TOWARDS INTEGRATED EARLY CHILDHOOD DEVELOPMENT

An evaluation of the Sobambisana Initiative
Ilifa Labantwana is a multi-donor partnership which supports integrated early childhood development (ECD) in South Africa. The donor partners include the ELMA Foundation, the UBS Optimus Foundation and the D G Murray Trust. Ilifa Labantwana aims to increase access to and improve the quality of integrated early childhood development services for children in underserved communities; and to support South African policy implementation of integrated ECD interventions in a sustainable manner.
TOWARDS INTEGRATED EARLY CHILDHOOD DEVELOPMENT

An evaluation of the Sobambisana Initiative

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Executive summary

Background to the study

In 2008 the D G Murray Trust contracted five non-profit resource and training organisations (RTOs) active in Early Childhood Development (ECD) to implement high quality models of ECD provision that would improve the access of children younger than six to developmental opportunities, and smooth their transition to their first schools.

These organisations were the Centre for Early Childhood Development (CECD) and Early Learning Resource Unit (ELRU), based in the Western Cape; the Khululeka Community Education Development Centre (KCECD), based in the Eastern Cape; Ntataise, based in the Free State; and Training Resources for Early Education (TREE), based in KwaZulu-Natal.

In 2009 The ELMA Foundation and the UBS Optimus Foundation joined the D G Murray Trust in funding Ilifa Labantwana ('Children's Heritage'), an expanded initiative aimed at promoting ECD. Sobambisana became one of seven components of Ilifa, tasked with developing, implementing, and evaluating models of ECD provision that would increase access to and improve the quality of ECD for children in underserved communities in five areas in four provinces.

The central thrust of Ilifa Labantwana is to test different approaches to ECD which could inform the government’s unfolding national ECD programme. More specifically, it has sought to design and evaluate different models of social sector ECD service delivery to establish which are most effective and can most easily be taken to scale on a regional or national level.

Given these objectives, monitoring and evaluation formed an essential part of the Sobambisana Initiative. This process was set in motion when the initiative began, and continued throughout its life.

Sobambisana ended in 2011, but Ilifa’s relationship with its partner organisations is continuing as it seeks to extend the lessons learnt thus far, and find ways of embedding the most successful models in government systems at the provincial and national level.

This executive summary sets out the background to the Sobambisana Initiative, and summarises the interventions, the M&E programme, and the main findings.

National ECD policy

South African Early Childhood Policy is aimed at expanding services to children younger than five. The main vehicle for this policy is the National Integrated Plan for Early Childhood Development in South Africa, 2005–2010 (2005), which is currently being revised. This plan deals with children's health, nutrition, support, and stimulation at ECD centres as well as by primary caregivers in home and community settings. Vulnerable young children are the priority target.

While there is much local experience of work done to improve ECD centres, and evidence that good centres can significantly improve learning readiness, much less is known about the effective delivery of home and community-based programmes for young children, which are meant to comprise 80 per cent of ECD services. Sobambisana created an opportunity for exploring various dimensions of the National Integrated Plan, including integrated service delivery and programmes targeting primary caregivers as well as ECD centre practitioners and management.

The Sobambisana Initiative

Sobambisana is the first attempt in South Africa to develop a local evidence base for interventions aimed at improving ECD, particularly those relevant to rollouts under the National Integrated Plan.
A research team led by the Department of Psychology of the University of Cape Town in partnership with the Early Learning Resource Unit (ELRU) was appointed to undertake four tasks:

1. Design systems for monitoring and evaluating the various interventions, and instil a culture of M&E in the partner organisations.
2. Monitor and evaluate programme implementation by each partner.
3. Evaluate the outcomes of interventions implemented by each partner.
4. Evaluate the impact of these programmes on children by the time they reach Grade R.

Programmes were implemented by four partners in six communities in four provinces: Indaka in KwaZulu-Natal; Grabouw and Vredenburg in the Western Cape; Lusikisiki and the Queenstown area in the Eastern Cape; and the Viljoenskroon/Rammulotsi area in the Free State. All these sites are characterised by high levels of poverty and deprivation.

**Evaluation methods**

Starting in April 2008, the M&E team adopted a participatory approach to the evaluation. Partners were introduced to evaluation methodology, as well as the importance of the regular monitoring of programme implementation and beneficiary participation. Monitoring tools were developed, and designs for outcome and impact evaluation were constructed collaboratively with each partner.

The evaluation team had minimal control over the content or implementation of partner programmes, or their plausibility in relation to the evidence base. These factors were largely determined when the various project proposals were accepted by the donor. However, each partner had many years in the field of ECD.

Four classes of evaluation were conducted:

1. **Participatory evaluation:** Partners were introduced to evaluation methods and the importance of regular monitoring of programme implementation and beneficiary participation. Monitoring tools were developed, and methods for evaluating outcomes and impacts were designed collaboratively.
2. **Implementation evaluation:** This was aimed at assessing whether programmes had reached their intended beneficiaries, whether they had been implemented as intended and designed (fidelity), and their benefits and barriers as perceived by programme staff and beneficiaries.
3. **Outcome evaluation:** This was aimed at measuring the effects of partner programmes on adults and children and on the responsiveness of local authorities to the needs of vulnerable families and young children.
4. **Impact evaluation:** This was aimed at measuring the long-term effects of partner programmes on children once they had reached Grade R.

Impact was measured by comparing the performance of children in Grade R who had participated in a Sobambisana intervention with those of children who had not been exposed to an ECD programme (with early stimulation components) once they had reached Grade R. Indicators used for this assessment included children’s level of cognitive and language development, numeracy, and academic readiness.

**Table 1: Sobambisana interventions managed by each NPO**

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>TREE</th>
<th>KCECD</th>
<th>ELRU</th>
<th>NTATAISE</th>
<th>CECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre-based training and enrichment aimed at improving ECD site quality</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Advocating the improvement of public services to children</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home-based interventions for improving the health, nutrition, and early learning of children not in formal ECD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community playgroups aimed at educating parents and stimulating children not in formal ECD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Parent education workshop programmes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Ethics

Clearance for all aspects of the evaluation was obtained from the Faculty of Humanities Research Ethics Committee at the University of Cape Town. Consent to test children was received from caregivers. Consent was also obtained from practitioners and beneficiaries for interviews and observations. Permission to assess children in schools was obtained from the relevant provincial departments of basic education.

Common measures

The following instruments were used in the course of the evaluation:

Outcomes in respect of adults:

■ The Safety and Hygiene Checklist – used to assess changes in the quality of safety and hygiene in the home environment (outcomes only).

■ The Acceptance, Responsivity, Language Stimulation and Academic Stimulation subscales of the Early Childhood HOME Inventory – used to assess changes in parenting and early stimulation in the home (outcomes only).

Outcomes and impacts in respect of children:

■ The Grover-Counter Scale of Cognitive Development – used to assess the effects of the various programmes on cognitive development (outcomes and impact).

■ The Peabody Picture Vocabulary Test (PPVT4), adapted for each language in the Sobambisana Initiative – used to compare children across interventions in Grade R (impact only).

■ The Sobambisana Language Development Standards Assessment based on the National Early Learning Development Standards assessment and adapted for each language in the Sobambisana Initiative – used to assess the effects of the various programmes on language development (outcomes only).

■ The Academic Readiness and Resilience subscales of the South African Child Assessment Scales (SACAS) – used to compare children across interventions in Grade R (impact only).

■ Disability and Growth Status using standardised World Health Organisation (WHO) instruments – used to assess children’s status (outcomes and impact).

■ The Numerical and Counting Concepts tests from the Evaluation Scale for Cognitive and Motor Development Tasks for Black Children – used to compare children across interventions in Grade R (impact only).

The quality of the teaching and learning environment:

■ The Language and Reasoning, Activities, and Interaction subscales from the Early Childhood Environmental Rating Scale – Revised (ECERS-R) – used to measure changes in classroom quality following teacher training and ECD site support (outcomes only).

All these tests and measures are discussed in greater detail in Part 3 of this publication.

Limitations of the evaluation

While the implementation evaluation is robust, having relied on a range of tools designed by the M&E team, the outcome and impact evaluations have limitations due to the relatively weak statistical power of the outcome evaluations, and the lack of comparison groups for several tests of programme outcomes.

A number of the findings are promising, but need further investigation. In order to improve the South African evidence base in respect of ECD programmes for vulnerable children and families, the outcomes and impacts of programmes such as these should be tested more rigorously, using appropriate designs with the necessary statistical power.
## Key findings

### 1. OUTCOMES OF FORMAL ECD PROGRAMMES

**Interventions aimed at improving the quality of ECD centres (all partners)**

<table>
<thead>
<tr>
<th>Reach</th>
<th>Practitioners and teachers exposed to training and / or enrichment: 138</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECD site and classroom quality</td>
<td>Data is available for all partners. Regardless of the type of intervention, classroom quality improved in almost all cases, sometimes substantially so.</td>
</tr>
<tr>
<td>Impact of training and enrichment on children in Grade R in respect of cognition, numeracy, language, and emotional development</td>
<td>Impact data is available for all partners. Children who had attended centres where teachers were trained by partners achieved better scores than children who had not been exposed to an ECD programme, or had been exposed to a home visit or playgroup programme.</td>
</tr>
</tbody>
</table>

### 2. OUTCOMES OF ADVOCACY PROGRAMMES

**Interventions for advocating the integration of services to children, and facilitating improved access (four partners)**

| Access to social grants and the integration of services to children | Data is available for all four partners. The outcomes are mixed. Advocacy was most successful when efforts were sustained, had a clear purpose, and when officials and community members met to discuss the steps required to improve children's access to services. |

### 3. OUTCOMES OF HOME- AND COMMUNITY-BASED INTERVENTIONS

**Home visiting programmes (three partners)**

<table>
<thead>
<tr>
<th>Reach</th>
<th>All three partners succeeded in reaching vulnerable children and caregivers. Caregivers reached: 794. Children reached: 1 513</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to social grants and services for children</td>
<td>Outcome data is available for all three partners. Initial levels of access to grants and services were high in most communities except Lusikisiki in the Eastern Cape. A holistic community development approach significantly improved access to services in Lusikisiki.</td>
</tr>
<tr>
<td>Safety and hygiene in the home</td>
<td>Outcome data is available for all three partners. When initial levels of safety and hygiene were low, the interventions improved them significantly.</td>
</tr>
<tr>
<td>Knowledge of the value of and need for ECD</td>
<td>Outcome data is available for all three partners. Findings are variable. Longer programmes with good oversight succeeded in improving parenting and early stimulation in the home.</td>
</tr>
<tr>
<td>Caregiver coping</td>
<td>Outcome data is available for one partner, which achieved significant improvements.</td>
</tr>
<tr>
<td>Child cognitive, numeracy, language and emotional development</td>
<td>Outcome data is available for two partners. Home visits did not improve these indicators. Impact data for Grade R is available for all three partners. Home visits did not improve these indicators.</td>
</tr>
</tbody>
</table>

**Community playgroups with parent education components (two partners)**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved safety and hygiene in the home</td>
<td>One programme measured safety and hygiene in the home. Significant improvements were recorded.</td>
</tr>
<tr>
<td>Knowledge of the value of and need for ECD</td>
<td>One programme monitored parenting and early stimulation in the home. Significant improvements were recorded.</td>
</tr>
<tr>
<td>Access to social grants and other services for children</td>
<td>Data is available for both partners. Access to grants and services was high in Rammulotsi in the Free State, and lower in the Queenstown area in the Eastern Cape. Access was improved in the latter area, where a strong holistic community development approach was adopted.</td>
</tr>
</tbody>
</table>
3. OUTCOMES OF HOME- AND COMMUNITY-BASED INTERVENTIONS

| Community playgroups without parent education components (one partner) |
|---|---|
| **Reach** | Vulnerable children were reached. Children reached: 1 175 |
| **Child cognitive, numeracy, language, and emotional development** | Impact data for Grade R is available. No impact was evident. |

**General lessons**

**The challenge of the delivery context:** Factors such as working in remote and underserviced areas, delivering programmes at a distance, and having to train and supervise local staff all need to be addressed.

**Effects of growth and cognitive status on programme outcomes:** High levels of stunting were recorded at all programme sites. Moreover, levels of cognitive development were below the norm for age. Both factors significantly reduce the chances of community-based ECD interventions improving cognitive and language development.

**Effect of caregiver and household vulnerability on programme outcomes:** Caregiver wellbeing and health, education levels, cultural factors, and household resources were not assessed in this evaluation. However, observations suggest that these factors probably significantly moderated the effects of the interventions.

**Playgroup programmes:** If these programmes are to make a difference, they need to be of high quality, and focus on school readiness. They need to be sustained over long periods, and children need to attend regularly. Playgroups can also be a vehicle for facilitating access to health, nutrition and social services.

**Home visiting programmes** are very effective vehicles for reaching very vulnerable households and facilitating service access. The employment of local home visitors facilitates community acceptance and helps build social solidarity among vulnerable families, including those who are not enrolled in the programme.

**Parent education:** Workshops for parents are generally not well attended, and the benefits are limited to the small proportion who do attend regularly. ECD workshops do not attract members of communities who prioritise basic needs.

**Teacher training:** Short training courses (such as 10 workshops) can substantially improve teaching and learning. Effective management and support of ECD practitioners also make significant contributions.

**Advocacy** of improved services to children among government officials and civil society representatives can be challenging, and works best when it utilises local practice (such as imbizos) in conjunction with sustained engagements with role players.

**Training and support:** Effective training and frequent and regular support are essential for effective programme implementation and high levels of fidelity.

**Sustainability** is enhanced when programmes are locally embedded and are not entirely dependent on volunteers.

**Scaling up:** Costs, demands on institutional capacity, and fit with local contexts should be carefully considered before programmes are scaled up. Sound programmes will be more easily implemented in different settings, provided implementation is adapted to local circumstances.
Incentives: Food offered at meetings, food parcels, and food gardens are powerful incentives for participation in programmes in vulnerable communities. Effective incentives for caregivers are making toys and other items to take home, and the social support and fun provided by group sessions.

Local staff: Staffing programmes with local people is a viable strategy, provided they are well trained and provided with ongoing support. This is also an effective way of getting communities to accept and appropriate the interventions.

Monitoring and evaluation are essential for ensuring fidelity, tracking progress, learning lessons, and adapting programmes where necessary. Robust and simple systems should be set up and utilised.

Protocols and manuals: Clearly written protocols and manuals play a vital role, and should be completed before implementation begins.

Evidence-based programming: Interventions must be planned with evidence bases in mind. All interventions must be based on a sound theory of change, which should be used to guide programme design and formulate realistic outcomes.

Further evaluation: Some of these community-based programmes achieved promising outcomes among young children as well as caregivers. This corresponds with international evidence. More rigorous evaluations with sufficient statistical power will contribute to the body of local evidence.
Ilifa Labantwana | The Sobambisana Initiative
ECD policy and Sobambisana

Since South Africa’s transition to an inclusive democracy, Early Childhood Development (ECD) has become a growing priority.

The government is seeking to rapidly massify and scale up services to young children. The National Integrated Plan (NIP) for ECD, 2005–2010 (DoE et al 2005) and the Children’s Act No 38 of 2005 (as amended) provide the framework for delivering a comprehensive range of ECD programmes and services for children under schoolgoing age. While the NIP was meant to end in 2010, it is still being implemented while a new plan is being finalised. The NIP defines integration as:

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

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

The NIP service package includes the universal registration of births; the Integrated Management of Childhood Illnesses (IMCI); the promotion of healthy pregnancy, birth and infancy; immunisation; nutrition; referrals to health and social services; early learning stimulation; and the development and implementation of psychosocial programmes.

As only about 30 per cent of children attend formal ECD centres, the NIP recognises the need for multiple approaches to developing young children, including direct services to children; training caregivers and educating parents; promoting community development; and building public awareness.

The NIP embodies a phased approach, with an initial focus on improving access to ECD centres as well as their quality. Phase 3, which has not yet been implemented, comprises a ‘mother–child programme’ featuring visits aimed at providing support to parents in vulnerable contexts, delivering early stimulation programmes, and providing a route for referrals to appropriate services.

Even though many NGOs have developed these sorts of programmes, they have not been rigorously evaluated. The national need to rapidly scale up these sorts of programmes has intensified the need for the best possible evidence about their efficacy.

The Sobambisana Initiative therefore sought to explore the interventions envisaged by the NIP. Participating partners were asked to submit proposals for interventions which would:

- Dramatically increase access to developmental opportunities for children younger than six;
- Be of a high standard and address the very real issue of the quality of implementation;
- Ensure seamless transitions between home, ECD sites and school; and
- Define the relationships between participating NGOs and the state (including service integration).

The five partners addressed these issues in various ways via comprehensive site-based interventions.

The evidence base for early intervention

Risks to sound early childhood development

The early development of children is influenced by several key factors, notably their genetic make-up as well as environmental influences both before and after birth (Richter 2003). Early home
care plays a particularly important role. Methods of child-rearing and cultural expectations of childhood development also have a major bearing on the way in which children’s development unfolds.

Levels of poverty in South Africa are very high. By the time many South African children reach school, they have already been compromised by the consequences of poverty, notably malnourishment. Early stunting as a result of malnutrition compromises neurological development, and significantly impedes the ability of children to benefit from education. Risks to early development are depicted in Figure 2.

This model is based on the work of Walker et al (2007); however, we have added caregiver health and wellbeing, which is also vital to early development. In their most recent paper (2011), Walker and her colleagues have also identified maternal depression as a threat to development.

Besides high levels of HIV / AIDS and infectious diseases such as tuberculosis, early child care in South Africa is also compromised by the burdens of poverty carried by many carers. Interventions designed to reduce these risks to ECD and promote development in the years prior to school need to appreciate each element of this complex set of relationships.

**Interventions**

Evidence of the efficacy of interventions in early childhood is robust, and derived from meta-analyses, systematic reviews of randomised controlled trials, and longitudinal studies, mainly in high-income environments but also in some poorer ones. The studies show that investment in ECD is both highly effective as well as cost-effective in terms of improving cognitive and mental health in the short term, but also reduces problems in later life that burden mental and physical health systems as well as other aspects of society (Anderson et al 2003; Engle et al 2007; Reynolds & Temple 2008; Walker et al 2007).

In 2000 the economist James Heckman won a Nobel Prize for demonstrating that early childhood interventions eventually yield far greater economic returns than interventions at any other time (see Heckman 2006). More specifically, he found that early interventions in the development of disadvantaged children were more effective as well as cheaper than later educational interventions such as reducing pupil teacher ratios, or adult interventions such as job training (see Figure 3).
South African policies and programmes focusing on ECD need to take account of the evidence that programmes with long-term effects are the most effective and cost-effective, and therefore need to be as well-resourced as possible.

The evidence of key inputs associated with positive outcomes at formal ECD centres is well-established. These include well-trained caregivers / teachers who are able to support and build on children’s learning; a formal curriculum; the availability of learning materials and play equipment; good management; financial stability; programmes that attend to children’s physical, social, and emotional needs as well as cognitive needs; and the involvement of parents and communities (Biersteker & Kvalsig 2007).

