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*Education for All Global Monitoring Report 2007*

*Strong foundations: early childhood care and education*

# Early childhood care and education in the Caribbean (CARICOM states)

Leon Derek Charles, Sian Williams

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## BACKGROUND

### Purpose and Scope

This Report is intended to inform the next Education for All (EFA) Global Monitoring Report (GMR) which will review country and regional progress towards six education goals with special attention to Goal 1, "*expanding and improving early childhood care and education, particularly to the most disadvantaged and vulnerable children*".

For the purposes of this Report, Early Childhood Care and Education (ECCE) is defined as services and supports provided to children "*prior to their entry into primary schooling (Grade 1) in formal and non-formal settings (delivered by partnerships of governments, NGOs, communities, and families), with a focus on supporting children's comprehensive growth, development and learning (e.g., health, nutrition, hygiene, cognitive, social, and emotional development*)"[1].

During these initial years, the stages through which children progress can be defined as follows:

- a safe and healthy birth;
- to an infant stage characterized by good health, nutrition and initial stimulation;
- to a toddler stage characterized by appropriate and adequate early stimulation and early developmental monitoring;
- to a preschool stage characterized by adequate stimulation e.g. development of motor skills and appropriate numeracy and literacy activities designed to develop school readiness by age five

This definition excludes the services normally performed by the health system in the pre-natal and immediate post-natal period e.g. immunisation and breastfeeding. It assumes that children have had a safe birth and is targeted at ensuring their appropriate all-round development through good health, nutrition, initial stimulation and appropriate school readiness programming that develops their cognitive, social and emotional capabilities.

### Methodologies

A variety of methodologies were used in developing this Report. These included:

- Design and administration of a questionnaire aimed at capturing the current status of ECCE in the Caribbean region. The questionnaire was administered to early childhood coordinators[2] in nineteen countries across the region and responses were received from sixteen[3]. A copy of the questionnaire is attached as Appendix 1.

[1] GMR ECCE Outline, pg. 6

[2] The early childhood coordinators are government officials responsible for the management of the early childhood services in their respective countries. Their responsibilities include monitoring and supervision of the early childhood provision by both the public and private sector operators. All countries have at least one official in this capacity.

[3] The countries that submitted completed questionnaires were Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, British Virgin Islands, Cayman Islands, Commonwealth of Dominica, Grenada, Jamaica, St. Kitts-Nevis, St. Lucia, St. Vincent and the Grenadines, Montserrat, Trinidad and Tobago and Turks and Caicos Islands.

- One-on-one discussions with early childhood coordinators in sixteen countries across the region.

- Review of research material and papers (published and unpublished) related to early childhood programming in the Caribbean region.

- Field work carried out by the authors in seven (7) of these countries during the period January to April 2006. The opportunity was taken during these field visits to validate the information provided in the questionnaires.

The Report was also influenced by the proceedings of the Caribbean Early Childhood Policy Forum held in Jamaica, March 22 and 23, 2006. The Forum was a collaborative effort of the Caribbean Community (CARICOM) Secretariat and four (4) regional organisations involved in Early Childhood Development – Caribbean Development Bank (CDB), Caribbean Support Initiative (CSI) of the Bernard van Leer Foundation, United Nations Education, Scientific and Cultural Organisation (UNESCO) and United Nations Children Fund (UNICEF). The Forum brought together representatives from Governments and Civil Society to examine the relationships between early childhood development and poverty reduction, early childhood development and human capacity development and early childhood development and social vulnerabilities.

**Limitations**

The preparation of the Report was hindered by communication and logistical difficulties in administering and following up the questionnaires across sixteen countries. Extensive follow-up was required in some cases to ensure consistency in the treatment of data, consistency with time periods for which data was reported and comparability between the different types of programmes that were in operation in the different countries.

There were also limitations arising from the different levels of sophistication of the data collection and processing systems within the countries. Some, for example, were able to provide data with the levels of disaggregation required, while others were not. This is highlighted in the Report, where the number of countries reporting is indicated wherever data is being used.

The exercise highlighted once again, the need for upgrading the quality of early childhood record-keeping at country level and the need to upgrade the capacity of the early childhood coordinators in the analysis and use of data for reporting and decision-making.

## 1. CONTEXT FOR ECCE AND CHILD WELL-BEING[4]

### Political, Economic and Social Context

The English speaking[5] Caribbean States in CARICOM comprise nineteen (19) countries bound together by a common history of colonialism at the hands of Great Britain, France, The Netherlands and Spain. Many of these countries changed ownership many times during the turbulent 16th, 17th and 18th centuries and as a result today carry place names and cultural traditions that are not English.

Thirteen (13) of these countries[6] have attained political independence from England or the Netherlands (Suriname) between 1962 and 1983, while the remaining six (6) are either classified as British Overseas Territories[7] or British Dependencies[8]. Among the independent countries, ten (10) have retained the Westminster system of government, with the British queen as the Head of State, while three (3) have become independent Republics, with a President as Head of State[9].

Most of the independent countries have been classified as middle income countries by the World Bank, with three (3) of them in the Lower-middle-income grouping[10], nine (9) in the Upper middle-income grouping[11] and one (1) in the high-income grouping[12]. This classification has been based on relatively high per capita income as compared with the rest of the developing world[13]. The countries have also attained relatively high rankings on the United Nation's Human Development Index[14] with four countries being ranked in the High Human Development category[15] and the remainder in the Medium Human Development category.

These rankings however, mask the fact that these countries are very vulnerable and have not performed as well as these generalised macro indicators suggest.

The economic performance over the last decades has been characterised by relatively slow growth and increasing levels of debt as Governments have borrowed to finance expansion and growth. An IMF Working Paper entitled **Stabilisation, Debt and Fiscal Policy in the Caribbean[16]** concludes that for the period 1983 – 2004 "*GDP growth in the Caribbean region*

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[4] Based on submissions from Early Childhood Coordinators at country level

[5] The language of government in Suriname in Dutch; however the language used in CARICOM is English.

[6] Antigua and Barbuda, Bahamas, Barbados, Belize, Commonwealth of Dominica, Grenada, Republic of Guyana, Jamaica, St. Kitts-Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago, Suriname

[7] Bermuda, British Virgin Islands, Cayman Islands, Turks and Caicos Islands

[8] Anguilla, Montserrat

[9] Summaries of the history, political and economic status of each country can be found at www.caricom.org

[10] Guyana, Jamaica, Suriname

[11] Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago

[12] The Bahamas

[13] Economies are divided according to 2004 GNI per capita, calculated using the World Bank Atlas method. The groups are: low income, $825 or less; lower middle income, $826 - $3,255; upper middle income, $3,256 - $10,065; and high income, $10,066 or more (http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS)

[14] Summarised from list of countries by Human Development Index (2003), as included in the United Nations Development Programme Report 2005

[15] Barbados, St. Kitts-Nevis, Bahamas, Trinidad and Tobago.

[16] Sahay, Ratna (2005). Stabilisation, Debt and Fiscal Policy in the Caribbean. IMF Working Paper WP/05/26

*relative to other developing countries during 1980–2003 was low*" and that "*Even the average rate of growth of all "small island states" in the world was higher than that of the Caribbean.*" By the end 2003, "*14 of 15 Caribbean countries ranked in the top 30 of the world's highly indebted emerging market countries … with seven among the top 10.*"

Poverty[18] is also a significant feature of the economic landscape, with the results of recent poverty surveys showing a range of 14% to 39% across the region – Table 1. These high poverty rates, in the face of the relatively high HDI rankings indicate the existence of significant inequalities in income distribution within these societies. This is borne out by the Gini coefficients for these countries which range from 0.23 to 0.56[19]. To put this data into a global perspective, European countries Gini coefficients vary between 0.25 (Sweden) and 0.36 (Britain), while the USA ranks 0.41.

**Table 1.1 – Poverty in the Caribbean[17]**

| COUNTRY | POVERTY % POPULATION |
|---|---|
| Barbados | 14 |
| Belize | 33 |
| Dominica | 39 |
| Grenada | 32 |
| Guyana | 35 |
| Jamaica | 19.7 |
| St. Kitts and Nevis | 32 |
| St. Lucia | 25 |
| St. Vincent and the Grenadines | 38 |
| Trinidad and Tobago | 21 |

This economic performance is further compromised by the countries' vulnerability to hurricanes and other natural disasters. The President of the Caribbean Development Bank (CDB) noted in 2003 that "*there is compelling scattered evidence about the considerable economic damage resulting from natural hazards in recent years."* [20] This included Hurricane Hugo in 1980 which caused $3.6 billion damage to Antigua and Barbuda, St. Kitts and Nevis, Montserrat, and the British Virgin Islands and Hurricane Gilbert in 1988 which inflicted an estimated $1.1 billion damage to Jamaica. This was before Hurricane Ivan in 2004, which devastated Grenada, destroying or damaging 89% of the housing stock and inflicting overall damage in excess of 200% of GDP[21].

The impact of hurricanes on the early childhood sector was amply demonstrated by the impact of hurricane Ivan in Grenada in 2004. The hurricane completely destroyed 36% of the day care centres and 45% of the preschools. The remainder were all significantly damaged. In addition, furniture and materials were destroyed by exposure to water and wind. Children were also very traumatised[22].

[17] Source: UNICEF World Fit for Children in the Caribbean: Beyond 2002

[18] Poverty is defined as "the inability to maintain a minimal standard of living". This minimal standard of living is defined as the minimal food requirements necessary for existence or survival. The poverty line is therefore the cost of that minimal food basket.

[19] Inequality and Poverty in the Eastern Caribbean: Caribbean Development Bank, 2002

[20] Statement by Dr. Compton Bourne, O.E. President, Caribbean Development Bank at the Thirty-Third Annual Meeting of the Board of Governors St. Kitts Marriott Royal Beach Resort, St. Kitts May 14 and 15, 2003. All dollar amounts are quoted in local currency.

[21] Organisation of Eastern Caribbean States - Grenada: Macro-economic Assessment of the Damages Caused by Hurricane Ivan, September 7th 2004

[22] UNICEF, Office for Barbados and the Eastern Caribbean (2004). Grenada Education Sector Preliminary Assessment

The response programming necessitated reopening day care centres and preschools in temporary facilities, including tents donated by UNICEF and the initiation of a national psychosocial programme – the UNICEF Return to Happiness Programme - to assist children in coping with the trauma and anxiety created by the experience. Repairs to some of the facilities are still ongoing in 2006.

**Table 1.2 – Orphans in the Caribbean**

| COUNTRY | ORPHANS % CHILDREN |
|---|---|
| Bahamas | 7 |
| Barbados | 5 |
| Belize | 5 |
| Cuba | 4 |
| Dominican Republic | 7 |
| Guyana | 9 |
| Haiti | 15 |
| Jamaica | 4 |
| Trinidad and Tobago | 7 |

On the social front, the countries are being increasingly challenged by high incidences of HIV/AIDS, rising crime and drug trafficking. The average HIV/AIDS prevalence rate is 2.1%, with a range of between 0.1% and 6.1%. This has placed the Caribbean second only to Sub-Saharan Africa in terms of HIV prevalence rates. It has also placed a number of new issues on the development agenda, including that of providing for increasing numbers of orphans, estimated at between 4% and 15% of children at the end of 2003. Table 2 provides data on the increasing number of orphans in nine regional countries (six of which are included in this report)[23].

The context within which early childhood programming is located is therefore one in which the local governments are operating under significant fiscal constraints, while having to contend with a range of social and economic challenges all demanding urgent attention.

**Children in Caribbean Society**

Considerable research on historical and current family structures within the Caribbean has taken place over the past two decades, with particular attention given to the matriarchal nature of families within the African-Caribbean diaspora, the role of mothers, and to a lesser and more recent degree, the role of fathers.

Little focus has been given to the meanings given childhood within these family structures, or to the ways in which parents and the wider family and community actually raise children.

A researchers' seminar to be held in Dominica in May 2006 will help those engaged in research in the region to answer many questions about the cultural/social strengths and deficits that manifest in the childrearing practices that have been observed, and the rationales behind them.

