

# NEEDS ASSESSMENT

OF UNDER-RESOURCED AND VULNERABLE EARLY  
CHILDHOOD DEVELOPMENT CENTRES IN NAMIBIA





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# background

**T**he needs assessment was commissioned by the Office of the First Lady (OFL) to gauge the conditions at thirty-two poor and vulnerable Early Childhood Development (ECD) centres in eight regions of Namibia. The assessment was conducted by the University of Namibia (UNAM) multi-disciplinary research unit with technical support from the Ministry of Gender Equality and Child Welfare (MGECW), the Ministry of Education, Arts and Culture (MoEAC) and the United Nations Children's Fund (UNICEF).

The objective was to conduct an analysis of the services provided at these centres and how they affect the growth and development of children who attend these centres. The assessment looked at the health, hygiene, cognitive stimulation, development of motor skills and the psycho-social, economic, and physical environment of these centres situated in mostly poorly resourced areas. The assessment sought to contribute to the existing body of knowledge on ECD and using an evidenced based approach, inform intervention programmes that could improve the status of Integrated Early Childhood Development (IECD) services at community level and existing ECD centres.

# about the needs assessment

**T**he needs assessment examined ECD centres through an integrated services lens, focusing on the physical, emotional and social environment at home, at the centres, and within the community.

At present the mandate for health, care and development for children between the ages of 0-8 is fragmented, falling mostly under the MGECW, the MoEAC, and the Ministry of Health and Social Services (MoHSS).

Traditionally, there has not been a strong culture of integrated ECD in rural Namibia, however this is starting to change. The policy environment is increasingly supportive of ECD interventions. The implementation of expanded, integrated comprehensive ECD services will contribute to the 4th National Development Plan (NDP4) and future National Development Plans. This includes NDP5 currently under development and ultimately Vision 2030's objective "to promote and support quality, sustainable, and holistic Integrated Early Childhood Development for children aged 0 - 8 years and to develop capacity of care-givers (educarers) to improve quality."

Addressing integrated ECD will also contribute towards Namibia's response to the Sustainable Development Goals (SDG), particularly in reducing the under-5 mortality rate, currently at 54 per 1000 live births (2013) and child malnutrition, currently 24% (2013). ECD centres play an important role in the development of children, however, there are other variables and contributing stakeholders whose contribution to the foundation stage of a child's life should not be overlooked, or undervalued. The high levels of Grade 1 repetition which increased from 18.9% in 2002 to 22.7% in 2015, are a clear indication of the need for more, and improved IECD services and increased access to ECD services for children with disabilities.

This needs assessment explores the standard of services provided at some of the poorest and most vulnerable centres in the country, in order to inform the development of realistic, pro-poor, cost effective and context-based interventions which would benefit those most in need. It takes into consideration the foundation laid by various players to get ECD to where it is today.

**"I just love to work with children... our children were just wandering around the neighbourhood. There was no one to teach them. Then I started a kindergarten under a tree". (Kunene, August 2016)**



# how we did it

The assessment was conducted using both quantitative and qualitative approaches. A questionnaire, observation check list, interview guide and focus group discussions were used to collect data from 32 caregivers and 32 ECD Committees in the sampled ECD centres. The quantitative data sought to establish the number and ages of caregivers, and types of qualifications they held. The needs assessment also collected data on the number and ages of children at ECD centres as well as availability of appropriate infrastructure and learning and teaching support materials.

Qualitative research comprised descriptions of ECD centres, quality of teaching and services rendered by the caregivers, community members, and other stakeholders. The qualitative research sought to identify factors affecting the growth and development of children attending the centres. Further, qualitative data was obtained from parents and communities regarding their involvement in supporting the ECD centre, specifically on issues related to nutrition, health, hygiene and physical environment.

A sample of thirty-two ECD centres from eight regions, namely; Hardap, Kavango West, Kavango East, Kunene, Ohangwena, Omusati, Otjozondjupa, and Zambezi, was identified by the OFL in consultation with the MGECCW. The identification took into account the following selection criteria:

## a) Characteristics of centres

- Registered with partner Ministry (MGECCW);
- Remote and rural;
- Located in a classified poor rural constituency; and
- Poorly resourced.

