

# SUCCESS AGAINST THE ODDS

A Positive Deviance Study Of

**COMMUNITY-BASED CHILDCARE CENTRES IN MALAWI**

Wendy Fisher, Foster Kholowa, Khama Chibwana, and Lois Silo

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# ABBREVIATIONS AND ACRONYMS

ADEA	Association for the Development of Education in Africa
ADEA-WGECD	Association for the Development of Education in Africa – Working Group on Early Childhood Development
AIDS	Acquired Immuno-Deficiency Syndrome
APPM	Association of Pre-school Playgroups in Malawi
CBCC	Community-Based Childcare Centre
DSWO	District Social Welfare Office
ECD	Early Childhood Development
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
GoM	Government of Malawi
HIV	Human Immunodeficiency Virus
IECD	Integrated Early Childhood Development
IGA	Income-Generating Activity
KII	Key Informant Interview
MoEST	Ministry of Education, Science and Technology
MoHP	Ministry of Health and Population
MoWCD	Ministry of Women and Child Development
NAC	National AIDS Commission
NGO	Non-Governmental Organization
OECD	Organisation for Economic Co-operation and Development
TA	Traditional Authority
UNESCO	United Nations Educational Scientific and Cultural Organization
UNICEF	United Nations Children’s Fund

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*All mistakes in this report remain the responsibility of the consultants.*

# EXECUTIVE SUMMARY

## Introduction

Community-based childcare centres (CBCCs) are critical in providing early childhood development (ECD) services to children under five in Malawi. UNICEF Malawi has supported the Government of Malawi (GoM) to develop its ECD agenda and community initiatives to implement CBCC activities.

In 2006-7, the Ministry of Women and Child Development (MoWCD) and UNICEF carried out a national inventory of CBCCs in Malawi, which confirmed the need to improve the quality of services in most cases. However, the inventory also highlighted the fact that a few CBCCs manage to provide above average services to children.

This positive deviance (PD) study looks at why some CBCCs are more successful than others, despite operating under the same constraints.

## Literature review

The literature suggests that ECD is a developing field: many African countries have made considerable efforts to ensure that every child has the opportunity to develop optimally. International organizations played a crucial role in the early stages of ECD policy development in Africa, and integrated approaches have been widely adopted.

Reports from 11 African countries show that most have embraced an integrated approach to ECD, although they are at different stages with regard to policy formulation and implementation. It appears that deliberate efforts are being made to bring together the various services for children at all levels. Formal pre-schools are another approach to ECD.

The Malawi CBCC approach has been rated as a more successful ECD model, and the community-based and -managed approach has been suggested as a replicable model for other countries.

## Methodology

Positive deviance is based on the observation that certain individuals or entities adopt uncommon practices or behaviours that enable them to find better solutions to problems than neighbours with access to the same resources.

The definition of a 'positive deviant CBCC'<sup>1</sup> in this study is ***one which is consistently operational with children attending; has basic infrastructure; active and committed caregivers; some community involvement; and some level of resources including food, and kitchen and play materials.*** This study looked at 10 CBCCs - six positive deviant CBCCs and four poorly functioning CBCCs - across three regions and five districts of Malawi.

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1 PD CBCC; also referred to in this report as 'better' or 'well functioning'

This is a qualitative study using Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and Observations. KIIs were conducted with national stakeholders, including government ministries and international organizations, while FGDs were mainly conducted at community level with caregivers, CBCC committees, parents and guardians, and primary school teachers. Observations were done over two days at each CBCC. All the interviews and FGDs were tape-recorded and later transcribed, and the data were analysed qualitatively. Debriefing sessions were held daily during fieldwork to discuss the key issues emerging. The transcripts and notes were then studied to identify themes and categories which formed the basis of the findings.

The study was conducted during the rainy and lean season (February to March 2009); a time when many CBCCs are forced to close because of lack of food. The research team believes that any CBCC that continues to run during such a period is truly well functioning and will be likely to display even more positive characteristics outside the lean season.

## Findings at positive deviant CBCCs

### *Attendance (children and caregivers)*

As specified in the definition given above, all the positive deviant CBCCs had some children attending consistently during the study. However, the percentage of enrolled children actually attending varied from under 10% to over 50%. Children were mainly motivated to attend because these centres were providing food, and the fact that the CBCCs were still running at this difficult time of the year is noteworthy in itself.

The attendance of caregivers was generally high. In four out of six PD CBCCs, most of the caregivers were women.

### *Infrastructure and facilities*

Our definition specified basic infrastructure – in fact, the positive deviant CBCCs had permanent premises made of brick with concrete floors and either corrugated iron or thatched roofs. The buildings are specifically dedicated to providing CBCC services, but are often used by the community as a focal point for other development activities. One positive deviant CBCC hires out its hall to generate income.

The positive deviant CBCCs had reliable, readily accessible sources of safe water. Four had boreholes and two had access to running water. One CBCC had western toilets while the other five had blocks of pit latrines. With one exception, they were clean and child-friendly.

Better CBCCs had both indoor and outdoor play materials, including locally made items. All the positive deviant CBCCs had some cooking and eating materials, including pots, plastic plates and spoons.

### *Quality of care: caregivers*

Many of the caregivers at the positive deviant CBCCs have worked voluntarily for many years, for little or no reward. In two of the positive deviant CBCCs, caregivers receive a very small allowance every month. In other cases, volunteers from the CBO reward caregivers by helping in their gardens.

The caregivers at most of the positive deviant CBCCs have undergone ECD training, typically conducted by the District Social Welfare Office (DSWO) and usually for the recommended period of 12 days. A few had been trained beyond this level, and this was clearly reflected in improved activities, use of materials and interactions with children.

### *Quality of care: food*

Positive deviant CBCCs provide at least one meal a day (often vitameal or *nsima*<sup>2</sup> and beans) throughout the year. Children who arrive at these centres extremely malnourished are now healthy and strong due to the regular nutritious feeding they receive.

Most of the positive deviant CBCCs in this study have a communal garden, the produce of which contributes towards feeding the children. When the harvest is poor, the better CBCCs rely on both community contributions and food donations from NGOs and local organizations.

### *Management of CBCCs*

The management of positive deviant CBCCs has clear parental and community involvement, and there is often a link with a CBO or NGO. There may be a committed individual who inspired the activities of the CBCC.

Communities are involved in the running of a CBCC through the parent committee, which checks CBCC activities and the availability of food daily, helps the caregivers with cooking and other chores, and liaises with the other parents outside the committee. The committee of a positive deviant CBCCs usually makes financial or food contributions when necessary. At the better CBCCs, parents who are not on the committee also volunteer when needed to clean the CBCC surroundings, cook and help the caregivers.

Five out of the six well functioning CBCCs that we visited either fall under the management of a CBO or are helped technically and financially by an NGO which monitors the CBCC and significantly helps to source funds.

It was clear that the success of some CBCCs was strongly linked to the commitment of particular individuals, who were often instrumental in setting up the CBCC and were all involved in its day-to-day running. These individuals also had the skills and networks to access various kinds of support.

### *Community networks*

Positive deviant CBCCs were found to be linked to a number of partners that provide (or support the provision of) ECD-related services. Three of the positive deviant CBCCs were inextricably linked with their CBOs: these CBCCs are located at the CBO headquarters and effectively share both material and human resources with the CBO. All the positive deviant CBCCs are linked to and network with supporting organizations, either through the CBO or through a local or international NGO. In some cases the links are fostered through the skills and networking ability of committed individuals.

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2 Maize meal

Positive deviant CBCCs also have some links with other sectors (e.g. education, health and agriculture) that provide ECD services at community level. The most common partner linked to all PD CBCCs is the health sector, which provides under-five clinic services once a month at either the CBCC itself or the nearest primary school or clinic.

### *District networks*

At district level, the positive deviant example of networking among the different ECD stakeholders is Mchinji, where we found good collaboration in ECD service delivery. Various forums exist to address ECD-related issues, and the ECD stakeholders for Mchinji were devising a district children's committee to further enhance the effectiveness of their collaboration. The commendable way in which different ECD stakeholders collaborate with each other is in part attributed to the District Assembly leadership.

### *National networks*

The ECD policy spells out the type and quality of services that should be provided to children in Malawi, and stipulates the structures through which different stakeholders should collaborate to maximise ECD service delivery. Other documents exist to guide the translation of policy into implementation.

Most stakeholders at national level are knowledgeable about ECD policy; networking between ECD stakeholders happens to some degree through the National ECD Network.

### *Sustainability*

The positive deviant CBCCs sustain themselves in a variety of ways. Four out of our six PD CBCCs rely on their communal gardens to feed the children and often sell excess produce to generate income. Support for fertiliser is often received, either from the community or from external organizations. Some communities make food and / or financial contributions to the CBCC when possible.

Most of the better CBCCs in this study had very humble beginnings and have reached their current level through the support received from various organizations. Indeed, external assistance is a significant factor in how our PD CBCCs continue functioning and providing meals. These organizations also support caregiver and committee training, and communal garden projects. A few CBCCs attempt income-generating activities to improve their sustainability.

### *Factors shared by positive deviant CBCCs*

To summarise the above findings, the positive deviant CBCCs in this study have several things in common, all of which appear to be important in allowing them to do better than the average. The better CBCCs:

- are affiliated and / or directly linked to a CBO or NGO;
- have strong leadership, often in the form of a committed and dynamic individual;
- have committed and dedicated volunteer caregivers (usually women) who have undergone at least one 12-day ECD training course;
- rely on diverse means to mobilise funding and support for sustainability;
- benefit from some level of stakeholder collaboration and coordination at both community and district levels.

## Findings: challenges facing all CBCCs

### Seasonal issues

Attendance at CBCCs is greatly affected by the seasons. The serving of at least one meal a day is a significant factor for parents sending their children to a CBCC and if no food is available attendance declines dramatically or the CBCC closes. This was an issue even at positive deviant CBCCs. Low attendance may also occur when parents are busy in the fields and are unable or unwilling to escort their children to the CBCC. At the lean time of year, parents (and indeed children) may be too hungry and weak to walk long distances. Finally parents do not want their children to walk far in the rain, particularly if they have to cross flooded rivers.

Intermittent caregiver attendance and the closing of CBCCs was blamed on the lack of incentives for caregivers and their need to work in the fields or do piece work during difficult periods of the year.

### Health and safety

Our observations highlighted a number of health and safety issues. Access to safe water is a significant problem for some CBCCs. We rarely saw children using the latrines even when there were latrines available, but instead we saw many children using the surrounding areas of the CBCC. Moreover, in many CBCCs the surrounding environment needed attention (cutting grass, ensuring proper drainage of rainwater, etc.).

Although the children washed their hands before eating at every CBCC we visited, the standard of hand washing varied. We never witnessed children washing their hands after going to the toilet.

Some CBCCs do not have a kitchen and food is prepared, cooked and served outside in the open.

### *The voluntary nature of caregiving*

In many CBCCs the caregiver turnover is high due to a lack of benefits and, in order to retain caregivers, it was suggested that incentives be given. Many caregivers, particularly those who have worked for many years, hope and believe they will eventually receive some sort of tangible reward for the work they do.

### *Training: caregivers*

The high turnover of caregivers necessitates the recruitment of new caregivers who, in turn, require training. However, the recommended 12-day training course covers a lot of information and caregivers, who themselves may have received very little formal education, may be unable to apply what they have learned. Regular supervision, followed by frequent refresher training courses, is needed to give caregivers the confidence and skills they need to apply what they have learned.

### *Training: parent committees*

Most parent committees at the ten CBCCs we visited (including the positive deviant centres) were weak and had not been trained. Many members freely admitted ignorance of their roles and said they did not know how to run a CBCC. Committee members generally do not have the skills and knowledge to network with other stakeholders. This problem is compounded by the frequency with which new committees are elected and the lack of standardization in the length of a term for a committee.

### *Sustainability*

A major challenge for most CBCCs is how to support themselves. For true sustainability, CBCCs need several sources of funds and support, including access to a variety of income-generating activities (e.g. farming, a maize mill, or livestock production). A communal garden is vital, but not all CBCCs have them (only four out of the six positive deviant CBCCs and two of the developing CBCCs in this study, for instance). CBCCs that do have gardens may be unable to afford fertiliser, so yields are low. For these and other reasons, many CBCCs would not survive without the support of an outside organization.

### *Monitoring and support*

In most cases there is little or no monitoring of CBCCs, partly due to weak coordination of services at community and district levels. CBCC committees, mostly lacking training, do not monitor activities effectively (if at all), and community extension workers from the relevant line ministries are not brought in to help. Where monitoring does take place, it is often simply a formality.

### *Stakeholder coordination and collaboration*

For all the CBCCs visited there is a clear lack of collaboration between ECD stakeholders at both community and district levels. In some cases community ownership of a CBCC is diminished if the CBCC is affiliated to a supporting organization. At district level there is a reluctance to step into another sector's territory: staff from different sectors or departments find it difficult to work together. Reasons cited for this poor collaboration include lack of capacity and resources.

### *Transition to primary school*

It is clear that there are few, if any, links between CBCCs and primary schools. Many teachers do not know that there are pre-school options apart from private nursery schools; others have heard of CBCCs but think of them solely in terms of orphan care. However, it was recognised that cooperation would benefit both teachers and caregivers, and would make the transition to primary school easier for children.

Despite the lack of links, teachers can usually identify children that have come from CBCCs, because they are often easier to manage. And, according to the teachers, children from CBCCs were usually far ahead of their fellow pupils educationally. However, many teachers do not know how to manage different ability levels in their classrooms. There is the real possibility, therefore, that a child's flourishing potential, nurtured at a CBCC, could deteriorate on entering primary school. CBCC children were occasionally said to "run away" from primary school when they discover it does not provide the food they were used to receiving at the CBCC.

