



Annual Review Publication

2014-2015

LIST OF ACRONYMS

ACEP	Advancing Childhood Education Project
CDO	Child Development Officer
CDT	Child Development Therapist
CHASE	Culture, Health, Arts, Sports and Education
CHDP	Child Health and Development Passport
EC	Early Childhood
ECC	Early Childhood Commission
ECD	Early Childhood Development
ECE	Early Childhood Education
ECI	Early Childhood Institution
GoJ	Government of Jamaica
GOILP	Grade One Individual Learning Profile
MCSR	Monthly Clinical Summary Report
MDG	Millennium Development Goal
MLSS	Ministry of Labour and Social Security
MOE	Ministry of Education
MOFP	Ministry of Finance and Planning
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NPSC	National Parenting Support Commission
NSP	National Strategic Plan
NVQ-J	National Vocational Qualification-Jamaica
PATH	Programme of Advancement Through Health and Education
PIOJ	Planning Institute of Jamaica
PROMAC	Programme for the Reduction of Maternal and Child Mortality
STATIN	Statistical Institute of Jamaica
TQ	Ten/Eleven Questionnaire
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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Vision statement of the Early Childhood Sector in Jamaica

All Jamaican children are loved, valued, safe, healthy, well-nourished and fully actualising their potential resulting in a positive impact on national development. Engaging, involved parents and stakeholders; motivated, committed, highly trained and dedicated early childhood practitioners; effective leadership; adequately funded; good governance and effective monitoring and evaluation are the hallmarks of the Early Childhood Sector.

EXECUTIVE SUMMARY

Annual Review Publication 2014-2015

Parenting Education & Support



Parents' Places

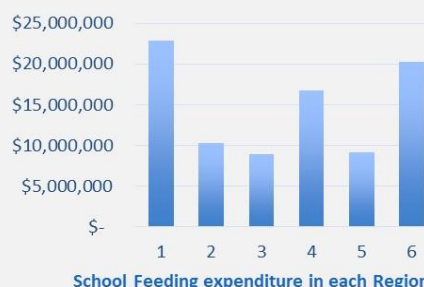
- 90.4% operate within primary and secondary schools
- 24.8% (majority) located in KSA
- 60 established by USAID between 2013 and 2014

Parenting Programmes

- 92 offered by public and private entities
- 41% assessed and 35% recommended for certification

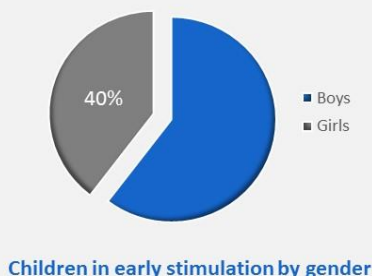
Preventive Healthcare and Nutrition

- Promotion of proper nutrition remained high on the agenda
- \$88,491,120 in nutrition grants was provided to 61,124 children in 1,204 ECIs
- The Infant and Young Child Feeding Policy, designed to address poor nutrition practices, was tabled as a green paper in parliament in June 2014
- Perennial issue of access to reliable data being addressed with issuance of CHDPs – coverage of 97.6% of 0-3 year olds for the year
- Reach of health care services impacted by limited staffing and facilities



Screening, Diagnosis and Early Intervention

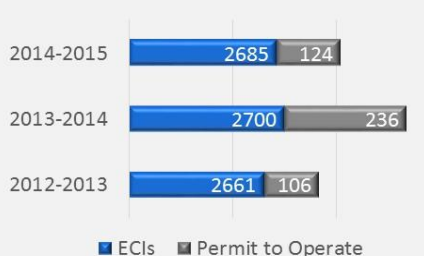
- 51,232 children 0-6 years (16% of recipients) received PATH benefits
- PATH provided an additional gateway for developmental screening – 1,444 children
- A new tool for assessing readiness for primary school was successfully piloted in June



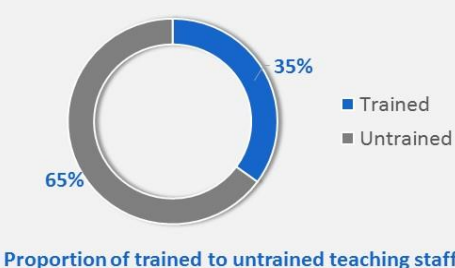
- 1,595 children received early stimulation treatment, 40.9% of whom were newly referred
- 39% (majority) of children treated were boys from KSA
- More CDOs are needed to meet the growing demand for early stimulation

Safe, Learner-Centered and Well-Maintained Early Childhood Facilities

- 94% of ECIs applied for registration
- 5% were granted a permit to operate
- There is still no ECI that has been certified
- Number of inspections fell to 1,216 due to staff attrition, from an initial cadre of 40 inspectors to 26
- Some facility improvements were possible through donor involvement



Trained Early Childhood Teachers/Practitioners



- Approximately 35% of teaching staff trained at the tertiary level (i.e. diploma, bachelor's or master's)
- Several scholarships and grants were disbursed to enhance teaching and learning in ECIs
- 386 ECIs benefitted from additional teaching support in the form of trained teacher volunteers under the JEEP

Abbreviations

CDO - Child Development Officer
CHDP - Child Health & Development Passport
ECI - Early Childhood Institution

JEEP - Jamaica Emergency Employment Programme
KSA - Kingston & St. Andrew
PATH - Programme of Advancement Through Health & Education

INTRODUCTION

The Early Childhood Development (ECD) sector in Jamaica is multi-sectoral, requiring collaborative inputs from multiple partners – private and public, local and international – in order to attain our vision of “all children having access to high quality ECD services.” In this edition of the Annual Review Publication, covering the financial year extending from April 2014 to March 2015, we highlight the activities, accomplishments and challenges across the sector, presented within the broader context of the National Strategic Plan and its primary objectives.

