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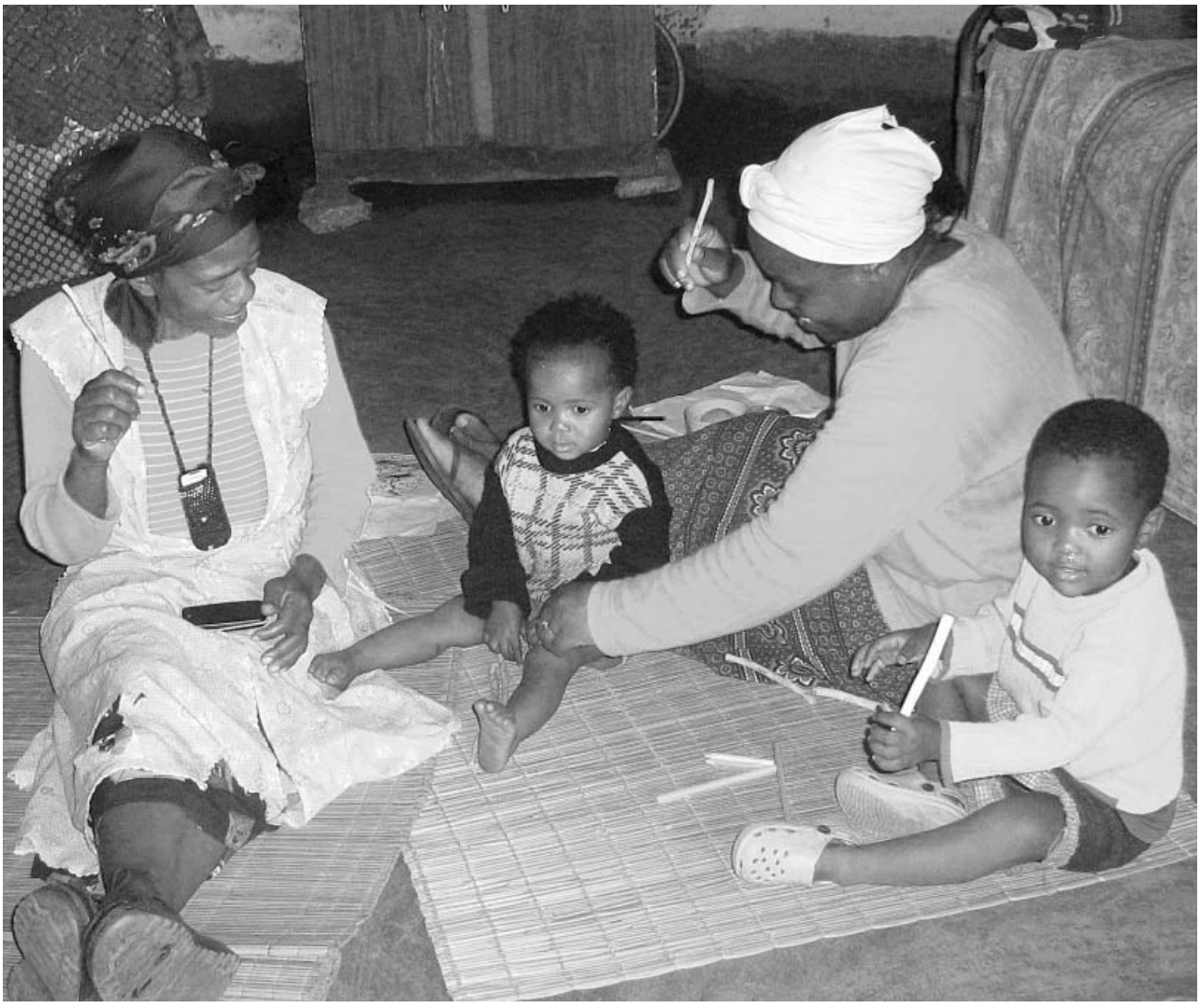
SOBAMBISANA INITIATIVE

PARTNER EVALUATION REPORT

The Early Learning Resource Unit (ELRU)

Wakh'umntwana Wakh'isizwe Programme

Lusikisiki, Eastern Cape



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Wakh'umntwana Wakh'isizwe Programme
Lusikisiki, Eastern Cape

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INTRODUCTION

About the Sobambisana Initiative

In 2008, the D G Murray Trust contracted five non-profit resource and training organisations (RTOs) active in Early Childhood Development (ECD) to design and implement sets of interventions for expanding access to ECD in underserved areas in different parts of the country. Called the Sobambisana Initiative, this project had the broader aim of testing new approaches to ECD which could inform the government's unfolding national ECD programme.

In 2009 the Elma Foundation and UBS Optimus Foundation joined the D G Murray Trust in funding Ilifa Labantwana, an expanded programme supporting innovation in ECD with a specific focus on rural and other deprived areas. Sobambisana became part of the Ilifa programme, tasked with testing models of ECD which could be taken to scale at the provincial or national level. It ran for four years until the end of 2011.

The Sobambisana partners included the Early Learning Resource Unit (ELRU), which implemented a set of interventions in Lusikisiki in the Eastern Cape. This report evaluates its activities over the four-year programme period. While the Sobambisana Initiative has ended, Ilifa's relationship with its Sobambisana partners continues, and some of the interventions discussed in this report are still being implemented.

ELRU Evaluation Report Format

The report starts with a quick overview of the key findings of the suite of interventions delivered by ELRU. This is followed by an overview of ELRU's goals and interventions.

Each of the ELRU interventions is then dealt with in turn. Questions relating to both programme outcome and implementation are addressed. The evaluation method for all partners is largely generic and is described in the main report on the Sobambisana Initiative entitled *Towards Integrated Early Childhood Development: An Evaluation of the Sobambisana Initiative* (2012). Where statistical analyses have been conducted, these are not reported in detail but have been summarised in endnotes, and the reader is referred to the Statistical Appendix for the details. Common assessment tools are described in the 'Test and Measures' section of the main report. This partner evaluation report was sent to ELRU before being finalised. Where appropriate, comments by ELRU personnel have been included.

OVERVIEW OF KEY FINDINGS

Wakh' umtwana, Wakh' isizwe is a holistic community development intervention based on a human rights approach to programming and aimed at building a supportive environment for vulnerable young children. A variety of interventions target families, schools and ECD centres, community members and service providers.

The Family and Community Motivator (FCM) home visiting programme

In this programme, vulnerable households with young children receive two two-hour home visits a month. Visits include providing emotional support to the caregiver, linking the family to services and key messages about providing a safe, healthy and stimulating environment for young children. Each visit includes a session where the FCM and caregiver are engaged in play activities with the children using locally available materials and a toy kit.

The FCM programme reached 330 caregivers and 702 children in Lusikisiki from 2009 to 2011. Evidence of programme outcomes indicates that:

- The programme improved access to documents, grants and services;
- Hygiene and safety in the home improved and caregivers provided more play and stimulation activities for their children;
- The child stimulation component of the intervention did not make a significant difference to children's cognitive and language outcomes. This indicates that a different or more intense intervention may be needed to achieve change in children who were severely malnourished and whose developmental level was below the norm for age.
- Home visited children were not more advanced than those who had not had exposure to an ECD programme when tested in Grade R. This is likely to be due to the significantly lower level of cognitive development in the visited group (ELRU targeted the most vulnerable children in the area).

Lessons from the evaluation

- The FCM programme is able to reach significant numbers of caregivers and children and provide support, enable service access and involve them in activities which stimulate their development and improve the health and safety of the home environment.
- For improved cognitive and language outcomes, the following factors should be investigated: Strengthened nutritional support for pregnant mothers and young children, and the effect of extending the duration of the programme and number of visits.

The School Enrichment Intervention

Capacity building for teachers in Foundation Phase classes and community preschools was designed to improve the quality of these services. Workshops were offered during ELRU visits to the area 7 times a year. Community preschool committees were involved in training to help get these established and eligible for DoSD funding.

All the public schools and the five community schools in the Mfinizweni area participated (30 teachers and 1118 children) though work in the public schools was on hold from May – December 2010 due to strike action.

The outcomes of the intervention included:

- Reports of a more holistic understanding of children and their circumstances from public school teachers and principals;
- Improved communication between Grade R teachers, other Foundation Phase teachers and principals;
- Slight improvements to classroom environments in the public Grade R classes but these were still below adequate levels on the ECERS-R measure;
- Significant improvements in community preschool quality achieved through improvisation and the use of local materials to provide activities;
- Provisions for further development through community construction of new preschool buildings, registration as NPOs and development of business plans for DoSD with support from the social worker.

Lessons from the evaluation

- Participation of both school management and teachers is important to provide support for capacity building initiatives.
- Public school classes in under-resourced areas are particularly challenging and require longer interventions as well as assistance with equipment to deliver less formal play-based programmes.

Interactions with NGOs, local and district government officials, teachers, community members and community leaders

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

Outcomes of this intervention were:

- Greater service access for children in the area as a result of the imbizo and stakeholder process. For example Home Affairs came to the area to assist with getting documents so that families could access grants; the Department of Health links with the FCMs for distributing food supplements and immunisation campaigns and has undertaken to service a health post in one area if the community constructs it. Similarly the Department of Social Development has assisted the community preschools with developing business plans and has undertaken to support the FCM programme once the local FCM coordinators have registered it as an NPO;
- Greater community awareness of the importance of certain services and how to access them;
- Evidence of a growing community consciousness of young children, interest and appreciation of the programme by people not directly involved in it and wider sharing of what they have learned by programme beneficiaries
- Engaging departments required ongoing efforts due to changing staff and in some cases were unresponsive:
- Establishing a new LOMAS responsible for young children was abandoned in favour of continuing to work with the Community Development Committee after learning of the challenges an established local NGO had with the establishment of Child Care Forums.

Lessons from the evaluation

- Building on existing structures is more likely to have traction and be sustainable
- A broad community involvement strategy appears to strengthen service demand and capacity.

Community Child Safety Intervention

This was intended to improve child protection in the community by creating awareness and assisting the community to develop an action plan. It was delivered through community imbizos and also through specific workshops for different stakeholders including primary school children aimed at mapping risks and discussing how to address these.

The outcome of this intervention was that a number of risks to child safety were identified and proposals made for addressing them. Community members have approached the Community Development Committee to take these forward with the local authority.

Lessons from the evaluation

Community based processes for child protection promote awareness and buy-in by community members promotes social solidarity around child protection.

Realising plans of action especially when they involve local and provincial authorities depends on securing commitment of appropriate role players.

Implementation Lessons from the Wakh' umtwana Wakh' isizwe approach in Lusikisiki

Like many other poor rural areas, Lusikisiki did not have nearby ECD resource organisations and ELRU was approached to provide assistance. This provided the opportunity to test a distance approach. This involved the challenge of keeping a close eye on things from ELRU's Cape Town base. ELRU had initially planned for 4 five day trips a year but this was insufficient for the complex set of interventions, the need to involve local stakeholders who were not always available and the demands on inexperienced FCMS in relation to data gathering for the M&E process. Trips were increased to 7 a year with the concomitant costs of travel and the burden on staff. Further challenges included the lack of infrastructure and resources in a rural area such as photocopying capacity, and having to bring basic training resources from Cape Town. However, distance was also enabling for leadership transfer in that the local programme staff and stakeholders had to take the work forward in ELRU's absence and this enhanced their independence and ownership of the work. It also required ELRU to manage the contact times efficiently and to put in protocols to assist with the monitoring and support processes. These strengthened the programme management and also provided opportunities to grow local capacity.

Central to success was a Human Rights Approach to Programming as an integrating concept which enabled both community members and service providers to understand their respective roles. A second contributor to success was continuous effort spent on repeated engagements with local role players in the NGO and government sectors and in the community.

Modelling, mentoring, reflective reviews and building on local strengths were integral to implementation. Evidence from the process evaluation shows that this was valued and has led to a growth in capacity both in caregivers, teachers, local leaders and programme field staff. Ultimately, the success of implementation depends upon relationship building at all levels, top down and bottom up. This all takes time and the long term nature of this project which allowed a year for startup was essential.

There was no measure in place to determine the extent to which interaction of the different interventions improved the support for vulnerable young children in the area. However, there is evidence that awareness of young children was raised more broadly, of how the FCM programme became a way that the Department of Health could reach families, of how public schools became more aware of the need to link to children's homes and finally a greater sense of social solidarity and mutual sharing and support.