## Findings - CBCCs as an approach to ECD

Stakeholders recognise the many benefits of CBCCs for children, their parents and the community at large. Children attending CBCCs were said to develop well, and were well prepared for primary school. Sending their children to a CBCC allows parents to work and reduces the pressure to find food, since they know their children will have at least one nutritious meal a day. A CBCC often becomes the focal point for development activities and brings other services, such as an improved water supply, to the community. A centre is frequently a source of pride for the community and admired by other villages.

Both short- and long-term benefits are said to outweigh the costs involved in setting up and running a CBCC. Establishing a CBCC is generally seen as the biggest expense (building costs, training, supplying play and other materials, providing a water supply etc.), but informants claimed costs can be minimised with community support. Once the CBCC is up and running, the recurrent costs are mainly food production, training and maintenance. It was generally argued that the community, as much as possible, should meet these costs. However, it was emphasised that this community-based approach only works if it is given the necessary support and funding, since these communities are already deprived and expecting them to take on full ownership stretches them considerably.

# RECOMMENDATIONS

- Provide CBCCs with basic infrastructure: a permanent main building, child-friendly sanitation, a safe water supply and a covered, hygienic kitchen.
- Promote a sustainable food supply throughout the year so that CBCCs can stay open during the lean season. This will include promoting communal gardens, ensuring an adequate supply of fertiliser, and promoting crop diversification.
- Consider breaking the current 12-day caregiver training course into shorter sessions, and provide caregivers with materials and activity plans covering the different stages of child development for future reference. After initial caregiver training, provide regular support supervision and further training as necessary, so that caregivers are confident to use donated play materials and cooking equipment. Sensitise caregivers on the use of pit latrines and how to encourage children to use them, and on the importance of children washing their hands thoroughly, particularly after using the toilet.
- Consider remunerating caregivers.
- Help CBCCs to rely less on external support by establishing income-generating activities, and build community capacity to sustain a CBCC and be creative when mobilising resources.
- Develop a capacity-building programme for those involved in running CBCCs, to reduce dependency on supporting organizations or individuals. Standardise training of CBCC parent committee members to manage and monitor their CBCC, and to mobilise resources when required.
- Investigate and address the lack of monitoring and support of CBCCs. Revise monitoring tools so that they are user-friendly and cover all aspects of CBCC operations, and train relevant stakeholders in their use.
- Create clear mechanisms to link CBCCs with local ECD service-providers. Develop efficient reporting mechanisms from CBCC to the relevant authorities and stakeholders.
- Build ECD capacity of primary school teachers and encourage links between primary schools and their local CBCC.
- Raise awareness in communities of the services they should expect and demand (in terms of health, education, social support, agriculture, and child protection) and train them how to develop links between the CBCC and these services.
- Recognise that community ownership does not preclude the need for external support and resources.
- Hold a stakeholder conference to determine how best to formalise stakeholder coordination on ECD and scale up ECD activities.

# 1 INTRODUCTION

Research has conclusively stated that the first five years of a child's life are particularly important and that brain development is modified by the quality of a young child's environment. Most children under five in Malawi live in poverty, are malnourished, and lack opportunities for play and early stimulation; they are also exposed to stressful environments. Early cognitive, social and emotional development is a determinant of school progress, so providing young children with quality care and early learning and stimulation opportunities has benefits throughout life.

In 2006 *The Lancet* published research that established a clear connection between child survival and access to early childhood development (ECD) services. The Government of Malawi (GoM) recognises the importance of ECD and is improving access to such services, especially in rural areas. As part of its mandate to improve the lives of children, UNICEF supports the GoM and its partners to provide ECD programmes, particularly through community-based childcare centres (CBCCs). CBCCs provide care outside the home for under-five children, giving guardians a break from the burden of care and the opportunity to engage in household and other productive activities.

The important link between the health, education and well-being of children and poverty reduction is widely recognised: five of the eight Millennium Development Goals relate to health, nutrition and education of young children. A CBCC acts as an entry point to link communities with development programmes such as education, health, agriculture and other services. Furthermore, meeting the basic health, nutrition and educational needs of young children is a vital part of breaking the cycle of poverty, so CBCCs are important in the wider field of poverty reduction.

For a number of years UNICEF Malawi has supported the government to develop its ECD agenda and community initiatives to implement CBCC activities. In order to improve the quality and number of CBCCs in Malawi, and to aid planning, UNICEF has supported the ongoing process of identifying and categorizing all CBCCs in the country. As part of this exercise UNICEF commissioned a study, *Community-Based Childcare Centres in Malawi: Past, Present and Future* (June 2007), examining the origins of CBCCs in Malawi, their history and development; their current status; the constraints they face; their place in society; and their potential.

In 2006-7, UNICEF supported the Ministry of Women and Child Development (MoWCD) to carry out a national quantitative inventory of CBCCs in Malawi, which provides valuable empirical data on the quality and status of CBCCs. The inventory recorded 5,665 CBCCs in Malawi with 407,468 children registered, but it showed that the quality of service offered by most CBCCs was poor (Munthali et al, 2008).

However, the inventory did highlight some CBCCs that, despite facing the constraints common to all CBCCs, manage to provide above-average services to children. The purpose of this Positive Deviance study is to examine the reasons for these successes. The full Scope of Work for this study can be found in Appendix 1.

## Literature review: an overview of ECD models in Africa

### *ECD in the African context*

In Sub-Saharan Africa, studies on child rearing practices in Namibia, Malawi, Mali, Nigeria and Zambia have shown that, within traditional communities, there are mechanisms to support children's physical, emotional, social and intellectual development through traditional games, stories, toys, songs, and ways of playing that are passed on from older to younger children (Evans, 1994, p.8). However, formal school systems do not necessarily utilise or adapt themselves to some of the already existing practices to enrich children's experience in the pre-school setting: "*there is little recognition by the formal school system of the knowledge, skills and beliefs that children bring to school. This is not a problem of the traditional culture; it is a problem with current practice.*" (Evans, 1994, p. 25)

Africans have always possessed knowledge, practices and values through which they provide for the developmental needs of their children. This persists even in the context of westernisation, urbanisation and formal education (Nsamenang, 2008; Prochner & Kabiru, 2008). It can only be correct to consider the preparation for formal education as one element of childcare that Africa owes to those that brought with them the formal system of education.

Most caregivers and providers for children in Africa are women, as they are in most parts of the world. However, the socio-economic condition of most women in Africa is distinct, and most of those working in ECD programmes lack formal training and / or professional accreditation in ECD education (Bernard van Leer Foundation, 1994 in Chibwana, 2007).

The traditional and community setting is a model for the care and development of children in Africa and deserves an important place in ECD policy and implementation. The greatest threat to this model in most African communities is the disintegration of the communal practice of raising children within the traditional system and the influence of global ECD perspectives on indigenous African ECD practices (Nsamenang, 2008 in Garcia, et al 2008, pp.135-149; Swadener et al 2000).

It is generally accepted that young children develop at home, in day-care centres, and in the community. ECD models in Africa are either centred on an integrated model or on a model more focused on education, the main intention of which is to prepare children for primary school. Young (2002) however argues that whether home-based or centre-based, all programmes aimed at developing children can consist of a combination of the following complementary approaches:

- *Centre-based approaches*: attend to the immediate needs of the child and can also be used at home;
- *Caregiver and parental education programmes*: seek to show parents and caregivers how to improve both their interaction with young children and the quality of care the children receive, thereby enhancing their development;
- *Community development promotion*: stresses community initiative, organization, and participation to create a basis for the political and social changes needed to correct conditions adversely affecting child development. It usually requires extensive involvement and assistance from NGOs engaged in the community and considerable sensitivity to local cultural needs. By providing safe and affordable childcare, these programmes allow parents and guardians the opportunity to pursue work outside the home;
- *Institutional resource and capacity strengthening*: seeks to strengthen the institutions responsible for implementing early childhood interventions and is aimed at improving the availability of resources such as infrastructure, learning and teaching support materials, as well as the skills of those who are involved in ECD services;

- *Public awareness building and demand strengthening*: focuses on producing and disseminating the information needed to create awareness of, and demand for, early childhood services, targeting parents, community leaders, and policymakers.

These approaches are not mutually exclusive; indeed the preferred approach would be one that combines strategies (Government of South Africa, 2005) and is therefore relevant where situations and needs are diverse.

### *ECD policy development in Africa*

In terms of ECD policy, African countries appear to have adopted a common framework. In the case of sub-Saharan Africa, ECD policy development has been driven by external forces, more specifically efforts to meet the international agenda on Education for All (EFA). Policy planning and development has emphasised convergence of services to provide ECD; that is to say adopting a holistic or integrated approach.

In the early 1970s, developments in ECD in Africa culminated in a general awareness, recognition and embracing of ECD as a field in its own right by many governments<sup>3</sup>. Major contributions to policy development in Africa include the International African ECD seminars of 1997 and 1998 (which led to the development of the Early Childhood Development Virtual University (ECDVU)<sup>4</sup> between 2001 and 2004), and the Association for the Development of Education in Africa (ADEA) (formerly known as Donors for African Education), which prepared the ground for ECD policy development in Africa.

ADEA, through its Working Group on Early Childhood Development (WGECD), carried out two major policy-related projects in Africa. The first, the Policy Studies Project, was a continental survey with three country case studies: Ghana, Namibia and Mauritius. The second was a Policy Planning Project that engaged three Francophone countries - Senegal, Burkina Faso and Mauritania – which aimed to support national ECD policy planning activities for 2002-2003 (Vargas-Baron, 2003, in Pence, 2004). The latter project developed a framework for ECD policy formulation, which African governments could use as a basis for their own country policies.

According to Pence (2004), two key themes are identified in both projects. The first is the need for a multi-sectoral/multi-organization and multi-country approach to ECD policy planning and implementation to achieve enhanced synergy and cost-effectiveness; and the second is *“to proceed with flexibility and sensitivity regarding where each country is at in terms of its readiness for policy planning and implementation activities”* (ibid, p.13). This suggests that individual African countries have to assess their specific needs and gaps with regard to the situation facing children and families, and need to be familiar with the structural concepts being promoted, including an understanding of the integrated approach and its implications (see Evans *et al*, 2000).

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3 Kenya is considered as a special case: it was the first African country to develop a comprehensive ECD policy. In 1971 the Kenyan Ministry of Education, with the help of the Bernard van Leer Foundation, launched the Pre-school Education Project at the Kenya Institute of Education. It is argued that this project has had great positive impact on the Kenyan basic education system for many years (Kipkorir, 1993).

4 ECDVU is based at the University of Victoria in Canada and grew out of a series of two- and three-week seminars which were requested by UNICEF Headquarters in 1994 to promote ECD in developing countries. The first international seminar took place in 1995 at the University of Victoria in Canada and was followed up by Regional Seminars in South East Asia/Pacific (1997) and in Africa (1997, 1998). The seminars brought together ECD leaders from each region as part of network-building and knowledge-sharing process (Pence 2004, p. 14).

## Pre-school and integrated models of ECD in Africa

Historically, the literature identifies two main models of services for children, one focused on care, while the other more deliberately focused on education (formal pre-school) (Prochner & Kabiru, 2008). In most African countries, the pre-school model is linked to the colonial era and includes infant school, kindergarten, and nursery school. Haddad (2002) explains that historical forces arising from cultural beliefs and values regarding the responsibilities of care of both the family and the mother have determined the dichotomy between the two models. In most countries, including those in Africa, the current status of ECD is in transition from the old order, in which pre-school education was emphasised, to a more holistic view, in which responsibility for ECD is shared among various stakeholders, thereby bringing together the social and educational dimensions (Pence, 2004).

In the literature there is a clear emphasis by organizations and governments on providing and implementing ECD services that are integrated, often called *Integrated Early Childhood Development* (IECD) or *Holistic Approach to ECD* (see for instance, Heaver & Hunt, 1995; Evans, *et al*, 2000; Haddad, 2002; Hyde & Kabiru, 2003). The OECD (1998, 2001), defines IECD as a specially co-ordinated policy for children, with emphasis on the formation of integrated networks among related sectors such as social welfare, education, family, employment and health services. This is also corroborated by Hyde and Kabiru (2003) who argue that ECD services are by nature multi-dimensional and hence there is a need to break barriers between disciplines and bring them together to inform policies, decisions and practices (see p.15). Hyde and Kabiru's framework for a holistic approach to child development is provided in Appendix 2.

The major argument for the convergence of ECD services is that there are countless socio-economic benefits for children, adults, communities, and the society in general (Evans, *et al*, 2000; Hyde & Kabiru, 2003). Heaver & Hunt (1995: 14) explains:

“Evidence from around the world clearly shows that ECD programs that integrate health, nutrition, and early education interventions have more impact than those aimed at one aspect of child development alone. This is because disadvantage in one aspect of development reinforces disadvantage in another.... Children who are malnourished are more likely to fall ill, and vice versa. And children who are malnourished or ill learn more slowly. The mutually reinforcing nature of child development problems means that integrated programs benefit greatly from synergy. Strategies to ensure the convergence of services in the field assume particular importance in this context.”

However, there are still questions over whether 'holistic' delivery of ECD services is more feasible than a purposefully organized conventional pre-school which caters reasonably for children's other needs as well as education (UNESCO, 2004). Another major challenge posed by the integrated approach is the coordination of kindred sectors in ECD, especially in contexts where many players or departments are used to sectoral rather than inter-sectoral operations in implementing ECD-related policies (Kholowa, 2007; Pence 2004). Literature and research appear to be clear about the need to consider the prevailing conditions and requirements for each context before applying any model for early childhood development.

## National ECD programmes and models

An examination of country reports on ECD and ECD programmes from eleven African countries (South Africa, Malawi, Zambia, Kenya, Tanzania, Uganda, Lesotho, Nigeria, Eritrea, Gambia, and Ghana) shows that in terms of policy, these countries have generally embraced the integrated approach to ECD, although they are at different stages of policy formulation and implementation (Pence, 2004). In these countries, deliberate efforts are being made to bring together the various services for children at national, district/provincial, community and household levels. Formal pre-schools exist as one of the approaches, but most of them are private and located in urban areas. Appendix 3 details the various ECD models in selected African countries.

