected to fall into this category.] [May or may not receive ECD operational grants; May or may not be NPO registered].

[44] Full or conditional registration
[45] Main reason this might take more than a few months would be where there has been infrastructural damage e.g. roof blown off.

CATEGORY B2: Low-functioning with moderate potential to eventually provide 'acceptable ECD services':

1) Weak governance and capacity with potential to improve over time (with support)
2) Weak ECD programmes with potential to improve over time (with support)
3) Infrastructural, health and safety problems (typically present) can be mitigated.
4) Usually unregistered but can be registerable as a partial care facility (usually with flexibility) over time and with support (typically 5 years).
5) May have DSD-registered ECD programme or can achieve this over time and with support (within 5 years).
6) Thus viable for investment and support (e.g. to address infrastructure deficits, training).
[Significant proportion of centres in underserviced, low income communities are expected to fall into this category.] [May or may not be NPO registered].

CATEGORY C1: Low-functioning with limited/no potential to provide 'acceptable ECD services' (basic childminding only):

1) Weak or no governance and capacity with limited/no potential to improve over time.
2) No ECD programmes with limited/no potential/interest to improve over time – basic childminding function only.
3) Infrastructural, health and safety problems (often present) can be mitigated with support/investment.
4) Usually unregistered and not registerable as a partial care facility – *though some of these centres may have received registration:*
5) Usually will not have a DSD-registered ECD programme and not viable to attain this.
6) Thus viable for limited investment and support (e.g. to address imminent health and safety threats) especially where there are no other accessible and affordable alternatives for children.
[Significant proportion of centres in underserviced, low income communities are expected to fall into this category.] [Typically will not be NPO registered].

CATEGORY C2: High risk and dysfunctional - need to be rapidly closed-down (no potential/ hazardous)

1) Weak or no governance and capacity with no potential to improve over time.
2) No ECD programmes with no potential/interest to improve over time – at best, basic childminding function only.
3) Significant health and safety threats (often arising from infrastructural deficiencies) which cannot be mitigated with support/investment.
4) Usually unregistered and not registerable as a partial care facility – *these centres will seldom if ever have received registration*.
5) Usually no DSD-registered ECD programme and not viable to attain this.
6) Thus should be closed down (even if there are no other alternatives for children though all efforts should be made to find alternatives for children) and are not viable for investment and support.
[A relatively small proportion of centres in underserviced, low income communities are expected to fall into this category. Typically, will not be NPO registered].

13.5 Categorisation of ECD centres

WORK UNDERTAKEN

The purpose of the categorisation is to provide a preliminary categorisation of all surveyed centres for purposes of broad population-based planning and to assist with ECD response planning at area-level (e.g. capacity building, programme support, infrastructure investment). Categorisation utilises the survey data

collected. The categorisation provides a useful overall picture of the status of ECD centres within a particular locality and gives a good predictor in respect of:

- The level of functionality
- The level of capacity
- The potential a centre is likely to have, to be able to provide acceptable ECD services or improve to the point where it can do so (i.e. registration with flexibility).

It is a very useful tool for population based planning and for prioritising centres for infrastructure investment and other support.

The categorisation (and related survey data) is not sufficient to enable detailed planning, costing and decision-making at centre-level. Additional assessments (infrastructure and operational) would be required by professionals with suitable qualifications and experience.

PPT developed a base document as part of the parallel project undertaken in conjunction with Ilifa Labantwana called the "ECD Categorisation Framework and Programmatic Response Model" in September 2015. All eThekwini PSC stakeholders made inputs in the development of this framework. (Refer to **Annexure N.**)

However, **the categorisation framework still had to be unpacked, developed and refined during the categorisation process**. The key areas to be targeted, the marker questions and the weighting assigned to the individual questions and the key areas were all developed during this process.

The three key areas that were identified in close consultation with key stakeholders are: a) Capacity and Governance, b) Programme and c) Health and Safety and can be summarised as follows

Capacity and governance (25 questions with combined weighting of 40%)	**Programme (11 questions with combined weighting of 25%)**	**Health and Safety (16 questions with combined weighting of 35%)**
▪ Governance committee, minutes ▪ Parent consultation ▪ Constitution ▪ Financial admin ▪ Principal education & training ▪ Practitioner adequacy ▪ Administrative records ▪ Policies	▪ ECD programme registration ▪ Daily programme ▪ Educational equipment / toys ▪ Book corner ▪ Art equipment ▪ Outdoor play area / equipment	▪ Gross space ▪ Health and safety issues (sharp objects, unfenced water, exposed to electrical wires, etc.) ▪ Fencing ▪ Cross ventilation ▪ Dedicated food preparation area ▪ Unsafe building (e.g. collapsing walls / roof) ▪ First aid training ▪ Enough and acceptable toilets ▪ Refuse removal

Table 6: Summary of marker questions for categorisation.

The individual marker questions and associated weighting assigned to individual questions are as follow:

Capacity and Governance: Survey questions/parameters	Survey question vs. Calc.	sub category	Questions	% total assess score	Notes on scoring
Is there a **Committee** for the facility? (Y/N/under establishment)	Survey	institutional	7	10,0%	Yes= 1, No- 0
If so ,are there **minutes** available?(Y/N/ do not know)	Survey	institutional			Yes= 1, No- 0
How many times in the last year did the staff and a group of **parents meet** to discuss the crèche? Add number or do not know	Survey	institutional			4=1,3-0.75,2 0.5, 1=0.25, 0=0
Does the Centre have a **constitution** (Y/N)	Survey	institutional			Yes= 1, No- 0
Are there documented annual **financial statements** in place: (Y/N / do not know)	Survey	institutional			Yes= 1, No- 0
Highest owner/manager/**supervisor qualification:** tick one: no school education, passed grade 7, passed 10, passed grade 12, obtained a diploma or degree / do not know	Survey	Capacity			Degree= 1, .075= matric, Grade 10 = 0.5, grade 7 = 0.25,and no education = 0
What is the highest owner/manager/supervisor formal ECD **qualification** obtained by the principal, supervisor or owner? tick :None, NQF Level 1, 2, 3, 4, 5, higher, other (evidenced by Certificate) do not know	Survey	Capacity			0.2 points per nqf level up to max nqf5 = max 1 point
Gross practitioner adequacy ratio (calculated from survey) incl. owner	calculated	gross practitioner ratio	1	15,0%	RATIO: 100%+ = 1; 75%-99% = 0.75, 50%-74% = 0.5, 25%-49% = 0.25, less = 0) (required baby ratio 1:6, non-baby ratio 1:20) required ratio for each centre calculated based on relative number of babies vs non babies
Trained practitioner adequacy ratio (calcualted from survey) incl owner	calculated	skilled practitioner ratio	1	5,0%	RATIO - as above except for those who have ECD training
Enrolment admission forms for their children (Y/N/ do not know)	Survey	records	10	7,50%	Yes= 1, No- 0
Staff job descriptions	Survey	records			Yes= 1, No- 0
Staff attendance registers for (Y/N/ do not know)	Survey	records			Yes= 1, No- 0
Children's attendance registers (Y/N / do not know)	Survey	records			Yes= 1, No- 0
Receipt book (Y/N/ do not know)	Survey	records			Yes= 1, No- 0
Visitors book	Survey	records			Yes= 1, No- 0
Accident / incident register for children (Y/N/ do not know)	Survey	records			Yes= 1, No- 0
Road to Health Register(Y/N/ do not know)	Survey	records			Yes= 1, No- 0
Medication registers for children (Y/N / do not know)	Survey	records			Yes= 1, No- 0
Fees register (Y/N/ do not know)	Survey	records			Yes= 1, No- 0
Does the ECD centre have **policies** for: Tick all applicable: health, admission, HIV/AIDS, child abuse, finances, complaints procedures? Do not know	Survey	policies	6	2,5%	4+ out of 6 listed policies = 1; 3=.75. 2=0.5, 1=0.25, 0 = 0
		C&G weighting	**25**	**40,0%**	

Programme: Survey questions/parameters	**Survey question vs Calc.**	**Sub category**	**Questions in group**	**% total assess score**	**Notes on scoring**
Is the **ECD Programme registered** with the DSD?(*evidenced by Form 17*) (Y/N/underway / do not know)	Survey	program	11	25,0%	Yes= 1, No- 0
Is there a d**aily programme on the wall** that is usually folled every day ? (Yes on wall, Yes but not on wall, /No)	Survey	program			Yes_on_wall=1; Yes_but_not_on_wall= 0.5; No = 0
Is there a **book corner**?(Y/N)	Survey	program			Yes= 1, No- 0
Are there **educational puzzles** or toys (e.g. blocks, jigsaws, balls, shape sorter) for children (Y/N)	Survey	program			Yes= 1, No- 0
Is there **drawing/painting equipment** (Y/N)	Survey	program			Yes= 1, No- 0
Are Children's **work displayed**?(Y/N)	Survey	program			Yes= 1, No- 0
Are there **learning posters** on the walls (e.g. 1,2,3; ABC etc) (yes many, Yes some, Hardly any, None)	Survey	program			Yes_many = 1, Yes some= .75 ; hardly any= .5 ; None = 0
Are there separate **'spaces'** or playrooms assigned for children of different age groups participating in different programmes? (Y/N)	Survey	program			Yes= 1, No- 0
Is there an **outdoor play area**? Y/N	Survey	program			Yes= 1, No- 0
Outdoor **play space adequacy** ratio	Survey	program			>=2sqm score 1, 1sqm=0.5, less score 0. Norm is 2sqm per child
Outdoor play equipment score	Calculated	program			Yes= 1, No- 0
		PROG weighting	**11**	**25,0%**	

Health, Safety / Infrastructure Survey questions/parameters	**Survey question vs Calc.**	**sub category**	**ques-tions in group**	**% total assess score**	**Notes on scoring**
Gross internal space adequacy for children (total space relative to what is required)	calculated	space	1	5,0%	<2m2 = 0 and > 2m2 = 1
Are there any obvious **health and safety threats**: tick one or more: open trenches, exposed electrical wires, sharp objects, unfenced water body, buildings that may collapse, exposed refuse/ landfill, exposure to railway line, exposure busy road, exposure to shebeen/ or other drug abuses, unsafe pit latrines, exposure to cooking area, exposed water containers, other- specify, none	Survey	safety	1	5,0%	none = 1 , threats = 0
Is the **property fenced? (**Y/ N vs partially)	Survey	safety	14	25,0%	Yes= 1, No- 0 ; Partially , 0
Are medicines , detergents and harmful substances stored in lockable cupboard, and **kept out of reach** of children: (Y/N)	Survey	safety			Yes= 1, No- 0
Toilet adequacy ratio (including adult toilets)	calculated	hygiene			Combined number for children & Adults / 20. Less than 1: 20 = 1 and rest fractions
Are there **hand wash facilities**?	Survey	hygiene			None = 0 & all others 1

Is there more than one **external door**?	calculated	safety			1= 0, >1 = 1
How many of the staff at the ECD centre have **formal first aid training?** : Add number / do not know	Survey	safety			Yes= 1, No- 0
Is there a dedicated space used only for **food preparation**? (Y/N)	Survey	safety			Yes= 1, No- 0
Are the **problems with walls** y/n	calculated	safety			none = 1 , threats = 0
Are there **problems with the roof**? y/n.	calculated	safety			none = 1 , threats = 0
Cross ventilation (Y / N)	Survey	safety			Yes= 1, No- 0
Is there a separate space for a **sick bay** (Y/N)	Survey	safety			Yes= 1, No- 0
Does the ECD Centre have **water**? (Y/N)	Survey	safety			Yes= 1, No- 0
Safe/acceptable **toilets**	Survey	safety			Only flush/VIP / chemical - not pottie/bucket/pit
Is there **refuse disposal?**	Survey	safety			0 for no refuse - rest = 1
		H&S weighting	**16**	**35,0%**	
		Total		**100,0 %**	

Table 7:Marker questions & weighting

The percentages assigned to each key area are as follow

Categories	Marker questions	Weighting
Capacity & Governance	25	40%
Programme	11	25%
Health & Safety (incl infrastructure)	16	35%
TOTAL	52	100%

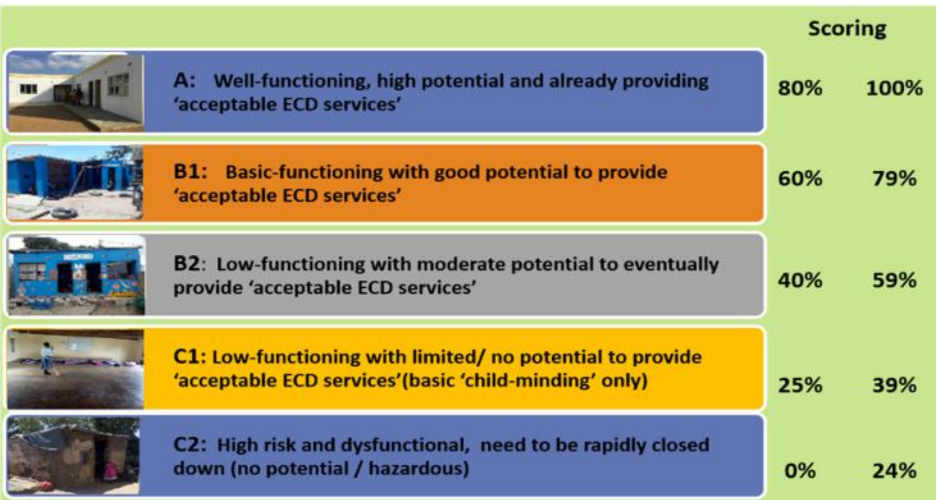
Table 8: Percentages assigned to categories

Categories and scoring ranges

There are five categories (Refer to *Part 2: Section 13.4*). The scoring ranges indicated in *section 14* of the Categorisation Framework[46] followed the scoring ranges as indicated at that stage for the DSD's proposed gold silver bronze registration levels. The scoring ranges were however amended and are as follow:

[46] ECD Categorisation Framework and Programmatic Response Model" developed by PPT, September 2015 in collaboration with Ilifa Labantwana

Categories and scoring ranges



Category	Scoring	
A: Well-functioning, high potential and already providing 'acceptable ECD services'	80%	100%
B1: Basic-functioning with good potential to provide 'acceptable ECD services'	60%	79%
B2: Low-functioning with moderate potential to eventually provide 'acceptable ECD services'	40%	59%
C1: Low-functioning with limited/ no potential to provide 'acceptable ECD services'(basic 'child-minding' only)	25%	39%
C2: High risk and dysfunctional, need to be rapidly closed down (no potential / hazardous)	0%	24%

Table 9: Categories and scoring ranges

Categorisation results

The results of the categorisation applied to the **Amaoti ECD Centres** surveyed are as follows

Categorisation scoring ranges			No. of centres	Results: Percentage
A	80%	100%	3	7,1%
B1	60%	79%	17	40,5%
B2	40%	59%	11	26,2%
C1	25%	39%	10	23,8%
C2	0%	24%	1	2,4%
			42	**100,0%**

Table 10 Categorisation Results Amaoti

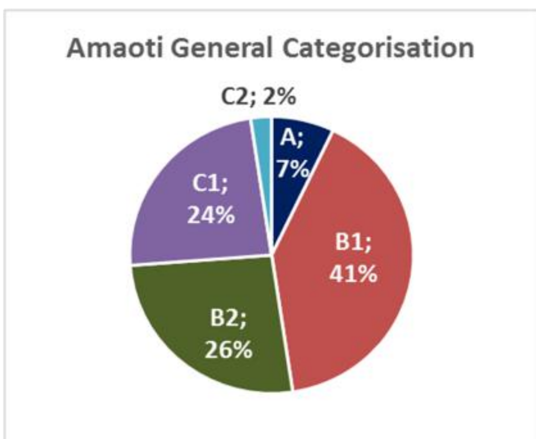


Figure 3: Categorisation Results Amaoti

The majority of centres are falling in category B1 to C1.

The Amaoti categorisation scores differs from that of the Umlazi ECD Centres where most of them are falling within Categories A and B1. The Umlazi scores are as follows: Category **A** -15, 39%; **B1**- 19, 48%; **B2** - 4,10%; **C1** -1,3%; and **C2** – 0,0%). This is directly linked to the fact that the informal settlements in Umlazi are distributed among the formally developed areas, which means that most of the centres for children in informal settlements are found on the edge of formal townships and therefore in a better condition than in Amaoti. The Amaoti results are more in line with the results for rural centres.