THE ELRU EVALUATION

Introduction

ELRU works in a participatory manner in which community consultation is at the core of all its programming. Their focus in Sobambisana was on building an enabling and supportive environment for vulnerable children under age six through raising awareness of the developmental needs of young children among families, communities and government, and through engaging with government and the NGOs in the delivery of the necessary services.

A vulnerable child is described by ELRU as being: 'A child whose survival, care, protection or development may be compromised due to a particular condition, situation or circumstance and which prevents the fulfilment of his or her rights.' Community members and stakeholders identified vulnerable children as: children from single parents/unemployed; HIV and AIDS infected/affected/orphans; no proper supervision/not well looked after; neglected children; disabled children; abused children.

While the different elements of the approach are dealt with separately for purposes of this report, the Wakh'umtwana Wakh'isizwe programme is conceived as an integrated approach to supporting ECD with all the different elements contributing to the ultimate goal.

Programme location

ELRU was funded to deliver the Wakh'umtwana, Wakh'isizwe programme in two regions of the country: Lusikisiki in the Eastern Cape and Vredenburg in the Western Cape. Apart from establishing the reach of the Vredenburg programmes, this region is not included in this report. This evaluation is restricted to the Lusikisiki programme and to the period 2008 to December 2011.

ELRU had trained community members and teachers on the Basic Child Development, Antibias and HIV electives in the Lusikisiki area in 2004-2005 and those with whom they had worked requested ELRU to continue their work in the area. Follow-up consultations occurred in 2007 prior to the development of their proposal. These consultations led to the decision to locate the project in Thafelibanzi, a rural village of about 238 households located within the Mfinizweni area of the Quakeni Municipality near Lusikisiki. According to the South African Index of Multiple Deprivation for Children (SAIMDC),[1] Quakeni has one of the highest levels of child deprivation in the Eastern Cape. On that basis, this was an appropriate site in which to access vulnerable children and families.

ELRU programme context: Lusikisiki in the Eastern Cape.

APPROACH, GOALS AND INTERVENTIONS

Approach

The Lusikisiki interventions were implemented in four phases with 2008 being community entry; 2009 being a period in which the programmes commenced; 2010 a consolidation phase; and 2011 being the exit phase.

It should be noted that Lusikisiki is some 1300 kilometres away from Cape Town where ELRU is based. Staff had to visit Lusikisiki up to seven times each year for support, training and oversight.

In their proposal, ELRU indicated that their interventions would be needs driven and depend on what emerged during extensive participatory work with the target community and stakeholders (prior to and during 2008). As part of the community entry process ELRU compiled a Community Profile based on Participatory Rural Appraisal[2] methods. A community baseline survey of households was also undertaken. The following were local stakeholders' priorities for ECD in the area:

1. Taking care of the vulnerable children;
2. Improving parents' involvement in childhood development;
3. Training (of teachers and others in early childhood);
4. Getting the community involved (in early childhood issues);
5. Provision of equipment in ECD Centres.

Goals

The principal goal of ELRU's suite of interventions was to build an enabling environment for children and families in difficult situations.

In their proposal to the D G Murray Trust, ELRU stated that their specific aims were to:

1. Promote awareness of the situation of young children;
2. Build commitment to securing rights for children and families;
3. Survey local needs with community members and use the information in the planning and implementation of interventions for vulnerable children in the area;
4. Strengthen safety nets and nodes of support for vulnerable young children;
5. Establish co-ordinating and monitoring mechanisms;
6. Advance the lobby for alternative initiatives for providing access to vulnerable young children;
7. Build capacity – skills, leadership, networks and projects to promote child and family wellbeing;
8. Explore ways of ensuring that genuine account is taken of indigenous knowledge and institutions as the basis of interventions;
9. Ensure sustainability of key aspects of the project;
10. Link the project to relevant policy planning and implementation, providing feedback for further policy development.

Interventions

In order to achieve these objectives, ELRU proposed to implement the following interventions:

1. The Family and Community Motivator (FCM) Home Visiting Programme;
2. The Community Child Safety intervention to promote child protection;
3. Training, skills programmes and support for teachers in ECD sites and Grades R through 1;
4. Preparation of carers and children for transitions to Grades R and 1;
5. Establish a Local Monitoring and Action Structure (LoMAS) to ensure that action was taken to improve service delivery to vulnerable families and young children.

In 2008 and 2009, the M&E team worked with ELRU to finalise the main goals of their interventions. These are presented in Table 1. The table lays out the relationship between programme goals and outcomes and includes the central intervention.

Table 1: ELRU Lusikisiki goals, activities, outputs and outcomes

Overall goals per funding proposal	Specific goals	Activities	Outputs	Short-term outcomes	Long-term outcomes (Grade R)
To develop a model that: Dramatically increases access to developmental opportunities Addresses *modern* issues such as bereavement, nutrition and the ongoing holistic development of children Provides quality programme implementation Ensures seamless transition between the ECD site and school Defines the relationship between participating NGOs and the state	Improve access to state services and resources for families and young children Strengthen coping of caregivers with particular needs Improve early stimulation in the home Improve hygiene & safety in the home	FCM Programme	Family Community Motivators are enrolled, trained and supervised Vulnerable parents/ caregivers with children 0 to 60 months who have no access to ECD are enrolled Home visits and cluster workshops take place as designed and scheduled	Children have Enhanced cognitive and language development, and access to nutrition, documents and services Parents / caregivers practise appropriate safety, hygiene, and early stimulation in the home	Children perform better on developmental assessments than those who have not had ELRU interventions
	Improve the quality of ECD sites and Public School Grade R & 1	Training and Support for ECD Practitioners and Teachers	Teachers and practitioners are enrolled Training workshops are held Equipment and educational resources are provided	Teaching and learning environment quality is enhanced	
	Improve access to state services and resources for vulnerable families and children.	Meetings and Workshops with Stakeholders and the Community	Formation of a Local Monitoring and Advisory Structure (LoMAS)	Vulnerable families and their children receive the services required	
	Improve child protection	Community Safety Intervention	Community imbizos are held Risks to children are identified Plans for child protection are developed.	A Child Protection Plan is presented to the Community Development Committee for action	

Adaptations

The LoMAS structure: Over the course of the intervention it became clear that the establishment of a new community structure to advocate for children's services was not going to succeed and was abandoned. Engagements with local role players continued to form a key part of the ELRU approach, but through existing community structures.

Transitions to school: As Grade R programmes were running ineffectively in 2009, the intervention was postponed to 2010. However, no activities in schools were possible from May due to disruptions occasioned by the long mid-year break due to the Soccer World Cup, a subsequent SADTU strike, and the 'non-compliance campaign' which followed. It became apparent by late 2010, that a specific transitions to school intervention was not going to be possible. However, in June 2010 home to school transition was discussed and the Education Department talked to parents at an imbizo about enrolment in Grade R and what was required. In 2011 ELRU reported that the home to school discussion gained impetus with the Department of Education and the public and community schools. Principals recognised having open days during the last term would be helpful with enrolments for 2012. Open days were advertised locally and held in November. FCMs were invited to attend. The result was different groups including the FCMs recognised the important role they could play in making home to school transitions. Links between community preschools and public schools have also strengthened.

We now proceed to discuss each the ELRU programmes in turn.

THE FAMILY COMMUNITY MOTIVATOR (FCM) HOME VISITING PROGRAMME

Programme description

This programme seeks to target particularly vulnerable households with young children. Vulnerable households include those affected by unemployment, illness, disability, and lack of support. A common denominator is long-term poverty.

The FCM programme has been offered by ELRU in a number of communities for many years. It is delivered by FCMs who are nominated by the local community and screened and trained by ELRU and supervised by a local coordinator. In Lusikisiki additional oversight is provided at visits conducted by the programme managers (based in Cape Town). FCMs are paid a stipend.

The ELRU FCM Programme consists of 20 home visits (two per month) of about 2 hours duration, plus a monthly c*luster workshop* at which a group of parents / caregivers who live in close proximity come together with their FCMs for educational inputs and support while the children attend a playgroup.

FCMs follow the programme manual, which provides guidelines for home visits in Chapter 5 (Lake and Newman, 2008)[3]. The programme is not manualised in the strict sense, but guidelines for visits are provided to support an intervention that is sensitive to the needs of the family. Forms are provided for the visitor plan sessions and workshops and to record notes and actions to be taken.

The coordinators and ELRU team read the reports to help plan for cluster workshops and for additional training for the FCMs. As the area in which they operate is rural and as homesteads are scattered across the hills, FCMs have to walk some distance to each homestead. Inclement weather can disrupt the visit schedules, and affect workshop attendance.

The visits are also intended to raise awareness of the rights of children and the responsibilities of duty bearers; provide ECD information (e.g. holistic development, and age appropriate behaviours); deliver key messages about hygiene, health and safety; link carers to cluster workshops; facilitate access to services (e.g. NGOs; social grants; health services etc); and identify caregivers with particular emotional needs for referral where appropriate.

These are among the twenty three 'Key Topics' for home visits suggested in Chapter 5 of the FCM Manual, to which the visitor may add depending on the needs of the family. Caregivers are given Masithethe materials, simply written guides (in local languages) with key messages and code pictures for different topics. FCMs are expected to spend at least an hour with the primary caregiver and children on early stimulation, storytelling and play inputs (including the use of basic toy kits and improvised toys made of materials available in the home). Examples of FCM training, visits and cluster workshops are depicted below.

An FCM training session in progress.


An FCM home visit and cluster workshop.

The M&E team worked with ELRU to assist them to develop an explicit Theory of Change (TOC) for the FCM programme. The TOC submitted to the M&E team in 2010) states:

> *'If we support parents and caregivers to understand what young children need in order to develop to their full potential and provide them with knowledge, skills and resources to access relevant services and learning opportunities, AND if we provide long term, sustainable support THEN children will have a stronger foundation for schooling, resilience and coping with later life.'*

Note: It is assumed that local leadership is developed through a corps of FCMs who remain in the community, that the FCMs as a group greatly strengthen safety nets for young children, and that a human rights/child rights approach is entrenched during the intervention that will endure.

Outcomes of the FCM intervention

Reach

As the evaluation focuses on Lusikisiki, data for Vredenburg is restricted to targets and enrolment in Table 2.

Table 2: Reach of Vredenburg FCM home visiting programme, 2008-2011

Parents	
Parent Target	320
Parent Reach	95
Children aged 0-6 years	
Child Target	Not specified*
Child Reach+	152

*Notes: * ELRU stated that they intended to reach 720 children in both Vredenburg and Lusikisiki. + All children of visited homes in which practitioners are trained. Source: ELRU Report July 2011.*

Targets, reach and attendance for Lusikisiki are presented in Table 3.

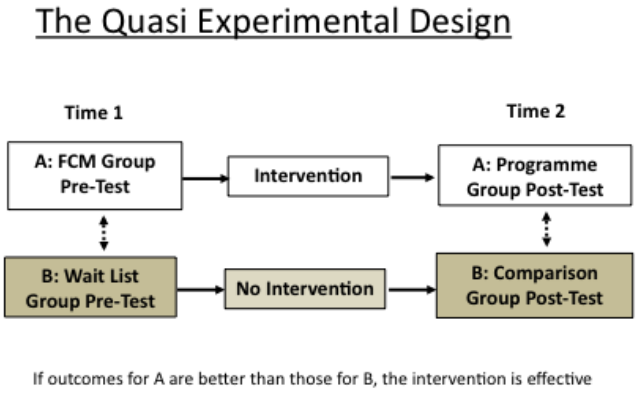
Table 3: Reach and attendance of Lusikisiki FCM home visiting programme, 2008-2011

Parents with children	
Parent Target	Not specified
Parent Reach	330
Children aged 0-6 years	
Child Target	Not specified
Child Reach+	702
Average parent visit attendance with a child	100%
Average number of Cluster Workshops attended by parents / caregivers and children (out of a possible 8 sessions)	5

Note: + All children of visited homes.