The Malawi CBCC model has been rated as a more successful ECD model in Africa and such a community-based and -managed approach has been suggested as a replicable model for other countries.

# 2 METHODOLOGY AND SITES

## Positive deviance

The positive deviance (PD) approach is historically linked to Marian Zeitlin (1980s), and Jerry and Monique Sternin (1990s)<sup>5</sup>. Positive deviance is premised on the fact that in every community there are certain individuals or entities whose uncommon practices or behaviours enable them to find better solutions to problems than their neighbours who have access to the same resources in the environment. Discovering what the positive deviants are doing that is different from their neighbours or counterparts, given the same contextual provisions and constraints, can help a community find solutions to its challenges. Lewis (2007) ably summarizes the central features and role of positive deviance:

*“PD is one of a number of asset-based approaches to change.... Its unique feature is the highly practical approach to formulating and re-framing the problem and in learning from existing practice within resources that are already available. It is about discovering the wisdom you already have, then acting on it.” (Lewis, 2007: 7)*

It is clear that, unlike the traditional needs-based or problem-solving approach, which focuses primarily on identification of needs and the external inputs necessary to meet those needs or solve problems, positive deviance instead seeks to identify and optimise existing resources and solutions within the community.

One way of examining the many challenges faced by CBCCs in rural communities in Malawi is through the positive deviance approach, which is the central intention of this study.

## Positive deviant CBCCs

For this study, the definition of a ‘positive deviant CBCC’ was derived from the *CBCC National Inventory*, which divides CBCCs in Malawi into four categories (see Appendix 4), with category 1 being the most fully functional CBCC and meeting all the standards in the *CBCC Profile* (MoWCD-UNICEF, 2007).

However, the inventory clearly showed that there were no CBCCs in the highest category and most were in the lowest, with very little difference across the country. In all districts, at least 94% (5,547 CBCCs) of CBCCs were category 4, 1.4% of CBCCs (78) were category 3, and 0.7% (40) category 2. For the purposes of this study, therefore, our positive deviant CBCCs were described as lying between categories 2 and 3.

5 Marian Zeitlin in the late 1980s researched on hospitals in developing countries, trying to understand why in the groups of malnourished children being rehabilitated, there were always a few children who seemed to recover faster and better than the majority. She labelled them ‘positive deviants’. In the 1990s, Jerry and Monique Sternin, working on assignment in Vietnam for Save the Children and familiar with Zeitlin’s thinking, took positive deviance one step further. At that time, nearly half of the children in Vietnam were malnourished, and yet there, too, were those few deviants who fared better than the majority. The Sternins decided to seek out the families of these positive deviants to uncover what these families did that was different from the practices of the majority. Once they uncovered what these practices were, they decided to attempt to make the behaviour of the positive deviant families into model behaviour, using the members of the families to be the facilitators for positive change. <http://www.odemagazine.com>

UNICEF and MoWCD were consulted to decide on how to choose our positive deviant CBCCs, bearing in mind the contextual constraints of the CBCC – they are mainly located in rural areas and managed by poor communities with minimal resources. Overall, therefore, we agreed that a positive deviant CBCC is ***one that is consistently operational with children attending; has basic infrastructure; active and committed caregivers; some community involvement; and some level of resources including food, and kitchen and play materials.***

## Tools and fieldwork methodology

The study used a qualitative approach. Prior to the fieldwork, there were consultations between UNICEF and the research team on various issues, including the study design and choosing appropriate sites.

### Choosing sites

Five districts were selected for this study: Blantyre and Zomba in the Southern Region; Lilongwe and Mchinji in the Central Region; and Mzimba in the North. The choice of these districts was based purely on the likelihood of finding a well-functioning CBCC (based on MoWCD and UNICEF field experience). In all, there were ten CBCCs for this study: six positive deviant (also referred to in this report as ‘well functioning’ or ‘better’) and four that were functioning poorly (also referred to as ‘developing’). Table 1 shows their geographical distribution. Three were in peri-urban locations in Blantyre, Zomba and Mzimba (Namasimba, Makungula and Kazando) and the rest were in rural areas.

Table 1: Region and district of selected CBCCs

Region	District	Positive deviant CBCC	Poorly functioning CBCC
<b>Southern</b>	Blantyre	Chinansungwi	Chilambalale <sup>1</sup>
		Namasimba (peri-urban)	
	Zomba	Muula	
		Makungula (peri-urban)	
<b>Central</b>	Lilongwe		Chitukula
			Kaso
	Mchinji	Chimteka	
<b>Northern</b>	Mzimba	Tenecha	Kazando (peri-urban)

### Choosing specific CBCCs

The selection process involved consultations with UNICEF and MoWCD. Based on their field experience, a long-list of 16 possible positive deviant CBCCs was produced (see Appendix 5). The national ECD Network was also consulted to suggest the possible districts and CBCCs to include.

The research team also played a role, particularly in the field, where some of the chosen CBCCs in Lilongwe, Blantyre and Mzimba districts were found not to meet the study's criteria for a positive deviant CBCC. In these cases, the team asked the DSWO or appropriate local NGOs for help to find alternatives, but in some cases this also proved difficult. For instance, Kaso CBCC in Lilongwe had originally been earmarked as a better CBCC but the team found that it had closed in November 2008. MoWCD, UNICEF and the research team replaced Kaso with Makungula in Zomba (see Table 1 above). Similarly, Kazando CBCC (in Mzimba district) was originally recommended, but it did not meet our criteria for a positive deviant CBCC (there were no usable toilets for the children and no access to water within and around the CBCC premises). The DSWO suggested two possible replacements but neither was suitable. The research team finally approached Plan Malawi for recommendations, and Edundu and Tenecha CBCCs were suggested. We found Edundu CBCC had been closed since November 2008, but Tenecha CBCC fitted the study criteria for positive deviance. Kaso and Kazando CBCCs therefore became examples of poorly functioning CBCCs.

### *Data collection and study tools*

The research team prepared the tools (key informant interviews (KIIs), focus group discussions (FGDs) and direct observations) for the study between November 2008 and January 2009. They were finalised during a one-day meeting with MoWCD and UNICEF in Lilongwe on 2 February 2009, and piloted at our first CBCC in Lilongwe. They were further revised before continuing with data collection.

All the interviews and focus group discussions were conducted in either English or the local language as appropriate, tape-recorded (after verbal consent was obtained from the participants) and then transcribed in the field. Two research assistants supported the four research team members.

### *Key informant interviews*

The team conducted interviews with various stakeholders at national and district levels, including government staff from various ministries, international organizations and local NGOs (see Appendix 6 for list of key informants). These stakeholders provided information on overall ECD policy and implementation issues. The team also conducted interviews with Group Village Heads (GVHs), village chiefs and community-based organization (CBO) directors at community level where appropriate.

### *Focus group discussions*

The team set up focus group discussions with various stakeholders at community level, including caregivers, CBCC parent committee members, parents and guardians, and primary school teachers from the nearest primary school (Standards 1 and 2 - the infant section).

### *Observations*

The team made observations in ten CBCCs: six positive deviant CBCCs and four that were functioning poorly. The detailed observations were done both indoors and outdoors at the usual meeting place. In order to ensure that, as far as possible, we were observing a typical day, we tried not to inform the CBCC of our arrival. However, although this prevented CBCCs from making special preparations, the activities were perhaps atypical because some caregivers were clearly agitated about our presence, especially early on the first day. In such cases we assured the caregivers that we were not evaluating their performance, and the tension eased by the second day of observation.

We generally observed as unobtrusively as possible over two days, usually spending the entire morning (8.00 – 11.30am). We sat quietly in a corner, following an observation guide and writing notes on a data capture sheet or in a field notebook. At times it proved difficult not to become involved in the activities, as some children naturally wanted us to join in.

### *Data analysis*

In order to ensure the research was an iterative process, the team met at the end of every day in the field for debriefing. These sessions were central to our analytical process, allowing us to synthesise the day's activities and discuss key issues as they emerged.

All the interview, FGD and observation transcriptions and notes were entered electronically in the field. At the end of the fieldwork, members of the team read and re-read the transcripts and notes to identify themes and categories which then formed the basis for the findings.

### *Timing of study*

The study took place in February and March 2009. This is the rainy season, when food is scarce in rural areas, and this can affect the operation of CBCCs. Although the timing of the study was not intentional, it turned out to be useful for the researchers because any CBCC that was able to operate consistently during such a period was truly deviant in the positive sense. The positive deviant CBCCs in this study may well display more positive characteristics outside this difficult season.

# 3 FINDINGS AT POSITIVE DEVIANT CBCCs

## Attendance: children and caregivers

Although there were differences in the numbers of children attending, all our positive deviant CBCCs had some children attending consistently during the study. This attendance was noteworthy, as was the fact that the CBCCs were still running in this most difficult time of year. Children are mainly motivated to attend the positive deviant CBCCs because they are given food there.

However, all the well functioning CBCCs had fewer children in attendance than the enrolment figures reported by caregivers and CBO directors (see Table 2 below). There were several reasons for this: most of the CBCCs had just graduated a large number of children to the nearest primary school; and the enrolment period was still in progress at the time of this study (e.g. Namasimba CBCC). Parents were busy tending crops (this applied to all the CBCCs); and the long distance to walk to the CBCC often in the rain, coupled with the danger of crossing flooded rivers, were further deterrents to attendance (e.g. Chinansungwi CBCC).

Four of the six positive deviant CBCCs had women only as caregivers; Chimteka and Muula had some male staff (see Table 2 below). The dominance of women in caregiving reflects the overall national pattern in CBCCs found by other studies, including the CBCC national inventory (MoWCD & UNICEF, 2007; see also Kholowa, 2007 and Chibwana, 2007). Moreover, traditionally caregiving is seen as the role of women rather than men in most African contexts, including Malawi. This could also mean that traditionally society assumes that women are better caregivers than men and therefore ECD centres engage more women than men (Evans, 1994). However, it was reiterated during the fieldwork that men are less likely than women in Malawi to work on a purely voluntary basis.

Table 2: Enrolment and attendance figures at the six positive deviant CBCCs

CBCC	Enrolment (reported)	Actual numbers of children present during study	Number of caregivers present during study	Caregiver to child ratio <sup>2</sup> (to nearest whole number)
Chinansungwi	250	23	3 <sup>3</sup> (F)	1:8
Namasimba	85	55	4 (F)	1:14
Chimteka	257	66	4 (2F, 2M)	1:17
Tenecha	70	29	3 (F)	1:10
Muula	210	170	3 (2F, 1M)	1:57
Makungula	80	27	6 (F)	1:5

Except at Muula CBCC, the caregiver to child ratio for all the well functioning CBCCs was less than 1:20, suggesting good interaction in our positive deviant CBCCs between individual children and caregivers. However, the ratios would have been much higher if all the children officially enrolled at the CBCCs were to attend.

## Infrastructure and facilities of positive deviant CBCCs

### *Permanent, dedicated structures*

Positive deviant CBCCs had permanent structures of brick with concrete floors and a corrugated iron roof, except in one where the main building has a thatched roof (see Pictures 1-5). Although there are some specific differences in the design, the structure included a main building with a playroom, an office, a storeroom, and usually a kitchen (sometimes this was separate).



*Picture 1: Chimteka CBCC, Mchinji*



*Picture 2: Muula CBCC, Zomba*



*Picture 3: Namasimba CBCC, Blantyre*



*Picture 4: Tenecha CBCC, Mzimba*



*Picture 5: Makungula CBCC, Zomba*

These buildings are specifically dedicated to providing CBCC services, but some are also used by the community as a focal point for other development activities. For example, one of the classrooms at Tenecha CBCC is used for community youth meetings. The buildings may also be used for income-generating activities: Chimteka has a hall which is hired out to further support the CBCC.

### *Water and sanitation*

All the better CBCCs have a reliable source of safe water readily accessible to children and caregivers. Water is supplied either from a borehole (four of the CBCCs – see Picture 6) or running water (two CBCCs). Tenecha and Chimteka CBCCs also have tanks to harvest rainwater.



**Picture 7: Pit latrine with rain harvest tank / hand washing facility, Tenecha CBCC**

Five of our positive deviant CBCCs have blocks of pit latrines and the sixth, Namasimba, has western toilets (although out of order at the time of our visit). The latrines had in most cases been constructed when the main building was built. We found the latrines clean and child-friendly; the holes were small. Tenecha CBCC had a hand-washing facility attached to the row of pit latrines (see Picture 7).

### *Playground and play materials*

All of the positive deviant CBCCs have playgrounds with various types of equipment. This includes metal structures (such as swings, climbing frames, see-saws and slides), concrete tunnels and rows of tyres embedded in the ground. The type and amount of play equipment available differs between CBCCs, as does the size of the playground.

Generally the better CBCCs had at least basic equipment and sufficient space, outside the main building. However, Namasimba CBCC playground is quite cramped with very little space or shade. In all the positive deviant CBCCs, the playground appeared to be highly favoured and was much used by the children (see Picture 8). Older children often play in the playground when the CBCC is not in session.

Positive deviant CBCCs have adequate quantities of play materials at their disposal. There is evidence that better CBCCs use locally made or locally available materials to enhance children's play and learning (see Picture 9). Table 3 (below) summarises the play materials seen at the better CBCCs. The most popular materials seem to be soft dolls (see Picture 10), wooden blocks, cars, footballs and a basin of water with various plastic containers (used to pour water and to make mud pies).