The combined results for the two eThekwini informal settlement areas, 5 rural municipalities and the overall results (all included) are summarised below

Categorisation scoring ranges			Informal settlement areas	Rural	Overall Total	%age
A	80%	100%	18	69	87	16,9%
B1	60%	79%	36	227	263	51,0%
B2	40%	59%	15	112	127	24,6%
C1	25%	39%	11	26	37	7,2%
C2	0%	24%	1	1	2	0,4%
			81	**435**	**516**	**100,0%**

Table 11: Combined categorisation: informal settlements vs rural vs overall scores

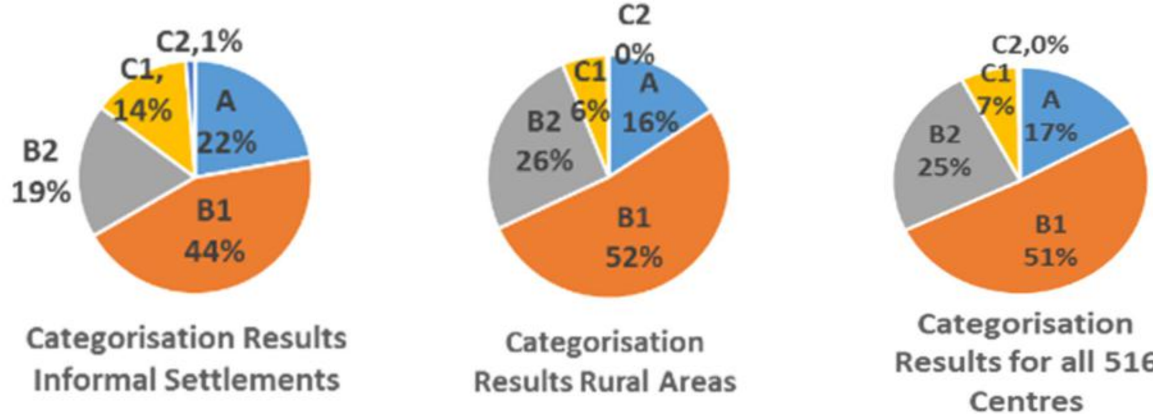


Figure 4: Categorisation results for informal settlements, rural areas and overall results

- The combined results for informal settlements (22%) is "skewed" by the inclusion of Umlazi results Umlazi ECDs obtained significantly higher scores than Amaoti as explained above. 17% of the 516 centres fall within Category A.
- More than half of centres falls within the B1 category which means that these centres are basic functioning with good potential to provide acceptable ECD Centres with support of centres. Although it was expected that a significant proportion of centres would fall within this category it was not expected that more than half the centres would fall in this category. Support and investment will be appropriate. This result suggests possible opportunities for expansion in areas of high demand and where capacity and other resources permit.
- Almost a quarter falls under category B2 in the rural and for all 516 centres while there are only a few centres falling within the C1 category and almost none in the C2 category.

The category is not always an indication of the condition of the infrastructure

The model initially assumed a fairly direct relation between the category of the centre and the infrastructure one is likely to find. This is however not always the case. A big structurally sound building (though in need of repairs) may be totally empty and devoid of any learning activities as illustrated in the pictures below while a centres with a poor building may render good services

Photo 1 Example of big structurally sound building

Photo 2: No educational programme, equipment

Photo 3:Informal corrugated iron structure

Photo 4: Evidence of educational programme & equipment

So for purposes of investment, only the scores for capacity and governance and programme are used to determine the "potential" of the centre. The first centre on the list below is a good example of how a fairly good centre can be housed in poor facilities.

Centre overview						General categorisation					Potential (indicative)
Facility_Name	NPO	DSD Reg	Years of operation	Building Type	No. of Children	Capacity %age score	Programme %age score	Health & Safety %age score	Categorisation weighted % age score	General Categorisation	Potential calc &age
Amaqhawesizwe Creche and Pre-School	Yes	Unregistered	9	Formal	34	84,8%	65,9%	39,3%	**64,1%**	**B1**	78%
Angels Day Care Centre	No	Unregistered	7	Informal	25	47,6%	25,0%	25,0%	**34,1%**	**C1**	39%
Bheka ECD centre	Yes	Full_registration	20	Formal	87	75,0%	88,6%	65,7%	**75,2%**	**B1**	80%
Fisani Okuhle Creche and Pre-School	Yes	Full_registration	16	Formal	193	91,3%	90,9%	67,9%	**83,0%**	**A**	91%
Goodness from God	Yes	Unregistered	5	Formal	47	58,6%	38,6%	34,3%	**45,1%**	**B2**	51%
Mpilonhle Creche	No	Unregistered	26	Informal	40	37,5%	6,8%	22,9%	**24,7%**	**C2**	26%

Table 12: General categorisation scores & calculation of potential

Other scoring frameworks using survey data

Marker questions were also developed to provide a score for infrastructure adequacy and investment potential:

- Infrastructure adequacy: The health, safety and infrastructure score is merely indicative of the state of infrastructure. A further breakdown to indicate where the main problems are found without having to run through the whole database was required. Marker questions were again identified with specific weights assigned to each. Four main categories were identified namely a) basic services; b) building structure; c) accommodation and; d) site conditions. This framework is used to provide an indication as to where the deficiencies are and the percentage score indicates the level of adequacy/ deficiency. If any of the two scores for basic services (water, toilets and hand wash facilities) and building structure (formal vs informal, type of building materials, roof materials, wall and roof problems cross ventilation, etc.) scored equal or below 60%, it would register infrastructure deficiency. This score was used during shortlisting fully registered centres with infrastructure deficiencies. However, the scoring cannot be utilised as a final decision making tool for detailed planning, costing or decision making

- Investment potential: Investment potential is based on the scoring of the following seven factor:
  a) General categorisation,
  b) NPO registration,
  c) DSD registration (full or conditional),
  d) Who owns / is in charge of the centre (NPO, CBO/ FBO, private person),
  e) Who owns the underlying land (Private individual, ECD centre, school; church; municipality; traditional authority; government department; etc.)
  f) Secure tenure (title deed, lease, PTO, etc.),
  g) Years operational.

  An average score indicates the investment potential. This score is indicative and can be utilised to prioritise centres, but cannot be used as a final decision making tool.

Categorisation Correlation

A detailed categorisation correlation assessment was undertaken Refer to summary on following page. Overall there was a good correlation between the categorisation determinations made using the survey data and the actual status and potentials of surveyed centres. This means that, on the whole, the categorisation framework is a good predictor of ECD functioning and potentials and is therefore an effective tool for population based ECD planning, including gaging existing local ECD capacity at area-level and shortlisting centres for ECD support. For registered centres, the correlation was particularly high. Score for investment potential and health and safety mitigation were lower than expected in certain categories (especially B2) mainly to informal settlement constraints such as centre and land ownership, tenure, NPO registration. It is also noted that some centres with high function and potential (e.g. A and B1) were not be registered whilst others with constrained function and potential (e.g. B2) had achieved registration as a partial care facility. DSD seems to be registering centres with limited infrastructural problems despite a relatively low level of capacity and poor ECD programme.

Overall the average correlation for all categories is either high or acceptable. The framework is therefore regarded as functional and fit for purpose as a general categorisation and preliminary filtering tool. The correlation for separate markers is also acceptable: two high scores, four adequate, and only one marginal

(health and safety). The main deviation was with respect to health and safety mitigation potential and viability for support in certain categories. Reasons for this are outlined below. To strengthen the correlation for separate markers (in each category) would require different marker questions and weightings in different categories. This would significantly complicate the categorisation method and make it costlier and time-consuming to implement. This is not regarded as necessary given that Categorisation is utilised as a general predictor and method of 'shortlisting' and determining overall area-level ECD status quo and capacity. In any event, individual centres must be subjected to site visits and further assessments before response plans are formulated.

Categorisation Correlation Assessment: Amaoti ECDs

Note: Correlation scores 80% and more are regarded as indicative of a high correlation, 60%-79% as adequate, 40%-59% as marginal, below 40% as poor.

COMBINED CATEGORISATION CORRELATION SCORES

	Number of centres	Capacity & Governance	ECD Programme Pot.	H&S mitigation	PCF reg. potential	Progr. Reg potential	Viability for support	Subtotal
gross correlation scores>	**42**	**30**	**38**	**24**	**37**	**33**	**26**	**186**
%age correlation scores>		**70%**	**89%**	**56%**	**87%**	**79%**	**62%**	**74%**

Comments:

Overall the average correlation for all categories is either high or acceptable. The framework is therefore regarded as functional and fit for purpose as a general categorisation and preliminary filtering tool. The correlation for separate markers is also acceptable: two high scores, four adequate, and only one marginal (health and safety). The main deviation is was respect of health and safety mitigation potential and viability for support in certain categories. Reasons for this are outlined below. To strengthen the correlation for separate markers would require different marker questions and weightings in different categories which could significantly complicate the method and make it more costly and time-consuming to implement. In any event, individual centres must be subjected to site visits and further assessments before response plans are formulated.

CATEGORY A: Well-functioning, high potential and already providing 'acceptable ECD services':

correlation scoring protocol>		*>80%=1; 60%-79%=0.5; <60%=0*			*Pot>80%=1; >60%=.5; >60% = 0*		*IP>60% or selected pilot*	
	Number of centres	**Good gov & capacity**	**Acceptable ECD pogr.**	**No sign. H&S threats**	**PCF reg or reg'able**	**Progr reg. achievable 1yr**	**Viable 4 invest. / support**	**sub total**
gross correlation scores>	**3**	3,0	3,0	2,5	3,0	2,5	3,0	17,0
%age correlation scores>		100%	100%	83%	100%	83%	100%	**94%**

Comments

None. High correlation for all parameters.

CATEGORY B1: Basic-functioning with good potential to provide ‘acceptable ECD services’:

correlation scoring protocol>		*>80%=1; 60%-79%=0.5; <60%=0*		*If selected as a pilot=1*	*Pot>80%=1; >60%=.5; >60% = 0*		*IP>60% or selected pilot*	
	Number of centres	**Basic G&C - potential**	**Basic ECD progr - pot**	**H&S prob. Mitigatble**	**PCF Reg or reg'able**	**Progr reg. - achievable 2yr**	**Viable invest. Supp.**	**Sub total**
gross correlation scores>	**17**	10,0	14,5	12,5	12,5	11,5	11,0	72
%age correlation scores>		59%	85%	74%	74%	68%	65%	**71%**

Comments

1) Aggregate correlation score is acceptable at 71%.

2) The correlation in Capacity & Governance within the category is only at a marginal level since most of the centres received scores of between 60-79% which resulted in them being given a grade of 0,5 and achieved 57% (score of 0). The categorisation scoring questions and weighting should be reviewed before further rollout to determine which aspect caused the deflection in scoring (e.g. was it due to gross practitioer ratios vs record keeping vs general institutional capacity)

3) The correlation in regards to viability for investment is though acceptable should be further reviewed and possibly refined in respect of marker questions or weightings.

CATEGORY B2: Low-functioning with moderate potential to eventually provide ‘acceptable ECD services’:

correlation scoring protocol>		*>80%=0.5; 40%-79%(or if selected as pilot)=1; <40%=0*			*Reg=0.5; regable 1, unregable= 0 (eg low C&G)*	*Pr & C&G both >50%=1, both>40%= 0.5, otherwise 0*	IP>60% or selected pilot=1; >40%=0.5, oth 0	
	Number of centres	**Weak gov & cap - pot**	**Weak ECD progr - pot**	**H&S prob. Mitigatble**	**Unreg but reg'able with supp**	**Progr reg. - achievable 5yr**	**Viable invest. Supp.**	**sub total**
gross correlation scores>	**11**	10,0	9,0	4,5	10,0	8,0	3,0	44,5
%age correlation scores>		91%	82%	41%	91%	73%	27%	**67%**

Comments

1) Aggregate correlation score is acceptable at 67%.

2) The lowest correlation score is that of viability for investment. This is due to centres with relatively low scores nonetheless being selected by government for support. Centres were scored based on their selection by the DSD/eThekwini as pilots or otherwise based on them receiving an Investment Potential score of above 60%. Only three of the centres werre selected. Many of the centres within this category did not meet the required score and thus have created a low correlation because of their Investment Potential.

3) The category has a low correlation in regards to Health & Safety as a result of them having low scores in their individual H&S scores - however it is evident that H&S challenges can often be mitigated (evidenced by DSD selection).

CATEGORY C1: Low-functioning with limited/no potential to provide 'acceptable ECD services' (basic childminding only):

correlation scoring protocol>		*>80%=0; 40-59%=0.5; <40%=0*		*H&S<40% & IP>40=1; H&S40-59 &IP>40 = 0.5, otherwise 0*	*Unreg & unregable= 1; registered or in progress =0*	*no reg pr & unregable = 1; pot <40%*	*H&S<40% & C&G>25% & IA>25% = 1. H&S>40 & ditto C&G & IA =0.5, oth 0*	
	Number of centres	**Weak/no gov & cap - no pot**	**No ECD progr - no pot**	**H&S prob. Mitigatble**	**Unreg or not reg'able**	**No progr reg. - not achievable**	**Viable for LIMITED support**	
gross correlation scores>	**10**	6,0	10,0	3,0	10,0	10,0	8,5	48
%age correlation scores>		60%	100%	30%	100%	100%	85%	**79%**

Comments

1) Aggregate correlation score is acceptable at 79%.

2) Under this category centres were given score of (*H&S<40% & IP>40=1; H&S40-59 &IP>40 = 0.5, otherwise 0*) for Health & safety. Most centres received 0 as their scores because of them receiving low Infrastructure potential scores. It is evident that a low H&S score is not a good predictor of 'mitigatibility'.

3) Most centres received an intermediate grade for Capacity & Governance as a result of them scoring low when being categorised. This has resulted in a score just above average in the correlation of the C1 category.

CATEGORY C2: High risk and dysfunctional - need to be rapidly closed-down (no potential/ hazardous)

correlation scoring protocol>		*>50%=0; 25-49%=0.5; <25%=1*			*Unreg & unregable= 1; registered or in progress =0*	*no reg pr & unregable = 1; pot <40%*	*C&G<25% & Pot<25% = 1. if 25-40% =0.5, oth 0*	
	Number of centres	**Weak/no gov & cap - no pot**	**No ECD progr - no pot**	**H&S prob. - not mitigatble**	**Unreg or not reg'able**	**No progr reg. - not achievable**	**Not viable for any support**	**0**
gross correlation scores>	**1**	0,5	1,0	1,0	1,0	1,0	0,5	5
%age correlation scores>		50%	100%	100%	100%	100%	50%	**83%**

Comments

None. High aggregate correlation. Only governance potential was a weak correlation - indicates that the C&G of some of these weak centres is better than one would expect. The sample size is however very small - only

LEARNING AND KEY FINDINGS

- **Categorisation provides a useful basis for prioritising centres for registration and investment.** It is imperative to concentrate on higher capacity centres / quick wins e.g. Category A & B1 and preferably those with the most children - i.e. where the impact will be greatest.
- **The Categorisation Framework is effective.** Overall there was good correlation between the categorisation determinations made using the survey data and the actual status and potentials of surveyed centres. It was shown to be a good predictor of ECD functioning and potential. It is an effective tool for population based ECD planning, including gauging existing local ECD capacity at area-level, shortlisting centres for ECD support and determining local ECD capacity and potential.
- **Categorisation can be used to help determine investment risk for government by using a number of marker questions.**
- **Categorisation enables DSD as well as training and resource organisations to identify low functioning ECD Centres that can be clustered for collective support** i.e. a B2 and C1 centres will take longer and require specific interventions by DSD to get the centre to render good quality services.
- **Two thirds (66%) of the centres were found to be either well-functioning (A category - 22%) or basic functioning with good potential to render good services, if provided necessary support and infrastructure improvement (B1 category – 44%). (***vs rural - 16% Cat A well-functioning and 52 % Cat B1 basic functioning with good potential vs overall trend almost the same - 17% cat A well-functioning and 51% Cat B1 basic functioning with good potential*) The higher score in informal settlements may be due to the fact that centres in informal settlements may be closer to the city's training facilities and donors which can account for better equipped centres. The higher score (19%) for C1 facilities in the informal settlements (vs rural 6% and overall 7%) may be due to more informal facilities and thus related infrastructure health and safety issues.
- **There is not always a correlation between the category and the condition of infrastructure**. While most category A and B1 centres generally have better facilities, it cannot be made a hard and fast rule as centres may be well equipped, practitioners may be trained and may follow a good programme but the centre may struggle with water, lack of sanitation or the roof may have blown off. The opposite is also true, some centres are structurally sound, provide adequate space and facilities but the place may be run by someone with no education or may follow no educational programme.
- **The additional frameworks for determining infrastructure adequacy and investment potential are indicative** and can be utilised for prioritisation of projects but cannot be utilised for detailed planning, costing, resource allocation or final decision making.
- **The categorization is a fairly intensive excel exercise and requires appropriate expertise.** A more use-friendly tool will have to be developed in order to roll out the method at scale.

13.6 Selection of pilot centres

WORK UNDERTAKEN

Shortlisting of ECD Centres for infrastructure & operational /capacity assessment was done in two phases.

- Computer based filtering of centres using the database on criteria agreed with stakeholders
- More subjective selection by stakeholders based on the need and drawing on stakeholders' knowledge and experience of the area.

While the main focus of the selection of pilot projects was the identification of unregistered ECD Centres, it was eventually agreed that if would be unfair to only assist unregistered centres with infrastructure improvements as many centres with conditional and / or full registration also experience infrastructure problems which they are unable to attend to. Not including them could be regarded as these centres being penalised for registering. The selection of sites was thus done in three categories: a) unregistered centres in sub categories A, B1 and B2; b) conditionally registered centres (no further criteria applied) and c) fully registered centres.

a) Phase 1: computer based filtering of survey data

The database was filtered according to the criteria agreed to by stakeholders

1) **Unregistered ECD Centres (main focus)**
    a. Categorisation (A, B1, or B2)
    b. Potential (Percentage score of 50%⁺ for capacity and programme)
    c. Partial care registration (unregistered
    d. Number of children (minimum of 20+ children)
    e. Years operational (minimum of 5+ years)

2) **Conditionally registered ECD centres**

    It was initially agreed that conditionally registered centres would be filtered out without taking into account any of the other criteria due to the fact that eThekwini District Office of the Department of Social Development had to identify, assess and cost ECD Centres with conditional registration to qualify for the ECD Infrastructure Maintenance Grant[47] announced in terms of the new ECD Policy approved in December 2015 and to be implemented in April 2017.

    There were however no conditionally registered centres in Amaoti or Umlazi.

