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SCALE - UP SERVICE DELIVERY OF EARLY CHILDHOOD DEVELOPMENT PROGRAMMES

Deliverable 4: Support Structures

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1 INTRODUCTION

When it comes to social program delivery, one of the critical distinctions between state institutions and civil society organisations (CSOs[1]) is that the state must, by necessity, take a bird's eye view of delivery in order to ensure that social spending reaches the majority of the population, while civil society organisations and community-based organizations (CBOs) in particular, must primarily take into account the needs of the community around them. Thus, the state must put less emphasis on accommodating community peculiarities (in favour of a more generalized approach) while CSOs must be more sensitive to culture, economic diversity and local attitudes toward social spending.

At this juncture, the state has recognized that civil society organisations have a major role to play in delivering social programs and are essential partners of government in delivering services to the needy in South Africa. They deliver effective programmes and projects, have greater experience in servicing communities' needs and they are often based within communities. CSOs have a strong appreciation of human rights issues, and in the ECD sector specifically, child rights. In addition, Not-for-Profit Organisations (NPOs) are well-placed to partner with government and the private sector in service delivery and also provide a range of employment opportunities at the community level. They can also frequently be found in social development forums where there is an opportunity to mentor one another within the sector.

Still, despite massive state resources, funds for social development are not reaching the grassroots. This is compounded by the blockages in delivery of those resources to NPOs and communities, which have difficulty accessing the funds or are constrained by requirements that are too prescriptive to easily qualify for. In order to address this problem, it may therefore be necessary to build "intermediary" organizations that can help bridge the gap between institutional delivery goals and community-based delivery goals on the ground.[2]

This paper thus seeks to present potential solutions to improve access to social services by using a combination of approaches that take into account the important role of CBOs, while at the same time introducing intermediary organizations as bridging organizations that can accommodate the developmental objectives of both the state and the people it serves.

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[1] The definition of CSO includes Not For Profit Organisations (NPO) and Civil Society Organizations and Faith Based Organisations (FBOs)

[2] Presentation drafted by Miriam Altman, 2007

The overall aim, however, is to consider whether an intermediary support agency would contribute to the pace of scaling up quality ECD. This paper provides a brief sector analysis and review of possible approaches to scaling up,. The changing context where new policy, norms and standards and funding is being introduced into the sector suggests that ways of introducing coordination and linkages would be useful.

To gain a better understanding of delivery models, the research involved a comprehensive review of both local and international experience. Interviews with key informants in government and supporting agencies in the ECD and other sectors were also conducted to gain firsthand insights into regional and provincial discrepancies, gaps and bottlenecks.

We also took into account existing contemporary research, which suggests that some provinces are better than others at administrating funding support for ECD. There are also a wide range of implementing organizations and NGOs that currently operate within this environment and which use a portion of this funding. It has also been found that monitoring and evaluation systems in these cases are weak, as well as administration systems to distribute the funds available to the intended beneficiaries. This was the basis for seeking a solution that could be founded upon a more standardized model of service delivery.

The various models investigated were: social franchising; network associations; and capacity building and mentoring models. Even though these can be described as distinct models, they have overlapping elements. . In this paper, we present them as a continuum from pure franchising to ad-hoc models of support, with replication being the main differentiation. The next section aims to briefly contextualize ECD environment in South Africa.

1.1 Brief description of the context

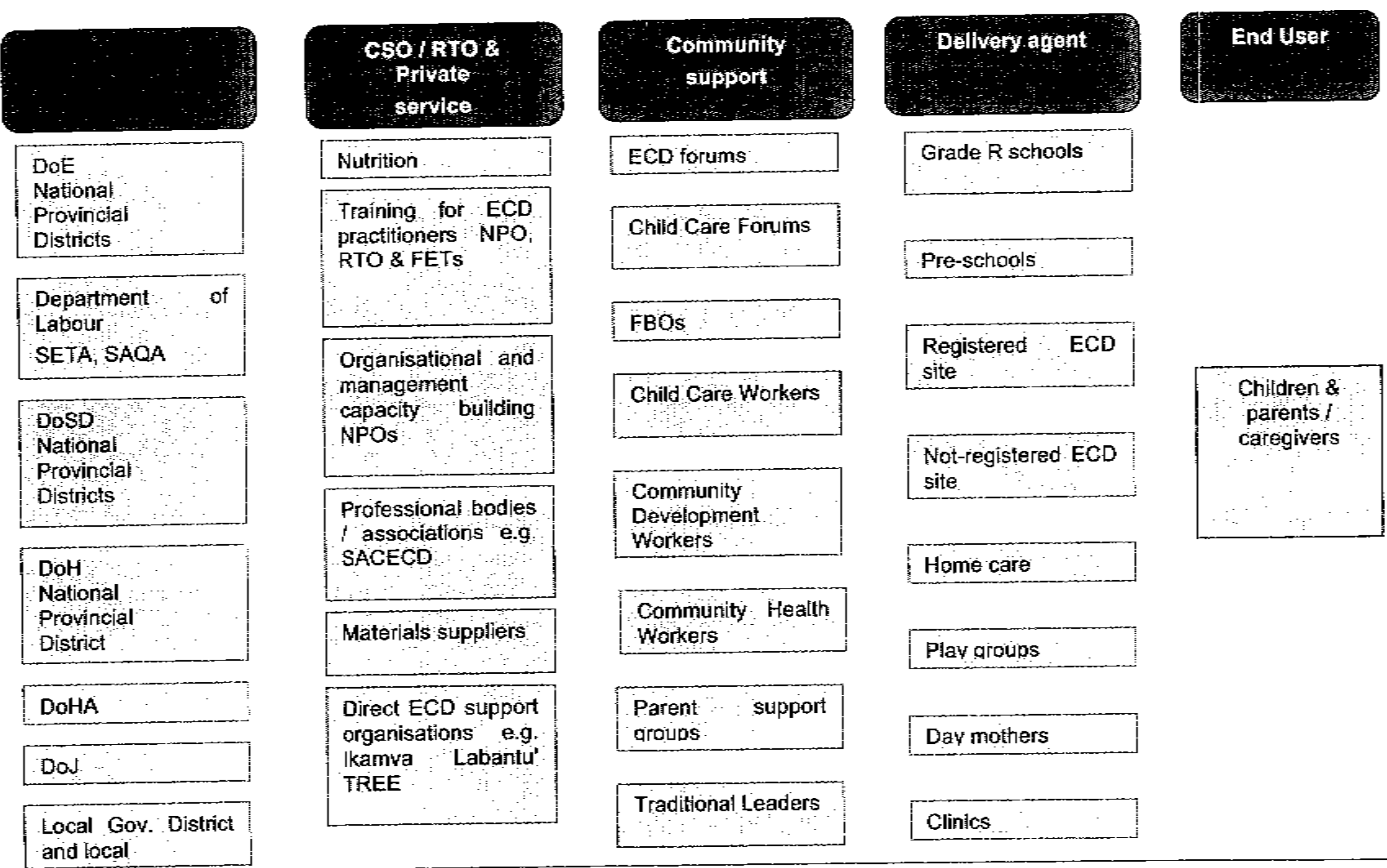
It is estimated that there are currently 5.16 million children aged from birth to four years, 86% of whom are African. The largest numbers are located in KwaZulu Natal, Gauteng and the Eastern Cape (Biersteker and Streak, 2008). This represents 9.9% of the country's total population, according to the fourth draft conceptual framework of the document entitled "ECD Centres as Resources of Care and Support for Poor and Vulnerable Young Children and their Families (including OVC's)" (July, 2006). There are currently 8,920 ECD centres registered by the DoSD in South Africa, of which 5103 receive subsidies from the Department (Ibid). A Department of Education audit conducted in 2000 identified 23 482 ECD sites (Ibid), which means

that 37.9% of ECD sites in the country are not registered, and can not access any state subsidies. Most ECD sites are poorly resourced and serve children who are affected by poverty, malnutrition or poor nutrition, and HIV and AIDS. ECD practitioners and school principals / supervisors are often poorly paid and weakly educated, even though many may have years of experience in the sector.

The majority of children from birth to 5 (84%) are not accessing any formal ECD provision at all and rely on their parents / primary care givers for any stimulation and development needs (Ibid). There are 18,268 community or home based ECD centres in the country.

The current ECD environment can therefore be said to be fragmented, and service delivery inconsistently applied throughout the country. As a consequence, there has been a proliferation of delivery organizations with ad hoc approaches to ECD and less corresponding standardization and control over the quality and delivery of services by the state. Ultimately, however, the programs implemented by these organizations have become increasingly entrenched in some provinces and communities, so much so that there is a resistance to altering these programs, particularly where they are seemingly working (i.e. don't fix what isn't broken). There are organisations that have developed models and are poised to support their replication, if they are able to secure funding and support.

Figure 1 Roleplayers in the ECD sector



Role players and linkages in the sector

Figure 1 depicts the roleplayers in the ECD sector. The role of the state in the delivery of ECD is to create an enabling environment for the ECD sector to thrive by providing legislation and policy, ensuring that funds flow into the sector, monitoring quality and evaluating outcomes, and facilitating expansion. In terms of the Department of Social Development, the District office is the key roleplayer for ensuring that ECD providers are registered and able to access state support (subsidies) and donor support (funding). There is also a need to create stronger connectors between the role-players; particularly between the State, the NPO and Private Sector Service Providers, who can assist with improving quality, can expand the community groups that support ECD on the ground as well as the ECD centres themselves and their connection to children and parents at home.

A map of a hypothetical ECD centre (Rose's ECD Centre) is depicted in Figure 2 below and shows the range of services and requirements that Rose needs to provide quality ECD to the children in her care.

For ECD centres such as Rose's, the three key elements that are needed for improving quality are 1) being registered with the DoSD 2) funds to purchase services and materials / equipment and for facility maintenance and upgrades and 3) regular monitoring of service provision. Each of these three aspects is provided by the Department of Social Development at District Office level, yet there are fundamental backlogs and blockages in delivery. Rose must also link with other ECD sites in networks or forums so that they can organise collectively for professional development and support and for group buying of materials at discounted prices, amongst other things.

The many children and caregivers in home based settings also need a myriad of support systems and the associate with the formal ECD site could be critical to their development. A greater connection between the formal ECD site and the home and family space could also be an important part of support to the sector. In addition, the ECD forums could play a greater role in linking the two. .According to Linda Biersteker, these organisations can act as important gatekeepers or enablers for communities. One of the problems cited, however, is that they do not always recognize home-based provision as important and thus, this can be a challenge when these organizations try to divert resources into their existing sites. Nevertheless, they are an important partner at community level and may need to be

established or strengthen (including greater representivity) as part of an implementation model if they don't exist.