## b) Characteristics and social background of children benefitting from the intervention

- Confirmed from poor homes and vulnerable communities;
- Names are registered with the ECD centre.

## c) Characteristics of Educators

- Interest to participate in the activity and be regional resource persons;
- Eager to improve delivery of IECD services within their communities;
- Interest to share experience during and after the intervention;
- Interest to work and share expertise with three other constituencies identified in their regions; and
- Can read and write in own language and have basic understanding of English.



# what we found

## Physical infrastructure and safety requirements:

The centres were poorly constructed and did not meet requirements set-out in the guidelines for establishing ECD centres, as they did not provide sufficient and safe gross motor play space. Some did not have appropriate ventilation or lighting, while others posed a health and safety hazard to the children since they provided limited shelter, leaving children directly exposed to the harsh conditions of heat, wind and rains. Further, the lack of fences posed a danger to the safety and welfare of the children, because it allowed unauthorized entry of people and animals. A significant number of centres did not have immediate or reliable access to water and sanitation facilities.

## Health and hygiene requirements:

The majority of ECD centres did not have running water, toilets, or a dedicated kitchen area. The lack of running water in particular, affected the entire operation of the ECD centres in terms of health, hygiene and sanitation.

At most of the centres, there were no easily accessible health facilities nearby; in some cases the ECD centre was more than 30km away from the nearest health centre. None of the centres had a First Aid Box, nor had the majority of caregivers received First Aid training, and were not in a position to treat minor injuries or illnesses. The lack of First Aid capabilities, and limited access to health facilities, resulted in some communities making use of traditional medicine for minor illnesses, often with less than desired results.

## Nutritional requirements:

More than 90% of the ECD centres assessed did not provide any food for the children, and only a few of the children were sent to the centre with food from home. In some instances where the ECD centres were co-located with primary schools, some principals extended the School Feeding Programme (SFP) to the ECD centre, at the principal's discretion. Where food was provided it was mostly soft maize meal porridge.



## Children's physical, socio-emotional and cognitive needs:

The ECD centres did not, in general, maintain comprehensive records on the enrolled children. Some of the children at the centres did not have official identification documents (birth certificates) or immunization records (health passport).

The number of children with disabilities was relatively small. However, these children were not professionally assessed to determine the nature and extent of their disabilities, and as such the caregivers were not able to provide appropriate assistance to them.

Various mother tongues were used as means of communication at each ECD centre. This was considered a positive indication given that the use of mother tongue is important in developing a child's cognitive capabilities and assisting them to easily acquire a second language.

There appeared to be signs of neglect among some of the children, as observed in the often dirty and torn clothing of some children, and poor personal hygiene (Rhinorrhea, unkempt hair, dirty skin, and body odour). It was also observed that at some centres, children were related to the caregivers and as such the observed interactions were warm and

reflected mutual respect and love, resulting in a conducive caring and learning environment.

The lack of awareness of policy guidelines is cited to have affected enrolment procedures, including the collection of important data, and the maintenance of comprehensive records on children. This has a negative impact on the outcomes of the ECD centres, as caregivers do not focus their activities on the set goals of the ECD programme in Namibia, which includes: to develop children's fine motor skills; to develop children's language skills; to promote early literacy, to develop children's social skills; to develop children's cognitive abilities; and to help children's physical development.

### **Capacity of caregivers:**

The majority of caregivers were females, and it was found that thirteen of the 32 caregivers had attended the 7 weeks ECD Basic Course Curriculum provided by MGE CW, making up a small minority of all the surveyed ECD Centres, and raising concerns about the capacity of caregivers expected to facilitate the required development outcomes. According to the MGE CW (2005) guidelines the caregivers should "...at least have Grade 6 education and should have at least 12 weeks of training in ECD before they start working with children..." Most ECD centres could not comply with the MGE CW's standard for the maximum number of children allowed per ECD caregiver.

### **Teaching references and learning materials:**

Most caregivers had neither an ECD Policy nor an ECD curriculum in their possession to inform caring and teaching. Those who received training, taught from what they knew and or had learnt from the 7 weeks ECD Basic Course Curriculum training. The lack of a policy or curriculum in the caregiver's possession was further compounded by the lack of the necessary learning materials - compromising the standard of quality ECD provision.