3) **Fully registered ECD Centres**
    a. Without DSD operational subsidies and a minimum of 20 ⁺ children
    b. With DSD operational subsidies, with a minimum of 20 ⁺ children and infrastructure problems[48]

It was noted that infrastructure deficiencies cannot always be directly linked to a specific category

A total of 36 centres were shortlisted (23 ECD centres for Amaoti and 13 for Umlazi)

[47] The purpose of this Maintenance Grant is to 1) To expand **subsidy** to poor children in existing ECD Centres 2) To improve **conditionally registered facilities** to meet basic requirements in order to become fully registered. The Department of Social Development followed a specific process as highlighted by Mr Timla at the eThekwini ECD Stakeholder Workshop on 27 January 2017 to plan, identify, assess, and cost 1,053 conditionally approved centres to the National Department of Social Development for approval in August 2016. The final business plan has been submitted on 10 February 2017. The next National Planning Meetings are scheduled for 13 – 14 February and 9 – 10 March 2017.

[48] **Infrastructure problems** – Basic services (water, sanitation, etc.) and building issues (e.g. formal/ informal buildings, problems with walls, roof, floor, etc.

Group	Amaoti (23)	Umlazi (13)	Total	%
Unregistered				
Category A	**1**	**2**	**3**	**8%**
Category B1	**7**	**7**	**14**	**39%**
Category B2	**5**	**0**	**5**	**14%**
Conditionally registered	**0**	**0**	**0**	
Fully registered				
No DSD subsidy	**4**	**3**	**7**	**19%**
With DSD subsidy	**6**	**1**	**7**	**19%**

Table 13:Breakdown of initial computer site selection results for Amaoti and Umlazi

The centres were profiled to demonstrate visually the difference between the various categories.

b) Phase 2: More subjective selection of the pilot sites by stakeholders

Since stakeholders had no or very little prior knowledge of these centres and since the sample was really small, it was decided to first undertake technical assessments at all 23 sites in Amaoti and 13 in Umlazi with the DSD to gain more detailed knowledge of these centres before pilot sites would be prioritised. The effects of the withdrawal of Environmental Health Services impacted on the work as their input would have been very helpful. Assessments for only 22 sites were done in Amaoti as one of the centres was temporarily moved to other premises for improvements to be done at their centre. Only 10 were assessed in Umlazi as 3 of the centres were forced to close due to non-support by government and non / poor payment by parents.

Stakeholders were presented with centre profiles and pictures and were then requested to assist with the selection of pilot sites.

The selection was highly influenced by eThekwini's indication that they would not be able to finance centres carrying too much risk that may result in fruitless expenditure. Municipalities have to comply with stipulations of the Municipal Finance Management Act and the specific fund criteria and stipulations. The DSD has similar stipulations[49] that states that "provinces must ensure that centres that are chosen for assistance of this grant are rationalised in respect of location, propensity for success and good governance". This automatically excludes the weaker and therefore more vulnerable centres. The project was thus not able to test one centre from each of categories as originally planned.

Six sites were selected for each of the informal settlement areas taking into account further criteria such as the number of children, NPO registration, Centre ownership, land ownership and issues, etc. The selection was done mainly by DSD in the absence of the EHP representative. PPT later added another two sites for Amaoti using the same criteria when it became apparent that more centres could be assisted with the available funding. Refer to **Annexure I** for a summary and improvement plans of the 8 centres[50] selected. A total of 14 sites were thus submitted to Council for consideration.

PPT identified 2 centres from Amaoti that were not NPO or partial care registered and would therefore not qualify for state support as they are privately owned and require minor repairs and /or extensions as well as basic services PPT applied for donor funding to see if donors would have an appetite to assist private centres in informal settlement areas.

[49] Guidelines for implementation of the ECD Conditional Grant: ECD Maintenance Grant Component "(Draft 1)

[50] PPT identified 3 sites for emergency interventions to Human Settlements and Environmental Health Services (via email)

LEARNING AND KEY FINDINGS

- **A fair and transparent site selection system is required to ensure accountability and good and sensible service delivery.** It is imperative that the criteria be agreed to and understood by all parties. The first round of selection is done by filtering the database according to the set criteria e.g. category A, B1 or B2 with a minimum of 20 children and 5 years operational. The next round of selection is done from the shortlisted centres by stakeholders.
- **Though there were no conditionally registered centres found in Amaoti** and Umlazi, PPT learned on the parallel Ilifa Labantwana project that the decision not to filter conditionally registered centres for the other criteria, may not have been the best as quite a few conditionally registered centres showed far less potential and capacity than unregistered centres. It is thus recommended that the criteria for unregistered centres also be applied to conditionally registered centres as it is unfair to give priority to weaker conditionally registered centres than to unregistered centres with better potential. Conditionally registered centres are already part of the DSD system and can thus qualify for the DSD Conditional Maintenance Grant. This arrangement thus disadvantaged unregistered centres. It is recommended that the same criteria be applied to conditionally registered centres as for unregistered centres but with the added criteria as to whether or not it receives DSD subsidies.
- **Centre selection criteria for state funding excludes a large number of centres from state support.**
- **Even though the DSD visited centres which were previously unknown, they tended to stick to the centres they knew** and found it difficult to be led by the results of the survey and their visits to these centres when eventually selecting pilot sites.
- **The DSD was sensitive about equity among wards** and this also influenced the selection Process.
- **The selection of pilot centres from the shortlisted sites however proved to be challenging** as the application of criteria involved more discussions and it was found that stakeholders tend to revert to “old” selection patterns - e.g. to stick to the familiar centres they know and to ensure that centres are selected from each ward.
- **The selection of centres for funding can easily become politicised** and care must be taken that this process remains unbiased, fair and transparent. Enough time should be allowed for the actual selection process

13.7 Flexibility necessary for registration and infrastructure

WORK UNDERTAKEN

Consensus over a flexible approach:

Consensus was obtained for a flexible approach as per the following extract from the base documents developed in 2015 on Categorisation (**Annexures N)** and Norms and Standards **(Annexure P)** for Ilifa Labantwana.

“It is accepted that there are non-negotiable minimum norms and standards (e.g. there must be clean drinking and handwashing water at a centre; there should be adult supervision at all times; etc.). However, it is also accepted that there needs to be some flexibility in the application / assessment of the minimum requirements as set out in the Children’s Act and municipal bylaws especially by environmental health practitioners in particular with regard to rural and informal settlement areas.”

The need for flexibility is already well accepted within the relevant legislation as well as government's policy and strategies:

- Such flexibility is already provided for in the Children's Act as summarised in the Children's Act Guide for ECD practitioners.[51]
- This acceptance of the need for appropriate flexibility is echoed in the National ECD Policy (**Annexure D**-"Strategies to Improve Registration and Access to Funding for ECD Centres and Programmes")[52] which included the identification of specific issues and proposed policy changes including in respect of norms and standards which it indicated were being too rigidly applied. Amongst other things, it suggests that: "Standards of environmental health in informal settlements and rural areas must be amended so as to be less onerous, whilst continuing to ensure minimum safety standards. This has been done in some municipalities with good effect".
- This need for greater flexibility is also reflected the gold, silver and bronze standards for ECD which are being considered by the NDSD (as per the SA Integrated Programme of Action for ECD Moving Ahead 2013-2016). For each of these standards, varying levels of compliance will apply as well as different timeframes to achieve full registration.

It was accepted that certain minimum standards are applicable to all centres. It was also recognised that underserviced and disadvantaged rural or informal settlement areas may not be able to meet the full requirements specified, without government support. Municipalities are required to follow a more proactive and supportive developmental approach that will allow unregistered ECD Centres to "grow" toward compliance. Support may include infrastructural improvements, programme improvements, practitioner training etc."

Consensus over types of PCF registration flexibility:

Substantial consensus was obtained over specific types of flexibility which are appropriate and necessary for partial care registration:

- Waiving the requirement for municipal approved building plans for existing centres in informal settlements as these typically do not exist nor can they be readily acquired.
- Waiving the formal zoning requirement for centres in informal settlements where there is no proclaimed township.
- Accepting traditional and less-formal building methods (where these are otherwise safe and functional).
- Permitting containerised water instead of running water.
- Waiving unaffordable and often impractical requirements e.g. for double sinks, hot water supply, a separate hand basin in kitchens (especially in informal settlement, peri urban and rural areas).
- Permitting alternatives to hand-basins such as 'tippy-taps' or water containers where there is no piped water supply.
- Permitting 1 potty for every 5 toddlers instead of one potty each.
- Permitting acceptable on-site sanitation provided there is a reasonable toilet to child ratio (e.g. current 1:20) and possibly factoring in potties as toilets (e.g. for children under three years).
- Permitting open-trench on-site refuse disposal in informal settlements, peri-urban or rural areas provided such areas are inaccessible to children.
- Permitting short-term on-site refuse storage in black bags in a fenced off area whilst waiting for refuse collection

[51]Children's Act Guide for Early Childhood Development Practitioners November 2011.Lizette Berry, Lucy Jamieson and Mary James Children's Institute, University of Cape Town and Little Elephant Training Centre for Early Education (LETCEE)

[52] National Integrated Early Childhood Development Policy 2015 Limited distribution edition - Approved by Cabinet on 9 December 2015.

- Permitting no 'cooling facility' in rural and informal settlements where there may not be any electricity supply or connections.
- Accepting slightly higher practitioner-child ratios (only for 3 - 5year olds) where there are no other alternatives.
- Accepting that children of different age groups may share space (only for 3-5year olds).
- Accepting slightly reduced floor area per child where there are no other alternatives.
- Accepting a reduced amount of outdoor play space - such centres may solve this problem by different groups playing outside at different times.
- Accepting that a registered ECD programme may not yet be in place but that the centre is working towards achieving this.
- Accepting that not all ECD practitioners will have minimum training (i.e. level 1 certificates) but that the practitioners are willing to work towards achieving this.

Consensus over infrastructural flexibility:
Substantial consensus was obtained in respect of the closely related issue of infrastructural flexibility for extensions and new builds: Some of these flexibilities are already outlined in the preceding section. They are also outlined in more detail in *section 13.8* below and **Annexure P.**

DSD's flexible gold-silver-bronze registration framework:
This new framework was first mooted during 2015 and taken further in late 2016 by DSD (including a national workshop in September 2016 in which PPT participated). The process of consultation with Provinces is complete, but final feedback from the National Department of Human Settlements and Environmental Health are still awaited. The framework is significant because it creates space for unregistered with potential to enter the system as bronze level centres, only having to fulfil very basic requirements, and with a prescribed timeframe for them to improve (e.g. by stepping up to silver level).

13.8 Minimum infrastructure norms (flexibility)

WORK UNDERTAKEN

PPT assessed minimum infrastructure norms for infrastructure improvements (minor improvements as well as new-builds and extensions) taking into consideration the Children's Act and National ECD Policy as well as the prevailing status quo within informal settlements.

New builds and extensions:
PPT assessed the current DSD spatial norms for ECD buildings and infrastructure and found that it was not attainable and suitable for ECD centres operating in informal settlements and other underserviced, low income communities because it would be unaffordable for centres to improve to these standards and to maintain them given their highly constrained operational income. It is noted that there is limited state and donor funding for new builds. Funding for these will have to be optimised (i.e. new builds should only be built where they are necessary and, preferably, where they can also serve as hubs which support surrounding under-resourced ECD centres).

The DSD norms and standards provide for 7,5m^2 per child or up to 450m^2 for a centre of 60 children. At state-build specifications (per square meter cost of approximately R7 000), an ECD facility for 60 children would cost in the order of R3,15 million. Even at a modest construction cost of R4,000 per square meter, such a new build would cost in the order of R1,8 million. The current norms and standards cannot be

applied to centres owned and operated by NPOs and typically funded utilising limited funding from municipal infrastructure and donor sources. It is unaffordable for the fiscus to support an ECD 'massification' programme where these norms are to be applied to improvements to existing centres, extensions and new builds.

Municipal ECD bylaws, such as those of eThekwini, typically set standards for infrastructure provisions that are unattainable in informal settlements or rural areas (e.g. double sink and hot water - heat regulated).

Standard, simple modular designs were prepared for four different size new builds catering for 40, 60, 80 and 100 children via PPT's concurrent Ilifa Labantwana ECD project. These will also be utilised for the Amaoti project.

A standard, steel frame structure for new builds is proposed to ensure structural integrity, especially for foundations and roofs. The designs also aim to make optimum use of materials. The materials used must to a large degree be obtainable from the local hardware or building supply stores for maintenance purposes. Standard raft foundations suitable for H2 soil conditions are utilised to limit problems for maintenance as well as cracking walls. The design creates a strong roof which cannot easily be blown off or otherwise damaged. The design will also enable better involvement of local artisans in the construction process and allow for shorter delivery periods.

The following table provides a summary of minimum space norms for extensions and new builds:

Spaces	30 children (24+6 babies)	40 children (34+6 babies)	60 children (42 + 18 babies)	80 children (62 + 18 babies)	100 children (76+24 babies)	Comments
Nuresery for babies (0-2 years)	14	14	40	40	52	Separate nurseries to be provided - preferably with movable walls so that the size of the nurseries can be adjusted according to the number of babies Allow 2m^2 per baby (for sleep area, play, and feeding area) plus 2m^2 for nappy changing area for every 12 babies
Playroom for toddlers (3-5 years)	36	51	63	93	114	1,5m^2 per toddler
1 kitchen	12	12	16	16	16	Many centres do not have kitchens . Kitchens should be provided - once registered and subsidised they will have to prepare food for the children 12m^2 up to 40 children and 16m^2 for 60 - 100 children Prefer kitchen to be part of the main building Should have lockable walk in cupboard
1 office cum sickabay	12	12				12m^2 for under 50 children for office cum sickbay
Office separate	0	0	9	12	12	Office separate - 9m^2 for 60 children and 12m^2 from 80 to 100 children

Spaces	30 children (24+6 babies)	40 children (34+6 babies)	60 children (42 + 18 babies)	80 children (62 + 18 babies)	100 children (76+24 babies)	Comments
Sick bay separate	0	0	9	9	12	Sick bay separate ($9m^2$) between 50 and 100 children and $12m^2$ for 100 children
1 store	5	5	5	7	7	$5\ m^2$ standard (preferably as part of the main building for storage of toys and equipment) and $7m^2$ for bigger buildings
Ablution facilities part of main structure where running / piped water available on site and where water bourne sanitation systems / septic tanks are used Ablution block for 3 Plus VIP toilets No ablution block for 2 and less VIP toilets & hand wash facilities	9	9	12	15	20	1 adult toilet for each centre + 1 toilet / hand basin per 20 children Total number of children are used to determine number of toilets and hand wash facilities (including babies as number of babies vary each year - also allows for growth) Toilet for wheel chair users part of the total toilet calculation For centres requiring 3 + toilets = ablution block Allow $3m^2$ per toilet for ablution block and $4m^2$ for toilet used by wheel chair user plus $1m^2$ added space for handwash facility
Total - m^2 for a centre	**88**	**103**	**154**	**192**	**233**	

Table 14: Minimum space norms for extensions and new builds

Minor infrastructure improvements

The minimum standards outlined above for extensions and new builds are also relevant for minor infrastructure improvements. However greater flexibility may be required given the need to work within limited available ECD infrastructure budgets. This is to accommodate for the absence of approved building plans for most centres and the impediments in making large investments at centres which may not yet enjoy full tenure security (via a title deed, formal PTO or long lease).

A flexible approach to minor infrastructure improvements is therefore appropriate. Taking into account the afore-mentioned factors as well as the category of the centre (informed largely by it potential) and the number of children it provides for. Where a centre has a high potential for improvement, good tenure security, and caters for large numbers of children (or can expand to meet local demand as agreed to by the DSD), then a higher level of investment in improvements may be appropriate as opposed to smaller centres with constrained potential, where the driving imperative is to address health and safety threats.

In general, the following are some of the key infrastructural aspects which should be considered for redress when planning an infrastructure response improvement plan for ECD centres:

- Toilets
- Water - drinking and handwashing
- Fencing – especially when there are potential nearby threats.
- Damaged doors and windows
- Leaking roofs
- Jungle gyms or other basic outdoor play equipment.

In general, the extent of investment in improvements should be considered in the light of the following factors:

- Prevailing health and safety threats (the worst of these should be addressed at a minimum)
- Potential of centre
- Number of children served (current and potential to expand subject to DSD agreement)
- Tenure security
- Quality of existing building
- Centre ownership.

LEARNING AND KEY FINDINGS

- Defining minimum norms allows for much-needed flexibility and puts existing centres in a better position to meet registration requirements.
- It is however much easier to define a set of minimum norms for new builds compared to minor improvements.
- There is substantial stakeholder buy-in (including government) in respect of the need for flexibility in minimum infrastructure norms.
- Simple, standard designs, using minimum norms, for new- builds and extensions and major renovations / upgrades are a viable design solution. They also enable centres to make use of good quality materials (SABS approved). The use of skilled and experienced local artisans / contractors will keep the money in the community but will also create a resource for the ECD centres with regard to long-term maintenance. This is very important as centres cannot afford to call in engineers / architects or other professionals when problems arise that are too complicated for the community to address on their own. (e.g. complicated roof structures.)
- It is equally important to make use of basic yet good quality materials for minor repairs (i.e. SABS approved). These materials should be available at local hardware stores so that ECD Centres can purchase these materials for maintenance purposes in future.
- It is important to distinguish what is essential from what is a “nice to have”. This distinction helps to determine the level of flexibility, affordability, sustainability and the effective reach of objectives. Strategic trade-offs are unavoidable in any ‘massification’ process.