Funding and capacity

If Rose had a sustainable source of sufficient funding, including high fee paying parents (ECDs in the private sector charge as much as R5000 per term), and the knowledge and capability to do so, she would be able to procure much needed services herself. However, cost recovery in Rose's poverty stricken community is low and she is probably not aware of or able to access the type of support she needs.

The CSOs who could provide services to Rose for free or at low cost are also hamstrung by a lack of sufficient funding and the quality of their delivery varies. Raising quality and professionalism in the sector, at both ECD sites and by requiring service providers to register (either as an ECD or as an NPO) would assist with transparency, accountability, quality control and good governance. This, however, raises two important issues: One, the barriers to entry are high -- many NPOs and ECDs do not have the skills or means to register, leaving them in the margins of the sector where they operate with less legitimacy.[3] Secondly, once registered the requirements put strain on organizations, many of whom have limited capacity to deal with bureaucracy and little additional funds for administration, let alone to pay for auditors. In this regard, donors are often not willing to fund the operations or core functions of these NPOs since funding is normally tied to programme outputs only.[4]

This adds further pressure to Rose's situation, particularly where work in the NPO sector is incredibly demanding and levels of staff burnout are very high. There is a high reliance on volunteers in the sector because there is not enough money for hiring the required staff. A common problem is that once staff are trained and volunteers are capacitated, they become mobile in the employment market and will often leave for better opportunities or higher pay.

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[3] "During 2005/06, 13 405 organisations applied for registration. Of these, 8 398 met the registration requirements. By March 2006, the total number of registered organisations was 37 532." (http://www.gcis.gov.za/docs/publications/pocketguide/022_social.pdf accessed April 2007)

[4] "... NPOs must enter a world in which social relationships are replaced with contracts – a world designed and operating by the legal and accounting professions. The new public space is not just about the legal right to register in order to operate, but about the more important need to access resources." (Habid, Ed, 2002)

The high level of voluntarism in the sector is a strength, but volunteers require supervision and training, and will also often terminate their services at short notice if their personal circumstances change. This, unfortunately, leaves the sector without vital skills and services. Because of this and given the context of unemployment and poverty in South Africa, there are increasing calls for the provision of stipends to volunteers. In this regard, organisations or state departments who are able to remunerate their volunteers will draw away skilled volunteer capacity from those who are not.[5]

From this depiction, one can see that the sector could benefit from an intermediary organisation that can coordinate and supervise many of these different aspects and provide a bridge between Government, the CSOs and the ECD sector, while at the same time building the capability of each one.

[5] "Most problematic, however, is the fact that our organisation can only pay their Community Development Workers (CDWs) a maximum stipend of R600 per month. It is very difficult to keep highly motivated when you yourself are in great poverty and are trying to help others. Volunteers often lose morale and leave the programme, often wasting an enormous amount of training. Our organisation has both the capacity to train more CDWs and to employ them in a greatly expanded programme if funds were available. " (Mary Turok, Advocacy Officer – Age-In-Action) (Lomofsky, 2007

Figure 2 Cluster map in relation to an ECD site e.g. Rose Early chilhood development centre

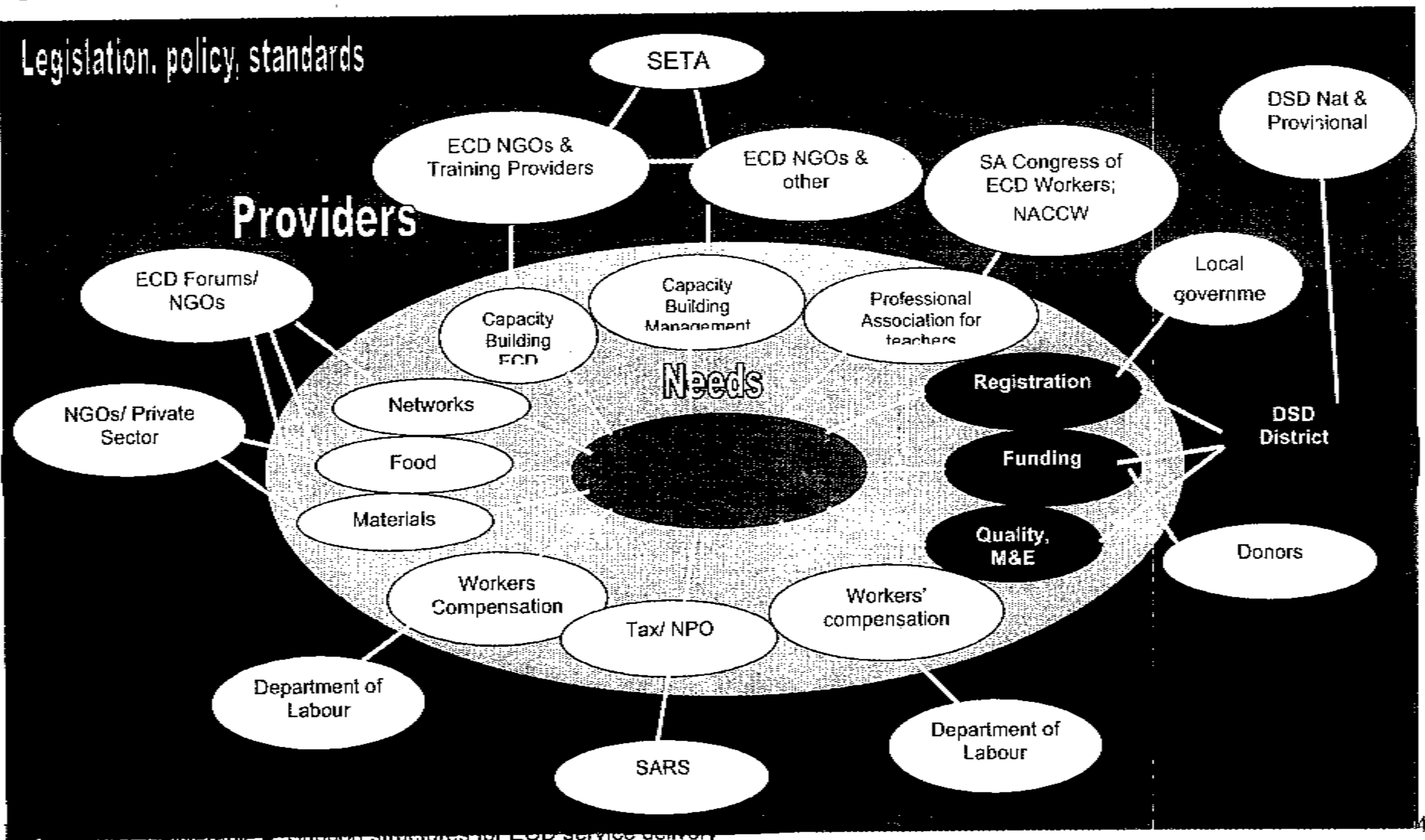
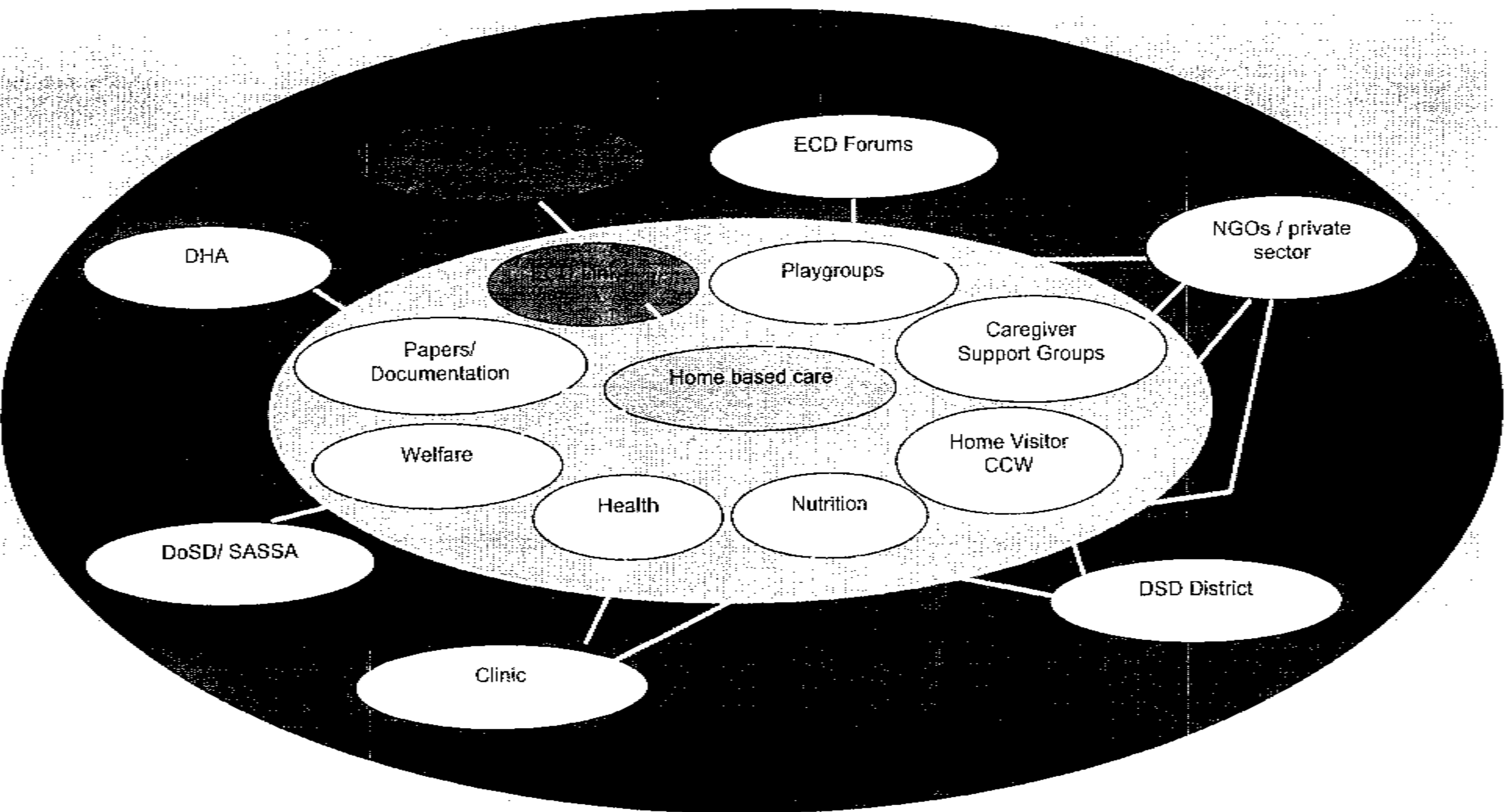


Figure 3 Needs of children at home



When NPOs are contracted to provide services, there is a need to ensure that the inputs, activities and outputs are leading to the desired quality outcomes. The skills required for conducting outcomes based monitoring and evaluation are often not contained within NPOs and need to be outsourced. This is often costly, and NPOs often do not have the skills to engage effectively with evaluators, and government M&E systems are still in the early stages of development.