Following the successful conclusion of the first five-year World Bank-funded National Strategic Plan (NSP) in 2013, the current NSP (funded by the same entity) was developed to guide the development of initiatives across the sector from 2013 to 2018, referred to as the Early Childhood Development Project. Considered in the NSP are the distinctive characteristics of specific age cohorts that have implications for programme development and implementation:

- **children from birth-3 years old:** most are not enrolled in an early childhood institution (ECI) but access public services primarily through state healthcare
- **children aged 3-6 years old:** most are enrolled in an ECI
- **children aged 6-8 years:** enrolled in primary schools which are governed by the Education Act

In recognition of these crucial differences, five strategic objectives relating to the internal processes of the Early Childhood Commission (ECC) were purposely designed to reflect these developmental transitions:

- 1. Effective parenting education and support for ECD**
 - To provide parents with accessible and high quality parent education and support allowing for optimal development of children
- 2. Effective preventive healthcare and nutrition support for 0-6 year olds**
 - To enhance the preventive healthcare services (Well Child Clinics) through improvement in human resource facilities, public education and monitoring of child health, nutrition and development status
- 3. Early and effective screening, diagnosis and early intervention for at-risk children and households**
 - To develop a system that allows early identification of and appropriate intervention for households and children at risk
- 4. Safe, learner-centered, well-maintained ECI facilities**
 - To improve the quality of services offered by early childhood institutions
- 5. Effective curriculum delivery by trained early childhood practitioners**
 - To ensure that teachers are highly trained in ECD

The publication is organised around these strategic objectives as a means of gauging progress within the sector in those key areas deemed to be of greatest interest to the public and other early childhood (EC) stakeholders. It is worth noting, however, that accompanying the internal processes are four additional objectives dealing specifically with the working environment. These speak to the efficiencies that must characterise the operations of EC entities and are designed to support the successful execution of the internal processes. Among these working environment processes is a previously overlooked objective concerned with public education – providing effective public education to drive and foster increased support and involvement in ECD initiatives.

Since 2014, public education has taken the form of a comprehensive Communication Strategy that is interwoven with all strategic objectives, giving special attention to parenting, nutrition and early stimulation. Progressive implementation of the Communication Strategy began in the last quarter of 2014, focusing heavily on establishing the operational framework that necessarily included feasible agreements with sector partners. Though not featuring prominently in this review, the existence of the Communication Strategy as an ongoing activity supporting the achievement of the strategic objectives should be acknowledged. The contribution of the Communication Strategy to these objectives will be more evident in subsequent years.

In pursuit of the ideals of equity, equality and high quality of ECD services, the Early Childhood Commission (ECC) intensified its efforts to overcome new and existing challenges, and to expand the reach of its services throughout the 2014-2015 financial year.

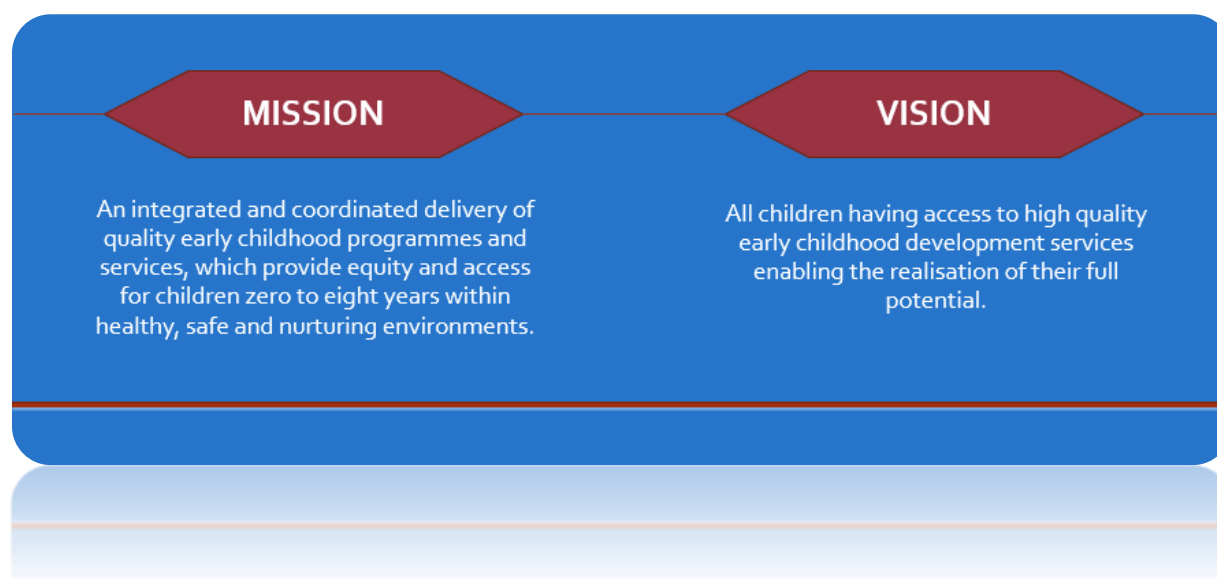
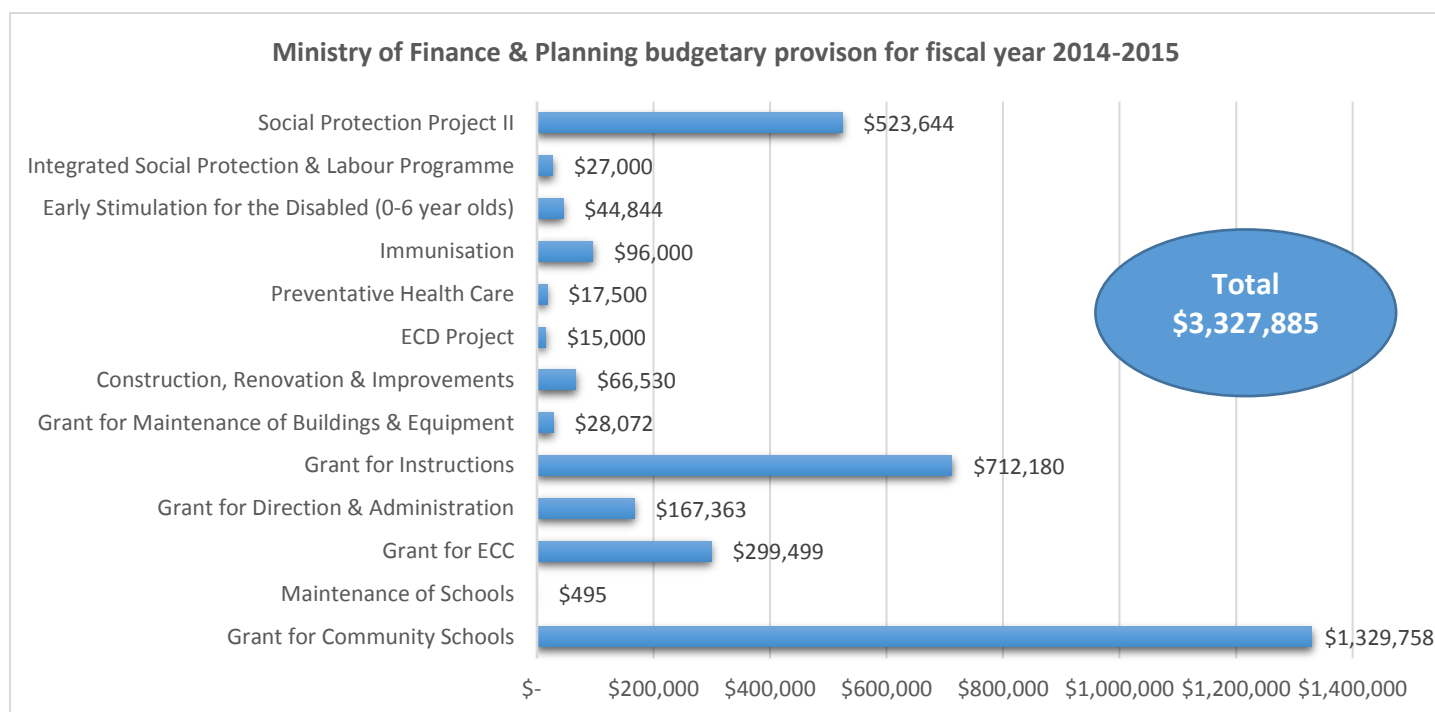
The high incidence of teenage pregnancy and percentage of single-parent households, among other social issues, underscored the need for continued support of parents in the form of resource centres and targeted programmes. The establishment of these support systems progressed, though slowly, hampered by limited financial investment. This was a recurring theme throughout the year, particularly noticeable in the delivery of child health and development services.