## summary of findings

It is clear from what we found that the 32 centres surveyed in the eight regions lacked the essential requisites for the provision of quality ECD services. Most ECD buildings were not fit for the purpose, and the lack of sanitation facilities was of particular concern. The training of the caregivers seems to be lower than the Level 4 of the Namibia Qualifications Authority (NOA) Standards (MGE CW, 2012). The caregivers did not demonstrate a broad understanding of ECD concepts (Ministry of Education, 2006), and how they can nurture the children's potential. Despite these limitations, ECD centres served as centres where children were able to learn and develop, even if not at an optimal level.

It was surprising to find a number of children above the maximum age for ECD's. This was in many instances linked to their not having the requisite documentation to enter the formal schooling system. There was often a lack of coordination between stakeholders in providing integrated ECD services - Ministry of Health and Social Services, Ministry of Home Affairs, Ministry of Agriculture, Water and Forestry, Ministry of Education, Arts and Culture, Ministry of Gender Equality and Child Welfare, and the Office of the Prime Minister. The communities' input was often limited by general poverty, with families often failing to support the caregivers financially, and not being able provide any in kind support, as their time was taken up with economic activities for their families' survival. No evidence of the systematic monitoring of the ECD programmes was found.

# what can we do?

**G**iven the observations and findings derived from the analysis of the centres, there are some recommendations and suggestions on what can be done to improve the quality of IECD at centre and community level. These focus on policy and operational level interventions. Note that these recommendations are suggestions and are not exhaustive nor are they prescriptive. They aim to illustrate the kind of interventions that stakeholders can jointly implement to give children the best start in life. We all need to support the development of a physical environment which is more conducive to ECD. More so, we need to forge smart partnerships to provide ECD services that meet the health, sanitation, nutritional, physical, socio-emotional and cognitive needs of the poorest children in Namibia.

## Infrastructure and physical facilities:

### SHORT TERM:

- Agreements should be entered into with local authorities to incorporate minimum infrastructure standards in the approval of dedicated ECD centres, and in the proper registration of ECD centres.
- Resources permitting, ECD centres should be provided with adequate furniture, including chairs and tables.
- Relevant authorities (local authorities, Ministry of Urban and Rural Development (MURD), and Ministry of Agriculture, Water and Forestry (MAWF)) should be sensitised to attend to the broken water points on time.
- Communities should be sensitised to the needs of the ECD centres and be encouraged to help improve the facilities, some infrastructure, such as fences, can be made by community members out of naturally occurring materials.

- Outdoor play equipment of various types such as slides and swings should be provided to assist children in developing appropriate motor skills.

### MEDIUM TERM:

- Support should be provided to the development of ECD centres in under-serviced areas, including the identification of a number of ideal sites, based on easy access – closer to homes or to parents and guardian's primary income generating locations.
- Consideration should be given to support existing ECD centres to enable them to meet the minimum infrastructural standard.
- Water points should be developed at nineteen of the surveyed ECD centres to ensure that they have safe drinking water, additionally, water containers should be provided.

### LONG TERM:

- ECD implementing partners should explore different technologies to ensure access to sanitation at ECD centres (showers, wash basins, conventional toilets, double-vault urine diverting toilet, waterless urinal, dry toilet, waste and waste water disposal, etc.)



**Integrated services (health, hygiene, sanitation, safety and nutrition):**

**SHORT TERM:**

- The provision of integrated services should be used as an opportunity to solicit greater parental involvement in ECD, and the development of ECD centres as community service nodes. ECD centres also provide an opportunity for parents, caregivers and households to collectively work on issues related to the safety, health and early educational stimulation of children.
- An opportunity exists for stronger coordination between MGEWCW and the MoHSS to make ECD Centres service points for the health extension programmes (including vaccination programmes), synchronized with key dates in the ECD calendar, such as enrolment periods. Where Community Health Care Workers exist, they should visit the ECD centre to conduct health screening of the children.
- Community members involved with the centres should engage directly with their local health extension worker to coordinate services in the short term.
- All centres should have access to First Aid kits that could be used for treating minor injuries, and caregivers should be trained

in basic first aid during the delivery of such equipment.

- Where drought is declared, ECD centres should be considered as beneficiaries in addition to individual households.