Integrated Service Delivery Model (ISDM)

In terms of government, the Department of Social Development acknowledges that its support for the NPO sector has been lacking, and that funding has been skewed towards social grants. At the launch of the new Integrated Service Delivery Model of the Department of Social Development, Dr Jean Benjamin (November 2005) stated that:

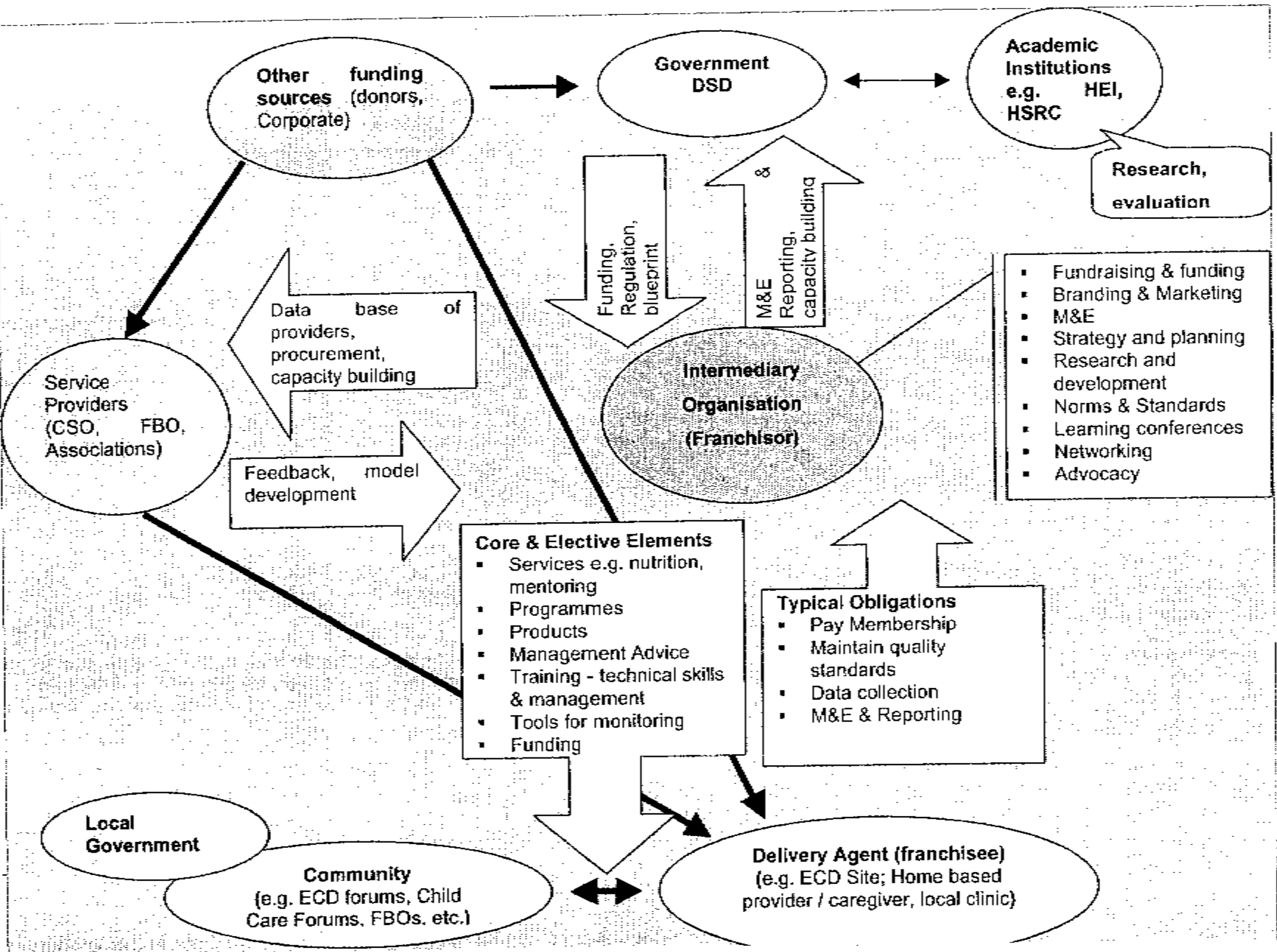
" ... it is also true that because of the focus on social security, attention to other services have been inadequate to date. The crowding out effect of the social security budget has led to significant pressure on social services provided by both government and the non-governmental organisation (NGO) sector. The budget for social services has therefore not kept pace with the demand for services. It has not been adequate to address the social conditions that are causes and consequences of poverty and vulnerability. This state of affairs has placed severe limitations on human, financial and physical resources in this sector."

According to one NPO Director, "... the DSD in Limpopo rolled over R2m in 2007 of funds that were supposed to given to the social sector. In 2006 they gave back R8m rand." (Fiona Nicholson, TVEP)

The ISDM attempts to change all this and recognizes NPOs as key partners in the implementation of social programmes. Launched in 2005, the implementation of the ISDM will take time. In the Western Cape, which is one of the strongest provinces of the DoSD, the implementation of the ISDM is only now being conceptualized and is yet to be devolved effectively to the District Office level who will take over funding responsibility from the Provincial Department.

From this depiction, one can see that the sector could benefit from an intermediary organisation that can coordinate and supervise many of these different aspects and provide a bridge between Government, donors, academic institutions, the CSOs and the ECD sector, while at the same time building the capability of each one.

Figure 4 Cluster map with intermediary organisation


Other funding sources (donors, Corporate)
Government DSD
Academic Institutions e.g. HEI, HSRC
Research, evaluation
Funding, Regulation, blueprint
M&E & Reporting, capacity building
Data base of providers, procurement, capacity building
Service Providers (CSO, FBO, Associations)
Feedback, model development
Intermediary Organisation (Franchisor)
Fundraising & funding
Branding & Marketing
M&E
Strategy and planning
Research and development
Norms & Standards
Learning conferences
Networking
Advocacy
Core & Elective Elements
Services e.g. nutrition, mentoring
Programmes
Products
Management Advice
Training - technical skills & management
Tools for monitoring
Funding
Typical Obligations
Pay Membership
Maintain quality standards
Data collection
M&E & Reporting
Local Government
Community (e.g. ECD forums, Child Care Forums, FBOs, etc.)
Delivery Agent (franchisee) (e.g. ECD Site; Home based provider / caregiver, local clinic)

Gaps in scaling up ECD delivery

There are clearly a number of gaps in existing government policy, which recognizes the need to improve the quality of education and care in ECD sites. This requires that certain linkages be established and actions taken to address these gaps, which an intermediary organisation could facilitate, and we highlight the following as key considerations to meet the needs of the ECD sector at different levels. (As depicted in **Error! Reference source not found.**).

Professional Development:

a. Provide training and professional development opportunities for ECD practitioners and principals in ECD sites, and for home and community based care practitioners and parents / care givers, as well as follow up support and mentoring at the site of service provision
b. provide ongoing professional development for ECD practitioners along identified career paths

Nutrition:

c. provide nutritional support to ECDs and families in need

Materials and resources:

d. provide materials and resources for educational activities (e.g. stationary, toys, educational games)
e. assist with infrastructure development for registration if necessary

Organisational development

f. Provide support ECD sites to meet registration requirements and to register with the DoSD
g. Fundraising and transferring funds
h. Distribute donations received in the forms of goods, clothing etc.
i. Managing human resources
j. Organisational governance and leadership
k. Financial management
l. Supervision, quality assurance, monitoring and evaluation

Networking and external relations

m. support community based networks of ECD sites and related organisations

n. Network with other providers to provide services in line with Integrated Development Needs as per the NIP such as the social development and health needs of Orphans and Vulnerable Children such as Childline (survivors of physical or sexual abuse), Isibindi (Child and youth care workers who provide a range of critical support working in the Life Space (define) of the child e.g. setting routines in the family, cooking, regisrations for social grants, homework support etc.).

o. Communication with parents / caregivers

Some of these could be perceived as core modules which are non-negotiable elements of the model, and others as electives or desirables.

The following section outlines the various models or methods (supervisory structures) that could be used to scale up ECD provision in South Africa.

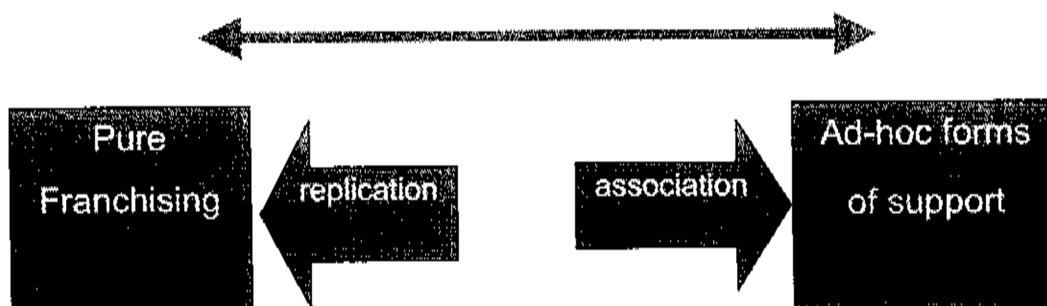
2 MODELS OR SUPERVISORY STRUCTURES FOR SCALING UP ECD PROVISION IN SOUTH AFRICA

In this paper, we consider a number of different organizational formats that are and can be used in the ECD sector to assist with scaling up. The first is "social franchising," which implies degrees of replication of a model. The second is networks, associations and support groups and the third is capacity building and resource NPOs.

It should be noted that a social franchise model can contains elements of the other formats and usually using different techniques for delivering on the various aspects of the franchise.

2.1 Models of social franchising

Figure 6 Continuum of social franchising



Social franchising is a loose term used to describe a number of different social program delivery models. These can be placed on a continuum where the scale is the degree of replication.

The scale moves from "pure franchising" to "adaptive" models of franchising to ad-hoc support mechanisms. Looking at it on this spectrum helps to locate the different organizational forms that social franchising takes. The common denominators with all social franchising models are a) acceptance and use of the brand b) agreement to adhere to quality and to norms and standards c) agreement to work towards the same development goals and d) agreement to collect data for monitoring and evaluation purposes.

2.1.1 . *Definitions*

Business-format franchising (also described as the "carbon-copy" format by Castrogiovanni & Justis (1998, cited by Du Toit, 2003)), involves an agreement between two legal entities, the franchisor and the franchisee whereby *"The franchisor is a parent company that has developed some product or service for sale; the franchisee is a firm that is set up to market this product or service in a particular location."* Franchising involves the replication of a proven business formula and system, and can be seen as a business relationship with mutual benefits to franchisor and franchisees. Well known examples in South Africa are fast food outlets such as Nandos and St Elmos Pizza, and property retailers such as Seefe.