Although the number of children being served through the healthcare, education and social intervention systems maintained its annual increase, there remained significant shortfalls, most evident in inadequate staffing and facilities. However, with committed investment in the recruitment of qualified personnel and professional development of existing staff, as well as the securing of agreements geared towards improving service delivery, significant strides were made during 2014-2015 with promising prospects for upcoming years.

Severe financial constraints within the ECD sector are not unique to Jamaica. A clear indication of the challenge faced is the pattern of relatively minimal government spending on early childhood education (ECE) which stood at 0.2% of the country's GDP in 2014. Meanwhile, expenditure on education as a whole amounted to 6.03% of GDP. This translates to a mere 3.4% of the government's total education expenditure going to the early childhood level (UNESCO Institute of Statistics, 2016). Despite the tight fiscal space within which the sector has had to operate, the commitment to having cohesive delivery of ECD services remained strong throughout the 2014-2015 financial year.

Many of the ECC's accomplishments would not be possible without on-going collaboration with its dedicated and generous partners that include: international funding agencies; foundations; government

ministries and agencies; non-governmental organisations (NGOs); parents and community members. This Annual Review Publication highlights the determined efforts and resources expended to meet the growing needs of our ECD sector through partnership, dedication and a thorough belief in the Mission and Vision of the ECC.



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*To provide parents with accessible and high quality parent education and support
allowing for optimal development of children*

Intuitively and by empirical evidence, it is understood that the quality of parenting received by a child, particularly during the earliest years, greatly influence several crucial aspects of development that can have implications even into adulthood. For example, parental behaviours that promote early secure attachments that are sustained as the child gets older provide the foundation for socio-emotional, cognitive and moral competencies across developmental stages (Boyd & Bee, 2006).

One significant threat to the quality of parenting is parenting-related stress which is documented as being higher than average among Jamaican parents (Parenting Partners Caribbean, 2010). Negative child outcomes (direct and indirect) of parental stress alone have been found to include developmental delays, separation anxiety, higher negative affect, and poor self-regulation, which in turn are associated with poor outcomes later in life in areas including social adjustment, school performance and mental health. Parents themselves become susceptible to unwanted effects such as depression and the adoption of poor parenting styles (Huang, Costeines, Kaufman, & Ayala, 2014). A local report on parenting identified several additional factors that negatively impact the quality of parenting in Jamaica (Parenting Partners Caribbean, 2010):

- High incidence of teenage mothers (61 in every 1,000 births is to an adolescent mother aged 15-19 (World Bank, 2016))
- High percentage of single-parent households with usually the father being absent (36.3% of households have no father figure and 81.8% have the birth mother performing the parenting role (PIOJ & STATIN, 2012))
- Limited financial resources (national prevalence of poverty at 17.6%, with children accounting for 36.3% (World Bank, 2016))
- Increasing child neglect and abuse (11,749 reports of abuse concerning 8,568 children in 2014 alone (Office of the Children's Registry, 2016))
- High rate of crime and violence
- Conflicting views on ideal parenting practices

The individual, social and economic cost of sub-optimal parenting and the need for parental support are clear. While evaluations of parenting education and support programmes have yielded mixed results, there is convincing evidence that these programmes can improve parenting skills leading to favourable outcomes for children and families, provided that certain key elements are in place. These key elements (e.g. early intervention, cultural sensitivity, monitoring) were captured by a comprehensive evaluation of parenting in Jamaica and incorporated in the development of the *National Parenting Support Strategy for Families of Children from Pre-natal to Eight* (Parenting Partners Caribbean, 2010), currently being implemented through the work of government agencies, tertiary institutions, NGOs and partnerships with other interest groups.

NATIONAL PARENTING STRATEGY

The National Parenting Strategy was designed to cater to the support needs of families from the prenatal period up to age eight, providing a network of relevant and accessible parent support services to ensure children are the beneficiaries of positive parenting. To do this, the strategy has as its central component the delivery of certified parenting programmes through Parents' Places scattered across the island.



Figure 1: Schematic representation of a Level II Parents' Place

Parents' Places and Parenting Programmes

A Parents' Place is a 'safe space', located in every major community, where all parents and families can find support in raising their children well. Here, access is given to parenting information, income-support training, short courses and workshops, mentoring support from other parents, and (where resources allow) diagnostic and therapeutic services. These 'spaces' can take one of three forms identified as levels:

- Level I – Provides a place where information is available to parents
- Level II – Parenting Support Training Programmes offered by trained facilitators are provided in addition to Level I services
- Level III – Specialist Referral Services available on site, in addition to Level II services

A Parents' Place is a concept more than a building – flexible and 'portable' in some aspects – and can be linked to a range of public or private service providers such as schools, clinics or churches. Currently, the majority of Parents' Places (90.4%) are located within primary and secondary schools. The goal is to have at least 480 Parents' Places established and in operation by 2020. When launched in 2011, seven (7) locations were operational. By the end of the 2014-2015 financial year, that number increased to 105 scattered across the island (see Figure 2). The highest concentration of Parents' Places is within the urban areas of Kingston and St. Andrew having 24.8% (26) of these locations. Sixty (60) Parents' Places were established by USAID between 2013 and 2014, and full ownership transferred to the Ministry of Education (MOE) in May 2014. Although progress is below the initial target of 50 Parents' Places being established per year, with the commitment of the ECC's Community Interventions Unit, other supporting agencies and appropriate financial backing, it is hoped that there will continue to be steady progress towards this goal.

