

In every issue of *Ilifa Insights*, we will introduce innovative thinking and practice that we believe to have the potential to be game changing for ECD in South Africa.

GAME CHANGERS

Social Franchising for ECD¹

CAROL-ANN FOULIS *explains the possible value of using this entrepreneurial strategy for improving ECD access and quality in South Africa.*

What is Social Franchising?

Social franchising is being used all over the world as a game-changing strategy for bringing essential services to poor people at scale. Social franchises operate across a range of sectors, including health care, education, and social support and protection. A social franchise is significantly different from a commercial franchise, in that it is set up to **maximise social impact** rather than maximise profits. However, it draws from systems, processes and approaches in commercial franchising to provide a consistent range of services, by creating an organised network of providers, achieving economies of scale in common activities and processes and developing common metrics to monitor and assess performance.

Much like the Montessori pre-school approach, an ECD social franchise would employ a common organisation and processes to deliver a defined package of essential ECD services, sharing training, teaching and learning materials, quality assurance, monitoring and reporting. Social franchising can be regarded as one of a number of growth and replication strategies for ECD.

Examples of Successful Social Franchising

Most successful social franchises require donor investment for the start-up phase, with many going on to generate their own income. Here are some positive examples of franchises from various sectors and countries:

In India, *CHILDLINE India* provides a toll-free help line for street children in distress. As of March 2013, a total of 27 million calls had been serviced (since its inception in 1996), with operations in 291 cities or districts in 30 states drawing on a network of 540 partner organisations across the country.

In Ghana, *Omega Schools* is a for-profit social franchise aimed at expanding access to high quality, low-cost private education for low income households. Started in 2009, it operates in three districts in the Greater Accra and Central regions, supporting children from pre-school (two years plus) to grade 6. Currently there are 20 franchisee schools, serving 20,000 students. On average, students of these schools score 30% higher grades than students in public schools.

In Kenya, *Bridge Academies* is also a for-profit social franchise, providing low-cost quality nursery to grade 8 education to children in Nairobi, Mombasa and other urban areas. Bridge Academies launched in 2009 and currently has 134 franchisee schools and 53,000 students. Student learning (measured by national tests) also outperforms public schools by 30%.

A reliable, cost-effective system of quality assurance would be an essential feature of the social franchise.

In Colombia, the social franchise *aeioTU* presently provides holistic ECD services (education, nutrition and care) to more than 5,000 children. Founded in 2008, and starting with the inauguration of four franchisee centres in 2009, *aeioTU* has expanded rapidly to 16 franchisee centres in five years. By the end of 2014, *aeioTU* will reach more than 7,500 children directly, through the operation of 20 *aeioTU* centres. The majority of *aeioTU* beneficiaries (98%) are, and will continue to be, children from families representing the lowest socio-economic groups in the Colombian government's system of benefits entitlement assessment.

In 2012, there were at least 74 *clinical social franchise programmes operating in over 40 countries*, with more than 75,000 providers, ranging from hospitals and clinics to independent doctors, nurses, pharmacies, midwives and community health workers. The franchised services include maternal and child health, reproductive health and family planning, HIV, TB, and STIs. Almost 15 million visits to social franchise outlets were recorded in 2012. (Social Franchising For Health)

And in South Africa, *loveLife*, the largest national HIV prevention initiative for young people in the world, has fractionally² franchised a number of its programmes, with offices in all nine provinces, coordinating activities across 23 different regions. A national network of approximately 900 hubs - including *loveLife* Y-Centres, community-based organisations, "youth-friendly" clinics and schools - provides a platform for *loveLife* volunteers - known as *groundBREAKERS* and *Mpintshis* - to reach out to approximately 8,000 schools, providing educational, recreational and sexual health services in resource-poor communities throughout the country. The HIV prevalence

rate among *loveLife*'s target group (youth aged 15-24 years) declined significantly from 10.3% in 2005 to 8.7% in 2008 and 7.3% in 2012.

What is Currently Holding Back ECD in SA?

In South Africa, there has been progressive evolution of the policy and regulatory environment for ECD since 1994. The government has led an important expansion of ECD services for children 0-5 years, through the expansion of grade R for 4-5 year olds by the Department of Basic Education (DBE), and subsidies to disadvantaged 0-4 year olds attending ECD centres, through the Department of Social Development (DSD).

However, while the data shows substantial increase in access to early education for 5 year olds, there remains limited access for 0-4 year olds:

- Enrolment of 5 year olds in grade R increased from 40% in 2005 to above 80% in 2011.³
- Approximately only 32% of children 0-4 years old attend some kind of ECD facility outside the home.⁴
- Attendance at an ECD facility among children in the poorest 40% of households lags even further behind, at around 20%.⁵

The significant coverage gap in ECD services for the poorest children results mainly from the combined effect of fragmented and/or insufficient supply in the areas where they live and the limited ability of households to pay fees. Additionally, the highly regulated environment for ECD centres to become (and remain) registered, although necessary, limits the formation and sustainability of new ECD centres. In addition to this coverage gap, where ECD services are provided they are characterised by:

1. A partial, highly idiosyncratic package of ECD services.

There is high variability in the ECD services children receive, with a strong correlation between the "resources available" to the service providers and the services actually delivered in ECD facilities and programmes. Thus, services range from solely custodial day-care or child-minding services at somebody's home, to attendance at a guided playgroup, to participation in an ECD centre with comprehensive and integrated services.