13.9 Response planning - ECD infrastructure improvements

This section deals with various aspects influencing the actual work undertaken in terms of ECD infrastructure improvements and can be summarised as follow:

- Infrastructure response packages;
- Defining minimum infrastructure norms (flexibility);
- Infrastructure assessments & improvement plans;
- State infrastructure investment criteria;
- Cost estimates for ECD infrastructure improvements;
- Cost-benefit of an infrastructure improvement model;
- Capital funding for infrastructure improvements and;
- Implementation of ECD infrastructure improvements.

Each section will be discussed in terms of work undertaken and learning and key findings.

13.9.1 Infrastructure response packages

WORK UNDERTAKEN

The identification of five infrastructure responses was done in terms of the Ilifa Labantwana Strategic ECD Infrastructure Support Programme in parallel with the PSPPD research project. PPT prepared a document in this regard and it can be described as follow:

a) **Basic services: Water and sanitation *(Typically between R25k and R150k, typically for categories A, B1, B2, C1):***
This response focuses on basic services - e.g. acceptable water provision on site, acceptable handwashing, adequacy of number of toilets and condition. Fencing and outdoor equipment are included in this intervention. It is anticipated that basic services would be provided to all ECD Centres A – C1 Categories (Category C2 only in special cases) **regardless if owned by NPO or private individual and how long the centre has been operational**. The provision of basic services to all centres is based on the fact that such services are provided to all private beneficiaries of RDP housing. Therefore, a similar arrangement is appropriate for poor centres in underserviced areas. This intervention seldom stands alone and is usually combined with both minor and major building improvements as well as extensions where required.

b) **Minor building improvements**

Minor improvements can be made in 2 cases:

- **For buildings with potential: (*Typically between R25k and R150k, typically for categories A, B1, B2).***
This response focuses on structural issues and assesses the construction material components (formal / informal, conventional type of materials for walls, floor, roofs). It notes problems with walls, roofs, number of external doors, cross ventilation. All ECD Centres categorised A – B2 will qualify for minor building improvements. This intervention will in all likelihood be combined with the basic services package.
- **For short term relief in case of serious health and safety threats for centres without potential *(Typically between R25k and R100k and typically for categories C1 and C2).***
Though the same marker questions are used, the lack of potential will be overruled in the light of the seriousness of the prevailing health and safety threats. This option will only be considered where the District DSD indicates in writing that there is no other ECD and care option for children in that area in the short to medium term. Only the most basic and urgent repairs / improvements will be made to create a safe space for children until an alternative can be found.

c) **Major building improvements ((Typically more than R100k per centre up to R0.3million. Typically, categories A or B1):**
This response focusses on issues relating both to structure (roof, wall, door, problems) and accommodation in terms of poor differentiation of functional areas (e.g. separate food preparation area, sick bay, office, separate playrooms for different age groups). New ceilings will not be installed if it was not there previously but will be addressed if existing ceilings are problematic. Adequacy of basic services was assessed and major building improvements were combined with the basic services package. It needs to be stressed that basic norms and standards will be applicable

in major building improvements, which includes approved building plans, especially where structural changes are made. Only centres that scores high (80%+) in terms of the Infrastructure investment framework with marker questions such as: registered NPO, registered or conditionally registered with DSD, secure tenure (title deed or written PTO), number of years operational and with a combined weighted score on general categorisation over 60%.

d) Extensions (Typically more than R200k – R350K per centre. Typically, categories A or B1):

Extensions will be considered in three cases:

- To relieve overcrowding in which case additional information will be looked at e.g. gross space adequacy ratio below $2m^2$ per child or $1,5m^2$ in playroom areas.
- To provide access to additional children, where the local demand is in excess of supply. It is important to check on the number of children currently attending and whether there is space for extensions. Playroom extensions must be cost effective and the maximum number of children will have to be accommodated to make optimum use of space (i.e. it is not cost effective to add a small room for 5 to 10 children. Playrooms for three to five year olds can accommodate 20 children and this should thus be the norm when extending playrooms. For this scenario, additional information needs to be obtained e.g. Ward data from Stats SA on children under 5 years and the ECD distribution map for that area. Written confirmation of the need must also be obtained from the local DSD Service Office
- To address the need for certain dedicated spaces e.g. separate kitchen, office, sick bay.

Considerations

- Extensions will only be considered for centres that achieved a high Capacity, Governance and ECD Programme and a combined weighted score on general categorisation over 60% as well as a high infrastructure investment score (80%) based on marker questions that include registered NPO, registered or conditionally registered with DSD, secure tenure (title deed or written PTO) , number of years operational etc.
- There needs to be ample convergence of the figures on the number of children collected through the survey, technical assessment, EHP reports and DSD figures (if available), as there is an off chance that operators may inflate enrolment numbers if they think there is a chance that they may benefit from DSD subsidies (currently paid per child). It is however doubtful that ECD centres in informal settlements will be underutilised.
- Optimal use of existing space - Where access for additional children is not required, it is unlikely that an extension will be considered for kitchen, sickbay and office facilities where there is enough indoor space to subdivide areas for these purposes.
- The site size needs to be taken into account to determine if it is big enough to accommodate both the extension and the added outdoor space required per child.
- Adequacy of basic services e.g. toilet and handwashing adequacy must be assessed with each extension.
- Major building improvements may be combined with extensions for overcrowding or to provide access for additional children in the centre.
- Norms and standards have to be met which include the approval of building plans by the local municipality.

Limitations

- Space to extend,
- Topography and,

- Must be centrally located, accessible by road and in walking distance of surrounding households

Note: There was initially some uncertainty as to whether improvements should be done incrementally. It was decided that it would not be wise to motivate for incremental improvements. Taking into account the huge backlogs and need, it is highly unlikely that any municipality will be allocating funding twice to a centre over a period of three or five years while other centres have not been assisted.

e) New builds (Typically more than R700k per centre up to R1.3million. Typically, categories A or B1):

New builds will be considered for the following scenarios:

- **New builds on existing site** where existing building is not suitable (i.e. in bad state of repair): This intervention should only be considered as a last resort as new builds are expensive. It is imperative to determine local need as it would be more cost effective to erect a new building where access for additional children in the centre can be provided. Consideration must be given to the number of children currently attending the centre, local demand for child care services, and whether there is space for a new build with consideration of the topography on site. This intervention will be very selective. Consideration will be for the following: where the existing building is an informal building constructed with unsuitable materials, such as a wattle and daub building which is not properly constructed or maintained, where there are risks of collapsing walls / roof, where a conventional building was not built according to acceptable norms and standards, and where the structure cannot be renovated.

- **New builds on new site for:**
  - existing children: this intervention should only be considered when the existing site and surrounding environment prove to be unsuitable and / or totally unsafe; the site is too small or too steep to accommodate a new build; the centre is owned by an NPO, but the underlying land is privately owned which prevents improvements. The existing tenure is thus not relevant. Secure tenure must be possible on the new site and a feasibility study would be required. A new build on a new site for existing children will only be considered as a last option – especially if additional access is not required. It is unlikely that this option will be considered for recently established centres (i.e. where the centres have not yet established a good track record). The District DSD will have to provide a written letter of support for such intervention.
  - additional access in underserviced areas: New builds should be considered where local demand is in excess of supply and the existing building or site is not suitable for whatever reason e.g. private ownership and/or existing building unstable, site too small, etc.). For this scenario, additional markers which are not covered by the survey will be used: Written confirmation of need by the District DSD, Ward data obtained from STATS SA data on children under 5 years and the ECD distribution map for that area. More work needs to be done on population based planning and appropriate responses.

Considerations

- New builds will only be considered for centres that achieved a high potential score for Capacity & governance and ECD Programme – combined weighted score on general categorisation over 60 % as well as a high infrastructure investment score (80%) based on marker questions that

include registered NPO, registered or conditionally registered with DSD, secure tenure (title deed or written PTO), number of years operational etc.
- Norms and standards have to be met, including approval of building plans by the local municipality.

Limitations
- Location;
- Adequate space for a new build;
- Topography;
- New builds must be accessible by road and within walking distance from surrounding households;
- Approval by the local / traditional authority and;
- Written support from the District DSD.

LEARNING AND KEY FINDINGS

- These response packages adequately address the needs for infrastructure improvements. It is not expected that the response packages will be changed but more refinement might be required
- Though basic services are combined with all other interventions in the above response packages, from a service delivery point of view, it is possible that these might be delivered separately to building improvements (e.g. via a municipal infrastructure response). Whilst this cannot yet be determined in an eThekwini context (since the pilots have not been implemented) this was investigated in rural municipalities where PPT is working on the delivery of ECD response packages (e.g. addressing water and sanitation at ECD centres via annual programmes; Fencing and outdoor equipment via special EPWP programmes).

13.9.2 Infrastructure assessments & improvement plans

WORK UNDERTAKEN

As mentioned earlier, it was decided by stakeholders that all 36 sites shortlisted for Amaoti (23) and Umlazi(13) should be assessed. The assessment would obtain a better picture of the condition of infrastructure within the informal settlements. Only 22 assessments were done in Amaoti as one of the centres temporarily moved premises for implementing improvements to their facility, and 10 in Umlazi as 3 centres were forced to close due to financial problems – in total 32 ECD Centres were assessed.

The original plan involved technical assessments undertaken collaboratively with Department of Social Development and eThekwini Environmental Health Practitioners responsible for that particular area. However, eThekwini Environmental Health Services were not allowed to participate in this project as the HOD required Council resolution that could not be obtained (as eThekwini Council did not meet between May and October 2016 on project related matters due to the local election processes). This resulted in (Ms Fekile Mkhise and the ward social worker from the eThekwini DSD North Office accompanying PPT on these technical inspections in Amaoti and Ms Geraldine Job and the Ward Social Worker in Umlazi). PPT and DSD found the joint assessments very informative and valuable. It is noted that not having the EHPs on assessment team hugely undermined this research.

PPT developed guidelines for assessment and a guiding form to assist with the assessment. The assessments involved discussions with ECD centre staff members, DSD officials accompanying PPT and providing observations, and the taking of measurements and photographs. Attention was given to what the DSD regards as acceptable and unacceptable practice in terms of the use of facilities (e.g. with regard to the use of private homes in terms of child protection). Related issues such as NPO registration, centre and land ownership issues also had to be considered.

Although all the required improvements were listed and costed, the funding requested for the pilots had to be aligned with what can realistically be provided in terms of the MFMA and funding guidelines. For instance, a centre privately owned may require basic services, building improvements and possible extensions but will only qualify for basic services as the state will not "enrich" the private owner.

The improvements required for pilot centres identified can be summarised as follow:

Areas	Basic services	Minor repairs / improvements	Major repairs / improvements	Extension[53]	New built	Fencing	Outdoor equipment
Amaoti informal settlement	19	19	0	14	3	8	9
Umlazi informal settlement area	7	9	0	6	1	5	8
Informal settlement total (32)	**26 (82%)**	**28 (88%)**	**0 (0%)**	**20 (63%)**	**4 (13%)**	**13 (10%)**	**17 (54%)**
Rural municipal areas (80)	67 (84%)	47 (59%)	6 (8%)	9 (12%)	18 (23%)	34 (43%)	55 (69%)
Overall total (112)	**93 (83%)**	**75 (67%)**	**6 (6%)**	**29 (26%)**	**22 (20%)**	**47 (42%)**	**72 (65%)**

Table 15: Summary of improvements required at pilot centres- informal settlements vs rural vs overall

- More than 80% of the centres in informal settlements require improvements to basic services (water sanitation, electricity), minor repairs and extensions that include the building of ablution blocks while 54% require outdoor equipment.
- New builds are only required for 13% of the ECD Centres in informal settlements of Amaoti and Umlazi.

Updated centre baselines

PPT established three baseline documents via:

- Survey – data;
- Infrastructure assessments to develop ECD response plans and;
- Operational assessments by TREE.

The assessment to measure change realised and the impact after the implementation of such response plans could not yet be undertaken as the pilot projects have not yet been implemented.

[53] Including the construction of ablution blocks

LEARNING AND KEY FINDINGS

- The involvement of the DSD and EHPs in the infrastructure assessment is highly recommended. It promotes learning, better understanding among role players and it fast tracks the registration of centres.

Bylaws and EHPs:

- The Bylaws and other norms and standards stipulating infrastructure standards make compliance virtually impossible for the average ECD Centre within Informal Settlements.
- eThekwini Metro launched their new bylaws for ECD centres in April 2016 and insists on strict adherence to the bylaws. The application of the same bylaws for middle and high income areas to informal settlements, peri-urban and rural areas, is unrealistic. EHPs, working in poor and disadvantaged areas, are faced with the reality of poverty and generally apply some flexibility to enable registration.
- Some disparity was noticed between PPT technical assessments and the inspection reports of EHPs on the same centres. The technical assessment reports listed generally more issues for improvement than found in the EHP reports. Possible reasons for this may include that EHPs only list the major health and safety issues, and that they apply some flexibility to make it possible for poor centres to register. Disparities related mostly to construction deficiencies – e.g. an enlarged door way without lintels, unsafe roof construction etc.
- The withdrawal of Environmental Health Services had a negative effect on the research. Joint assessments would have created a better understanding of the flexibility that can be applied to norms and standards especially with regard to infrastructure, health and safety improvements.
- Unregistered ECD centres are totally dependent on the monthly fees of between R50 and R150 per child. They are struggling to fix infrastructure deficiencies in order to meet the conditions for registration. Without DSD registration centres do not qualify for any government funding. Therefore, children in poor and underserviced communities have remained trapped by circumstances.
- Even if Centres were registered and funded by DSD at R17 per child per day, they would still not be in a position to attend to major works (e.g. a roof blown off, the fixing of a major crack) or adding an extension. The DSD stipulates that 50% of the operational subsidy should be spent on food which only leaves the centre with R8.50 per child to cover all other expenses, e.g. water, electricity, stationery, stipends for practitioners.

Assessment

- Varied health and safety issues were found in informal settlements – e.g. effluent spilling from neighbouring sites that required storm water management, proper closure of on-site pits
- It is important to photograph all issues needing attention to illustrate the extent of the problem
- Assessments should ideally be done in close consultation with the operator / committee members to ensure that all the issues are highlighted by the assessor. There may otherwise be latent issues not easily spotted - e.g. roof leak due to short overlap of corrugated iron roof sheets

Improvement plans

- **Determining the centre size in terms of the number of children it should accommodate, is difficult**. The number of children reported during the survey sometimes differed quite a bit from

the number of children found at the centres during the technical assessments and may also differ from the number of children on DSD records.

- **Conventional buildings are often cheaper and a more appropriate solution than ECD containers** ECD containers are heavily promoted but they are less durable and costlier in the long run than a conventional new build. Container delivery to site may be problematic in the absence of access roads, and the manoeuvring of a truck with cranes may be difficult where there is limited space.
- **Improvements, extensions and new builds are designed to meet minimum standards to enable the provision of acceptable services.** Simple centre and roof designs are required to ensure that improvements are affordable. Construction materials used must be SABS approved and obtainable from local hard ware stores to enable centres to attend to maintenance works themselves.
- P**reference should be given to the utilisation of registered small contractors / experienced artisans (**e.g. plumbers, carpenters, electricians) from the local community with proven work records. These contractors should be overseen by qualified construction managers for quality control purposes. Using local contractors is important as it creates resources for the ECD Centres to be utilised for future maintenance.

13.9.3 State infrastructure investment criteria

WORK UNDERTAKEN

Initially it was envisaged that a mix of centres across four categories (A,B1,B2,C1) would be piloted and that additional criteria would be developed and applied by the project stakeholders. However, it became evident that government was constrained in its ability to invest infrastructure funding in centres with limited potential to achieve registration and meeting the requirement of good governance (i.e. C1 category – noting that it was always anticipated that C2 category would not be viable for state support).

The following criteria were applied for the selection of the pilot sites (refer to *Section 13.6* for further details):

- Categorisation results
- NPO registration
- Owner of underlying land
- Owner of building
- Secure tenure
- Centre ownership (NPO, CBO, FBO, private individual / entity)
- DSD partial care registration
- Years operational

a) General categorisation results

Categorisation results are utilised in the shortlisting of centres for possible state infrastructure investment. Because health, safety and infrastructure issues can often be resolved with appropriate state investment, the score for “potential” (determined only by capacity & governance and ECD programme marker questions) was also utilised in determining the risks associated with state infrastructure investment. Centres with low “potential” score carry a higher risk than those with a high “potential” score.

b) NPO registration

The Municipality preferred that only centres which are registered NPOs receive state infrastructure funding support. All eight selected centres for infrastructure pilots were registered NPOs.

Note: *An NPO is defined, in terms of section 1 of the NPO Act, as a trust, company or other association of persons established for a public purpose and of which its income and property are not distributable to its members or office bearers except as reasonable compensation for services rendered. Nongovernmental organisations (NGOs) and community based organisations (CBOs) are collectively known as non-profit organisations (NPOs).*[54] *Most ECD centres (63%) in the informal settlements of Amaoti and Umlazi are NPO registered. Their constitutions should also provide for assets to be transferred to an NPO with similar objectives upon closure.* ***Under these conditions all NPOs should be able to qualify for state investment*** *- i.e. basic services, minor / major improvements, extensions or a new build. This situation is however complicated where the DSD recognises private centres as "community based centres" and register them as NPOs.*

c) Owner of underlying land

Normally the issue of land ownership is a key factor for determining capital investment by government / municipality within a proclaimed township. In the context of ECD, if the land belongs to the municipality, a government department, a traditional authority or a registered NPO, the municipality would be able to invest in infrastructure improvements including extensions and new builds. However, if the ECD centre makes use of a building for ECD purposes on private land (either owned by the ECD operator or third party private owner) then the only investment possible would be that of basic improvements necessary to mitigate basic health and safety threats and/or any other basic services to which all low income households are eligible. This means that typically such investments as water, sanitation, fencing electricity etc. are viable, but subject to the issue of total cost.