Assessment and Certification

To ensure that there is little to zero deviation in the quality of these parenting programmes, each programme is assessed against six standards, compliance with which leads to certification by the National Parenting Support Commission (NPSC). The standards address the following areas:

- Standard 1 – Programme's physical environment
- Standard 2 – Programme design
- Standard 3 – Programme administration
- Standard 4 – Human resources
- Standard 5 – Programme materials
- Standard 6 – Programme monitoring and evaluation

In 2013, there were identified 92 parenting education and support programmes offered by the ECC, as well as NGOs, government agencies and private organisations. At the end of the period under review, 38 of these programmes (41%) were assessed, 32 (35%) of which were recommended for certification (see Figure 3). Efforts continue with a target of 60% of programmes being assessed and 45% certified by 2017-2018. The progress made to date indicates that this will be achieved.

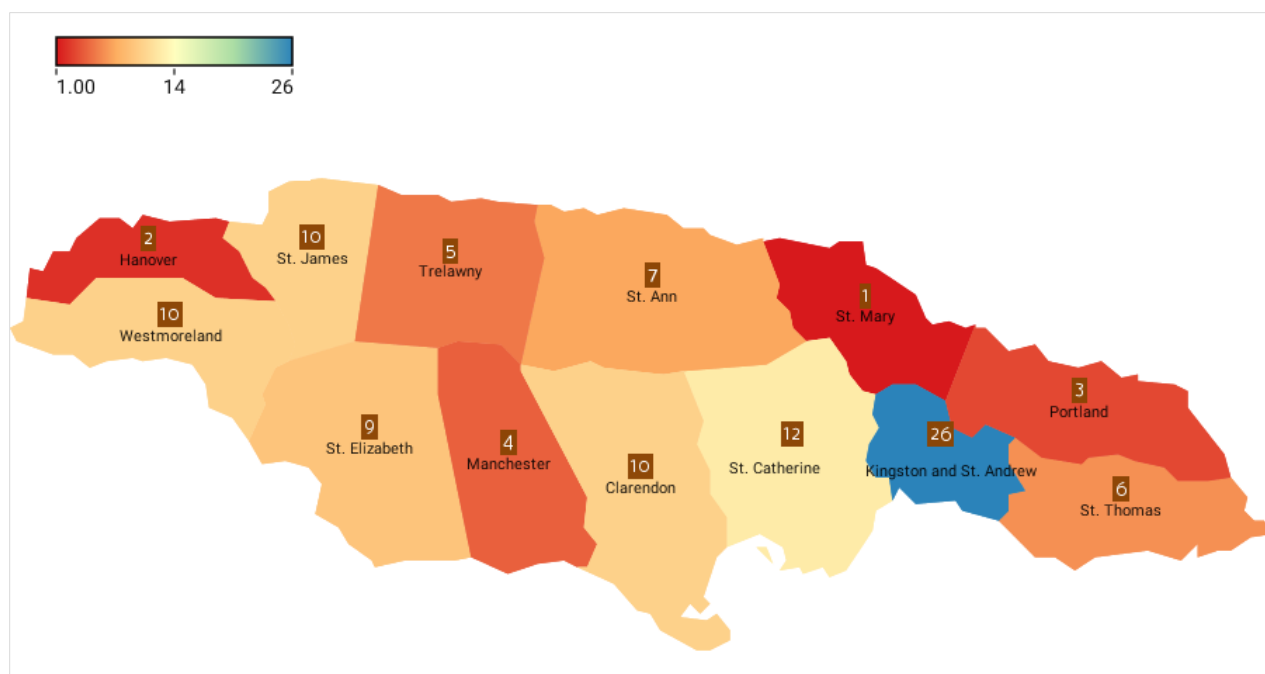


Figure 2: Number of Parents' Places in each parish (Kingston = 15; St. Andrew = 11)



Figure 3: Number of assessed Parenting Programmes in each parish that are certified and not certified

To enhance the preventive healthcare services (well child clinics) through improvement in human resource, facilities, public education and monitoring of child health (including nutrition) and development status

Article 24 of the UN Convention on the Rights of the Child (1990), to which our nation is signatory, states that every child has the right to the “highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” Our commitment has been not only to the treatment of illness, but to its prevention and the promotion of optimal health, beginning as early as the prenatal period. To do this, multi-dimensional approaches continue to be employed, addressing primarily the areas of policy formation and implementation, infrastructure development, human capital investment, public education, and monitoring of child health and development outcomes. This is a progressive work involving considerable input predominantly from a most dynamic sector – the healthcare sector. It is through the untiring effort of the Ministry of Health (MOH), in conjunction with other partners within the early childhood (EC) sector, that pursuit of the ideals relating to child health remains ongoing.

For the period under review, efforts intensified in addressing matters relating to maternal and child mortality, child nutrition, child health and development monitoring, and investment in personnel and facilities. Greater strides were made in some areas more so than others. Nevertheless, where targets were not met, there were incremental advances with plans in place for work to continue.

INFANT MORTALITY AND PROMAC

The infant mortality rate, though criticised for its potential to narrow the attention of health policy makers to only a small part of the population, remains an important indicator of the health status of a population. Calculated as the number of deaths among children under the age of 1 per 1,000 live births within the same year, it speaks to an association between the causes of infant mortality and factors that influence the health status of a population, including socio-economic development, living conditions, morbidity, and environmental conditions. Neonatal death is the major contributor to infant mortality, while infant death is the major contributor to under-five mortality (Serbanescu, Ruiz, & Suchdev, 2010).

Despite the steady decline in the mortality rates of Jamaica’s infants and children under 5 years old since the 1990’s, the current rate of 16.2 remains notably higher than Millennium Development Goal (MDG) 4, which has a target of 9 out of every 1,000 live births (see Figure 4). The main identified causes of death are respiratory disorders, cardiovascular disorders and infections specific to the perinatal period, as well as disorders relating to length of gestation and fetal growth (Pan American Health Organization, 2012). This appears to be at odds with the fact that the vast majority of live births (99.1%) are attended by skilled personnel (i.e. doctor, nurse/midwife or auxiliary nurse), and that 97.7% of women receive antenatal care at least once during pregnancy, 85.6% of whom receive four or more visits (STATIN & UNICEF, 2013).