Method: Measuring the effects of the FCM programme on children and adults

Where possible, programme outcomes were assessed by comparing children and parents who had received the FCM intervention with those who had not, using a quasi-experimental evaluation design.[4]



Following recruitment of the participants for the FCM programme in each year, a subgroup of parents with at least one child in the 36 – 48 month age band was identified. They constituted the intervention group to be compared over time with a waitlist group (also with a child aged 36-48 months). This *quasi-experimental sample* was smaller than the total number of children who were in the entire Sobambisana initiative in Lusikisiki (as depicted in Table 3). It was not possible to randomise assignment to the two groups (best practice) as ELRU felt it would be ethical to only enrol the waitlist group once the programme was subscribed rather than raising expectations. As a result there remain unknown sources of bias. For example, the two groups may have different characteristics

that could affect their response to the FCM programme. These would be likely to affect the outcomes for both groups. Random assignment would have reduced this probability. In each of years 2009 and 2010 both adults and children were assessed on a number of measures at baseline before the start of the FCM intervention and after delivery. Wait list groups received the intervention in the next cycle. The design is depicted in Figure 3 below.

As in the case of all partners evaluated, once outcome evaluations have been reported, these are followed by data gathered as part of the process evaluation, including interviews with programme staff and beneficiaries, and extracts from partner reports.

Programme outcomes of the FCM intervention: parents and caregivers

Did the FCM Intervention change parents' early stimulation and safety and hygiene practices?

As indicated above, while the home visits were tailored to the family, all were provided with inputs designed to improve the safety and hygiene of the home environment, and to assist participants with parenting and the promotion of children's early learning and development.

In order to assess the benefits of these inputs for beneficiaries, they were rated at baseline and follow-up on the Safety and Hygiene Checklist and four subscales of the H.O.M.E. inventory for Early Childhood (Acceptance; Responsivity; Academic Stimulation; and Language Stimulation). The amount of change on these measures was assessed and subjected to statistical analysis.

The findings are:

Safety and Hygiene:[5]

Safety and hygiene *improved* in the Intervention Group (n=183) over the course of the home visits. However, there was *no difference*[6] on this measure between the FCM Intervention (sub-sample of the larger intervention group of n=18) and Waitlist groups (n=15) at follow-up.

H.O.M.E. Subscales:[7]

The Intervention Group (n=102) *improved* over the course of the home visits on all the subscales. Beneficiaries' interactions with their children were more accepting and responsive, and they provided improved academic and language stimulation. However, there was no difference between the FCM Intervention (n=23) and Waitlist (n=15) groups at follow-up.

The findings for the FCM Intervention group seem promising. Why did this not show up when comparing them with the Wait List group?

First of all, for the statistical analysis of the Intervention group Safety and Hygiene outcomes, we had 162 participants who could be followed over time. This is a very solid number of statistical purposes. But when the FCM Intervention and Wait List groups were compared, only valid complete pairs of data were used (so that the same individuals were compared on the extent of change between the baseline and follow-up times of measurement). This resulted in attrition of scores and (as follow-up scores were not available for a number of participants) and very small numbers were available for comparison purposes. This is certainly likely to have affected the statistical analysis. For these reasons, we would not make much of the null findings.

Programme outcomes of the FCM intervention: Children

One of the key objectives of FCM programme was to enhance the rights of vulnerable children, and in part this was to be achieved by providing assistance to parents / caregivers so that they might access state services (e.g. documents, social grants and health services). Children in need of services were referred to the relevant authority. In parallel, ELRU's advocacy initiative with local and provincial district authorities sought to increase local responsiveness to parents requesting one or other service.

Did the FCM intervention improve access to services?

As will be evident from Table 4, this goal was achieved. Significant numbers of referrals were made and across both years, *in excess of 83%* were resolved.

Of concern is the fact that 14% of cases referred in 2009 and 10% in 2010 were not resolved by 2011. This can occur for a variety of reasons. ELRU indicated cases in which children are cared for by a grandmother and the mother is not in contact but has the child's birth certificate, thus preventing access to the necessary services.

While significant gains are evident, the above figures cannot tell us whether or not these outcomes would have been obtained in the absence of an FCM intervention. It is possible that progress could have occurred without this support or that other changes in the service environment could have contributed to the difference. Data for the wait list comparison group is not appropriate for statistical comparison due to small numbers. In addition there were many other interventions to which the wait list group was exposed which would have invalidated the comparison.

The awareness raising campaign and interactions with NGOs, local and district government officials, teachers, community members and community leaders which were another aspect of the Wakh' Umtwana Wakh' Isizwe intervention were also intended to promote access to documents and services. For example the Department of Home Affairs came to the area to help with documents following a widely attended community imbizo set up as part of the programme Further, community members who were not enrolled in

the programmes approached the FCMs and even parents for assistance and information about services, documents and grants.

Table 4: Lusikisiki child services: referrals and outcomes, 2009 and 2010

Service	Referrals+	Referrals resolved	Referrals unresolved at July 2011
2009			
Birth Certificate	35	31	4
ID Document	21	18	3
Immunisation & Road to Health Charts**	66	66	0
Child Support Grant	40	30	4
Foster Grant	9	8	1
Disability Grant	3	3	0
Family Health issues including HIV&AIDS	17	13	4
Malnutrition *	30	27*	0
Poverty (Food parcels)	15	1	14
Total	236	203 (86%)	33 (14%)
2010			
Birth certificate	31	28	3
ID Document	7	2	5
Immunisation**	42	42	0
Road to Health Charts**	17	17	0
Child Support Grant	37	30	7
Foster Grant			
Disability Grant			
Family Health issues including HIV&AIDS	8	7*	0
Malnutrition*	46	45	?
Poverty (food parcels)	26	21	5
Total	214	192 (90%)	20 (10%)

*Source: ELRU July 2011 Progress Report. Notes: + One child may be referred for more than one problem. For this reason, referrals rather than cases are counted. * Of those referred due to malnutrition: in 2009, three died; in 2010, one child died. ** In 2009, ELRU's record-keeping system combined referrals for immunisation and Road to Health Charts. It is not possible to separate out the numbers referred for each service in that year. They were separated for 2010.*

Description of the child outcomes evaluation sample

The criterion for inclusion in the quasi-experimental comparison of the effects of the FCM programme on children's cognitive and language outcomes was that children had to

be in the age range 36 to 48 months. Numbers of children enrolled in the 2009 and 2010 cohorts were combined for the analysis.

Ninety six (96) children were recruited over the two years, 47 in the FCM intervention and 49 for the Wait List. Unfortunately fewer could be contacted for assessment at follow-up and each group was smaller than desirable for statistical analysis. Figures are presented in Table 5.

Table 5: Average age of child participants at time of assessment

Year	FCM Intervention		Wait List	
	Baseline sample size & average age	**Follow-up sample size & average age**	**Baseline sample size & average age**	**Follow-up sample size & average age**
Cohort 1: 2009	N = 21 Age 3.94 (SD 0.44)	N = 19 Age 4.50 (SD 0.46)	N = 18 Age 3.98 (SD 0.35)	N = 12 Age 4.47 (SD 0.31)
Cohort 2: 2010	N = 25 Age 4.36 (SD 0.81)	N = 23 Age 4.94 (SD 0.82)	N = 30 Age 4.13 (SD 0.47)	N = 20 Age 4.67 (SD 0.43)
Total Sample	46	42	48	32

It was not possible construct groups matched for age prior to embarking on the evaluation. However, there is no statistical difference between the mean ages of the intervention and wait list groups at any point in time. The groups can therefore be considered equivalent on age.

Child growth status

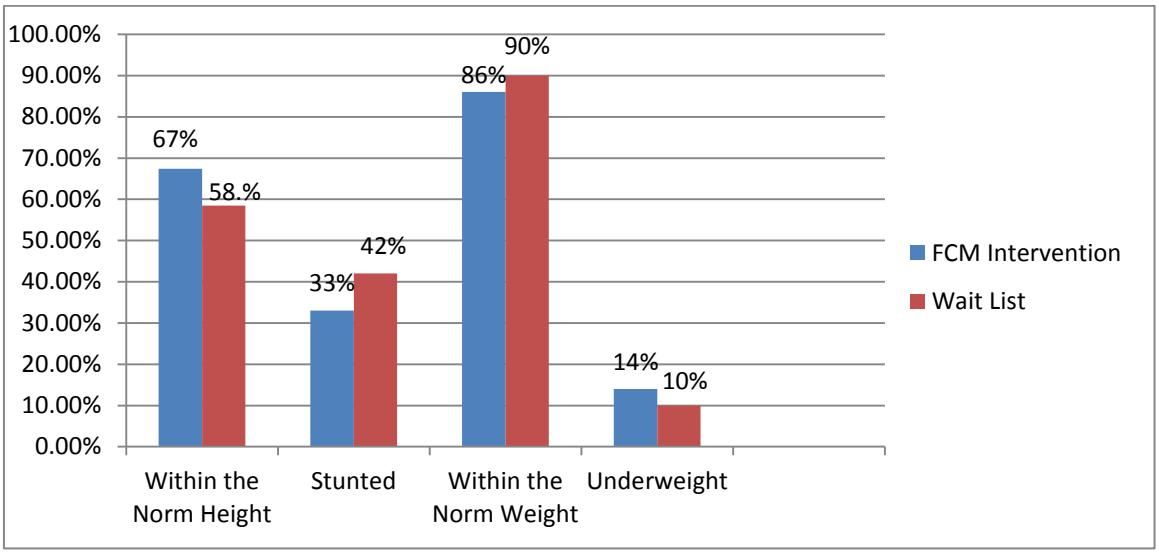
Malnutrition in the early years is known to affect psychological development as a consequence of its detrimental impact on neurological development, particularly in the first 36 months (Walker and colleagues, 2007)[8]. It is therefore important to measure each child and examine the impact of growth status on the developmental outcomes of interest. As in the other Sobambisana programmes, children's growth status was assessed at the commencement of each FCM programme cycle using WHO standard procedures and height for age and weight for age was calculated using the WHO *Anthroplus* package. Table 6 and Figure 4 provide the relevant information for both groups. The underweight numbers are too small to warrant graphical presentation. On average, (both samples), 37% are stunted and 13% of the children are underweight.

Table 6: Evaluation sample: growth status (2009 and 2010 cohorts combined)

Groups (2009 and 2010 combined)	Height for age: 84 children assessed		Weight for age: 79 children assessed	
	Within the norm	Stunted	Within the norm	Underweight
FCM intervention	29 (67.4%)	14 (33%)	32 (86%)	6 (14%)
Wait list	24 (58.5)	17 (42%)	37 (90%)	4 (10%)
Total	53 (63%)	31 (37%)	69 (87%)	10 (13%)

The stunting figures are not representative of the under-five population in the study site However, they are alarmingly high and well above the stunting rate of twenty percent (20%) recorded for *children in rural areas* such as Lusikisiki in the 2005 National Food Consumption Survey. The data indicates that the development of many of the sample was compromised. Under-weight rates are similar to the average for children in rural areas (8%) (Labadarios, 2007)[9].

Figure 4: Stunting and underweight rates of FCM intervention and wait list groups



The families targeted were very vulnerable, so the stunting rate is perhaps not surprising. Clearly early nutritional assessments and interventions are indicated in the area.

We turn now to presentation of the findings on the effects of the FCM intervention on child cognitive and language outcomes.

Child cognitive and language outcomes

While not an intensive school readiness intervention, the M&E team established that FCM programme was expected to have an effect on cognitive and language development.

Did the FCM intervention improve child cognitive and language outcomes?

The Grover Counter Scale was used to assess children's cognitive level. The test has norms for black rural children[10] (the level at which children are expected to perform on the test).

A test constructed specifically for this evaluation based on Shipley and McAfee (1992)[11] was used to assess language development (Sobambisana Measures Appendix). As the test is not normed and children would be expected to improve with age, effects of age are controlled in analyses.

The FCM intervention and Wait List groups were compared between baseline and follow-up on both the tests. One would expect positive change on both measures due to the child's maturation and development. For this reason each child's *change scores* were used in the analysis - that is the difference between the child's baseline and follow-up scores.