**MEDIUM TERM:**

- All ECD centres should have access to separate toilet facilities for boys and girls. Where flushing toilets exist, these should be maintained in partnership with relevant resources (local authorities, Ministry of Works and Transport, vocational training centres, etc.). Alternatively, dry toilets should be acquired, particularly in rural areas with no access to running water.
- The ECD implementing partners should consider providing all ECD centres with fencing materials, gardening implements and other agricultural stock (seeds, chickens, etc.) and equipment, as start-up kits for sustainable nutrition programmes.

**LONG TERM:**

- The MGEWCW and the Ministry of Agriculture, Water and Forestry (MAWF) can collaborate for the provision of agricultural extension services to ECD centres, to allow them to sustainably provide basic nutrition to the children, through the development of community gardens and other agricultural activities.

## Children's physical, social-emotional and cognitive needs:

### SHORT TERM:

- All children should be helped to acquire necessary documents such as birth certificates and health passports.
- Community members should be sensitised about the importance of obtaining these documents.
- The use of mother tongue or a language commonly spoken in the area should be encouraged at all ECD centres.
- If children with disabilities are admitted to ECD centres they must be helped to participate in or enjoy all provided activities.

### MEDIUM TERM:

- Multimedia resources should be availed to facilitate the rapid development of mother tongue language skills. This will help to build strong bonds between the ECD centres and the community. English should still be used in some activities such as songs and rhymes to familiarize them with the sounds of the English language.
- Children with hearing impairments should be assisted to acquire hearing aids. Children with speech impairments should be referred to speech therapist for professional assistance. Children with visual impairments should be assisted to be give visual aids. Caregivers should be trained on how to interact and deal with vulnerable children and children with disabilities.

## Training and capacity building of caregivers:

### MEDIUM TERM:

- The overcrowding of ECD centres, and the lack of caregiver assistants does not allow for quality childcare, guidance and support. Accordingly, the MGECW should provide guidelines on the recruitment of assistant caregivers and related allowances. MGECW could also offer incentives for ECD centres to hire assistants.
- The 7 weeks course offered by the MGECW may require review to match its content to the level of caregivers' education. Training workshops can be offered more regularly. These workshops should be aimed at upgrading skills of the caregivers and should provide information on various aspects of ECD concepts, teaching skills, curriculum development, basic bookkeeping and centre management.
- In addition, workshops could be provided by MoHSS to train caregivers in basic health practices to ensure that ECD centres are ready to tackle minor health risks that may occur at the centre, such as the identification and management of communicable diseases, and the prevention of environmental diseases.
- Caregivers should be trained so that they have the capacity to identify abuse and trauma in children and have access to, or create support mechanisms for, children who have had their rights violated.