Children at greatest risk are those who: live in rural areas; are born to mothers with low educational achievement and; are born less than 24 months apart from their siblings (Serbanescu, Ruiz, & Suchdev, 2010).

To accelerate progress towards MDG 4 and address other matters relating to infant and maternal mortality, the European Union allocated funding to Jamaica's Programme for the Reduction of Maternal and Child Mortality (PROMAC) which was launched in April 2013 (Patterson, 2014). PROMAC also addresses MDG 5 which is the reduction of maternal mortality by 75% to 26.5 out of every 100,000 live births between 1990 and 2015. (MOH, 2016). The latest recorded figure stands at 81.3 per 100,000 live births, down from 110 in 2010. Steady progress is being made towards these and other goals under the Programme which is scheduled to end in March 2017. More specific objectives include:

- reducing the incidence of neonatal deaths due to lack of access to high dependency care
- reducing the incidence of maternal deaths due to lack of access to emergency obstetric care
- improving the quality of management of high risk pregnancies at both tertiary and primary care levels
- improving the population's health-seeking behaviour regarding maternal and child health
- enhancing public awareness and understanding of healthcare processes and patients' rights
- strengthening the institutional capacity of the MOH and Regional Health Authorities.

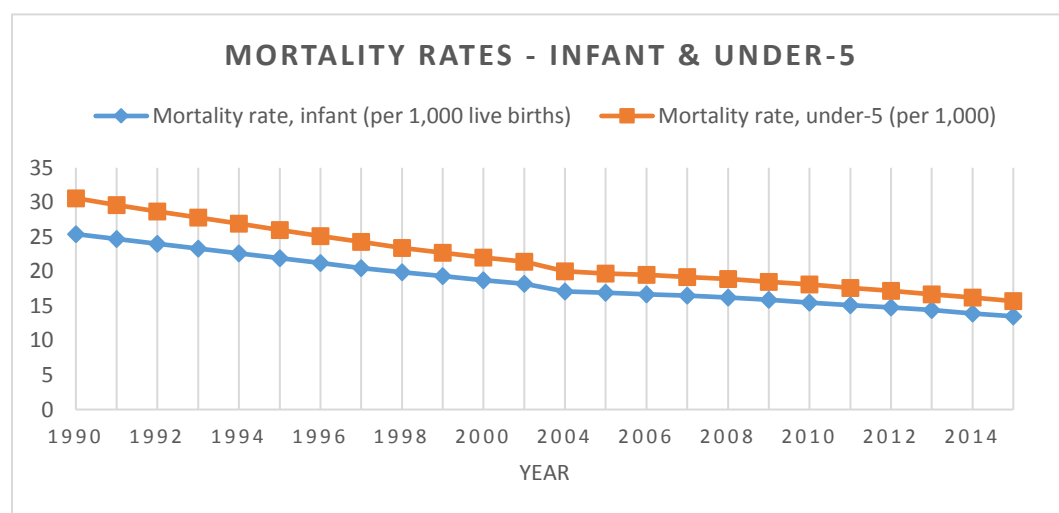


Figure 4: Infant and under-5 mortality rates in Jamaica from 1990 to end of calendar year 2015 (data missing for 2002 & 2003)
Source: World DataBank

NUTRITION

As the growing economic burden of non-communicable diseases is forcing national attention towards the associated factors, greater prominence is being given to the role of proper nutrition in the prevention, management, and reversal of these diseases. Knowing, too, that poor nutrition in childhood can have devastating effects on physical health, cognitive functioning and behavioural development with consequences extending well beyond the formative years (Bellisle, 2004; Cote, Harris, Panagiotopoulos, Sandor, & Devlin, 2013), efforts with respect to proper nutrition among the early childhood cohort continue to intensify. While global attention has shifted to childhood obesity (i.e. overweight or overnutrition), other primary indicators of (mal)nutrition include underweight (i.e. low weight for age), wasting (i.e. low weight for height), and stunting (i.e. low height for age).

The World Health Organisation (WHO, 2016) highlights childhood obesity as “one of the most serious public health challenges of the 21st century” with prevalence increasing at an alarming rate, particularly among developing countries. In 2013, seventy-four percent of children (31 million children) under age 5 found to be obese were from developing countries (WHO, 2016). Locally, while there appeared to be a downward trend in overweight among under-fives between 2007 and 2010, in 2012 there was a sharp increase of 4.4 percentage points to a prevalence rate of 7.8% (PIOJ & STATIN, 2012). Among primary-aged children aged 6 to 10 years old in the North-East Health Region, a 2013 study found a 17.7% prevalence rate of overweight and obesity, with rates being higher among girls as well as students of urban-public and private schools (Blake-Scarlett *et al.*, 2013).

The inverse relationship between overnutrition and undernutrition confirms the upward trend in overweight, but in no way diminishes the need for continued efforts in addressing undernutrition. In fact, both continue to coexist in Jamaica and the region (Gaskin, Nielsen, Willie, & Durant, 2014; Rivera *et al.*, 2013). For example, while the prevalence of stunting has been relatively low compared to other developing territories such as Eastern Africa and Asia, its prevalence remains a health burden, in some periods surpassing other indicators of malnutrition (see Figure 5).

Despite the upward trend in childhood obesity across Latin America and the Caribbean, policies in most countries tend to be biased towards the prevention of undernutrition, with only a few countries developing and implementing national policies and strategies to address the problem of overnutrition. Fortunately, Jamaica is one such territory.