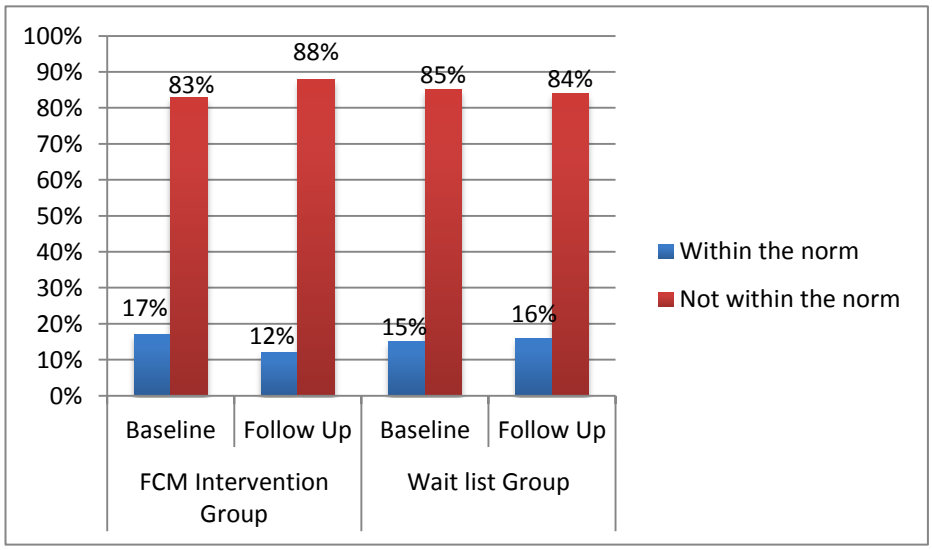
The true test of the advantages conferred by the FCM programme is whether children in this group would make *greater gains* due to the early stimulation guidance their parents received from FCMs, and due to the participation in the early stimulation play activities conducted during the visits.

First we report on the proportions of children within the norm for their age on the Grover Counter Scale of Cognitive Development (not possible for the language assessment as there are no norms). Summary findings for both cohorts are presented in Table 7 and graphically in Figure 5.

Table 7: Proportions of children within the norm for age on the Grover-Counter Scale

FCM Intervention	Within the norm for Grover		Not within the norm for Grover		Total
	N	% of total	N	% of total	
Baseline	8	17%	38	83%	46
Follow up	5	12%	37	88%	42
Wait List	Within the norm for Grover		Not within the norm for Grover		Total
	N	% of total	N	% of total	
Baseline	7	15%	41	85%	48
Follow up	5	16%	27	84%	32

Figure 5: Proportions of children within the norm for age on the Grover-Counter Scale (2009 and 2010 cohorts combined)



As will be evident, at both baseline and follow-up and in both the FCM Intervention and wait list groups, more than 80% of children were not within the norm for their age on cognitive development at both times of assessment.

This is of considerable concern, and may be due to several factors. They include variation in testing conditions – for example a child performed below par on the day or an assessor did not establish a good relationship with a particular child; a child's unfamiliarity with the sorts of tasks required in the test could have played a role.

Also possible is that the compromised cognitive functioning revealed on the test is due to neurological deficits as a consequence of prolonged early malnutrition.[12] For stunting to be evident at age three as found in more than 35% of the children, malnutrition must have occurred within the first two years of life during which neurological development is rapid. Unfortunately the relationship between Grover-Counter Test scores and stunting could not be established as too few children were within the norm on the test to permit statistical analysis.

Were children who participated in the FCM Intervention more likely than the Wait List group to be within the norm for cognitive development after the intervention?

Chi^2 analysis of the proportions of children within the norm for age after the intervention showed that there were no differences between the FCM and Wait List groups.[13]

This finding indicates that the FCM intervention did not have an effect on the cognitive development of the children *as assessed on the Grover Counter Test*. This does not mean that other benefits may not have accrued to these children, and it is possible that on another test differences may have been found.

Were children who participated in the FCM Intervention likely to improve more that the Wait List group on cognitive and language development?

The amount of change in cognitive and language development test scores between baseline and follow-up was examined separately for each group. The FCM and Wait List groups were also compared. Each child's *change scores* (the difference between the child's baseline and follow-up scores) were used because they control for the child's age.

Findings showed that, while scores had improved over time, there was no significant difference in the amount of improvement in language or cognition between the FCM intervention and wait list groups.

Reflections on FCM programme implementation

Data sources

Data sources for this section of the report are drawn from the common data sheet compiled by ELRU, M&E reports, reports to donors, records of meetings with programme staff conducted over the period of the evaluation, field visits by the M&E team, and

interviews with programme staff and parents conducted by an independent researcher for process evaluation purposes in June 2011.

Did the FCM programme reach its intended targets?

The FCM programme targeted vulnerable parents who had at least one child under the age of five years. FCMs were local and knew which families were struggling and whose children were not in an ECD programme. As has been indicated the area is particularly deprived and the poor nutritional status of the children is a further indication of this, so most children in the area could be considered to be vulnerable. Interviews with programme participants and FCMs provide evidence that children identified as vulnerable in the community consultation process were targeted.

> *'Since we are dealing with poor families, you will find that they are struggling and they don't have food' (FCM)*

> *'The extent of poverty in some of the families I am working with surprises me. I have always known that people are in poverty but not to the extent I have been exposed to – it is reflected in the faces of the young children in those families.' (FCM)*

> *'What touched me most was when I saw a child who was not clothed warmly and it was raining and the child's milk bottle had flies all around it with no cap.' (FCM)*

There were also a number of references to children with disabilities, children (including orphans) in the care of elderly grandparents, and caregivers with TB or HIV, instances of domestic abuse and violence, and isolation.

Was the FCM programme delivered as intended?

The ELRU FCM programme was an holistic intervention that sought to be responsive to the needs for assistance (required for children and other household members) identified in the course of visits and cluster workshops. Particular attention was paid to leveraging services so as to support children's rights to health, social security and development. Also integral to the programme were inputs on parenting and early stimulation. A two-generation approach to supporting parents to scaffold early learning was central to the practice carried out during home visits. This was observed in the field during visits to homesteads by the M&E team.

In their December 2008 report to the M&E team ELRU observed that, in the recruitment phase of the project, trust was an issue. For example, there was resistance on the part of the community to collecting information on households during the community scoping and baseline exercise. However, as the programme became established this changed. One caregiver commented:

> *'I didn't immediately become part of the programme even when I was recruited I refused because of suspicion that they wanted my documents. When I saw it work in those families they are visiting I informed her that I would like to become part of the programme.'*

This point has relevance for others collecting data in early phases of an intervention. One cannot be sure that beneficiaries will be truthful about these matters for understandable reasons. Reliable counts of finances grants and other such information may not be possible until trust has been established.

The programme name seems to have attracted participation which is of interest in the light of Ilifa Labantwana Executive suggestions about the need for branding ECD to encourage parent involvement. For example two caregivers commented:

> *'The name itself caught my interest.'*
>
> *'I am inspired by the concept Wakh' Umtwana Wakh' Isizwe – that is what invited me to the programme'.*

When the M&E team visited and was walking through the area, people greeted us and called out '*Sakh'umtwana Sakh'isizwe'*, indicating the footprint that the intervention has made in the area.

ELRU also noted that a major gain for this community was the employment opportunity created by the programme (13 jobs were created). As part of their exit strategy, ELRU has been in discussion with the Department of Social Development which hopes to support a local NGO to continue employing FCM staff.

As would be understandable in a home visiting programme, participation of parents and their children at visits was 100%. Cluster Workshop attendance was much lower at 50%.

Assessment of programme delivery suggests that the intended transfer of ECD knowledge to parents is likely to have occurred. This is also evident from positive changes in the quality of safety and hygiene conditions and in the quality of parenting and early stimulation observed at the end of the intervention.

The M&E team was provided with records of FCM programme oversight and supervision that indicated that the quality of the programme was consistently monitored. ELRU documents indicate that a number of provisions were developed to maintain and develop quality of delivery including developing a specific Play and Stimulation Form to assist FCMs to plan the children's sessions, capacity building during every visit by the ELRU team and a mentorship programme in which four weaker FCMs, who were observed to be shy and lacking in confidence, were paired with four more competent FCMs to help build their skills in home visiting, presenting cluster workshops and data collection for the research.

In an interview the local FCM coordinator described how she supports the work checking planning forms and reports and doing monthly visits with each of them. She also checks on referrals and has twice monthly meetings with all the FCMS to discuss challenges and to give feedback.

FCMs had also learned how to be good facilitators. They spoke in interviews about the importance of having the right approach to working with families:

'We must be confidential, trust worthy and show love with children and parents.'

'Since we are dealing with disadvantaged backgrounds we must be in the same level as them, not to think we are superior to them, so that parents can trust us.'

All these provisions assist in the programme being responsive to the needs of families and that the child and parent components are delivered.

Interviews with programme staff and participants highlighted the benefits of participation.

Both FCMs and parents described benefits of participation but stressed that a major change in beneficiaries was a realisation of children's rights and the importance of play.

The external researcher who facilitated focus groups with beneficiaries and FCMs commented:

'Play comes out as the most important element of the project that comes across so powerfully … Caregivers talked about the knowledge they got about coming closer to the children and take time to play with them and make space for children to play.'

Benefits of participation included:

Helping the primary carer cope:

'The FCMS played a very big role into improving our daily lives. When we have problems we talk to them, they are free to help us and our problems get solved easily.

Assistance with access to documents and services:

'It also helps with getting birth certificates and IDs so we can get child support grants'

'I was not attending the clinic for immunisation but the FCM motivated me and told me the outcomes of a child if she does not get immunisation'

A disabled child identified by the FCM now gets a grant and goes to preschool and her mother says 'My child is no longer disabled' (referring to the extent to which she has improved).

Helping parents to understand their own role in child development and preparing children for school:

'I am my child's first teacher and responsible to build up his future.' (Parent)

'Children are now learning numeracy, literacy and their names through the home visits and cluster workshops' (FCM)

Both caregivers and FCMs reported on how the programme was implemented at home

'My grandchildren are active, we play together, make toys with clay and they help with the house chores.'

'The FCMs are coming to our homes and the only thing they need from us is to listen and watch what they do with children; then we do the activities with the children when they leave.'

FCMs made similar comments:

'Families are gaining a lot of knowledge and developing hunger to learn numeracy and literacy. They incorporate some of the stuff we teach them into their daily activities'

'Families are doing or taking further what I do with children, like toy making and playing with children.'

There were also a number of comments about improved caregiver-child relationships and how it has helped with building communication between a parent and a child.

FCM programme conclusion

The FCM programme reached 161 caregivers and 228 children in Vredenburg and 330 caregivers and 702 children in Lusikisiki.

As attested by the interviews with beneficiaries, the FCM programme was instrumental in providing holistic support to very vulnerable families. Access to documents grants and services improved. While support of all kinds took place it is particularly interesting how significant the child development aspects presented in the programme were for caregivers. This is of interest when there were so many unmet basic needs in beneficiaries. It suggests that FCMs played a significant role in changing beneficiaries' perspectives on child development and rights.

While there is a strong child stimulation component the FCM intervention may not be long enough or sufficiently focused on activities that would address deficits in cognitive and language development to make a significant difference to child outcomes in this vulnerable population. Parents/caregivers themselves indicated that they would have liked more frequent sessions and/or a longer programme:

'Increasing days would make a lot of difference in the child stimulation.'

'We plead for the continuation of the programme. Our children are still young. I have grown to be very active with my children, but there are things I can't do that the FCM can do better with these children.'

The findings of the evaluation point to the considerable challenge of achieving change in children where early malnutrition is so prevalent. Stunting is very likely to have *reduced* the probability that the FCM programme would enhance children's development. Indeed these children are likely to be neurologically compromised and interventions of considerable intensity and time would be required to realise even a modest change. The FCM programme is not of this kind.

In our view the greatest benefit of the FCM programme has been in its ability to reach significant numbers of children and vulnerable parents, provide support and access to

services, and introduce parents to the value of engaging their children in play and other activities likely to enhance early learning. Improving cognitive and language development is likely to require a much more intensive, specialised and long term intervention and FCMs would require additional training.

THE SCHOOL ENRICHMENT INTERVENTION FOR PRIMARY SCHOOLS AND COMMUNITY PRESCHOOLS

Programme description

ELRU had had a footprint in the area since 2004–2005 when 48 practitioners were trained at Level 4. In consultations with the M&E team before starting this intervention, ELRU reported a number of issues that undermined the quality of schooling in the area.

- Despite training, Grade R and primary learning environments remained very poor. ELRU spoke of a 'situation of great neglect'.
- Principals were frustrated by the neglect of their situation by the Education authority.
- Teachers do not get paid regularly, and Grade R teachers received pay for 10 months of the year.
- The school feeding programme was not being implemented.
- Parent involvement was very low.