Franchising typically includes a range of techniques, as discussed by LaVake (2003). These are promotion and marketing (creating brand awareness and demand); training to deliver on the product or model and to run the organization; quality assurance and standardization of services; information sharing and referral mechanisms; cost recovery mechanisms (if possible); and a franchise agreement or contract.

Figure 7 Typical franchising techniques

1. **Promotion and Marketing -** Targeting a product to a market niche, such as an age or ethnic group, is important for social franchising projects as selling a product or service depends on branding and marketing. This is relevant to the ECD sector in that the training programmes can be branded (e.g. programmes developed and branded by the well established RTO's such as ELRU, TREE, Ntataise, and Kululeka for instance, would be highly esteemed and in demand by practitioners and also attract donor funding). On a larger scale, the whole ECD concept and programme could be branded such as the Bright Child Campaign in the Philippines.
2. **Training -** The franchisor trains staff, volunteers, and others involved with the franchising venture, ideally with a certification program and an emphasis on quality of service. (Training is normally linked to on-site visits and mentoring to ensure that what is learned in the classroom is transferred into the site of work).
3. **Quality Assurance and Standardization of Services –** Clients (practitioners or ECD sites, and parents / caregivers and funders / government) are encouraged by predictable service quality, which will meet norms and standards of ECD provision and can be monitored and evaluated to measure child outcomes.
4. **Information Sharing and Referral Mechanisms -** Referral forms are used in most franchises to direct clients to resources both within the franchise and to other organizations that provide more specialized services. This type of networking serves specific client needs and also expands links between collaborative community groups.
5. **Cost Recovery Mechanisms -** The cost of services can be reduced by economies of scale such as centralized purchasing and fee schedules. Charging a fee, even if it is nominal, is important in order to have the client value the service, to be able to monitor client use through financial records, and to provide for cost recovery to the extent possible. Fees may be charged on a sliding scale based on the client's ability to pay. A modest initial or annual "franchise membership fee" may also charged to the provider. Unless networks are large enough, franchises are unlikely to benefit from economies of scale. The costs of fixed overhead, brand advertising, and training can be reduced by spreading them over a large number of service sites, or the provider must accept that cost recovery will only be partial. In the South African examples, it is almost universal that there is no expectation of cost recovery at all in donor or government funded social franchising models.
6. **Franchise Contract -** Formal agreements can clarify goals and directions for the franchise, thus helping to expand and sustain programs. Such an agreement should outline the respective obligations of the franchisor and franchisee. Culturally appropriate, relevant, and mutually understood formats coupled with an interview or screening and preparation program, including a business plan, adds value in the application of contracts. Organisations that are part of the Ntataise network sign an agreement to adhere to certain conditions of being a Ntataise training organization (in effect a training franchise model)

Social franchising is mostly defined as franchising with social rather than profit making goals. (Du Toit, 2003). Montagu (2002: 129) defines a social franchise as *"...a franchise system, usually run by a non-governmental organization, which uses the structure of a commercial franchise to achieve social goals."*

While in the for profit sector the market may indicate demand, in the ECD Sector, Governments and normally address market weaknesses and step in to scale up quality ECD programmes and identify where the spokes should be.

"Social franchising" thus is a term loosely used to describe a number of different methodologies related to scaling up delivery of a particular social program concept.

These programs can be very broad, e.g., poverty alleviation programs as administrated by global organisations such as UNICEF, World Vision, etc., or they can be very specific, e.g., fertility clinics distributing condoms produced by a particular medical company using a model (or blueprint) for birth control or HIV education at the local level. In the latter case, often there are social franchising networks that offer funding to organizations in order to develop blueprint models and these organisations then need to seek financial assistance to scale-up or "scale out" their models.

Other models take social mandates developed at a state level and look at how to diffuse these social goods to widely disbursed communities throughout an entire country. This approach normally requires the use of intermediary organisations (usually NGOs), which are trained and capacitated to deliver social goods and services with the use of state funds (either raised through taxes or through international donor agencies). In this case, the state acts at the top of the organisational structure, providing oversight, branding and advertising of the concept, while the NGOs and their partner CBOs must deliver the products or services mandated. In this regard, states look to the franchise model concept to best standardize delivery of the programs and ensure equality of delivery. LoveLife is a good example of this in South Africa.

Much of the literature on social franchising is based on experiences in the reproductive health sector, which are more likely to be driven by the distribution of products but also provide social goods (e.g. reproductive health products or contraceptives by large medical companies than in other sectors).

Franchisees can either start up from scratch and offer only the products and services of franchisor (e.g. McDonalds), or they can add the franchise products and services to an existing business or organisation (e.g. a clinic that agrees to offer a particular

reproductive health model as part of its package of services.) The metaphor of a Hub and Spoke model is useful for understanding this latter form of social franchising. It refers to a situation where there is a central hub where the product or service originates. The hub organisation wants to reach a target and beneficiary group in another location, but instead of opening a site of its own, it partners with an entity that already exists and that can carry the product or service. The hub then supplies all of the promotional materials, capacity building and marketing support to the spokes. Where "hub and spoke" models are used, these generally are regarded as more cost-effective alternatives to get products or services more widely distributed (or scaled out), and are scaled up using social franchising techniques. From the case studies conducted, it seems that most social franchises use the hub and spoke model. These tend to work well where a particular training methodology or healthcare product compliments an existing social development mandate. For instance, this model is usually used in conjunction with a World Health Organisation Mandate, e.g.,, to eradicate malaria using a particular drug or concept, or HIV with condoms or other protective measures. All that this suggests is that the WHO usually provides funding to organisations that are on the ground already and can distribute the particular healthcare product or service. Similarly, a programme that has been developed for a pre-school, together with products that could be used to support it, such as toy kits, could be distributed to existing ECDs as part of franchise that will help meet the government mandate in terms of rapidly scaling up quality ECD.

In the following sections, we distinguish between these approaches based on the definition of three models that we place on different places in the spectrum. These are pure franchising (top end), adaptive franchising (middle) and ad-hoc associative franchising (low end).:

Pure franchising, requires a high degree of standardisation, and includes strict monitoring, supervision and control. The franchisee adopts the blueprint or format with a strict set of implementing procedures and policies (Royle, 2001) and this model can be replicated again and again, as long as there are sufficient resources to fund the blueprint. LoveLife is such an example in South Africa.

Adaptive franchising provides for more flexibility and allows a franchisee a fair amount of autonomy in how they implement the model. In this case, the franchisor blueprints a social development *concept* that can be handed over to other organisations who can use and adapt the model as appropriate (within broad guidelines).

In both cases, institutions or organisations are able to quickly step into a social franchise-type model without having to bear the development costs of designing the model. In addition, because the model has already been proven to be effective, this allows the organisation to tap into funding resources on its own account without necessarily having to rely only on the central organisation to access these. For example, if the government is funding the distribution of its blueprint for ECD service provision, the ECD practitioners (including home base sites) will have autonomy in how they operate, how they organise their activities, etc., as long as minimum standards are met. NOAH is an example of this in the ECD sector in South Africa.

Ad-hoc associative franchising, on the other end of the spectrum, is where there is no imperative to replicate or adapt a model at all, yet all the organisations associated with the brand and network are bound to deliver on set objectives and work towards the same goal, and support each other in doing so. For example, in the ECD sector, government has set norms and standards and has determined specific ideal outcomes. A partnership can be formed with role-players in the sector who agree to adhere to these norms and standards and to work towards these outcomes. Funding, capacity building, mentoring, branding, opportunities for learning and sharing, resources could be provided to the partners, yet these partners can still deliver on the objectives as they see fit. In this regard, they will receive funding to work with their own preferred service providers as long as they follow certain procurement procedures. Cape Action for People and the Environment (C.A.P.E) is such an example in the Western Cape.

More detail on the case studies can be found in Appendix 1.

Figure 8 Case Study of Pure Social Franchising: loveLife

loveLife, was launched in September 1999 to address the growing need for a dedicated HIV prevention programme. It was established by a consortium of leading South African public health organisations, the South African government, major South African media groups and private foundations and in partnership with South Africa's national HIV prevention programme for youth, which is a coalition of more than 100 community-based organizations. LoveLife has established a very strong brand and uses a highly visible awareness campaign to gain pubic attention. It has also has established a countrywide network of adolescent friendly outreach and support programmes for youth.

Its partnership with media groups has led to its innovative use of marketing approaches to get its message "out there." This includes a sustained multi-media education and awareness campaign using television, radio, outdoor media and print – educating young people about HIV and promoting dialogue about sexual health issues. loveLife has developed an evaluation programme regarded as one of the most comprehensive of its kind in the world, and it partners with local and international academic and research institutions for this.

- The main replicated model of loveLife is the Countrywide programme of community-level outreach and support to young people (called loveLifestyle.

loveLife is very well funded by major international and local donors and the South African Government.

The loveLife social franchising system...

loveLife positions itself as a healthy lifestyle brand for young South Africans. There are 130 community-based organizations associating themselves with the brand through the 'loveLife franchise' system.

loveLife uses an approach which leverages their community development expertise. In turn, they are assisted to implement a systematic HIV prevention programme for teenagers using a co-branded theme and product, loveLifestyle.

Each franchise holder implements loveLifestyle in at least five schools. This enables loveLife to delegate responsibility to the franchisee for the successful transference of the model to the communities.

A youth serving organization which has applied to loveLife and meets basic criteria in terms of governance, programme and financial management can be eligible to become a franchisee.

A 'loveLife line manager' is identified in each organization and provided with training in HIV prevention, loveLife-style. Franchisees thereafter recruit two 'loveLife groundBREAKERS' from their community each year. These individuals are then trained to implement loveLifestyle in schools. groundBREAKERS are paid a stipend of R880 per month.

Each groundbreaker, in turn, recruits five mpintshis ('buddies') who are also given in-service training by loveLife. Mpintshis receive no stipend. Outside of this, franchisees receive resources and promotional materials each quarter, as well as monthly distribution of loveLife's lifestyle magazine UNCUT. Once a loveLife franchise has been successfully established, this becomes a loveLife 'hub'. There are currently 710 of these, including clinics and youth centers. Young people at these franchisees then are entitled to participate in loveLife leagues (debating, sports & recreation), which is regarded as a special privilege by the participants.

Franchisees commit to specific targets in terms of youth participation (both in- and out-of-school youth).Line managers are expected to supervise and support groundBREAKERS and mpintshis and to create the loveLife hubs that become a part of the youth lifestyle.