It is reasonable to expect that the same factors would apply to community playgroups, which are also a group experience. Sessions might be more infrequent, and managed by less qualified community volunteers, but there is evidence that this type of intervention can also be very effective (Rao et al, 2012).

The evidence in respect of home-based interventions is less clear because programmes tend to target children of different ages and have different goals and approaches, making them difficult to compare. Nevertheless, evidence of the positive impact of these interventions is emerging from the health, social development, and education sectors. These interventions have also been shown to stimulate demand for services (Mandhar et al 2004). Home visits in particular are emerging as a promising strategy for helping parents and promoting the growth and development of young children (Weiss & Klein 2006; Paulsell et al 2010).

Studies also show that encouraging links with other local services is another important aspect of home- and community-based ECD (UK Government 2010). While outcomes vary across different programmes, favourable outcomes have been demonstrated in respect of child development and school readiness, parenting practices, maternal health, the treatment of children, and the economic self-sufficiency of families.

Lessons learnt from these studies include:

- Parent participation needs to be active, regular and sustained.
- Home visits need to be frequent, ideally taking place at least once a week, as well as long-lasting, ideally for at least a year.
- The relationship between participants and practitioners needs to be stable, warm, supportive, and uncritical.
- Practitioners must be specially trained to work with parents.
- Practitioners must work jointly with children and parents if the goal is to enhance readiness to learn prior to school.

The Sobambisana Initiative has created an opportunity for assessing whether, and to what extent, the South African experience conforms to international evidence.

The Sobambisana interventions

This study presents findings from the central interventions, including: the training of centre-based ECD practitioners, advocacy of improved public services to children, home-based ECD programmes, community playgroups, and parenting education.

Training and enrichment aimed at improving ECD centres

**The ELRU Enrichment Intervention**

This intervention comprised workshops and on-site support for teachers in Foundation Phase classes in primary schools as well as community preschools. These took place during ELRU visits to the target areas, initially four times a year and later seven times a year. Community pre-school committees were established to facilitate this process and to qualify for the subsidies to community-based ECD centres paid by the Department of Social Development.

**The Ntataise Enrichment Programme (NEP)**

This intervention was aimed at assisting practitioners with formal training (preferably Level 4) to implement a quality classroom-based learning programme for children aged three to five, and prepare them for school. It comprised learning materials, monthly workshops, and on-site modelling of good practice in individual classrooms held twice every term.

**CECD ECD Practitioner Training**

This intervention comprised level 4 training for practitioners in 2009–10, and 15 workshops as well as on-site support aimed at improving learning and teaching environments in 2010.

**The Khululeka Preschool Enrichment Programme**

This programme comprised a Level 4 (FETC in ECD) training programme comprising 20 week-long workshops over a period of two years. Theory sessions alternated with practical workshops where trainees were taught to make teaching aids, toys, and other relevant equipment. On-site support was also provided.

**The TREE ECD Site Training and Support Programme**

This intervention comprised practitioner training at Levels 1 and 4, management training, and the establishment of local ECD forums. Only the outcome and impact of practitioner training was evaluated.

Advocacy of improved public services to young children

**The CECD Advocacy Programme**

This intervention was aimed at improving public services to children at the local level. CECD engaged with officials from different government departments as well as local municipalities.

**ELRU Wakh’ Umtwana Wakh’ Isizwe**

This intervention was aimed at raising community awareness of ECD, and improving local and provincial government officials’ understanding of the need for integrated service provision for children. It involved information-sharing and discussions at imbizos of community members, representatives of non-profit organisations (NPOs), and government officials. These were held three or four times a year, and were also used to provide feedback on progress made. ELRU practitioners also met with various stakeholders during its visits to the programme area.

**The TREE advocacy programme**

This intervention was aimed at facilitating the formation of local forums of stakeholders in services to children, including government officials, political and traditional leaders, and service organisations. One goal was to have ECD included in municipalities’ Integrated Development Plans.
Home-based ECD interventions

These interventions were aimed at improving the health, nutrition, and early learning environments of children not receiving formal ECD.

The CECD Family Outreach Programme

This programme comprised 18 home visits delivered three times per month to vulnerable children and their caregivers, and one workshop per month at which toys were made from waste materials, information provided about ECD, and food parcels handed out. During the home visits, which lasted about one and a half hours, home care practitioners provided caregivers with knowledge and support, and demonstrated early stimulation activities with children.

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

This programme comprised 20 two-hour visits delivered twice a month to vulnerable households with young children, and a monthly workshop with other participating caregivers at which an informal playgroup was offered to their children.

Caregivers were provided with emotional support; exposed to key messages about providing a safe, healthy, and stimulating environment for young children; and made aware of social grants and services. During each visit, the FCM and caregiver also played with the children using local materials and a toy kit.

The Khululeka Family Home Visiting Programme (FHV)

This programme provided eight or more visits (if necessary) twice a month. Visits lasted up to two hours. In the first year the programme included referrals to public services, nutrition, caregiver support, and child stimulation. Because child stimulation was not a priority for very vulnerable caregivers, the programme was adjusted in 2010 to focus on basic needs such as access to social grants, health and nutrition, and caregiver support. Children were provided with toys, but there was no focused educational input in year two.

Community playgroups for parents and children

These programmes were aimed at stimulating children not receiving formal ECD, as well as educating their parents about the need for ECD.

The Ntataise Mosupatsela Playgroup Programme

This programme comprised a weekly two-hour playgroup session for parents and children aged three to five in different outdoor settings, with a focus on preparing them for school. It was targeted at children who were unable to attend preschools, mostly because their parents could not afford the fees. Parents were expected to attend with their children, so that they could learn to support the children attending the sessions as well as other children at home, but attendance was poor and inconsistent in both years. Attendance was too poor to permit an evaluation of parent outcomes.

The TREE Structured Playgroup Programme

This programme sought to provide children aged three to five who did not have access to preschools with developmentally appropriate experiences. In practice, many younger children attended. In its first year, 2009, play facilitators (PFs) chosen by the community and trained and supported by TREE were made responsible for ten playgroups of ten to 15 children each. The PFs, in turn, trained parents of participating children to run the groups on a rotating basis. While large numbers of children were reached, the programme deviated from its original design, with several playgroups becoming more like ECD centres and enrolling too many children. Quality control could not be maintained.

In 2010 the programme was revised to improve oversight and quality. PFs were made responsible for four playgroups each, and facilitated a session once a week. Volunteer parents hosted other sessions. PFs received refresher training once a month. This programme is continuing, and has no limit. Children may attend as many sessions as parents choose.

Parenting education workshop programmes

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

This programme was directed at the caregivers of children aged 0–6 who were not receiving any formal ECD. Caregivers attended weekly group sessions lasting two to three hours, accompanied by the children in their care. They received information about ECD, and were taught to make toys and other resources while the children participated in informal play activities. During the first programme cycle, 35 sessions were offered. Due to poor attendance, the number of sessions was reduced to between 16 and 19 in the second cycle.
**The Ntataise Parent Support Programme (PSP)**
This programme comprised ten workshops held once a month for the parents of children enrolled in preschools. Run by specially trained matrons (preschool supervisors), parents received support and information on early mental development, were taught how to make books, and taught learning games which they could play with their children at home. Attendance was too poor to permit an evaluation of parent outcomes.

**The evaluation process**

The evaluation was undertaken in two stages. The first was managed by the Human Sciences Research Council (HSRC) in the period April 2008 to April 2009. The contract for the second stage was awarded to the Department of Psychology of the University of Cape Town (mid 2009-December 2011) after the team had left the HSRC and returned to UCT. The first author led the evaluation in partnership with the second, who was based at ELRU.

The brief was to:

1. Monitor and evaluate programme implementation by each partner;
2. Evaluate the outcomes of interventions implemented by each partner;
3. Evaluate the impact of the interventions on children by the time they reached Grade R.
4. Strengthen M&E procedures in each partner organisation, and instil a culture of M&E.

The activities of the M&E team over the four years from 2008 to 2011 are listed in Box 1.

---

**BOX 1: Activities of the Sobambisana monitoring and evaluation team**

**During 2008, the team developed:**
- A participatory approach to M&E with all five partners.
- An approach to the provision of regular partner support for the M&E process.
- Evaluation designs for all partner interventions.
- Common tools for monitoring programme implementation, and for measuring outcomes and impacts so as to enable comparisons across different interventions.
- A common Excel® template for recording beneficiary data, programme participation, and programme outcomes and impacts (the Common Data Entry Tool).
- A format for quarterly progress reports to the M&E team.
- A process for facilitating regular reflective sessions with partners on programme progress, obstacles and emerging findings.
- A culture supportive of M&E in each partner.

**During 2009-2011, the M&E team:**
- Provided each partner with continuous remote M&E support (via email and telephone), and contacted each partner at least once a month.
- Provided inputs on the M&E process to Sobambisana partner meetings held twice a year.
- Finalised instruments for measuring outcomes in respect of children, adults and ECD sites.
- Developed interview schedules for measuring the views of beneficiaries and staff on programme implementation.
- Evaluated the outcomes of all partner interventions.
- Evaluated the impact of the Sobambisana programmes on children who had reached Grade R.
- Supervised all data collection, checked data entries, and cleaned data sheets provided by each partner.
- Conducted statistical analyses.
- Conducted qualitative analyses of partner proposals, reports to donors, and quarterly M&E reports.
- Wrote reports required by donors.
- Presented the findings of the study to several conferences and academic seminars.
- Disseminated the findings of the study via briefings on ECD and lessons learnt from the Sobambisana Initiative.
Evaluation questions

As noted earlier, a key goal of the Sobambisana Initiative was to expand access to ECD. A further goal was to test the efficacy of different approaches to ECD in homes and at ECD sites. A final goal was to improve the quality and co-ordination of public services to vulnerable young children and their families.

If these goals were to be achieved, the programmes had to be well implemented, in line with the programme design. Implementation evaluation was used to assess the nature and quality of programme delivery. The evaluation questions and sources of data used to develop the responses appear in Table 3.

Evaluation methods

Recommendations for planning, implementing and evaluating these sorts of interventions are readily found in the research literature, as well as programme evaluation literature. They apply to home-based early stimulation programmes, ECD site enrichment programmes, playgroup programmes, and many others (see Engel et al 2007; Rossi et al 2004; Donaldson et al 2009). The main recommendations are:

1. Programme design, implementation, and M&E must be realistic, and informed by known risks to ECD.
2. Interventions must be frequent enough, and last long enough, to make a difference. This is normally determined by referring to research findings or the prior experience of the implementing organisation.
3. Interventions must be informed by a strong theory of change – in other words, a clear conception of why it will make a difference.
4. This conception must be informed by evidence of the efficacy of these sorts of interventions in producing specific outcomes.
5. Programmes must be clearly described in terms of participants, beneficiaries, goals, activities, and outcomes. Activities must be clearly linked to objectives, and clear, measurable indicators for measuring progress and outcomes must be developed.
6. Interventions need to target those characteristics of participants and their circumstances that, when changed, are likely to improve outcomes. This applies to children as well as caregivers.
7. Interventions must be implemented as designed, and implementation must be logged by the implementing agency. Known as programme fidelity, this requirement often does not receive sufficient attention. When programmes fail, this is often because they were not implemented as designed.
8. Measures of outcomes need to be valid and reliable, and must be aligned with goals and inputs. If measures of success are inappropriate, an intervention may in fact be successful but fail to show positive formal results.
9. New interventions (those not based on established and tested programmes) should be thoroughly evaluated before any claims of efficacy are made.

The Sobambisana evaluation team sought to take all these aspects into account in supporting partners and designing the evaluations. The multifaceted method used was informed by a number of sources, all of which emphasised the importance of producing actionable evidence (Julnes & Roq 2009; Rossi et al 2004). The evaluation was designed in four stages, reflected in Table 4.
## Table 3: Questions and data sources

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>DATA SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td><em>Were partner interventions delivered as intended?</em></td>
<td>Project proposals submitted to donors (projections of reach). Annual partner M&amp;E reports (2010 and 2011). Programme descriptions, implementation manuals and plans, and theories of change for each intervention. Minutes of meetings and consultations with partners. Interviews with programme staff and beneficiaries. Site visits by the M&amp;E team.</td>
</tr>
<tr>
<td><em>What were the perceived benefits of beneficiary participation, and what impeded this?</em></td>
<td>Annual partner M&amp;E reports (2010 and 2011). Minutes of meetings and consultations with partners. Interviews with programme staff and beneficiaries conducted by M&amp;E team and independent interviewers.</td>
</tr>
<tr>
<td><strong>Outcome 1: Reach</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did the interventions reach their intended targets?</em></td>
<td>Annual reports to donors. Quarterly partner M&amp;E reports. Annual partner M&amp;E reports (2010 and 2011). Interviews with programme staff.</td>
</tr>
<tr>
<td><em>Did the interventions improve the development of vulnerable children?</em></td>
<td>Project proposals submitted to donors (projections of reach). Enrolment and participation data captured with the common data entry tool. Quarterly partner M&amp;E reports. Interviews with programme staff.</td>
</tr>
<tr>
<td><strong>Outcome 2: Adult outcomes</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did the interventions improve the capacity of caregivers to provide children with safe, hygienic, and stimulating environments?</em></td>
<td>Common data entry tool: Scores on the HOME inventory and the Hygiene and Safety Checklist.</td>
</tr>
<tr>
<td><strong>Outcome 3: Child outcomes</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did the interventions improve the cognitive and language abilities of children, as well as their access to services?</em></td>
<td>The Common Data Entry Tool: baseline and follow-up on tests of: 1. Cognitive and language development. 2. Referrals for services. Child growth was assessed at baseline but not tracked over time.</td>
</tr>
<tr>
<td><strong>4: ECD site outcomes</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did site enrichment interventions (practitioner training) improve the quality of early care and learning environments?</em></td>
<td>Common data entry tool: Scores at baseline and follow-up on the ECD Rating Scale – R. Annual partner M&amp;E reports (2010 and 2011). Minutes of meetings and consultations with partners. Interviews with programme staff and beneficiaries.</td>
</tr>
<tr>
<td><strong>5: Effects of advocacy initiatives</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did advocacy initiatives make stakeholders more responsive to the needs of vulnerable families and young children?</em></td>
<td>Annual partner M&amp;E reports (2011). Interviews with programme staff.</td>
</tr>
<tr>
<td><strong>6: Impact evaluation</strong></td>
<td></td>
</tr>
<tr>
<td><em>Did children in Grade R who benefited from Sobambisana interventions perform better in assessments of cognition, literacy, numeracy, and academic readiness than those who did not?</em></td>
<td>Common data entry tool: Scores in tests of cognitive development; language; numeracy; emotional development; and growth status.</td>
</tr>
</tbody>
</table>
Table 4: The participatory evaluation of Sobambisana interventions, 2008-2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop relationships with partner organisations</td>
<td>Enrol first cohorts*</td>
<td>Enrol second cohorts</td>
<td>Testing of children in Grade R</td>
</tr>
<tr>
<td>2. Develop evaluation design and tools</td>
<td>Monitoring implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child, adult and ECD site assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Baseline Follow-up</td>
</tr>
</tbody>
</table>

* Note: In some instances, first cohorts were enrolled in the latter half of 2008.

The impact evaluations were meant to take place at two points – in 2010 (after the first programme cycle), and in 2011 (when the programmes formally ended). Permission to test children in Grade R in 2010 was not granted. Relevant provincial education departments were approached for permission to test children in 2011, and all granted the necessary permission.

**Establishing a participatory approach**

A participatory approach to the evaluation was adopted and followed throughout the process, but was particularly important during the first year when the M&E team sought to establish a collaborative M&E culture within each partner.

This approach involves the development of a partnership between the M&E team and the partner that optimally endures for the life of the process. The team builds a relationship of trust with the partner, and then involves it as far as possible in designing the evaluation process while maintaining a professional distance. This approach is also flexible as it allows the M&E team to change its methods if needs be.

Central to ‘getting the partners on board’ was attention to building trust and understanding between the M&E team and each partner. In the process, individual evaluation methods and indicators were designed in collaboration with each partner.

To address partners’ concerns about the demands of the M&E process, funding was secured for the part-time employment of in-house M&E staff.

Besides building a constructive relationship, this process enabled the M&E team to assess the plausibility of interventions by examining documents and interviewing partners about their theories of change (which were largely implicit prior to the evaluation).

The team did not have the authority to insist on changes to interventions that seemed implausible, or whose delivery mechanisms seemed unsound. However, in some instances partners did change the programme intensity and other aspects of delivery on the advice of the M&E team.

The evaluation systems were regularly reviewed, and sometimes changed significantly. In September 2009 all the evaluations were changed because of changes in the programmes themselves, or in their external environments. For example, one partner was unable to enrol enough children for testing and tracking because there weren’t enough children of the right ages in the villages in which it worked.

The M&E team did not fully appreciate the degree to which partners would need to be prepared for the evaluations, and underestimated their anxieties about the evaluation process. While this was partly due to the proposed approaches (standardised assessments of children and adult outcomes), it largely stemmed from increased costs and additional burdens on staff. The M&E process did have a significant impact on the day-to-day functioning of these organisations, especially those without M&E capacity and expertise.
This suggests that donors should ask grant applicants to build M&E into their proposals, and include the costs in their budgets. Moreover, large ECD service providers should appoint dedicated M&E staff.

**Developing evaluation designs and tools**

**Design issues**

Programmes were individually designed for their environments. While three partners (ELRU, Khululeka and CECD) implemented home visiting programmes, and two (Ntataise and TREE) offered playgroup programmes, the programmes differed significantly from one another and were therefore not strictly comparable. The most comparable programmes were practitioner training programmes. These differences were significant enough to warrant different processes for each partner. At the same time, some commonalities had to be introduced.

The gold standard for testing the efficacy of interventions are randomised controlled trials (Rossi et al 2004). When this is not feasible (as was the case here), the next best option is a quasi-experimental process with suitable controls comprising groups of beneficiaries as well as wait listed comparison groups. This design was initially chosen for the Sobambisana evaluations.

Efforts were therefore made to enrol groups of beneficiaries (intervention groups) as well as matching wait list comparison groups for every intervention, and test them at baseline and follow-up. These groups comprised children and adults who had participated in various interventions. In order to secure sufficient statistical power, an effort was made to include at least 60 people in each group.

For reasons that differed across partners, and are explained in their evaluation reports, these goals could only be achieved in a few instances. Intervention and wait list comparison groups were enrolled and measured at both baseline and follow-up in respect of the ELRU Family Community Motivator Programme and the CECD Family Outreach Programme.

Children who had participated in Ntataise playgroups were divided into two groups – those who had attended more or less than 50 per cent of the sessions. The latter acted as a comparison group, enabling dose response to be tested.

In all other cases, the team could only conduct baseline and follow-up tests of beneficiaries. This is not an optimal approach because the results cannot be measured against those obtained from control groups which had not participated in the interventions. Nonetheless, such an approach can yield promising findings which can be tested more rigorously at a later stage.

**Ethics**

Ethical clearance was obtained from the Department of Psychology and Faculty of Humanities Research Ethics Committee of the University of Cape Town. Partner organisations asked parents to consent to their children being tested.

**Procedures**

Selection criteria differed across partners, but all targeted vulnerable children and families. Children aged between 36 and 60 months were included in both intervention and wait list groups (where these were used). While some younger and older children were also tested, children in this age group formed the core of the impact evaluations.