It is emphasised that land ownership issues in informal settlements are often complex and Amaoti is no exception. Often the underlying land may not belong to the state or the ECD centre and such ownership therefore cannot be imposed as a precondition for infrastructure investments, especially for basic improvements. One of the main reasons for the comparative lack of formal development of Amaoti lies in the underlying land ownership as mentioned in *Sections 6.7 and 8.5.4* above. It took many years for the Metro to complete the process of land acquisition (via purchase and expropriation) from multiple private owners. The transfer of land has now been completed. The underlying land in Amaoti now officially belongs to the eThekwini Metro. A proposed land use framework had been drafted. Formal town planning and township establishment is currently in the preparatory stages.

It is noted that the Metro was not able to provide PPT with an overlay of the spatial plan to clearly identify which centre would be able to remain where they are in terms of the land use framework. Once funding for the pilot centres is approved, PPT and the eThekwini Metro will attend to this matter on a case by case basis. Investments in minor improvements are not expected to be constrained by this process. Investments on land earmarked for residential development may also not be problematic but resolutions will have to be found where the centres are located in areas planned for green belts, high density areas or light industrial use.

---

[54] NPO information: http://www.dsd.gov.za/npo/

d) Owner of building

For minor improvements, the municipality was flexible in respect of building ownership (provided the centre operator had de-facto, beneficial occupation of the site). However, for major improvements, secure, formal tenure would be expected (i.e. title deed or formal lease with the state).

In proclaimed townships, the land and buildings belongs to the same owner. This is not the case in informal settlements, as explained above. In informal settlements, it is usual that the building improvements on the land were paid for by occupants who settled on the land.

The Municipality accepts that residents' rights to their houses / buildings should be respected. In the case of residential homes, they will either retain their homes or, in the event that areas of Amaoti are re-developed, they will receive alternative state-funded housing. In the case of ECD centres which are an essential community service, this will need to be resolved as part of the town planning process at some point in the future. However, from a compensation and cost point of view, it will be prohibitive to replace all viable/functional ECD centres at Amaoti using state funding. In the case of Amaoti, the land has been acquired specifically for purposes of human settlement development. ECD forms a key element of human settlements and will need to be provided for within any future formal town plans. In the case of in-situ upgrade projects (such as Amaoti), the existing settlement pattern and housing is usually preserved, for obviously reasons. It is noted that the information pertaining to the locality of existing ECD centres at Amaoti was provided to eThekwini Municipality to inform town planning processes.

e) Secure tenure

Secure tenure normally refers to land ownership evidenced by a title deed, a long lease with a government department or municipality or a Permission to Occupy (PTO) where the land belongs to traditional authorities. There are a few (4) centres owned by the Municipality within the Amaoti area and one in Umlazi. These centres have signed lease agreements with the Municipality. Secure tenure in this case may not be the predominant factor that informs capital investment.

f) Centre ownership (Private, CBO, FBO, registered NPO)

For state investments in minor improvements, it emerged that government is willing to be very flexible. Such state investments (i.e. in basic infrastructural improvements) appear viable provided the centre is either a registered NPO or, if privately owned[55], it is regarded as a 'community-based ECD centre' by the DSD (i.e. a privately owned centre operated for community benefit and providing an essential community service but on a subsistence basis by the private operator who has typically invested significant personal savings into the centre and it may often not be viable to transfer assets into an NPO vehicle)[56].

The effect of ownership on state investment is already outlined in d) above. A closely related and important state investment consideration is actual ECD owner/operator, since operators do not always own the building and usually do not own the land. ECD Centres can typically be run by an NPO, Community Based Organisation (CBO), Faith Based Organisation (FBO) or private person. These entities

[55] Either a private individual or a Faith Based Organisation (FBO) or a Community Based Organisation (CBO).

[56] It is noted that the DSD social worker's /service offices do not appear to apply this 'protocol' consistently across different areas. It may therefore not be equitable (with some centres losing out on state support) unless the protocol is standardised.

may either own the building[57] or may be renting space from another person/entity, in which case this underlying ownership also comes into play.

At Amoati, most operators have beneficial occupation with no legal/formal tenure although one centre has a formal lease with the Municipality who owns the building and the land.

Scenarios for privately-owned centres:

The issue of private ownership emerged as being important and was further explored and unpacked. The following scenarios were identified which impacted on the acceptability of a centre to the DSD as well as the ability of the state to provided financial support (DSD operational subsidies and/or infrastructural investment). The first two categories may be regarded by the DSD as a 'community-based ECD centre'[58].

i. A dedicated ECD centre on a separate site (with no sharing of facilities with the family) is regarded as an acceptable ECD centre by the DSD and is eligible for PCF registration. It is also eligible for DSD subsidies (as a 'community based ECD centre) provided it is a registered NPO. Such centres should be eligible for minor, state-funded infrastructure improvements. In all cases it would be preferable that the centre should be overseen by either a governing committee (unlikely if not a registered NPO) or at least a parent committee.
ii. A privately owned centre in a separate structure in a backyard or garage may be considered by the DSD as an acceptable centre and eligible for PCF registration subject to certain conditions. It may also eligible for DSD subsidies if it is registered as an NPO. Such centres should be eligible for minor state-funded infrastructure improvements. DSD requires that such centres be fenced off from main house and that key use areas i.e. playrooms, toilets, play area, sick bay, are not shared with household members. It is emphasised that the sharing of toilets whether inside or outside the main house is unacceptable from a child protection point of view as it often happens that children will be making their way to toilets unsupervised. The following are however permitted: A) shared use of the kitchen in the main house, but only if the kitchen meets the basic standards and if the children are prevented from visiting the main house unsupervised. B) Use of the main house for keeping administrative records or to meet parents providing children are supervised at all times. It may be possible in some cases, to subdivide the site, and for the ECD centre portion to be transferred into the ownership of an NPO. It is also accepted that this will often not be possible for various reasons (e.g. underlying land ownership).
iii. Facilities operating from within a private home and sharing space and facilities (e.g. toilets) with household members are unacceptable to the DSD and do not qualify as ECD centres or for PCF registration. They are not eligible for DSD subsidies (even if more than six children are cared for). Such centres would typically not be eligible for minor state-funded infrastructure improvements. The number of children may vary significantly (as many as 15 to 20 children). Homes are typically overcrowded and children are utilising household space such as toilets, lounges and bedrooms which is highly inappropriate in terms of child protection issues. Supervision is difficult if children are spaced out in different rooms. The available space cannot be utilised optimally due to household furniture and arrangements (e.g. use of TV). It is also difficult to create a viable learning environment within a such a setting.

[57] In the Amaoti context, this means operators who have beneficial occupation of the land and who typically are acknowledged as 'owning' the building – meaning that they typically either built it or have occupied it for a long period in which case they have also typically made significant investments in the building.

[58] I.e. a privately owned centre operated for community benefit and providing an essential community service but on a subsistence basis by the private operator who has typically invested significant personal savings into the centre and it may often not be viable to transfer assets into an NPO vehicle.

g) DSD partial care registration

Partial care registration is an important consideration for government and donor investment as it shows that the centre is part of the DSD system of support and that the centre complies with the requirements for registration.

This project aimed to assist unregistered ECD centres to meet the infrastructural requirements that will enable the centres to get registered. there is support from both the eThekwini Municipality and DSD for this type of development.

h) Years operational

Some informal centres were referred to by EHPs as "fly by nights" which defined centres operating for transient periods. One of the selection criteria for infrastructure improvements is therefore that the centre must be operational for a minimum of 5 years (with the exception of urgent health and safety issues that might need to be addressed – e.g. storm water management to prevent effluent from neighbouring sites to overflow playgrounds of the neighbouring ECD Centre.

The number of years a centre is operational is thus generally an important investment indicator for both municipalities and private donors of viability, sustainability, community support and general resilience.

i) Other considerations

Other considerations for municipalities for capital investment may include

- Equity in terms of centre distribution across the wards.
- Political support by ward councillors
- Long term settlement plans (see below).

Long-term settlement plans should not block ECD response planning:

Long-term settlement plans (e.g. for formal town planning and township establishment and formal housing provision) are typically very slow processes taking many years, and often decades. They are also subject to available implementation funding (e.g. housing subsidies). Unless the implementation of such settlement plans is already underway and funding is available for implementation, ECD response planning and support should go ahead, even if a greater emphasis is on major investments such as new builds or major extensions. As always, this should be done in close cooperation with Municipality. At Amaoti, the long-term upgrading plans are expansive and costly and will take many years to be rolled out. The process of land acquisition at Amaoti has only recently been completed and took many years. Decisions on the allocation of specific sites for different types of use have not yet occurred. Future housing projects at Amaoti will inevitably need to be phased. Layout decisions in upgrading projects are usually made in close consultation with the local community. Given the high level of investment by local residents in their homes and other buildings such as ECD centres, it is both unlikely and unviable that substantial ECD centres will be demolished unless in exceptional circumstances. In settlements such as Amaoti, the likelihood of ECD centres being removed or demolished is thus regarded as unlikely. Refer also to *section 13.9.3d*).

LEARNING AND KEY FINDINGS

The following factors are considered for capital investment for infrastructure improvements by government and to a lesser degree by private donors.

- **Long-term settlement plans should not block ECD response planning**: See preceding section
- **Ownership issues (centre ownership, land and building ownership) are complicated in informal settlements** and solutions need to be found on a case by case basis with all stakeholders involved – i.e. learning by doing.
- **Balancing state obligations with investment risk**: Given the above complexities and constraints, and noting the need for the state to balance the rights of children with being prudent with its investments, it was evident that ownership and tenure issues do not present a major barrier to small state investments (minor improvements) provided other preconditions are met (e.g. DSD support, centre has potential, centres is not too small in size etc.). However, for larger state investments (e.g. major extensions or new builds), formal tenure (e.g. title deed, long lease, formal PTO) would be necessary.
- The general rule is that **investment on private land or for private centres will be limited to minor improvements such as basic services (water sanitation, etc.)** whilst larger investments (e.g. major improvements, extensions and new builds) can be made by government where the centre and underlying land are owned by a registered NPO which either holds ownership (title deed or formal PTO) or else has a secure, long term lease with government (as opposed to a private entity).
- **Complications with NPO registration in informal settlements (and to a lesser extent in rural areas):** The DSD regards some poor, privately owned centres in disadvantaged areas that financed the building and its contents from their own pockets, as "community based organisations". This is because these centres are managed on a subsistence basis and provide essential community services to an equally poor community. They are often the only centres available in a particular area. Monthly contributions are insufficient to sustain the centres and cannot cover even the most basic necessities (e.g. food and trained practitioners) The only way that the DSD can assist the community and the children is by registering these centres as NPOs which makes them eligible for state support. The result is that 23% of the registered NPOs are privately owned ECD centres (*vs rural 78% NPO, 8% privately owned and overall 75% NPO, 10% privately owned)*.

  NOTE: The above situation causes much confusion for all parties especially when it comes to state investment in infrastructure improvements for centres registered as NPOs where the building and content of the building may be owned by a private person. It is also clear from informal discussions with such NPOs that they have no understanding of the implications of NPO registration other than an opportunity for the centre to benefit from DSD subsidies. It is doubtful that they intend donating the land, building and contents for community use. Such operators may wish their own children to inherit the ECD Centre, building and its contents or be able to sell it if necessary. PPT did not launch a specific investigation into this complex matter due to time and funding constraints. PPT raised the issue at the feedback session on 11 July 2016, but it was decided to rather deal with this challenge on a case-by-case basis with the owner, management, DSD and municipality during implementation. It is suggested that the following options should be investigated for risk management purposes in these cases:

  - *Registering of a long lease for the land and building for more than 10 years by the management committee at the deeds office*. This can only be done in cases where: a) land ownership is formalised, b) the ECD centres premises is not situated on the same premises as the residence

of the owner (i.e. it does not share the same site); or c) where it is currently shared, but can easily be subdivided. Such arrangement can be used to safeguard minor to major improvements and or an extension. This way the owner keeps the asset in the family but the state-support asset is still protected for public benefit purposes for a reasonable period. Such a lease should be renewable.

- The *state may consider buying the ECD structure* if suitable and in good condition and if located in a suitable area, as per the spatial plan for that new development area. Such building can then be made available to the said NPO at a minimal monthly / annual rent.
- The *Management Committee (NPO) purchases the centre* should the owner wish to sell by securing funding from private donors and should the Metro agree that the site can remain where is.

It is however suggested that such centres should not be "side-lined" by merely "replacing" the private centre registered as a NPO with a new facility. Notwithstanding the high costs of new builds, this would also be unfair to an ECD operator who has struggled and sacrificed much over many years to provide the community the ECD / child care services without any government support. The value of existing well-functioning ECD centres should be acknowledged and they should be supported as far as possible.

13.9.4 Cost estimates for ECD infrastructure improvements

WORK UNDERTAKEN

Determining standard rates for every possible variation is difficult due to the mix of building materials required

Some costing is difficult to quantify - e.g. storm water intervention that may also include work on neighbouring sites.

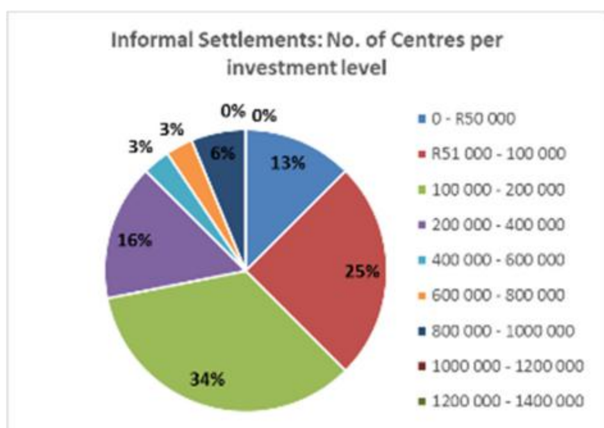
Costing was done on the basis that work would be done by small registered contractors (material and labour contracts) or an assisted construction management programme where local artisans with good references are contracted on a labour only basis. The cost rates are unlikely to be attractive to big construction companies with huge overheads and high profit margins. The cost rates were submitted for comments to an NGO construction support organisation and a quantity surveyor. The cost rates are similar though slightly higher than rates applicable to RDP housing. Refer to costing summary – **Annexure H**

The costing of improvements and new builds in informal settlements can be summarised as follows:

Investment levels	Amaoti	Umlazi	% of centres	Amaoti _ Amount per investment level	Umlazi- Amount per investment level	% of total investment
0 - R50 000	3	1	**13%**	R55 211	46 836	**2%**
R51 000 - 100 000	6	2	**25%**	R462 118	138 308	**9%**
100 000 - 200 000	6	5	**34%**	R801 270	695 133	**23%**
200 000 - 400 000	4	1	**16%**	R1 089 211	269 232	**21%**
400 000 - 600 000	0	1	**3%**		496 808	**8%**
600 000 - 800 000	1		**3%**	R661 938		**10%**
800 000 - 1000 000	2		**6%**	R1 903 170		**29%**
1000 000 - 1200 000	0		**0%**	R0		**0%**
1200 000 - 1400 000	0		**0%**	R0		**0%**
TOTAL	**22**	**10**	**100%**	**R4 972 918**	**R1 646 317**	**100%**

Table 16: Summary of investments required

The vast majority (72%) of the ECD Centres require investments less than R200 000, 16% between R200 000 and R400 000 while only 12% require investments between R400 000 and R1000 000 as 5illustrated on the graph (figure 2) below.



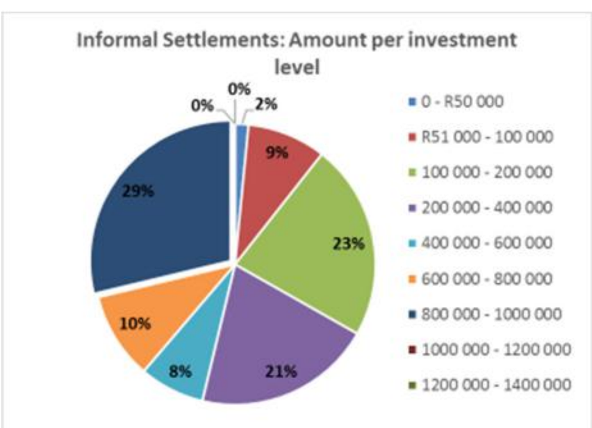


Figure 5: No of centres per investment level

Figure 6: Amount per investment level

However only 34% of the total funding required is allocated to 72% of the centres referred to above. Just more than a fifth (21%) of the total amount is required for investments R200 000 to R400 000, 18% is required for investment levels between R400 000 – R800 000 while 29% is spent on investment level R800 000 to R1000 000 as reflected in Figure 6 above.

Costing took into account investment considerations discussed in *Section 13.9.3* above

The same trends were found with the costing of the improvements of the 80 rural ECD Centres

LEARNING AND KEY FINDINGS

- Almost **three quarters (72%) of the centres require investments of less than R200 000.** This makes it affordable for municipalities to assist a number of ECD Centres, there by assisting many children to gain access to a safe centre with reasonable infrastructure.