The value of loveLife's direct contribution to the franchisee is about R200,000 per franchisee per annum. Indirect contribution (in terms of training etc) is also significant

love Life 0800 121 900

Figure 9 Case Study Adaptive Approach: NOAH

(http://www.noahorphans.org.za/NoahArks/tabid/1756/Default.aspx) and interviews

Figure 10 The NOAH Model

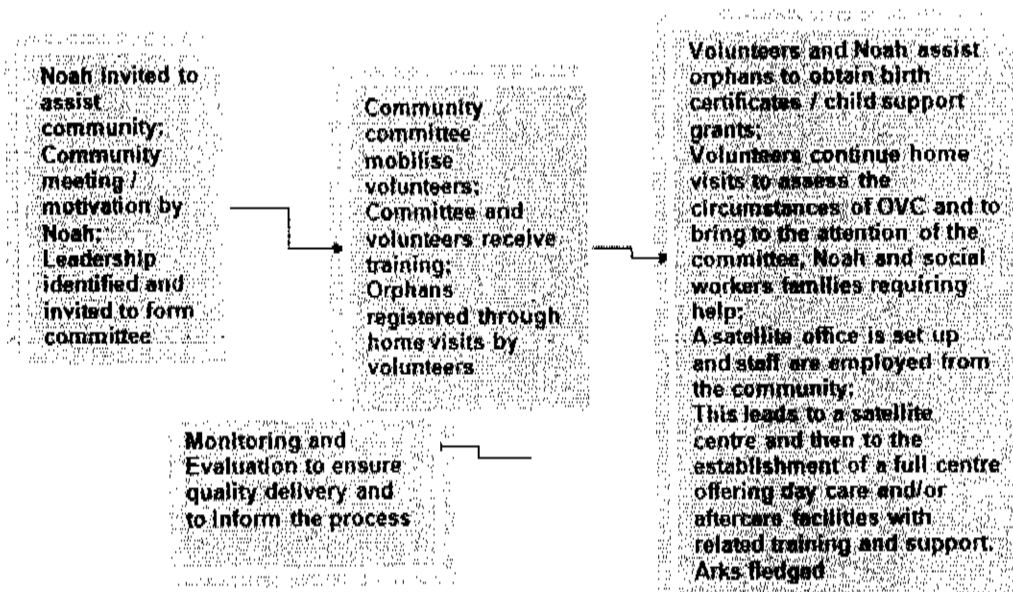


Figure 11 Cape Action for People and the Environment (C.A.P.E)

C.A.P.E is a multi-lateral and multi - sectoral partnership to save Cape Floristic Kingdom. It receives GEF and Government funding. C.A.P.E has partners with agreements signed at highest levels in government e.g. with DWAF, CapeNature, DEA&DP, DEAT, DOA, Botanical Institute, Table Mountain Fund, DBSA, SANPARKS etc. The Memorandum on Understanding established the C.A.P.E. Implementation Committee, which represents government departments, municipalities, statutory bodies and accredited non-governmental organisations that will carry out the vision of C.A.P.E. The C.A.P.E partners implement the C.A.P.E strategy and work towards the same goal using their own programmes and methods. C.A.P.E task teams, lead by the various partner organizations, oversee various aspects of the strategy. C.A.P.E is operated by the South African National Botanical Institute (Government) through a small Cape Coordination Unit that does the following:

- Co-ordination and networking
- Communication and conferences
- Monitoring and evaluation
- Branding
- Learning and sharing
- Advocacy and lobbying on behalf of the partnership
- Grant making
- Capacity building of partners

CAPE

Figure 12 Case study:

Case Study Partnership between the Biruh Tesfa franchise and the Medical Association of Physicians in the Private Practice in Ethiopia (MAPPP-E)

'The Biruh Tesfa, or "Ray of Hope" in Ethiopia is an example of an adaptive franchising model This is a network of private providers initiated by Pathfinder International in 2000 with support from the Packard Foundation, with the goal of increasing access to Reproductive Health (RH) / Family Planning (FP) services in the private sector. The network is comprised of private clinic facilities, work-based sites and community based health workers and market agents. The network currently includes 130 private clinics, 27 workplace sites, 90 market place agents and 350 CBHAs operating in five zones (regions) of the country.

All clinic franchises offer RH/FP and STI services. Depending on their qualifications, some providers also offer ANC, delivery, immunization and/or VCT services. Among the key benefits that franchised providers receive are support to improve the quality of care they provide – through clinical training like Norplant/IUCD implant/insertion, syndromic management of STI, program management for RH/FP, and the provision of equipment and contraceptive supplies.

During its first phase, the focus was on recruiting providers to grow the network. As it entered the second phase of operations in 2002, the network shifted its focus to developing a strategy for sustainability. It sought to institutionalize the key functions of the franchisor by partnering with an existing professional association that would gradually take on the role of franchisor.

A partnership with the Medical Association of Physicians in the Private Practice in Ethiopia (MAPPP-E) was initiated in 2005 with the goal to transition certain core functions, such as monitoring and quality assurance, from the franchisor to the association. While the partnership is still in the early stages, MAPPP-E is playing an increasing role in ensuring quality of services provided at franchised clinics, advocacy, and improving public trust and perception of private health providers. MAPPP-E operates with a paid staff of three and seven physician volunteers, and is supported by a grant from SIDA.

Recognizing their current limited capacity, the association plans to develop a strategic plan to identify opportunities to generate revenues and work towards financial sustainability. MAPPP-E must also position itself so that it may legally function as the franchisor for the Biruh Tesfa network, which is the long-term goal. (http://www.psp-one.com/section/technicalareas/networks_franchising/network_exchange/

case_study_biruh_tesfa 3 April 2008

Figure 13 Adaptive Franchising: Green Star Pakistan

The Green Star Network was designed by Population Services International (PSI) and its local affiliate, Social Marketing Pakistan (SMP) to contribute to the Government of Pakistan's family planning strategy by complementing its rural-based public services expansion with an urban-based private sector strategy (IUD Toolkit 2005). By 2002 Green Star franchised a range of family planning services through its network of 2000 private doctors (Montagu, 2002).The network grew to include more than 11,000 private health providers in more than 40 cities during its first five years of operation (1995-2000), receiving more than 10 million client visits per year. (Stephenson et al, 2004).

The Green Star network incorporates private sector health providers who provide services to low-income populations and who are willing to upgrade their knowledge and skills in order to add family planning to the services they offer (IUD Toolkit 2005: 2). The network uses advertising over local television and radio to generate demand, leading to a dramatic increase in clinical services. (Agha & Ahmed, 1997, cited in Lavake, 2003)

The franchising concept was used in the design of the Green Star network to provide functioning service delivery points with a standard package of high-quality reproductive health services. SMP (the franchiser) and selected providers (franchisees) form partnerships, agreeing that providers would integrate a defined package of services, to be delivered according to the high-quality standards established by SMP. In return SMP offers the provider/ franchisee specialized support, training, and rights to the franchise brand for as long as the franchisee maintains minimum quality standards. Benefits to the franchisee include association with the brand equity, indicating quality and reliability, created by the franchiser. (IUD Toolkit 2005)

Managing a rapidly growing network has been a challenge. As monthly supervision is not possible with a large network, focus is placed on learning from high- and low-performing outlets to synthesize lessons. Decentralizing training to local NGOs allowed the program to support local capacity for service.(IUD Toolkit, 2005)

While the Green Star project demonstrated the capacity for social franchising to support a very rapid scale-up in the delivery of health care services. an analysis of the project by Commercial Market Strategies concluded that "*On the opposite side of this coin are the great difficulties encountered in monitoring outlets and managing information from a large number of franchises brought on board quickly*" (Mc Bride & Ahmed, 2001, in DaVlake, 2003: 10).

Green Star's aims to achieve and sustain positive public health impact over time through minimizing its financial vulnerability. This is done by:

- Maximizing efficiency and controlling costs through sound financial management
- Developing a diversified funding mix
- Maximizing sales revenues from socially marketed products in a manner consistent with serving the poor (IUD Toolkit, 2005)

Sustaining provider involvement continues to be a challenge for the Green Star Network. "*The key is keeping providers involved in the development of the network, through protocol development, referral systems, and support.*" (IUD Toolkit, 2005: 4)

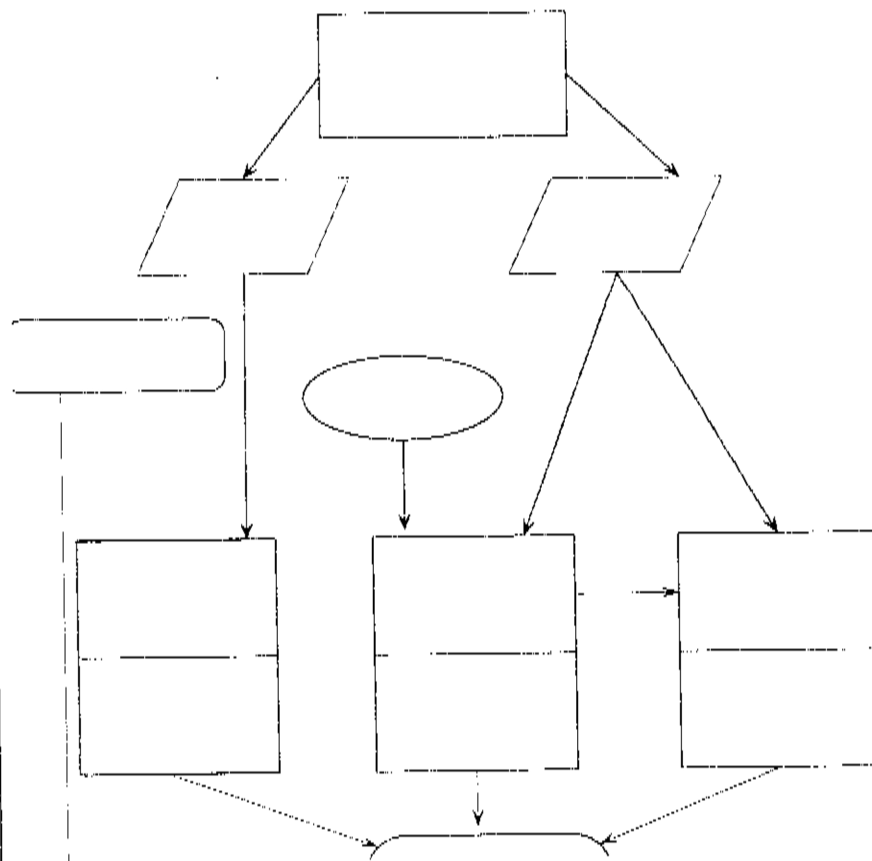
Figure 14 Case study of Janani India

Janani is used as an example of a public-private network social franchise that provides:

- Training and capacity building of qualified doctors as well as community health practitioners
- A referral network system between doctors and rural practitioners
- Hierarchical but inclusive management practice whereby responsibility and accountability is devolved to all levels of staff.
- Participatory Monitoring and evaluation in which the community is involved to ensure quality standards.

The Janani programme has various financial schemes and partnerships with different types of clinics and role-players involved, which are outlined in the example. Illustration of commitment is required through membership fees. Emphasis on communication is cited as a critical success factor of the Janani Programme.