**Historical Evolution of Early Childhood Programming**

Across the region, the history of the evolution of services and supports to young children reflects the same theme. With the exception of the health issues related to birth and immunization that have been the traditional responsibility of governments, the initiation of programming in all of the other areas identified has been reliant upon the initiative of concerned citizens and/or organisations – UNICEF, Bernard van Leer Foundation (BvLF), religious denominations. With the exception of three (3) countries[24], this predominance of private/charitable initiative is still a defining feature of early childhood programming today.

[23] Source: UNICEF World Fit for Children in the Caribbean: Beyond 2002
[24] Barbados, Grenada, St. Kitts-Nevis

The earliest record of early childhood care and education programming in the region is found in St. Kitts-Nevis where the history of education for young children predates the abolition of slavery[25]. Infant schools for children aged 3 to 8 were established by the Moravian and Methodist Churches soon after they arrived on the island in the late 1700's. Their aim was to evangelize the population especially the Negro slaves. A basic philosophy of both groups was that individuals should learn to read so they could understand the Bible for themselves. Because children went to work on the estates from age 6 or 8, priority was given in the Infant School to the teaching of Reading. Writing and Arithmetic were also taught.

Private individuals began to offer formal childcare services outside the home in 1918, when working mothers started leaving their children with trained nurses. In 1920, the Baby Saving League was formed and opened six (6) Creches to serve a total of 40 infants. At this same time, some community members started small preschool care and education centres in their homes.

During that period, initiatives were being started in other countries and in Barbados, for example, in 1837, an organisation called the Mico Charity erected the first infant school in the suburbs of Bridgetown (the capital) to accommodate two hundred (200) children in the 2 – 4 year age range. In 1850, legislation was passed to provide infant schools in rural areas and by 1900, one hundred and twelve (112) infant schools had been established.

Programming developed unevenly across the region in the years that followed – Trinidad in 1934, Jamaica in 1938- and today most countries have some level of ECCE programming in place.

The main demographic, economic, social and political factors that have influenced these developments have changed over time. Davies[26], writing in 1997, identified three (3) distinct phases in the evolution of ECCE programming, viz:

- ***The Post War Period to 1969*** – where rapid industrialisation created new employment opportunities for both men and women and led to the gradual erosion of the traditional extended family structures and an increased demand for child care services outside of the home. These tended to be primarily custodial in nature.

- ***The Decade of the Seventies*** – during which programming responded to the outcomes of a 1967 UNICEF Regional Conference on "The Needs of the Young Child in the Caribbean". This conference highlighted the deteriorating social and economic conditions of individual countries which jeopardised the normal healthy development of young children. It proved, in Davies' words, "… to be the catalyst which intensified activities in advocacy, training and programme expansion in the region."

- ***1980 to 1997*** – which saw a rapid expansion in ECCE and other child-related services triggered by the designation of 1980 as the International Year of the Child (IYC). Local committees were set up to develop proposals and plans for achieving IYC objectives and some of these activities continue to the present e.g. in Child Month celebrations. In

[25] Submission by Early Childhood Unit – St. Kitts-Nevis
[26] Rose Davies, A Historical Review of the Evolution of Early Childhood Care and Education in the Caribbean

addition, many governments recognised the need for regulations regarding the care and welfare of the preschool child. This increase in advocacy was supported by continuing inputs from UNICEF, which at that time shifted its focus to direct country assistance.

In the post 1997 period, programming at the operational level has been influenced by the processes that were developed to monitor the implementation of the Caribbean Plan of Action for Early Childhood Education Care and Development (CPOA). At the political level, these have been reinforced by international developments including the outcomes of the Education For All (EFA) 2000 processes and the United Nations Special Summit on Children.

**Characteristics of Early Childhood Service Provision**

These foregoing examples from St. Kitts-Nevis and Barbados highlight one of the critical features of the evolution of ECCE – namely that it evolved outside of the scope of governmental action and evolved in many countries as a response to the need to provide services to working mothers. The net result of this has been:

- Little or no attention being paid to the health issues beyond basic immunisation. In most countries there is little systematic nutritional programming/monitoring, nor is there any systematic programming for developmental monitoring and early intervention.

- Little or no attention being paid to early stimulation.

- A primary focus on the provision of custodial care for children either through day care centres and/or preschools.

*Nutritional Programming*

UNICEF, in the publication *World Fit for Children in the Caribbean: Beyond 2002*, has noted that "Children in the region generally have a satisfactory nutritional profile … however, widespread micronutrient deficiencies (iron, vitamin A and beta-carotene) are reported among vulnerable groups in the Caribbean (Gordon et al., 2002). Iron deficiency, in particular, constitutes a significant public health problem. In addition, there are a growing number of cases of obesity among children. The Caribbean Food and Nutrition Institute (CFNI) has compiled obesity data on children and adolescents in the region reporting that "high prevalence of overweight and obesity is evident" (Xuereb et al, 2001). This study noted that over the decade of the 1990s, there was a systematic increase in trends of obesity among children and young adults in the region, with rates among 15-19 year-olds doubling."

Within this context, the main focus of nutritional programming for children has been on the promotion of breastfeeding and appropriate weaning practices. This has been incorporated into standard Maternal and Child Health (MCH) programming across the countries, but more emphasis needs to be placed on monitoring the effectiveness of the programming.

*Developmental Monitoring and Early Intervention*

This is an area where the region is seriously deficient, with no country having a sustainable system in place to perform developmental screening and provide adequate follow up support. The net result is that children with developmental delays – physical, behavioural, social

emotional, sensory, communication as well as cognitive – are not systematically identified until they are well past the age of 5, many times as a consequence of poor performance in primary schools. This is much too late for significantly helping many of them.

Some countries – St. Lucia, Jamaica and Barbados – have initiated programming aimed at strengthening this area. The former now has a comprehensive system in place that is being implemented through the public health system. The system was developed with the support of the Child Development and Guidance Center (CDGC), a non-governmental organisation, which also provides the follow-up treatment for children identified through the screening process. Attempts to get the Government to become more involved in the treatment phase have not been successful, with the result that the system remains heavily dependent on the CDGC.

**Annex 1** contains a case study of the development of this system.

*Early Stimulation*
Early stimulation of children traditionally takes place in the home or, in the case of working parents who do not have anyone at home to look after their children, in day care centres. The quality of early stimulation is therefore dependent on two factors i.e. parenting knowledge and expertise of the parent or caregiver in the home and/or the quality of service provided by the day care centres.

In the case of *parenting practices*, there is little rigorously researched information on which to base any information on the quality of the experiences within the home. The Jamaica Profiles Project has highlighted that:

- Homes with the lower socio- economic status had little physical material to stimulate children's development; and

- Homes also lacked appropriate parent-child interaction to promote emotional development.

Anecdotal information from practitioners in the field and the high incidence of teenagers who become parents also indicate that many parents do not have access to information on the importance of early stimulation, or techniques for providing such stimulation. A survey done in Grenada among 179 rural families revealed that 46% did not have any information on how to stimulate young children[27].

One country, Suriname, has experimented with a pilot project aimed at incorporating parenting education into their Under 5 health clinics. It was well received by mothers and health professionals alike, and the health officials indicated an interest in bringing it to scale at the national level. This has not been done to date.

**Annex 2** contains a Case Study of the pilot project.

[27] Project Proposal, Mobile Caregivers Programme, GRENADA

This is an area in which more urgent research work needs to be done across the region, given the critical importance of early stimulation to a child's future development.

In the case of *day care services*, the regional survey carried out for this report has revealed that there are 682 institutions providing day care services to children between birth and three in the thirteen (13) countries that provided data on this subject. The results of surveys of the quality of early childhood learning environments conducted across the region in the 1998 – 2006 period has raised serious concerns over the quality of the provision in these day care centres and consequently the adequacy of the stimulation that is provided. This will be discussed in more depth in the following section on progress towards EFA goals.

*Custodial Care for Children*
Many of the early day care and pre-school institutions started in people's homes, providing a baby sitting service, or responding to the perceived need to teach little children "the ABCs", or provide day care services while the parents went to work. The net result is that, in most countries (except Grenada, St. Kitts-Nevis, Barbados), Governments were not seriously involved in the evolution of the ECCE provision, until well past the formative years.

The reality today is that in many countries, ECCE provision is primarily private sector driven, with little or no government involvement. Across the region as a whole (13 countries) the private sector, churches and community organisations own 87% of the day care and preschool institutions.

The informality with which the ECCE provision has developed has also resulted in:

- ***Varying standards of care and quality*** – Many of the providers themselves do not have a strong theoretical understanding of child development and/or do not have the resources to provide the kinds of learning environments that are required.

- An ***absence of national standards*** for the provision of ECCE;

- ***Weak licensing, certification and monitoring systems*** which make it difficult to enforce standards of care;

- A preponderance of ***small, undercapitalized operators,*** many of whom lack the resources to improve the standard of service provision, even if they wanted to do so; and

- ***Low levels of training among caregivers***, with the result that the children in these centres are left in the hands of adults with a poor basic education and little or no training/understanding of child care.

It has become increasingly clear that there is an URGENT need to move the outputs of the ECCE service provision to a higher level, including:

- Improvement in learning environments to provide stimulating experiences for children;

- Development and implementation of appropriate curricula, learning materials and learning environments;

- Training and development of teachers; and

- Strengthening of the enabling environment including national policy frameworks, national service standards backed by a certification and regulatory framework and strong institutional leadership with a capacity for ongoing monitoring and evaluation of the service delivery.

**Policy and Programmatic Response**

In response to these challenges, the Caribbean Plan of Action for Early Childhood Education Care and Development was adopted by the CARICOM Heads of Government in 1997[28]. The CPOA focused on the need for mechanisms and strategies to achieve nine (9) specified objectives, viz:

1. Legislative framework for coordinated provision of services and monitoring of standards in the sector.
2. Integrated social planning and implementation of initiatives.
3. Adequate financing.
4. Equitable access to quality provisions to minimise the plight of the large percentage of children in high risk situations.
5. Education and training for all providers of early childhood education and development.
6. Appropriate curriculum development and materials development towards improving quality of ECECD provisions.
7. Increased parent, community and media awareness and involvement.
8. Coordinated action at both national and regional levels and multi-sectoral participation (government, NGO and private sectors).
9. Increased research to inform development of the sector.

This has provided a common framework within which ECCE development in countries in the region have been monitored over the last ten years. The results and impact will be discussed in more detail in the Section 3 – Recent Initiatives and Lessons Learnt.

[28] The Caribbean Plan of Action for Early Childhood Education Care and Development

## 2. ASSESSING PROGRESS TOWARD THE EFA GOALS

### Programme Descriptions

ECCE programmes in the Caribbean typically target children at two stages of development - the birth to 2 year olds and the three year olds to primary school entry. In all countries except Jamaica, compulsory education begins at age 5 and all children enter primary school at that age. In some countries children enter primary school directly into Grade 1[29]. In the others, they spend some time in kindergarten classes before entering Grade 1 at age 6[30].

*Birth to 2 Cohort*

The service provision for this cohort goes by a number of different names across the region - day care centres[31], crèches[32], child minders[33] and play groups[34]. These programmes typically cater to working parents and therefore provide services for most of the working day – typically from 8am – 4pm at a minimum. In some countries they remain open throughout the year, while in others they close during the school vacations. They typically provide a custodial service, although efforts have been made at the day care centres to provide a more developmental service in recent years.

There are also home visitation programmes in five countries[35] that are based on the Roving Caregiver Model that was developed in Jamaica. This intervention is specifically targeted at families of poor, unemployed mothers. Under this programme, trained caregivers visit the mother's home on a weekly basis[36] and provide stimulation activities with the child. Typical sessions last between 30 minutes and one hour, and mothers are encouraged to repeat the activities with the children between visits.