- The remaining **28% requires two thirds (66%) of the total funding for extensions and new builds.**

13.9.5 Cost-benefit of the infrastructure improvement model

WORK UNDERTAKEN

Achieving optimal cost benefit is vital, given the imperative of realising 'universal ECD access' and maximum population coverage and noting the prevailing fiscal constraints. The cost benefit of the proposed infrastructure improvement model is discussed in relation to a new build model

The assessment below shows substantial cost-benefits with the alternative, mixed delivery model as summarised in the table below. Seven (7) times the number of centres (28 versus 4) and almost seven (7) times the number of children can be assisted (2,012 versus 293) for an equivalent level of infrastructure investment with an 83% cost saving per child.

	Improvements			New builds			Total
	Amaoti	Umlazi	Total	Amaoti	Umlazi	Total	
Total costs	R 2 407 810	R 1 149 509	**R 3 557 319**	R 2 565 108	R 496 808	**R 3 061 916**	**R 6 619 234**
Number of centres	19	9	**28**	3	1	**4**	**32**
Number children	1 575	437	**2 012**	237	56	**293**	**2 305**
Average cost per centre	R 126 727	R 127 723	**R 127 047**	R 855 036	R 496 808	**R 765 479**	**R 206 851**
Average cost per child	R 1 529	R 2 630	**R 1 768**	R 10 823	R 8 872	**R 10 450**	**R 2 872**

Total costs: Improvements and New builds	
Amaoti	R 4 972 918
Umlazi	R 1 646 317
TOTAL	**R 6 619 234**

Table 17: Costing of improvements and new builds

The majority of centres in the eThekwini informal settlements requires an average of R127,047 per centre or R1,768 per child for improvements to existing centres, while the average cost of the new built comes to R765,479 per centre or R10,450 per child. New builds are 6 x more expensive than infrastructure improvements.

The same trend was found in the case of 80 rural ECD centres.

LEARNING AND KEY FINDINGS

- **New builds should only be considered as a last resort** in the following cases: a) where there is an area not serviced by an existing ECD centre; b) where more centres are required for the vast majority of children not currently attending ECD Centres and where the current centres in the area do not have capacity to accommodate more children (e.g. due to limited site sizes), c) where a well-established ECD Centre has very poor infrastructure that may be a health hazard d) where the current centres are located in areas not earmarked for this type of development (e.g. within road reserves, green belts, light industrial or commercial areas) in terms of the spatial planning approved for the upgrading for Informal Settlements such as Amaoti
- **New builds are very expensive. Up to six ECD Centres can be assisted with infrastructure improvements for the same amount for new builds** if designed to meet minimum standards.
- **Many more children (7x more) can be assisted with improvements than with new builds.**
- **Centres selected for improvements are well established community facilities providing services where the need has been for many years - most without any state support.** It just seems fair that

government should acknowledge the efforts of these courageous ECD centres and support these centres with improvements and operational support.

- **Improvements of existing centres** is the quickest and more affordable way to go in order to achieve government's objective of 'massification'.

13.9.6 Capital funding for infrastructure improvements

(Including extensions and new builds)

WORK UNDERTAKEN

a) Brief overview

Chapter 8 of the National Integrated Early Childhood Policy on Funding for Early Childhood Development Services recognises that

i. "the objective is to secure and distribute sufficient funds to ensure universal availability of, and equitable access to, the comprehensive quality early childhood development programmes and services, with prioritisation of the identified essential components thereof, especially for low-income families that cannot afford user fees***."***

ii. "The solution lies in increased investment of public funds and the development of national early childhood development funding norms and related policy in terms of which Government takes the lead and responsibility for the mobilisation and allocation of sufficient human, financial and other resources to implement the national early childhood development policy and programme"

iii. Funding for early childhood development services should thus:
   - Ensure sufficient resourcing to secure delivery of services, provision of infrastructure and adequate overall resources for early childhood development, including both centre and non-centre based programmes providing early learning and development, and especially for the most vulnerable children;
   - Develop flexible funding mechanisms which promote and are responsive, to local early childhood development contexts, needs, risks and strengths; and
   - Mobilise diverse and innovative financing sources from Government departments, development partners and the private sector in support of early childhood development.

b) Funding for infrastructure development of pilot projects

The National Integrated ECD Policy discusses two channels of government funding namely:

i. **"The Department of Human Settlements and the Department of Cooperative Governance and Traditional Affairs will give directives to municipalities** that the following infrastructure funds may be used to develop and maintain municipal infrastructure in order to support early childhood development as a nationwide priority:
   - Municipal Infrastructure Grant;
   - Urban Development Settlement Grant;
   - Integrated City Development Grant (for metropolitan municipalities)."

ii. **"The national Department of Social Development will establish a national early childhood development infrastructure grant in collaboration with National Treasury** designed for national delivery of early childhood development infrastructure. It will receive, and in turn allocate to the provinces, ring-fenced conditional grants to support the national early childhood development

infrastructure as required in this policy. The early childhood development infrastructure grant will focus on:

- Construction of public early childhood development centres, and
- Provision of funds for Non-profit organisations (NPOs) to improve their existing early childhood development centres, based on predetermined criteria, to meet minimum norms and standards through the establishment of an NPO infrastructure improvement grant. This provision shall not apply to private homes, business properties, or properties not owned by NPOs, amongst others."

c) Funding for infrastructure improvements in eThekwini

PPT's main aim with the identification of funding streams was to test the availability of government funding as discussed above for the selected pilot projects within the informal settlement areas (Amaoti and Umlazi) following the normal municipal processes.

i. eThekwini Municipal funding report prepared for infrastructure improvements

The eThekwini Metro reserved Integrated City Development Grant (ICDG) funding for ECD centre improvements in previously disadvantaged and poor communities for the next 3 years (2017 – R2 million, 2018 – R3 million and 2019 – R4 million) but it still has be approved by Council for implementation purposes. A report was prepared shortly after the 2016 municipal elections and inauguration of Council, in close collaboration with the eThekwini Human Settlements Department for submission to Council for the approval of the R2 million reserved for the pilot projects and the Amaoti to the value of R911 949 and in Umlazi to the value of R808 603 for the current Financial Year. This report has however not yet been submitted to the two portfolio committees (Human Settlements and Infrastructure as well as Health, Safety and Social Services) with the result that the infrastructure improvements was not implemented.

Delays in processing and approving the submissions to the eThekwini Council resulted in ECD Centres not being added to the IDP for 2017 / 2018 and no provision was made for improvements and new builds on the 5 year IDP in terms of the information generated by this project. There was some uncertainty at municipal level on the role of ward councillors that used to identify ECD centres for IDP purposes.

Many other delivery issues could therefore also not be raised e.g. a) reviewing of Town Planning population based criteria to adequately provide for ECD centre site within walking distance; b) Accommodation of existing ECD centres in Spatial Planning for Amaoti; c) motivation for eThekwini Metro to provide water and sanitation services to all ECD centres in informal settlements where required and d) the motivation for ECD centres in disadvantaged areas to qualify for free basic services as they are servicing indigent families of whom many are qualifying to this type of assistance

ii. Department of Social Development

National Treasury (NT) allocated an Infrastructure Maintenance Grant as part of the Conditional Grant for ECD for 2017/18 & 2018/19. Various workshops were held with provinces in February, July and September 2016 to prepare for the allocation of the grant. Provinces submitted information on assessed conditionally registered ECD centres that need improvement to be assisted to get full registration.[59] The maximum value to be spent per ECD centre for maintenance improvements is R100 000.

[59] Presentation: "Early Childhood Development Knowledge Building Seminar 08 November 2016: Re-Imagine ECD by 2030: The

The DSD District Office had to identify ECD Centres conditionally registered throughout KZN during 2016. There were no ECD Centres in Amaoti or Umlazi with conditional registration and therefore no ECD Centres could be identified. Though some unregistered ECD Centres with A or B1 categorisation scores were ready for conditional registration, the social workers were not able to attend to it within the limited time frames.

iii. **Donor funding**

Due to the extent of the need observed in Amaoti, PPT with the assistance of LIMA prepared and submitted an application in November 2016 for two additional centres requiring urgent interventions to the Victor Daitz Foundation to the value of R347 307. This application will be considered in June 2017.

LEARNING AND KEY FINDINGS

- **It is difficult to synchronize donor funded research project** (i.e. EU PSPPD research funding) **with government processes**. Government processes are hard to fast track.
- **Municipal elections slowed down metro decision making processes** on projects which requires funding from the Metro due to preparations of elections, orientation of new councillors, changes in high level staff, etc.
- **The lack of high level communication between Provincial and/ or National DSD and the eThekwini Metro** is problematic as the Metro and municipalities in general are faced with a shared function but unfunded mandate. SALGA should be tasked to bring metros and municipalities on board and to help clarify the issue of this unfunded mandate.
- **There is no close collaboration between the Provincial DSD and the Metro in terms of planning, funding, monitoring and evaluation.**
- **MOAs between Provincial DSDs and Municipalities would address some of the uncertainties** regarding roles, responsibilities, procedures, collaboration on planning, funding, monitoring and evaluation.
- **DSD is not forthcoming with information that directly influence the planning of ECD centre improvements in the city** e.g. the selection of conditionally registered centres, due to internal protocol that prevents them from sharing information with other stakeholders. It is possible that there may be duplication in centres listed for improvement by DSD and that are included in the municipal IDP.
- **There are only a few donors that were willing to provide capital funding for the construction of new centres or the upgrading of existing ECD centres.**
- **Funding applications were dependent on donor funding cycles** - some allow funding applications once in a three-year cycle, others once a year while there are only a few considering applications on a quarterly basis.

13.10 Response planning - operational improvements

WORK UNDERTAKEN

Assessment & improvement planning[60]

Initially operational assessments were planned for after the pilot centres were selected. The eThekwini Metro Health Department insisted that the pilot programme and pilot projects be approved by Council. The project team struggled for a year to obtain the approval. When it became clear in November 2016 that the resolution will not be obtained before the final date for completion[61] of the project for which a 2 month extension was granted, it was decided to go ahead with the assessments[62] at the centres identified for infrastructure improvements.

TREE's Monitoring and Evaluation Framework / Baseline Assessments Tools are designed such that the information drawn from them equips them to: (a) have detailed knowledge about the status quo of project participants; (b) recommend appropriate Programmes and interventions; and (c) formulate targets in terms of reach and the impact to be achieved. The Assessment covered three main issues:

- **Technical skills of practitioners** in regards to quality programming; the availability of resources in regards to sufficiency and variety that provide different learning experiences for young children enrolled.
- **Water, sanitation, and hygiene (WASH) practices**; especially in regards to access, water treatment, and programming for young children.
- **Management of the ECD sites** in regards to management procedures and processes; registration; policies; record keeping; and networking with available community resources.

TREE could only inspect six of the eight pilot centres as tow centres have already closed for the December 2016 break. TREE had limited time and could only do observations in one classroom. Refer to the **Amaoti ECD Practitioner Baseline Report, December 2016 –** prepared by TREE **Annexure J**.

- The analysis of the Baseline data reveals that a number of interventions are required in order to ensure that quality ECD services are delivered to the children.
  - **Practitioners need to be equipped with the necessary skills to ensure they render quality ECD services; and are able to properly manage their sites.** An Orientation Course and a Basic Course in ECD will be adequate for creating a strong foundation for the Practitioners**.**
  - **Practitioners need to be further trained on Classroom Practice Workshop as well as on Managing Small Scale ECD Sites Course**. These courses will equip Practitioners with the necessary skills to design programmes for the children, as well as better manage their sites.
  - **An Enrichment Course for site supervisors** is necessary to ensure that they are able to identify areas of need, and accordingly support Practitioners. The **Governing Bodies need to be trained on the Committee Skills Course** to ensure strict financial management and site management practices.
  - **The Water, Sanitation, and Hygiene (WASH) programme will be of great help** to the Practitioners as they will be equipped with the necessary knowledge for good hygiene and sanitation practices. Knowledge gained here will ensure that the children practice good hygiene, and cholera incidents are a thing of the past.

[60] Extracted and summarised from Amaoti ECD Practitioner Baseline Report, December 2016, compiled by TREE
[61] Despite an approved 2- month extension
[62] No ECD operations assessments were done in the parallel project and no comparisons can thus be made

- **Practitioners need to be further enrolled on the NQF Level 4 qualification**. This qualification will build the overall knowledge of Practitioners and equip them to better work with families and communities in support of ECD. Expertise drawn from this qualification will enable Practitioners to start facilitating holistic development for babies, toddlers, and young children.
- **All sites must be supported with Toy Kits** to furnish all the learning areas in the classroom. To sustain this intervention; we must also train practitioners on the Toy Making course so we equip them with skills to use everyday waste materials for the production of learning resources.

LEARNING AND KEY FINDINGS

- **All centres have daily programmes** which are visibly displayed in their walls for all to observe. 5 of the 6 sites were found to religiously follow their programmes; supporting a consistent approach to learning and allowing children to expect what follows in terms of learning activities and daily routines.
- **Half the practitioners assessed demonstrated that they conduct large and small group activities;** use aids during story-telling; and display the work (or art) of children in classroom walls.
- **Four of the six practitioners can actually support children with special needs**; Only one practitioner reported having a special needs child enrolled. **The centres are lacking in educational toys** one practitioner has toys made from waste; and only three have a variety and sufficient number of toys to offer children different learning opportunities and experiences
- **Educational resources (blocks, books, puzzles, educational games, etc. needed to be replenished** as they were found to be old; and in most cases; not serving the educational purposes.
- **All sites had access to water** but it is essential that all practitioners be trained on the techniques and importance of treating water stored in buckets for potential germs
- **All the sites have some form of hand washing area**; with four using the bucket system, and two using taps. WASH training is required for all sites.
- **Five of the six sites have governing Constitutions that specify membership, structures and decision-making procedures; and meeting procedures**
- **Registration** - Four sites were not fully compliant with DSD norms and standards for partial care facilities.
- **Site policies need attention:** none of the sites have a child protection and HIV/AIDS policies; and only one has a health and safety policy. Four were found to have fees policies; three have admission and financial policies; and only two have disability policies.
- **Record keeping is largely acceptable** there is some consistency in the keeping of records across the six sites; with the exception of application forms, staff attendance registers, and in the keeping of medicine administration books.
- **Financial Administration needs attention -** accepted financial practices are not observed in all the sites. While a majority of the sites have bank accounts; receipt books, fees registers, and produce monthly and annual financial statements; some sites were found not having annual and monthly budgets; as well the inventory of materials available in their sites
- Centres were trying their best but practitioners, principals and management committees **need training and mentoring.**
- **Year ends are not the ideal time to attend to centre assessments** as the centres are very busy with graduations and some (2) were already closed.

13.11 Implementation of ECD infrastructure improvements

WORK UNDERTAKEN

No infrastructure improvements could be implemented as a) the ICDG funding reserved for this purpose is not yet approved by the eThekwini Council b) DSD maintenance funding was not applied for as there were no conditionally registered ECD Centres; and c) the donor funding applied for from Victor Daitz will only be considered in June 2017.

The technical preparation work has been completed. PPT already engaged with the eThekwini Architectural section regarding them handling the rapid procurement of contractors and assisting with oversight of implementation. It has been confirmed on 4 April 2017 again that the funding is still reserved for ECD improvements - it just needs Council approval. The delay in obtaining the approval seems to be due to the fact that there is no institutional home yet for ECD in the City. Safer were pulled in to strengthen the institutional alignment. The draft Social Development Strategy (April 2017) requires the City to develop an ECD Strategy / Policy. PPT is positive that the approval is imminent. PPT will continue to work closely with the Safer Cities Programme Manager and the HOD for Human Settlements in this regard.

LEARNING AND KEY FINDINGS

- It was evident that the **City is committed to finding solutions which are programmatic.**
- Some **barriers to implementation at the proposed pilot ECD sites related to the City's desire to first address the broader pre-requisites for ECD** (e.g. in respect of inter-governmental relations (IGR), roles, and funding mandates) so that a functional and sustainable ECD support programme can be achieved which moves beyond a pilot phase.
- It was also evident that there was **some caution in respect of pilot interventions creating precedent and expectations** and hence a desire to address some of the key issues before implementation at pilot sites. This was contrary to a fundamental design assumption, which was to first undertake pilots so that the learning from them could inform policy, strategy and programme formulation.
- **Municipal Processes are slow and cannot always be fast tracked to coincide with research / donor time frames**

13.12 Implementation of ECD operational improvements

WORK UNDERTAKEN

Training

The intervention and the improvement plans were informed by findings from the baseline analysis. The baseline study was done and completed in December 2016. The actual activities were conducted in January for three consecutive weeks, from 11th January to 26th January 2017. PPT mandated TREE to train eight ECD sites from Amaoti instead of the six as specified in the initial agreement. However only representatives of seven ECD sites attended due to internal problems experienced by Amaqhawesizwe ECD Centre.

TREE covered broadly two courses for two representatives (principals and / or practitioners) from each identified centre

TRAINING	Module	No. of practitioners	Status	Date
WASH	1	14	Completed	13/01/17
THEMES	1	14	Completed	19/01/17
THEMES	2	14	Completed	26/01/17

Table 18: Training modules provided by TREE

i. Water, Sanitation and Hygiene (WASH)

TREE's interventions were directed towards ensuring that play activities with children, either teacher directed, guided or supported or through free play, enhanced language development, social competence, creativity, imagination, and thinking skills. Considering the informal settlement where these children play, there are a lot of WASH principles that raise a flag. Hence this training capacitated the practitioners on WASH and its importance.

This training was key in not only supporting practitioners with appropriate programming for children focusing on WASH; but also giving them the skills to elevate the discussions with parents and the general community. This indeed went a long way into increased awareness on WASH; and improved well-being; increased attendance; and less instances of preventable diseases and sickness.