Children were tested in the mornings, at suitable community venues. In line with accepted South African ethical practice, all the tests were administered by trained assessors supervised by registered psychologists.

**Cross-partner outcome measures**

A key aspect of the evaluation was the use of common measures in respect of all the interventions across all the partner organisations. These are fully explained in the Measures Appendix, and summarised in Tables 5 and 6.
Table 5: Cross-partner outcome measures for adults

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>INDICATOR</th>
<th>ASSESSMENT TOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and early stimulation</td>
<td>Quality of caregiver responsiveness to child</td>
<td>The HOME inventory Responsivity Subscale (Caldwell &amp; Bradley 2001)</td>
</tr>
<tr>
<td></td>
<td>Quality of caregiver stimulation of the child’s language</td>
<td>The HOME inventory Language Stimulation Subscale</td>
</tr>
<tr>
<td></td>
<td>Quality of caregiver stimulation of academic competencies</td>
<td>The HOME inventory Academic Stimulation Subscale</td>
</tr>
<tr>
<td></td>
<td>Quality of caregiver parenting and relationship with child</td>
<td>The HOME inventory Acceptance Subscale</td>
</tr>
<tr>
<td>Hygiene and safety</td>
<td>A safe and hygienic environment in the home</td>
<td>The Hygiene and Safety Checklist *</td>
</tr>
</tbody>
</table>

Table 6: Cross-partner outcome measures for children

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>INDICATOR</th>
<th>ASSESSMENT TOOL</th>
</tr>
</thead>
</table>
| Access to services            | Successful referrals: number of children referred for services who have accessed them at follow-up. | Checklist *  
Road to Health card/booklets  
Child Support Grants, Care Dependency (Disability)  
Grants, Foster Child Grants.                                                                 |
| Cognitive development         | Improved levels of cognitive development (controlling for maturation age). | Grover-Counter Scale (Sebate 2000).                                                                                                                                 |
| Language development          | Improved levels of language development (controlling for maturation age).  | Sobambisana Language Development Standards Assessment **                                                                                                                                 |

NOTES
* Children’s access to other services, such as obtaining identity documents and emergency food parcels, were also recorded.
** Developed for the Sobambisana Initiative and subsequently used in the National Early Learning Standards language validation assessment.

Growth status
While the Sobambisana Initiative was not aimed at improving children’s growth, children were assessed for underweight (weight for age) and stunting (height for age), using World Health Organisation (WHO) anthropometric standards. This data was collected because it is an important indicator of children’s well-being, and because it allowed the M&E team to link the growth status of beneficiaries to the outcomes in question (cognition and language development). Growth status could moderate the effects of the Sobambisana interventions, as malnutrition in the early years is known to impact on neurological development, and therefore on cognitive and related functions.

While the team initially set out to test the outcomes of all home visit and playgroup programmes on language and cognitive development, this could only be done in the case of programmes run by two partners, namely ELRU and Ntataise.

Limitations of the outcome evaluations
There are clear limits to the validity of uncontrolled outcome evaluations. Among other things:

- One cannot be sure that external sources of influence are responsible for the observed change (contamination). However, steps were taken to capture information about other interventions that were being delivered in the area.
The lack of randomisation is a potential source of bias in that members of intervention and wait list groups may have particular characteristics that favour a certain outcome. However, households within the Sobambisana target communities were very similar, which reduces this risk to some extent.

Unknown selection effects are another potential source of bias. For example, caregivers who were enrolled in intervention and wait list groups could have differed in some important respects from those who were not. In fact, those who attended diligently were likely to differ from those who did not.

It is well known that conditions in the home play a key role in children's development. However, it was not possible to control for this variable.

The performances of young children in tests such as the Grover-Counter Scale of Cognitive Development vary depending on their state on the day of assessment – for example, whether they are ill, tired or hungry (children who were obviously ill were not tested). All children were tested in the morning to avoid the effects of fatigue, which is more likely later in the day. While tests were discontinued if children were unco-operative, it was not possible to control for children's orientation to the testing situation. Findings can also be affected by assessor variations. While the assessors who tested children were trained and supervised, their approach to testing might have differed. For example, they might have been more or less able to set young children at ease, thus affecting their engagement with the tests. They might also have been more or less strict with scoring. When large numbers of children are tested, this variation is not critical. As sample sizes in these evaluations were relatively small, though, variation among children and assessors on testing day would have affected the validity of the evaluations.

These limitations need to be borne in mind when considering the results of both the outcome and impact evaluations.

**Impacts on children in Grade R, April–June 2011**

As there was no baseline data for certain groups in Grade R, impact was measured post-hoc (Campbell & Stanley 1963). This means that the performances of children who had benefited from Sobambisana programmes were compared with those of children who had not been exposed to any ECD programme with an early stimulation component.

**Group comparisons**

Comparisons varied across partners depending on their interventions, as displayed in Table 7.

**Table 7: Post hoc comparisons in respect of Grade R**

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>CECD</th>
<th>KHULULEKA</th>
<th>ELRU</th>
<th>NTATAISE</th>
<th>TREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1: children whose teachers had received practitioner training</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Group 2: Children who participated in a home visiting programme</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 3: Children who had participated in a playgroup programme</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Group 4: Children with no exposure to an ECD programme</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Procedures**

In September 2010, Sobambisana partners established which children participating in their programmes would attend Grade R in 2011, and where they would be enrolled. Once children had been enrolled, partners contacted each school to check whether the children had in fact enrolled there. They then established which children in Grade R had not participated in an ECD programme. These children constituted the intervention and comparison groups for the impact evaluations.

The schools were located in the programme areas, and therefore exhibited similar levels of deprivation. The numbers of schools involved in the tests are presented in Table 8.
Table 8: Number of schools that participated in Grade R testing

<table>
<thead>
<tr>
<th>PARTNER</th>
<th>AREA AND PROVINCE</th>
<th>NUMBER OF SCHOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELRU</td>
<td>Lusikisiki, Eastern Cape</td>
<td>4</td>
</tr>
<tr>
<td>Khululeka</td>
<td>Villages around Queenstown in the Eastern Cape</td>
<td>4</td>
</tr>
<tr>
<td>TREE</td>
<td>Indaka, KwaZulu-Natal</td>
<td>4</td>
</tr>
<tr>
<td>Ntataise</td>
<td>Rammulotsi and Odendaalsrus, Free State</td>
<td>7</td>
</tr>
<tr>
<td>CECID</td>
<td>Grabouw, Western Cape</td>
<td>6</td>
</tr>
</tbody>
</table>

Grade R testing was supervised by experienced staff. Each wrote a report on the conditions under which testing occurred. Conditions varied, but the M&E team judged these to be within acceptable limits.

**Measures**

Measures used to assess children in Grade R are presented in Table 9. Details of measures are to be found in the Sobambisana Measures Appendix.

Table 9: Measures used for children in Grade R

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>ASSESSMENT TOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>WHO 10 Point Disability Screen</td>
</tr>
<tr>
<td>Growth status</td>
<td>WHO Anthropometry Growth Standards</td>
</tr>
<tr>
<td>Cognitive development</td>
<td>Grover-Counter Scale</td>
</tr>
<tr>
<td>Language development</td>
<td>Peabody Picture Vocabulary Test (PPVT-4)</td>
</tr>
<tr>
<td>Numeracy</td>
<td>Counting concepts and number concepts</td>
</tr>
<tr>
<td></td>
<td>Numerical concepts</td>
</tr>
<tr>
<td>Academic adjustment</td>
<td>SACAS* Academic Readiness Subscale (Readiness to Learn)</td>
</tr>
<tr>
<td></td>
<td>SACAS* Resilience Subscale</td>
</tr>
</tbody>
</table>

* South African Child Assessment Scales.

Children's growth status was measured to test for its moderating effects on child development. The Grover-Counter Scale was used to assess cognitive development in both the outcome and impact evaluations.

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

Children's emotional maturity affects their adjustment to school (readiness to learn), their ability to work constructively with peers, their ability to regulate their emotions and behaviour, their degree of self-confidence, and their ability to work independently. These characteristics were assessed on two subscales of the South African Child Assessment Schedule, namely Academic Readiness and Resilience. The SACAS was developed for the assessment of young children in the Birth to Twenty cohort study, and has been used in other studies (Van der Merwe & Dawes 2000). The child's teacher rates the child on a set of items using a three-point scale.

Children were tested in the morning at their schools, either in a classroom or under a gazebo erected in the school yard.

**Limitations of the impact evaluation**

Because the impact evaluation compared different groups at one point in time, one has to be cautious when interpreting the findings. This is because the findings may be affected by other, uncontrolled factors. For example, if children who attended preschools prior to Grade R perform better than those who did not, this may be because their families are better off (and can afford the fees), or provide a more stimulating environment in their homes. These are known as selection effects and could not be fully controlled in the Sobambisana evaluation. However, as all the children lived in the same deprived areas, their socioeconomic circumstances probably did not differ substantially. Controls for age variation were employed in the statistical analyses.

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

As is the case of the outcome evaluation, both variation in children's approaches to the testing situations and variations in assessors constitute threats to the internal validity of the evaluation.
General findings

The findings of the Sobambisana evaluation are summarised in Table 10. They are rated in terms of their alignment with the international evidence summarised above. Details are provided after the table.

Table 10: Summary of the Sobambisana findings

<table>
<thead>
<tr>
<th>SOBAMBISANA INTERVENTION</th>
<th>INTERNATIONAL EVIDENCE</th>
<th>SOBAMBISANA EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits</td>
<td>Parent / caregiver education (safety, hygiene, early stimulation, nutrition)</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>Access to services (e.g. social welfare and health)</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>Caregiver support</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>School readiness</td>
<td>–</td>
</tr>
<tr>
<td>Community playgroups</td>
<td>Parent / caregiver education (safety, hygiene, early stimulation, nutrition)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>School readiness</td>
<td>+ / –</td>
</tr>
<tr>
<td></td>
<td>Links to services</td>
<td>+</td>
</tr>
<tr>
<td>Parent education workshops</td>
<td>Parent / caregiver education (safety, hygiene, early stimulation, nutrition)</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>School readiness</td>
<td>–</td>
</tr>
<tr>
<td>Training of ECD Centre practitioners (accredited and support workshops)</td>
<td>Classroom quality</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>School readiness</td>
<td>++</td>
</tr>
<tr>
<td>Advocacy of integrated service delivery</td>
<td>Community awareness</td>
<td>+ / –</td>
</tr>
<tr>
<td></td>
<td>Local and provincial authorities, NGOs</td>
<td>+ / –</td>
</tr>
</tbody>
</table>

++ = strong evidence of efficacy in line with international evidence
+ = fairly positive results;
+/– = mixed results; – = no evidence of efficacy
– = no evidence of efficacy

Outcomes of home visits

The three home visit interventions were delivered in different ways, but shared parent/caregiver education about health, hygiene, nutrition and stimulation; caregiver support; and linking households with services.

Two programmes (ELRU and CECD) worked with parents and children, while the third (Khululeka) focused on caregivers but also provided children with toys and other materials. Khululeka also demonstrated the utility of food gardens, while CECD provided food parcels.

The home visit programmes reached significant numbers of caregivers and children. They succeeded in providing caregivers with support, providing children with access to services, and
involving children in various activities which stimulated their development and improved the health and safety of their homes.

Between 2009 and 2011, Sobambisana home visiting programmes reached 794 caregivers and 1,513 children. They succeeded in reaching children who would not otherwise have enjoyed access to ECD, and supporting and empowering caregivers.

The Khululeka and ELRU home visiting programmes succeeded in improving hygiene and safety in the home as well as parenting, including academic and language stimulation and affectional care. The CECD programme did not achieve significant changes in parenting.

Home visiting programmes recorded improvements in caregiver coping, indicating that the support provided improved their sense of wellbeing and their ability and motivation to take control of their situations.

ELRU’s home visiting programme did not improve children’s cognitive skills or their use of language. This was not assessed in respect of any other home visiting programme.

All the interventions succeeded in improving access to services in areas where baseline access had been limited.

However, no difference was found between the cognition, language, numeracy, and emotional maturity of children in Grade R who had received home visits and children who had not received any formal ECD.

Evidence from Sobambisana home visiting interventions accords with international experiences in the following ways:

- Home visits are an effective strategy for reaching children and caregivers in vulnerable households. They improve caregiver coping and agency, hygiene and safety in the home, as well as parenting. Parents become more responsive, affectionate, and conscious of their children’s developmental needs.
- Cognitive and language outcomes did not improve beyond that expected due to maturation. A number of factors might have contributed to this, including the highly compromised nutritional status of children at different locations, the relatively short duration of most programmes, and too few visits in some instances. In particular, the stimulation components might not have been sufficiently aligned to school readiness skills, and the home visitors, who were all selected from local communities, might have been insufficiently trained in ECD to facilitate the transfer of these skills to caregivers.

Outcomes of the community playgroup interventions

Two community playgroup interventions that utilised structured curricula and were delivered weekly (over different programme periods) were evaluated. Key differences were that Mosupatsela (the Ntataise intervention) was strongly focused on school readiness activities, and was offered once a week by a formally trained ECD facilitator. TREE provided a broader developmental programme facilitated by a trained, locally chosen playgroup facilitator once a week, and volunteer caregivers on other days.

Parental participation was a key feature of the former intervention, based on the assumption that the stimulation would continue at home. Both interventions targeted children aged three to five with no access to preschools. The recommended size of playgroups under both interventions was about 15 children.

Mosupatsela reached only 116 children in 2009 and 2010, and levels of parent participation were low (33 per cent). By contrast, the TREE intervention reached 1,175 children in the same period.

The cognitive abilities of children who had attended 15 or more Mosupatsela play sessions were significantly greater than those of children who had attended fewer sessions.
Members of TREE playgroups were referred to state agencies for documentation, health services and social welfare services, and some issues were successfully resolved (but data is limited).

In Grade R, the scores of learners who had participated in playgroups were not higher than those of children who had not benefited from ECD. However, the scores indicated that Mosupatsela had the potential to improve children’s readiness for school.

**Lessons from the playgroup interventions**

The data shows that a highly structured programme managed by well-trained staff and resourced with suitable equipment can have positive effects with relatively light exposure. Attempts to reach parents tend to be less successful, and may not be a vital element.

Playgroup programmes should seek to secure the highest possible levels of attendance, as lower doses may be insufficient to change cognitive and language outcomes. Levels of attendance of both programmes were much lower than those expected to make a difference.

Playgroups managed by volunteer parents and held in private homes are likely to be more difficult to sustain in the longer term.

Mosupatsela delivered promising outcomes, but reached relatively few children. High costs per child may make it more difficult to take this type of programme to scale.

Playgroups run by volunteers attracted larger numbers of children. This may be because the children accompanied the volunteer caregivers, or because they were fed during the sessions.

The outcomes largely conform to international evidence that group experiences can significantly improve children’s cognitive abilities and their readiness for school.

Children who attended informal play experiences offered by the Khululeka Infant and Toddler programme showed improved cognition even when their parents did not attend frequently. However, children in Grade R who had participated in the playgroups run by volunteers did not achieve better scores than those who had not been exposed to organised ECD.

**Outcomes of parenting education workshop programmes**

The Ntataise Parent Support Programme comprised monthly workshops for parents of children attending 14 preschools, held by the preschool supervisors. Khululeka’s Infant and Toddler Support Programme comprised weekly sessions for caregivers of children up to age six who were not receiving any organised ECD. Children participated in unstructured play activities during the sessions.

- Some 230 caregivers from 14 ECD centres were enrolled for the Ntataise programme in 2009 and 2010. However, the programme was poorly managed and attendance levels were very low.
- Some 76 of 92 parents who joined Khululeka support groups in 2008–10 attended more than two sessions. Attendance in 2010–11 was 66 per cent. Some 146 children attended the sessions during the evaluation period.
- The Khululeka programme was less successful in reaching parents whose children were not receiving other ECD. Only a third of families who had completed the home visiting programme enrolled, and many parents of children in local preschools joined as well.
- Attendance at group programmes of all kinds tended to be inconsistent.

Data for child and caregiver outcomes is only available for Khululeka. No Grade R follow-up was possible because no cohort had completed the programme when the tests were conducted.

- Caregiver coping scores improved significantly, showing that the support provided made a difference to their wellbeing.
- Caregivers were more accepting and responsive, and provided improved academic and language stimulation.
- Most children were already benefiting from social grants and other state services, but 62 per cent of referrals for grants had been resolved by the end of the evaluation period.
- Children’s cognition and use of language improved in the course of these interventions. Higher rates of child and caregiver attendance led to greater gains.
- The Ntataise programme met its initial enrolment targets, but due to low attendance levels managed to deliver its services to fewer than one third of the initial participants.
Lessons from parenting education workshop programmes

- Many caregivers who were given the opportunity to participate in a parenting programme did not do so. The main reasons were that they were burdened by poverty and everyday tasks, lived far from venues to which they had to walk, were unwell, or felt they did not need assistance with parenting or ECD.
- Parent education programmes must do everything possible to maintain high attendance levels. This is challenging when parents have other duties.
- Programme implementers must be well trained and highly motivated, and should receive regular support. The preschool supervisors who were meant to deliver the Ntataise programme had many other duties, and a lack of incentives made it difficult for them to implement the intervention.
- Participants in both interventions appreciated practical workshops where they made items they could take home with them, as well as the social support and fun of the group setting. For these reasons, the Khululeka programme attracted many parents of children attending preschool as well as parents whose children were not exposed to formal ECD.
- Take-up by some of the targeted caregivers was disappointing. Parent education programmes must therefore do everything possible to meet the needs of their target beneficiaries and achieve high attendance levels. This is challenging when parents have many other pressing duties.

Outcomes of training of ECD practitioners at ECD sites and schools

- Three accredited level 4 training programmes reached only 38 practitioners. Three shorter workshop programmes reached 138 practitioners. People dropped out of longer programmes due to illness, death, leaving or losing their jobs, or transferring to Expanded Public Works Programme learnerships with stipends.
- Almost all the training interventions improved classroom practice in community preschools, sometimes significantly so. This included teacher mediation of language and reasoning, learning activities, and interactions between teachers and children. Slight improvements from a very low base were identified in Grade R classes in the Eastern Cape where sessions were limited by the teachers' strike in 2009.

- Grade R learners who had attended preschools staffed by trained teachers achieved higher cognition, language, numeracy, and readiness to learn scores than children who had not been exposed to an ECD programme, or had attended a home-based programme, playgroup, or a parenting education workshop programme.\(^1\)

Figures 4 and 5.1 and 5.2 display the cognition and language, numeracy, and academic readiness scores of Grade R learners who had not been exposed to an ECD programme and those who had attended a preschool with teachers trained by a partner organisation. All the differences are statistically significant (age was controlled).

**Figure 4:** Scores of Grade R learners by exposure to ECD: cognition and language

![Figure 4: Scores of Grade R learners by exposure to ECD: cognition and language](chart.png)
Figure 5.1: Scores of Grade R learners by exposure to ECD: numeracy

![Bar chart showing scores of Grade R learners by exposure to ECD: numeracy](image)

Figure 5.2: Scores of Grade R learners by exposure to ECD: Academic Readiness

![Bar chart showing scores of Grade R learners by exposure to ECD: Academic Readiness](image)

Lessons from the training of ECD practitioners

- Implementation improves when practitioners are supported by the school management committee, principal, and/or head of department.