*Age 3 to Primary School Entry*

Service provision for this cohort is typically provided in pre-schools[37], nursery schools[38] or basic school (the name given to preschools in Jamaica)[39], although some children particularly of working parents remain enrolled in day care centres. These preschools follow the normal educational cycle and provide services during regular school hours and term-times. The programming in these institutions has varied depending on the degree of proactive engagement in curriculum and training by the early childhood units and officers in each country. As private operators, ultimately the choice of content of daily activities is left with the programme supervisors. Without an overarching curriculum framework at national level, tied to programme standards and expectations under licence, and a guiding system of belief and support in

[29] Belize, Cayman Islands, Dominica
[30] All other countries
[31] In all sixteen countries responding
[32] In Antigua
[33] In Cayman Islands
[34] In Anguilla
[35] Four of these – Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines – are pilot projects run Government Departments or NGOs and supported by the BvLFs Caribbean Support Initiative, with the collaboration of UNICEF.
[36] Twice per week in the pilot projects
[37] In all 16 countries
[38] In Barbados
[39] In Jamaica

pedagogy for the early years, this has resulted in many cases, in a primarily custodial approach. This has been combined with a heavy emphasis on assuaging parental anxieties about school readiness by providing formal, structured instruction in the ABCs and arithmetic.

**Service Providers**

Survey responses from 13 countries reported a total of 4,097 early childhood institutions[40] across the region – 17% (682) providing services to the birth to three cohorts and (83%) 3,415 providing services to the age three to primary entry cohorts.

**Table 2.1 – % Ownership of ECCE Providers**

| OWNER | TOTAL | BIRTH - 2 | 3 - PRIMARY |
|---|---|---|---|
| **Government** | 13 | 13 | 14 |
| **Private** | 30 | 78 | 20 |
| **NGO** | 5 | 7 | 4 |
| **Community** | 52 | 1 | 62 |
| **TOTAL** | **100** | **100** | **100** |

Only 13% of these institutions are owned by Government, although Governments also provide small subventions to selected community and private institutions in some countries. 52% are owned by private operators and the remainder is owned by NGOs and community organisations[41]. Most of the latter provide services to the age three to primary entry cohorts and service provision to the birth to two cohorts are primarily in the hands of the private operators – 78% - Table 2.1.

Across the region, Government is a majority provider[42] in services for the birth to 2 cohorts in 2 countries – Montserrat (67%) and St. Lucia (54%), and for the three to primary school entry cohorts in three (3) countries – Montserrat (100%), Grenada (67%) and Barbados (69%).

**Participation in ECCE**

Participation rates in ECCE vary across countries. Table 2.1 contains Gross Enrolment Ratios (GERs) at a number of levels, based on data submitted by the ten (10) countries listed – the entire birth to five cohort, the birth to two cohort and the three to five cohorts. The data is further disaggregated by gender for each of the categories.

The table shows that:

- The participation of children from the birth to 2 cohorts in institutionalised settings (including the home visiting programmes) ranges from 5% to 53%. There is little gender disparity between the participation rates for this cohort across the region, with one exception being the British Virgin Islands, where the female participation rate is higher (51%) than the male (45%).

- The participation of children in the three to 5 cohorts is much higher, ranging from 55% to 95%. There is little gender disparity between the participation rates for this cohort across the region, with the exceptions being the British Virgin Islands, where the female

[40] Including the Home Visiting Programs
[41] The community ownership refers to the basic schools in Jamaica, which constitute 2,062 (50%) of the 4,097 institutions
[42] Owns and operates 50% or more of the institutions

participation rate is higher (96%) than the male (87%) and St. Kitts-Nevis where the female participation rate is higher (84%) than the male (78%).

**Table 2.2 – Gross Enrolment Ratios**

| | SVG | JCA | ANG | MONT | GRE | ANT | BVI | SKN | SLU | DOM |
|---|---|---|---|---|---|---|---|---|---|---|
| **Gross Enrolment Ratio** | | | | | | | | | | |
| - Entire Cohort | 39 | 44 | 46 | 69 | 42 | 32 | 65 | 64 | 36 | 33 |
| - Birth – 2 | 5 | 6 | 17 | 40 | 9 | 12 | 48 | 53 | 19 | 10 |
| - Pre school | 89 | 80 | 79 | 111 | 95 | 61 | 92 | 81 | 57 | 55 |
| **Gross Enrolment Male** | | | | | | | | | | |
| - Entire Cohort | 39 | n.a | 56 | 67 | 40 | 33 | 62 | 63 | 36 | 41 |
| - Birth – 2 | 5 | 6 | 18 | n.a | 10 | 12 | 45 | 52 | 19 | 11 |
| - Pre school | 89 | n.a | 79 | n.a | 88 | 62 | 87 | 78 | 56 | 84 |
| **Gross Enrolment Female** | | | | | | | | | | |
| - Entire Cohort | 39 | n.a | 53 | 71 | 44 | 32 | 69 | 66 | 36 | 41 |
| - Birth – 2 | 5 | 6 | 17 | n.a | 8 | 13 | 51 | 54 | 20 | 9 |
| - Pre school | 88 | n.a | 80 | n.a. | 102 | 60 | 96 | 84 | 57 | 83 |

n.a. – Data not available

## Equity

*Targeting Vulnerable Populations*

Most of the service programming across the region is universal in nature and there is generally no specific targeting of vulnerable populations. This is understandable given the private sector orientation of the service provision. Notable exceptions include the day care provision by the Government of St. Lucia, which was specifically established to assist rural women working in the banana sector, and the Roving Caregivers Programme in Jamaica and its replica pilot programmes in Dominica, Grenada, St. Lucia and St. Vincent and the Grenadines, which are specifically designed to address the needs of poor, unemployed mothers.

*Rural-Urban Provisions*

The disaggregated data needed to assess rural-urban disparities were not provided by any country. Five (5) countries provided data on the rural- urban distribution of the enrolment data – Table 2.3. In all of these countries the majority of the population reside in rural areas. In this context, the data show a relatively low proportion of the children attending institutions that are located in the rural areas.

**Table 2.3**
**Rural Enrolment**

| Country | Rural % |
|---|---|
| St. Vincent | 26 |
| BVI | 18 |
| St. Kitts-Nevis | 49 |
| St. Lucia | 61 |
| Belize | 31 |

*Special Needs*

Specific programming for children with Special Needs was reported by three countries – St. Lucia, Barbados and St. Kitts-Nevis. In each of these countries, such students are mainstreamed wherever possible to ensure that there is equality in educational opportunity and to ensure that all students benefit from the same quality of education being offered. In addition, Special Education

Programmes are also provided that cater specifically to children with global developmental delays.

*Children with HIV/AIDS/Orphans*
It is not know whether present services are including children affected or infected by HIV/AIDS, as anecdotal evidence indicated that these children are usually cared for by the extended family, or provided for under the limited existing safety net programmes administered by Governments or NGOs, without their status being obvious.

**Quality**

*Surveys of the Quality of Learning Environments*
The findings from the Profiles Project and much international research pointed to the importance of the *quality of the environment* in which children learn as a key indicator for developmental outcomes. The concept of the learning environment goes beyond the standard of teacher/caregiver, resources and structure to encompass the interactions between adults and children, parents and institution, children and children, resources and their use, and learning opportunities as directed by adults or as chosen by children.

Observations of the learning environments in Caribbean preschool and day care centres were undertaken as part of research studies on nationally representative samples (in the Bahamas, Dominica, Grenada (2000), Jamaica, St. Lucia, St. Vincent and the Grenadines) and on the whole sector (Montserrat and Grenada (2005)) between 1998 and 2005.[43]

The purposes of the national surveys of the quality of environments in early childhood centres were to:

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[43] Williams, S. (2006) *National survey of the quality of learning environments in early childhood basic schools in Jamaica,* Early Childhood Commission/Dudley Grant Memorial Trust, Jamaica. Report Forthcoming;
(2005) *National survey of the quality of learning environments in preschools and day care centres in Grenada.* Ministry of Education, Grenada;
(2005) *Survey of the quality of learning environments in early childhood basic schools in three parishes in Jamaica,* Bernard van Leer Foundation/Dudley Grant Memorial Trust;
(2004) *Report of the national survey of quality of learning environments in early childhood centres in the Commonwealth of the Bahamas*, Child Focus II Project/IADB;
(2002) *Report of the national survey of quality of learning environments in early childhood centres in St. Lucia*, Government of St. Lucia/UNICEF Caribbean Area Office;
(2001) *Report of the national survey of quality of learning environments in early childhood centres in Montserrat*, Government of Montserrat/UNICEF Caribbean Area Office;
(2000) *Report of the national survey of quality of learning environments in early childhood centres in Grenada,* Government of Grenada/UNICEF Caribbean Area Office;
(2000) *Report of the national survey of quality of learning environments in early childhood centres in the Commonwealth of Dominica,* Government of the Commonwealth of Dominica/UNICEF Caribbean Area Office.
Williams, S. and J. Brown. (2000) *Report of the national survey of quality of learning environments in early childhood centres in St. Vincent and the Grenadines*, Government of St. Vincent and the Grenadines /European Union.

- establish a baseline for policy development and service improvement;
- inform the understanding within the Ministry and amongst early childhood stakeholders of the priorities for change;
- provide a "snapshot" of the status of quality of environments in the sector;
- to cite examples of good practice; and
- inform the development of training for the sector

The instrument used in the survey was the Early Childhood Environment Rating Scale (ECERS) Revised Edition (1998) by Harms, Clifford and Cryer[44]. The ECERS-R is an observation-based measure of early childhood environment quality with 43 items grouped under seven subscales. Scores for each of these 43 items are derived from rating patterns on multiple dichotomously scored indicators. The first subscale, *Space and Furnishings* includes items pertaining to the use of space and room arrangement. *Personal Care Routines*, the second subscale, includes questions regarding the quality of meals and snacks and health practices. The third subscale, *Language-Reasoning*, includes items such as whether books are accessible and organized in a reading center. The fourth subscale is labelled *Activities* and includes items that focus on the availability of important materials in the areas of dramatic play, sand, and water. *Interaction* is the fifth subscale and includes items addressing concerns such as the quality of staff-child and child-child interactions. *Program Structure*, the sixth subscale, addresses issues including whether the schedule is posted in the room. The last subscale, *Parents and Staff*, includes items relating to whether parents receive information in writing and whether they are encouraged to observe the program prior to enrolment.

The findings were broadly similar across the region in terms of relative strengths and weaknesses. Early childhood learning environments lacked adequate space, material, furniture and programme structure. Critically considering the importance of exposure to books and the

[44] Developed at the Frank Porter Graham Child Development Centre, University of North Carolina at Chapel Hill as an instrument for both research and programme improvement, the ECERS has been in use in a number of countries of the world for 15 years. Appropriateness of the ECERS-R for the Caribbean Region was addressed in two ways. One was based on content validity and the other on the psychometric equivalence of the ECERS-R factor model for the region.

- To address content validity concerns an expert review of all items on the measure was conducted, where early childhood practitioners and researchers in each country reviewed the items on the measure and determined their fit for the region. All experts agreed that the items adequately captured early childhood settings in the region.
- To test the appropriateness of the ECERS-R factor model, Michael C. Lambert, Ph.D, Millsap Professor and Licensed Psychologist, Department of Human Development and Family Studies and Adjunct Professor, Department of Psychological Sciences University of Missouri-Columbia conducted tests to determine whether the data were normally distributed. These tests revealed than the data were skewed to the right and a positive kurtosis. He therefore fitted polychoric correlations for the item scores and to avoid the assumption of multivariate normality, he used weighted least squares with standard errors and mean- and variance-adjusted chi-square test statistics (Muthén & Muthén, 2004). RMSEA was used as the primary index of model fit because it has been identified as the best performing fit index for WLSMV (Yu & Muthén, 2002). Yu and Muthén (2002) found that RMSEA values of < .06 indicate good fit, while other model fit indices do not perform well for binary or ordered categorical outcome variables (i.e., items). Nevertheless, he also computed the Tucker-Lewis Index (TLI; Tucker & Lewis, 1973) and the Comparative Fit Index (CFI; Bentler, 1990) for secondary fit information. He used Browne and Cudeck's (1993) criterion of 80 to .90 as indicating acceptable fit. With an RMSEA of .05 and TLI of .81 and CFI of .83 the existing factor model for the ECERS-R fit the Caribbean data acceptably.

process of being read to in the development of pre-literacy skills and motivations, the environments lacked books and story-book activities. However, a relative strength in two thirds or more of learning environments (except in one country survey) was the quality of staff child interactions; the combination of teacher directed learning and the lack of hands-on learning experiences for children appears to have resulted in a greater emphasis on staff child interactions, perhaps an indication that staff are making a virtue out of necessity.