Photo 5: Practitioner with WASH equipment

ii. **The Classroom Practice Workshops (Module 1 & 2)–** "*Thematic Model of Learning is providing the providing the Practitioner with detailed guidelines for a series of 10 themes with supporting themes, linked discussions, puzzles and learning activities, creative activities, ideas for music and movement rings, physical activities, experiments and other ideas related to each theme around which a whole year's programme can be organised. The Programme is based on sound theoretical principles of learning through activities – activities that enable learners to fully experience and cognitively structure their world. It is a practical application that recognizes the value of inexpensive and easily made educational material.*

Photo 6: TREE Instructor

Photo 7: Practitioners busy with practical work

The participant's accolade the opportunity to learn about different creative activities; learn how to teach around Themes and set up Theme tables; learn to write story books". (TREE, 2017 - **Annexure K**)

533 children will be benefitting directly from the new skills acquired by the 14 practitioners of the seven ECD pilot centres that attended the training.

The following courses were recommended

Course	Outcomes
1. Basic course in ECD	For laying strong foundation and skills required for daily practice
2. Training on Managing Small Scale in ECD (MSSECD)	To improve the management and sustainability of the ECD site
3. Enrichment course for site supervisors and committee members	To support improved management, administration, networking and sustainability of the site
4. Toy making course training	To sustain the resources to be provided, ensuring there is enough variety offering different learning opportunities.

Table 19: Further training courses recommended for practitioners

One of the supervisors, Thuthukile Mhlungu from Inkhanyezi ECD Centre immediately enrolled for a Level 4 ECD training course starting April 2017.

Educational equipment

Each of the seven participating pilot centre was provided with equipment and learning materials as provided for in the project budget which included (e.g. educational toys and play equipment, art materials, tables, chairs, etc. at a total cost of R75 000 or R9 375 per centre. Okuhle Educare Centre that was part of the shortlist and which practitioners were previously trained by TREE was identified to benefit[63] from the educational equipment which brings the total of children benefitting to 788.

LEARNING AND KEY FINDINGS

a) Training

- **There was a huge need for ECD Practitioner training especially in neglected centres in informal settlements but training was unaffordable**. Principals and practitioners emphasised the huge need for ECD practitioner training at the Dissemination workshop in January 2017, but indicated that they cannot afford the cost of these training courses with the limited income they receive from parents. Practitioners were very thankful and impressed with the practical training they received in this regard from TREE.
- **Practitioners from unregistered ECD Centres could not be nominated by DSD for financial assistance from Department of Education to attend NQF Level 4 Training**. They were excluded and could not afford to enrol themselves. DSD was requested by Practitioners of unregistered centres to take up this matter with Department of Education.
- **Practitioners felt they had no professional status in the education system**. They requested assistance from government to increase the status of ECD practitioners

b) Educational equipment

- **ECD Centres in informal settlement areas were hugely under resourced when it came to educational equipment and toys**. Their very limited income does not allow the purchasing of enough educational equipment. Some had so few items that they do not unpack them as the children start fighting for limited resources.

[63] Note: it should be mentioned that Okhuhle ECD Centre benefitted replacing the Amaqawesizwe ECD Centre that has withdrawn from the project due to internal challenges. Practitioners of Okhuhle ECD Centre was trained by TREE and was one of the centres that will now be considered to replace Amaqawesizwe as pilot project.

c) Mentoring

- **For any intervention to have meaningful impact; it must have mentoring aspects in order to facilitate understanding from theory to practice.** From TREE's 32 years of experience in the sector; this goes a long way into sustaining interventions and giving practitioners the skills to better engage with children and support superior ECD provisioning in rural and marginalized communities.

13.13 Post implementation: score card assessment & structured interviews

WORK UNDERTAKEN

A score card assessment against the ECD centre improvement plans was planned as a quantitative assessment of each of the pilot sites for which infrastructure investments were to be made – i.e. a primary assessment against the base line.

Structured interviews (qualitative assessment) with operators/owners as well as fieldworkers by the project team were planned to gage impact. Questions would have pertained to both the survey and scorecard (e.g. whether improved infrastructure improved health and safety, whether improvement plans were implemented and reasons why or why not etc.)

None of the above was done as infrastructure improvements were implemented

LEARNING AND KEY FINDINGS

Not applicable as the infrastructure improvements were not implemented.

13.14 Partial Care Registration by DSD

WORK UNDERTAKEN

The DSD officials accompanying PPT on the technical assessments used the opportunity to familiarise themselves with the newly identified ECD Centres and to initiate the partial care registration process. As previously mentioned, EHPs were not allowed to accompany PPT and DSD. DSD thus had to request EHP inspections after their visits to the shortlisted centres. Good progress was made - one centre was registered after the survey was done; 18 were awaiting EHP reports; three Centres could not register due to conditions stipulated by EHP that the centres first have to meet and six centres have not been reported on. Many of these conditions included improvements to infrastructure, health and safety issues (fencing, toilets, separating of kitchens from playroom, first aid kits, etc.).

Different processes were followed in rural municipalities where the DSD launched a registration process with the assistance of NAG in the municipalities of Msinga, Umvoti, Umzumbe and Vulamehlo (now Umdoni)- making use of a systematic approach to partial care registration using jamborees to interact with ECD Centres and flow boards to track progress. All new centres were expected to be included utilising this new systematic approach. No progress reports were available on these processes.

LEARNING AND KEY FINDINGS

- **The identification of centres enabled the DSD to initiate the partial care registration process** *(Refer to Section 13.3)*
- **The registration process could have been fast tracked if the EHPs accompanied PPT and the DSD to the ECD Centres**. It would have created closer collaboration between the EHP and Social Workers as well as shared accountability.
- **Following a more systematic approach to partial care registration as facilitated by NAG in selected rural municipalities would benefit ECD Centres in informal settlements as well** as it was clear from the individual in-depth interviews (IIDIs) with ECD operators that some of them do not know how to go about partial care registration (Refer to *Section 13.5.5* below and **Annexure L** for the Report on the focus group discussions).
- **Registration flexibility was essential:** Registration requirements were out of reach for most centres due to low levels of income at centres, too-stringent by-laws, and a lack of building plans, zoning and formal tenure. Some flexibility was applied by EHPs. DSD's gold-silver-bronze framework of incremental registration will result in the inclusion of many more centres in the DSD's system of oversight and support.
- The good news is that **once the unregistered centres were identified, the DSD immediately commenced with a registration process** proving the importance of area based surveys. The process included visiting of centres, issuing of requests for EHP inspections, and issuing of partial care registration certificates, etc.

13.15 Individual In-depth Interviews and Focus Group Discussions[64]

WORK UNDERTAKEN

The qualitative research was initially due to take place in February 2016. When this could not be done, the fieldwork was rescheduled for April 2016 which also could not take place due to the challenges described in *Part 1: Section 6.10*. Finally, with the project timeframe for expenditure ending at the end of January 2017, new plans for UKZN's qualitative research were put in place in December 2016. The fieldwork took place from 17 to 27 January, 2017.

13.15.1 Qualitative Research Objectives

The main aim of this qualitative research was to enhance information on child care centres in Amaoti, mainly adding depth of understanding and an alternative perspective to the quantitative data collected by PPT on ECD centres, for the purpose of assisting those who plan and implement improvements to the centres (including the centres themselves). The secondary aim was to help inform government policy at a national level. This was needed because there are many child care centers that are struggling to provide the kind of care and education they would like to and there many children that need our government to help their centre (or crèche) to provide them with the kind of early childhood development opportunities that they need to have a chance at a better life. Government needs to know what the current ECD and other centres are like, for the children that attend them; what the problems are; and importantly, how the people using these centres think they should be improved, so that government can support programmes for child care centres that help children develop to their full potential.

[64] Extracted from the "Qualitative Research Report: ECD Centres in Amaoti", March 2017. UKZN, Durban.

13.15.2 Qualitative research methods used

Qualitative research methods were used to gain a holistic view of the potential and challenges facing ECD centres in Amaoti. This study used focus group discussions (FGDs) with parents of children at six ECD centres and individual in-depth interviews (IIDIs), with ECD operators, either principals, supervisors or owners.

The overall focus was to gain understanding of the nature and operation of child care centres in informal settlements. The key topics to be explored from the perspectives of parents and staff at ECD centres in Amaoti included:

- Problems with ECD centre and improvements
- Funding and related decision making
- Issues surrounding DSD registration
- Different features considered by parents when selecting a child care centre

13.15.3 Selection of Centres

The guidelines for the selection of centres for qualitative research in January 2017 differed from the guidelines used to select centres in February 2016 (for fieldwork in February and March). This is because by the end of 2016, PPT had already selected centres as pilots for upgrading (as well as identifying another four centres in need of some form of emergency assistance). A sample for qualitative research had to consider the stage the project was at and linked to that, the aspects of differentiation between the centres in Amaoti that should be recognised in a diverse sample. More detail is provided on the process to select the ECD Centres for the qualitative sample in the Qualitative Research Report on ECD Centres in Amaoti **(Annexure L**)

The guidelines used to select the qualitative research sample in December 2016/ January 2017 were:

- half the sample selected as pilots for upgrade or for emergency assistance
- all five of PPT's categories ranking categories (A, B1, B2, C1, and C2) should be included
- at least one centre should to be included in the sample where the fieldworkers' qualitative ranking and PPT's quantitative ranking differed substantially

13.15.4 Limitations

- Poor timing at the start of a school year, therefore teachers were busier than usual and less available for discussions
- Parents were busy and it was difficult to secure appointments with parents for group discussions. As a result, available parents were picked up by the research team.
- Taking notes by hand allowed participants more freedom to raise issues, however it does mean that some valuable information may have been missed.
- The fieldwork was rushed having to finish before the end of January.
- General working conditions were restrictive as some centres did not have enough space to accommodate FGD participants.
- Parents had preconceived perceptions that researchers were going to select their centres for upgrading. The researchers rectified this by describing the FGD process, hence this perception added to the findings but did not steal focus from the main purpose of the FGD.

13.15.5 Individual in-depth interviews (IIDIs)

A discussion guide was used to facilitate the IIDIs, which also provided an opportunity for ECD operators to raise issues which they wanted to discuss. Visual mapping of the ECD centre was done with operators (who were willing) in order to enhance their engagement with the issues at hand and to allow the fieldworker to ask about parts of the centre not referred to by the respondent. The discussion guide asked operators to consider improvements (rather than asking them about needs or problems) in an effort to move away from "shopping list" responses – which often emerge when either individuals or organisations are asked their individual or organisational needs are. There is a tendency for people to respond according to what they think the interviewer might be able to deliver. The discussion was not audio-recorded but rather notes were taken by hand. The IIDI lasted between 45min and 120 minutes. A copy of the IIDI discussion guide is included in the Qualitative Research Report on ECD Centres in Amaoti– **Annexure L.**

UKZN field workers met with six principals / operators. All principals indicated that they have been operating ECD centre for more than ten years

a) Common factors among these principals/ operators can be summarised as follow:
   - All six informal ECD centres were business owned by females
   - Four of the ECD practitioners were above fifty years of age
   - Most of the ECD centres were child minding/ day care centres
   - Owners of the informal ECD centres used their own homes to look after children
   - All centres looked after children from zero to five years of age
   - All six interviewees indicated that they had been operating for more than 10 years.; and
   - All six interviewees were the founders of the ECD centres.

   One uncommon factor included an ECD practitioner who could not draw or sign the informed consent form (she could not write at all).

b) Centres were started because of a need in the community i.e. children were found loitering in the streets without supervision, parents cannot afford fees of formal centres hence the need for affordable care, there was also apparently an increase in teenage pregnancies and those going back to school require care for their babies.

c) Mapping of the ECD Centres
   Principals were asked to draw and describe the centre (including grounds) and to specify the improvements/ changes needed, to provide the reasons for the improvements and to prioritise the improvements.

Photo 8: Mapping of ECD centres

d) Positive and negative aspects of running an ECD Centre in Amaoti
   Positive
   - All the principals mentioned that Amaoti is a great place for business.
   - Parents were always available when it came to matters regarding the Centre.
   - Parents trust principals to take good care of their children.
   - One principal mentioned that they run their own businesses and do not have to look for work.

Negative

- All the principal's complained that the level of crime was very high. Stolen appliances and food gets stolen were major setbacks for the centres.
- Parents were unemployed and could not afford to pay crèche fees and as the principals are parents themselves they found it difficult to chase children away.
- Another principal mentioned that "*It's difficult operating in this area as sometimes when they see that you are becoming successful they use witchcraft on you*".

e) Other main issues highlighted by Principals

i. Registration and lack of funding / support

Two of the six centres were registered and benefit from DSD support (funding, formal training of practitioners. The principals explained as follow:

- *"I have received the grant aid; the crèche fee from DSD. I also receive donation from eThekwini municipality. This assists me with running and improving the centre", (Fisani Okuhle Crèche and Preschool).*
- *"I receive funds from the government. I also receive a monthly income to assist me run the centre. Last year on the 16th of March 2016 I was given a R30 000 donation from the municipality which helped me a lot in buying a few things for my centre - I bought a laptop, a car port, cement for the concrete, and I was able to pave the yard. I also get information and training from government which has improved me as the head of the centre", (Sandile Crèche and Preschool).*

The other four centres were unregistered and indicated that they need assistance with registration. Principals had the following to say:

- *"I have not registered the centre and I have never tried to register before, I would like to be registered so that my centre could be recognized and formalized. I have heard news before about registration of child care centre but I do not know who I would approach if I were to do it" (Siyazama Crèche)*
- *"I have not registered my centre but I tried before to apply and they need many things. They need the centre to have the proper toilets for the children, centre to be fenced, a separate kitchen and classes for different ages. I just gave up because they need many things which I do not afford. I like my centre to be registered because there are many benefits" (Tholokuhle ECD Centre).*
- *The centre is unregistered. I have never heard anything about registration. I have never heard anyone mentioning registration. The only people who visit the centre are the nurses that come to immunize the children. I would like to register the centre because I will get support and the centre will be developed" (Kwa Nomarashiya Crèche).*
- *The centre is unregistered. Someone will take me to TREE, I will register it. Someone told me that if I register the centre I will get funding, food for children and pay for teachers", (Mpilonhle Crèche).*

All six centres required fee payments. ECD centres not subsidised are totally reliant on the payment of monthly fees but fees are often not paid on time and sometimes not at all

- *"Many parents of this area are not working and I end up buying food with my own money because they do not have money to pay. It is difficult for me to send back home the child because I know the situation. Some children are not paying anything but I keep them in the centre. It is difficult for the parents to pay if they are surviving with the grants" (Tholokuhle ECD centre).*
- *"Most parents do not work which has led to poor payments and I end up having to cater for their children without any fees. Poverty is affecting a lot of people, some parents come and ask for work but I cannot offer them anything due to the fact that I am trying to raise funds" (Sandile Crèche and Preschool).*
- *Some parents do not want to pay. Some parents do not pay at the end of the month; they do not pay on time.* "*Sometimes I use my own money to buy pampers for children who run out*" *(Kwa Nomarashiya Crèche).*

Monthly costs involve paying electricity bills, maintenance, rent, food for children and some learning materials. The principals of informal ECD centres that did not receive any form of funding indicated that they face various financial constraints; they have limited resources. The non-funded facilities struggle to make certain improvements of the centre.

ii. Decision-making in ECD Centres

The two registered centres indicated that they had an ECD committee. The ECD committee was involved in decision making. The two registered ECD centres indicated a formality or sense of partnership in decision making; the principals organize a committee meeting whenever there were decisions to be made regarding the ECD centre.

- *"I have established a committee that assists me to make decisions with regards the running of the centre" (Sandile Crèche and Preschool).*
- *"The decisions are made by the ECD committee. If I need anything to improve the centre I meet with the ECD committee. Therefore, I do not take decisions on my own", (Fisani Okuhle Crèche and Preschool).*

The four unregistered ECD centres had no ECD committee; an ECD committee did not exist. There was a no sign that indicated that the principals are aware of the concept ECD committee. One principal indicated that she makes decisions on her own. Three principals indicated that they seek advice from family members and make decisions with the family members.

- *My sister works in the centre, she looks after children within the centre. She is aware of the running of the centre hence we make decisions together" (Tholokuhle ECD Centre).*
- *"I make decision regarding the centre. My daughter also helps me with decision making; the running of the centre, child minding and communicating with the parents" (Kwa Nomarashiya Crèche).*

iii. Health and safety

The following concerns were listed

- Centers that were not properly fenced and did not have a lockable gate as a child might end up in the streets, criminals are able to enter the premises.

- The lack of mattresses (sponges) and blankets for each and every child to prevent children contracting illnesses like eczema.
- The lack of dedicated toilets for children - children were using unsafe pit latrines that they share with adults. Principals were concerned that children sometimes went inside these pit latrines, unsupervised.

Most of the principals expressed the wish for require new building as the ones they are using are not conducive for children, some are not properly built and children might get harmed and there's not enough space to accommodate children.

f) Message to Government

Most of the informal ECD centers' principals indicated that they would like to receive funding or any form of support from the government.