- Practical on-site support during which appropriate teaching practice is modelled, practitioners are assisted to develop particular skills, and appropriate equipment is provided (whether improvised or bought) is vital to improving programme quality.

- Short practical courses and a planned programme can improve ECD classroom practice relatively quickly.

- Maintaining participation in learnerships and skills programmes which do not have the incentive of a stipend or qualification is challenging in certain contexts.

- Personal support by trainers and group training experiences can significantly improve the motivation of practitioners, encouraging them to improve their teaching and undergo further professional development. Evidence from the Sobambisana training interventions confirms the international experience that support from managers, training, and equipment play major roles in improving practitioners’ capabilities.

Outcomes of advocacy for integrated service delivery

Four of the five partner organisations were working in new areas and therefore actively advocated improved public services for young children. The fifth worked in an area where such services were reasonably well established.

Partners with a community development approach rather than a service delivery orientation invested more heavily in community processes.

Two partners facilitated the development of local structures to help young children gain access to services. Both found it was very difficult to build new structures offering no concrete incentives in communities whose leaders were already overburdened, and decided to add ECD elements to existing community forums and structures instead.

Regular community report-backs and imbizos were found to be invaluable in creating interest in and demand for services to children. In one approach, the community development facilitator became the contact point for linkages with government services; in another, the partner involved public and civil society service providers in imbizos and individual follow-up meetings.
course of the latter programme, members of the community committee, home visitors, and preschool staff came to know government officials and others involved in providing services to children, and could therefore interact with them more effectively. The other two partners targeted local municipalities.

The outcomes of advocacy initiatives were mixed. Two of the four interventions were not very successful. The other two succeeded in improving community interest in ECD, and improving access to public services for children.

Lessons from the advocacy interventions

The evaluation shows that advocacy is most successful when it is sustained, and has a clear goal and strategy. Bringing together community members, government officials, and representatives of relevant civil society organisations is a particularly successful approach, and the imbizo or community report-back format adopted by one partner proved to be a culturally appropriate and powerful medium.

While ECD organisations may seek to play a role at the local or regional level, there are many processes over which they have no control, and which may thwart their efforts.

However, the evaluation shows that community involvement in awareness and advocacy campaigns strengthens demand for and the uptake of services, and can improve the responsiveness of service providers. It also increases mutual support among caregivers in the programme as well as for other caregivers in the community. This finding corresponds with international evidence.

General lessons from the Sobambisana Initiative

Proximity versus distance

Most of the partners worked at a distance from the programme sites. This is common, as deprived areas tend to lack resource organisations. However, it increases the cost of interventions, and creates a number of other problems. Resource organisations unknown to the community require time for a careful entry process, and it is less easy to monitor implementation by local field workers. Two partner organisations were compelled to increase their budgeted time on site because local field staff needed more supervision than they had originally planned. However, working at a distance also enabled leadership transfer as local staff and stakeholders had to take the work forward when the partner’s staff were absent. This enhanced their independence and ownership of the work.

Protocols, manuals, and quality assurance mechanisms

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

Regular quality assurance procedures, monitoring protocols, step-by-step implementation guidelines, and manuals helped to standardise implementation across different households and villages. Not all partners had allocated sufficient time for developing and managing M&E systems. Several partners used their systems to review how their programmes were working and adapted them along the way, which included varying content and methods of delivery. However, in some instances the partners did not make these adaptations, which meant that the same problems remained in respect of their second cohorts.

Theories of change and programme adaptations

Few partners initially articulated an underlying theory of change for each programme. In some cases implicit assumptions were not sound, resulting in the failure of some programme components. For example, one partner assumed that a cascade model of training using relatively new and low-skilled play facilitators would be effective. While this rapidly increased access to ECD, the quality of implementation could not be controlled. Some partners assumed that parents would attend group programmes on a regular and sustained basis, but attendance was often poor.

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

**Staffing**

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

Most partners employed local field staff who needed to be trained from scratch. This created community buy-in and capacity, but the initial training and subsequent support took a lot of time. In the event, well-supervised field workers with low qualification levels succeeded in delivering programmes aimed at improving the care and education of young children, and supporting their caregivers.

However, there may be limits to the services these sorts of workers can be expected to deliver. Moreover, they were working with a limited number of households and groups, to clear sets of deliverables. Generalist health workers or community development workers could probably not deliver these services besides performing their other duties at the community level.

**A community development versus a service approach**

A service delivery approach gives the service provider greater control over implementation, and programmes can start up more quickly as deliverables need not be negotiated with locally recruited workers.

When partners have a simple service delivery orientation, they alone determine whether the service will continue or not.

A community development approach makes it more difficult for partners to ensure that the programme is implemented as designed. Among other things, they may need to take account of community choices in designing the programmes and selecting local workers. The advantage of this latter approach is that, if it succeeds, programme ownership shifts more easily to the community, which assists sustainability. For example, in two areas where partners adopted this approach, local structures are setting up NPOs to take aspects of the work forward.
Conclusion

The evaluation results are promising. The different interventions demonstrated that home visits and playgroups can be effective vehicles for ECD. However, levels of participation by both parents and children in playgroup programmes were frequently low. In programmes where access increased very rapidly, the quality of delivery was a challenge. Training and support succeeded in improving the quality of ECD centres.

The impact of programmes aimed at improving children’s readiness for Grade R (established by means of cognitive, language, numeracy and academic readiness tests) was mixed. Group programmes at ECD centres showed the best results.

Improving services to young children is not easy. In some cases NGO and local field staff were able to enhance service access by simultaneously raising community awareness of and demand for services to children, and advocating better service delivery. This required a community development approach which needed to be sustained over several years.

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

The first is that programmes must not only be well designed, but also well delivered.

The second is that regardless of the efforts put into community and site-based ECD programmes, some factors largely beyond their control, such as the growth status of children and the nature of their home environments, play a significant role in moderating the results. For example, the growth status of many children tested for this evaluation was found to be seriously compromised, which reduced the chances of achieving successful developmental outcomes.

The third is that vulnerable young children and their caregivers require a range of services, and that programmes which adopt a holistic approach are most effective in this regard. While programmes to improve children’s readiness for school are essential, they need to be nested in a holistic approach.

To conclude, the evaluation has provided practitioners with a number of important findings and lessons. However, given its methodological limitations, the outcomes and impacts of community-based programmes should be tested more rigorously, and on a larger scale. More rigorous designs with sufficient sample sizes to achieve statistical power are recommended.

Endnotes

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


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

Department of Basic Education. 2009. National Early Learning and Development Standards (NELDS) for Children from Birth to Four Years. Pretoria: Department of Basic Education.


Statistical appendix

Grade R comparisons

Comparison of children in Grade R who had attended preschools whose practitioners had been trained by Sobambisana partner organisations, and those who had not been exposed to formal ECD.

Statistical summary: ANCOVAs: Counting: F(2,268) = 9.13, p = .003; Number concept: F(2,268) = 12.85, p = .001; Language: F(2,268) = 3.61, p = 0.58; Cognition: F(2,268) = 8.22, p = 0.004; Academic readiness: F(2,210) = 4.45, p = .036.

1: COUNTING

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a. R Squared = .075 (Adjusted R Squared = .068)
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*a. R Squared = .153 (Adjusted R Squared = .147)*
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</tbody>
</table>

*a. This parameter is set to zero because it is redundant.*

### Estimated Marginal Means

**GRAND MEAN**

**Dependent Variable: Peabody Actual Score**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>46.729a</td>
<td>.736</td>
<td>45.279</td>
</tr>
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</table>

*a. Covariates appearing in the model are evaluated at the following values: Age at testing = 5.3539.*

### 4: COGNITION

**BETWEEN-SUBJECTS FACTORS**

<table>
<thead>
<tr>
<th>Value Label</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 2</td>
<td>159</td>
</tr>
<tr>
<td>Comparison Group No ECD</td>
<td></td>
</tr>
<tr>
<td>Group 3</td>
<td>111</td>
</tr>
<tr>
<td>Teacher Training Group</td>
<td></td>
</tr>
</tbody>
</table>

**DESCRIPTIVE STATISTICS**

**Dependent Variable: Actual Grover Score**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison Group No ECD</td>
<td>30.8616</td>
<td>16.97559</td>
<td>159</td>
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<tr>
<td>Teacher Training Group</td>
<td>38.4414</td>
<td>19.70172</td>
<td>111</td>
</tr>
<tr>
<td>Total</td>
<td>33.9778</td>
<td>18.49182</td>
<td>270</td>
</tr>
</tbody>
</table>
# TESTS OF BETWEEN-SUBJECTS EFFECTS

**Dependent Variable: Actual Grover Score**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>9138.806a</td>
<td>2</td>
<td>4569.403</td>
<td>14.727</td>
<td>.000</td>
<td>.099</td>
</tr>
<tr>
<td>Intercept</td>
<td>476.368</td>
<td>1</td>
<td>476.368</td>
<td>1.535</td>
<td>.216</td>
<td>.006</td>
</tr>
<tr>
<td>AGE_Testing</td>
<td>5383.264</td>
<td>1</td>
<td>5383.264</td>
<td>17.350</td>
<td>.000</td>
<td>.061</td>
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<tr>
<td>Group</td>
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<td>2552.015</td>
<td>8.225</td>
<td>.004</td>
<td>.030</td>
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<tr>
<td>Error</td>
<td>82845.061</td>
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<td>310.281</td>
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<tr>
<td>Total</td>
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<td>Corrected Total</td>
<td>91983.867</td>
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a. R Squared = .099 (Adjusted R Squared = .093)

# PARAMETER ESTIMATES

**Dependent Variable: Actual Grover Score**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>B</th>
<th>Std. Error</th>
<th>t</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>-11.606</td>
<td>12.131</td>
<td>-0.957</td>
<td>.340</td>
<td>-35.491 - 12.279</td>
<td>.003</td>
</tr>
<tr>
<td>[Group=3]</td>
<td>0a</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
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</tbody>
</table>

a. This parameter is set to zero because it is redundant.

# Estimated Marginal Means

**GRAND MEAN**

**Dependent Variable: Actual Grover Score**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>34.539a</td>
<td>1.090</td>
<td>32.393</td>
</tr>
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</table>

a. Covariates appearing in the model are evaluated at the following values: Age at testing = 5.3539.
### 5: ACADEMIC READINESS

#### DESCRIPTIVE STATISTICS

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison Group No ECD</td>
<td>11.7286</td>
<td>4.79184</td>
<td>140</td>
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<tr>
<td>Teacher Training Group</td>
<td>13.5417</td>
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<tr>
<td>Total</td>
<td>12.3443</td>
<td>4.78141</td>
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#### TESTS OF BETWEEN-SUBJECTS EFFECTS

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Intercept</td>
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<tr>
<td>AGE_Testing</td>
<td>111.398</td>
<td>1</td>
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<td>5.110</td>
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<td>.024</td>
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<td>Group</td>
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<td>1</td>
<td>97.146</td>
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<tr>
<td>Error</td>
<td>4556.163</td>
<td>209</td>
<td>21.800</td>
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<tr>
<td>Total</td>
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<tr>
<td>Corrected Total</td>
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</tbody>
</table>

a. $R^2 = .055$ (Adjusted $R^2 = .046$)

#### PARAMETER ESTIMATES

<table>
<thead>
<tr>
<th>Parameter</th>
<th>B</th>
<th>Std. Error</th>
<th>t</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
<th>Partial Eta Squared</th>
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</thead>
<tbody>
<tr>
<td>AGE_Testing</td>
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<td>.643</td>
<td>2.261</td>
<td>.025</td>
<td>.186 2.722</td>
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<tr>
<td>[Group=3]</td>
<td>0*</td>
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</tr>
</tbody>
</table>

a. This parameter is set to zero because it is redundant.
### Estimated Marginal Means

<table>
<thead>
<tr>
<th>DEPENDENT VARIABLE: SACAS: ACADEMIC READINESS: SACAS</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Interval</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.579a</td>
<td>.339</td>
<td>11.910</td>
<td>13.249</td>
<td></td>
</tr>
</tbody>
</table>

*a. Covariates appearing in the model are evaluated at the following values: Age at testing = 5.3951.*
Tests and measures

This report is divided into five sections:

1. **Measures for adults**: measures used to assess the outcomes of programmes for adults (CECD, ELRU and Khululeka).

2. **Tests for children**: tests used to assess the outcomes of ECD programmes for young children (ELRU and Khululeka) as well as children in Grade R (all partners).

3. **Measures of the quality of the teaching and learning environment**: measures used to assess the outcomes of teacher training and enrichment interventions (all partners).

4. **Interview schedules**: used to evaluate programme implementation.

5. **Quarterly report grids**: used by partners to report on programme implementation.
Section 1: Measures for adults

Stimulation of and support for children

The HOME Inventory

Devised by Caldwell and Bradley (1984), the Home Observation for Measurement of the Environment (HOME) Inventory measures the quality and quantity of stimulation and support available to children in their homes. The Sobambisana evaluation used four subscales of the Early Childhood version of this instrument, culturally adapted for rural Zulu-speaking households by Dr Jane Kvalsvig of the Child Development Research Unit at the University of KwaZulu-Natal, in accordance with the recommendations of Bradley and colleagues (1996). Assessors were trained to use this instrument. Efforts were made to ensure that the assessors were blind to participant conditions, but this could not always be achieved.

The HOME Inventory is presented in Table 1. This is followed by instructions for observers in Boxes 1 and 2. Table 2 contains definitions used to guide observers.

---

**Box 1: Instructions for Observers**

**Instructions**: The following items are based entirely on observation:

- Adult carer’s communications with the child and with the visitor: 5, 12, 13, 14
- Caregiver affect toward and interaction with the child: 6, 15, 16, 17, 8, 9, 10.

The interviewer asks informally in the carer’s language about any of the non-observational items (1, 2, 3, 4, 7, 18, 19, 20, 21). The interviewer can ask about all these items at the same time.

**Comments**: Please comment here on anything that you wish to note about your visit / observation – particularly things that may have affected your scoring. Please PRINT NEATLY!
Table 1: The HOME Inventory (four subscales)

<table>
<thead>
<tr>
<th>Carer name</th>
<th>Study identification no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer education (grade – not standard – completed)</td>
<td>Study identification no:</td>
</tr>
<tr>
<td>Child name</td>
<td>Age in years and months</td>
</tr>
<tr>
<td>Place of observation (place an X)</td>
<td>Child’s home</td>
</tr>
</tbody>
</table>

**Scoring:** For all scales except Acceptance (11) below, score Yes (1) or No (0) next to each item. All items should be scored before you leave the home. There is a comment section at the bottom of the score sheet for any information you feel should be noted. Always prompt for more information where necessary.

### I LANGUAGE STIMULATION
**SCORING: YES = 1; NO = 0**

1. Child is learning the names of animals (ask carer)  
2. Child is encouraged to learn the sounds of letters (ask carer)  
3. Household member teaches the child simple verbal manners (please, thank you, I'm sorry), as well as displays of respect (ask carer)  
4. Household member encourages the child to talk, and takes time to listen (ask carer)  
5. Household member uses correct grammar and pronunciation (observe)  
6. Household member's voice conveys positive feelings about the child (observe)

### II ACCEPTANCE
**SCORING: FOR THIS SCALE ONLY: SCORE 0 FOR A 'YES' AND 1 FOR A 'NO'**

7. Did more than one instance of physical punishment occur during the past week? (ask carer)  
8. Caregiver scolds or yells at or derogates child more than once (observe)  
9. Caregiver uses physical restraint during visit (observe)  
10. Caregiver slaps or spanks child during visit (observe)

### III RESPONSIVITY
**SCORING: YES = 1; NO = 0**

11. Caregiver holds child close for 10-15 minutes per day (ask carer)  
12. Caregiver converses with the child at least twice during visit (observe)  
13. Caregiver answers child's questions or requests verbally (observe)  
14. Caregiver usually responds verbally to child's speech (observe)  
15. Caregiver praises child's qualities and/or actions twice during visit (observe)  
16. Caregiver caresses, kisses, or cuddles child during visit (observe)  
17. Caregiver helps child demonstrate some achievement during visit (observe)

### IV ACADEMIC STIMULATION
**SCORING: YES = 1; NO = 0**

18. Child is encouraged to learn colours (ask carer how)  
19. Child is encouraged to learn patterned speech (ask carer how)  
20. Child is encouraged to learn numbers (ask carer how)  
21. Child is encouraged to learn to read a few words (ask carer how).

**TOTALS FOR EACH MODULE**  
I____ II____ III____ IV____
DURING THE VISIT
It is the observer’s responsibility to set the stage for the proper mood – one in which the caregiver is at ease.
Remember that you are trying to get a good picture of what the carer-child interaction is like in a normal day-to-day situation.
The observer must be totally objective – it is important that the observer never shows approval or disapproval of anything the caregiver says or does.
The observer should also not convey her feelings about anything the caregiver says or does.

1: Where do you observe? The observations are best undertaken during a visit to the home. This must be a standard arrangement for all the carer-child observations undertaken for this project. If you cannot undertake at least one home visit for this purpose (at the appropriate times of measurement – see your design), please contact Andy and Linda for guidance.

2: How long is the procedure? The visit/observation should not be less than one hour. Observations must take place during this visit, which may entail other activities.

3: The child must be present at least some of the time so that you can observe his/her interactions with the carer.
You can ask the child questions, particularly if you need clarification. But do not overdo the approach of asking the child questions rather than the adult. Most questions should be directed at the adult.

4: Who to observe? Remember that for this evaluation we will be following the child and the caregiver over time. For this purpose, please use the HOME inventory to observe interactions between the child’s caregiver (the person enrolled in your intervention), and the same three- or four-year-old child who is to be followed up over time (see the study design).

5: How do we avoid bias? If at all possible, the person using the HOME inventory should not be aware of whether the child and carer are members of the experimental or comparison groups, so that this knowledge does not bias his/her report. If (s)he knows which group the child and carer is in, this can, for example, lead to an expectation that mothers who have received the intervention should do better than those who have not. It is therefore best for the person administering the HOME to be ‘blind’ to whether the child and carer are in one or the other group. One way to deal with this would be to have somebody other than the person running the parent workshops etc to be trained to use this measure. The person recording the data on the HOME inventory should not be a friend of the person being observed.

6: Completing the HOME inventory can be part of a visit for another purpose as long as field staff take the time to complete the observations and record them. The observations are made while the field worker is discussing other matters.

Observers must be thoroughly familiar with the HOME items so that this will ensure that the observer will be aware of the actions and events that can be scored from observation alone.
There may sometimes be a conflict between what you observe and what the carer tells you about what normally happens at home (for example, the carer says she never smacks the child but you observe this). If this happens, point out the contradiction (in a non-judgmental way) and clarify the situation.
Sometimes you cannot observe one of the things you need to score on the HOME inventory. If this happens, you need to discuss the issue with the caregiver and then score the item.

Non-observational items: Towards the middle of the visit, the interviewer will ask informally about any of the non-observational items which were not covered in the open-ended account, prompting for more information where necessary.