The data in Table 2.4 on three key indicators taken from the quality surveys illustrate the range of inadequate ratings from 34% to 73% on the critical variable of access to books/picture books and the practice of reading to children. The high levels of inadequate ratings are repeated for many of the other 40 indicators that were measured. In contrast, the range of inadequate ratings for staff child interaction (with one exception) is 33% to 10%.

**Table 2.4 - Percentage Inadequate Ratings from Quality Surveys**

| **Country** | **#1** | **#2** | **#3** | **#4** | **#5** | **#6** | **#7** |
|---|---|---|---|---|---|---|---|
| **Year** | **2002** | **2001** | **2000** | **2004** | **2005** | **2005** | **2000** |
| **Space and Furnishings** | 77% | 67% | 30% | 29% | 60% | 39% | 40% |
| **Books and Pictures; Reading to Children** | 73% | 67% | 42% | 48% | 48% | 46% | 34% |
| **Staff-Child interaction** | 55% | 33% | 21% | 10% | 17% | 23% | 10% |

*Source: Sian Williams, Reports of National Quality Surveys (Unpublished).*

In general the learning environments were not structured in a way that reflected how children learn best at a very young age. The pace and coverage of training in how to support learning in the early years is reflected in the learning environments throughout the region. However, in every country surveyed, examples of best practices were identified with the potential to set up mentoring arrangements between centres and key personnel. Several improvements suggested required no financing but changes in attitudes and working practices from basic health and safety routines to management of classroom environments. For example, key areas for support to children's learning which emerged are:

- managing "difference" between children, helping children learn tolerance;
- guiding children to include one another in games, activities and everyday events at the centre;
- developing rules with children for being fair and kind to each other

Overall, the main benefit and use of the surveys have been to inform priorities for staff training and to provide data for sector plans, policies and priorities for capital investment

*Teacher Qualifications*

The overall level of caregiver training is low. Responses to the survey from 14 countries indicated that only 3 currently require post secondary training for lead staff at pre schools[45] and 2[46] require it for lead staff at day care centres. In addition, in 70% of the countries, employment

[45] Bahamas, Barbados, British Virgin Islands
[46] Barbados, Bahamas

in a day care centre does not require completion of secondary school as a criterion for support staff. The situation is the same for employment for support staff in preschools for 50% of the countries.

This low level of teacher training reflects in part the informal nature of service delivery and the low wages that characterise employment in ECCE.

Barbados is a notable exception in this case, where professional level ECCE training was introduced in the local Teacher Training College in 1987. As a result, the majority of teachers in the government nursery schools have acquired first degrees or teacher professional training. A significant number of teachers also have a Masters in Education in early childhood education and a significant number have completed in-service training in early childhood education.

Most other countries have initiated training activities aimed at upgrading the skill levels of the caregivers, but most of these are workshop based and do not lead to any certification and upgrading of the caregivers. Exceptions to these include programmes in Jamaica, Grenada and St. Vincent and the Grenadines where a recently developed competency-based certification system has been utilised as the basis for caregiver training.[47] The Government of St. Kitts and Nevis has also announced plans to introduce a competency-based ECD certification option as part of the vocational training that will be available in secondary schools from September 2006.

SERVOL in Trinidad and Tobago offers an accredited training programme in Early Childhood to which many regional countries send a small number of students annually.

*Adult-Child Ratios*

Most countries have stipulated adult-child ratios in keeping with international norms. The responses to the survey indicate that six (6)[48] out of ten (10) reporting countries maintain the stipulated ratios for the birth to 2 cohorts and six (6)[49] out of ten (10) maintain the ratios for the age 3 to primary school cohort.

*Curricula*

There is no standard curriculum or curriculum guide in use across the region. Service providers are generally free to use their choice of curriculum and the approaches in use include curricula based on High/Scope, Montessori, Servol's guides (based on the original curricula produced by the University of the West Indies in the 1970s) or combinations of several approaches. Established curricula exist in five countries[50] for children in preschools and in one country for children under three years of age.[51]

This is now being addressed at the regional level with the initiation of a regional process aimed at defining regional learning outcomes and aligning curricula with these learning outcomes.[52]

[47] This is discussed in more detail in the next section on Recent Initiatives
[48] Belize, British Virgin Islands, Grenada, Jamaica, Montserrat, St. Lucia
[49] Anguilla, Dominica, Jamaica, Montserrat, St. Kitts Nevis, St. Lucia
[50] Anguilla, Barbados, Cayman Islands, Guyana, St. Kitts Nevis
[51] Guyana
[52] This is discussed in more detail in the next section on Recent Initiatives

*Transition to Primary*
Except for St. Kitts-Nevis, there were no reports of a structured approach to the transition into primary school. In the case of the former, there is an organised programme where the Kindergarten teachers in the primary schools attend the Annual Orientation Training for Early Childhood caregivers. This enables them to understand the programming that the children have experienced and to plan a smoother transition for them when they enter the primary school.

**Governance**

*Management Structures*
In nine (9)[53] out of sixteen (16) countries, Government responsibilities for both day care and preschool provision are being managed by the same Ministry or Department. However, most units are understaffed, having 1 or 2 persons to service the entire country and these officers do not have the requisite levels of power and authority to effect change.

One example of an attempt to redress this problem is the recently established Early Childhood Commission in Jamaica where the power and authority to effect change is vested in an external body, answerable to the Minister of Education with full responsibility to manage the development of these services. This is a model that should be closely monitored in its development, as it can provide useful lessons for the rest of the region.

*Policy Frameworks*
There is a general absence of national policy frameworks to guide the sector's development, including a clear vision for where the sector should go – in all but four (4) [54] of the sixteen (16) countries. Drafts are under discussion in two (2) others[55].

*Inter-sectoral Coordination*
Advisory bodies, such as the National Council on Early Childhood Education in Trinidad and Tobago, have been established with the remit to guide the Minister of Education on matters of policy and practice. However, formal structured coordination between the different sectors – health, education, social development/welfare - in the provision of services for children does not exist in most countries. The only exception is Dominica, where an Inter-sectoral Committee, the Council on Early Childhood Education has been established under the Education Act, with legal responsibilities and has been functioning effectively. Jamaica's Commission will be a formal regulatory body once the provisions of the Early Childhood Act 2004 come into force.

*Monitoring and Evaluation Processes*
Monitoring and Evaluation of service delivery is weak and comprises periodic visits to service providers to assess their quality of provisioning. These assessments however take place against a

[53] Bahamas, British Virgin Islands, Cayman Islands, Dominica, Jamaica, Montserrat, St. Kitts Nevis, St. Vincent and the Grenadines, Turks and Caicos Islands
[54] Barbados, Grenada, Jamaica and St. Kitts and Nevis
[55] St. Lucia and Dominica

backdrop where there are no legally binding minimum standards in all but three countries[56]. This should improve in the near future as draft standards have been developed in seven others[57].

Guiding regulations[58] and compulsory licensing[59] exist in eight countries, but in the absence of standards of care many of these provisions focus primarily on the physical adequacy of the facilities and will have to be revised as programme standards are developed.

The Monitoring and Evaluation processes are also compromised by weak or non-existent data collection and reporting systems that make it difficult to effectively evaluate developments in the sector.

[56] Barbados, Dominica, St. Kitts Nevis
[57] Bahamas, British Virgin Islands, Grenada, Jamaica, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago,
[58] Anguilla, Bahamas, Barbados, British Virgin Islands, Belize, Dominica, Jamaica, St. Kitts and Nevis
[59] Anguilla, Bahamas, Barbados, Cayman Islands, British Virgin Islands, Belize, Dominica, St. Kitts and Nevis

## 3. RECENT ECCE INITIATIVES AND LESSONS LEARNT

Concern regarding Grade repetition and primary school failure, together with the recognition of the lack of information on the pre-school child for planning curriculum or interventions, gave rise to research and policy development initiatives during the 1997-2005 period at both the regional and national levels.

**Regional Initiatives and Lessons Learnt**
The Caribbean Plan of Action (CPOA) provided the frame of reference for much of the programming done in the region in the 1997 – 2005 period by international development partners (IDP). It explicitly influenced:

- The programmes of cooperation of UNICEF with participating countries;
- The technical assistance projects of the Inter American Development Bank in seven member countries and of the Caribbean Development Bank in a further eleven;
- The Caribbean Support Initiative, a programme of the Bernard van Leer Foundation (BvLF); and
- A World Bank Early Childhood Development project in Jamaica.

Regional initiatives to support national development processes and to forge understanding and promote cross-national exchange have been a feature of cooperation between IDPs and regional institutions. In the period 2001 -2004 the following initiatives were taken:

- The hosting of **regional early childhood conferences** in 2000 and 2002 facilitated follow-up on the implementation of the CPOA and provided opportunities for practitioners to exchange experiences and learn from each other.
- Development of ***learning outcomes for children*** from birth to 8 years following study visits in seven countries and a regional workshop process in 2004 with the participation of eighteen countries (IADB, UNICEF, Caribbean Development Bank (CBD)). **Annex 3** has a case study of this process of curriculum reform. Follow up work on curriculum reform and development in two countries is being supported by CDB in 2006-7.
- The design and delivery of a web-based ***masters degree through the UWI in ECD Leadership***, supported by the IADB, commencing with a pilot of 25 students in July 2004. The first cohort is scheduled to graduate with the UWI Class of 2006.
- The development of ***occupational standards for the early childhood 'workforce'*** (newly designated) in Jamaica in 1999 and the subsequently adoption by CARICOM for regional use in a ***competency-based certification system*** for ECD practitioners.

- Child-centred ***legislation, regulation and service standards*** developed in a 'package' in Suriname and the Bahamas, building on the earlier experience in Grenada. (IADB, UNICEF). Further work in two countries is being supported by CDB in 2006-7.

- Dissemination of ***parenting messages*** through the Caribbean early childhood website www.uwi.edu/caribecd following a regional workshop with 19 participating countries with parenting organisations and the media in 2001 (UNICEF, Parenting Partners). The work of supporting parents and informing parenting practices can be seen in the proliferation of home visiting programmes and the establishment of a regional community radio project. This is the most popular area for development at NGO level, attracting multi-partner support for research and practice (CSI, UNICEF, World Bank). A meeting of Caribbean and international researchers in May 2006 will review research on parenting practices and socialisation of young children and recommend future work to illuminate understanding how children are raised in the region (supported by CSI).

- The drafting of ***a fiscal planning model for the ECD sector***, based on standards, in Guyana and Suriname (IADB). Further work in two countries is being supported by CDB in 2006-7 on financing and investment strategies.

- The ***strengthening of ECD Associations*** through a network facilitated by UWI and supported by UNESCO and a regional workshop in 2003 supported by IADB, UNICEF and CDB for which tools and models for leadership and management were developed. A follow up case study in Trinidad and Tobago on financing/sustainability and strategic planning provided useful lessons for regional replicability.

- The ***collaboration with civil society organisations and Ministries of Finance and Planning*** in the Caribbean Early Childhood Policy Forum held in March 2006 to explore and examine the contribution that quality early childhood programming can make to the region's critical developmental priorities – poverty reduction, human capacity development and social development. The Forum was supported by CARICOM, UNESCO, UNICEF, CSI and the Government of Jamaica. The subsequent endorsement of the Forum's recommendations by the CARICOM early childhood working group are discussed in detail in Section 4 below.