Structure of Janani Social Franchise



2.2 The franchise model approach to scaling out social programs

2.2.1 *Approaches to franchising*

The Hub and Spoke concept is a typical way for a franchisor to expand into different geographical locations. The selection of the site for the spokes may be determined by Government policy (e.g. poverty nodal points) especially where Government is using franchising to scale up service delivery as market demand is not a factor. Franchises can be developed in a partnership between the franchisor and the franchisee, which is typically an NGO. They can also be community driven where community groups get together to develop a service delivery model that can be replicated. In some cases, franchisees are private providers, such as FET colleges, and in others they are government driven.

Some examples of this are as follows:

1. **Joint Venture or partnership approach** - In this model a central organization (the franchisor) works to create a joint enterprise with private providers or other NGOs (the franchisee). The franchisee should have the capacity to reach the target community. The franchisor may rent equipment, provide training and supplies at subsidized rates, and offer other support, including branding for the overall program. Franchisors and franchisees jointly own and co-develop the rights to a brand, technology or some other form of intellectual property. Franchises are businesses that have been systematized for replication. Most franchise networks create a long -term mentoring relationship between and among the franchisor and the various franchisees.
2. **Community Centered Development model** - Small NGOs often seek to develop collaborative community networks, including clinics, schools, churches, local governments, media outlets, private businesses, hospitals, pharmacies, and other NGOs. The community model uses social franchising techniques to structure a strategic alliance between providers of services and community groups. This collaborative approach might be called a "community franchise," which departs significantly from the classic social franchising model, yet retains many of its key elements.

3. **Private provider model** - This model involves expanding access to and use of services to additional facilities, typically by the use of logo branding, training of the new franchisees, monitoring of quality, and other techniques through a formal franchise arrangement.
4. **Governmental** - Governments may also operate social franchises themselves. Such efforts by ministries use social franchising techniques, especially quality standards, logos, training, and referrals, as well as incentives and subsidies, without involving the private sector. Governmental franchises are rewarded by incentives and subsidies similar to profits awarded to successful private franchises. (e.g. Thuthuzela Care Centres, Child Courts etc. but they do bring in some private providers for specific services)

2.2.2 *Required infrastructure*

Social franchises commonly work with existing organisations, many of whom have existing facilities (e.g. offices, training centres or ECD sites) from which to work. In other cases, facilities are provided or franchisees are provided with assistance in setting up the required physical infrastructure to provide their services (e.g. Titli clinics as part of the Janani programme, or Safe Parks as part of Isibindi).

2.2.3 *Selection of franchisees*

The requirements franchising organizations set for providers entering their networks vary. Preferred criteria for franchisee selection upheld by some franchisors include motivation, business skill, past business success, ties to the community, and personal characteristics, all aimed to improve retention and increase franchisees' chances of success (Stephenson et al, 2004).

2.2.4 *Standardization of the model*

Montagu (2002) emphasises the importance of standardization of services in franchises for a number of reasons, including the preservation of the notion of quality of the brand. Another reasons for standardisation includes ease of monitoring and evaluating outcomes. Monitoring is crucial to social franchises, and the central tool of affordable, replicable monitoring is standardization (Montagu, 2002). Protecting the rights of those who benefit from the service as they are expecting a specific quality standard by associating with that brand. (e.g. if you attend a Ntataise branded course you expect the quality of service delivery to be as good as if Ntataise was

offering it itself.) Standardisation also helps to attract funding as people can be assured on the quality of provision and outcomes.

2.2.5 *Monitoring and evaluation systems*

The importance of monitoring in social franchising is emphasised by Montagu, (2002), who argues that where the franchised brand represents a service, this must be highlighted in advertising and the monitoring of the programme must assure the quality of the service. Monitoring of client income levels is essential for ensuring affordability as well as for cost-recovery efforts among donor subsidized franchisers according to Harvey (1991, cited by Stephenson et al, 2004)

Montagu presents a three-fold solution to quality assurance problems. He believes that the technical quality of services can be improved through:

(1) training - to assure that providers are aware of best practices and trusting that practice will follow knowledge;

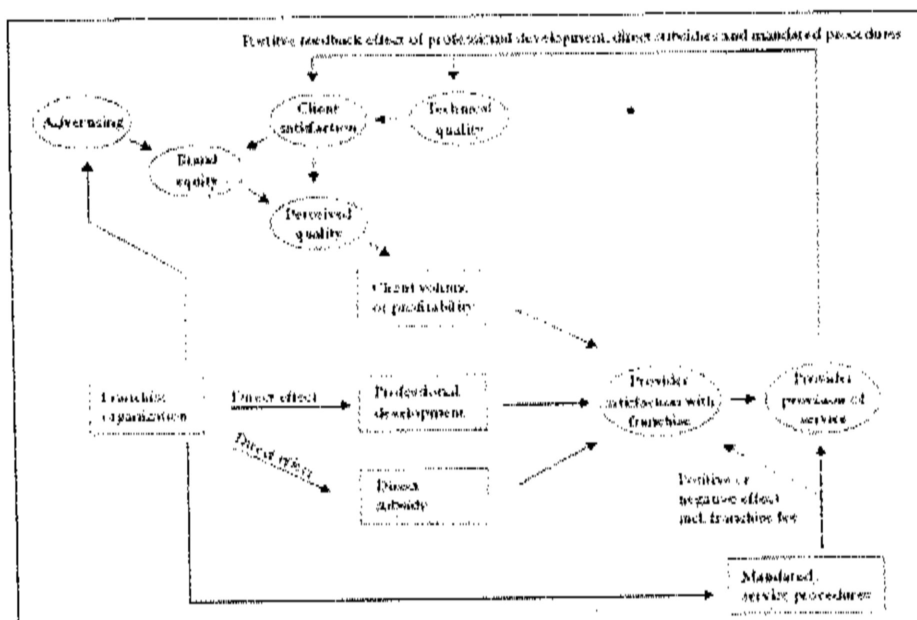
(2) encouragement - by advertising quality standards at franchise institutions, regular feedback through cooperative monitoring or offering fee remissions and other subsidies to providers who adopt best practice procedures; and

(3) penalties for providers who do not comply with franchise standards, including ultimately, expulsion from the franchise.

Although none of these solutions are likely to yield perfect compliance with desired practices, Montagu (2002: 128) believes that *"when benefits from membership are sufficiently valued by the member providers, a mixture of training, encouragement and penalties can together be used to assure that providers have an interest in improving quality"*

A model of Social Franchising emphasising the importance of feedback is provided in Figure 15 below:

Figure 15: Model of Social Franchising



Source: Montagu, 2002: 128

2.2.6 *Funding franchises*

The research highlights that franchising programmes in developing countries are predominantly donor funded, and may receive Government funding as well. (Stephenson et al, ,2004) In contrast to commercial franchising, franchisers and donors, instead of franchisees, bear the financial risk involved in setting up a site or establishing services in social franchises (Smith 1997, cited in Stephenson et al, 2004).

The appropriateness of pursuing a franchise approach depends to a large extent on the level of government funding and or donor support available. Some donors find franchising attractive because of its potential to mobilize the private sector to deliver services, control the quality of care, and offer some hope of sustainability through the use of fees to recover some costs. *"Balancing sustainability with meeting social goals is challenging, however, and involves issues such as capacity building, organizational strengthening, and business management skills training"* (LaVake, 2003: 11). Initial funding for full as well as fractional franchising is usually provided in the form of a loan or grant according to Frost (2006). Franchisors need to develop realistic financial planning and make this clear to the franchisee in a written contract. The franchisee may be required to place some form of deposit with the franchisor to ensure that initial funding is not completely lost if sustainability or repayment is not achieved. Financial assurances for the franchisor in what is referred to as the "boilerplate franchisee model" include:

- the initial franchise fee payable by the franchisee to the franchisor
- on-going royalty, or management services fees
- mark up on sale of products. (Frost 2006)

The chance of cost recovery in the ECD sector is low in South Africa, although some elements of the model may be able to recover particial costs e.g. people or organizations may be willing to contribute small amounts towards training or materials.

2.2.7 *Making franchises sustainable*

A franchise's ability to become financially sustainable depends on the target population it hopes to serve and the positioning of its brand in the market. Services targeted at the poor and/or rural populations are unlikely to ever become financially sustainable through franchising or any other market-based programme (Harvey 1999, cited by Montagu, 2002). Urban programmes can potentially become financially sustainable over time, *"depending upon the market size, potential demand for the service and structure of the private medical sector."* (Montagu, 2002: 127)

Continued participation in a franchise network is determined by the extent to which the benefits of membership outweigh its costs. A franchise fee and the potential for improvements in service provision should sustain commitment to the franchise network. Stephenson, et al (2004), note, however, that mandated franchise fees in a low-demand setting may compromise a franchising organization's ability to establish a large network of service delivery points. In very low-demand settings, cost-recovery from franchised services (e.g. family planning or crèche facility) may not always outweigh the cost of franchise membership.

Clients at franchised health establishments in Mexico and the Philippines were found to benefit from consistent standards of care at affordable prices, while franchisees benefited from subsidies and support in running their business. Both franchises were, however, dependent on significant start-up funds, ongoing support from U.S.-based agencies and donor-subsidized contraceptive supplies (Marie Stopes International 2002, cited by Stephenson et al, 2004).

2.3 Crucial considerations in choosing a franchise model

Frachises reduce the element of risk to the funder and the franchisors as they are usually based on tested models that have been shown to work. Risk is also reduced by the fact that the franchisee belongs to a support network and receives ongoing

support from the franchisor and possible also from other franchises in the network (if it is set up this way).

The blueprint also builds on the strength of other working copies of the blueprint by creating credibility for the model and giving donor funders more confidence that the programme will work.

Some advantages to the franchise model are:

- The franchisor can offer assistance to market the product or service and with the branding of materials and outputs.
- Franchisors will offer professional, organisational and managerial development assistance, as well as assistance with products and materials, so that the franchisee can quickly offer a going concern at the appropriate standardsThe franchisor can also distribute funds to the franchisee directly or through arrangements with lending institutions or government, which makes it easier for the franchisee to access the funds it needs to operate and/or expand.
- Supervision and quality control is usually built into the franchise concept (to differing degrees depending on whether it is first or second generation franchising). This, again, builds confidence in the service provided and facilitates better outputs and outcomes.