In the Sobambisana project from 2008 to 2011, rather than involving formal training toward some form of certification, ELRU's engagement with public schools and community preschools in the area may be described as driven by the needs of the school as determined through initial visits and assessments of the situation.

The ELRU TOC for this intervention was expressed as follows:

> *'Teachers need to know how children develop and learn, they need to be trained to create effective learning environments and to facilitate learning. If we provide skills for teachers through regular training and long term support in a participatory, problem solving approach that recognises how adults learn AND if we work in a holistic way involving school management, relevant departmental officials and parents, THEN teacher practice and classroom environments will improve and young children will benefit from age-appropriate programmes as well as the positive relationships between the adults in their lives.'*

The goal was to improve the quality of ECD sites and Public Grade R and Grade 1.

Activities included:

- Training and capacity building workshops for ECD and Grade R and Grade 1 practitioners on appropriate classroom practice informed by child development and which is sensitive to the local context.
- Provision of equipment and resources including learner support materials and toy kits
- Support visits to practitioners.

The key indicator of success was to be that ECD and Public Grade R and 1 classrooms would provide an acceptable quality of learning environment. The quality of these classrooms and school environments was to be measured at baseline and follow-up by independent assessors using subscales of the Early Childhood Rating Scales (ECERS-R), and through appraisals by programme staff.

Interventions commenced in September 2008 and included provision of needs-based support through workshops, support visits and practical demonstrations as well as assistance with NPO registration for preschools and also equipment.

During visits to the area, ELRU staff from Cape Town conducted day-long training workshops for primary school teachers. ELRU also spent time observing classrooms and providing on site feedback to teachers and ECD practitioners. The intervention also included meetings with school principals in an effort to inform them of the intervention and to engage them in improvement of the teaching and learning environment.

As has been mentioned, the intervention in public schools was severely disrupted from May 2010 until the end of that year.

Outcomes of the community preschool and public school enrichment intervention

Reach of the interventions

At the start of ELRU's engagement in Lusikisiki, there were two community preschools. Three others were established later. ELRU worked with five public primary schools in the area. As the evaluation focuses on Lusikisiki, data for Vredenburg is restricted to reach. Reach is presented in Table 8.

Table 8: Reach of the Lusikisiki and Vredenburg Schools Enrichment Intervention

Community Preschools*		Primary Schools+		Vredenburg community preschools and public Grade R ++	
Preschools	Teachers	Schools	Teachers	Schools	Teachers
5	6	5	24	29	65

*Notes: * 137 children enrolled in preschool classes; + 981 enrolled in primary school classes capacitated by ELRU, ++ 1 188.*

Because all the schools in the greater Mfinisweni area participated it was not possible for this intervention to have the possibility of comparison with schools that did not receive

the intervention. Outcomes are presented as a mix of narrative drawn from ELRU, external interviews, and ECERS-R assessments conducted in classrooms.

Interventions in preschools

At the time of entry to the area, no ECD sites were known. Over the course of time two very humble initiatives were identified. Neither was registered. The first picture below shows a community preschool being held in the veld at the start of ELRU's engagement. No building or equipment was available at the time. The second picture depicts this group after the ELRU intervention.

A community preschool before and after ELRU's engagement.

ELRU provided training and capacity building workshops for ECD practitioners in child development and stimulation that took account of indigenous knowledge and practice. ELRU also provided learner support materials. In 2009 noting that progress was slow in the community schools, ELRU decided to also engage the preschool committees and trained them on their roles and responsibilities and how to register the centre.

A teacher training session in progress.

Preschool practitioners were included in the training workshops for public school teachers in from 2010. In that year, seven training workshops were attended by six preschool practitioners. By combining the groups it was believed that preschool

practitioners would become more familiar with the expectations of formal schooling, and those teachers in public schools would become more aware of the needs of young children entering their classrooms.

Preschool outcomes

Outcomes for preschool interventions reported by ELRU are:

- By exit, three further ECD sites were established with ELRU support.
- Four are constructing new buildings for the children.
- Four of the five community preschools had received NPO registration certificates by the end of 2011 and one is still in the process. In 2011, the DoSD assisted all five to develop and submit business plans for funding in the next budget cycle.
- Negotiations with the Ingquza Hill Municipality promised a small amount of equipment and materials to each of the preschools but unfortunately the municipality delayed and the money was lost to the budget cycle. However, committee members raised this with the municipality at a public meeting and have received a commitment for equipment from the current budget to be delivered in November. When this did not materialise practitioners and committee members from each preschool challenged the municipality who then promised delivery by the end of 2011.
- One practitioner from each preschool will be doing Level 4 training in 2012.

Two new preschools built by committees and community members.

All five preschools were assessed on the ECERS-R at follow-up. Findings are presented in Figure 9. Only two were assessed at both baseline and follow-up. Findings for change in the average quality of the learning environment are presented in Figure 10.

Figure 9: Pre-school classroom learning environment quality at follow-up (five preschools)

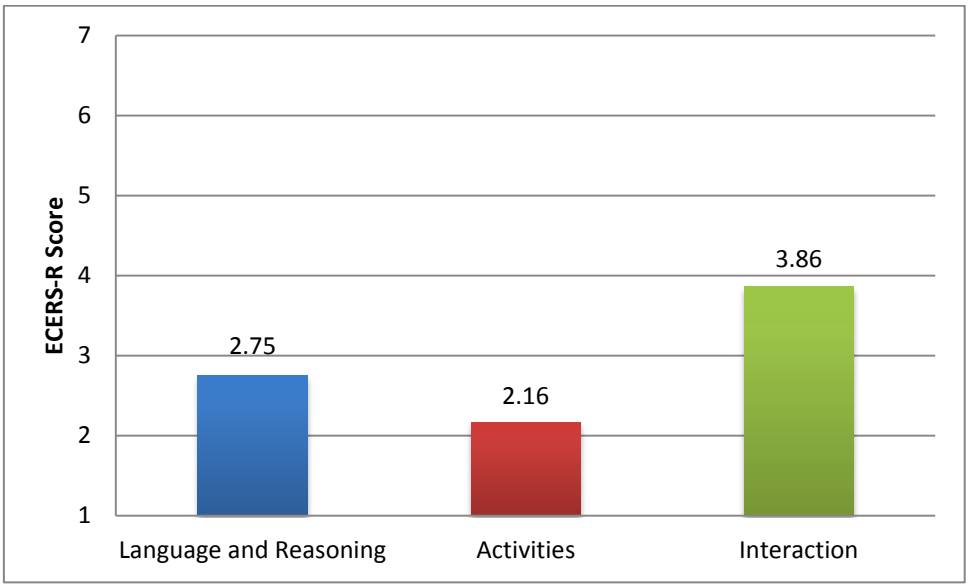


Figure 10: Change in pre-school classroom learning environment quality in two schools

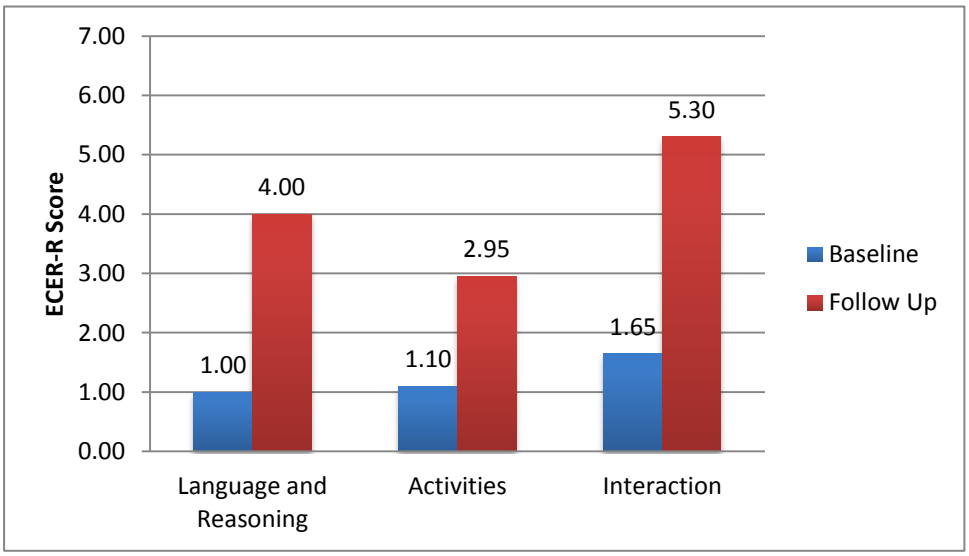


Figure 10 indicates low subscale scores at baseline for the two community preschools (a score of 1 is 'inadequate' and 3 is regarded as being of an adequate standard).

While no formal baseline assessment was undertaken for the other community preschools. Narrative reports indicate that they were all at a similar level at start-up. For the two that were assessed at both points (Figure 10), a considerable improvement is evident in a situation where resources were extremely limited.

The ECD trainer contracted to administer the ECERS follow up commented on the extraordinary level of improvisation in the preschools.

> *'The preschools are very poor (fees are R2 per month and parents still don't pay, so most schools have nothing store-bought. What excited me a lot is that they improvised so that children were involved irrespective of there being very little equipment. They copied what they see in children's homes. They made isleyi (locally used sleds for moving goods) with clay oxen, tripods of wood for mud pots in the make-believe area. They use mielie cobs which can be stacked in place of blocks and make paint from different colours of soil or boiled leaves. In pasting I saw an activity where children pasted ordinary leaves.'*

This together with the new buildings being constructed by the community give a real indication of what can be achieved with community initiative even in resource constrained circumstances.

The preschool teachers mentioned what they had gained from the workshops. Apart from practical ideas such as using concrete objects, keeping stories short and organising the daily programme, it was clear that the workshops play an important motivational role:

> *'I really enjoyed the day… these workshops are teaching and motivating us.'*

> *'Our facilitators know how to teach people, they are patient, approachable and they care about us…'*

Interventions in public schools

The interventions in public schools began in 2008. In December of that year ELRU reported that:

> *'The Departmental circuit manager has come forward with full support and has become involved in ensuring that schools use the resources we have brought in.'*

> *'Ongoing workshops and seminars for teachers and principals were held, including provision of Eastern Cape Grade R guidelines and policies and the difference between Grade R and 1, as the team was concerned a the over formality of the Grade R classes. A challenge was posed that they should work together to change the five Grade R classes into classes which could model more a more appropriate daily programme for young children.'*

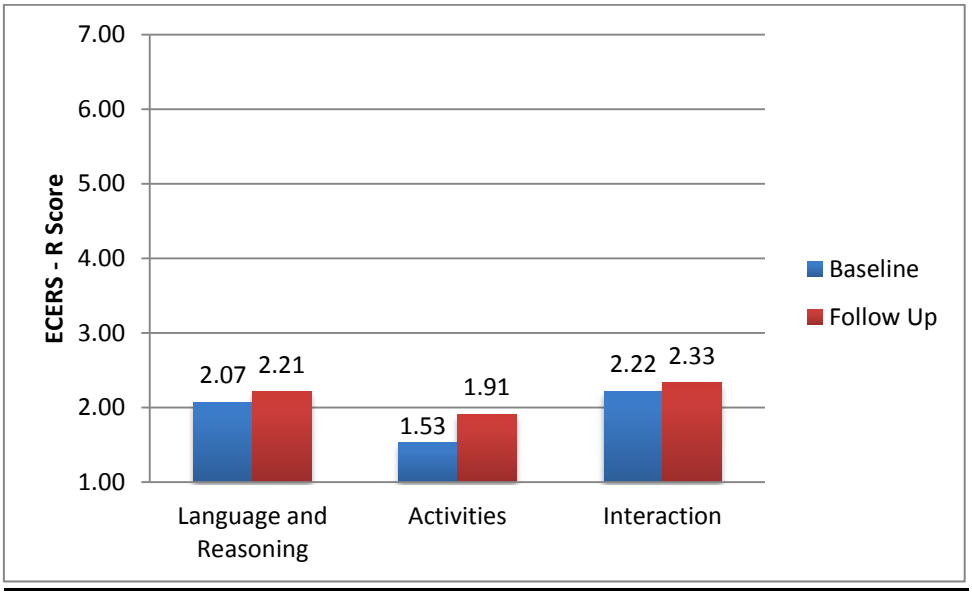
In the latter part of that year ELRU staff observed that some of the schools they had engaged with were better resourced and that teachers were becoming more responsive to training, and implementing what they had learnt.