## Teaching, reference and learning materials:

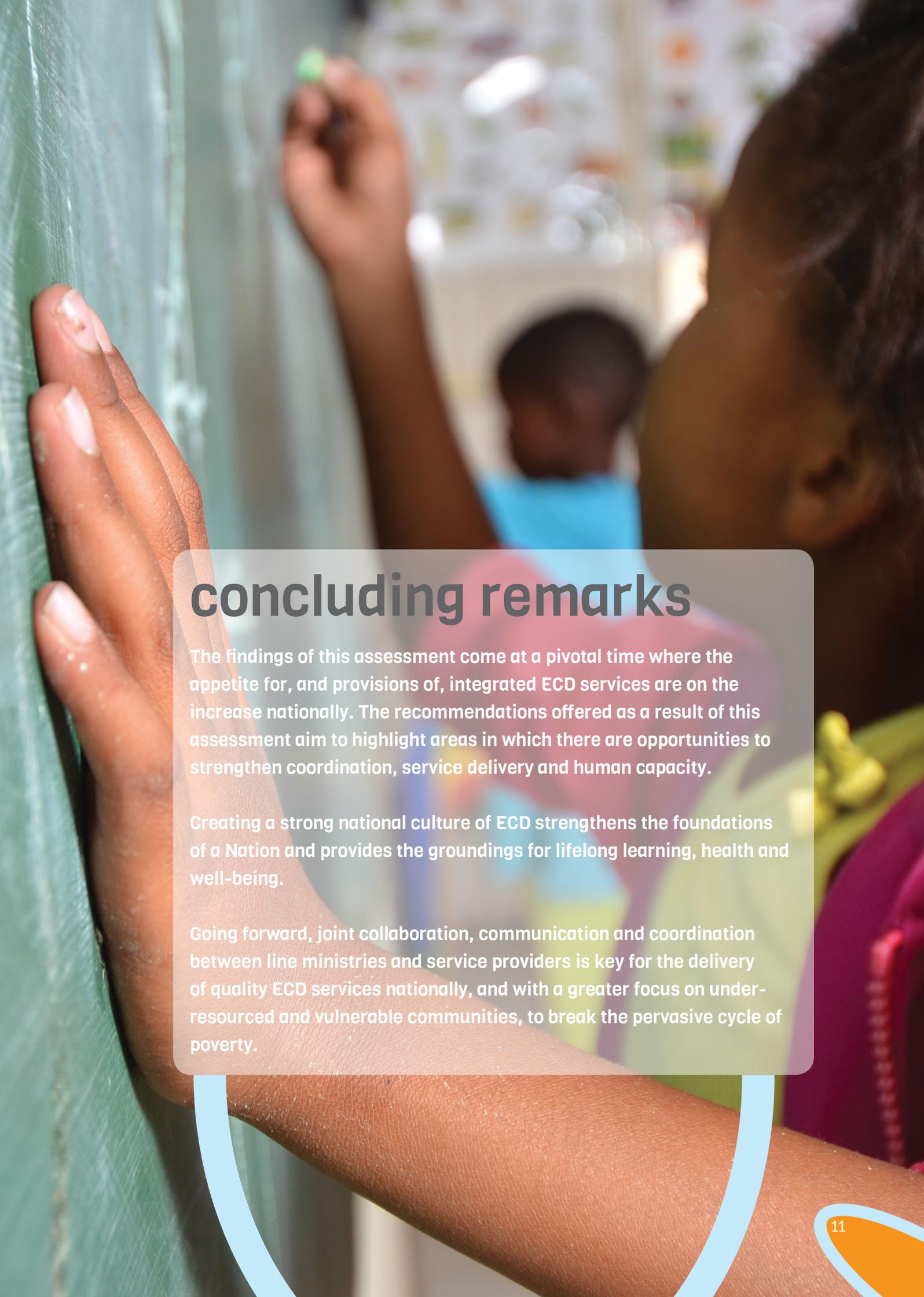
### SHORT TERM:

- Caregivers should have access to copies of the National IECD Policy, Guidelines on Establishing ECD Centres in Namibia, Curriculum Framework for Children in Namibia aged 3 and 4 years, and the Standards for ECD Centres. These are essential documents that would serve as reference in the implementation process of the ECD programme. The curriculum presents guidance in terms of what skills to cover for the year. The implementation of the guidelines suggested in these documents should be evaluated over time to provide information on areas for improvement.
- Caregivers should be trained and encouraged to make stimulating learning tools out of materials found in their local environment.
- Indigenous knowledge systems and culture should also be incorporated into caregiving methodologies, through indigenous languages, toys and other learning material.

### MEDIUM TERM:

- All centres should have access to teaching and learning resources such as story books, posters, puzzles, technological equipment, and clay.





## concluding remarks

The findings of this assessment come at a pivotal time where the appetite for, and provisions of, integrated ECD services are on the increase nationally. The recommendations offered as a result of this assessment aim to highlight areas in which there are opportunities to strengthen coordination, service delivery and human capacity.

Creating a strong national culture of ECD strengthens the foundations of a Nation and provides the groundings for lifelong learning, health and well-being.

Going forward, joint collaboration, communication and coordination between line ministries and service providers is key for the delivery of quality ECD services nationally, and with a greater focus on under-resourced and vulnerable communities, to break the pervasive cycle of poverty.

# Office of the First Lady interventions on the basis of findings:

- Campaign for core material support for ECD Centres;
- Promote partnerships aimed at building capacity of the caregivers at the 32 ECD Centres;
- Facilitate exchange between good performing centres and centres in need of support/capacity to improve the quality of their work;
- Call for dedicated support through the One Economy Foundation to ensure that the foundation education a Namibian child receives sets them up for a positive educational outcome; and
- Advocacy around indigenous knowledge systems about toys and play.



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