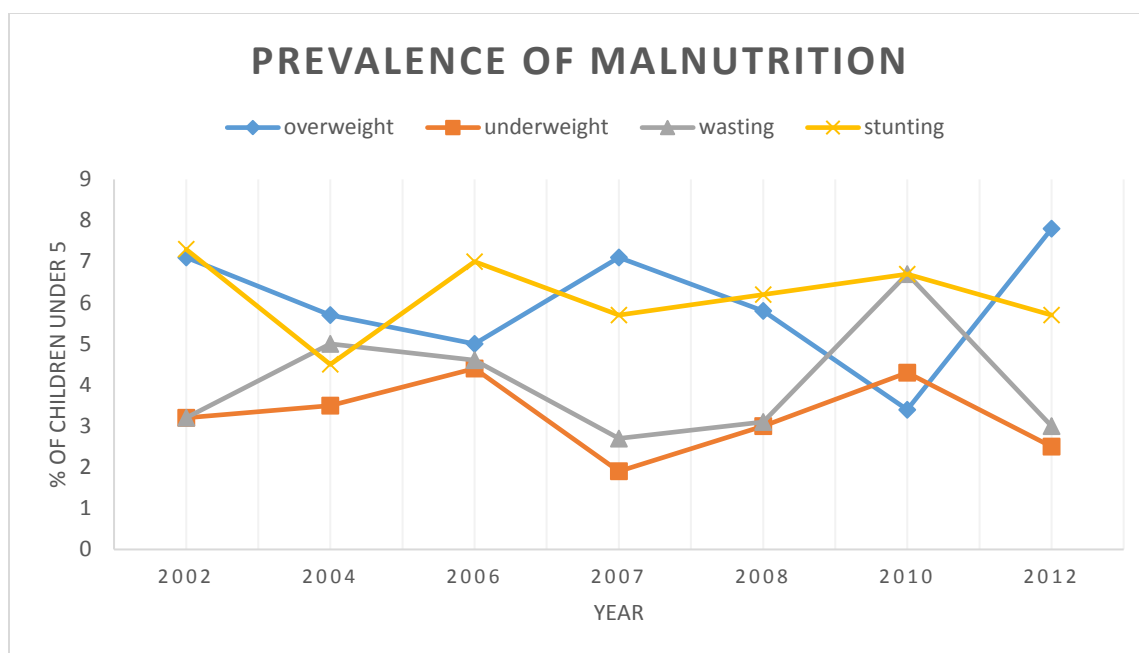


Figure 5: Prevalence of overweight, underweight, wasting and stunting in children under five. Data beyond 2012 currently unavailable.

Source: STATIN and PIOJ (2014)

Infant and Young Child Feeding Policy

In keeping with the WHO-UNICEF global strategy for infant and young child feeding, the MOH developed a National Infant and Young Child Feeding Policy which was tabled in parliament as a Green Paper in June 2014. This policy serves as the guiding operational framework for addressing deficiencies and challenges in infant and young child feeding, while providing a context for the development of effective approaches in tackling the many factors associated with feeding practices. Breastfeeding is the chief area of focus, having observed that the recommended feeding practices for optimal child health are not being adhered to by a large proportion of mothers.

The WHO recommends that children be breastfed exclusively for the first 6 months, continuing up to or beyond age 2 with complementary foods being introduced at 6 months. It is estimated that optimal breastfeeding alone has the potential to prevent 13% of deaths in children under age five (WHO, 2009), protecting the child against infection and being an economical and safe source of necessary nutrients. Yet, in a 2011 survey, it was reported that only 23.8% of children in Jamaica under 6 months were being exclusively breastfed, the highest percentage of children being those in the Kingston Metropolitan Area. Further, within those first 6 months, up to 90% of children were receiving other liquids or foods, and by the end of that period exclusive breastfeeding was down to 7% (STATIN & UNICEF, 2013).

The policy seeks to promote ideal feeding practices through a multi-pronged approach that targets:

- Advocacy/Legislation
- Training (for women of child bearing age, caregivers, pregnant and lactating women)
- Healthcare delivery
- Public information, education and communication
- Monitoring, evaluation and research

Implementation is a multi-faceted undertaking that includes examination of existing frameworks for policy integration. This is an important phase which continued throughout the financial year.

Nutrition Support Strategies and Service Delivery Models

Accompanying the nutrition policy are strategies designed to support parents and early childhood institutions (ECIs) in appropriate feeding practices. It should be noted that any strategy designed to target the EC cohort must reflect variations in care patterns and the way in which services are accessed. Only 11% of children aged 0-3 years attend an ECI (World Bank, 2013) while all children 4-6 years old are enrolled in some form of educational institution (PIOJ & STATIN, 2014). Children in the former group are generally cared for at home, making contact with public services primarily through well-child clinics, while those of the latter group spend most days being cared for at an ECI. Given this fundamental difference in child care and accessibility, it was decided that separate nutrition support strategies tailored to each age cohort would be needed to effectively reach the majority of children aged 0-6.

To this end, a nutrition support strategy and service delivery model for 4-6 year olds was developed. A strategy specific to the 0-3 age cohort is also to be developed. However, this has been delayed due to the complexity of research into meal preparation practices in homes and ECIs, as well as a dearth of qualified consultants within the field. During the 2014-2015 financial year, challenges hindering the piloting and subsequent implementation of the strategy for 4-6 year olds persisted. Nevertheless, the ECC provided nutrition support to those 4-6 olds attending an ECI in the form of nutrition grants, first distributed in this financial year. During the year, 64,124 children in 1,204 ECIs benefitted from funding for meals in the amount of \$88,491,120 (see Table 1). Recognising the tremendous positive effect of proper nutrition on school performance, it is hoped that this provision will be maintained.

Table 1: *School feeding expenditure by region and parish*

Regions	Parishes	No. of ECIs	No. of children	Expenditure (J\$)
Region 1	Kingston, St. Andrew	235	16,574	22,872,120
Region 2	St. Thomas, St. Mary, Portland	187	7,507	10,359,660
Region 3	St. Ann, Trelawny	137	6,475	8,935,500
Region 4	St. James, Hanover, Westmoreland	236	12,146	16,761,480
Region 5	St. Elizabeth, Manchester	156	6,684	9,223,920
Region 6	Clarendon, St. Catherine	253	14,738	20,338,440
Total		1,204	64,124	88,491,120

MONITORING OF CHILD HEALTH AND DEVELOPMENT

While much is being invested in meeting the nutritional and health needs of our nation's children, there is an evident lack of consistency in capturing data needed for determining impact. This is expected to change in coming years with the introduction of the Child Health and Development Passport (CHDP). With consistent use of the CHDP, access to reliable data through systematic monitoring of child growth and development is expected to be the standard.

Child Health and Development Passport (CHDP)

The Child Health and Development Passport (CHDP) was integrated into the healthcare system in September 2010 and is intended to be the primary tool for the monitoring and risk-screening of all children from birth to age 17. It includes an immunisation record, WHO growth charts, personal and family health records, nutrition checklists, parenting and child development tips, and primary screening tools for key developmental stages. Inclusion of standardised WHO growth charts, in particular, facilitates the monitoring of growth and development within the home setting. The various sections require completion by health professionals, parents, and/or education officials.

All 303 health centres in the 14 parishes have been distributing the passport. At the beginning of the financial year, 97.6% of children aged 0-3 years had received a CHDP and this number remained constant throughout the year. This represents a slight decrease compared to the previous year which saw 98% being issued with a CHDP. The high uptake is expected to be maintained and surpassed in coming years.