Remember: The HOME inventory is designed to assess the caregiving environment from the child’s point of view – what the environment offers the child. That is really important!
Everyone must score the HOME inventory in the same way, and everyone must use it in the same way. If those who administer the instrument understand these definitions and practise the tool on at least three occasions before using it in the study proper. This should be done in pairs.

In order to check that staff are recording their observations in the same way, two people should observe at a time during practice sessions. Do not discuss your observations during this time – just record.

When you are finished, check the degree of agreement and disagreement on how you scored the HOME inventory. Where you have disagreed on an item, examine the definition and make sure you understand it in the same way. Discuss why you may have differed, and see if this can be resolved.
Do two other observations and repeat this procedure. By the end of three rounds, if disagreement on more than 20% of the items (i.e. 4 items), then do as follows:

Place each of these staff with a member of another pair who have arrived at the same approach to scoring. For example, there are two pairs who have worked together for three trial rounds – persons A & B and persons C&D. Pair A&B have reached agreement while B&C have not.
Swop so we pairs A&C and B&D do an observation.

Check the degree of agreement in these pairs. This is likely to reveal that one observer is consistently disagreeing on scoring. That person may need to be assisted to get it right, or may need to be dropped from the team of observers.

If in doubt, contact Andy or Linda. GOOD LUCK!
Table 2: Definitions of HOME Items

(Become very familiar with them! Practise them!)

<table>
<thead>
<tr>
<th>LANGUAGE STIMULATION</th>
<th>DEFINITION</th>
<th>SCORING: YES (1) OR NO (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Child learns the names of animals and familiar objects (ask carer).</td>
<td>Any of these activities which would score a ‘yes’: teaching the child the names of local objects, including animals. The names of animals would be more familiar to rural children than those living in a town.</td>
<td></td>
</tr>
<tr>
<td>2. Child is encouraged to learn the sounds of letters and/or the alphabet (ask carer).</td>
<td>Any of these activities which would score a ‘yes’: teaching the child to sound out words and/or letters; talking about and pointing out letters (e.g. on a sign or a box); copying and writing letters or words; writing his or her name. If the caregiver reports that the child does not know any sounds or any letters of the alphabet, she must engage in activities that encourage the child to learn letter sounds or the alphabet in order to receive a credit.</td>
<td></td>
</tr>
<tr>
<td>3. Caregiver teaches the child simple verbal manners (please, thank you, I’m sorry) as well as displays of respect (ask carer).</td>
<td>It is not enough for the caregiver to tell the child to use ‘please,’ ‘thank you,’ and other forms of verbal politeness. She must occasionally explain why this should be done (e.g. because it shows respect for elders). Most attempts to teach and explain manners (both verbal and culturally appropriate displays) are acceptable for scoring a ‘yes’. To receive a credit, the caregiver should have instructed or be in the process of instructing the child in three or more manners, and should have explained why each of the manners are used (or currently be in the process of explaining) and should reinforce that explanation periodically. The caregiver must tell how he/she explained these manners. Simply saying, ‘Yes, I explained them’ is not sufficient to get a ‘yes’.</td>
<td></td>
</tr>
<tr>
<td>4. Caregiver encourages the child to talk, and takes time to listen (ask carer)</td>
<td>The key to this item is that the caregiver encourages the child to talk. She must do more than simply listen to the child. There must be a conscious effort on her part to enquire about the child’s activities and to listen as the child relates them. Note: Some children never need to be encouraged to talk. In these situations, the caregiver may never have a chance to do any encouraging. Credit may be given in these situations if the caregiver takes the time to listen.</td>
<td></td>
</tr>
<tr>
<td>5. Caregiver uses correct grammar and pronunciation (observe)</td>
<td>In order to receive credit for this item, the caregiver must communicate so well and so clearly that she can be easily understood by the observer. Communicating in an easily understandable way is more important than using completely correct speech. Severe speech impediments (stuttering, major difficulties with articulation, and pronounced voice disorders) should receive a ‘no’. The key to this item is the caregiver’s ability to communicate clearly and precisely.</td>
<td></td>
</tr>
<tr>
<td>6. Caregiver’s voice conveys positive feelings about the child (observe)</td>
<td>For this item, the observer should pay attention to the tone of voice the caregiver uses when talking about the child, as well as what she says. Caregivers should be pleased with the child, proud of the child, happy to have the child around, talk about the child in a pleasant way, talk about the child in a joyful way, etc. Observers should not be confused by or give negative credit to explanations of the child’s limitations.</td>
<td></td>
</tr>
</tbody>
</table>
### II ACCEPTANCE (REVISED)

**DEFINITION (REVISED) *

SCORING FOR THIS SCALE ONLY: YES (0) OR NO (1).

The key to this question is that physical punishment must have occurred during the past week to be scored ‘Yes’ (0). Physical punishment can include: spanking, slapping, hitting, pinching, shaking, hand slapping, etc. Instances of physical punishment inflicted by anyone in the home (another adult or an older child) would count ‘yes’ in scoring this item.

7. Did more than one instance of physical punishment occur during the past week? (ask carer)

The wording on this subscale was changed in order to avoid the use of double negatives, which field tests showed were problematic for respondents to understand.

8. Caregiver scolds or yells at or derogates child more than once. (Observe)

The intent of this item is to determine whether the caregiver speaks to the child in a cruel, demeaning, or abusive manner. Score ‘Yes’ (0) if disparaging remarks are made to the child or about the child in the child’s presence. If the caregiver makes a disparaging remark about the child to the observer when the child is not present, it does not count against the caregiver for this item. During the visit if any adult or older child in the home scolds, yells at or derogates the child more than once, the item would be scored ‘Yes’.

9. Caregiver uses physical restraint during visit. (Observe)

Any act which restrains the child physically would result in a score of ‘Yes’ (0). Acts which would be considered physical restraint include: forcing a child to sit in a chair; jerking the child back from handling objects; grabbing the child; shaking the child; holding the child down, etc.

10. Caregiver slaps or spanks child during visit. (Observe)

All slaps or hits must be done in anger to score a ‘Yes’ (0). An affectionate pat is not counted. Any adult or older child in the home slapping or spanking the child would result in a ‘Yes’ (0) score.

### III RESPONSIVITY

**DEFINITION SCORING: YES (1) OR NO (0)

11. Caregiver holds child close 10-15 minutes per day (ask carer).

For this item the observer may credit the caregiver holding the child while she is involved in another activity. The 10-15 minute period does not have to be done in one setting, it may be broken up into smaller portions of time throughout the day. The key is that the caregiver does spend that much total time holding the child and it should be in a more cuddly fashion.

12. Caregiver converses with the child at least twice during visit. (Observe)

To receive credit for this item, the caregiver must make an effort to converse with the child. Conversing would include such things as asking questions and talking about anything of interest. It may be initiated by either, but it must be more than vocalisations, brief directions, rhetorical questions, commands, scoldings and/or accusatory comments.

In order to receive credit for this item there must be at least two verbal exchanges by the caregiver and two by the child (the caregiver says something, the child responds and then the caregiver says something else and the child replies again).

13. Caregiver answers child’s questions or requests verbally. (Observe)

To score a ‘yes’, the caregiver must make an effort to answer most of the questions asked by the child. If the caregiver is unable to answer at that particular moment, she may tell the child they will talk about it later and still receive credit.

Any response which puts the child off with no promise of answering later would not receive credit. Examples would include: ‘Sh-h! I’m talking now,’ ‘I’m busy now, go away,’ ‘Don’t bother me now.’ etc.

If the child makes no verbal request and asks no questions during the data collection time, score ‘No’.
### III RESPONSIVITY

**DEFINITION**

**SCORING: YES (1) OR NO (0)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Caregiver usually responds verbally to child's speech. (Observe)</td>
<td>To receive credit for this item, the caregiver must respond in some verbal way to the child's speech. When the child vocalises, the caregiver must say something. This must occur most of the time for credit to be given. The key element in this item is that the caregiver recognises and acknowledges the child's vocalisations, does not ignore them. Vocal responses designed to quiet or dismiss the child (such as 'hush' or 'not now while I'm talking') do not receive credit. If the child does not vocalise in any way during the visit, the score would be 'no'.</td>
</tr>
<tr>
<td>15. Caregiver praises child's qualities and or actions twice during visit. (Observe)</td>
<td>For example: Carers may praise children for doing chores in the home, in order to encourage them. Examples were bringing the cattle into the kraal, washing dishes, shaking out the bedspread. Some children were praised if they did well in their school work.</td>
</tr>
<tr>
<td>16. Caregiver caresses, kisses, or cuddles child during visit. (Observe)</td>
<td>Any kiss and/or cuddle would receive credit. Observers must watch closely for caresses as some of these gestures may be very subtle. Examples of this are: stroking a hand, stroking the hair (not fixing it), rubbing a finger or hand, patting a portion of the child's body, etc. All of these more subtle caresses receive credit just as the more obvious do.</td>
</tr>
<tr>
<td>17. Caregiver helps child demonstrate some achievement during visit. (Observe)</td>
<td>Any conscious act of the caregiver to try to get the child to do something to show what the child can do (e.g. sing a song; count; show how a toy works etc.) would be credited. It is not necessary for the child to actually demonstrate the achievement in order to receive credit. The point is that the carer tries to get the child to show the skill. If the observer asks for the demonstration, credit should not be given.</td>
</tr>
</tbody>
</table>

### IV ACADEMIC STIMULATION

**DEFINITION**

**SCORING: YES (1) OR NO (0)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Child is encouraged to learn colours (Ask carer how).</td>
<td>The key element in this item is that the caregiver has actively helped or is helping the child learn about colours.</td>
</tr>
<tr>
<td>19. Child is encouraged to learn patterned speech (Ask carer how).</td>
<td>The intent of this item is to determine whether or not the caregiver is actively engaged in helping the child to learn patterned (rhythmic) speech. Any attempt to teach the following would receive credit: nursery rhymes, prayers, songs, etc.</td>
</tr>
<tr>
<td>20. Child is encouraged to learn numbers (Ask carer how).</td>
<td>Credit is given for any method of teaching the child about numbers (e.g. counting the items on the washing line; counting the chickens / the pots / the other children etc.).</td>
</tr>
<tr>
<td>21. Child is encouraged to learn to read a few words (Ask carer how).</td>
<td>The intent of this item is directed toward real reading, not just trying to teach the child to recognise her name and a few letters. This item is looking at true reading skills and not pre-reading skills (actually reading a few words as opposed to recognizing a few letters). To score a 'yes', caregivers should be helping the child learn the link between sounds/symbols; letters/words; and words/and their meaning. Activities which would receive credit include: pointing out words in books; responding to the child’s ‘what's that word’; pointing out words on packages, signs, etc. (particularly when there are no books). Credit for this item calls for direct caregiver activity. Where literacy levels are low and books are not available, it is common that the carer does not read with a child. However, if there are older children who are reading at school they may perform these tasks for younger children in the home. So score a yes (1) as long as somebody in the home is doing this. You can note in your comment who this is if it is not the caregiver.</td>
</tr>
</tbody>
</table>
Hygiene and safety in the home

Sobambisana checklist

This checklist was devised in consultation with the Sobambisana partners. Items are based on common safety and hygiene hazards identified in the course of field work. The checklist is presented in Table 3, and the instructions for training field staff in Box 3. The maximum score on the checklist is 16. Where items cannot be scored due to their absence (e.g. no electrical socket), the total is pro-rated (i.e., all the ‘yesses’ are divided by all items scored). Provision is made for entering scores at baseline and follow-up.

<table>
<thead>
<tr>
<th>BOX 3: INSTRUCTIONS FOR TRAINING FIELD STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preparation</strong></td>
</tr>
<tr>
<td>Go through all the items together to ensure that your raters understand them in the same way. You can ask them to think of examples which would tell them that the behaviour or practice was in place.</td>
</tr>
<tr>
<td>Make sure they know about items that are not applicable e.g. electricity safety in a household that does not have it, paraffin safety if it is not used.</td>
</tr>
<tr>
<td>Make sure to emphasise how useful it is to make notes about anything that is not clear and that if something is not observed it should be noted they should not leave a blank.</td>
</tr>
<tr>
<td>Explain about entry to the home, making the carer feel comfortable, explaining what the purpose is, consent if this has not previously been negotiated. Clearly the purpose should be explained loosely such as we are interested in watching your child and finding out more about her. Not that we are here to see how you help her learn etc. You would probably want to role-play this a few times.</td>
</tr>
<tr>
<td><strong>Field practice</strong></td>
</tr>
<tr>
<td>Select some homes where you have a good relationship with the carers. Some from last year might be best as you should not select any that will be baseline assessed in this cohort. Field coordinator and trainee should then complete the observation independently in two to three homes.</td>
</tr>
<tr>
<td>After the field: go through item by item and see if the raters concur and if not discuss the reasons why not so that you can refine the understanding of what you are looking for.</td>
</tr>
<tr>
<td>If their agreement is low then they need to repeat observations in other homes until they reach a high level of agreement. For both the HOME and Hygiene &amp; Safety checklist the score is essentially yes or no so there is not a lot of room for disagreement.</td>
</tr>
<tr>
<td>The objective is 90% concurrence.</td>
</tr>
</tbody>
</table>
### Table 3: Hygiene and Safety Checklist

<table>
<thead>
<tr>
<th>NAME OF CHILD</th>
<th>NAME OF ASSESSOR</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH OF CHILD</th>
<th>NAME OF MAIN CAREGIVER</th>
<th>PROGRAMMES INVOLVED IN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIMES MEASURED</th>
<th>T1: BASELINE</th>
<th>T2: FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hygiene in the household</strong> (observe or ask the main caregiver)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Children always wash hands with soap and water before eating and after using the toilet.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Adults always wash hands with soap and water after contact with faeces, and before handling food/ feeding children.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Toilets/ buckets/ containers for human waste are covered.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Water is collected in a clean container (if not on tap in household).</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Water is boiled before use (if not from a safe water source).</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Clean water is stored in covered containers.</td>
<td></td>
</tr>
</tbody>
</table>

| **Safety in the household** (observe or ask the main caregiver) | Yes | No | N/A | Yes | No | N/A |
| 1 | All medicines, cleaning materials and poisons are kept out of the reach of children (e.g. Rattex, insecticides, fertilisers, paraffin, bleach and other cleaning solutions, any medication). | | | | | | |
| 2 | Children are not allowed to play in potentially dangerous areas (e.g. cooking areas, on or nearby a busy road, near a drain, near rubbish pits or toilets, or near electrical appliances or fires). | | | | | | |
| 3 | Children are supervised by an older child not younger than 12 years or an adult at all times. (Supervision is defined as adults directly observing children as they play, and intervening where necessary to ensure safety). | | | | | | |
| 4 | There are no potentially dangerous objects lying around the house where children are playing (e.g. Sharp objects, plastic bags, rusty materials, wire, buckets of water, matches, small object a child can suffocate on and machinery). | | | | | | |

| **Safety in the household** (observe or ask the main caregiver) | Yes | No | N/A | Yes | No | N/A |
| 5 | Children are kept away from boiling water, hot drinks, hot pots and pans, fires | | | | | | |
| 6 | Bar heaters are not left on where there are children playing nearby. | | | | | | |
| 7 | Injuries and emergencies are quickly and calmly assessed and immediate action is taken. | | | | | | |
| 8 | Electrical sockets are covered if not in use. | | | | | | |
| 9 | Children are kept away from paraffin appliances. | | | | | | |
| 10 | Children are never left alone near water (baths, pools, dams or rivers). | | | | | | |

**TOTAL**

**SCORE:** (All the yesses divided by all items scored)
Coping strategies

The Brief COPE

In the course of 2008 and 2009, Khululeka field workers observed that a number of caregivers reached in the course of the home visiting programme appeared to be depressed and were not using a constructive approach to coping with their situation. They asked the M&E team to advise on a brief measure of coping strategies. The team selected the Brief COPE, an abbreviated version of the COPE Inventory for measuring coping strategies developed by C S Carver of the University of Miami (Carver 1997; Olley 2006). The full scale, comprising 28 items, has been used in South African studies to assess coping by people living with HIV. Validity and reliability have been established. South African studies have identified a five-factor structure for the Brief COPE (Brandt 2007; Olley et al. 2004, 2005). In order to provide Khululeka with an abbreviated scale for measuring coping strategies, the seven highest loading (of nine) items on Brandt’s Active Coping factor and the two highest loading items (of five) on the Religion/Acceptance factor were selected. The total possible score is 36, and high scores indicate more frequent use of the coping style. Given the cultural settings in the Sobambisana programme areas, the M&E team felt that the two Religion / Acceptance items would be an appropriate form of coping for this population. Item 9 (‘Learning to live with it’) does not imply resignation, but acceptance of a difficult situation (rural poverty) that is very difficult to change as an individual. The abbreviated COPE questionnaire appears in Table 4.
Table 4: Brief COPE questionnaire

<table>
<thead>
<tr>
<th>Ask the following questions:</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Medium</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I’ve been concentrating my efforts on doing something about the situation I’m in. (Ndizane ndazinikezela ngomdla wam wonke ukwenza endinako kwimeko yam.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I’ve been getting emotional support from others. (Bendifumana uncedo novelwano kwabanye kwimpelelelo.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I’ve been taking action to try to make the situation better. (Ndizame ukuzenzela imizamo yokujongana nokwenzabhetele imeko yam.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I’ve been getting help and advice from other people. (Bendifumana uncedo neengcebiso kwabanye abantu.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ask the following questions:</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Medium</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. I’ve been trying to come up with a strategy about what to do. (Bendizama ukufumana icebo elinobuchule lokuba nandenze njani.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I’ve been looking for something good in what is happening. (Bendikhangela into entle kulento yenzekayo.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I’ve been trying to find comfort in my religion or spiritual beliefs. (Bendizama ukufumana ulonwabo enkolweni (umzekelo njengenkolo yezinyanya, masilamuss, amaRasta njil) okanye kwinkolo yomphefumlo.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I’ve been trying to get advice or help from other people about what to do. (Bendizama ukufumana uncedo kwabanye abantu ngezinto endingazenza.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I’ve been learning to live with it. (Bendizama ukuphila nayo lemeko.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTALS** (add up the encircled numbers)
Section 2: Tests for children

Research ethics

All tests were administered by trained assessors, and supervised by registered psychologists. According to South African ethical practice, tests such as those used for the Sobambisana evaluation may be administered by persons who are not registered psychologists provided they are trained to do so, the tests are supervised by registered psychologists, and the results are not used for diagnostic purposes.

All tests were administered by trained examiners, supervised by a registered psychologist. The test was administered in the children’s home languages (isiXhosa, isiZulu, SeSotho, and Afrikaans, as applicable).

Cognitive development

The Grover-Counter Scale

This test was used to evaluate the impact of the various Sobambisana interventions on young children, and to compare the performance of children in Grade R who had benefited from ECD interventions with those who had not.

This test was developed in South Africa in the 1980s, and was standardised by the Human Sciences Research Council (HSRC) in 2000 (Seebate 2000; Grover 2000). Based on Piagetian theory, it is the only standardised non-verbal South African measure of problem-solving by young children aged 36 months and older. Increasingly complex problems are presented as their ages rise.

The picture shows the test being administered to a child, who is required to use various shapes to replicate the design presented by the examiner.