TThere are some disadvantages to operating a franchise. For franchisees, the main disadvantage is a loss of control. While they gain the use of a system, trademarks, assistance, training, marketing, the franchisee is required to follow the system and get approval for changes from the franchisor. This can be frustrating for organisations with a long history of service delivery and for those with a strong innovative spirit. In South Africa, there are examples where NGOs are fiercely protective of their individual identities and domain. For instance, in the Ntataise network, the NGOs that belong to the network purchase the right to use Ntataise's training programme for one year, (they have to purchase the Ntataise materials such as handbooks separately), yet they remain independent in terms of how they operate and run their organisation. Likewise, the GoLD Peer Education Programme is being delivered through implementing NGOs who resisted the standardisation of their existing programmes to fit the GoLD model, even though they wanted to be part of the GoLD network, receive the training, and use the GoLD Manuals in the way that they saw fit. This is where the associative form of franchising may be useful. Here organisations can associate with a brand, and receive the benefits of belonging to the franchise, but are able to implement the programme in ways that match their organisational culture and competencies.

Starting and operating a franchise business also carries expenses. In choosing to adopt the standards set by the franchisor, the franchisee often has no further choice as buy materials, kits, training programmes and so forth (these can, however, be funded as part of the model).

Another issue is that the franchisee may not be allowed to source less expensive alternatives. Added to this, the franchisee must still pay costly franchise fees and ongoing royalties and advertising contributions. The contract may also bind the franchisee to such alterations as demanded by the franchisor from time to time.

The franchisor/franchisee relationship can easily cause conflict if either side is incompetent (or acting in bad faith). For example, an incompetent franchisee can easily damage the public's goodwill towards the franchisor's brand by providing inferior goods and services, and an incompetent franchisor can destroy its franchisees by failing to promote the brand properly or by poor administration of the franchise. Franchise agreements are unilateral contracts or contracts of adhesion wherein the contract terms generally are advantageous to the franchisor when there is conflict in the relationship.

Further, public perception has to be driven by consistent and equal distribution of the concept. If an NGO, particularly in the South African context, is seen to be only benefiting a few (e.g., in communities where there may be splits along cultural or religious lines), this may affect the overall take-up of the program.

It may be difficult to get NGOs to scale up delivery of their models for a number of reasons.

- While they may be well aware of the replicability and adaptability of their blueprint, they may simply not have the know how or the ability to scale-up.
- Competition for scarce funding: This may lead some NGO leaders to believe that keeping an innovative and replicable project to themselves will give them an edge over similar NGOs approaching the same limited number of funders
- Unwillingness to give up control: Creators of great blueprints for social change sometimes fear that other NGOs will not be able to replicate their blueprint as successfully as they could on their own.

2.4 Success Factors and lessons learned

DuToit (2003) cites the following critical factors to consider in the implementation of a social franchise programme:

1. "Consumer demand is a prerequisite for the initiation of a social franchising programme. There must be a demand for the specific product or service in diverse geographical areas to make franchising a suitable expansion mechanism." In the ECD sector, this means that NGOs must want to be engaged in helping to improve Early Childhood Development, and ECD centres, home and community base stakeholders must want to improve standards and methods of ECD. In Brazil, the scaling up of ECD was combined with a large public awareness campaign to build an appreciation of the importance of ECD participation.
2. Even though generally it is desirable for consumers to pay for the product or service, even if it is a nominal amount, it is not always feasible in the context of abject poverty. The child grant in South Africa is only R210 per month, and this is not enough to cover education provision, and should be used for the basic needs of the child (food primarily), and for some families this is the ONLY income they receive.
3. A pool of suitable potential franchisees must be available and they must be motivated by the apparent benefits provided by the franchisor to join the network. There are many NGOs or NPOs who work in fields related to ECD in South Africa but they tend to be regionally concentrated. One will find typically that there are few NPOs in rural areas that can drawn into a support structure. Where they do exist, they often have very limited capacity. Similarly, ECD sites and home-based carers may not see the benefits of joining a franchise. Other more established NGOs or ECDs may not want to participate in a franchise or standardised approach for fear of losing their organisational integrity and independence.
4. A suitable franchisor must be available and willing to commit to the programme over a long-term period. Continuity and longevity of the franchisor is essential to the sustainability of a social franchise. In the case of ECD in South Africa, the franchisor may initially have to be government, but over the longer term, the franchisors can be decentralised and devolved. Still, sustainability may be an issue with regard to funding of the model.

5. Although ideally the franchisor should aim to be financially sustainable and reduce its reliance on funding over time, in the context of community poverty and low government subsidies, this is unlikely in the South African context. Organisations should rather try to diversify their funding sources, including those coming from government subsidies, other forms of cost recovery, and fundraising (from community efforts and donors). The Old Mutual Foundation Rural Economic Development Initiative (REDI) demonstrated that rural schools can raise significant funds if they know how (research conducted by Southern Hemisphere for an evaluation of the Soul City / Old Mutual Community Mobilisation Programme in 2004)
6. Piloting of the concept prior to franchising is critical. Only tried and tested concepts should be franchised and the franchisor must ensure that franchising is applicable to the needs of the target and final beneficiaries.
7. Franchisees need to have the correct level of skill to be able to operate the franchise and often the franchisor will have to provide training in management as well as early childhood development in order to bring the administrators, trustees and practitioners or caregivers in the home context the necessary skill to implement the programmes and services.
8. Socioeconomic, political, cultural, and commercial contexts affect the ability of a franchise system to work effectively.

2.5 Networks, Associations and Support Groups

Networks, associations and support groups refers to where organisations join a network and which typically facilitates information exchange, collaboration, mutual support, capacity building, research and/or distribution of funding to member bodies. Membership could include NGOs, CBOs, relevant government departments, representatives of local government, and/or faith-based groups. Groups may be:

- formal organizations with a secretariat and full-time staff;
- informal networks of organizations that meet periodically
- semi-formalized organizations with a secretariat that rotates among members or is a part-time responsibility for one of the members
- independent community based networks or networks associated with a particular NGO or programme .

Some networks receive funding from donors that they can thereafter provide grants to member organizations. Others play an advisory role by linking donors to legitimate grant applicants. In this regard, they may assist the donor in assessing the quality of grant proposals and the consistency of proposals with relevant national policies and plans. Donors may also contract with a network to monitor the use of granted funds and ensure accountability. (Williamson & Lorey, 2001)

In the ECD sector, there are examples of networks of ECD organisations. The prominent example is that of Ithemba Lesizwe, and another is the Ntataise Training Network (that also has a franchise component). See the case studies for more detail on these. Neither of these disburses funds, but they do provide other forms of direct support to members such as information and sharing sessions, distribution of donations such as materials, on-site mentoring and so on. The ECD Forums can also be considered networks of ECD sites at community level.

Figure 16 Case study: Ithemba Lebantwana

Ithemba Labantwana is a network of about 350 member ECD sites, has been in existence for 30 years, and is supported by the NGO Ikamva Labantu. The network has its own constitution and governance structure. The ECD practitioners meet monthly as a support group and to share information and learning, and at times to distribute donations received through Ikamva. Ikamva Labantu assists with some of the secretariat functions of the network, and supports the members in a number of ways; it distributes food to all the network members, and Ikamva's 'footsoldiers' provide on-site mentoring & monitoring to the ECD sites. The network allows Ikamva Labantu to support and access a group of ECDs in a geographic region. With more funding, Ikamva would be able to hire more 'footsoldiers' and intensify its on-site support and monitoring of the ECDs.

Figure 17 Ntataise Network Support Project

Ntataise Network Support Project is a network of organisations that implement the Ntataise training and support model. The members pay a membership fee of R10 000 per year to join the network and get the right to use the materials for one year. The network Support Project provides ongoing professional development for network members. In this regard, the training and support programme can be seen as the franchisor, while the franchisees belong to a network of support that enhances the delivery of the programme in the long run. The Ntataise Network has 16 members and does not want to grow bigger than this. Through its members the network has trained 15 000 practitioners in 13 000 pre-schools and has been in existence for 30 years.

Networks also take the form of groups that work in similar arenas such as a network of groups working for children. In contrast to a multi-layer committee (described below), the "coverage" of member organizations is not comprehensive but determined by the service areas of the member organizations.

It is an example of how social franchising and networking inter-relate.

Potential advantages of a networks as channels for donor funding and support to individual member organizations include:

- "Strong networks include key national and local NGOs and, in some cases, CBOs engaged in work with especially vulnerable children, HIV/AIDS, emergency response, etc. Some have developed training capacity and, in addition to channeling financial resources, can build the capacity of their member organizations.
- Member organizations, collectively, are often in a good position to assess the legitimacy and capacity of NGOs or groups that may seek funding."(Williamson & Lorey, 2001: 5)
- Grassroots networks can assist to draw in the home based ECD groups to the model.

Potential limitations include:

- The possibility of inducing competition for funding among member organizations, particularly if the network was formed for information exchange and seeks to take on a new role of funding intermediary.
- It can be difficult for a network constituted by its member organizations to effectively supervise the use and management of funds allocated to those members.
- Some more influential member organizations may receive priority over other members in the allocation of funding.

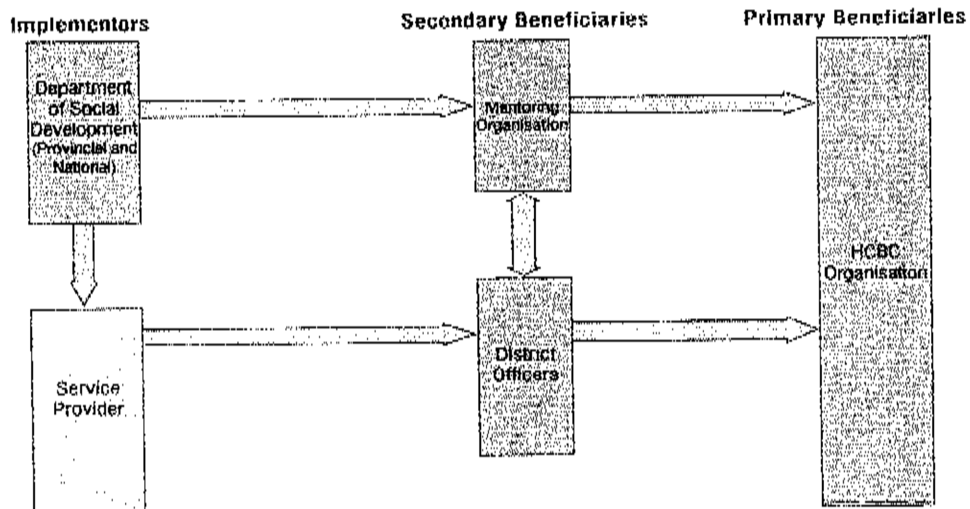
- Networks can give the appearance of providing greater coverage than is often the reality in practice. "Coverage" of member organizations is not comprehensive but determined by the service areas of the member organizations.
- Membership of some networks may be limited to established NGOs and not include grassroots community groups engaged in direct assistance efforts. Some investment in the capacity of the networks themselves may be necessary if they are to take on new responsibilities. (Williamson & Lorey, 2001: 5)

3 CAPACITY BUILDING (AND MENTORING) MODELS

There are a number of well established capacity building (or more narrowly defined as training) and resource organisations in South Africa (RTOs). They typically provide capacity building (including on-site training and follow up support), and resources to ECD sites, both formal and community based. Often the training is based on a specific model that has been developed by the organisation. RTOs such a TREE and ELRU fit this bill, as do the members of the Ntataise network. Yet these organisations are not able to offer the scale of services necessary to upscale ECD on their own.