However 2010 proved to be a particularly challenging year beset with long periods without schooling affected by a longer break at the time for the World Cup Soccer tournament followed by a teacher strike. Workshops resumed in 2011. ELRU reported that a highlight was a workshop for Principals, Foundation Phase Heads of Department, and DoE officials in which ELRU set up an exhibition of activities for Grade R children.

Public school outcomes

Seven Grade R classes whose teachers had participated in ELRU workshops were assessed on the ECERS-R at baseline and follow-up. Results are reported in Figure 11.

Figure 11: Change in public school classroom learning environment quality



These baseline and follow up assessments took place in June 2008 and May 2009 respectively. Scores are all in the inadequate range and reflect the ELRU team's comments that progress was slow and also a wry comment from the programme manager that:

'An ECERS score of 1 does not show just how 1 that could be.'

While there were changes, they were insufficient to bring the scores into the adequate range. This would require individualised interaction, language stimulation, and a range of play activities for children to do. It is what the National Department of Basic Education intends for Grade R but has been difficult for educators in formal institutions to implement. In the poorly resourced and overcrowded classrooms of the Lusikisiki area, it is not surprising that it proved to be a huge challenge. Nonetheless some change in the classroom environment was observed as depicted in the photographs below. Note the broken chairs and the absence of desks in the first photograph.

Grade R classrooms before and after the Intervention

Focus groups held with principals in 2010 and teachers in July 2011 indicate that the ELRU training and resources were helpful. ELRU reported that:

> *'Principals' and teachers' comments reflected that the workshops had given them a more holistic view of the children in these classes. Clearly the presentations on children's rights had hit home. A key message received was that the roles and responsibilities of the teacher go beyond the classroom.'*

One school had started a welfare committee for children who are HIV infected in order to provide better support to them and this had led to more openness about children taking treatment at school. Others felt they were more aware of difficulties children face and could speak to their caregivers if they felt that children's wellbeing was compromised.

The intervention also seemed to have strengthened relationships within the school between the Foundation Phase teachers and the principals. Teachers also noted that when they dealt with parents they now go with a positive and less authoritarian manner and parents respond well. They reported that the programme had made a difference to their teaching. A Head of Department is recorded as stating: 'We have been trained on these things but ELRU had a way of making them possible'.

ELRU provided numeracy charts, flash cards and books, and outdoor play was introduced as its educational potential had not previously been recognised. Learning through play and storytelling was introduced and teachers reported that children's attendance had improved because they enjoyed these things. This however, cannot be validated. Teachers expressed excitement that 'ELRU brought back the indigenous teaching methods'. Examples were teaching through stories and developing numeracy through games and rhythms.

Reflections on community preschool and public school interventions

Data sources

Data sources for this section of the report are drawn from M&E reports, reports to donors, records of meetings with programme staff conducted over the period of the evaluation, field visits by the M&E team, observations of classrooms, and interviews with programme staff and school personnel conducted by an independent researcher for process evaluation purposes June 2011.

Did the interventions reach their intended targets?

All the community preschools in the target area participated and received workshops and visits. All the primary schools in the area were enrolled in the programme and ELRU realised the goal of working with HODs and principals as well as Grade R classes. At the request of the principals all Foundation Phase teachers were included.

Was the intervention delivered as intended?

Both interventions was delivered by highly experienced ELRU staff on the basis of the needs that emerged during the workshops and visits. In other words they were customised rather than predetermined (as in a formal teacher training course).

From the beginning of their engagements with public schools, ELRU was aware of the lack of communication between parents and teachers at primary schools. The imbizos contributed to the development of dialogue between principals and teachers, the Education Department and the community.

2010 proved to be a very challenging year for the interventions designed to capacitate Grade R and Foundation Phase classes and work with principals. World Soccer Cup arrangements meant that schools closed for a longer than normal break over June through July. Shortly after pupils returned, the Teacher's Union SADTU embarked on strike action for a number of weeks. These events disrupted the intervention. From May 2010 therefore, the enrichment programme could not be delivered. These disruptions did not affect community pre - school teacher training workshops in 2010.

Preschool and public Grade R enrichment conclusion

The public school intervention did not achieve the improvements of quality observed in community preschools. This is certainly due in part to the non-delivery of the intervention for many months. However, it also points to the greater difficulty of working in the formal schooling system (even with departmental support and the involvement of principals). The formality of the Grade R classes in public schools, the lack of suitable learning materials, large classes and neglected buildings and equipment all contribute.

It is helpful that principals and teachers came to a broader understanding of holistic child development and report being more supportive of families but clearly a sustained

intervention would be needed to improve the quality of the teaching and learning environment.

By contrast, evidence of considerable improvement in preschool classroom quality was evident. This intervention also seems to have been successful in motivating the teachers and committees to improve the centres and registration as NPOs is a step towards receiving much needed departmental subsidisation.

In sum, the evaluation indicates that:

- Needs based workshops can be successful in changing attitudes and practices in both public schools and preschools, but barriers to improvement in quality are particularly evident in the former.
- Equipment was valued but improvisation (using readily available materials) can achieve a great deal.
- Local and indigenous content was included in the ECD programmes which supports home to school transition by affirming established knowledge and practices.
- Provisions are in place for further development though accessing departmental funding for the community based preschools to allow for feeding, salaries and certain equipment that cannot be improvised and their enrolment in accredited Level 4 training for 2012.
- The importance of greater linking between home, community preschools and the formal schools was appreciated by principals and teachers and activities put in place to strengthen this.

INTERACTIONS WITH NGOS, LOCAL AND DISTRICT GOVERNMENT OFFICIALS, TEACHERS, COMMUNITY MEMBERS AND COMMUNITY LEADERS

Programme description

Two community processes are grouped under this heading:

1. Raising awareness of early childhood development among the Thafelibanzi, Mhlophekazi, Magwambu, Red Hill, Gxelesha and Ntlonyane communities through community imbizos.
2. Raising awareness of the need for integrated services to early childhood development among local and provincial government officials.

These processes involved discussions of:

- Human rights and the responsibilities of duty bearers for young children;
- Holistic child development;

- The importance of play;
- Child health, safety and hygiene.

In addition, inputs were provided on: service access including documentation, social grants, child health and immunisation, and home gardens.

Outcomes of the imbizo process aimed at raising awareness of ECD among community members

ELRU hosted their first Imbizo with some 200 people in February 2008. It was included community members and officials. The purpose was to provide feedback on their community scoping exercise and receive input on issues facing vulnerable children and families. Other such events continued over the course of the intervention. Those consulted included the Community Development Committee, the Chief, government officials in various departments; local Councillors, principals and teachers of schools, local NGOs, the Dutch Reformed Church to which many members of the community belonged, and community members.

Following that first meeting, ELRU held three to four community imbizos in each of three years in the project area as planned.

An ECD awareness-raising imbizo.

It can be concluded that the advocacy initiatives with community members were delivered as intended. It is not possible to say whether the meetings resulted in changes in attitudes, behaviours and practices of those who attended as these were not assessed. However, those who attended would very likely have received a range of information that would have been new to them and which would have enhanced their understanding of the needs of young children.

According to ELRU's final report to the M&E team:

> *'Community members are now far more aware of their rights and empowered to access services.'*

The Community Development Committee commented on the stronger relationships that have been built between themselves, departments and other stakeholders and the ability to communicate if things are not working well.

> *'The stakeholder forums provided them with a lot of knowledge about what services are available as well as bringing services to the community'.*

Outcomes of engagements with government officials and other stakeholders

This activity served to complement the imbizos so that both community members and government officials were targeted in parallel in an effort to empower community members to seek support for their children, while enhancing the awareness of the need to provide improved services to young vulnerable children and families among government officials.

ELRU's TOC for this particular intervention stated that:

> *'If stakeholders are gathered on a regular basis in a child rights framework and if mutual accountability, information sharing, common understandings and, knowledge of how to access funding and resources are promoted among duty bearers in such a forum, then local service providers, including government offices, are able to identify gaps in services and to create access by extending and improving services and by mobilising resources.'*

ELRU staff report back to stakeholders.

ELRU staff report back to stakeholders.

Regarding the outcomes of this process, ELRU programme records show that a range of service delivery stakeholders that ELRU intended to reach, were consulted both individually and at meetings. They included:

- officials in the Departments of Education, Health, Social Development, Home Affairs and Agriculture;
- Officials from the Ingquza Hill Municipality;
- Local Ward Councillors;
- NGOs, including LUCARC (a child abuse service provider), the Paralegal service, and Siyakathala (an orphan and home based care project); and
- The Community Development Committee (CDC).

A number of departments and stakeholder partners signed a memorandum of understanding and committed to participation in the programmes.

The District Office of the Social Development Department (DSD) has expressed its commitment to funding the FCM programme once ELRU has exited.

It was not possible for ELRU to establish a separate Local Monitoring and Action Structure (LOMAS). At the end of 2009 learning from LUCARC whose child care forum became hard to sustain because of lack of payment to members, the initiative was terminated in favour of strengthening ECD within existing community structures.

It is evident from regular reports submitted to the M&E team that ELRU was able conduct its planned advocacy activities to advance the rights and well-being of children and vulnerable families. These occurred every time ELRU staff visited the area and were also carried forward by coordinators resident in the area between the visits of the Cape-Town based team.

At the end of this process, and according to ELRU, integration of government services remained a challenge. This is illustrated in the following quote:

'We have made various attempts to meet the Social Needs Cluster set up by the Municipality in Lusikisiki. Only one meeting materialised during the project period. We also met with the Education Department's District-based Support Service Team but they only provide services for children in school.'

It is difficult to assess the impact of advocacy with government departments on improvement of services for children. The fact that significant numbers of children did not have the required documents and service access at the start of the FCM programme indicates poor service access. However, this could also have been due to parental ignorance of procedures (which was not measured), as well as poor or complex service provision (which is in fact suggested by the quote below). It is very probable that the information provided to parents gave them the knowledge they needed to access services.

However, while it is more difficult to assess the effects of the advocacy process on improved service delivery as this tends not to be a smooth process there is certainly some evidence in the ELRU records including:

- The Department of Home Affairs brought their Mobile Unit to Komkhulu to assist families with documents. This took place at least three times at the request of ELRU and the Community Development Committee (CDC). Subsequently Home Affairs alerted the FCMs when they were coming to the area. The FCMs report that relationships with the office officials have led to them being more helpful and supportive with visited family needs.
- The Department of Health (DoH) uses FCMs to deliver nutritional supplements to families. This started when they had stocks but the FCMs now tell them how much they will need and the department plans for this amount.
- Relationships have been established with service providers which facilitates access to services. FCMs often take caregivers to see the relevant officials.
- When many children were identified who were not immunised the DoH was contacted and held an immunisation drive in Thafelibanzi. DoH has continued with supporting ELRU's immunisation campaign.
- ELRU introduced the CDC to the DoH who agreed to service a health post in Thafelebanzi provided that community provides the structure. Rains damaged the building that was being erected and the process has stalled. At the most recent imbizo the DoH challenged the CDC to move forward with the process as the health post is now a Departmental deliverable.
- Some of the practitioners reported that their principals had included them in the training after the imbizos.
- The DSD has asked the preschool supervisors to come to their offices so that they can assist them with business plans. They first met through the ELRU stakeholder process.

The fact that the majority of children *received* the services indicates that services were responsive but perhaps after a long and tedious process. The ELRU September 2009 report to the M&E team points to some of the challenges faced by those attempting to access services:

> *'When families apply to the Department of Home Affairs for IDs they're taken through a tedious process, which is costly to those who can least afford them. The information isn't given up-front by the Department, necessitating return trips to the office. This often requires them to obtain a letter from the Headman, as well as find someone who knows them, then have an interview before they can apply for an ID. Grandmothers struggle to obtain CSGs for their wards – the Department requires them to find their daughters and return with them to change the information in order for them to qualify.'*

Reflections on the advocacy process

Data sources

Data sources for this section of the evaluation are drawn from M&E reports, reports to donors, and records of meetings with programme staff conducted over the period of the evaluation.

Did the intervention reach its intended targets?

The proceeding narrative indicates that this is indeed the case as far as community members are concerned. While there was success in reaching government officials from most departments and engaging them, this remained a challenge throughout the project.