The HSRC standardised the test on a convenience sample of 419 children. Provisional norms are available. Construct validity was established. Correlations with the Blocks subtest of the Junior South African Intelligence Scale (depending on the age of the sample) range from 0.54 to 0.76 (averaging 0.67). Concurrent validity was established using the Goodenough Harris Draw a Man Test. Significant correlations range from 0.63 to 0.78. Kuder-Richardson reliability was established at 0.83 for 36 months, 0.85 for 48 months, and 0.84 for 60 months. This is acceptable for a test of this nature.

In the Asenze Pilot Project in the Valley of a Thousand Hills in KwaZulu-Natal, a correlation between age in months and Grover-Counter Scale scores has been established at 0.70 (personal communication from Dr Jane Kvalsvig). This further validates the provisional standardisation by the HSRC.

The Sobambisana evaluation used Rural Norms, established for 210 children living in informal dwellings, tribal areas, villages in tribal areas, and on farms. This sample is smaller than desirable for standardisation purposes and must be regarded as provisional. Administration and scoring procedures were highly standardised and objective.
**Numeracy**

*The Herbst Evaluation Scale*

Two subtests from the Herbst Evaluation Scale for Cognitive and Motor Development Tasks for Black Children (Herbst & Huysamen 2000) were utilised to test numeracy. Developed for South African children from deprived backgrounds, this instrument is appropriate for assessing children aged from 30 to 72 months. Norms are based on data from more than 1 000 children. The respective stability coefficients of 0.85 for the cognitive SRRA and 0.93 for the motor subsections indicate high test-retest reliability, and Construct Validity has been established.

**Numerical and Counting Concepts**

In this test, and following a demonstration, 20 plastic sticks (100mm in length) are placed before the child about 5mm apart. The child is then asked to count them. The total score for the task (based on increasing numbers of sticks counted) is 6.

**Number Concepts**

In this test, the child is required to a) count objects in pictures, b) match pictures with different numbers of animals to the equivalent number of dots, and c) perform simple additions and subtractions.

Each exercise is based on a series of cards. In the example of the dominoes and animals, the child is asked to match the number of animals with the number of dots. The highest possible total score is 8.

**Language development**

Two instruments were used to measure the impact of Sobambisana interventions on the language development of children aged 36 to 48 months: the Sobambisana Language Development Standards Assessment, and a modified version of the Peabody Picture Vocabulary Test (PPVT-4).

*The Sobambisana Language Development Standards Assessment*

Use of language is a key predictor of competence at school. This assessment is aimed at testing children’s attainment of the relevant age standards in specific areas of language development. It is based on research conducted for the National Early Learning and Development Standards (NELDS), and was used to age-validate the NELDS (Department of Basic Education 2009; Kvalsvig et al 2009). Research on the age validation of NELDS related to the cognitive development of children between 0-4 years.

The NELDS research was conducted among children in rural tribal areas, informal settlements and urban middle class settings in KwaZulu-Natal (isiZulu), North West (SeTswana), and the Western Cape (English and isiXhosa). The Standards, and the Sobambisana Assessment, are based on recommendations by Shipley and McAfee (1992).

Two changes were made to the Sobambisana assessment: photographs rather than drawings were used, and SeSotho and Afrikaans translations were added to the list of languages. These adaptations were developed in partnership with Dr Jane Kvalsvig. The NELDS Standards are presented in Table 5 (overleaf).
Table 5: The NELDS standards

<table>
<thead>
<tr>
<th>THREE TO FOUR YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands object functions</td>
</tr>
<tr>
<td>Understands differences in meanings (stop-go, in-on, big-little)</td>
</tr>
<tr>
<td>Follows two- and three-part commands;</td>
</tr>
<tr>
<td>Asks and answers simple questions (who, what, where, why)</td>
</tr>
<tr>
<td>Frequently asks questions and often demands detail in responses</td>
</tr>
<tr>
<td>Produces simple verbal analogies</td>
</tr>
<tr>
<td>Uses language to express emotion</td>
</tr>
<tr>
<td>Uses four to five words in sentences</td>
</tr>
<tr>
<td>Repeats six to 13-syllable sentences accurately</td>
</tr>
<tr>
<td>Identifies objects by name</td>
</tr>
<tr>
<td>Uses up to six words in a sentence</td>
</tr>
<tr>
<td>Uses nouns and verbs most frequently</td>
</tr>
<tr>
<td>Is conscious of past and future</td>
</tr>
<tr>
<td>Whispers</td>
</tr>
<tr>
<td>Speech is 80% intelligible</td>
</tr>
<tr>
<td>Appropriately uses the equivalent of ‘am’ and ‘are’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOUR TO FIVE YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imitates counting to 5</td>
</tr>
<tr>
<td>Understands concept of numbers up to 3</td>
</tr>
<tr>
<td>Continues understanding of spatial concepts</td>
</tr>
<tr>
<td>Counts up to 10 by rote</td>
</tr>
<tr>
<td>Listens to simple short stories</td>
</tr>
<tr>
<td>Answers questions about function</td>
</tr>
<tr>
<td>Uses grammatically correct sentences</td>
</tr>
<tr>
<td>Uses sentences of 4 to 8 words</td>
</tr>
<tr>
<td>Answers complex two-part questions</td>
</tr>
<tr>
<td>Asks for word definitions</td>
</tr>
<tr>
<td>Enjoys rhymes, rhythms and nonsense syllables</td>
</tr>
<tr>
<td>Produces consonants with 90% accuracy</td>
</tr>
<tr>
<td>Speech is usually intelligible to strangers</td>
</tr>
<tr>
<td>Talks about experiences at preschool or friend’s homes</td>
</tr>
<tr>
<td>Accurately relays a long story</td>
</tr>
<tr>
<td>Pays attention to a story and answers simple questions about it</td>
</tr>
<tr>
<td>Uses some possessive pronouns, future tense</td>
</tr>
</tbody>
</table>

The instructions to testers state: ‘These are the things that most children are learning to do between the ages of 3 and 5. Note: Because children develop at different rates, avoid strictly applying the age approximations. These time intervals are only a general guideline for age appropriateness.’

In the original assessment, children were asked a series of questions about four cartoon drawings. In the Sobambisana assessment, photographs rather than cartoons were used as these were found to elicit better responses. Two sets of photographs were used: one for children living in urban and peri-urban areas, and another for children living in rural areas. The test was presented in SeSotho and isiXhosa, the two languages spoken by children in the Free State and Eastern Cape.
<table>
<thead>
<tr>
<th>STIMULUS PICTURES FOR RURAL CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture 1</td>
</tr>
<tr>
<td><img src="image1" alt="Picture 1" /></td>
</tr>
<tr>
<td>Picture 3</td>
</tr>
<tr>
<td><img src="image3" alt="Picture 3" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STIMULUS PICTURES FOR URBAN CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture 1</td>
</tr>
<tr>
<td><img src="image5" alt="Picture 1" /></td>
</tr>
<tr>
<td>Picture 3</td>
</tr>
<tr>
<td><img src="image7" alt="Picture 3" /></td>
</tr>
</tbody>
</table>
The protocol for this test is presented in Box 4.

**BOX 4: THE LANGUAGE DEVELOPMENT OF PRESCHOOL CHILDREN**

| Name: ........................................................................................................... | Sex: ...........................................................................................................
| Home Language: ......................................................................................... | Test language: ....................................................................................... |
| Date of examination: | | | | |
| Date of birth: | | | | |
| Age: | | | | |
|Tester: .............................................................................................................|

**RESULTS:**

Scores:

- All Pictures =
- Picture 1 =
- Picture 2 =
- Picture 3 =
- Picture 4 =
- Total =

Test Age Range: 

General Comments:

**First question**

Ask: ‘Do you have a favourite song or rhyme that we can say or sing together?’

Score:
- 2 if the child produces a song or rhyme and recites or sings clearly and with enjoyment
- 1 if the child manages something but it lacks clarity
- 0 if the child is unable to perform

**Questions about the pictures**

Show the child all four pictures, and say: ‘Look at these pictures. This is a family called the Ndaba family. There is a father and a mother, called Mr and Mrs Ndaba, and a boy called Themba and a girl called Nosipho.’

**Standard:** Repeats 6-13-syllable sentences accurately.

‘Can you say who they are and what their names are?’

Score:
- 3 if they mention a mother, a father, a boy and a girl and get all their names correct.
- 2 if they get all the people correct, and some of the names.
- 1 if they get some of the people, and some of the names.
- 0 if they cannot respond to this.

Say: ‘The pictures tell a story of what the family did together one Saturday morning. Look at the first picture (1).’
### Picture 1

**Say:** ‘Mrs Ndaba got up early and started to wash the clothes. Themba and Nosipho helped their mother.’

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Follows 2- and 3-part commands;</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Show me Mrs Ndaba, and then show me Nosipho, and lastly show me Themba.’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 3 if all correct, 2 if all shown, but not in the correct order, 1 if 2 people shown in the correct order, 0 for all other responses</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Asks and answers simple questions (who, what, where, why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Where are they?’</td>
<td></td>
</tr>
<tr>
<td>‘What are they doing?’</td>
<td></td>
</tr>
<tr>
<td>‘Why are they doing this?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Identifies objects by name.</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Show me the spade.’</td>
<td></td>
</tr>
<tr>
<td>‘Show me a flower.’</td>
<td></td>
</tr>
<tr>
<td>‘Show me a leaf.’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for pointing correctly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Asks and answers simple questions (who, what, where, why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Who is washing the clothes?’</td>
<td></td>
</tr>
<tr>
<td>‘Where is Mrs Ndaba hanging the clothes?’</td>
<td></td>
</tr>
<tr>
<td>‘Why is she doing this?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Imitates counting to 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I am going to count the pegs. Help me count them?’ (Count to five and wait for the child to copy this. If s/he can do this continue counting to 10 and wait for the child. If s/he can do this, count the remaining pegs).</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 3 for being able to copy all the numbers (up to 13 in 3 batches) 2 for being able to copy up to 10 (in two batches) 1 for being able to copy up to 5 (in one batch) 0 if not able to reach 5.</td>
<td></td>
</tr>
</tbody>
</table>

### Picture 2

**Say:** ‘Meanwhile, Mr Ndaba was working in the garden planting flowers. When the washing was finished, Themba and Nosipho went to help him.’

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Identifies objects by name</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Show me the spade.’</td>
<td></td>
</tr>
<tr>
<td>‘Show me a flower.’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for pointing correctly</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Understands object functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘What is Nosipho holding?’</td>
<td></td>
</tr>
<tr>
<td>‘What is it for?’</td>
<td></td>
</tr>
<tr>
<td>‘What is the spade for?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Understands differences in meanings (stop-go, in-on, big-little)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Who is next to the father and who is behind the father?’</td>
<td></td>
</tr>
<tr>
<td>‘Who is standing up and who is kneeling down?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer (i.e. total 4)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Recognises 1 to 3 colours</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Show me a red flower?’</td>
<td></td>
</tr>
<tr>
<td>‘Show me a yellow flower?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard:</th>
<th>Understands differences in meanings (stop-go, in-on, big-little)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Which are the tall flowers and which are the short flowers?’</td>
<td></td>
</tr>
<tr>
<td><strong>Score:</strong> 1 for each correct answer (i.e. total 2)</td>
<td></td>
</tr>
</tbody>
</table>
**Picture 3**

Say: ‘Next, they change into clean clothes and Mr Ndaba takes Themba and Nosipho shopping.’

**Standard:** Counts to 10 by rote
- Themba says to his father, “I can count up to 10”. Can you do this too?
  
  **Score:**
  - 3 for all correct
  - 2 for any 7 numbers correct
  - 1 for any 5 numbers correct
  - 0 for less than 5 correct

**Standard:** Talks about experiences
- They are shopping. Have you ever been shopping? Tell me about it.
  (Prompts if necessary: Who did you go with? How did you get to the shop? What did you buy?)
  
  **Score:**
  - 3 an unprompted account of going shopping, mentioning at least 3 details.
  - 2 a prompted account of going shopping with at least 3 details
  - 1 a prompted account with only 2 details
  - 0 less than this

**General assessment**

**Standard:** Accurately relays a long story
- Can you tell the whole story of what Nosipho and Themba did with their parents on Saturday morning?
  
  **Score:**
  - 4 if the child can tell the whole story mentioning the four different activities accurately
  - 3 for 3 activities
  - 2 for 2 activities
  - 1 for 1 activity
  - 0 if the child is unable to tell the story at all

**Picture 4**

Say: ‘At last they finish shopping. When Themba and Nosipho get home, they find that their mother has prepared lunch for them so they help her get the table ready.’

**Standard:** Understands concept of numbers up to 3
- How many chairs can you see at the table?
  
  **Score:** 1 if correct answer

**Standard:** Answers complex 2-part questions
- What is the colour of the plates and can you see anything else that is the same colour?
  
  **Score:**
  - 2 if both answers correct
  - 1 if only one is correct
  - 0 if neither is correct

**Standard:** Future tense
- What do you think the family will do next?
  
  **Score:**
  - 2 if the answer makes sense and includes the use of the future tense.
  - 1 if the answer makes sense but does not include the use of the future tense

**Comments on the child’s ability to communicate**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you get the impression that the child’s performance was affected by shyness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the child have difficulty in concentrating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the child appear to have a difficulty in hearing or understanding your speech?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you notice any speech impediments?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give details of any communication difficulties:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Peabody Picture Vocabulary Test (PPVT-version 4)
This test was used to compare the linguistic abilities of beneficiaries of Sobambisana preschool programmes who had reached Grade R with those of non-beneficiaries. The PPVT-4 was developed and standardised in the United States.² It is a vocabulary test, and assesses listening comprehension of spoken words in Standard English from the early years to late adulthood.

It is used in a wide range of settings (including developing countries) for diagnostic assessments and research. Inter alia, it is used as an outcome measure of children’s age-related vocabulary in the United States Federal Head Start programme. Reliability and validity are well established. As scores are very precise, they are only minimally affected by sources of measurement error. Coefficient alpha is established at .97 or .96 (for the two forms). The PPVT-4 correlates (.84) with the American Expressive Vocabulary Test (2nd Edition).

Two South African studies have been conducted using an earlier version of the Peabody (Naidoo 2009; Pakendorf & Alant 1997). However, there are no valid norms for the PPVT-4. For this reason, raw scores were used in statistical analyses with controls for age. As the test was developed for an English-speaking Western population, adaptations were required. When adapting instruments across cultures, the following considerations need to be taken into account (Pena 2007; Naudeau et al 2010):

Functional equivalence: Do the test instructions elicit the same behaviour from the child as intended by the original English text? If not, is there a need to adjust the instructions? For example, ‘pointing’ to an object may not be acceptable in a given culture.

Culture fairness: Are the children familiar with the items depicted on the PPVT-4 cards? Which ones are not familiar? What do children and adults in the target culture call the image in the pictures which they recognise? Do they have single words or phrases for each of them? Are these words / phrases as difficult as those in the original English language version of the test?

The linguistic equivalence of target words: Do the words used to describe the objects in the English version of the test have exactly the same meanings as those in the language of translation? Local usage and not professional translations is necessary. In the language of translation, a phrase may be used instead of a single word. This could affect the difficulty of the item (see metric equivalence below). In addition, several synonyms may be in use. The objective would be to establish the most commonly used word or phrase used in the target community.

Cultural equivalence: Do the pictures have the same meanings in the different language communities which are to be assessed?

Metric equivalence: This refers to the difficulty of the item when expressed in different languages. For example, the word gun in English may be easier to say for a 48-month-old child than geweer might be for an Afrikaans child of the same age.

The first four issues were addressed. Time did not permit the M&E team to address the last issue, which would be necessary for a standardisation study.

Partners were asked to take the following steps to align the test in isiXhosa, Afrikaans, isiZulu and SeSotho, and report back to the the M&E team:

- Establish the functional equivalence of the test instructions, and translate them into the local language.
- Establish the culture fairness and linguistic equivalence of target words, and translate them into the local language.
- Establish the cultural equivalence of PPVT-4 pictures and words.
- Pilot the test in the four languages in question.

The process is outlined below.

Step 1: Establish whether the children accept and understand the instructions

In the PPVT-4, children are presented with a series of cards, each of which display four pictures. They are then asked to put a finger on the picture that represents a target word. Therefore, the first step was to establish whether the children accept and understand the instructions.
**BOX 5: ESTABLISHING THE FUNCTIONAL EQUIVALENCE OF THE TEST INSTRUCTIONS**

**Instructions for Step 1: Adaptation of the test instructions by adult native speakers**

- Assemble a small group of adults (say three) who speak the language in which the children will be assessed (e.g. Zulu, Xhosa, Sotho, and Afrikaans).
- Ask them whether the children will accept and understand the instructions. Will they be understood by a child aged 36 to 72 months? Will the child easily follow the instructions? Do the instructions need to be adjusted, and if so, how?
- Report any changes needed to the M&E team.

**Step 2: Use adult informants to translate the target words**

Partners were asked to work with native speakers in the areas in which children would be tested in order to translate the target words for Training Page A and sets 1 through 5 (for the different age bands).

**BOX 6: ESTABLISHING THE CULTURE FAIRNESS AND LINGUISTIC EQUIVALENCE OF TARGET WORDS**

**Instructions for Step 2: Translations by adult native speakers**

- Note whether a word or a phrase is commonly used for the picture; provide commonly used synonyms where appropriate. In some instances there may be more than one commonly used term. Please write down both.
- Once all the words have been translated, ask a person who has not been involved so far to translate the words back into English (this is called back translation). Write it in the column called ‘Back-translation’ in the table below.
- Note whether a word or a phrase is commonly used for the picture; provide commonly used synonyms where appropriate. In some instances there may be more than one commonly used term. Please write down both.
- Once all the words have been translated, ask a person who has not been involved so far to translate the words back into English (this is called back translation). Write it in the column called ‘Back-translation’ in the table below.

<table>
<thead>
<tr>
<th>Language into which target word(s) is being translated (tick one)</th>
<th>English word</th>
<th>Translation (word or words) and synonyms</th>
<th>English back-translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrikaans  Xhosa  SeSotho  Zulu  Other</td>
<td>Training Page A 1:</td>
<td>Boy</td>
<td></td>
</tr>
<tr>
<td>Training Page A 2:</td>
<td>Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Page B1:</td>
<td>Laughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Page B2:</td>
<td>Sleeping</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step 3: Establish whether the pictures will be recognised by children in the area.
An example from the Training page and Set 1 is presented in Box 7.

**BOX 7: ESTABLISHING THE CULTURAL EQUIVALENCE OF PPVT-4 PICTURES**

**Instructions for Step 3: Cultural adaptation of the pictures**

Ask your same group of adult informants to go through all the pictures on each page and indicate those that are problematic for the context (i.e. objects that the children will not know the names of, or pictures that are not appropriate). Complete the table below.

<table>
<thead>
<tr>
<th>Language into which target word is being translated (tick one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrikaans</td>
</tr>
</tbody>
</table>

In each set, the stimulus word is recorded in the correct picture column (1,2,3,4) as a guide, so that you know you are using the correct card.