The health sector has adopted a capacity building and mentoring model in its approach to HCBC service delivery and both the Department of Health and the Department of Social Development have management, mentoring and capacity building models (development of which have been funded by DFIF) which have allowed them to scale up HCBC services. In these models they would partner with the RTOs. The Department of Health works through the Mentoring Resource Network (MRN) and the DoSD is piloting the HCBC Management, Capacity Building and Mentorship model in a number of provinces (interview with Johan Loate, MRN and presentation from tender briefing in June 2007). Both of these use an intermediary organisation, such as MRN, to manage and operate the model. They then use a cascade approach and work with NGOs that have a regional base to conduct training and mentoring to the DoSD District Offices and to more community based NGOs to help them improve their capacity to support the even smaller HCBC organisations (which could be equated to the ECD centre).

Figure 18 Example of capacity building model.



4 APPROACHES TO SERVICE DELIVERY

How one approaches service delivery can be based on a combination of different approaches. It is important in the South African context that rolling out the model is based on a **community-centred approach** and that local role players and stakeholders are introduced first to the concept as they can otherwise either assist or block success in the community. The NACCW first point of entry into a community is a community meeting where the model is explained. This also assists with identifying the issues in a particular community. For example, they have had to explain to community leaders that political allegiance is not a criteria for benefiting from this project. This is also important because one may need to rely on Traditional Leaders or Municipalities to provide land and/or facilities to allow the model to operate.

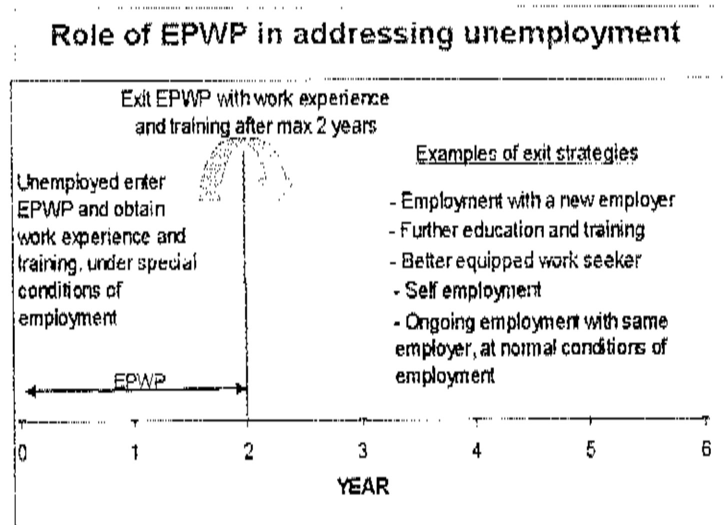
A **partnership approach** is also necessary as one organisation can not be expected to be good at everything. In the case of Isibindi, they partner with Childline to provide support to children who they discover have been abused or raped. One may also partner with a training provider, such as ELRU or an FET, to deliver the training components or an organisational development practitioner to help mentor the organisation in terms of OD issues.

5 GOVERNMENT FUNDING STREAMS

5.1 EPWP

The EPWP and the ISDM provide opportunities for government to release funds and skills into the ECD sector. The child grant and the ECD subsidy should be seen as mechanisms for families and ECD sites to cover basic needs (such as food) and should not be expected to cover education, day care and or paying for services. EPWP trained ECD workers can be absorbed into the sector if enough funding is released into it by Government, and then exit opportunities would naturally exist.

Figure 19 Role of EPWP in addressing unemployment



Both programmes intend to establish a cadre of skilled workers in these sectors and to lay the foundations for more formal service provision. The EPWP will support training of NQF level 1 – 5 learnerships and has identified a total of 66 300 potential work opportunities in ECD that will be introduced in a phased approach until 2009. (EPWP Social Sector Plan, 2007 V7), but without funding the sector will not be able to absorb them.

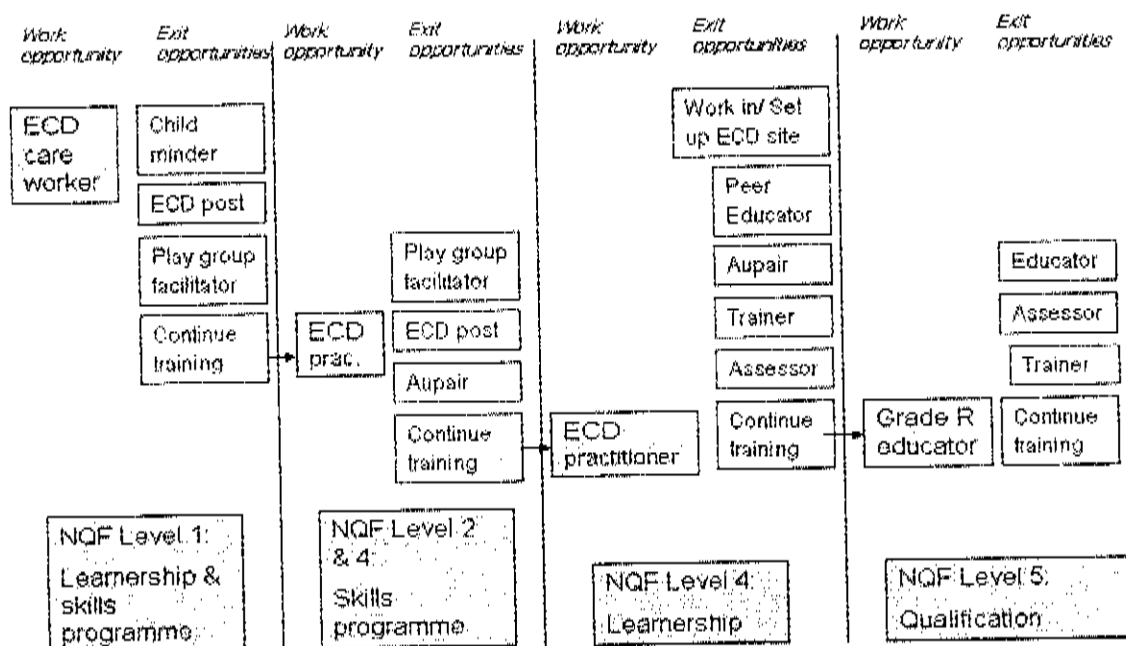
The EPWP Social Sector Plan recognises that funding into the sector is limited, and suggests that "... the Department of Social Development could potentially increase its support to the sector through its existing subsidy programme." (2002: p. 27) The plan recognises as a risk that the DSD has not included the expansion of ECD and the pressure it will place on the demand for subsidies in its MTEF budget projects.

The plan also proposes that the DSD establish a conditional grant mechanism.

Presumably, these suggestions are made because the concern is that the ECD sector itself will not have enough funds to absorb the workers produced by the EPWP.

An intermediary organisation would facilitate the flow of funds to the sector, by assisting ECD sites to get registration and by providing grant and other funding to ECDs, and can also assist with job placement of EPWP trained workers.

Figure 20 Overview of EPWP ECD work opportunities career-path map (EPWP Social Sector Plan, 2004, V7)



5.1.1 *ISMD – DoSD*

The Guidelines for Awards also emphasise that priority will be given to NPOs to render services, although not to the exclusion of Private Sector Organisations. These mechanisms can be used to enhance the capacity of ECD service providers and NPOs in the sector.

There are three mechanisms for funding or purchasing services of NPOs:

1) Subsidy for programmes that meet department priorities and needs in line with government policy
2) Purchasing and financing through closed tender
3) Purchasing and financing through open tender

There are also six different types of financing namely:

- Seed Financing;
- Capital Financing (for assets),
- Venture Financing (start up funding till they become self-sustaining e.g. second hand shop);
- Partial Financing (organisation will receive partial funding requested and will have to seek other sources as well. This can apply to any funding option);

- Shared financing (different funders decide to jointly fund a programme or fund different parts of a comprehensive service);
- Long Term Contractual Financing (services that operate over a longer period of time and have long-term objectives, the achievement of which is reliant on financing from department for typical ongoing, recurrent day-to-day operational costs).

Applications for financing can follow a sequential pattern in order to facilitate the development of services from seed funding through to long term financing for programme implementation.

6 CONSIDERATIONS FOR MODEL (S) OF SUPPORT

The purpose of support models or intermediary organisations would be to unblock the constraints in the ECD sector, to facilitate the relationship between the state and civil society, and to build a stronger sector in order to allow government to meet its policy obligations and take quality ECD up to scale. This paper raises a number of considerations when considering which modality to use.

It should be noted that Department of Social Development is familiar with all these support formats as it is either involved in directly piloting or in funding variations of these models. There should thus be a strong evidence base to draw on from within the Department. (e.g. DoSD in KZN is involved in supporting Isibindi which is a pure social franchise model, National is involved in piloting the HCBC Management and capacity building model, networks such as those in the Victim Empowerment Sector are supported in the Western Cape and on and on.) Having said this, some considerations are:

- Pure social franchising can allow speedy replication but needs massive funding commitment from state (or donor) over a sustained period and a very strong implementing or intermediary organization to drive it. This includes creating the demand through a branding and marketing.
- If there are constraints to funding and little support capacity to delivery on the components necessary for franchising, the result will be more ad-hoc forms of implementation – so if there isn't enough money, it would be preferable to design these types of structures in the first place.
- Networking and capacity building and mentoring are forms of organization that have existed in the ECD sector for many years and as such may be more easily introduced as means of scaling up.

- There is currently very little information on the actual costing of models, so there is a need to get more information first. Whatever approach is decided, the correct process for project cycle management and project design should be followed.
- It is difficult for organizations in the ECD sector to access funds (not like HIV), and it may not replicate easily so more adaptation could take place. This again highlights the importance of proper monitoring procedures.
- The involvement of communities is key in order to ensure buy in, relevance and sustainability.
- Competency in the sector is inconsistent and so models for replication or networking or capacity building must bare this in mind.
- Replication can either follow strict standardisation or can allow for adaptation. While the former makes it somewhat easier to monitor and evaluation processes and outcomes, the latter may be more desirable for adaptation to local contexts and to get existing organisations to participate without fear of loosing their autonomy and creativity and being overburdened with monitoring requirements.
- The model needs to help get a better match between the state environment and the CSO ECD sector. The DoSD needs more structured cooperation and coordination with sector to create an enabling environment and to upscale services to quality.
- There is a need for simple and effective quality assurance systems.
- Since cost recovery is low, there is a need to determine what level of sustainability can be expected and the corresponding commitment from government.

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