Work in the region in the last decade has demonstrated that much can be achieved at regional level through well-designed training, organization of workshops on specific areas, sharing of research and case studies on successful and unsuccessful approaches, involvement of senior policymakers and monitoring of implementation of policy and plans of action. These examples of regional and national initiatives have been successful to the extent that they have mobilized the early childhood sectors, provided specific tools for government officials and produced outputs for immediate use and implementation. In combination with the rapid development of access to email and internet connectivity, a network of early childhood practitioners in nineteen countries has grown and also therefore, the potential for collective advocacy at regional level and for maximising learning/sharing and use of tools and models.

**National Initiatives and Lessons Learnt**

All countries in the region have been involved in initiatives aimed at strengthening their ECCE provisioning in the post 1997 period. This has been influenced in part by the Regional Early Childhood Conferences which provided opportunities for networking and learning from each other. Despite this, the scope and intensity of ECCE programming at the national level has varied across countries, dependent in part on the resources available for ECCE programming and on the leadership capacity at the national level.

In ***Jamaica***, a research project[60] to develop a comprehensive "profile" of the status of children and their learning environments on entry to school was undertaken to understand the problems fully. A nationally representative sample of children (0.5%) in their last term of pre-school (age 5-6 yrs) was identified from the Jamaica Labour Force Survey in 1998. The explanatory variables measured were Socio-economic status, Parenting I - Family structure, Parenting II – Family functioning, Social home environment, Health status, including hearing and vision, Learning environment (home and school) and the outcome measures Cognitive function, Academic achievement, Behaviour problems and Behaviour strengths.

The findings from this Project were significant in the region for two main reasons - specifically for the policy implications in Jamaica for families and children, and particularly for children in transition to primary school, and generally for relevance for the region as a whole. The Project found that:

- Children of poorer social economic status showed poorer cognitive and academic performance which worsened with time; more behaviour problems (Withdrawn, Aggression, Delinquency) and fewer behavioural strengths;

- Poverty impacts directly on children's development and behaviour and indirectly through parenting, the learning environment and social exposure;

- Homes had little physical material to stimulate children's development; they also lacked appropriate parent-child interaction to promote emotional development; and

- The public and private early childhood institutions children attended lacked material, space, furniture and programme structure.

In summary, the factors affecting children's outcomes globally were: Socio-economic status, Parental education, Parental stress, Reading books and Early childhood experience.

The implications of these findings were that efforts to improve child outcomes must be comprehensive and critically, that these efforts must begin early as time worsens effects

[60]Initiative of Caribbean Child Development Centre, University of the West Indies (UWI) from 1994 in partnership with Section of Child Health, UWI from 1998 and Planning Institute of Jamaica, Government of Jamaica (1997-2003), funded by Inter-American Development Bank (IADB) from 1997 to 2001. Published as *The Profiles Project*, by the Planning Institute of Jamaica, 2005.

In Jamaica, in conjunction with the findings of the Profiles Project, the CPOA provided the motivation and framework for the national plan of action for early childhood, the Early Childhood Act 2004 and the establishment of a regulatory body the Early Childhood Commission.

This led to the development of other critical areas of policy and systems development in Jamaica, providing examples for regional application, viz:

- The development of a parenting module in 2003 attached to the annual National Survey of Living Conditions;

- Screening tools for children's health; and

- Occupational standards developed by the National Council for Technical and Vocational Education and Training (NCTVET) for the early childhood 'workforce' (newly designated) in 1999 and the standards subsequently adopted by CARICOM for regional use.

The CPOA also provided an enabling environment for programme and policy development in a number of countries. In ***Grenada*** for example, standards, policy and regulatory framework for early childhood were established and endorsed through a consultative process at every level in the society in the period 1998-2002.

Despite these initiatives however, at national level, the problems of limited capacity of mid-level bureaucrats to lead and manage service development and improvements persist. These problems include their scope of authority, the sufficiency of resources available to them and the existence of supporting systems.

The combination of political will with capable leadership is essential for mainstreaming early childhood development within a country's services and systems as can be seen for example in the policy and programme coherence in Barbados and St. Kitts- Nevis and the development of a regulatory body and authority in Jamaica.

Notwithstanding these developments, the absence of a structured approach to national ECD programming, policy making, data collection/sector analysis, stakeholder involvement at all stages, training and capacity building remains an obstacle in countries with weak management and/or leadership. Further work on public/private partnerships in the funding and support of ECD services needs to be undertaken in the region to sustain qualitative improvements in the sector.

The major challenges faced include:

- Establishment of an objective basis to guide programming including access to data, strengthening of research capabilities and acknowledgement of the impact of the enormity of the costs relative to GDP.

- Improving the quality of the existing provision. This will require upgrading of physical resources as well as curricula, teacher qualification and working conditions.

- Better targeting of vulnerable populations.

- Improving early stimulation services; and

- Strengthening early intervention systems.

This will require stronger enabling environment with clear policy frameworks, minimum standards, certification and regulatory systems, monitoring and evaluation processes, all supported by appropriate institutional and individual leadership capacity.

## 4. IMPROVING ECCE – MAKING IT HAPPEN

The critical factor that will make a difference in moving ECCE happen across the region is that of leadership – both at the regional and national levels. This paper has already referenced the pivotal role of regional action – in the post-1967 period and again in the post-1997 period. This role has been played by international agencies over the years and there is a need for that mantle to be taken up by a regional organisation.

The CARICOM Secretariat has tried to provide that kind of leadership since the 2002 Conference through the formation of a Regional Early Childhood Working Group of international development partner agencies, regional organisations and civil society partners. However, their lack of capacity to perform this role continued to leave a vacuum at regional level. In March 2006, the Working Group was reconstituted following the Regional Policy Forum as a basis for a partnership to support initiatives at the regional level with UNICEF in a coordinating role for at least the next year.

The partnership is developing an integrated support plan to:

- Generate generic materials that would provide the resources for advocacy to key stakeholders/different audiences;
- Identify a few key indicators that can be developed and implemented at the regional level in monitoring and evaluation;
- Develop a parenting policy framework linking parenting actions with existing work on adolescence, youth, HIV/AIDS, HFLE and the new work on crime prevention;
- Launch the Education for All Global Monitoring Report in October; and
- Review existing standards and establish Minimum Standards that can use used across the region, harmonizing with curriculum and learning outcomes.

The work of the CARICOM working group's integrated support plan will be reported to the Council on Human and Social Development, the body of CARICOM at ministerial level that provides coordination and promotes harmonisation of activities at the regional level.

At the national level, the key priority will be to continue technical support to build systems in government for quality assurance and to change management culture from supervision to monitoring and support: This task includes the need to:

- Establish common ground – what is in the best interests of children
- Build Public Private Partnerships – agree standards, and, fair/equitable implementation strategies, phase in requirements
- Reflect diversity - urban, rural, island, hinterland, marginal groups

- Make “good” law - keep it short, defining responsibilities and powers precisely, attaching regulatory instruments/guidance

- Use action research/surveys to identify no-cost improvements to kick start the process, and to plan sector-wide investment

Sustained support to further strengthen early childhood associations is extremely important for the maintenance of momentum amongst stakeholder groups and for the quality of the engagement of the sector with the government. This is an area to include in the development of future projects with governments to ensure that the participation in ECD policy and programming development is inclusive.

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## APPENDIX 1

## QUESTIONNAIRE ON NATIONAL DEVELOPMENTS IN EARLY CHILDHOOD CARE AND EDUCATION

The purpose of this questionnaire is to collect data and information on developments in Early Childhood Care and Education in the Caribbean for the period 2000 – 2005. It is intended to inform the next Education for All (EFA) Global Monitoring Report (GMR) which will review country and regional progress towards six education goals with special attention to Goal 1, "*expanding and improving early childhood care and education, particularly the most disadvantaged and vulnerable children*".

This GMR will use the commonly accepted definition of **early childhood** as birth to age eight. However, in order to maintain consistency with data from around the world, the questionnaire will be focused on **Early childhood care and education** (ECCE) that serves children prior to their entry into primary schooling (Grade 1) in formal and non-formal settings (delivered by partnerships of governments, NGOs, communities, and families), with a focus on supporting children's comprehensive growth, development and learning (e.g., health, nutrition, hygiene, cognitive, social, and emotional development).

The questionnaire is divided into three (3) sections:

- *Section 1* – deals with ECCE Policy and Programme Development at the national level and is aimed at identifying the progress made in that area.
- *Section 2* – deals with the description of the ECCE service provision at the national level and the management of this service provision.
- *Section 3* – deals with the data required to analyse the progress made in the provision of, and access to, ECCE services at the national level during the 2000 – 2005 period.

**The completed questionnaire MUST be returned by e-mail to Sian Williams at sianw@kasnet.com, no later than February 10, 2006. Earlier submissions would be welcomed!!.**

In completing the questionnaire:

- Please indicate sources for all the data reported.
- Where assumptions have been made, or extrapolations have been done, or estimates made, please indicate clearly, and explain the basis of these assumptions and/or extrapolations and/or estimates.
- Please use an additional sheet(s) of paper, if it is necessary to provide additional explanations that would be useful in interpreting the data presented in the questionnaire.
- For questions dealing with financial information, please indicate the currency in which the data is supplied.

We encourage you to consult with colleagues in the relevant ministries/departments in order to complete the survey as fully and as accurately as possible. We further suggest that you start by liaising with the person responsible for submitting Education statistics and the person responsible for compiling health statistics as much of the statistical data should be available from them.

All **queries and requests for clarification** should be directed to **Leon Charles** at Tel: 473-407-3054; Fax: 473-442-4681 or e-mail progman@caribsurf.com.

Thank you in advance for your assistance.

**SECTION 1 – EVOLUTION OF POLICY AND PROGRAMME DEVELOPMENT**

1.1. Please provide a brief description of the evolution of ECCE Policy and Programme development in your country. Include in your discussion the origins of ECCE programming in your country and the main phases through which it has progressed to its current state. Clearly identify the year in which a formal policy development process was initiated, the reasons for that initiative and the results to date.

_____

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1.2. Please indicate in the following table the main factors and influences that have **enabled** progress of ECCE Policy and Programme development in your country?

| **Main Enabling Factors/Influence** | **Description of Impact on ECCE Provision** |
|---|---|
| | |
| | |
| | |
| | |

1.3. Please indicate in the following table, the main factors and influences that have **hindered** further development of ECCE Policy and Programme development in your country?

| Main Hindering Factors/Influence | Description of Impact on ECCE Provision |
|---|---|
| | |
| | |
| | |
| | |
| | |

1.4. Please indicated in the following table **any new initiatives** that have been taken in ECCE in your country in the period **January 2000 – December 2005**? Why were these initiatives taken? What have been the results/impacts? (***Please use additional sheets of paper if necessary***)

| New Initiatives | Rationale for Initiatives | Results/Impact | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

1.5. What **new initiatives** are planned for **2006**?

| New Initiatives | Rationale for Initiatives | Expected Results/Impact | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Section 2 – DESCRIPTION AND GOVERNANCE OF ECCE PROVISION

2.1 Please indicate in the following table the different types of Early Childhood Care and Education programmes in your country e.g. Day Care, Nursery, Preschool, etc. Please include separately any programmes specially designed to provide services to poor and vulnerable children, children with special needs and children with disabilities. (***Please add to the number of rows in the table as necessary***)

| Type of Programme | Age Group Served | Brief Description of Services (including duration of program on a daily, weekly and annual basis) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

2.2. Please indicate in the following table, the number of institutions involved in providing services in each of the programmes identified e.g. How many basic schools are there? How many community based day care services are there? and the like. Please also indicate the distribution among the different types of owners e.g. Government, Private Sector, NGOs,

| Type of Programme | Number of Institutions (Total) | Government Owned | Privately Owned | NGO | Community-Based | Other (Please Describe) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

2.3. Please indicate in the following table, the rural/urban distribution of the ECCE institutions described in 2.2. (Urban is defined here as within the environs of the capital city and other major commercial centres within the country. ***Please attach an explanatory note in your submission***).

| Location | Number of Institutions (Total) | Government Owned (Total) | Privately Owned (Total) | NGO (Total) | Community-Based | Other (Please Describe) |
|---|---|---|---|---|---|---|
| Rural | | | | | | |
| Urban | | | | | | |
| Total | | | | | | |