Of as equal importance as distribution of the CHDP is its usage. Although all health professionals at Well-Child Clinics report entering clinical data into the CHDP, it is difficult to ascertain whether parents and education officials also utilise the passport in the manner for which it was designed. Anecdotal evidence suggests that promotion of the CHDP among non-healthcare professionals is essential if universal usage is to be realised.

MIS for Health

Crucial to the CHDP's usefulness is the information contained therein being accessible to authorised personnel from a secure centralised location. The transfer of data from the CHDP to a web-based system would accomplish that goal. To this end, the MOH's process of converting their paper-based Monthly Clinic Summary Report (MCSR) to an electronic format will include the design of a module for capturing CHDP data. Given the scope of work required to transfer information from the CHDPs to the MOH's management information system (eMCSR), it was decided that two consultancies would be needed to facilitate this activity. At the end of the 2014-2015 financial year, the Terms of Reference for the first consultant was drafted and approved by the World Bank. Commencement of the procurement process is scheduled for the first quarter of the upcoming financial year.

HEALTHCARE PROFESSIONALS & FACILITIES

The healthcare sector continues to suffer from a deficit in trained healthcare professionals and facilities needed to realise the desired impact of its programmes. Nevertheless, investment continues in training and strategically deploying officers through partnerships with local training institutions, as well as in ensuring existing facilities are of an acceptable standard.

Child Development Therapists

In 2012, a two-year Associate Degree programme in Child Development Therapy was introduced and received its first cohort at the University of the West Indies. In June 2014, fourteen (14) students graduated, 7 of whom are now serving in 4 parishes – Kingston, St. Andrew, St. Thomas and St. Catherine. This is far below number needed for islandwide coverage. However, with requests by MOH and MLSS having been submitted to the Ministry of Finance and Planning (MOFP) for the post to be formally established, it is expected that the number of persons trained as Child Development Therapists (CDTs) will gradually increase to meet the aim of each parish having at least 1 full-time CDT on staff in the public sector.

Well-Child Clinics & Play/Learn and Demonstration Centres

Well-Child Clinics are primarily community-based medical facilities that provide health services within existing health centres. To date, there are approximately 330 clinics island-wide. Well-Child Clinics cater to antenatal, post-natal, child welfare and family planning healthcare needs. Services include immunisation, nutrition support, growth monitoring, child development, oral healthcare and social risk intervention. Additionally, it is intended that more spaces be provided within these clinics to facilitate play and demonstrations. These spaces will function as areas in which parents can receive tips on proper nutrition, early stimulation and the importance of immunisation. The establishment of these Play/Learn and Demonstration Centres in 2013-2014 was not as successful as intended due to several factors including: limited space at many Well-Child Clinics; inadequate security for equipment and materials and; limited available MOH staff to implement the programmes at the centres. However, during the 2014-2015 financial year the ECC and MOH renewed their commitment to resolving these issues to ensure wide-scale implementation in upcoming years.

Standards for certifying Well-Child Clinics were created in 2013 and address areas such as: staffing; referral and treatment procedures; building health and safety; medical supplies inventory and storage; practitioner-patient communication; data collection and; infection control. Immediately following the creation of these standards, a service delivery model should have been developed to guide the assessment and certification of these clinics. However, due to several administrative changes at the MOH and challenges experienced by the consultant developing the service delivery model, there has been a delay in the process. Nevertheless, following project re-sensitisation among key personnel at the MOH (including the newly appointed Chief Medical Officer and Permanent Secretary), the year ended with the Ministry affirming its support of project continuity in the upcoming financial year. It is expected that by the 2015-2016 financial year, assessment of Well-Child clinics will be fully underway and a minimum of 10% of clinics certified.

To develop a system that allows early identification of and appropriate intervention for households and children at risk

Children in developing countries are at increased risk of developmental, behavioural, and psychosocial disorders due to the prevalence of multiple risk factors including poverty, malnutrition, birth trauma, inappropriate home environment, and inadequate stimulation (Smith & Ashiabi, 2007; Walker *et al.*, 2015; Wallender *et al.*, 2014). In these territories, it is estimated that more than 200 million children under age five, the majority of whom live in extreme poverty, are at risk of not attaining their full developmental potential (Gertler *et al.*, 2013; Grantham-McGregor *et al.*, 2007). If at a cognitive and socio-emotional disadvantage upon entering primary school at age six, these children's outcomes are likely to include poor school performance leading to low income potential and maladaptive parenting skills, thus perpetuating the cycle of poverty (Smith & Ashiabi, 2007; Walker *et al.*, 2015).

However, studies have consistently found that early intervention can significantly limit developmental decline with sustained influence into adulthood (Smith & Ashiabi, 2007; Gertler *et al.*, 2013; Walker, Chang, Vera-Hernandez, & Grantham-McGregor, 2011). For example, in a local 20-year follow-up study examining the impact of psycho-social stimulation and nutritional supplementation on stunted toddlers living in poverty, it was found that while nutritional supplementation had no significant long-term effects, early stimulation had significant impact on psychosocial development, in that, participants were less likely to exhibit violent behaviour, had better social skills and had lower rates of depression than those who did not receive the intervention (Gertler *et al.*, 2013; Walker *et al.*, 2011). Furthermore, the average monthly lifetime earnings of participants were found to be 49% higher than those who received no intervention and was on par with the earnings of those from a 'healthy' (i.e. non-stunted) comparison group, thereby interrupting the poverty cycle (Gertler *et al.*, 2013). This, the researchers attributed to increased parental investment, more education, and heightened cognition and psychosocial skills resulting from the stimulation treatment.

Local statistics on child development (e.g. cognitive and socioemotional development) are limited. However, we know that approximately 18.4% of children under five live in poverty (PIOJ, 2014). With the recognised association between poverty and developmental vulnerability, one may assume that this figure potentially represents the proportion of pre-primary children at risk and therefore in need of some form of intervention.

Jamaica's principal systems for assessing and providing suitable interventions to children at risk acknowledge the significant impact of poverty and the importance of early stimulation. The Programme of Advancement Through Health and Education (PATH) and the Early Stimulation Programme, both administered through the Ministry of Labour and Social Security (MLSS), focus on poverty alleviation and treating children with developmental disabilities. Plans are also in place for the introduction of a national assessment of four year olds to spot and treat children who may be on a downward developmental

trajectory before they enter primary school. Although various annual reports show incremental increases in the number of households benefitting from these programmes and in the amounts being invested, without reliable data on the precise number of households at risk, it is difficult to determine the extent to which the existing programmes are reaching those in need.