**Instructions:** For each picture on each card, write Yes if you think the picture is acceptable, and No if it is definitely not appropriate. Remember that many of the pictures may have small problems. Only write No if the picture is definitely likely to be foreign to children in the community where children will be tested. We will follow up with you to check if you have ideas for more appropriate pictures.

<table>
<thead>
<tr>
<th>Training Page A</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture 1</td>
<td>Picture 2</td>
<td>Picture 3</td>
<td>Picture 4</td>
</tr>
<tr>
<td>Boy</td>
<td>Chair</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Training Page B |  |  |
|-----------------|-----------------|
| Picture 1       | Picture 2       |
| Laughing        | Sleeping        |

**SET 1**

<table>
<thead>
<tr>
<th>Set 1 Item 1</th>
<th>Picture 1</th>
<th>Picture 2</th>
<th>Picture 3</th>
<th>Picture 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set 1 Item 2</td>
<td>Dog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set 1 Item 3</td>
<td>Spoon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set 1 Item 4</td>
<td></td>
<td></td>
<td></td>
<td>Foot</td>
</tr>
</tbody>
</table>

Step 4: Pilot the test and undertake final revisions.

Once the above steps had been completed, PPVT-4 Sets 1 to 5 (Items 1 to 60) with adjusted pictures and target words for each of the languages were administered to a sample of 10 children aged 48 to 72 months at each of the Sobambisana study sites. The M&E team then established which items passed and which failed, and for which age group.

The test was administered by partners in the child’s home language. Following a review of the way the children responded to the test items, the criterion for acceptance of the words and pictures in each set was consensus reached by assessors in each language community on the suitability of the word or picture, or the need for a substitute (suggested by the assessors themselves).

Following consultations with persons familiar with the language in each partner, the following final adaptations were made:

**Changed target words:**
- Target word 14: Changed from cookie (unfamiliar word and picture) to bread (picture changed);
Target Word 16: Changed from turtle (unfamiliar animal and word) to frog (another picture in the same set);

Target Word 21: Changed from toe to knee (the African languages used the same word for toe and thumb – hence an alternative picture and word was necessary from the same set);

Target Word 25: Changed from dancing (unfamiliar activity as depicted in the picture) to walking (another picture in the same set);

Target Word 35: Changed from squirrel (unfamiliar animal and word) to mouse (another picture in the same set);

Target Word 43: Changed from juggling (unfamiliar word and activity) to clapping (another picture in the same set);

Target Word 59: Changed from vest (unfamiliar word) to shirt (another picture in the same set).

**Changed pictures**
Locally appropriate pictures with the same target word produced by an artist in the same style as the original were substituted for:

- Picture Card 14: Changed from a blueberry pie to a loaf of bread.
- Picture Card 28: Changed from an electric lamp to a paraffin lamp.
- Picture Card 30: Changed from a wood picket fence to wire fence.
- Picture Card 37: Changed from an American-style farm to a South African-style farm with a tractor and no people.
- Picture Card 48: Door of house redrawn to look more like a door.
- Picture Card 60: Changed from an arrow to a spear.

Pictures that were problematic and unlikely to be identified by all children but could not be adapted: Picture Cards 34; 38; 44; 51. Examples of adapted stimulus pictures are presented below. (Spear substituted for an arrow, and hurricane lamp for a table lamp).

---

**Emotional development**

*The South African Child Assessment Scales (SACAS)*

The emotional maturity of children affects their adjustment to school. Their confidence and their ability to work constructively with peers, regulate their emotions and behaviour, and work independently are all indicators.

To measure these characteristics, two SACAS subscales measuring academic adjustment – Academic Readiness and Resilience – were used to assess children in Grade R. The SACAS is based on the Child Behaviour Checklist and several other measures. It was developed for the assessment of young children in the Birth to Twenty cohort study and has been used in other studies (Van der Merwe & Dawes 2000). Alpha coefficients for subscale item inter-correlations established for the Birth to Twenty Study are as follows: the Academic Readiness subscale .65; the Resilience subscale .64.

Teachers were asked to rate children on a set of items using a three-point scale. Response bias was controlled. All the responses were scrutinised for extreme response set (all items given one rating, either 0 or 3). These were excluded from the analysis.

The SACAS subscales were used to compare children in Grade R who had benefited from Sobambisana interventions with those who had not. Subscale items are presented in Box 8.
## BOX 8: SACAS SUBSCALES USED FOR THE SOBAMBISANA EVALUATION

School: ______________________
Class teacher: __________________
Child's first name and surname: __________________

WHEN YOU HAVE COMPLETED ALL THE FORMS PUT THEM IN THE ENVELOPE AND RETURN IT TO THE PRINCIPAL.

**Instruction:** Please think carefully about this child. You will see two scales below on which you are requested to rate the child’s behaviour. You will see that you can rate an item as Not True, Sometimes True and Often True. For example, if, in your experience, this child is often cooperative, make a cross under **often true** in the column next to the item.

### 1: Academic Readiness Scale:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not true 0</th>
<th>Sometimes True 1</th>
<th>Often true 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is (child’s name) cooperative?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is it hard to understand what (child’s name) is saying? (reversed item for scoring)</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is (child’s name) able to take turns and share?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) share things with others?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is (child’s name) sleepy during the day? (reversed item for scoring)</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is (child’s name) curious?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) carry out directions and requests responsibly?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) follow rules and directions?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) express needs and feelings appropriately?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is (child’s name) independent, does (child’s name) like to do things without help?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

### 2: Resilience:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not true 0</th>
<th>Sometimes True 1</th>
<th>Often true 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does (child’s name) adjust well to changes in the classroom or home routine?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) approach new experiences confidently, without fear?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Can (child’s name) accept things not going her / his way? (reversed item for scoring)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) face the pressures of competition well?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does (child’s name) know his or her strengths and weaknesses?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is (child’s name) a self starter?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is (child’s name) independent, does like to do things without help?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Finally, please indicate how well you think you know this child by circling a number on the following scale:

Not at all well 1 2 3 4 5 6 7 Very well indeed

THANK YOU VERY MUCH
Disability

The WHO 10 Point Disability Screen

The 10 Point Disability Screen (Durkin et al 1990, 1995) developed by the World Health Organisation was used to screen for significant disability (see Box 9). A recent study in India indicates that the sensitivity of the screen for significant disability in children aged 2 to 9 years was 100 per cent (Singhi et al 2007).

As children's cognitive and language development was assessed as part of the child outcome evaluation, it was not appropriate for those with significant disability to be included in the evaluation sample (they could still be programme beneficiaries). This was because they would be less likely to benefit from the intervention, and their scores could skew the findings.

All children to be tested for cognition and language development were therefore screened, and those with a marked disability that would have interfered with test performance were excluded from further assessments.

The instrument presented below was administered in the caregiver’s home language.

---

**BOX 9: THE WHO DISABILITY SCREEN**

**Instruction:** These are questions for the primary caregiver. They have been successfully used in many settings as an initial screen to identify potential difficulties. On the basis of the screen, these children can be referred to the clinic for assessment.

For purposes of the DGMT research, children in the programme who fit any of these categories should be **excluded** from the baseline sample. They should also be the basis for referrals.

1. Compared with other children, did the child have any serious delay in sitting, standing or walking? Yes / No
2. Compared with other children, does the child have difficulty seeing, either in the daytime or at night? Yes / No
3. Does the child appear to have difficulty with hearing? Yes / No
4. When you tell the child to do something, does he/she seem to understand what you are saying? Yes / No
5. Does the child have difficulty in walking or moving his/her arms, or does he/she have weakness and/or stiffness in the arms or legs? Yes / No
6. Does the child sometimes have fits, become rigid or lose consciousness? Yes / No
7. Does the child learn to do things like other children his/her age? Yes / No
8. Does the child speak at all (can he/she make him/herself understood in words? Can he/she say any recognisable words?) Yes / No

**For children aged 3–9, ask:**

9. Is the child's speech in any way different from normal (not clear enough to be understood by people other than his/her immediate family?) Yes / No

**For children aged 2, ask:**

10. Can he/she name at least one object (for example an animal, a toy, a cup, a spoon?) Yes / No
11. Compared with other children of his/her age does the child appear in any way ‘mentally backward, dull or slow?’ Yes / No
**Anthropometry (weight and height)**

Children’s weights and heights were measured using standard WHO methods. Instructions for measurement were provided.

This test was used as a descriptive and moderator variable for evaluating the effects of the Sobambisana programmes and comparing the cognitive and linguistic performance of children in Grade R who had benefited from Sobambisana interventions with those who had not.

Two measures were derived using the WHO Anthroplus programme:

1. **Height for age:** to derive stunting rates (HFA < 2 standard deviations below the international reference value).
2. **Weight for age:** to derive underweight rates (WFA < 2 standard deviations below the international reference value).

These measures were used to provide rates of stunting and underweight in partner child samples, and establish the effects of these variables on other measures such as cognition and language.
Section 3: The quality of the teaching and learning environment

The Early Childhood Environmental Rating Scale – Revised (ECERS-R)

The ECERS-R (Harms & Clifford 1980; Harms et al 2005) is a valid and reliable instrument developed in the United States for assessing the quality of the teaching and learning environment at ECD sites. The tool takes account of children with disabilities, and is culturally sensitive.

Studies conducted in the United States have correlated higher scores on this scale with positive development outcomes in areas considered important for later school success (Early et al 2007). The ECERS-R (or adaptations) has also been used in research studies in the ‘developing’ world, including South and East Africa (Mwaura 2009). Harms et al (2005) refer to the measure as a ‘relatively short and efficient means of looking seriously at the quality of the [early years] environment’, and as covering ‘the basic aspects of all early childhood sites’.

The ECERS-R has seven subscales, three of which were used in this evaluation:

**Language and reasoning**: Assesses the presence and utilisation of books and pictures; encouragement of communication, the practitioner’s use of language to promote reasoning skills, and the quality of informal use of language by the practitioner in conversation with children.

**Activities**: Assesses stimulation of fine motor skills, use of art, music and movement, blocks, sand and water, and dramatic play, maths/number, nature and science, and encouragement of acceptance of diversity.

**Interaction**: Assesses supervision of children’s activities (including gross motor), discipline, responsiveness of interactions with children, and encouragement of interaction between children.

A trained observer rates the quality of the environment on the following seven-point scale: 1–2 (inadequate), 3–4 (minimal), 5 (good), and 6–7 (excellent).

The ECERS-R system includes a comprehensive manual and scoring instructions for each item on each of the subscales. Training involves both classroom instruction and observation of classroom practice. Validity and reliability are well established. Inter-rater internal consistency correlations for the ECERS-R subscales were .83 for Language and Reasoning, .88 for Activities, and .86 for Interaction. As this was a revision of an established scale with good predictive validity, it was expected to maintain that form of validity (Peisner-Feinberg & Burchinall 1997; Whitebook et al 1990).

Except for Khululeka, which used its own staff, all classrooms were observed and rated by two independent external assessors trained by the M&E team. The assessors were experienced practitioner trainers who were very familiar with ECD sites and the ECD standards. The M&E team checked their scores.
Interview schedules for the evaluation of programme implementation

1: Centre for Early Childhood Development (CECD)

HOME VISITING 1: FAMILY OUTREACH PROGRAMME

A) Programme Staff Individual Interview: Questions about the programme coordinator’s view of the Family Outreach Programme (FOP):

Think about the FOP:
1. What was the programme trying to achieve? (Instruction to interviewer: probe for responses in regard to both adults and children). How did you think the programme would achieve these outcomes?

Questions about the participants and outcomes:
1. What sort of people did you approach to enroll in the FOP?
2. Do you think that the people who you enrolled met these criteria (did the programme reach those you intended to reach? If not please tell us about this).
3. Were there some caregivers you would have liked to enroll but who were not interested? Why do you think this happened?
4. What sort of caregivers are likely to enroll in a home visiting programme such as yours?
5. Are there people who you think would not be appropriate for this programme? If so, please describe them.
6. Did you observe differences between those parents who participated actively during home visits and those who did not?
7. Which aspect of the programme do you think made the greatest difference to the children? What was most affected? Why? How do you know this?
8. Which aspect of the programme do you think made the greatest difference to the caregivers? What was most affected? Why? How do you know this?
9. Do people in this community talk about the programme? What do they say?

Questions about implementation:
1. What things made it easier for you to run the FOP in the way it was supposed to be run?
2. What made it difficult to run the programme in the way it was supposed to be run?
3. What advice would you give to another organisation about the kind of staff one needs to run a programme like your FOP?
4. Please think carefully about this. We want to provide the best possible advice about home visiting programmes. If you could change it, to make it better, what do you think should be changed in the:
   ■ programme content?
   ■ programme delivery?
5. Do you have any other comments about the FOP programme that you think are important for those who might implement a programme such as yours in the future to know?
Interview Schedules for CECD Programme Participants and Programme Staff

1. HOME VISITING: FAMILY OUTREACH PROGRAMME

B Interviews with Parents / Caregivers

Individual interviews with participating caregivers in the Family Home Visiting Programme (6 to 10 parents)

1. What do you think the visits you received are trying to do for parents and their children?
2. Why did you join the programme? What did you think you and your child/children would gain from it?
3. Has the programme helped you and your family in any way (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc.)
4. What in the programme has made the greatest difference to you and your children?
5. Have you any suggestions for improving the home visits?
6. Do your neighbours and others with young children in the community know about the programme? What do they say about it?
7. Think about the monthly group meetings. Did they help you in any way? How?
8. Have you any suggestions for improving the monthly workshops

2. ECD PRACTITIONER TRAINING

Interviews with Trainees

Focus Group with CECD ECD Practitioner Trainees (5 trainees)

1. Why did you enroll in this course?
2. Did participation bring you any benefits? If so what?
3. What did you learn that you are able to implement easily? Why?
4. What did you learn that was difficult to implement? Why?
5. What in the programme made the greatest difference to your classroom? Why?
6. What in the programme do you think should be changed? Why?
7. What did participation in this course mean for you?
8. What are the most important things that you have learned from your experience in this programme?
9. If you think about what you would like to be doing in five years from now, what would that be?

2: Early Learning Resource Unit (ELRU)

Interview Schedules for ELRU Programme Participants and Programme Staff

1: THE WAHK' UMTWANA (FCM) HOME VISITING PROGRAMME

A) Focus Group for FCMs who facilitate Wakh' Umtwana

Questions about Home Visitors (FCMs):
1. Why did you sign up to be a home visitor (FCM)?
2. If you think about your training and supervision, which aspects/parts have you applied most in the programme?
3. What else do you think would help you to deliver this programme well? If, so, what would it be?
4. What are the most important things that you have learned from your experience in this programme?
5. If you think about what you would like to be doing in five years from now, what would that be?

Questions about the Fem.'s views of the Home Visiting programme
1. Please think about the programme. What do you think the programme is trying to achieve for the children and families?

Questions about the Participants and Outcomes:
1. What sort of people did you approach to enroll in the Home Visiting programme?
2. Were there some households you would have liked to enroll but who were not interested? Why do you think this happened?
3. What sort of caregivers are likely to enroll in a programme such as Wakh' Umtwana? What sort of people are they?
4. What in the programme do you think made the greatest difference to the children? What was most affected? Why? How do you know this?
5. What in the programme do you think made the greatest difference to the caregivers? What was most affected? Why? How do you know this?
   ■ Tell me about the Cluster Workshops:
   ■ Why do you think the caregivers attended?
6. Was there anything the caregivers and their children gained from the workshops that was different from the home visits?

7. Do people in this community talk about the Wakh’ Umtwana programme? What do they say?

Questions about implementation:
1. What things made it easier for you to run this programme in the way it was supposed to be run?
2. What made it difficult to run the programme in the way it was supposed to be run?
3. What advice would you give to another organisation about the kind of person who makes a good FCM?
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about home visiting programmes. If you could change Wakh’ Umtwana, to make it better, what do you think should be changed in the:
   - Content of the programme (e.g. the topics you cover in your visits and workshops)?
   - What happens when you visit a caregiver in her home, and when you run a cluster workshop?

B) Focus Group with Participating Caregivers in Wakh’ Umtwana (5 to 6 parents)
1. What do you think the visits you received and the workshops you attended are trying to do for parents and their children?
2. Why did you join the programme? What did you think you and your child/children would gain from it?
3. Has the programme helped you and your family in any way (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc).
4. What in the programme has made the greatest difference to you and your children?
5. Have you any suggestions for improving the home visits?
6. Do your neighbours and others with young children in the community know about the programme? What do they say about it?
7. Think about the cluster workshops. Did they help you in any way? How?
8. Have you any suggestions for improving the cluster workshops?

2. EDUCATOR TRAINING AND SCHOOL SUPPORT
   Interviews with Trainees

Focus Group with ECD Enrichment Programme participants (Grade R teachers and Community based practitioners in the ELRU enrichment programme).
1. Why did you enroll in the programme run by ELRU?
2. Did participation bring you any benefits? If so what?
3. What did you learn that you able to implement easily? Why?
4. What did you learn that was difficult to implement? Why?
5. What in the programme made the greatest difference to your classroom? Why?
6. What in the programme do you think should be changed? Why?
7. What participation in the workshops mean to you?
8. What are the most important things that you have learned from your experience in the workshops?
9. If you think about what you would like to be doing in five years from now, what would that be?

3: Khululeka

Interview Schedules for Khululeka Programme Participants and Programme Staff
   Interviews with Community Development Practitioners (CDPs)

Instruction to Interviewer: CDPs conduct both the home visits and the I&T Playgroups. Questions about both these responsibilities are included in this focus group.

Questions about being a CDP:
1. Why did you sign up to be a CDP?
   Being a CDP in the Home Visiting programme:
2. If you think about your training and supervision, which aspects/parts have you applied most in the Home Visiting programme?
3. Is there anything else you think would help you to deliver the Home Visiting programme well? If, so, what would it be?
4. What are the most important things that you have learned from your experience in the Home Visiting programme?
   Being a CDP in the Infant and Toddler programme:
5. If you think about your training and supervision, which aspects/parts have you applied most in the I&T programme?
6. Is there anything else you think would help you to deliver the I&T programme well? If so, what would it be?
7. What are the most important things that you have learned from your experience in the I&T programme?
8. If you think about what you would like to be doing in five years from now, what would that be?

Questions about Home Visiting:
1. Please think about the Home Visiting programme. What do you think it is trying to achieve for the children and families?

Questions about Home Visiting Participants and Outcomes:
1. What sort of people did you approach to enroll in the Home Visiting programme?
2. Were there some households you would have liked to enroll but who were not interested? Why do you think this happened?
3. What sort of people are likely to enroll in a programme such as your Home Visiting programme?
4. Which aspects of the programme do you think made the greatest difference to the children? What was most affected? Why? How do you know this?
5. Which aspect of the programme do you think made the greatest difference to the caregivers? What was most affected? Why? How do you know this?
6. Were there other effects on the household? Please describe them.
7. Do people in the communities where you work talk about the Home Visiting programme? What do they say?

Questions about implementation of Home Visiting:
1. What things made it easier for you to run the Home Visiting programme in the way it was supposed to be run?
2. What made it difficult to run the programme in the way it was supposed to be run?
3. What advice would you give to another organisation about the kind of person who makes a good CDP?
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about home visiting programmes. If you could change it, to make it better, what do you think should be changed in the:
   - Content of the programme (e.g. the topics that are covered in your visits)?
   - What is done in home visiting sessions?