2.4. Is there one government ministry, or department with overall responsibility for the management of early childhood care and education services? □ Yes □ No

*If **YES**, answer **2.5.** and then **go straight to 2.7**.*

*If **NO**, please **skip 2.5** and **continue with 2.6** **onwards***

2.5. **If YES to 2.4**:

(a) What is the name of the Ministry or department? _____

(b) How many officers employed in that department are working full time in ECCE?_____

(c) Briefly describe the role of these officers _____

_____

_____

_____

_____

_____

_____

_____

_____

**NOW GO TO 2.7**

2.6. **If your answer to 2.4 was NO**:

Please indicate in the following table the relevant ministries that are responsible for the different services identified in Question 2.1.

| **Type of Programme** | **Responsible Ministry and Department** | **Number of Full time ECCE Officers** | **Role of Officers** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2.7. Please indicate in the following table the regulatory environment governing the provision of Early Childhood Care and Education services, by answering either **Yes** or **NO** for each of the programmes identified in Question 2.1.

| **Type of Programme** | **Are <u>Licenses</u> Required to provide these services?** | **Are there <u>formal</u> regulations in force governing the provision of these services (specify Act of Parliament and Date)** | **Are these programmes Monitored and Evaluated (Describe below)** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Description of Monitoring and Evaluation (M&E) Processes (***Please include details on the methodologies used for monitoring and evaluation and the frequency with which individual service providers are visited for M&E purposes):***

_____

_____

_____

_____

_____

_____

_____

General comments on any other aspect of the information contained in the table above:

_____

_____

_____

_____

**SECTION 3 – PARTICIPATION IN ECCE PROGRAMMES (For this section, please use data applicable for December 2005, or December 2004, if 2005 data is not yet available. Please indicate the year in the space provided and ensure that <u>all data provided is applicable to that year</u>).**

***Year for which data is being provided: _____***

3.1. What is the age at which Compulsory Education begins in your country? _____ yrs.

3.2. What is the stipulated age for entry into grade 1 (primary education) _____ yrs.

3.3. How many children were there in the national population as per the age and gender categories contained in the following table? (This data may be sourced from the National Statistical Departments and should be current based on the results of **the most recent** National Census.)

| Age Group | Male | Female | Total |
|---|---|---|---|
| Less that 1 Year | | | |
| 1 Year | | | |
| 2 Year | | | |
| 3 Years | | | |
| 4 Years | | | |
| 5 Years | | | |
| 6 Years | | | |
| 7 Years | | | |
| 8 Years | | | |
| **TOTAL** | | | |

3.4. Please indicate in the following table, the numbers of children enrolled in each of the programmes identified in Section 2.

| Type of Programme | Age Group Served | Total Enrollment | # Male | # Female |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **TOTAL** | | | | |

3.5. Please indicate in the following table the number of children **enrolled in the regular programmes** with **identified special needs**.

| Type of Programme | Cognitive Needs | Language Needs | Social/Emotional Needs | Physical Needs | Sensory Needs | Other Needs |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **TOTAL** | | | | | | |

3.6. Please indicate in the following table the distribution of enrolment by the nature of the ownership of the service provision.

| Ownership | Total Enrolment | # Male | # Female |
|---|---|---|---|
| Government Owned | | | |
| Privately – Owned | | | |
| NGOs | | | |
| Community-Based | | | |
| Other | | | |
| **TOTAL** | | | |

3.7. Please indicate in the following table, the rural/urban distribution of participation in ECCE programmes. (Urban is defined here as within the environs of the capital city and other major commercial centres within the country. ***Please include an explanatory note in your submission***).

| Location | # Children in eligible for ECCE services | # Children enrolled in any ECCE Programme | # Children in Government Owned Institutions | # Children in Privately Owned Institutions | # Children in NGO - owned Institutions | # Children in Community-based Institutions | # Children in Other Institutions |
|---|---|---|---|---|---|---|---|
| Rural | | | | | | | |
| Urban | | | | | | | |
| **TOTAL** | | | | | | | |

***<u>Note</u>: For Column 2, please include # children in population that are below the age of entry into Grade 1. If the Grade 1 age of entry is 5 years, then use the number of children below 5; if the Grade 1 age of entry is seven years, then use the number of children below 7.***

3.8. Please indicate in the following table, the adult/child ratios used for regular ECCE programming – public/private (please separate programmes by differences in stipulated adult/child ratio)

| Type of Programme | Age Group Served | Total Enrollment | Total adults employed | Actual Adult/Child Ratio | Stipulated Adult/Child Ratio |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL** | | | | | |

3.9. Please indicate in the following table, how the Stipulated Adult/Child ratios are adapted for children with special needs

| Type of Programme | Age Group Served | Total Enrollment (Special Needs) | Total adults employed | Actual Adult/Child Ratio | Stipulated Adult/Child Ratio |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL** | | | | | |

3.10. What is the minimum academic qualification required for **lead staff** (supervisors, teachers or caregivers with responsibility for a group of children) to work directly with children?
*Check one box for each row*

| Type of Programme | None | Some primary | Completion of primary | Some secondary | Completion of secondary | Some tertiary | Other – please specify |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

3.11. What is the minimum academic qualification required for **support staff** (e.g., assistant to teachers or caregivers with responsibility for a group of children) to work directly with children? *Check one box for each row*

| Type of Programme | None | Some primary | Completion of primary | Some secondary | Completion of secondary | Some tertiary | Other – please specify |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

3.12. Please provide in the following table a sampling of the annual expenditure incurred in providing ECCE services in your country. Use one typical centre/service provider for each type of programme. Please provide rationale choice of centre/service provider. **Please provide data in local currency**.

| Type of Programme | Total Government Funding | Total Owner Investment | Total Fees paid by Parents | Total Fund Raising | Total Grants and Donations | Total In Kind Contributions | Total Other |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **TOTAL** | | | | | | | |

Rationale for selection:_____

_____

_____

_____

Prepared by: _____ (Name)

_____ (Job Title)

_____ (Name of Ministry or Department)

_____ (Country)

_____ (Date)

## ANNEX 1

## DEVELOPING AN EFFECTIVE EARLY INTERVENTION SYSTEM
## The St. Lucian Experience

An effective early intervention system consists of a structured assessment system and the availability of services for treatment and follow-up of children identified with developmental delays.

### BACKGROUND TO THE INTERVENTION

Structured developmental assessments started in St. Lucia in the late 1980s and consisted of routine checks of weight for height, head circumference and basic vision and hearing tests. These checks were conducted when children were brought in for immunisation during their first 18 months. Outside of this, children with developmental delays were only identified when problems were noticed at school or at home and the children were referred for further diagnosis and treatment. For children identified through these processes, there were limited services and no therapists e.g. speech and language therapists, pediatric physiotherapists or occupational therapists on the island.

The need for further assessment and the development and implementation of an individual intervention/treatment plan by a multi-disciplinary team of professionals at the Centre was the rationale for the initiative in 1997 to start the Child Development and Guidance Centre in St. Lucia.

### THE INTERVENTION

The CDGC is a registered non-profit organisation affiliated to SLADD, St. Lucia Association for Developmental Disabilities and its main source funding is from short term private grants, in kind donations and contributions secured mainly in Europe.

#### Developing and Strengthening Developmental Monitoring Processes

Since its formation in 1997, the Centre has worked with the Ministry of Health to strengthen the developmental screening processes. In 2001, a grant of US$10,000 was received from the Dutch Government which financed a series of workshops during the 2001 – 2003 period for nurses and community health nurses on methodologies of developmental assessments. It also supported the provision of an early intervention kit in each of the medical centres across the island. These kits are used to perform a comprehensive developmental check on children at 6 weeks, 8 months, 3 years and 5 years. Any children identified as having problems are immediately referred to the CDGC for follow-up.

#### Treatment and Follow-up

The CDGC provides a multi-disciplinary team that consists ideally of a paediatrician, a paediatric physiotherapist, a speech and language therapist and an occupational therapist. The physiotherapist is being paid by the Ministry of Education. Volunteering therapists from England, USA and Germany support the team as frequently as possible. All members of the team also give extra time to the project. In order to make these services available for all needy children

there are no fees /charges for assessments and therapy sessions for parents referred by health centres. Parents are however invited to make a contribution.

Since its establishment in 1997, the CDGC has assessed and provided therapy to 380 children from across St. Lucia. It has also been active in programs aimed at increasing community awareness of children's needs, including broadcast of 14 radio programs; training of individual caregivers and community health aides and nurses at annual summer camps; and provision of equipment like therapeutic chairs, wheel chairs, crutches and other physiotherapy materials to individuals and institutions in need.

**CHALLENGES**

The major challenge facing the system is one of sustainability. The CDGC is the technical support arm of the entire developmental monitoring system, ensuring the continuing development of the monitoring processes and skills and providing the follow-up treatment and support. However, the CDGC is an independent non-profit organisation, staffed mainly by expatriates and supported financially by charitable funding from abroad. Efforts to get the government to integrate it within the Ministry of Health and therefore assume financial responsibility for its operations have not been successful to date, despite the critical role that it plays within the St. Lucia Health system.

## ANNEX 2

## INTEGRATED SERVICE PROVISION
## A Pilot Project from Suriname

### BACKGROUND

One of the Issues identified in the Caribbean Plan of Action was the need for increased access to integrated services and support for the benefit of the child.

This need was premised on the fact that Early Childhood development had to address that all round development of the child – physical, emotional, cognitive, creative, and the like. Addressing these developmental needs requires access to the following minimum services:

- *Disease Prevention* – usually through the provision of immunisation services.
- *Nutritional Development* – through monitoring for underweight, obesity, malnutrition and iron deficiency and initiating remedial action where necessary.
- *Developmental Monitoring and Early Intervention* – to identify and respond to problems with hearing, sight, rates of growth and the like.
- *Early Stimulation* – to facilitate social, emotional and cognitive development.

These services are traditionally provided by many different players and the existing reality was typified by the following features:

- Fragmentation and Duplication of service delivery systems;
- Lack of cooperation, coordination and convergence between government programs;
- Lack of integrated approaches at management level; and
- Lack of service provision in one or more of these areas.

This case will examine the efforts of Suriname in addressing this need for the provision of a holistic service to parents and children.

### RATIONALE FOR THE INTERVENTION

In Suriname, primary health care is the responsibility of the Ministry of Health executed by several actors including private practitioners and non-governmental organizations. All of these actors have a part in providing care throughout the first 4 years of life of the approximately 10,000 children born each year in Suriname. Most deliveries take place within the hospitals and some 15% take place within health centres in the rural areas and the interior, or at home. Trained health workers, mostly midwives, attend almost all deliveries. After delivery, parents take their

children to so called Under Five (U5) clinics, though most children will visit them only in the first 18 months.

The Bureau of Public Health (BOG) is the designated department of the Ministry of Health with responsibility for development and monitoring of policy and practices aimed at protection and improvement of the health of all people in Suriname.

The Unit for Under Five care in the BOG is responsible for development of adequate policy and practices aimed at improvement of the health of children under five. Their mandate includes guidance and training of health workers and day care centre workers.

The Unit for Under Five care decided that there was a need to initiate urgent action to improve the care provided to children and women. This decision was based on the following factors *inter alia:*

- *The status of key child indicators (2000)* such as the IMR (22.8), the PMR (29.8) and the MMR (>8.7).

- *A lack of sufficient, up-to-date knowledge and skills among care providers* in the area of growth and development monitoring, early detection and guidance for under-fives.

In 1998, an assessment was conducted in 20 under-five clinics. It showed that health workers did not have proper criteria or routines for growth monitoring/interpretation, or adequate advice concerning feeding of the young. It was a matter of instruction and not of education, or guidance to parents of young children.

There was no proper or adequate attention for developmental screening.