13.15.6 Focus Group Discussions

Focus group discussions were organised with parents and caregivers of children who were attending the ECD centre. The purpose of these was to get insight into the nature of the centres, any problems they may have and ideas for improvements to centres, from the parents of children attending. A discussion guide was used to facilitate the focus group discussion, which also provided an opportunity for the parents to raise issues. The following topics were discussed: reasons for sending their child to an ECD centre; reasons for choosing a specific ECD centre; what parents liked most about the ECD Centre and which improvements they would like to see. Parents were asked to rank the improvements in order of importance. Visual participatory exercises were done with parents to improve the quality of the information gathered and to promote participation. The discussion was not audio-recorded but rather notes were taken by hand. The FGDs lasted between 60 and 120 minutes**.** A copy of the FGD guide is included in the Qualitative Research Report on ECD Centres in Amaoti (**Annexure L)**

Photo 9: Focus Group discussions with parents

Photo 10: Identification of improvements

a) Motivating factors for sending children to ECD Centres

- For safety reasons:
  - One of the key reasons for parents sending their children to an ECD centre is to ensure that their child is in a safe environment during the day when the parents are at work. The fact that parents are working long hours and odd shifts is also a motivating factor for sending a child to

an ECD centre. "*Some of us are working, we need someone to look after our children. We do not have people at home, like grandmothers to look after children*".

  - They also feel that there may be too many people in one house and no one will take the responsibility to look after a young child. The child could also fall victim to abuse and rape by other family members. It is important to have someone responsible to take care of their child instead of leaving it with other family members who either are too busy to monitor the child or they are too old to take care of the child.
- <u>In preparation for formal education:</u>
  - Parents want their children educated and prepared for formal education. This also prepared children for formal schooling by making them used to being taught by a stranger. In this case they would quickly adapt to primary school and they will be disciplined enough to excel in their first year of formal schooling
  - Parents felt that their children developed good communication skills and displayed general improvement in basic education.
  - They notice their children show significant educational development from attending an ECD centre & are happy when children are reciting poems and songs
  - Children also have the opportunity to learn things that their parents will not have time to teach them.
- <u>For development of social skills</u>:
  - It is easier for children to develop social skills and learn to make friends from a young age.
- <u>Health reasons</u>**:**
  - Parents want to ensure someone responsible is monitoring of the child's health and general development.

b) Reasons for choosing a specific child care centre

- <u>Caring teachers and love for children</u>
  - Parents tended to choose centres where teachers are caring and genuinely love to be around children. One parent indicated that she chose her centre because *"teachers have a good care and where I previously sent my child teachers used to beat our children so I removed my child from that centre because of that abuse and I have noticed that my child is very happy to be learning here".*
- <u>The quality of education</u>
  - *"Many schools (including the Indians' school in Phoenix) recommend their ECD centre because they see good performance of children coming from this centre and some children even skip grades because they are well trained from this centre"*
- <u>The provision of food</u>
  - *"it is hard for some children to watch other kids eat when they don't have food"* so they choose to send their children in centres where food will be provided.
- <u>Children safety and security</u>
  - Parents were inclined to choose centres that were not located on busy roads so that their children would be safe at all times.
  - One of the parents was impressed by the fact that in her centre only she can pick up her child and no other unauthorised person can pick the child up, unless if she has indicated to the teachers that someone will come to fetch her child.
- <u>Proximity to home</u> –
  - Parents prefer centres that were located close to home as it is convenient for them to drop and pick the child up. But other parents indicated that they preferred centres that are not too

close to their homes, because their children sometimes run back home instead of staying at the centre until they come back from work

- Low fees
    - Low fees influenced majority of the parents in choosing an ECD centre, for example most parents indicated that their ECDs were affordable (R130 at most per month) as they earn low wages and salaries.
- The flexibility in opening and closing times
    - One of the parents indicated that one of the centres has flexible times that can accommodate them "*Her opening and closing times accommodate us, they are flexible. There are no after care costs and a child can stay over-night"*
    - Parents further stated their satisfaction by saying "*Some centres close early and they leave a child crying but we do not experience that at this centre, we are happy to leave our children here"* (FGD Parent).
    - In other cases, the teen parents preferred sending their children in centres with flexible times because they are able to attend and go for study groups during exams.
- Cleanliness and general condition of the centre
    - Some parents indicated that they have sent their children to centres that were not up to their hygienic standards so they decided to pull them out and look for a cleaner and hygienic centre. Parents indicated that they prefer their chosen centre because it is clean and will not expose their children to infectious diseases. Factors like availability of clean toilets and clean class rooms were frequently mentioned as in the focus group discussions.
- Assistance with health related matters
    - In one of the centres the principal takes the children to the clinic if they are ill and the principal also gives advice to parents on their children's health.
    - In other cases, the principal encourages parents to pay close attention to the well-being of their young children.
    - One parent was quoted saying that "she even goes as far as using her own medicine and traditional methods" (FGD Parent).
- Centres where their neighbours also send children because they wanted to their child to be close to children they know.

c) Other issues raised

- Parents feel that **government officials including their local councillors are not doing enough to ensure that ECD centres are in a condition that is satisfactory**. For example, participants feel that their centres should be free as they are very poor and the food should also be provided by relevant government departments. Some of the ECD centres are of very **poor standards in terms of hygiene and safety** but because parents have nowhere else to take their children due to financial constraints, they end up sending their child to such centres and risking exposing their children to ill health.
- **Teachers in these centres are not well looked after in terms of their salaries and their development as child care specialists**.

d) Most liked features in the chosen centres

Parents were asked to identify the features most liked and then to prioritise the top three features.

- **Teachers and principals –**Love for children, level of care, support, patience, respect for parents
- **Trained teachers**
- **Quality of education**
- **Secure setting and responsible staff**

- **Accessibility** and convenience
- **Flexible hours** (for opening and closing)
- **Affordable fees** and flexibility on payment dates

e) Improvements parents wish to see at their centres

- **Financial support** for the centre
- **Improvements of site** - fencing, play area,
- **Infrastructure improvements-** building repairs and extensions and a new build
- **Basic services** (water, sanitation)
- **Health and safety issues** (separate kitchen from playroom,
- **Play equipment, toys, books**
- **Improved nutrition** / feeding scheme
- **Training of staff**

The most important features ranked by parents are as follows:

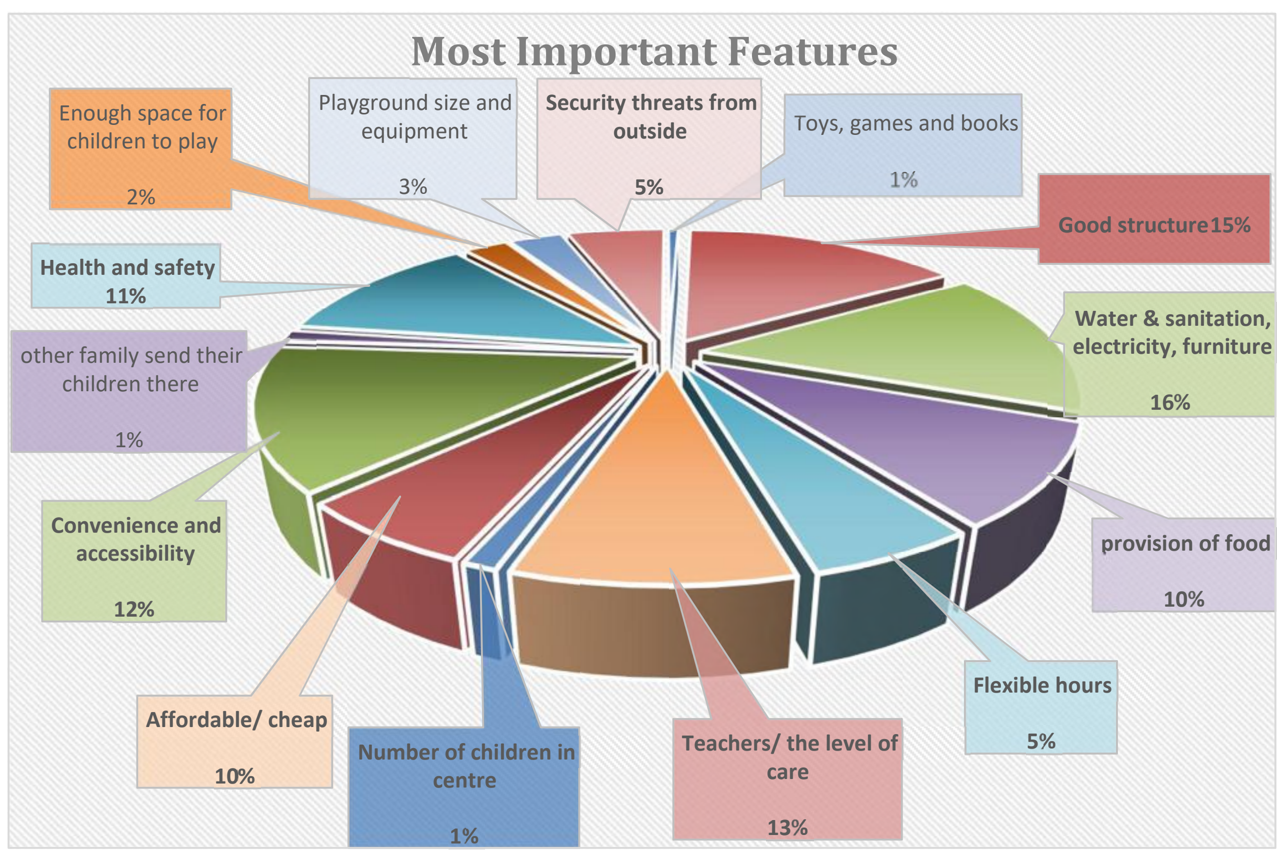


Figure 7: Ranking of most important features by parents

Parents were asked what their **message would be to government**. This is what they had to say:

- *"Department of education must **provide training to the teachers**"*
- *"Department of Health to **vaccinate children in the centre** because some parents are working"*
- *"We would appreciate if the DSD support or assist children that do not have **birth certificates**".*
- *"We would appreciate assistance from each department, help such as **food, infrastructure** because we are poor. We need assistance".*
- *"I am a grandmother supporting grandchildren; we would like to have **food, beds and many things at the centre**"*

- *"It is good to see people like you visiting us. Some people come and go away. You must come back again, be patient with us, **we appreciate your knowledge and any form of assistance to develop us further"***
- *"**The principal of the centre needs support**, I have another child that used to attend here, my child is doing grade three at school now, and she gets position 3 all the time. I am proud of the principal of this centre; my child received a foundation here"*
- *"**The government should further train teachers and also give them decent salaries** so that they can commit fully to their work. The government should also offer programs to vaccinate our children as some of us have to work all the time and we never get time to take our children to the clinic. The department of health should also draw up **food programs** that are recommended for young children. Social development should assist parents that are in deep poverty by providing food parcels and clothes to these families. Department of education should sponsor poor centres by providing black boards and other stationery."*
- *"**Windows and doors should be replaced. Add more staff that specializes in cooking, children's education, and there should also be special teachers for 4-5 year olds**"*

LEARNING AND KEY FINDINGS

Interviews with principals

- **Unregistered centres wish to register** as partial care facilities but
  - There is a lack of information on the DSD registration processes and principals indicated that they need assistance in this regard, and
  - Infrastructure deficiencies prevent registration
- **Parents are unemployed and poor** with the result that unregistered centres are struggling. Monthly fees do not provide sufficient income and can be irregular but they do not send the children away. Some principals are paying for nappies or food from their own pocket
- There seems to be a **direct correlation between the registration of centres and the prevalence of centre management committees**. Unregistered centres did not make use of either management or parent committees. Decisions were taken with family members
- **Health and safety issues** revolves mainly around the lack and condition of toilets, unfenced sites and gates without locks, a shortage of mattresses for each child and the buildings that are either poorly built, unsafe and/ or not big enough

Focus group discussions with parents

- **Principals / teachers should be loving and caring** and their children receive good quality education that will help prepare them for formal education.
- Parents wanted **teachers to be trained** and were **concerned that teachers are not paid well.**
- Parents needed **assistance with health related matters**
- Important considerations for parents were
  - **Safety issues** (as a reason for sending children to the centre and at the centre - e.g. not keen on busy roads, centres to be fenced)
  - **Provision of food**
  - Convenience and **proximity to home**
  - **Flexibility in terms of opening and closing times**
  - **Affordability of monthly fees** (and some flexibility)
  - General condition of the centre and **health, safety and hygiene issues**.
- **Community based ECD centres are more than just places of care and education. They play an important and supportive role in assisting families to cope with everyday pressures** – e.g. by

a) merely being in close proximity - walking distance, b) offering care and education at affordable rates and by allowing some flexibility with the payment of monthly fees; c) by extending operational hours to accommodate parents using public transport, as some leave early and return late; d) by providing assistance with health related matters (e.g. taking children to the clinic), etc. It is unlikely that this type of support would be possible where children attend big "school like" facilities

- Parents indicated that **improvements to basic services, buildings and health and safety issues** were needed
- Parents wanted **government to fund and support their centres** (e.g. with infrastructure improvements, food, training of teachers, teachers' salaries, vaccination of children at the centre, assistance with children's birth certificates,

13.16 Community-based ECD Centres

Arising from many aspects of the action research work undertaken, it became evident that the nature of ECD centres in informal settlements such as Amaoti is distinctive and significant in many important respects. Community-based ECD centres play an important and supportive role in assisting families to cope with everyday pressures

The DSD, as mentioned above, recognises that 'community-based ECD centres' are a key feature in such under-serviced communities, to the extent that they often encourage privately-owned centres to register as NPOs in order to access state support. Such centres may or may not be registered NPOs and in many instances, the assets of the centre are privately owned. However, such centres provide an essential service in underserviced communities, the operators themselves are typically low income and operating on a subsistence basis and the kind of relationship with parents helps poor families cope in various ways. Such owners have typically also invested significant personal resources into their centres.

It is unlikely that the type of support provided by these centres would be possible where children attend large "school-type" ECD facility (100 or more children). This is significant, since it is sometimes suggested by government that the provision of large, new-build centres can offer a solution to the ECD challenges within under-serviced communities such as informal settlements. Notwithstanding the prohibitive cost implications to the fiscus off such an approach, there are thus also other compelling reasons why this is not viable (and as outlined further below).

This does not imply that such centres do not have problems, not only pertaining to infrastructural deficiencies but also to their capacity (e.g. in terms of trained ECD practitioners) and available operational income. However, it would be difficult to replicate or substitute for the kind of service and relationship which exists between these centres and the parents/families of young children.

<u>Key functional characteristics of community-based ECD centres:</u>

- Often there is a personal relationship between parents and the Centre which forms part of the social networks in the community which enable famillies to cope with multiple pressures and stresses they are under.
- There is often a high level of flexibility e.g.:
  - Flexibility in respect of dropping and collecting children out of normal operating hours (e.g. due to parents leaving early or getting home late, sometimes unexpectedly due to reliance on public transport or other emergencies).

- Flexibility in respect of paying for services rendered.
- They are usually in close proximity of the home – within an easy walking distance for parents and with an access route through the settlement (or outside it) which is acceptable in terms of personal safety/hazards.
- The centres are affordable (low fees) - offering care and education at affordable rates.
- Principals sometimes assist parents with health related matters (e.g. taking children to the clinic).
- Principals sometimes pay for food, nappies or other essentials out of their own pockets when parents are unable to provide for their children.

14 References

- Atmore, Eric, van Niekerk, Lauren & Ashley-Cooper, Michaela. 18 April 2012. *Challenges facing the early childhood development sector in South Africa. A Comprehensive Research report on Early Childhood Development to the National Development Agency (NDA)*
- Berry, Lizette, Jamieson Lucy and James Mary*: November 2011. Children's Act Guide for Early Childhood Development Practitioners Children's Institute, University of Cape Town and Little Elephant Training Centre for Early Education (LETCEE)*
- Buthelezi Busi (Human Settlements Unit).10 July 2016. *Report on the Amaoti Greater Housing Project*. Durban.
- Department of Social Development: *Guidelines for implementation of the ECD Conditional Grant: ECD Maintenance Grant Component "(Draft 1) (Internal document) Pretoria*
- Economic Policy Research Institute for National Department of Social Development South Africa. 31 July 2014. *Audit of Early Childhood Development (ECD) Centres: National Report*. DSD website.
- eThekwini Municipality. October 2015. Human Settlements*: Planning progress at Greater Amaoti Area (wards 53, 56, 57,59). Monthly progress report (internal document),* Durban
- eThekwini Municipality. October 2015: *Informal Settlement Project List (Internal document) Durban*
- Financial and Fiscal Commission for Submission for the Division of Revenue 2016/2017. 29 May 2015. (ISBN: 978-0-621-43719-5 RP173/2015)
- Golder Associates (Pty) Ltd: January 2009. *Report on Social Vulnerability of Amaoti (*Report No: 10612), Durban.
- Harrison David (CEO DG Murray Trust). September 2012. *The state of provision of early childhood development services in South Africa*. Cape Town. DG Murray Trust Website.
- *National Integrated Early Childhood Development Policy 2015*. Limited distribution edition. Approved by Cabinet on 9 December 2015. Department of Education website.
- National Planning Commission. November 2012.*National development plan* 2030*. Our future- make it work.* ISBN: 978-0-621-41 180-5
- Ngcobo-Mbere Musa (Chief Director for Early Childhood Development, Department of Social Development). 08 November 2016. Presentation at Early Childhood Development Knowledge Building Seminar. *Re-Imagine ECD by 2030: The National Integrated Policy for Early Childhood Development: ONE YEAR LATER.*
- NPO registration*: http://www.dsd.gov.za/npo/*
- Project Preparation Trust for and in collaboration with the Housing Development Agency, 2014. *Informal Settlement Upgrading Guidelines: Informal Early Childhood Development Centres in Informal Settlements in South Africa,* Houghton.
- Ward based ECD data: *https://wazimap-ecd.code4sa.org/profiles/ward-59500053-ethekwini-ward-53-59500053/*