*Picture 8: Playground, Chimteka CBCC*



*Picture 9: Local play materials, Makungula CBCC*



*Picture 10: Dramatic play area, Namasimba CBCC*

Table 3: Play materials at the positive deviant CBCCs

CBCC	Play materials
Chimteka	Soft dolls, some picture books, art materials (crayons, plasticine, chalk, etch-a-sketch type slates (although a couple were broken) and 2 large blackboards), lego-style bricks, wooden blocks, large wooden plastic beads and rope, a couple of plastic trucks, and 2 hand puppets.
Makungula	Musical instruments (drums, guitars, maracas and tambourines made from bottle tops), beads, blocks with rope for threading, bamboo containers, bottle tops, wooden building blocks, soft dolls, pad of newsprint paper, tubs of coloured blocks, hand puppets, <i>chitenjes</i> , empty tin cans, hand-made books, basins, plastic cartons, footballs, ropes, homemade balls, paints.
Muula	Art materials (coloured paper cut-offs, chalk, crayons, Pentil pens, paint and clay), wooden blocks, picture books, 2 footballs, ropes, coloured blocks, tin drums, locally-made guitars, handmade books, handmade toys, basins of water, plastic cups, plates and spoons.
Chinansungwi	A variety of locally-made musical instruments (guitars and drums), art materials (2 large blackboards, coloured paper cut-offs, chalk, paint and clay), wooden blocks and wooden trucks, picture books, a big soft doll, 3 footballs, 2 ropes, a large basin of water with plastic cups, 5 wooden mortar and pestles and 2 local drums.
Namasimba	Wooden blocks, paints, crayons, chalk and paper cut-offs, coloured blocks and beads, a local drum, a small broken guitar, locally-made maracas (2 vitamin containers filled with sand), a number of picture books, empty plastic bottles, cartons etc, many locally-made soft dolls, small blankets and pieces of cloth, two wooden mortar and pestles, some plastic boxes, a basin of water and clay.
Tenecha	Soft dolls, wooden blocks, some coloured beads and thread, 8 hacky sacks, a couple of reading books, 6 slates, a couple of wooden trucks, hula-hoops, a couple of tubs of coloured blocks, small plastic badminton rackets and shuttlecocks.

All the positive deviant CBCCs have cooking materials including pots, stoves, plastic plates and spoons. There are sufficient plates and spoons to use for eating. UNICEF or other partners mostly sponsored these materials.

## Quality of care

### Caregivers

It is obvious that CBCCs would not function well, or indeed at all, without the caregivers. Many of the caregivers at the positive deviant CBCCs have been volunteering their services for many years and, being “*touched by the conditions of our children*”<sup>6</sup>, are very committed to helping the children in their community. In Chinansungwi CBCC, for example, all of the six caregivers have been there for ten years - it is their desire to ease the burden of poor parents and to care for the local children that encourages them to continue. One caregiver said that, if she were to stop volunteering, “*A lot of children would suffer. This is why I keep on coming despite some people laughing at us that we work for free.*”

In two of our positive deviant CBCCs (Muula and Makungula) caregivers receive a very small allowance every month for ‘soap’. In Muula, when asked what would happen if that allowance were to be removed, a caregiver replied, “*We would continue...this would be very hard in terms of our families but we will continue*”. This highlights their commitment to the CBCC. Caregivers at our other better CBCCs do not receive any incentives except that in Chinansungwi and Chimteka volunteers from the CBO help the caregivers tend their gardens in recognition of the time they spend, and good work they do, with the children.

Our findings reveal that the caregivers at most positive deviant CBCCs have undergone ECD training, typically conducted by the District Social Welfare Office and usually for the recommended 12 days. However, some caregivers had been trained for a shorter period, and a few had not been trained at all.

At Makungula CBCC, we were able to see the benefit of additional training. Three of the Makungula caregivers have attended three training courses, and one caregiver has been twice and is also a trainer of trainers. The results of this training were evident, as we witnessed a nice mix of play and educational activities with confident use of materials, many of which were locally made. The caregivers interacted well with the children, who were clearly enjoying the activities and play materials. One caregiver claimed during the focus group discussion:

“If we do not go for training we teach in ignorance. But we know how to do things with children. For example in private preschools children are just forced to memorise things. This forces them to assimilate things beyond their age. We were trained not to make children memorise but let them learn through playing in and out of the classroom. We know this through the trainings we get.”

The caregivers realise the importance of training and, in the better CBCCs, apply what they have learned. In Chimteka CBCC a caregiver stated:

“It is true that we taught our children ignorantly before we went for training. We did not know that children are supposed to be grouped according to stages of development, things we were taught during training. Now we group the children according to years of birth and the approaches we use depend on the age group of the children. Furthermore, we did not give them playtime before since we concentrated much on the teaching itself. But during training, we were taught the importance of exercise to the children and we do follow that in our daily programme.”

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6 Caregiver, Chinansungwi CBCC

## Food

Due to poverty and the lack of food in many communities, children do not at home receive the vital energy and nutrition needed for their development. Positive deviant CBCCs provide at least one meal a day (often vitameal or *nsima* and beans) throughout the year to the children that attend (see Picture 11). At Namasimba, for example, the Director told us of individual children who had arrived at the centre extremely malnourished and who were now healthy and strong due to the regular nutritious feeding they had received at the centre. At Makungula CBCC, a caregiver had a similar story:

“We also give them food. It is even seen ... some of them are deficient when they come. But after some time they change showing improvements in health and appearance. That is a sign that when they come here they eat something that is of help to them.”

Positive deviant CBCCs usually have a communal garden, the produce of which feeds the children at the CBCC. Districts like Mchinji are fortunate enough to produce good yields - the DSWO referred to the area as a “*sort of a food basket of the central region*” - but in other areas where the harvest is not sufficient to provide food throughout the year, the positive deviant CBCCs rely on both community contributions and food donations from NGOs and



**Picture 11: Meal time, Namasimba CBCC**

local organizations. For example, the CBO that runs Chinansungwi CBCC has received food donations from Blessings Hospital in the past and currently receives 240kg a month of *likuni phala* from Feed the Children Malawi. During our observation at Tenecha, CBCC we saw a delivery of 19 bags of rice donated by the Lion’s Club for all the projects at the CBO.

Fertiliser is expensive: frequently those CBCCs that are functioning well have received some assistance with fertiliser. The DSWO in Blantyre informed us of an initiative whereby the Chiefs in the district donate one or two fertiliser coupons to a CBCC for use on their gardens. The Director of the CBO that covers Chinansungwi CBCC confirmed that they benefit from such an arrangement and that the villagers contribute a further MK20<sup>7</sup> towards fertiliser costs. At Tenecha CBCC we were informed that they *“have no problems with flour because last year, UNICEF gave us fertiliser and we grew a lot of maize.”*

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7 US\$1 = MK142 in May 2009: 20 kwacha is the equivalent of about 14 dollar cents

## Management of CBCCs

### *Parental and community involvement*

The management of positive deviant CBCCs involves parents and community at large. This involvement is usually in the form of the parents' committee, whose members are expected to check the progress of the CBCC activities daily. This includes checking that food is available, helping the caregivers with cooking and other chores, and liaising with other parents outside the committee when necessary. Some committees at better CBCCs make financial or food contributions when necessary and this contribution is often crucial, as shown by this comment made by a caregiver at Namasimba CBCC: *"Committee members are urged to contribute a little something to the CBCC and this is what we rely on"*.

Outside the committee, some parents at positive deviant CBCCs volunteer their help when needed. They might clean the CBCC surroundings, cook and tend to the caregivers' fields (as at Chimteka and Chinansungwi CBCCs) and were involved in constructing the CBCC buildings by moulding bricks, transporting sand etc. Some parents also contribute food and / or money when called upon and when able.

### *Community-based organizations and NGOs*

Almost all the positive deviant CBCCs (five out of six<sup>8</sup>) either fall under the management of a CBO or receive technical and financial help from an NGO. The running of the CBCC is monitored to a large extent by the CBO and/or NGO, and significant assistance may be provided by the organizations to find sources of funding and other support.

### *Committed individuals*

It was evident during the study that the success of certain CBCCs was closely linked to the commitment and management of a particular person. For example, at Chimteka it is the Group Village Head (who is also the CBO Director), at Makungula it is the Chief (continuing the work of his brother, the late Chief), at Chinansungwi it is the CBO Director, and at Namasimba it is the CBCC Director. These people were often instrumental in setting up the CBCC and are all very involved in its day-to-day running. At Tenecha, for example, the CBO Director comes daily for CBO duties and also helps monitors the CBCC activities. These individuals also have the skills and networking ability to seek out and access various kinds of support to assist in the management of the CBCC.

## Networking and links

Positive deviant CBCCs are linked to a number of partners that in one way or another provide or support the consistent provision of ECD-related services.

<sup>8</sup> Chinansungwi and Chimteka are both managed by a CBO; Makungula is being funded and assisted technically by SAFE; Tenecha has a CBO and is supported by Plan Malawi; and Muula was initiated, and is significantly supported, by Chancellor College.

## *Community level*

### *Community-based organizations*

The first notable linkage is that between a CBCC and a CBO. Tenecha, Chinansungwi and Chimteka have strong and inextricable links with their CBOs, being located at the CBO headquarters and effectively sharing both material and human resources. At Chimteka, the CBCC benefits from the food and financial contributions that CBO volunteers make to the CBO. The Group Village Head for Chimteka stated:

“So the people said when we use the treadle pumps they should be bringing a bag of maize at a fortnight [to the CBCC] because maize is ready for harvest within three months. We gave them in November and we expect maize bags this month and after that in August. The aim is to have food.”

The CBO Director for Tenecha attributed the success of their CBCC to the existing link with the CBO as follows:

“It is because of this cooperation that things are running [...] smoothly since we work hand in hand. When we have problems, we ask the CBCC committee to help and when they have problems, they tell us the CBO to assist them and we are the ones who write proposals to donors to ask for some donations... when all caregivers are absent, one of the CBO members teaches the children.”

At Chinansungwi, some of the members of the CBO committee are also members of the CBCC committee and thus represent the CBCC at CBO meetings.

Coincidentally, the three CBCCs mentioned above were established first and then the CBOs grew out of them, confirming that CBCCs can and do act as entry points into the communities for multiple socio-developmental activities, as stated by a key informant:

“We have this vision of these CBCCs, well it just makes this complete sense they are an entry point, you know, you look for entry points when you do community work. It doesn't matter what you are going in the community to do either [if] you have got an entry point....”

### *NGOs and support organizations*

The remaining three positive deviant CBCCs (Namasimba, Muula and Makungula) do not fall under a particular CBO, but they do have strong direct links with supporting organizations outside their community. (The three already discussed are linked to such organizations indirectly through their CBOs.) Makungula is linked with SAFE; Muula with Chancellor College; and Namasimba with many including Mary Meals, St. Andrews, MASAF and UNICEF.

### *Dynamic leadership*

Another strong finding regarding networking and links at the community level is related to leadership and the existence of the committed individuals mentioned earlier. Chinansungwi and Chimteka have dynamic CBO directors, the director of Namasimba CBCC is very active, and the Village Chief for Makungula CBCC is very involved in the running of the CBCC. These leaders are able to write proposals to various supporting organizations and establish viable partnerships. It was clear to the research team that much the success of these CBCCs stems largely from the efforts and abilities of these individuals.

### *Community extension workers*

Positive deviant CBCCs also have links with other ECD service providers in the education, health and agricultural sectors. For example, Chinansungwi CBCC has some engagement with the nearest primary school, whereby Standard 1 teachers are invited to the CBCC on closing day to verify that children who are graduating from the CBCC into Standard 1 have the skills to cope with school. A key informant explained:

“The first thing we do is that we consult the primary school teachers who do interviews with the children. We do not have holidays at CBCC so we open like this year on January 4 and shall close on 24 December. [...] The teachers conduct the interviews. They come on closing day. They ask them questions and it is upon completion they are sent to primary school. We buy different items for example pens, books, vegetables, fruits. They have to be able to identify them correctly.”

Makungula CBCC has had joint seminars with teachers from the nearest primary school, as one teacher described:

“In the past, we were involved in a seminar which Dick Day organized at Makungula. Teachers from here patronized the seminar. We learnt how to use teaching and learning aids. I was one of the beneficiaries. The idea behind our involvement was to apply the same skills with our children, so there is a relationship.”

Makungula also has a primary school teacher on the CBCC committee:

“In addition, one of the teachers here was elected into Makungula's [CBCC] committee. She is a chairlady for the committee so that we work hand in hand in running the [CBCC] and sought challenges together to eliminate further problems when kids are enrolled at the primary school level.”

A common link for all except one of our positive deviant CBCCs is between the health sector and the CBCC, usually through Health Surveillance Assistants (HSAs). HSAs deliver under-five clinic services (including immunization, growth monitoring, treatment of common illnesses, vitamin A supplementation and de-worming) every month, either at the CBCC itself (such as at Chinansungwi), or at the nearest primary school or clinic. The Director from Tenecha CBCC states:

“The only linkage we know of is that of the health section from the mission hospital. They provide under-fives' clinic, de-worming, vitamin supplements and others.”

There are also links between the agricultural sector and some of our positive deviant CBCCs. The evidence from Tenecha of the benefits of this relationship was clear, as children were being fed from the CBCC garden at a time when most CBCCs do not have any food. The CBO Director described the link:

“They come when we ask them to come in case we need some agricultural advice. We work hand in hand with the agricultural sector and last year we installed an irrigation farming programme and we have dimba [riverbank] gardens where we grow crops through irrigation. Frankly speaking, we have had bumper yields from these gardens this year.”

Another key informant from Chimteka said:

“...We also have agriculture programme that looks at the way farming is done in our fields. ...They teach people of this community. The members who help the CBCC are the village people. So when they learn they come to apply at the community garden here. They teach all people who cultivate the garden. ...Another is the Forest group who checks on the trees and we have planted other trees around this CBCC.”

### *District level*

Links between positive deviant CBCCs and the various ECD stakeholders at this level is evident in Mchinji district. We found good collaboration in the delivery of ECD services, as a NGO key informant described:

“...We are working hand in hand with our friends like social welfare, as also members of DEC... the DEC also provides checks and balances...We are working with the Ministry of Youth, the Youth Department, we are also working with NICE of course they are providing materials ... So, we are not all alone. We are collaborating nicely with other NGOs and the other Government Departments that are key stakeholders in this area.”