Although a team in most U5 clinics officially consisted of a registered nurse/nurse-aid and a medical doctor (MD), the latter, if present, paid almost no attention to healthy children. They saw children mainly for physical screening when vaccination should be administered (3$^{rd}$ month DTP1/OPV1 and 12$^{th}$ month DTP1/OPV & MMR). Their focus is mainly on children that were referred to them by the nurse, in case the nurse felt a physical examination was necessary because of illness, or insufficient growth.

In general the emphasis in Under five clinics was mostly on vaccination (97%), the physical examination (94%) and feeding practices (87%).

Attention for feeding practices concerned questions and instructions about what food the child gets/ should get and not the frequency, the quality or whether it met the child's need and how to evaluate the child's needs. This left in the risk of under nutrition, especially when criteria for evaluating growth were not clear.

Nurses had the main responsibility for these activities in the U5clinics. MD's confined themselves to the physical examination of healthy children.

When observing the growth of children visiting the clinics, it showed that most children grew below the 50th percentile and that more than 50% of the curves had a slope, which was not parallel to the reference.

Observing parents and children in waiting rooms showed that there was little verbal or other communication between them. Most of the parents did not bring with them a toy, or enough food and drinks for the children though waiting times varied from 45 minutes to 135 minutes, with an average of 88 minutes.

Meetings with the staff of the under five clinics showed that there was some routine in the activities (weighing and questions about feeding) within the clinics. But the workers had no overall view/ vision of the importance and value of the activities within the under five care clinics for the development of the children's full potential e.g. there was hardly any knowledge of the impact of early development on the lives of children/ people, let alone that this aspect was emphasized.

In general the nurses at the U5 clinics asked parent questions concerning developmental milestones, but did not know how to value this, or what advice to give. Most MD's in U5 clinics did not pay attention to development. In a questionnaire they filled in themselves, 75% paid attention to motor development, 40% to speech / language development (though only 10% ever inspected the tympanic membrane), 4% to safety and 25 % to parent child interaction.

It is not strange then that children with developmental problems are not referred to developmental specialists, speech therapists, psychologists, or physiotherapists by U5 health workers, although children pay an average number of 5 visits to the clinics from month 2 to 12.

**THE INTERVENTION**

Based on the above, the Unit for Under Five care initiated a process with the following objectives:

- *To increase knowledge and skills of medical doctors and nurses working in under-five clinics* to adequately monitor the growth and development of under fives in an early stage (*growth and development*), detect and guide deviation from the normal; and

- *To enable care providers to properly advise and guide parents of* children under five to feed and care for their child (*nutrition, early stimulation, safety and disease prevention*).

The overall strategy of the intervention was to empower the health professionals in the Under-Five clinics to provide an integrated service to the parents who visited the clinics and to pilot test in two clinics.

**Training**

The training focused on providing Medical Doctors (MD) with the basic knowledge needed to monitor healthy children and place more emphasis on developmental evaluation. To be able to do so, the MD (and afterwards the nurses working with them) received basic information

concerning normal development in the field of motor, emotional and social development, speech and adaptation. The training elaborated on how to evaluate normal development and detect early signs of disturbances and how to make parents aware of the importance of normal development and early stimulation and on how to make use of diagnostic networks

In the first year, 28 MD's attended and 24 participated in at least 50% of the sessions; 17 of them received a certificate for 80% attendance. The following year, 26 medical doctors started the training, of which 22 attended at least 50% of the sessions and 60% received a certificate for 80% attendance.

Nurses working with MD's participating in the training were offered training in the first year. 23 nurses of U5 clinics and 8 nurses of the Bureau of Public Health participated. 25 received a certificate for 80% attendance.

The participants expressed appreciation for the new knowledge and tools concerning care for healthy children, with emphasis on early child development. Many of them gained new insights in the importance of:

- Their input in the field of under five care (monitoring, screening, guiding parents, team meetings, administrative restructuring).
- Continuing the activities concerning growth and development monitoring even after the administration of the final vaccination in this age group up until at least 4 years of age.
- The importance of early child development and the impact of their attention in this field.
- Parents knowledge about normal growth and development, about parenting and health workers' possible influence therein.
- Putting more emphasis on the above mentioned and achieving a more balanced approach in the activities in under five clinics.

**Pilot Implementation Projects**

A pilot project to transfer the skills learnt into practice was followed the training. The objectives of the pilot were:

- To make an effort into introducing a new strategy in under five care;
- To improve growth and development monitoring and parental knowledge concerning the health of their offspring;
- To guide the trainees in the field during their actual work in under five care; and
- To have some training days throughout the year to evaluate and add necessary information.

In this pilot, a special team consisting of one MD and one or two nurses were assigned to deliver preventive U5 care exclusively, in two selected U5 clinics. The pilot sought to improve and reorganize the functioning of the under-five clinics to accommodate implementation of what was presented during the training and to make the care more parent- and child friendly. Activities included selection, procurement and installation of child friendly furniture and toys, procurement and use of developmental monitoring and screening material, and weekly monitoring and support visits by the BOG staff.

The pilot also included the following changes to the modus operandi at the U5 clinics:

- Assigning specific tasks to the nurses and to the MD, with clear instruction about how to handle overlapping aspects of care.

- Changing the procedures - from a system in which every client with an appointment registered from 07.00 am to 09.00 am to one where every client had a specific time to register. The parent and child received care within 1 hour and left.

- Making better use of the growth chart and filling in all the required information - (pregnancy, delivery, family history); proper attention to vaccination status (fill in the type of vaccine only after administering the vaccine) and plotting in of weight.

- Proper techniques and criteria for evaluating growth: accurate weighing, immediate and accurate plotting and proper interpretation according to instructions from training material.

- Proper use of the growth chart and writing down more detailed information concerning the visit.

- Putting more effort into building a relationship with parents by respecting privacy during the visits, by focusing on listening to the parents and encouraging them to tell and ask questions.

- Informing parents according to their level of understanding and education.

- Aiming at having and using adequate and proper knowledge of normal growth and the conditions for healthy grow in every stage from 0-4 years of age e.g. how to evaluate growth properly and how to inform parents about the growth of their child; how to educate, support and guide parents to have proper feeding practices within their economical possibilities/reach; and informing them not only on what the child needs, but also how much, what frequency, how to prepare it and how to establish a stimulating environment.

- Striving for, having and using adequate and proper knowledge of normal development and evaluate parent-child interaction. Discuss the findings with parents and advise and

guide them on how to stimulate their children in the different stages of development and how to create a safe and stimulating environment.

The above changes resulted in the clinic visits becoming more intensive and interactive and a limit had to be placed on the number of visits to guarantee quality of care (15 minutes for consultation with the nurse, in series with 15 minutes for consultation with the MD).
Every week there were team meetings:

- One week with all of the nurses, the MD and the guidance staff member of the BOG to:
    - Evaluate the progress in administrative changes and new measures introduced.
    - Solve problems encountered and make adaptations.
    - To practice with information from the training - in rotation each nurse had to prepare a presentation concerning one of the subjects from the training after which questions were posed, discussion occurred or role-play was performed.
    - To discuss interesting cases that presented themselves during clinic hours, or because of which questions had arisen.
- The other week with the MD and the guidance staff member of the BOG to:
    - Evaluate progress and difficulties in applying the new system and managing the team.
    - Discuss special, interesting or difficult cases concerning growth, development, parenting or vaccination practice and discuss development monitoring and interpretation.

Twice the team organized and executed educational activities for a group of parents:

- Informing young mothers about breastfeeding.
- Informing parents with children in the age group 1-2 years of age, about development of will- power and discuss with them and amongst them their experiences in dealing with it.

## RESULTS

### *Under 5 Clinics*

The pilot had a great impact on the functioning of the U5 Clinics, because some form of specialization took place. These included:

- The MD’s who were not assigned to the project focused on curative care only and organized their clinic hours better.

- These MD's noticed that they saw less sick children in the age group concerned and when parents brought their children because of illness they were well informed about how to deal with aspects like feeding during illness and fever.

The change in the system resulted in some nurses feeling left out, because in the old system every nurse carried out one or two aspects of care during U5 clinic hours. Some of them in were not pleased in the initial stages at having being left out of U5 care. These feelings subdued after a while when it became clear that there were other activities requiring their involvement.

This is one aspect of the pilot it was learnt that it is best to introduce changes, after having not only informed, but also explained to all concerned.

***Pilot Team***

The pilot- team members at first felt uncomfortable and insecure about their new activities. The team meetings helped resolve this problem, because in the first meetings much attention was paid to case-discussions and role-play.

Initial difficulties in implementation were encountered, including:

- Lack of adherence to the time schedule by clients, because the latter did not believe that they would receive care timely and registered according to the old system (first in, first out).

- Being accurate in administrative procedures, because in the old system, several health workers carried out different aspects of care on one and the same infants. Now every aspect was the responsibility of the nurse and the MD as a team.

- Respectfully listening to parents and training oneself to have an open communication. Until the training and especially the pilot, the communication between healthcare worker and client/ patient was quite authoritarian.

- Educating parents according to their needs instead of instructing them.

Gradually the team members felt more secure and enjoyed their new relations with parents and children.

They also enjoyed the fact that there were noticeable changes in attitudes of parents toward the U5 clinics. Parents came in time for their visits and they made use of information concerning feeding practices and development.

Team members gradually felt very much at ease with this way of working and would like to keep this system going. They noted that it is far better to have enough knowledge in a specific field and to be able to support parents and children in an adequate way, than to be superficially involved in a mixture of primary health care activities.

Team workers noticed clearly that child growth improved and children with inadequate growth were asked to return earlier then the regular appointment. Though it was thought that parents would not keep these extra appointments, almost all parents returned on time. Because there was far more explanation to parents concerning growth and development of their children, parents also took more interest in how well their child was doing.

***Parents***

Interviewing parents who had experienced the new system produced a number of positive responses. These included:

- Appreciation that they spent less time in the U5 clinic than before. They were able to do a better planning of their day and working parents did not need to take the day off anymore.

- A feeling of being more involved in the well being of their children, because they were better informed by the health workers and received even more explaining and special attention, if necessary.

- They appreciated the attention from the MD and felt free to ask questions, even if it did not concern that specific child, or the specific situation at that time of the visit.

## ANNEX 3

## FORGING A REGIONAL UNDERSTANDING ON LEARNING OUTCOMES

### INTRODUCTION

Strategies to support learning across the Caribbean region have been developed successfully at secondary and tertiary levels, by educational institutions and governments in dialogue with the churches and educational foundations that support the education system. For example, the University of the West Indies is a regional institution supported by 15 participating countries and States with campuses in three countries and distance learning centres in others. The Caribbean Examinations Council supports qualifying examinations in secondary schools in 16 participating countries, blending regional requirements for consistency with national concerns reflected in syllabus content and coursework options. In recent years, a regional qualifications framework has been adopted by CARICOM representing 15 Member States and 5 Associate Member States to facilitate the harmonisation of training, progression routes and service standards across the Caribbean Single Market Economy (CSME)[61]. From the perspective of early childhood advocates in the early 2000s, therefore, it was only a matter of time before the diversity and commonalities within the region's populations and cultures could be articulated throughout the other phases of learning including primary and early childhood.

### OPPORTUNITY FOR DIALOGUE

A golden opportunity arose in 2001 during the design stage of a regional technical assistance project[62], the Child Focus II Project, to explore the potential for taking a regional approach to learning in early childhood. It was seen as a means of bringing together into one regional discussion, several development priorities, namely:

- To support development in the very early years from ***birth to three***. This had become a major concern for policy and practice since the results of recent brain research had become more widely known and appreciated following Fraser Mustard's presentation at the regional early childhood conference in 2000.

- To infuse early learning approaches and content into largely custodial programmes of learning in early childhood settings in day care centres and preschools for children predominantly in the ***three to five*** age group.