Was the intervention delivered as intended?

In large measure the answer is yes. However, there were changes in response to local conditions. For example, by the end of 2009 it became evident that the goal of establishing a Local Monitoring and Action Structure (LoMAS) would not be possible. However the Community Development Committee was very instrumental in guiding the overall process and in facilitating community meetings. ELRU has been working with them to support them in taking more responsibility as the organisation exits.

As indicated in their 2008 reports to the DG Murray Trust, the original intention was for ELRU staff to undertake its stakeholder engagements and related activities on a quarterly basis during visits from Cape Town. It became apparent in late 2008 that the number of visits would have to be extended to six or seven per year in order to reach the goals of the project.

Key reasons included difficulties in getting people together; cancellation of meetings due to bad weather and other factors and the need for rescheduling at short notice; growing appreciation in the team of the time required to build and sustain relationships with stakeholders.

These problems continued into the third quarter of 2009 after which there were some improvements. For example, in their July 2009 report to the M&E team, ELRU noted that:

> *'Meetings with the Department of Health and Municipality Departments are repeatedly cancelled, causing delays in implementation of some of the goals.'*

This improved in 2010 but a constant challenge was the fluidity of departmental officials which required ongoing engagements on an individual basis. However as was reported above there were many examples both of government departments and other services becoming more accessible to the community.

Intervention conclusion

It is clear from reports to the M&E team that ELRU made ongoing efforts to work with government agencies and others despite these obstacles. At each of their visits, attempts were made to meet with one or other NGO, government departments, the Community Development Committee and community members.

Failure to establish the LoMAS points to the challenges of attempting to initiate an additional structure and that it is perhaps advisable to build on what exists and strengthen these structures even if they are not specifically concerned with young children. This could also ensure that children's issues are part of mainstream community concerns.

A significant achievement by ELRU through its engagement with the District Office of the Social Development Department (DoSD) is DoSD's commitment made in late 2010 to fund the FCM programme once ELRU has exited. If realised, this will not only ensure the continuity of the support to vulnerable parents and children. It will also provide much needed employment.

A further achievement is the sense that through the imbizo process, the community does seem to have become much more active than prior to ELRU's intervention at a number of levels and in various ways in initiatives for the betterment of conditions for children. The effectiveness of the imbizo for advocacy purposes is likely to have been enhanced by the fact that the imbizo is an existing community practice for communicating information and addressing local concerns.

The intention of the approach was to create an enabling environment for young children which would include both service providers and community members. Certainly young children have benefitted from more service access. In addition awareness and interest in the initiative was evident beyond direct programme beneficiaries. This was indicated in interviews the FCMs said:

> *'There are those who seem to be interested because they see a great change in the community. Some attend the cluster workshops even though they are not part of the programme'.*

There is also evidence of a growing collective consciousness for young children, expressed in the way community members referred to Sakh' Umtwana Sakh' Isizwe (meaning We build a child, we build a nation, rather than You build a child, you build a nation).

The independent researcher who conducted interviews for the process evaluation commented that caregivers who benefitted from the programme mentioned that what they learnt is not only for them but for other families as well. Her overall comment in her report to the M&E team was that there was empowerment at all levels of the project. She spoke to passers by and asked them about the intervention and how they saw it – One woman said:

> *'I know about the project of those with children and it is helping them.'*

A man said:

> *'This must not stop as it helps those living with children and we are also benefitting by accessing the grant.'*

THE COMMUNITY CHILD SAFETY INTERVENTION

Programme description

The goal of *the Community Child Safety* intervention was to improve child protection in the community.

The principal activity provided by ELRU was facilitation of community workshops aimed at creating awareness of child protection issues, and assisting the community to develop action plans to improve child safety and protection. Child protection issues were included in the community imbizo meetings described in the previous section. The Community Child Safety Initiative was delivered through those forums.

Areas of risk to children were to be mapped and primary prevention child protection messages and campaigns to improve child safety were to follow. If the risk areas were known, this would facilitate a community process of keeping an eye on children through increased child supervision and monitoring.

The TOC developed by ELRU for this component of their programme stated:

> *'If child safety awareness is raised and constantly reinforced through community workshops, imbizos and training, AND if a human rights/child rights approach is entrenched THEN community members will be in a better position to identify children at risk or being abused or neglected and will know how to take action to protect or defend them and would also be in a better position to form safety nets to take action.'*

ELRU established a system for recording all meetings (including attendance of community members local officials and NGOs), and notes on attendance as well as activities concerned with child protection.

Indicators of success as originally formulated with ELRU were:

1. Awareness of safety threats to children to be identified at workshops and areas of risk in the community were to be mapped.
2. An action plan that would flow from this process.

Outcomes and processes of the Community Child Safety intervention

As this was a participatory process in which members of the community (including children) were to seek and implement their own solutions, ELRU could only play a facilitation role and could not determine the outcome.

The issue of child safety was strongly identified in the community scoping exercise conducted early in the project, and was raised at several imbizos. In 2010 local and indigenous understandings of child safety were explored with community members at meetings, risk areas were mapped and a programme of action was developed over time. A map of risk areas for children is displayed below.

Community map of risk areas for children

Having identified the main risks to children's safety, proposals for improving child safety were agreed:

- Completion of a bridge (already planned) over a river that prevented some children from attending school when it was in spate; the river also constituted a risk of drowning;

- Engagement with the Department of Education about the provision of school buses to reduce distance walked and risks of assault on the way to school;
- The provision of the pedestrian crossings on main roads;
- Caregivers would ensure that children are walked to school by a responsible person, and are helped to cross main roads;
- Caregivers should refrain from sending children to shops that are linked to shebeens.

Because local understandings of child safety were much broader than accident prevention and closely linked with child health a proposal to help community members to be conscious of their health practices was mooted. Also, those attending an imbizo felt that dialogues should be held with health professionals to sensitise community members about dangers to children posed by certain traditional practices to children and how these could be made safer.

It is not possible to say whether this intervention had the effect of improving safety and reducing risk as neither baseline nor follow-up measures were taken.

At the end of the intervention, the bridge had not been built and there were no pedestrian crossings in place. However such matters take time to implement.

ELRU staff stated that they hoped that this approach would enhance continued dialogue and deepen the community's understanding of child safety and protection. At the final report-back to the CDC and the community at large in 2011, community members resolved to ask the CDC to ensure that issues raised in meetings are followed up with councillors and government departments where required.

Reflections on the Community Child Safety initiative

Data sources

Data sources for this section of the report are drawn from M&E reports, and records of meetings with programme staff conducted over the period of the evaluation.

Did the intervention reach its intended targets?

Based on the lists of participants at imbizos provided to the M&E team this appears to be the case.

Was the intervention delivered as intended?

The intervention was delivered as proposed by ELRU, through a series of imbizos in which both children and adults participated to shape proposals for child safety.

After introducing the intervention in 2010, the process was followed up with a series of focus groups and interviews. Discussions and mappings allowed for identification of risks,

information sharing, exploration of safety practices and knowledge and a proposal for promoting child safety.

Intervention conclusion

It is of interest that participants focused on child safety issues related to risk of injury and health practices rather than child protection issues such as abuse, particularly as these came up as major concerns in the community profiling conducted in 2008. Although they did recognise the risk of assault associated with being in proximity to shebeens and walking in lonely places.

It is not possible to say whether this intervention had the effect of improving safety and reducing risk as neither baseline nor follow-up measures were taken. At the end of the intervention, the bridge had not been built and there were no pedestrian crossings in place. However such matters take time to implement.

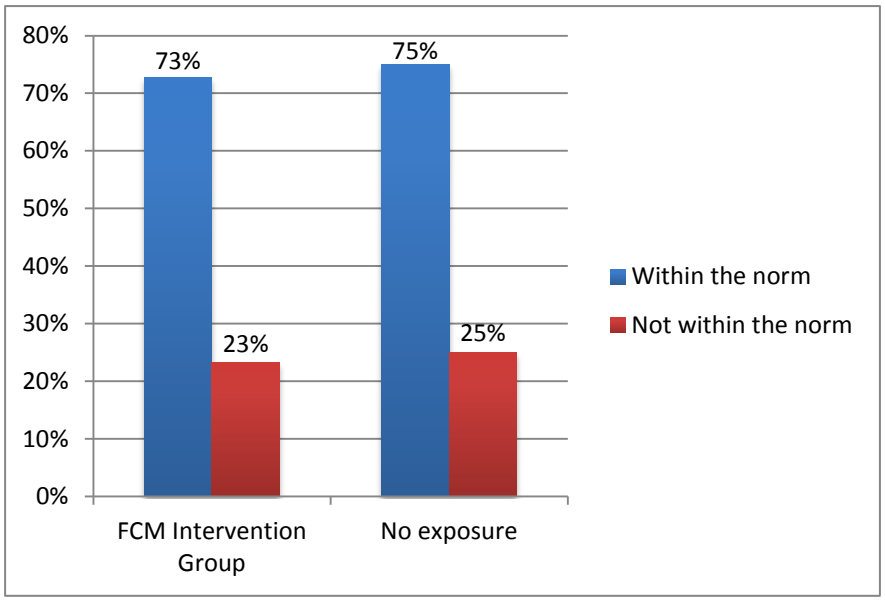
Although recommendations were made by participants, follow up is the responsibility of the local Community Development Committee. ELRU therefore only had the power to facilitate a process and not the authority to drive the solutions.

IMPACT AT GRADE R

As with the other partners involved in Sobambisana, programme impact was assessed in Grade R during the first term of 2011. In the case of ELRU, children who had received the FCM programme (n=23) were compared on six outcome measures[14] in a post-hoc design with children who have not had exposure to ECD (n=36). Statistical analyses (in which child age was controlled by Analysis of Covariance) showed that:

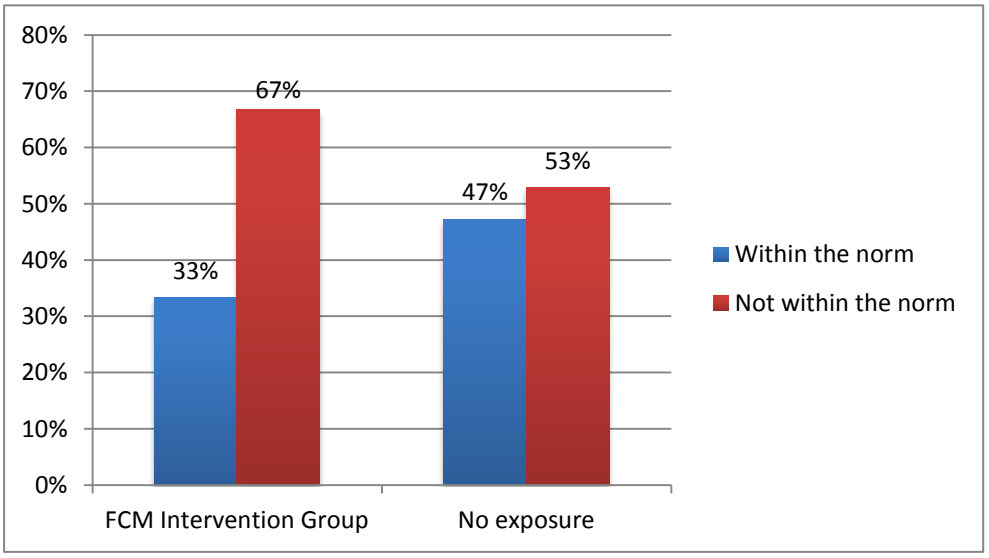
Home visited children were not more advanced than those who had not had exposure to an ECD programme. This finding could be due to a number of factors including the small sample size of the FCM group, and more likely, differences between the groups that could have affected the scores. As is evident from Figure 15, a history of malnutrition (assessed by growth status) does not account for the findings – there is no statistical difference between the two groups.

Figure 15: Comparison between Groups on Height for Age at Grade R



It is also possible that differences in cognitive development between the FCM and 'no ECD' exposure group could account for the findings. If the 'no ECD' group started off as more advanced than the FCM group, then this could be expected to affect performance on the other measures (e.g. language and numeracy). To examine this possibility, the proportion of children within the norm for age on the Grover was investigated within each group using Chi-squared analysis (see Figure 16 below).