Working together, the stakeholders in Mchinji district are able to provide ECD services through the CBCCs. A key informant in Mchinji stated that:

“The people know that they cannot do on their own. So we [...] always come together to help each other. It’s all about the team work spirit in the people.”

Another key informant explained the collaboration further:

“...What we do is, when I am carrying out say another activity, and where I am going there are CBCCs I make sure I rush by. So, I combine one service with the other and also those field workers we have, when they are doing other activities in the CBO there, the CBCC they will go and visit and give us a report and say I was able to visit this CBCC and what I observed [was] this, this and this... Also at the district level the involvement of the other partners, the agreement is that when I am out in the community and I have to maybe pass by maybe a school project, as...a District Executive Committee member, I have to drop by and see what is going on and report maybe to the Director of maybe Planning and Development.”

In Mchinji district there appear to be forums available and in use to address ECD-related issues, as another key informant clarifies:

“Mainly, the structure that is used at the district level is the one known as the District Executive Committee where this is composed of all heads of government partners and NGOs and we meet together to discuss issues related to anything at all taking place in the district. So, we also take advantage of these gatherings just to discuss issues related to CBCC activities. And we have also a structure whereby as an office, a Social Welfare office, we also call for meetings with the other stakeholders involved to discuss issues related to early child development...this is where we discuss a number of issues, what roles each partner can play in that... you know we have a number of other structures like the DACC, this is the District AIDS Coordinating Committee, and anything related to the care of the children affected and infected by HIV/AIDS.”

It was also evident that the different ECD stakeholders for Mchinji are forward thinkers in that they were ready to set up a new structure that would further enhance the effectiveness of their collaboration, as stated by a key informant:

“... As of now as a district, we feel we have a lot of structures at the district level, now what we are coming up with [a] sort of a Children’s Committee at the district level which will have sub-committees under it...”

The commendable way in which different ECD stakeholder collaborate with each other can be attributed in part to the District Assembly leadership, as the previous key informant continued:

“I think, maybe it [the success] is due to the kind of leadership. The spirit in the executive committee is strong. Again, the District Commissioner is always looking at all the sectors to ensure that they are working very well.”

### *National level*

At national level the environment is conducive to the effective delivery of ECD services through CBCCs. The ECD policy spells out the type and quality of services that should be provided to all children in Malawi, and stipulates the structures through which different ECD stakeholders should collaborate to maximise ECD service delivery. There are documents and manuals in place, including the ECD Training Manual and the CBCC Profile, to guide the translation of ECD policy into implementation.

Our key informants revealed that most stakeholders are knowledgeable about ECD policy and are aware of the available structures for collaboration on ECD issues. There is some degree of networking between the different ECD stakeholders, and in particular the ECD Network (composed of ECD stakeholder representatives) has the potential to further the cause of ECD in Malawi and enable efficient and effective policy implementation.

## **Sustainability**

All our positive deviant CBCCs can be described as having some degree of sustainability. This was seen in the form of one or more of the following: food, material, labour and finance. They also received regular contributions from various sources.

### *Communal gardens*

Most of the communities in which CBCCs are located depend on subsistence agriculture for their income and food. It is not surprising, therefore, that most of our participants in focus group discussions indicated that apart from outside support from organizations, CBCCs depend on farming for their sustainability. CBCCs use the produce from these communal gardens to feed the children and may generate income by selling surplus produce. The four positive deviant CBCCs in rural areas (Tenecha, Chimteka, Chinansungwi and Muula) have communal gardens (the two in peri-urban areas do not). These are cultivated by members of the community but rely on support from other organizations for fertiliser. Two of the poorly functioning CBCCs (Chitukula and Kazando) have small maize fields, but they are not enough to supply food for the children throughout the year. One of the CBO Directors from Tenecha stated:

“In terms of food, things are fine because we had bumper yields since we applied enough fertiliser - from UNICEF - to our fields. So we knew February was coming and we stored enough maize in preparation of the hunger period. That is why we still have food though many CBCCs are starving. Had it been that UNICEF gave us maize grain, it could have already been gone by now, but fertilizer helped us to multiply the maize grain and we still have food for the children.”

### Community contributions

At the positive deviant CBCCs, communities also make food contributions, depending on their household reserves. Some communities also make financial contributions when possible. In some cases, such as Namasimba CBCC, committee members make donations to ensure that children at the CBCC always receive a meal.

Moreover, better CBCCs manage to operate throughout the lean season. They may have to cut down on food or, for short periods, not provide food at all. But one of the parents from Chinansungwi pointed out:

“...This CBCC does not close due to lack of food. There are some who close during the months of December to February. We do not do that. Our children stay here throughout the year. There are very [few] days when the kids fail to eat.”

### External support

Where the harvest from the communal garden is insufficient and the community has not been able to contribute, positive deviant CBCCs rely on external assistance to continue functioning and serving meals. As mentioned earlier, CBCCs that fall under a CBO and those that have direct links with supporting organizations are much better placed to access the necessary resources, so these links ensure the effective and consistent delivery of ECD services at better CBCCs.

Most of the positive deviant CBCCs in our study had very humble beginnings. Children at both Muula and Makungula CBCCs first met under a tree; at Chinansungwi they met in a church; at Namasimba in a borrowed building and at Chimteka in a temporary structure now used to house chickens. Each of our better CBCCs received support, either through a CBO or NGO, which enabled them to improve their premises. The table below summarises the sources of funding at the positive deviant CBCCs.

Table 4: Sources of funding for positive deviant CBCC buildings

Name of CBCC	District	Sponsor
Chinansungwi	Blantyre	Raising Malawi
Namasimba	Blantyre	UNICEF
Chimteka	Mchinji	UNICEF
Tenecha	Mzimba	Plan Malawi
Muula	Zomba	Chancellor College, Home Economics Department & District of Saanich, BC, Canada
Makungula	Zomba	SAFE <sup>4</sup> & Community

For Muula and Makungula CBCCs, the continuing provision of caregiver allowances has been possible due to the viability of their links to supporting organizations. Such relationships have also been fundamental in building the capacity of CBCCs to offer quality ECD services (e.g. through support towards training of caregivers and committee members, or supporting communal garden projects).

### *Income-generating activities*

Four of the CBCCs we visited (three positive deviant and one poorly functioning) generate a little income, and most of the positive deviant CBCCs rely on a combination of activities.

Chinansungwi and Chimteka (both PD) sell excess produce and have a maize mill, but both of these mills were broken at the time of the survey. Chimteka also hires out its hall to other users. Namasimba (PD) has a working maize mill, but makes very little profit, especially during the rains. It does not have a garden and currently relies on flour donations from a local NGO (Mary Meals), contributions from the CBCC parents' committee and the small income from the mill. Kazando (poorly functioning, peri-urban) has three cows to provide milk for the children, and sells any excess to generate a small income.

Even with diversified income-generating activities, none of the CBCCs makes much profit. But it is better to have a broad base for sustainability than to rely solely on communal gardens or household contributions.

# 4 FINDINGS: CHALLENGES FACING ALL CBCCs

As explained earlier, the positive deviant CBCCs, although of a higher standard than the current norm, do not fall into the highest category as defined in the CBCC National Inventory. They all have room for improvement and all face challenges: the four CBCCs that were not functioning well face even more challenges.

## Seasonal issues

The timing of our study enabled us to see first hand that attendance is greatly affected by the season. It drops considerably in the rainy season, and some CBCCs close temporarily: during the study, for example, we found that Kaso, Chilambalale and Edundu (one of the CBCCs suggested by Plan Malawi as a possible PD CBCC in Mzimba) CBCCs had been closed for several months. The serving of at least one meal a day is a significant factor for parents sending their children to a CBCC: if no food is available, attendance declines dramatically or the CBCC closes. Even at the better CBCCs this was an issue: Chimteka had not fed the children during the previous two weeks and attendance had dropped; and Chinansungwi was only serving one meal a day instead of two - only 23 children turned up during the two days of our observations (although lack of food was not the only reason given for this).

Intermittent caregiver attendance and the closing of CBCCs was also blamed on the lack of incentives for caregivers and their need to work in the fields or do piece work during difficult periods of the year.

## Health and safety



*Picture 12: Flooded uninal,  
Chimteka CBCC*



*Picture 13: Broken toilets, Kazando  
CBCC*

Our observation activity highlighted a number of health and safety issues, not only at the poorly functioning CBCCs. Access to safe water is a significant problem for some. For example, Chitukula (poorly functioning) has no access to safe water and caregivers have to walk quite a distance to collect water for the CBCC.

We rarely saw children using the latrines even when they were available – everywhere except Chinansungwi (a PD CBCC) children were seen urinating in the surrounding area. In Chimteka (PD) the open air toilets were flooded due to the rain (see Picture 12) and at Kazando (poorly functioning) the toilets were in an appalling condition and dangerous for the children (see Picture 13); this led the research team to question what is being looked at when monitoring visits take place.

A caregiver talking about the development of Chimteka CBCC (now PD) said, *“There was an incident when one of the children fell inside the pit latrine because the old ones were of poor quality,”* so it is perhaps not surprising that children choose not to use latrines, even where they are available.

Moreover, in many CBCCs the surrounding environment needed attention, as there was long grass and deep puddles of water.

Although the children washed their hands before eating at every CBCC we visited, the standard of hand-washing varied, ranging from the most thorough at Namasimba (a PD CBCC), where soap was used and children were encouraged to scrub thoroughly, including up their arms, to the least thorough where children just dipped their hands into a basin of water. We never witnessed children washing their hands after going to the toilet.

Some CBCCs, including Tenecha (a PD CBCC), do not have a kitchen and so volunteers cook on makeshift fires and prepare and serve food in the open, on the ground (see Picture 14). Naturally, this has safety and hygiene implications: open fires are dangerous for young children, and the uncovered food attracts dogs and flies.



**Picture 14: Cooking area, Tenecha CBCC**

## The voluntary nature of caregiving

We have mentioned that the CBCCs could not function without the services of the volunteer caregivers, but in many CBCCs the caregiver turnover is very high. For example, despite being trained, 12 caregivers at Namasimba (a PD CBCC) have left the CBCC since 2003 because they were not receiving any benefit. A similar number have left from Makungula CBCC (also PD) because, according to one caregiver, they:

*“...were discouraged as they did not like the idea of not receiving anything. Some left for greener pastures. Some husbands of them were not allowing them to keep on coming to a task that had no pay”.*

In order to retain caregivers, the issue of incentives needs to be addressed. Caregivers are as poor and resource-constrained as other members of the community - sometimes more so, with many looking after orphans within their own families. If an allowance is given, it should not be derisory. As stated earlier, caregivers at Makungula and Muula receive a small allowance, but it is not considered sufficient for their daily needs, as the following statement indicates:

*“We get little amount of MK2,000<sup>9</sup>. The people who give us even say that it’s not salary but little something to buy soap to be presentable teachers because we get dirty with the kids when carrying or playing with them. The government should do some thing ...K2,000 is little money compared to the cost things are on the market.”*

The funding for the incentive schemes at both CBCCs is due to come to an end in the near future, so caregivers will soon not receive even this little benefit.

Many caregivers, particularly those who have volunteered for many years and seen the improvements and the assistance given over that period, hope and believe that they will be next in line for some support and given some recognition for the hard work they do. A caregiver at Namasimba, who has been volunteering for six years, said:

*“The work we do is recognised by the government and we have been taken for training by UNICEF. This motivated me that if these organizations recognise our help, there is going to be a day in future when they will consider us with something. If they were able to pay for my training, definitely there is going to be some benefits from my qualification”.*

## Training

### Caregivers

The high turnover of caregivers affects the quality of care delivered at the CBCCs and necessitates the recruitment of new caregivers who in turn require training. A lot of information is covered in the 12-day training course and this fact, along with the low education levels of many of the caregivers, means that caregivers are often unable to apply what they have learned: this was clearly seen by the research team during the observations.

There is a need for regular support supervision to identify gaps in training, followed by frequent refresher courses to instil the confidence and skills that caregivers need to apply what they have learned. This would also ensure that caregivers’ knowledge and skills are updated. An example of lack of confidence and knowledge was seen at Tenecha CBCC, where boxes of coloured blocks and a large number of plastic badminton rackets and shuttlecocks were lying unopened and unused in the store cupboard. Caregivers told the researchers, *“Materials are bought but we do not know how to use them so they stay new”*<sup>10</sup>.

### CBCC parent committee

9 US\$1 = MK142: 2,000 kwacha is roughly equivalent to \$14

10 It was also obvious from our observations that volunteers at Chitukula CBCC did not know how to use the fuel-efficient stoves that had recently been supplied by UNICEF; wood was put at the top under the pot, rather than at the bottom, making it no longer fuel-efficient.

Almost all the parent committees at the CBCCs we visited, both positive deviant and poorly functioning, had not been trained and as a result were weak. Many members freely admitted that they do not know what their roles are or how to run a CBCC: *“We cannot know if there is another way of running the school because we do not know how a CBCC is run,”* (Committee member, Makungula). Also, some committee members who see the need to network and forge links with other stakeholders do not have the skills and knowledge required to do this, as illustrated by the same committee member at Makungula who asked, *“How can we coordinate with all the stakeholders to come up with something concrete for the school?”*

This problem is compounded with the frequency with which new committees are elected and the lack of standardization in the length of a term for a committee; some are elected yearly, some every two years, some never change. As a consequence some committees never receive any training.

## Sustainability

A major challenge for most CBCCs is how to support themselves. As already described, a communal garden is key to the sustainability of a CBCC, but too few CBCCs have a garden. Our findings were in line with the CBCC national inventory, which found that only 40-50% of CBCC in Malawi have a communal garden (MoWCD-UNICEF, 2007, p.54): only four out of the six positive deviant CBCCs and only two of four the poorly functioning CBCCs in this study has a garden. Of the latter two, neither is large enough to feed the children throughout the year.