[61] The CSME is "removing all obstacles to intra-regional movement of skills, labour and travel, harmonising social services (education, health, etc.), providing for the transfer of social security benefits and establishing common standards and measures for accreditation and equivalency" (www.caricom.org/singlemarket)

[62] Strengthening early childhood in the Caribbean: Child Focus II Project. ATN/SF-7526-RS. Technical cooperation between the Inter-American Development Bank and the University of the West Indies/(UWI) through the Caribbean Child Development Centre (CCDC), School of Continuing Studies (SCS) in collaboration with project partners UNICEF Eastern Caribbean Office (ECO) and Caribbean Development Bank (CDB) (2001-4)

- To advocate for early childhood methodologies to inform curriculum reform in early primary education. Most of the primary sector reform projects in the region had progressed without input from early childhood thinking on the need to address transition from early childhood settings into primary school settings through harmonized curricula and learning approaches for children in the age group ***five to seven*** years.

**APPROACH TO THE TASK**

The Caribbean Plan of Action for early childhood care, education and development 1997 (CPOA)[63], guided the approach taken to the task by the Child Focus II Project. Three important conceptual decisions were made at the outset of project work:

- To develop a framework for learning in early childhood from birth through to eight years in order to address the piece-meal and isolated approach to the different age groups. However, pragmatically, we decided to do this in three overlapping segments to reflect the realities of the social and education structures that support learning in the region: birth to three years in day care or home visiting programmes; three to five years in day care and preschool settings; and five to seven years in the early years of primary schooling.

- To address directly the work of caregivers and early childhood practitioners in support of children, with a focus on involving parents and community. Our work would therefore address the issue of parenting only indirectly.

- To claim the concept of a 'curriculum' for children from birth to eight as an all encompassing term to describe '***what*** and ***how*** a child ***learns***'. In so doing we had to ensure that this did not backfire and intimidate the process through association solely with 'what is taught'. This was a tricky decision; although it made the work comfortable and accessible for those working in schools and to an extent in preschools, it was initially, at least, an alien concept for practitioners with children birth to three years of age.

To commence the regional discussion, the Child Focus II Project appointed a small team of persons in 2003 to prepare for a regional workshop, inviting two representatives from each of eighteen[64] CARICOM countries to participate with a group of regional early childhood specialists in child health and development, preschool education, teacher and practitioner training, care of children from birth to three and in research on the quality of early learning environments in the region. A review of the international examples of 'frameworks of support' for children in their early years and of 'foundation' or early childhood curricula was undertaken by an experienced practitioner and teacher trainer in the region. She also undertook seven

[63] Section 7 of the CPOA is: *PROMOTE the child's learning and development in community pre-school settings.* Two main goals in this section are: REFOCUS pre-school settings to be developmentally and culturally appropriate and SUPPORT process of developing child centered curricula with practical support tools and materials

[64] Two could not participate: Haiti because of the national crisis at the time and Bermuda because donor funding criteria do not include Bermuda.

country study visits in the region to identify best practices and what were the explicit or implicit learning goals and outcomes for children from birth to eight years of age.

This process clarified the objectives for the workshop and opened up the possibilities for developing a regional consensus. It was an exciting period in which two main dynamics were driving the process:

- The international literature on 'readiness' which, together with the research in Jamaica on 'what makes the difference in raising a child[65]' and the innovation of 'outcomes' or 'foundations' approaches to curriculum reform around the world, shaped our thinking and gave us a very interesting platform for the workshop. We realized we could focus our discussions on what we could agree were the fundamental pillars of early childhood learning and development and express this dynamically in the language of 'outcomes'. This we hoped could move our thinking on from 'aims' and 'aspirations' in early childhood learning to envisaging what we wanted for children's development without becoming trapped in the quagmire of the language of 'results' and 'testing'.

- The findings from the study visits which revealed not only a wide diversity of approaches and communities involved in early childhood service provision, but commonalities in values systems, concerns for children's development and in levels of support from communities for early childhood provisions for children.

Objectives for the workshop were developed as follows, to:

- Share the common goals, values, approaches and outcomes emerging from the best practices in early learning identified in the region.
- Develop a consensus on the foundations for learning by children in early childhood.
- Identify what is valuable and applicable for informing early childhood curriculum development at the national level.
- Strengthen regional cooperation and networking.

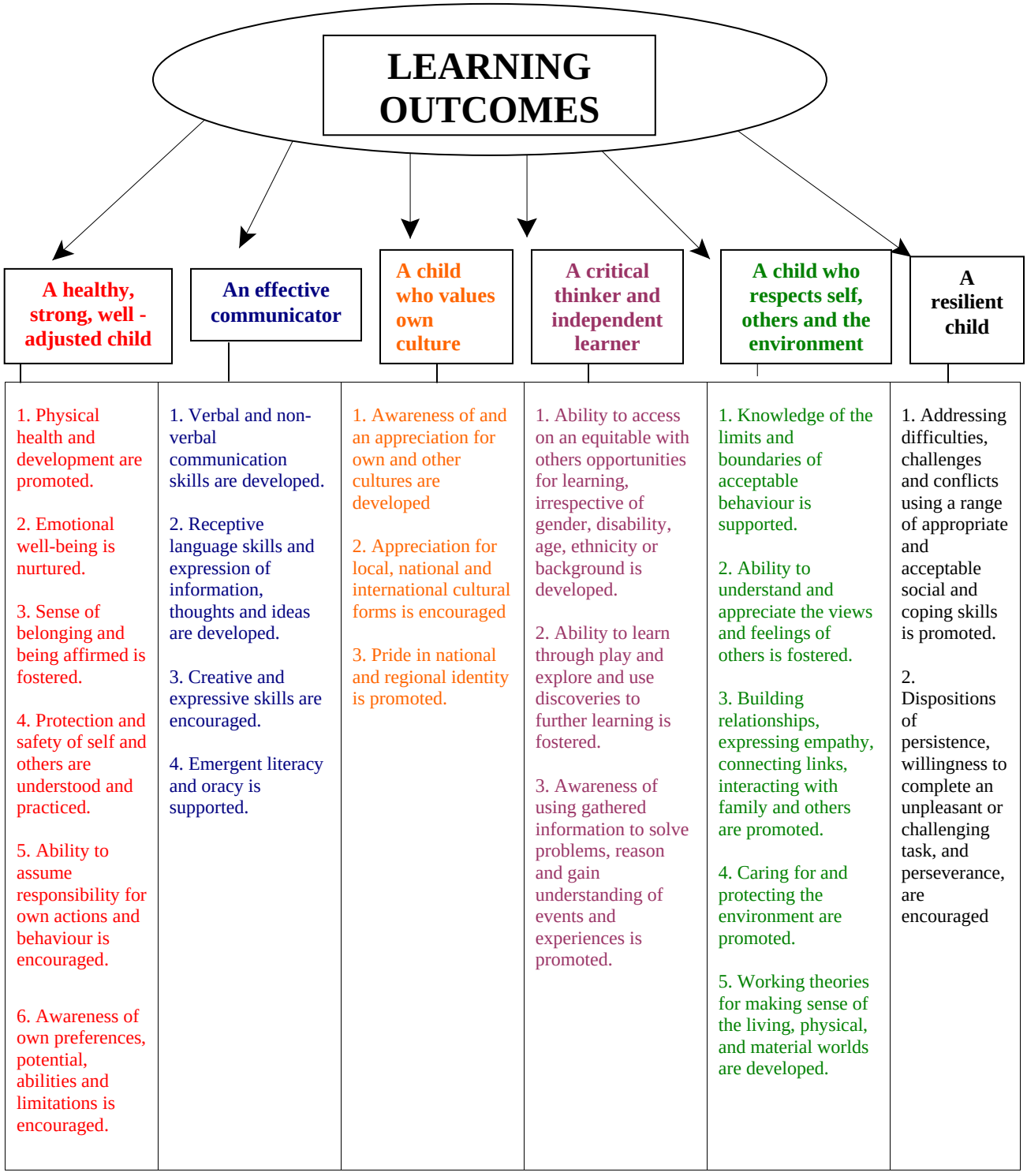
The workshop agenda was structured to introduce curriculum development as a process in which learning outcomes were located in the driving seat. The proposal to build a consensus on a framework for learning outcomes in early childhood was expanded in a sequence of sessions, each one building on the one before. The methodologies used were experiential in nature, designed to utilise the practical experiences of the participants and to assist them in internalising the understandings from research and the concepts being introduced. The workshop was held in 2004.

## PRODUCING THE REGIONAL FRAMEWORK

The workshop process was more productive than we had anticipated: a draft framework for curriculum development was fleshed out with key areas of learning and child development

[65] Samms-Vaughan, Maureen (2005) Profiles. The Jamaican Pre-school child. The status of early childhood development in Jamaica. Planning Institute of Jamaica, Grenada Way, Kingston 5, Jamaica (doccen@mail.colis.com)

expressed as ‘outcomes’. Participants also developed recommendations for how these outcomes could be used to drive the process of development of learning environments, organisation of schedules and daily activities, and curriculum content.



We were keenly aware however that the reality at the national level is that the sector is under-resourced in a number of ways – lack of trained personnel, lack of institutional supports and lack of finances. Even the participants themselves, in many cases, lacked the skills and capacities to move the processes forward, regardless of how much they may wish to do so. Implementation of the results of the workshop would therefore be dependent on the extent to which the national process could be stimulated and supported by ongoing initiatives and interventions at regional level.

**SUPPORT AT NATIONAL LEVEL**

In response to this reality, the Project designated additional resources to the production of a curriculum resource guide. Working within the framework developed at the workshop with the six groupings of outcomes (wellness, effective communication, valuing culture, respect for self, others and the environment, resilience, and intellectual empowerment) the resource guide models the progression of supports to learning through the overlapping phases of birth to three, three to five and five to seven years. In each phase the resource guide shows:


- Mileposts of development – what children are expected to do
- Signals of performance in learning settings – what we see children doing
- Signals of appropriate practices – what we can do to support children's development
- Signals of inappropriate practices
- Involving parents and community
- Useful supports and resources
- Supporting diversity and children with special needs
- Challenges and dilemmas faced - in the field
- What really works – in the field
- Examples of flexible learning environments (architect's scale plans and drawings were commissioned and reproduced based on designs by working groups at the workshop) and photographs of best practices across the region.

It is, most importantly, a document intended for the practitioner and the early childhood officer working with the practitioner.

Following dissemination of the workshop report in 2004, followed by the resource guide in print and on CD during 2005, the early indications at national level are that technical assistance is needed to make practical reforms in curriculum content, scheduling and organisation of environments, and supports to training and orientation of teachers and caregivers. There are two major challenges typically seen in countries in the region:

- Where countries were already (at the time of the regional process) in the midst of drafting detailed early childhood curricula – involving scope and sequence, detailed content and statements of requirements, lesson plans, daily activity scheduling of the most minute detail – these processes have continued, informed perhaps even enlightened by the regional process, but not either simplified or streamlined by it. Therefore in those instances curriculum tomes have been produced, impressive but not user friendly.

- Where countries had not commenced produced curricula, and wanted to use the framework and approaches suggested in the resource guide, there have been requests for help in 'implementation' rather than in the *development* of approaches to organisation and resourcing of learning environments, orientation of teachers and caregivers, review and possible harmonisation of existing materials and documented approaches and production of new ones to fill the gaps.

**WHAT WILL IT TAKE?**

Technical assistance will be needed at national level to steer the curriculum development process *over years*, including the establishment of specialist early childhood curriculum development units. We should not be surprised at this reality: primary curriculum units, secondary curriculum units and faculty/departmental curriculum development processes are institutionalized throughout the region's learning structures. It is just one more 'gap' in the provision of support to early childhood development that such specialized on going assistance is still considered a short term project not a long term structural necessity.

In summary, the task of effective early childhood curriculum development at national level will take sustained support and leadership to provide:

- Training of teachers and caregivers to provide skills and confidence in what it takes *in practice* to make the difference in children's learning in the management of learning environments, scheduling and securing parental involvement.

- Dedicated programmes to harmonise curricula, pedagogy and teacher training to ease transition between provisions for birth to three, three to five and five to seven years.

- Establishment and support for centres that can demonstrate effective curriculum practices, resource centres, mentoring arrangements and exchanges between centres for staff dialogue and learning.

- Quality Assurance mechanisms, such as an Early Childhood Advisers and an Inspectorate.