Instruction to Interviewer: Say: ‘Thanks for answering the questions about home visiting. Now I would like to ask you about the Infant and Toddler Playgroup Programme.’

Questions about the KCECD Infant and Toddler (I&T) Playgroups
1. Please think about the I&T programme. What is it trying to achieve? Instruction to interviewer: probe for responses in regard to both adults and children bearing in mind that the primary focus of the programme is on the adults.
2. How did you think that the I&T programme would achieve these outcomes?

Questions about the I&T Participants:
1. What sort of people did you approach to enroll in I&T?
2. Do you think that the people who came and brought their children were the sort of people you intended to enroll? (did the programme reach those you intended to reach? If not, please tell us about this).
3. Were there some caregivers who you think would have liked to have come along but who did not come to I&T playgroups? Why do you think this happened?
4. What sorts of caregivers / parents are likely to enroll in a programme such as the I&T programme?
5. Of those caregivers / parents who were enrolled, did you observe any differences between those who attended regularly and those who did not? What were they?
6. Of those children who were enrolled, did you observe any differences between those who attended regularly and those who did not? What were they?
7. Which part of the programme do you think made the greatest difference to caregivers / parents? Why? How do you know this?
8. Which part of the programme do you think made the greatest difference to children? Why? How do you know this?
9. Do people in this community talk about the programme? What do they say?
Questions about implementation of I&T
1. What things made it easier for you to run I&T as it was supposed to be run?
2. What made it difficult to run I&T as it was supposed to be run?
3. What advice would you give to another organisation about the kind of staff one needs to run a programme like this?
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about programmes such as I&T. If you could change it, to make it better, what would you think should be changed in the:
   - **Content** of the programme (e.g. the topics you cover in the sessions)
   - What you do in the sessions – the activities with the parents and the children
5. What are the most important things that you have learned from your experience in this programme?

**Interviews with Parents / Caregivers**

1. **Infant and Toddler Playgroup Programme**
   1. Focus Group with Parents/Caregivers who participated regularly in the Infant and Toddler programme (5 to 6 participants)
   2. What do you think the Infant and Toddler programme sessions are trying to do for parents and their children?
   3. Why did you attend the programme? What did you think you would gain from attending?
   4. Has the programme helped you in any way? (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc.)
   5. What in the programme has made the greatest difference to you and your children? (Instruction to interviewer: Probe for both adult and child).
   6. Do your neighbours and others with young children in the community know about the programme? What do they say about it?
   7. Have you any suggestions for improving this programme.

2. **Home visiting Programme**
   1. Focus Group with Participating Caregivers in the Family Home Visiting Programme (5 to 6 parents)
   2. What do you think the visits you received are trying to assist you with or teach you?
   3. Why did you join the programme? What did you think you and your child/children would gain from it?
   4. Has the programme helped you and your family in any way (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc.)
   5. What in the programme has made the greatest difference to you and your children? Have you any suggestions for improving the home visits.
   6. Do your neighbours and others with young children in the community know about the programme? What do they say about it?

3. **ECD PRACTITIONER TRAINING**
   1. Focus Group with KCECD ECD Practitioner Trainees (5 trainees)
   2. Why did you enroll in this course?
   3. Did participation bring you any benefits? If so what?
   4. What did you learn that you are able to implement easily? Why?
   5. What did you learn that was difficult to implement? Why?
   6. What in the programme made the greatest difference to your classroom? Why?
   7. What did participation in this course mean to you?
   8. What are the most important things that you have learned from your experience in this programme?
   9. If you think about what you would like to be doing in five years from now, what would that be?
4: Ntataise

Interview Schedules for Ntataise Programme Participants and Programme Staff

A) Programme Staff: Interview with Bonnie

Questions about the implementing staff’s view of the playgroup programme:
1. Please think about the Mosupatsela playgroup programme. What is it trying to achieve (probe for responses in regard to both adults and children)?
2. How did you think the programme would achieve these outcomes?

Questions about the participants:
1. What sort of people did you approach to enroll their children in the Mosupatsela?
2. Do you think that the people who brought their children were the ones you were trying to reach? If not, please tell us about this
3. Were there some children who you think would have liked to have come along but who did not come to Mosupatsela? Why do you think this happened?
4. What sorts of caregivers / parents are likely to enroll their children in a playgroup programme such as Mosupatsela
5. Of those caregivers / parents who were enrolled, did you observe any differences between those who attended regularly and those who did not? What were they?
6. Of those children who were enrolled, did you observe any differences between those who attended regularly and those who did not? What were they?
7. Which part of the programme do you think made the greatest difference to caregivers / parents? Why? How do you know this?
8. Which part of the programme do you think made the greatest difference to children? Why? How do you know this?
9. Do people in this community talk about the programme? What do they say?

Questions about implementation
5. What things made it easier for you to run Mosupatsela as it was supposed to be run?
6. What made it difficult to run the programme as it was supposed to be run
7. What advice would you give to another organisation about the kind of staff one needs to run a programme like Mosupatsela?
8. Please think carefully about this. We want to provide the best possible advice to stakeholders about playgroup programmes. If you could change it, to make it better, what do you think should be changed in the:
   - Content of the programme (e.g. the topics you cover in the sessions)?
   - What you do in the sessions – the activities with the parents and the children?
   - What are the most important things that you have learned from your experience in this programme?

B) Focus group with parents of children in Mosupatsela playgroups (5 to 6 parents)
1. What do you think the Mosupatsela programme sessions are trying to achieve?
2. Why did you join? What did you think your child/children would gain from attending?
3. Did you ever attend? Why did you attend the programme?
4. Has the Mosupatsela programme helped you in any way? (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc)
5. What in the programme has made the greatest difference to you and your children? Instruction to interviewer: Probe for both adult and child).
6. Do your neighbours and others with young children in the community know about the programme? What do they say about it?
7. Have you any suggestions for improving this programme
2. PARENT SUPPORT PROGRAMME (PSP)

A) PSP Programme staff individual interview (with Mildred).

Questions about Mildred's view of the PSP programme:
1. Please think about the PSP programme. What was it trying to achieve? (Instruction to interviewer: probe for responses in regard to both adults and children).
2. How did you think the programme would achieve these outcomes?

Questions about the participants:
1. What sort of matrons and schools (their characteristics) did you look for when you were selecting the matrons and preschools to participate in this programme?
2. What sort of parents were matrons targeting to attend these workshops?
3. Do you think that the people who brought their children were the ones you were trying to reach? If not please tell us about this?
4. What sorts of parents are likely to enroll their children a playgroup programme such as this?
5. Are there any differences between those who attended regularly and those who did not?
6. Did you observe differences between those parents who attended and who participated actively in the sessions and those who attended but were not that active?
7. Which parts of the programme do you think made the greatest difference to parents? Why?
8. Do people in this community talk about the programme? What do they say?

Questions about implementation
1. What things made it easier for you to run PSP as it was supposed to be run?
2. What made it difficult to run PSP as it was supposed to be run?
3. What advice would you give to another organisation about the kind of staff one needs to run a programme like this?
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about parenting programmes. If you could change it, to make it better, what do you think should be changed in the:
   - **Content** of the programme (e.g. the topics that are covered in the sessions)?
   - **What** the Matrons do in the PSP sessions?
5. What are the most important things that you have learned from your experience in PSP?

B) Focus group with PSP matrons
1. Please think about the PSP programme. What was the Parent Support Programme trying to achieve (probe for responses in regard to both adults and children)?

Questions about the participants:
1. Which parents did you invite to attend these workshops?
2. Are there particular parents who you think are more likely to enroll in a programme such as this? What sort of parents are they?
3. Are there any parents who you think would not be appropriate for this programme? If so, please describe them.
4. Of those who enrolled, did you observe any differences between those who attended regularly and those who did not?
5. Did you observe differences between those parents who attended and who participated actively in the sessions and those who attended but who were not that active?
6. Which parts of the programme do you think made the greatest difference to parents? Why?
7. Do people in this community talk about the programme? What do they say about it?
8. Have you any suggestions for improving the playgroups?
Questions about implementation
1. What things made it easier for you to run the PSP?
2. What made it difficult to run the PSP?
3. What advice would you give to another preschool about what one needs to run a programme like PSP?
4. Please think carefully about this. We want to make the PSP as good as we can. If you could change it, to make it better, what do you think should be changed in the:
   - Content of the programme (e.g. the topics that you covered in the sessions)?
   - What you do in the PSP sessions?
5. What are the most important things that you have learned from your experience in PSP?

C) Focus group for participating parents/caregivers
1. What do you think the Preschool Support Programme is trying to achieve?
2. Why did you join the programme? What did you think you and your child/children would gain from it?
3. It seems that not all parents are able to attend the programme regularly. Why is that?
4. Has the programme helped you and your family in any way (Instruction to interviewer: Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc.)
5. What in the programme has made the greatest difference to you and your children? Instruction to interviewer: Probe for both adult and child).
6. Do other parents with young children in the preschool know about the programme? What do they say about it?
7. Have you any suggestions for improving the PSP programme?

3. ECD PRACTITIONER TRAINING
A) Programme staff: individual interviews with Teacher Training Programme Coordinators

Questions about the views of the programme coordinator (Aletta) Training Programme:
1. Think about the programme. What was the programme trying to achieve?
2. How do you think the programme would achieve these outcomes?

Questions about the participants:
1. What sort of people did you approach to enroll in the training programme?
2. Do you think that the practitioners who came were those you intended to reach? If not please tell us about this).
3. Are there particular practitioners who you think are more likely to enroll in a training programme such as this? What sort of practitioners are they?
4. Of those who enrolled, did you observe any differences between those who participated regularly and implemented what they learnt, and those who did not?
5. Which aspect of the training do you think made the greatest difference to the teaching and learning environment? What was most affected? Why?

Questions about implementation
1. What things made it easier for you to run this programme in the way it was supposed to be run?
2. What made it difficult to run the programme in the way it was supposed to be run?
3. What advice would you give to another organisation about the kind of staff one needs to run a programme like this? 
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about practitioner training. If you could change it, to make it better, what do you think should be changed in the:
   - Content of the programme (e.g. the topics that you covered in the course)?
   - What you do in the training sessions?
5. Do people in this community talk about the programme? What do they say?
B) Focus group with Ntataise ECD practitioner trainees (5 trainees)
1. Why did you enroll in this course?
2. Did participation bring you any benefits? If so what?
3. What did you learn that you able to implement easily? Why?
4. What did you learn that was difficult to implement? Why?
5. What in the programme made the greatest difference to your classroom? Why?
6. What in the programme do you think should be changed? Why?
7. What did participation in this course mean to you?
8. What are the most important things that you have learned from your experience in this programme?
If you think about what you would like to be doing in five years from now, what would that be?

5: TREE

Interview Schedules for TREE Programme Participants and Programme Staff

1. TREE PLAYGROUPS
   Playgroup Facilitators

A) Programme staff focus group with TREE playgroup facilitators (5 to 6 facilitators and Horace)

Questions about being a playgroup facilitator (do not ask Horace):
1. Why did you sign up to be a facilitator?
2. If you think about your training and supervision, which aspects/parts have you applied most in the playgroups?
3. Is there anything else you think would help you to deliver the playgroups well? If, so, what would it be?
4. What are the most important things that you have learned from your experience in the playgroups?
5. If you think about what you would like to be doing in five years from now, what would that be?

Questions about the facilitator’s views of the playgroup programme (include Horace):
1. Please think about the playgroup programme. What is it trying to achieve?

Questions about the participants:
1. What sort of people did you approach to enroll their children in the playgroup programme?
2. Do you think that the people who brought their children were the ones you were trying to reach? If not, please tell us about this.
3. Were there some children who you think would have liked to come along but who did not come to the playgroups? Why do you think this happened?
4. What sorts of parents are likely to enroll their children in a playgroup programme such as this?
5. Of those children who were enrolled, did you observe any differences between those who attended regularly and those who did not? What were they?
6. Which aspects of the programme do you think made the greatest difference to children? Why? How do you know this?
7. Do people in this community talk about the programme? What do they say?

Questions about implementation:
1. What things made it easier for you to run the playgroup programme as it was supposed to be run?
2. What made it difficult to run the playgroup programme as it was supposed to be run?
3. What advice would you give to another organisation about the kind of staff one needs to run a playgroup programme like this?
4. Please think carefully about this. We want to provide the best possible advice to stakeholders about playgroup programmes. If you could change it, to make it better, what do you think should be changed in the:
   - **Content** of the programme (e.g. the topics you cover in the sessions)?
   - What you do in the sessions – the activities with the children?
### Parents / Caregivers

**B) Focus Group with Parents/Caregivers who participated regularly in the playgroup programme (5 to 6 participants)**

1. What do you think the playgroup sessions are trying to achieve?
2. Why did you join? What did you think your child/children would gain from attending a playgroup?
3. Do you ever attend playgroups? Why do you attend?
4. Has the playgroup programme helped you in any way? (Instruction to interviewer: Take open response, then probe for specifics such as skills development, support, enjoyment etc)
5. What in the programme has made the greatest difference to you and your children? Instruction to interviewer: Probe for both adult and child.
6. Do your neighbours and others with young children in the community know about the playgroup programme? What do they say about it?
7. Have you any suggestions for improving the playgroups?

### 2. TREE ECD PRACTITIONER TRAINING

**Practitioners**

**Focus Group with TREE ECD Practitioner Trainees (5 trainees)**

1. Why did you enroll in this course?
2. What benefits did participation bring to you?
3. What did you learn that you able to implement easily? Why?
4. What did you learn that was difficult to implement? Why?
5. What in the programme made the greatest difference to your classroom? Why?
6. What in the programme do you think should be changed? Why?
7. What did participation in this course mean to you?
8. What are the most important things that you have learned from your experience in this programme?
9. If you think about what you would like to be doing in five years from now, what would that be?
Quarterly reports on programme implementation

Partners were required to submit quarterly reports on progress made with implementing programmes and capturing data. They were provided with reporting templates, or grids, to ease this process. The templates were adjusted for each partner, taking into account their specific interventions. The template below was designed for the CECD’s 2012 programme cycle.

<table>
<thead>
<tr>
<th>M&amp;E Quarterly Record: CECD</th>
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<td><strong>Report date:</strong></td>
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<tr>
<th>Intervention (as specified in your M&amp;E design)</th>
<th>Current status</th>
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<tr>
<td>Briefly indicate progress that has occurred in each aspect of the programme in the past three months by reporting on the questions below. Please type in the boxes.</td>
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<th>1: Family Outreach Programme</th>
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<td>How many families are enrolled in the programme:</td>
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<td>How many children:</td>
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<tr>
<td>Number of carer child pairs enrolled in 2010 in the intervention group:</td>
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<td>Number of carer child pairs enrolled in 2010 in the waitlist group:</td>
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<tr>
<td>Has Baseline data been completed (note when this took place or is intended to take place)? (Yes / No)</td>
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<td>Tick which baseline measures have been completed:</td>
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SOBAMBISANA MONITORING AND EVALUATION REPORTING GRID
Updated (2010)

This is to be completed and sent to research@elru.co.za every quarter (at end March, June, September and December)
SOBAMBISANA MONITORING AND EVALUATION REPORTING GRID
Updated (2010)
This is to be completed and sent to research@elru.co.za every quarter (at end March, June, September and December)

M&E Quarterly Record: CECD

Report date: [ ]

<table>
<thead>
<tr>
<th>Intervention (as specified in your M&amp;E design)</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly Indicate progress that has occurred in each aspect of the programme in the past three months by reporting on the questions below. Please type in the boxes.</td>
<td></td>
</tr>
</tbody>
</table>

1. **Family Outreach Programme (cont.)**
   - Has the intervention commenced? (Yes / No)
   - If so, when?
   - When do expect to conclude the intervention? (Approximate month)?
   - For later Reports:
     - How many adult / child participant pairs have dropped out of the programme at this stage? ___________
     - When do you propose to gather the follow-up data (approximate month)? _________________

<table>
<thead>
<tr>
<th>Referrals for</th>
<th>Referred (n)</th>
<th>Resolved (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID documents</td>
<td></td>
<td></td>
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<tr>
<td>Clinic card</td>
<td></td>
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<tr>
<td>CSG</td>
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<tr>
<td>CDG</td>
<td></td>
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<tr>
<td>Foster Grant</td>
<td></td>
<td></td>
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<tr>
<td>Health problem</td>
<td></td>
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<tr>
<td>Other, specify</td>
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2. **Quality of ECD sites**
   - Enrichment programme
   - Management training & ECD Forum

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<tr>
<th>Enrichment Programme</th>
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<tbody>
<tr>
<td>Has this intervention commenced? (Yes / No)</td>
</tr>
<tr>
<td>If so, when?</td>
</tr>
<tr>
<td>Total number of sites enrolled:</td>
</tr>
<tr>
<td>Total number of practitioners enrolled:</td>
</tr>
<tr>
<td>Total number of children in classes whose practitioners are enrolled:</td>
</tr>
<tr>
<td>Number of sites in Sobambisana target area:</td>
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</table>
# SOBAMBISANA MONITORING AND EVALUATION REPORTING GRID

**Updated (2010)**

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### M&E Quarterly Record: CECDF

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2. **Quality of ECD sites (cont.)**

   **Enrichment programme**

   **Management training & ECD Forum**

   - Baseline data collection – ECERS (when did this take place or when is it intended to take place?)
   - How many classes have been assessed:
   - In the last quarter how many sessions have been offered?
   - % Attendance by practitioners in the last quarter:
   - For later reports:
     - How many participants have dropped out of the programme at this stage)?
     - When do you propose to gather the follow-up data (approximate month)?

   **Governance and management training**

   - Has this intervention commenced? (Yes / No) Yes
     - If so, when?
     - Number Enrolled in Ward 12:
     - Sites
     - Committee members
     - Children in these sites:
     - Baseline data collection (when did this take place or when is it intended to take place?)
     - For later Reports:
       - How many participants have dropped out of the programme at this stage)?
       - When do you propose to gather the follow-up data (approximate month)?

   **ECD forums**

   - Has this intervention commenced? (Yes / No)
     - If so, when?
     - Number of sites involved?
     - How many sites in Sobambisana target area:
     - When do you propose to gather the follow-up data (approximate month)?

   Briefly note the activities that have happened in the past quarter

3. **Provincial government service providers**

   - Has the intervention commenced? (Yes / No)
     - If so, when?
     - Briefly note the activities that have happened in the past quarter (e.g. 3 meetings with I officials to discuss.)
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4. Municipality

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| Briefly note the activities that have happened in the past quarter (e.g. 3 meetings with council officials to discuss) |

Please comment on anything you think we should know about that has affected your progress. In particular note any changes to the design that we provided to you.

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Endnotes

References


Carver, C S. 1997. You want to measure coping but your protocol’s too long: Consider the Brief COPE. International Journal of Behavioral Medicine, 4. 92–100.

Department of Basic Education. 2009. National Early Learning and Development Standards (NELDS) for Children from Birth to Four Years. Pretoria.


Rao, N and E Pearson. 2007. An Evaluation of Early Childhood Care and Education Programmes in Cambodia. Faculty of Education, University of Hong Kong.