Moreover, fertiliser is needed to improve yields, but the price is often prohibitive. If a CBCC cannot afford to buy fertiliser and does not have access to fertiliser coupons, it must rely on donations and contributions from the community and external organizations. As an informant from Tenecha (a PD CBCC affirmed), *“If we always have fertiliser it will always be vibrant here”*. Further, a committee member at Chimteka (also PD) claimed they usually experience bumper yields, the proceeds of which go in to purchasing other necessities such as sugar, salt, relish and for milling maize, but due to a lack of fertiliser they are not expecting much of a harvest this year:

*“Last year we harvested 200 bags from the whole farmland [3 acres]. This year, it will probably be only 100 bags or less since we have applied fertilisers to half of our garden.”*

Additionally, the *“emotional attachment to maize”* in Malawi, as one key informant called it, means that many CBCCs are not diversifying their crops. Apart from the problem of no food for the CBCC if the maize harvest fails, the children have a monotonous diet that lacks the variety and micronutrients needed for healthy growth and development.

As mentioned earlier, when the harvest is not sufficient to feed the children for the whole year, and for those CBCCs without a garden, the CBCC relies on contributions of food from the community and on donations from organizations and well-wishers. Many communities are unable to make contributions from January to March, because whatever food they have is needed for their own families, so external support for CBCCs is often necessary. As a caregiver from Chitukula CBCC remarked, *“Assistance is required at such times that our efforts cannot meet our needs”*.

It is therefore clear that many CBCCs would not survive without the support of NGOs. Both the committee and the Group Village Head at Makungula CBCC, for example, claim that the CBCC would not run without the NGO SAFE: the GVH said, *“The CBCC depends on SAFE for its existence”*. Despite this parent from Namasimba’s hope that *“These organizations...continue helping us”*, to ensure sustainability, CBCCs need to build their networking capacity and other fundraising skills, and not expect current support to continue indefinitely. As a parent from Chinansungwi commented, *“We cannot just depend on donations as they can fade away”*. There is also risk in relying on the efforts of committed individuals described earlier: what happens when this individual is no longer there? Such personalities are rare in most rural communities where CBOs and CBCCs exist, and replacements are hard to find.

CBCCs that are aiming for sustainability talk of the need for a variety of income-generating activities (IGAs) such as farming, a maize mill, and livestock production: *“IGAs would help sustain us instead of begging for donations each and every year”*, (key informant, Tenecha). Although many CBCCs would require a loan or a ‘starter pack’ to set up a small business, they find that some donors will not provide such funds: the Director of Namasimba CBCC, for example, asked the NAC for assistance but her request was refused.

## Monitoring and support

At community level, CBCC committees are charged with the responsibility of monitoring and supporting CBCCs. However, most CBCC committees that we interviewed lacked the knowledge and skills to do this effectively. It was evident that, while there is an ECD training manual that is used for training the caregivers, there is no standard manual and training for CBCC committees. As previously mentioned, very few of the committee members we interviewed had received any training at all. Therefore, there is a clear gap in the capacity of CBCC committees.

According to our findings, very little monitoring and support supervision takes place at district level. The District Social Welfare Offices complain this is due to a lack of human and financial resources. Unlike Mchinji district, where there is good cross-sectoral collaboration, other districts seem unable to make use of the community extension workers from the various line ministries to assist with monitoring, as a key informant claimed:

“Challenges are there because [of] some of these extension workers, even as the coordinating ministry sometimes we don’t have the resources to take on board all these people [...] to go to monitoring...”

Another key informant explained the situation further:

“There isn’t much collaboration amongst organisations like the NGOs, Social Welfare and the CBOs themselves and there isn’t much monitoring. Only those CBOs near to the city are frequently monitored because they are easily accessible. But there is need for multi-sectoral collaboration among the different organizations and even the government so that we should put together the tools that would be user friendly. This gap has to be filled if we are to have the required success... even the Ministry of Education has to come in and check the success of education in CBCCs since they are educators. You discover that the CBCCs are solely in the hands of Social Welfare, and yet there are other organizations available.”

Further, where monitoring attempts are made, the exercise is often just a cursory visit to ‘tick boxes’. Another key informant voiced the following concerns with the current monitoring tools:

“Just ... elementary ... in which we indicate feeding, the number of children at the CBCC, attendance, how many have come, have they taken some food? And then we encourage them to weigh the children as a monitoring tool to check if some children have protein-energy malnutrition. If the child [needs] health therapy, then we refer him/her to nutrition rehabilitation units. So these are the things we do, the quarterly reports, the monthly reports, the annual reports, as monitoring tools. But these are really elementary and we are planning to sit down and redesign these tools.”

So the content of what is being monitored needs to be addressed. It should go beyond checking attendance to include environmental issues (as the toilets at Kazando would indicate), as well as assessing how the caregivers are delivering their activities. Such monitoring should be followed up with support, advice and training as required.

## Stakeholder coordination and collaboration

### *Community level*

In some cases, community ownership of a CBCC is diminished if the CBCC is affiliated to a supporting organization such as Chancellor College (Muula CBCC) or SAFE (Makungula CBCC). A key informant underlined his concerns about the perceived identity of a CBCC:

“...In the area of ownership...people say this CBCC is for World Vision [or] this CBCC is for social welfare...I would rather a community should say this is our CBCC with support from World Vision... [or] social welfare.”

Indeed, we were told at Namasimba, for example, that parents and the community do not make financial contributions to the CBCC because they think that the CBCC must be ‘rich’ to have such an impressive building and therefore does not need the community’s help. Similarly, at Chimteka, parents stopped coming to play with the children at the centre and helping out when the CBCC received donations of learning materials; one parent explained:

*“We felt like the children have a lot of toys to play with so they should be doing that [rather than playing with us].”*

Moreover, for all the CBCCs visited, there is an evident lack of collaboration between the different ECD stakeholders. In many cases the community extension workers from other line ministries have no role in delivering ECD services through the CBCCs in their community. The lack of viable links between CBCCs and their nearest primary school raises a number of transition issues, which are discussed later in the report.

### *District level*

At district level, except for Mchinji, the collaboration and coordination of ECD services is not satisfactory. Most of our key informants at district level admitted to this lack of collaboration, despite acknowledging that such collaboration was essential for effective, holistic delivery of ECD services to children. A key informant asserted the following with regard the role of a District Education Manager in the running of CBCCs:

“Actually, there is no role whatsoever. Occasionally, maybe the social welfare people will call me for a function or something like that or otherwise as district education manager it is somebody else’s area. I don’t even have a list of reputable centres and those which are not registered or whatever. I am not aware of even what they are teaching.”

Reasons cited for this lack of collaboration include no capacity, no resources (either human or financial), and too many responsibilities for the DSWO to undertake. Another key informant went further in explaining the reasons behind not working together:

*“For example, maybe if we want to do a joint monitoring exercise with our colleagues, you would then involve the DEC members – and each and every DEC member would want a vehicle and something like that. And may be you would say issues of allowances get in – “we would want to get allowances”. If we empower those that are there [the community extension workers] then the costs will be reduced... And I think the other things are like motivation as well because I think when you are confined to your own sector, for example, you may not want to appreciate what is happening in other sectors.”*

This issue of being “*confined to your own sector*” came up continuously in our key informant interviews: there seems to be a reticence, as someone said, to “*tread in each others territory*”. A key informant from the education sector said:

“CBCCs are under the Ministry of Women and Child Development and our mandate is basic education, so there is a kind of respect not to interfere with other people’s areas.”

This mentality of ‘this is my job and that is yours’ appears to be endemic in all the government ministries, as does the issue of expecting allowances referred to in the earlier quote. A key informant from the health sector complained that child survival is also seen as just a health issue and that departments like to work only on their own programmes. As one key informant said, “*We have not yet started to say okay let’s work together.*” The coordination and collaboration that has begun to some degree at a national level is not yet trickling down to other levels.

### **Transition to primary school**

It is clear from our interviews with primary school teachers close to the CBCCs we visited that there are few, if any, links between a CBCC and its nearest primary school. Many teachers have never heard of CBCCs and talk only of private nursery schools; others think of them as solely taking care of orphans, and believe that all caregivers are untrained. However, there was the recognition that links, such as meetings and exchange visits, would be beneficial for both primary school teachers and caregivers, and would ensure a smooth transition for children when they start school.

Despite this lack of links, teachers said they could usually identify children who had come from a CBCC, as they “*show a lot of skills*”. All the Standard 1 and 2 teachers we spoke to complained of the problems they face dealing with extremely large classes; they find controlling the children particularly difficult. Teachers said that the children from CBCCs were often easier to manage and lessened their burden by acting “*as leaders*” and helping other pupils. One teacher in Zomba who knew of Muula CBCC said:

*“Personally, I would be very happy if CBCCs like Muula were many...because this would reduce the workload that we have with Standard 1 pupils.”*

However, teachers also said that children from CBCCs are usually far ahead of their fellow pupils in terms of educational development and quickly become bored. Parents also complain that their children are not learning anything new when they first go to primary school. This is particularly noticeable in the first term of Standard 1 (the orientation to school life programme), where children do the same activities they did at the CBCC.

Many teachers do not know how to manage different ability levels, particularly in such large classes, and teach to the majority. One teacher complained that the children from CBCCs were “*over-taught*” and another just shrugged her shoulders and said, “*Even if they would be bored it is part of the programme*”. So, there is a danger that a child’s flourishing potential, nurtured at the CBCC, might deteriorate on entering primary school. Indeed, some children run back to the CBCC or drop out of primary school altogether.

Another problem identified is that children from CBCCs are used to receiving at least one meal a day and if this is not continued at the primary school they “*run away because of hunger*”, sometimes back to the CBCC where they know they will get food. Also, children are used to playing with toys at the CBCC and these are not available at primary schools in Malawi.

# 5 FINDINGS – CBCC AS AN APPROACH

All stakeholders interviewed for the study, at community, district and national levels, recognise the many benefits of the CBCC, not just for the child, but also for parents and the community in general. The children attending CBCCs were said to be “*clever*” and “*intelligent*” and to develop well intellectually, socially, physically and spiritually. The CBCCs were said to prepare their children amply for primary schools where their performance is often excellent, their attendance good and drop-out rate low. They are also said to develop leadership skills, learn respect and show improved behaviour. Because children are treated equally at CBCCs, discrimination of children from poorer backgrounds and of orphans is said to be eliminated. Ultimately, the children themselves enjoy going to the CBCC, a fact we witnessed in all our observations and as a parent at Muula confirmed, “*Now they even cry that they want to go to school*”.

Being able to send their child to a CBCC allows parents the freedom to go to work and lessens their worry of finding food since they know their child will have at least one nutritious meal a day; as a parent at Namasimba commented, “[*a CBCC*] *lessens the burden of child rearing*”. A CBCC often becomes the focal point for development activities in the community, as well as bringing other services to the community - such as water and growth monitoring. The centre is frequently a source of pride for the community and admired by other villages; a parent at Chinansungwi claimed people from other villages say the CBCC “*looks like in town*” and Chief Magalasi declared that the success of Muula CBCC “*has brought fame to my village*”.

## Cost effectiveness

Key informants at district and national level generally see CBCCs as a good way of delivering ECD services: a CBCC empowers the community, is community owned and promotes ‘community spirit’. In terms of cost-effectiveness, the short- and long-term benefits are felt to outweigh the costs of setting up and running a CBCC. Establishing a CBCC is generally the biggest expense: constructing a building, training caregivers and committees, supplying play and other materials, ensuring the availability of water, and so on. However, informants claim many of these costs can be minimised. Training costs are reduced when training is brought as close to the community as possible, and construction costs are decreased with community involvement (moulding bricks and volunteering labour, for example).

Once the CBCC established, the recurrent costs are mainly training, food production and maintenance. It was generally argued that the community, as much as possible, should meet these costs.

However, it was emphasised many times that this community-based approach only works if it is given additional support and funding, since these communities are already deprived: expecting them to take on full ownership stretches them considerably. A key informant eloquently sums up this point, “*The notion of community ownership should not be a substitute for resources for a CBCC. We should be talking of community ownership in terms of acceptance, participation... monitoring, assisting in management [etc.]*”. Moreover, for a CBCC to be truly successful, it needs multi-sectoral support (both financial and technical) and stakeholder collaboration is essential.

## 6 CONCLUSIONS

The positive deviant CBCCs in this study have several things in common which appear to be important in allowing them to do better than the average. The better CBCCs:

- are affiliated and / or directly linked to a CBO or NGO;
- have strong leadership, often in the form of a committed and dynamic individual;
- have committed and dedicated volunteer caregivers (usually women) who have undergone at least one 12-day ECD training course;
- rely on diverse means to mobilise funding and support for sustainability;
- benefit from some level of stakeholder collaboration and coordination at both community and district levels.

The following characteristics are also defining features of better CBCCs – they generally:

- operate throughout the year, despite food shortages and low attendance;
- provide at least one, usually nutritious, meal a day consistently throughout the year;
- have a permanent structure<sup>11</sup>, dedicated to CBCC activities, which contains at least a playroom, storeroom and an office;
- have a kitchen, which is sometimes separate to the main building, adequately equipped with cooking and eating utensils;
- have adequate safe, child-friendly toilets (usually in the form of pit latrines);
- have access to a close, reliable source of safe water;
- have a playground with a variety of strong, outdoor play equipment;
- have adequate play materials, both local and exotic;
- have caregivers (usually women) who use a child-centred approach with plenty of play; and who may receive some kind of incentive, either in the form of a small allowance or have their fields tended by volunteers from the community;
- have a communal garden and the ability to access sufficient fertiliser;
- have some level of community ownership and involvement, usually in the form of the CBCC parent committee and a core group of community volunteers;

Challenges are faced by all CBCCs, whether positive deviant or developing. The main challenges identified by this study are:

- a lack of a permanent structure built to the basic minimum requirements;
- to remain operational and maintain high attendance throughout the year;
- to provide nutritious food daily throughout the year;
- to ensure each child is consistently healthy and safe through, for example, encouraging the use of pit latrines and thorough hand washing, as well as regularly monitoring the CBCC environment;
- to build the skills and confidence of caregivers, through sufficient and relevant training, monitoring and support to ensure quality child-centred learning and stimulation;
- to reduce caregiver turnover, increase motivation and sufficiently reward their hard work and commitment;
- to effectively manage, monitor and support CBCCs which have weak, unskilled and untrained CBCC parent committees;
- a general lack of community commitment and ownership;
- a lack of reliable and diversified sources of support for sustainability;
- a serious lack of stakeholder coordination and collaboration at all levels; and
- an absence of any real monitoring and support supervision at district level.