Figure 16: Comparison between groups on Grover norm for children in Grade R



The home visiting group had significantly fewer children within the norm of age on the test. This is very likely to have depressed their performance on language and numeracy[15].

This may well be reflective of ELRU's approach of targeting of the most vulnerable children in the area. Home visiting to such deprived children is unlikely to raise their performance above that of others in the area who are not as compromised, while it has been demonstrated to bring other benefits.

STATISTICAL APPENDIX

SPSS Version 19

1: FAMILY HOME VISITING PROGRAMME

Caregiver outcomes: hygiene and safety

1. Statistical Summary: Intervention Group Baseline and Follow Up: Safety and Hygiene: One Sample Two tailed t Test significant t (179) =37.414, p > .001;

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Hygiene and Safety Baseline	183	64.7299	23.96067	1.77122
Hygiene and Safety Follow up	180	68.6703	24.62475	1.83542

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Hygiene and Safety Baseline	36.545	182	.000	64.72989	61.2351	68.2247
Hygiene and Safety Follow up	37.414	179	.000	68.67033	65.0485	72.2922

2. Statistical summary: FCM Intervention and Waitlist groups Follow Up Comparison Independent Samples Two Tailed Test not significant t (32) = -.861, p > .50

Group statistics

	Group	N	Mean	Std. Deviation	Std. Error Mean
Hygiene and Safety Follow up	Wait list Control	15	58.7400	15.68092	4.04880
	Intervention	18	63.3500	15.00675	3.53713

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Hygiene and Safety Follow up	Equal variances assumed	.106	.747	-.861	31	.396	-4.61000	5.35413
	Equal variances not assumed			-.857	29.415	.398	-4.61000	5.37624

Independent Samples Test

		t-test for Equality of Means	
		95% Confidence Interval of the Difference	
		Lower	Upper
Hygiene and Safety Follow up	Equal variances assumed	-15.52982	6.30982
	Equal variances not assumed	-15.59892	6.37892

Caregiver outcomes: H.O.M.E.

Statistical Summary: Intervention Group H.O.M.E: Acceptance, Academic Stimulation Responsivity: Two tailed t Test significant all subscales. Independent Samples t-test indicates no difference between groups at follow-up.

Intervention group baseline and follow up

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	HOME_Language_Baseline	4.80	100	1.393	.139
	HOME_Language_Follow Up	5.44	100	1.225	.123
Pair 2	HOME_Acceptance_Baseline	1.37	101	1.579	.157
	HOME_Acceptance_Follow Up	.92	101	1.671	.166
Pair 3	HOME_Responsivity_Baseline	5.63	102	1.647	.163
	HOME_Responsivity_Follow Up	6.06	102	1.717	.170
Pair 4	HOME_Academic_Baseline	2.28	101	1.727	.172
	HOME_Academic_Follow Up	3.01	101	1.261	.125

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	HOME_Language_B & HOME_Language_F	100	-.191	.057
Pair 2	HOME_Acceptance_B & HOME_Acceptance_F	101	.106	.292
Pair 3	HOME_Response_B & HOME_Response_F	102	-.097	.331
Pair 4	HOME_Academic_B & HOME_Academic_F	101	.440	.000

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	HOME_Language_B - HOME_Language_F	-.640	2.023	.202	-1.041	-.239	-3.164	99	.002
Pair 2	HOME_Acceptance_B - HOME_Acceptance_F	.446	2.175	.216	.016	.875	2.059	100	.042
Pair 3	HOME_Response_B - HOME_Response_F	-.431	2.492	.247	-.921	.058	-1.749	101	.083
Pair 4	HOME_Academic_B - HOME_Academic_F	-.733	1.630	.162	-1.055	-.411	-4.517	100	.000

Comparison: intervention group and wait list group at follow up

Group Statistics

	Group	N	Mean	Std. Deviation	Std. Error Mean
HOME_Language_F	Wait list Control	16	5.50	.730	.183
	Intervention	23	4.87	1.961	.409
HOME_Acceptance_F	Wait list Control	16	.63	1.204	.301
	Intervention	23	1.61	2.589	.540
HOME_Responsivity_F	Wait list Control	16	5.44	2.502	.626
	Intervention	23	4.83	2.807	.585
HOME_Academic_F	Wait list Control	15	3.33	1.291	.333
	Intervention	23	3.30	.703	.147

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
HOME_Language_F	Equal variances assumed	7.630	.009	1.224	37	.229	.630	.515
	Equal variances not assumed			1.408	29.903	.170	.630	.448
HOME_Acceptance_F	Equal variances assumed	9.332	.004	-1.413	37	.166	-.984	.696
	Equal variances not assumed			-1.591	33.113	.121	-.984	.618
HOME_Response_F	Equal variances assumed	.719	.402	.699	37	.489	.611	.875
	Equal variances not assumed			.714	34.648	.480	.611	.857
HOME_Academic_F	Equal variances assumed	5.628	.023	.090	36	.929	.029	.323
	Equal variances not assumed			.080	19.473	.937	.029	.364

Independent Samples Test

		t-test for Equality of Means	
		95% Confidence Interval of the Difference	
		Lower	Upper
HOME_Language_F	Equal variances assumed	-.413	1.674
	Equal variances not assumed	-.284	1.545
HOME_Acceptance_F	Equal variances assumed	-2.394	.427
	Equal variances not assumed	-2.241	.274
HOME_Response_F	Equal variances assumed	-1.161	2.384
	Equal variances not assumed	-1.128	2.351
HOME_Academic_F	Equal variances assumed	-.627	.685
	Equal variances not assumed	-.732	.790

CHILD OUTCOMES: COGNITION: PROPORTION WITHIN THE NORM

Intervention group at baseline and follow up

Statistical Summary: Chi^2 analysis on the proportions of children within the norm for age after the intervention, showed that there were no differences between the FCM and Wait List groups:Kruskil Wallis Test not significant at Baseline (p > .05) and Follow Up (P > .05)

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Grover Baseline_Norm * Grover Follow Up_Norm	41	87.2%	6	12.8%	47	100.0%

Grover Baseline_Norm * Grover Follow Up_Norm Crosstabulation

Count

		GroverFollow Up Norm		
		Not within the Norm Grover	Within Norm Grover	Total
Grover Baseline_Norm	Not within Norm Grover	31	3	34
	Within Norm Grover	5	2	7
Total		36	5	41

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.114[a]	1	.146		
Continuity Correction[b]	.672	1	.412		
Likelihood Ratio	1.736	1	.188		
Fisher's Exact Test				.196	.196
Linear-by-Linear Association	2.063	1	.151		
N of Valid Cases	41				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is .85.
b. Computed only for a 2x2 table

INTERVENTION AND WAIT LIST GROUP AT BASELINE AND FOLLOW UP

Cognition: proportion within the norm

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Grover Baseline_Norm * Grover Follow Up_Norm * Group	73	20.7%	279	79.3%	352	100.0%

Grover Baseline_Norm * Grover Follow Up_Norm * Group Crosstabulation

Count

Group			Grover Follow Up_Norm		Total
			Not within the Norm Grover	Within Norm Grover	
Wait list Control	Grover Baseline_Norm	Not within Norm Grover	24	4	28
		Within Norm Grover	3	1	4
	Total		27	5	32
Intervention	Grover Baseline_Norm	Not within Norm Grover	31	3	34
		Within Norm Grover	5	2	7
	Total		36	5	41
Total	Grover Baseline_Norm	Not within Norm Grover	55	7	62
		Within Norm Grover	8	3	11
	Total		63	10	73

Chi-Square Tests

Group		Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Wait list Control	Pearson Chi-Square	.305[a]	1	.581		
	Continuity Correction[b]	.000	1	1.000		
	Likelihood Ratio	.272	1	.602		
	Fisher's Exact Test				.512	.512
	Linear-by-Linear Association	.295	1	.587		
	N of Valid Cases	32				
Intervention	Pearson Chi-Square	2.114[c]	1	.146		
	Continuity Correction[b]	.672	1	.412		
	Likelihood Ratio	1.736	1	.188		
	Fisher's Exact Test				.196	.196
	Linear-by-Linear Association	2.063	1	.151		
	N of Valid Cases	41				
Total	Pearson Chi-Square	2.019[d]	1	.155		
	Continuity Correction[b]	.893	1	.345		
	Likelihood Ratio	1.714	1	.190		
	Fisher's Exact Test				.168	.168
	Linear-by-Linear Association	1.991	1	.158		
	N of Valid Cases	73				

a. 3 cells (75.0%) have expected count less than 5. The minimum expected count is .63.
b. Computed only for a 2x2 table
c. 2 cells (50.0%) have expected count less than 5. The minimum expected count is .85.
d. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 1.51.

COMPARISON OF PROPORTION OF CHILDREN AT BASELINE AND FOLLOW UP BETWEEN GROUPS: INTERVENTION AND WAIT LIST

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of GroverBaseline_Norm is the same across categories of Group.	Independent-Samples Kruskal-Wallis Test	.712	Retain the null hypothesis.
2	The distribution of GroverFollowUp_Norm is the same across categories of Group.	Independent-Samples Kruskal-Wallis Test	.645	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

2: GRADE R

Cognition: group comparisons on norm for age

Statistical Summary: A greater proportion of children in the in the FCM programme were not within the norm for their age on cognition than those who had no ECD exposure: Chi^2 (1, 57) = 1.050, p>.05).

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Group * Grover Norm	57	95.0%	3	5.0%	60	100.0%

Group * Grover Norm Crosstabulation
Count

		Grover Norm		
		Within Norm	Not within Norm	Total
Group	Comparison Group No ECD	17	19	36
	Home Visiting	7	14	21
Total		24	33	57

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.050[a]	1	.306		
Continuity Correction[b]	.557	1	.455		
Likelihood Ratio	1.063	1	.303		
Fisher's Exact Test				.407	.229
Linear-by-Linear Association	1.031	1	.310		
N of Valid Cases	57				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.84.
b. Computed only for a 2x2 table

ENDNOTES

[1] Barnes, H., Wright, G., Noble, M., & Dawes, A. (2007). The South African Index of Multiple Deprivation for Children (SAIMDC): Census 2001. Cape Town: HSRC Press.

[2] Chambers, R. (1994). The Origins and Practice of Participatory Rural Appraisal. *World Development*, *22(7),* 953-969.

[3] Lake, L. and Newman, M. (2008). Guidelines for Family and Community Motivators. Cape Town: Early Learning Resource Unit.

[4] Campbell, D. & Stanley, J.C. (1966). Experimental and Quasi-Experimental Designs for Research. Boston: Houghton Mifflin and Company.

[5] Statistical Summary: Intervention Group refers to all who participated in the programme. FCM intervention group refers to a sub-sample of the main Intervention group and only includes those who were measured at baseline and follow-up only. Waitlist group refers to those who were in the Wait List group.

[6] Statistical Summary: Intervention Group Baseline and Follow Up: Safety and Hygiene: One Sample two tailed t Test significant t (179) =37.414, p > .001; FCM Intervention and Waitlist groups Follow Up Independent Samples Two Tailed Test not significant significant t (32) = -.861, p > .50. See Statistical Appendix for details.

[7] Statistical Summary: Intervention Group H.O.M.E: Acceptance: Academic Stimulation Home Responsivity: Two tailed t Test significant all subscales. Independent Samples t-test indicates no difference between groups at follow-up. See Statistical Appendix for full details.

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

[9] Labadarios, D. (2007). National Food Consumption Survey-Fortification Baseline (NFCS-FB): South Africa, 2005. Pretoria: Directorate: Nutrition, National Department of Health. National Stunting Rate 1-3yrs = 23.4%; 4-6yrs = 12%; Underweight Rate: 1-3yrs = 11%; 4-6yrs = 8%; Rural Stunting Rate < 9 = 20%; Rural Under-weight Rate < 9 = 8%).

[10] Human Sciences Research Council (2000). Report on the Grover Counter Scale of Cognitive Development. Pretoria: Human Sciences Research Council.

[11] Shipley, K.G. and McAfee J.G. (1992).

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

13 Kruskil Wallis Test not significant at Baseline (p > .05) and Follow Up (P > .05). See statistical appendix for full details.

14 See Sobambisana Measures Appendix for the details.

15 Statistical Summary: Statistical Summary: A greater proportion of children in the in the FCM programme were not within the norm for their age on cognition than those who had no ECD exposure: 2 (1, 57) = 1.050, p>.05).