A social franchise is set up to maximise social impact rather than maximise profits.

2. **Uneven quality of existing ECD services, with children from disadvantaged backgrounds receiving lower quality services.** Quality ECD services result from a combination of factors and research is not conclusive as to which factors matter the most for ECD “outcomes” in different national contexts.⁶
3. **Most ECD providers operating on a stand-alone basis, with limited access to implementation support. This limits their ability to achieve economies of scale and expand the supply of ECD services.** The majority of ECD providers are small and self-contained operations, working with shoestring budgets and limited resources in a specific geographic area.
4. **Lack of clear accountability for ECD in the government that results in a coordination vacuum and red-tape that limit ECD scale-up and complicate service delivery.** Because child development is a multi-dimensional process, every child requires interventions from several sectors, including health and nutrition (Department of Health), stimulation and early learning (DBE) and social and income support (DSD). While relevant government departments have policies and standards in place regarding ECD, there is no overall structure supporting and promoting coherence, consistency and quality of ECD services provision at an aggregate level. This lack of coordination results in insufficient management and operational guidance for non-government ECD service providers, contributing to uneven practices and application of existing standards. There is also a lack of quality assurance of ECD services that not only reflects the leadership and coordination vacuum discussed above, but also low implementation capacity in the government agencies involved in ECD; the main focus there is on fiduciary compliance, as opposed to support for quality service delivery.



Approximately only 32% of children 0-4 years old attend some kind of ECD facility outside the home.

5. **Low levels of awareness amongst parents and caregivers about the value of quality ECD and what quality ECD looks like.** These are important factors that need to be addressed, in order to serve children better in their early years. The coverage gap is also simply too large to be dealt with through the expansion of existing programmes and therefore calls for innovative approaches. The existing body of evaluations shows that some of South Africa’s ECD programmes have a significant impact on child development. However, they have not been assessed in terms of costs (which is essential to determine their affordability), resources required to scale up and financing options. In addition, most of these programmes are small-scale. Organisational and managerial requirements to increase such scale-up also need to be assessed, to determine their institutional feasibility.

What Can Social Franchising Contribute to the Expansion of Quality ECD Services in SA?

The objective of an ECD social franchise would be to expand access to quality ECD to all poor children 0-4 years old in South Africa, so that they have the foundation needed to succeed in school and later in life. An ECD social franchise would employ the common scheme and processes of a franchise to deliver a standardised package of essential and integrated ECD services to children 0-4 years, at scale (in contrast to current programmes).

Addressing some of the problems currently experienced in the ECD sector (see previous section), such an approach should aim at greater consistency of services, increased support to small and stand-alone operations, faster expansion at lower costs, and the use of IT as an enabling component for various aspects and phases of ECD social franchise implementation (e.g. monitoring and reporting). It should also include greater public awareness and communication as a critical component in driving the demand side of provision.

To support consistency of services, a detailed and clearly “scripted” package would be developed and rolled out through a system of ECD facilitators, supported by a regional mentor/supervisor based at the ECD franchisee organisation. This quite prescriptive approach would be used to enable under-trained practitioners (as is currently the case) to deliver a consistent service.

Importantly, the issue of varying levels of ECD service quality should also be a key focus of an ECD franchise, as this area is not well addressed by current services at scale (at small scale, NGOs are trying, with varying degrees of success, to achieve consistently high quality service delivery). A reliable, cost-effective system of quality assurance would be an essential feature of the social franchise.

Opening an Exciting Door for ECD Scale-Up in South Africa

Social franchising provides exciting possibilities for the ECD sector. Much work needs to be done to design and develop models that can be successful in our context, as well as to provide ongoing opportunities for discussion and input on how this may work. Developing indigenous models that draw



on the best from elsewhere, while crafting programmes that have a good chance of success in local circumstances, is an important objective to have in mind as we look for new ideas and solutions for the ECD sector, and the majority of young children, in South Africa.

Endnotes

- 1 This piece draws on an unpublished paper written by Ana-Maria Arriagada entitled “Scaling-up Early Childhood Development (ECD) in South Africa”, November 2013.



- 2 Fractional franchising is a form of franchising in which a franchised service or product is added to an organisation's existing repertoire of services or products.
- 3 Estimates show that 80% of children in grade R attend public schools and 20% attend autonomous schools/centres. DBE funding for the latter can include teacher salaries or child subsidies. See SA Presidency (2012) *Diagnostic Review of Early Childhood Development*.
- 4 Harrison D. "Opportunities for Learning", Background Paper No.7, SA Presidency (2012) *Diagnostic Review of Early Childhood Development*. It should be noted that this includes

"any" kind of service/programme of any duration and/or content.

- 5 *Ibid.*
- 6 See review of international and South African research findings in Biersketer, L. et al., "*Predictors of Center-Based Early Childhood Care and Education Program Quality: A South African Study*" (2013), paper under review for *Early Childhood Research Quarterly*.