11 Usually made of burnt brick, with cement floors, and a roof of iron or good thatch

It is evident from this study that without active networking, viable links, and stakeholder coordination and collaboration, CBCCs will not develop the capacity to deliver quality ECD services effectively, nor will they be able to sustain delivery of such services. In order for children to be given the opportunity to develop to their full potential, ECD services need to be holistic, encompassing education, health, nutrition, water, sanitation, basic care, and social protection, as well as family and community empowerment. Therefore links and synergies need to be promoted, through the CBCC, in order to support the whole child.

In reality, however, the nature of inter-sectoral cooperation and coordination at different levels is limited. The government is organised sectorally (including planning and budget allocations), so multi-sectoral coordination for ECD is difficult. But the kind of synergy characteristic of Mchinji district focuses attention on CBCCs and brings about the eventual delivery of quality ECD services; it could therefore serve as an example to other districts. If the Government of Malawi is truly committed to ECD and to the concept of CBCCs as an approach to delivering holistic ECD services, then ECD needs to be incorporated into sectors such as health, education, and water and sanitation, through transparent inter-sectoral cooperation and sectoral contributions to financing ECD activities through CBCCs.

Community ownership and participation is essential for the continued success of CBCCs. If well supported, CBCCs have the potential to act as entry points for community development by incorporating various services that work through community participation. The formation of CBOs as a by-product of the CBCC points to this potential, as this study highlights. However, community ownership of their CBCC is often lessened by a strong affiliation to a primary supporting organisation and this is problematic for sustainability. Indeed, it is doubtful whether some positive deviant CBCCs would be able to support themselves if the external support they receive were to be curtailed. There exists to a certain extent a culture of dependency, with many communities expecting supporting organizations to take financial responsibility for the centre. Moreover, widespread poverty and seasonal food insecurity mean many communities find it difficult to mobilise resources to help sustain their CBCC. Community ownership does not, therefore, negate the need for external support.

Finally, to ensure quality services, training, monitoring and support is crucial. Effective and regular monitoring and support supervision is necessary to identify support needs and gaps. Such monitoring and support should be followed by further training as required.

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# Appendix 1: Scope of Work12 for Positive Deviance Research on CBCCs

## Desk Literature Review

- Carry out a desk review of literature to provide an overview of ECD models in Africa, providing comparisons of their approach, attributions of successful impact and outline limitations.
- Review should refer to national level activities, to the extent possible, including issues of policy, strategic planning and national agenda for ECD.

## Positive Deviance Assessment

- The consultant team will carry out all work in partnership with the Malawi ECD Network (or a Task Force identified by the Network), which will review the TOR and provide comments, assist to identify CBCCs for the Positive Deviance Assessment, review the draft tools and the draft report.
- Carry out an assessment in 2 districts examining 10 CBCCs which seem to have a successful impact on children's cognitive, physical, social, emotional and spiritual development
- Develop all tools for carrying out the assessment and submit them for review and comment by the ECD Network or Task Force for this assignment.
- Conduct a Positive Deviance assessment which examines the following issues:

*Organisational Structure:* carry out review around governance, management, financial issues, resources, how does the CBCC maintain itself? Assess the influence of organisational coherence to the CBCC effectiveness.

*Length of operation:* How long has the CBCC been operational? Does the length of time have any correlation to the apparent success of the CBCC? What is the history of the CBCC outlining, in particular, growing pains, lessons learned, difficulties faced and successes?

*Quality of care:* analyse the quality of care and support provided within a CBCC, the range of services, lessons learned, changes made in approach to strengthen limitations, observations from caregivers and community members on who attends, who does not attend and why? Is there an attempt to reach out to children who are within the age range of CBCCs which does not attend, but should? Issues around children with disabilities? This will need to be in the context of what kind of disabilities exist in the community, how the community addresses these issues, etc. What are the hours of operation at the CBCC? How long do the children remain? What type of learning and play materials are available at the centre? What is the infrastructure including toilets and water.

*Linkages with other services in the community and district:* What is the linkage with health care providers and/or Health Surveillance Assistants (HSAs) in the community (analysed in the context of whether MOH has deployed HAS to the catchment area and the location of the nearest health facility); how the CBCC handles child survival health issues; what are the linkages with the nearest primary school? What are the outcomes of the linkages? What is the impact of not making the linkages? Assessment of the CBCC in relationship to other services for children in the community.

*Support from district assemblies:* What kind of support does the CBCC receive from the district assembly?

*“Spill over” of other benefits:* Assessment of the spill over impact of the CBCC in the community? What other benefits has the CBCC brought to the community?

*Volunteers:* How long have the caregivers been involved, what makes them continue their work, what keeps them motivated, issues around volunteer fatigue, sufficient numbers, perceptions around community support, ratios of male to female caregivers and reasons for gender issues.

*Quality of caregivers:* perceptions around training and preparation to provide ECD services and what could be improved in the training, perceptions around what caregivers need to improve their service delivery, educational background of the caregivers.

*Community Support (including interview with the traditional authority):* assessment of the kind of community support and level of support, what is the role of the traditional authority, attitude of the parents, teachers, clergy towards the CBCC,

*Community CBCC Committee:* perceptions towards the volunteers, concerns about retention of volunteers, perceptions around training of the committee, perceptions around the quality of care at the CBCC, perception about the overall programme/objectives.

*Parent Issues:* perspective of parents towards the CBCC related to quality of care, quality of caregivers, successes and limitations of the CBCC, perceptions around what their supportive role towards the CBCC should be, perceptions around the impact on their children (cognitive, physical, social, emotional and spiritual), Perceptions around likes/dislikes, what could be improved, what they do not want to see change, perceptions on issues around transition to primary school

*Children at CBCC<sup>13</sup>:* Observations on the impact of the CBCC on children cognitive, physical, social and emotional development, children’s perception on their likes and dislikes of the CBCC

*Children 7-8:* Observations on the impact of the CBCC on children cognitive, physical, social and emotional development, children’s perception on their likes and dislikes of the CBCC, perceptions on the impact of CBCC attendance on their primary school performance, perceptions on what may have helped with transition.

*Teachers Issues (interview standard 1 & 2 teachers and head teacher from a nearby school where graduates from the CBCC attend, District Education Officer and Primary Education Officer):* understanding of the benefit of the CBCC on school attendance and performance, notable deficiencies in CBCC preparation, notable differences between children who attend or do not attend a CBCC, issues around transitions to primary school, suggestions for improvement in quality of services and transition to primary school.

*District Social Welfare Officer:* Perceptions on the reasons behind the success of the particular CBCC under review, perceptions on quality of services.

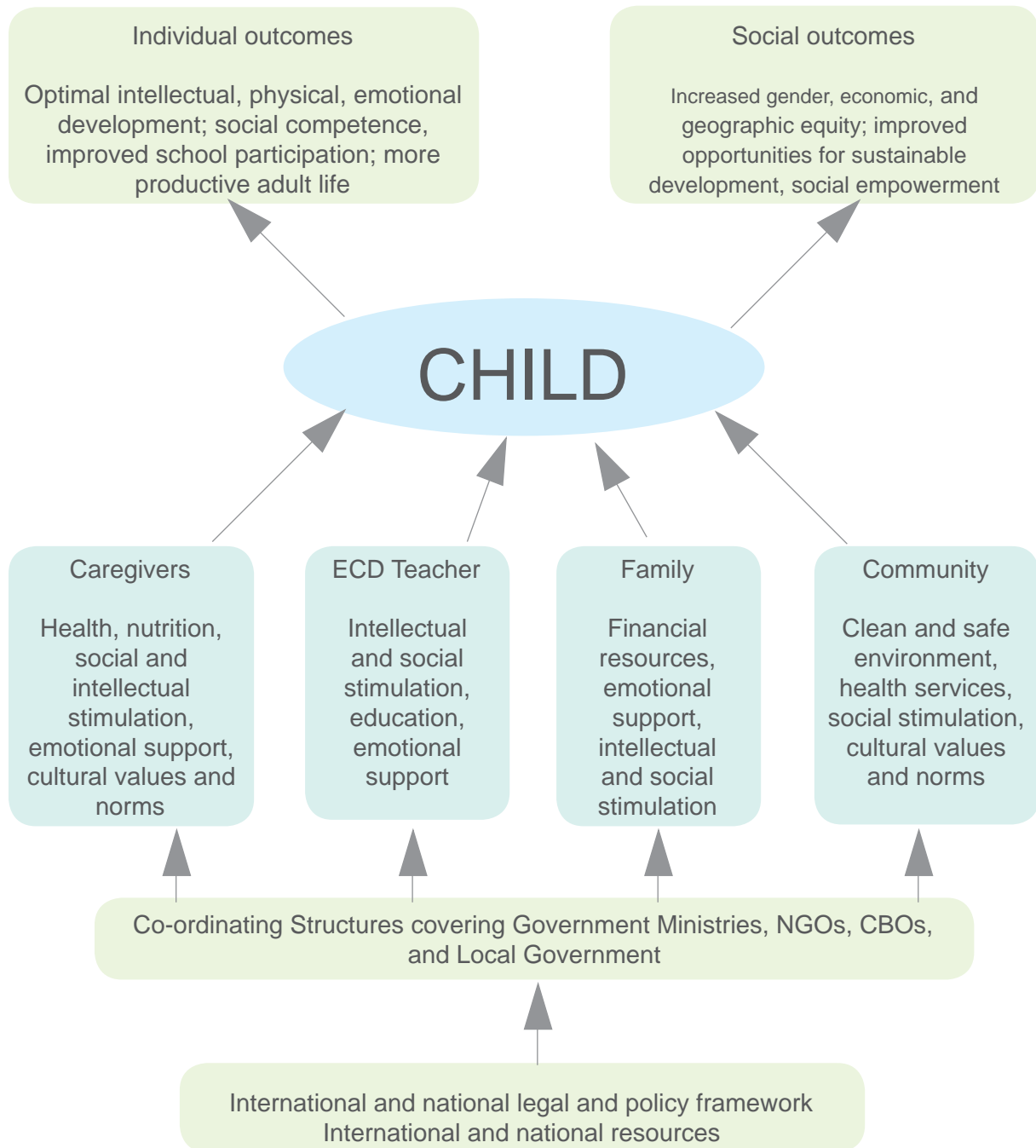
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13 Observations on the children (both CBCC & primary school) will be contingent upon the skill set of the consultant team and whether they have the skills and ability to appropriately gather information from children

*Cost Effectiveness of CBCCs:* Conduct a cost effective analysis of the ECD model taking into account the available different approaches vis a vis an ideal ECD centre to determine a meaningful sustainable approach for Malawi.

- Visit 8 CBCCs which are not performing well, preferably in the same districts as the functional ones, making the same inquiries as the positive deviance assessment capturing key lessons around causal factors that prevent achievement of full potential.
- Carry out all required interviews and focus group discussions with caregivers, community members, community CBCC committees, parents, children attending CBCCs, children in primary schools, teachers, District Education Officers, Primary Education Advisors, District Social Welfare Officers and others as required.
- Carry out appropriate level national discussions with Ministry of Women and Child Development and Ministry of Education, ECD Network members, UNICEF and others to understand the appropriate context for ECD in Malawi and issues around the national agenda and strategic plan.

# Appendix 2: Framework for Integrated Early Childhood Development



Source: Adapted from Hyde and Kabiru, 2003, p.16

## Appendix 3: ECD Models in selected 14 African countries

Country	Model	Primary Components	Responsible Key Stakeholders
Eritrea	Integrated	<p>Five major components (with the core aim of improving child growth and development).</p> <ul style="list-style-type: none"> <li><b>Early childhood education and care</b></li> <li><b>Child health and school health</b></li> <li><b>Maternal and child nutrition</b></li> <li><b>Economic and psychosocial support for children under difficult circumstances</b></li> <li><b>Management of the programme</b> involves monitoring and evaluation. Cross-cutting interventions in the areas of research, advocacy, and communication is being undertaken to facilitate programme implementation.</li> </ul>	<p>Ministry of Local Government (<i>Lead Ministry</i>)</p> <p>Ministry of Education</p> <p>Ministry of Health</p> <p>Ministry of Labour and Human Welfare</p> <p>Ministry of Agriculture</p> <p>Ministry of Fisheries</p> <p>Ministry of Finance</p> <p>Ministry of Information</p>

14 In the absence of comprehensive data on country status on ECD, in this table we have mostly relied on information from comprehensive country reports developed between 2001 and 2002. Therefore it is likely that some of the countries that were behind in terms of integrated ECD policy development have made progress to realize holistic development of children rather than the disintegrated provision of ECD services.

Country	Model	Primary Components	Responsible Key Stakeholders
Ghana	Integrated	<p><b>Child health – growth and nutritional programmes</b></p> <p><b>Safe motherhood programmes</b></p> <p><b>ECD programmes</b> [<i>Day Care programmes</i> based at centres or schools, <i>in-home</i> programmes (where caregivers go to the homes of children), <i>nanny homes</i> (where parents take children to homes of nannies), and <i>after-school-home care</i> (where children who close earlier from their centres are sent until their parents pick them up after work)]</p> <p><b>Training programmes for caregivers</b> (Involves training of caregivers - day care attendants, teachers and proprietors of ECD centres at various institutions)</p> <p><b>Child welfare programmes</b> (Orphans, abandoned children, children with disabilities, children from broken marriages, children born in the street and neglected children represent groups of children with special needs)</p>	<p>Department of Social Welfare (<i>Lead Department</i>)</p> <p>Ministry of Health</p> <p>Ghana Education Service</p> <p>Private proprietors</p> <p>NGOs, religious bodies and the private sector</p> <p>Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
Gambia	Not integrated but moving towards integration	<p>Mainly <b>formal pre-schools</b> by the private sector: “provision of Early Childhood Education is the franchise of the private sector and the NGOs”.</p> <p>There is a realisation and move towards “deliberate attempts by the government and development partners to raise more resources for establishing and running ECD services that are comprehensive, integrated and family focused, especially in the rural areas” ( Country Report, p.30)</p>	<p>Department of State for Education (<i>Lead Department</i>)</p> <p>Private sector and NGOs</p> <p>Department of Community Development</p> <p>Religious organizations</p>
Kenya	Integrated	<p><b>Antenatal, under-five services</b> (immunisation of children, growth and monitoring, and provision of counselling to mothers)</p> <p><b>Social services</b> (orphanages and children’s homes and issues related to children in need of special protection)</p> <p>Institutionalised academic oriented care [referred to by several names such as nurseries, kindergartens, pre-unit, pre-school and day care; home based, care by childminders (Ayahs)]</p> <p><b>Community organised home care</b></p>	<p>Ministry of Education (<i>Lead Ministry</i>)</p> <p>Ministry of Health</p> <p>Ministry of Culture</p> <p>Ministry of Local Government - some local authorities are employing pre-school teachers, they also allocate land for construction of ECD centres</p> <p>Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
Lesotho	Not integrated <i>but moving towards integration</i>	<p><b>Centre-based</b> (common and catering for children aged 2-6 years; some privately owned while the majority owned by community but fee-paying)</p> <p><b>Home-based</b> (started 2001 as pilot and is intended for families that are jobless and cannot afford heavy fees paid in the centre-based approach. Targets children 2-6 years of age and not fee paying)</p> <ul style="list-style-type: none"> <li>o <i>[The government of Lesotho promotes community-based childhood care, and this ensures local involvement - the community is seen to be accountable for the care and development of its own children]</i></li> <li>o ECD seen as preparation for primary school</li> </ul>	<p>Ministry of Education (<i>Lead Ministry</i>)</p> <p>Lesotho National Council of Women</p> <p>Lesotho Pre-School and Day Centre Association</p> <p>Local and international NGOs</p> <p>Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
<b>Malawi</b>	Integrated	<p><b>Antenatal</b> (pregnant mothers are encouraged to visit antenatal clinics at least four times before giving birth. This is because most clinics are very far from communities) – located in hospitals and clinics</p> <p><b>Under-five clinics</b> (immunisation of children, growth and monitoring, and provision of counselling to mothers) – located in hospitals, clinics and ECD centres in communities</p> <p><b>Pre-school</b> (Children from 3-5 years. The most popular ECD programme in Malawi. Provided in various categories: <i>Nursing</i> (for babies 0-2 years); <i>Nursery schools</i> (0-4 year-olds); <i>Kindergarten</i> (4year-olds); <i>Playgroups</i> (3-5 year-olds); <i>Crèches</i> (Day Care minder, for infants whose parents are employed); <i>Community-Based Child Care</i> (CBCC) (for children needing care and attention, administered by parents at community level)</p> <p><b>Supplementary feeding</b> (undernourished, malnourished and stunted children from birth to 8 years. Parents are taught how to prepare adequate nutritious food for children)</p> <p><b>Family planning</b></p> <p><b>Water and sanitation</b></p>	<p>Ministry of Women and Child Development (<i>Lead Ministry</i>)</p> <p>Ministry of Education, Science and Technology</p> <p>Ministry of Health and Population</p> <p>Ministry of Agriculture</p> <p>Ministry of Water and Development</p> <p>Local and international NGOs</p> <p>Ministry of Disability</p> <p>Partners such as UNICEF, Christian Service Committee (CSC), PLAN International, World Vision, Save the Children Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
Nigeria	Not integrated <i>but moving towards integration</i>	<p><b>Day care centres and nursery schools</b> for children aged 3-5 years provided by the private sector and supervised and inspected by the Federal and State Ministries of Education. Mostly in urban areas.</p> <p>[The major cities have two types of day care centres, one with high standards and quality facilities, but charging high fees and hence accessible only to the children of the elite, and the other with over-crowded facilities and poor quality care].</p> <p><b>Low cost community-based</b>, intersectoral ECD facilities, supported by Unicef, which can serve as a model</p> <p><b>Community-based ECD training</b> using a National Curriculum</p> <p><b>Promotion of child friendly schools</b> with ECD linkage</p>	<p>State Ministries of Education (<i>Lead Ministry</i>)  National Council for Education  Private sector  International organizations and NGOs  Ministry of Health</p>

Country	Model	Primary Components	Responsible Key Stakeholders
<p><b>South Africa</b></p>	<p>Integrated</p>	<p><i>Primary components</i></p> <p><b>Integrated management of childhood illnesses</b>  <b>Immunisation</b>  <b>Nutrition</b>  <b>Referral services for health and social security grants</b>  <b>Early learning stimulation</b>  <b>Development and implementation of psychosocial programmes</b></p> <p>[These components are located in homes, formal ECD centres, community childcare centres, informal ECD settings, prisons, child and youth care centres]</p> <p><i>Secondary Components</i></p> <p><b>Human resource development</b>  <b>Infrastructure development</b>  <b>Research</b>  <b>Monitoring and evaluation</b></p>	<p>Department of Education (<i>Lead Ministry</i> but in “equal” partnership with:)            Department of Social Development            Department of Health            Office on the Rights of the Child in the Presidency            Communities</p>
<p><b>Tanzania</b></p>	<p>Integrated</p>	<p>For many years there were formalised pre-schools in urban areas but much progress has been made towards integrated ECD</p> <p>In 2006 recommendation to develop an Integrated National Strategy for ECD comprising the following components</p> <ul style="list-style-type: none"> <li>Human resource development</li> <li>Curriculum development</li> <li>Service delivery</li> <li>Monitoring and evaluation</li> </ul>	<p>Ministry of Community Development, Gender and Children Affairs (<i>Lead Ministry</i>)            Ministry of Education and Culture            Ministry of Health            Ministry of labour - Department of Social Welfare            Ministry of Youth Development and Sports            Ministry of Agriculture            Local and International NGOs            Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
Uganda	Not yet integrated	<p><b>Immunisation programmes</b> for 0-6 year old children</p> <p><b>Nutrition and early childhood development project</b></p> <p><b>Education programmes</b></p> <p><b>Madrassa resource centre</b> EDC programme (an initiative of the Moslem community aimed at integrating Islam with secular education)</p> <p><b>Child-to-child programme</b> (<i>an approach to learning and teaching aimed at promoting and preserving the health of communities through the active involvement of school-aged children</i>)</p> <p><b>Training programmes for ECD tutors and teachers</b></p>	<p>Ministry of Education and Sports (<i>Lead Ministry</i>)</p> <p>Ministry of Gender, Labour and Social Development (MGLSD) [Childcare and Protection Department]</p> <p>National Council for Children (NCC)</p> <p>The private sector (NGOs, bi-lateral agencies and individuals)</p> <p>Ministry of Health Communities</p>

Country	Model	Primary Components	Responsible Key Stakeholders
Zambia	Not yet integrated	<p><b>Home-based pre-schools</b> in urban areas, and mostly private</p> <ul style="list-style-type: none"> <li>o There is urgent realisation for Zambia government “to explore integrated approaches to young children’s development through the Early Childhood Care for Survival, Growth and Development. However, organized ECCD in Zambia needs to be accelerated further”</li> <li>o The Ministry of Education in the National Policy on Education acknowledges the importance of Early Childhood Education in the multi-dimensional development of young children, and that the Ministry will encourage and facilitate the establishment of preschool programmes that would reach out to all children, especially to those living in rural and peri-urban areas”.</li> </ul>	<p>Ministry of Education (<i>Lead Ministry</i>)  District Councils  Local and international NGOs,  Religious organizations  Individual entrepreneurs  Communities</p>

## Appendix 4: Criteria for Categorising CBCCs (from National Inventory)

POINTS	Building	Sanitation	Water (safe & clean)	Caregiver to child ratio	Community involvement and links
5	Own permanent building, permanent fixed roof, cement floor, walls built of burnt bricks, large rooms (relative to number of children), store room, separate kitchen with energy-saving stove and food storeroom, roofed outdoor play area, open ground play area.	Child-friendly latrines, bathroom, rubbish pit, child-friendly hand-washing facilities, rainwater harvesting area.	Source within 500 metres	1:15 trained <sup>5</sup>	CBCC initiated by CBO/NGO, committee established, members elected by community or volunteers, community mobilising resources, communal garden available/ feeding twice a day, health extension worker visiting once a month
4	Own permanent building, permanent fixed roof, cement floor, walls built of burnt bricks, large size rooms, separate kitchen with food store room, open ground play area.	Child-friendly latrines, rubbish pit, child-friendly hand-washing facilities		1:30 trained or 1:20 untrained	As above, but feeding once a day only
3	Own building, mud floor, thatched roof, reed/ grass/ <i>mdindo</i> walls, separate kitchen, open ground play area	Pit latrines, rubbish pit, child-friendly hand-washing facilities.	Source within 1 km	1:40 trained or 1:20 untrained	Committee established, feeding once a day, health extension worker visiting less than once a month
2	Rented/borrowed building (e.g. church, shop, community hall), permanent fixed roof, cement floor, walls built of burnt bricks, open ground play area	Pit latrines, no other facilities		1:50 trained or untrained	No committee, health extension worker visiting less than once a month
1	No building available, CBCC open air 'under a tree', no facilities	No sanitation facilities	No water source within 1 km	no trained caregivers	No committee, no links with other services

### Categories of CBCC

Category 1 = 35 points

Category 2 = 26-35 points

Category 3 = 23-26 points

Category 4 = less than 23 points

Using criteria derived from the guidelines set out in the CBCC Profile, each CBCC was given a score according to the quality of its facilities. It was found that most of the CBCCs fell far short of the standard required. None was in the highest category; only 40 were in category 2 and 78 in category 3. The vast majority - more than 5,500 - fell into the lowest category.

It is clear from this inventory that although the numbers of CBCCs have increased rapidly in recent years, the standards of infrastructure, staffing and facilities do not meet the CBCC Profile guidelines.

**Source:** Munthali, A. et al, 2008, *A National Inventory of Community-Based Childcare Centres in Malawi*, Centre for Social Research, Zomba, Malawi

## Appendix 5: Initial List of Potential CBCCs for Positive Deviance Study

SERIAL	NAME OF CBCC	DISTRICT	REGION	TOTALS BY DISTRICT	TOTALS BY REGION
01	Chinansungwi	Blantyre	South	5	11
02	Khombwe (under Comfort Arms)	Blantyre	South		
03	Kalitsiro	Blantyre	South		
04	Tiwasamale	Blantyre	South		
05	Namasimba	Blantyre	South		
06	Makungula	Zomba	South	3	
07	Muula (Jali)	Zomba	South		
08	Kasonga	Zomba	South		
09	Grasten	Thyolo	South	1	
10	Manguwo	Chiradzulu	South	1	
11	Kubwera Kwa Yesu	Mulanje	South	1	
12	Kaso	Lilongwe	Central	1	3
13	Chimteka	Mchinji	Central	1	
14	Chikondi	Salima	Central	1	
15	Mzuzu CCAP	Mzimba	North	1	2
16	Kazando	Mzimba	North	1	

# Appendix 6: List of Stakeholders for Key Informant Interviews

Ministry/Organization	Key Informant(s)
Ministry of Education, Science and Technology	Director - Basic Education (Headquarters); District Education Managers (Blantyre, Zomba, Mchinji and Mzimba Districts)
Ministry of Health and Population	Head of IMCI Programme (Lilongwe); District Health Officers (Zomba and Mchinji)
Ministry of Women and Child Development	Director - Child Development (Headquarters); National ECD Coordinator (Headquarters); District Social Welfare Officers (Blantyre, Zomba, Mchinji, Mzuzu)
National AIDS Commission	Social-Economic Policy Officer (Headquarters)
UNICEF Malawi	Chief OVC and Child Protection; OVC Specialist
SAVE the Children (US)	Manager for Basic Education (ECD and Primary)
Plan Malawi	Learning Advisor
Oxfam	Programme Officer
Orphan Support Africa	Programme Coordinator; Training Coordinator
World Vision- Malawi	Manager - Mchinji District
Sub-Sahara Africa Family Enrichment Programme	ECD Officer
Group Village Heads and Chiefs of relevant villages	Blantyre, Zomba, Mchinji, Mzimba, Lilongwe (9 interviews)
Community-Based Organization Directors/ Programme Coordinators	KASO, Kazando, Chinansungwi, Namasimba

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- 15 CBCC Katete was supposed to be our developing CBCC in Blantyre. After asking a number of people for directions to Katete CBCC, we were told that the CBCC was no longer functioning, as the building it was using had collapsed a few months ago. We eventually found what the local people were calling Katete CBCC: it was a pile of bricks and very overgrown. During the interviews it became apparent that the committee, chief and caregivers were confused about whether the CBCC was called Katete or not. It was finally ascertained that this CBCC was not registered as Katete, but as Chilambalale.
- 16 Based on numbers of children actually attending during the study period
- 17 There were in fact 6 caregivers at Chinansungwi, with 3 on duty at any one time
- 18 SAFE actually came into being as a NGO after American well-wishers had funded the construction of the building.
- 19 Trained means having been trained for at least two weeks.