PROGRAMME OF ADVANCEMENT THROUGH HEALTH AND EDUCATION (PATH)

The Programme of Advancement Through Health and Education (PATH), introduced islandwide in 2002, is a Government of Jamaica (GoJ) and World Bank-funded conditional cash transfer programme that provides bi-monthly financial support to our most needy and vulnerable persons. It replaces three previous social assistance programmes: 1. Food Stamps; 2. Outdoor Poor Relief; and 3. Old Age and Incapacity. Beneficiaries include:

- children (birth to end of secondary education)
- persons over 60 not in receipt of a pension
- persons with disabilities
- pregnant and lactating women
- poor adults 18-59 years old

Eligibility is determined by established criteria relating to areas such as educational attainment and access to social amenities. For children aged 0-6, receipt of benefits is conditional upon compliance with “a schedule of health centre visits to ensure proper health status is maintained and their survival chances are strengthened” (MLSS, 2016), while older children must maintain regular school attendance.

Based on recipient characteristics, poverty tends to be concentrated among children (0-17 years), the elderly, those living in rural areas, female-headed households, and large families (Levy & Ohls, 2010; PIOJ & STATIN, 2014). Since the start of the programme, an average of 300,000 registered beneficiaries have been receiving assistance under PATH each year. For the 2014-2015 financial year, 311,781 individuals received benefits amounting to over 4 billion dollars in payments (see Table 2). For each payment month children, by far, constituted the largest proportion of recipients at 71% (221,606), with 16% (51,232) of those being children 0-6 years old (see Table 3). This amounts to a total of \$471,316,120 in cash transfers per payment month to this demographic alone (\$102,158,000 to children 0-6 years old) – an increase of 14% compared to the previous financial year.

Table 2: *Bi-monthly payments to PATH beneficiaries, April 2014-February 2015*

Payment Month	Amount Paid (JM\$)
April	646,232,4700
June	652,774,800
August	673,021,640
October	811,861,240
December	795,615,990
February	754,933,920
Total	4,334,440,060

Table 3: *Number of PATH beneficiaries and amounts paid per payment month during 2014-2015 financial year*

Category	Number paid	Amount paid (JM\$)
No Grade	2,258	4,686,970
Grades 1-6	86,328	156,930,750
Grades 7-9	51,311	125,964,800
Grades 10-13	30,477	81,575,600
Child 0-6	51,232	102,158,000
Elderly	57,873	199,661,850
Disabled	12,509	29,771,420
Pregnant/Lactating Women	1,713	3,759,360
Adult Poor	7,972	18,973,360
PAD/Poor Relief (Adults only)	10,108	31,451,810
Total	311,781	754,933,920

Having access to information on households benefitting from PATH provides an opportunity for children at risk to be more easily identified. With this in mind, as of 2013-2014, PATH beneficiary households with children aged 0-6 years were specially targeted for developmental screening with a view to escalating cases for referral and intervention, as deemed necessary.

Screening of Children Aged 0-6 years

The Ten/Eleven Questionnaire (TQ) was included in the CHDP as an easily accessible means of assessing child development. It is designed to detect the presence of physical and/or cognitive disability. The screening target for this financial year was 380 children who are on the PATH programme through the Early Stimulation Programme at MLSS. By the fourth quarter, those screened amounted to 1,444 children – three and a half times more than the projected figure and 350% more than the previous year. This suggests that more persons used available referral services during the period. It also indicates that more children suspected to have developmental delays were being screened at an earlier stage, thus, widening the window of opportunity for successful intervention and treatment.

While the targeting of PATH beneficiaries enables the screening, diagnosis and treatment of a larger number of children at risk than previously, there is need for this to be done on a much wider scale. For this, a national service delivery model for screening, diagnosis and early intervention for child development risks is required. Activities are currently underway to procure the services of a consultant to develop such a model. An essential feature of the model will be its compatibility with existing assessment frameworks of the MOH, MLSS, and MOE.

EARLY STIMULATION

The Early Stimulation Programme at MLSS is the only publicly funded service providing assessment and early intervention for young children (aged 0-6 years) with disabilities. Children are seen by referral from healthcare professionals, educators or parents who may suspect developmental delays. Upon admission,

a comprehensive assessment is done to determine whether an intervention is needed and the form such intervention will take. The programme accommodates children with various disabilities including:

- intellectual challenges, mental retardation, learning disability
- sensory impairment
- delayed language development
- physical challenges
- behavioural problems (e.g. ADHD)
- Autism, Cerebral Palsy, Down Syndrome

Interventions may be centre-based or community-based. Centre-based services are provided primarily at the MLSS Head Office in Kingston, and with the addition of a satellite centre in Portland, children in Orange Bay, Port Antonio, Buff Bay and surrounding communities are also able to access treatment without having to journey into Kingston. Community-based interventions involve visits by Child Development Officers (CDOs) to homes, schools, and day care centres to train parents and caregivers in the various stimulation techniques that the child may require (e.g. motor skills, socialisation). Although CDOs operate primarily out of four parishes, this financial year saw services being extended to two additional parishes – namely, Manchester and Clarendon. The early stimulation programme also includes a pre-school for children with special needs.

Since its inception in 1975, the Early Stimulation Programme has benefitted over 30,000 children (Brown, 2011). In this financial year alone, 1,595 children received treatment, 40.9% of whom were new referrals from all parishes (see Tables 4 and 5). As has been the case since the beginning, services were provided to a larger proportion of boys (963) than girls (632), and cases from Kingston and St. Andrew far outweighed those from other parishes (see Figure 6). Whether these distinctions indicate where the greatest needs lie or speak primarily to the matter of programme accessibility could not be determined.

The pattern of yearly increase in the number of referrals and children receiving intervention points to a need for corresponding increase in CDOs who administer these interventions to children from all across the island. With the submission to the MOFP regarding the formalisation of the role of CDTs, it is hoped that current shortfalls will be alleviated over time.

Table 4: Number of children, by parish, aged 0-6 who have accessed the Early Stimulation Programme since 1975. Colour coding represents regional divisions in sequential order from Region 1-6.

Parish	1975-1979	1980-1989	1990-1999	2000-2006	2007-2013	2014-2015
Kingston & St. Andrew	266	647	835	751	969	1034
St. Thomas	19	40	46	23	41	60
St. Mary	15	43	41	48	21	52
Portland	8	30	23	17	221	196
St. Ann	2	18	5	4	9	10
Trelawny	1	15	3	1	3	6
St. James	3	12	11	1	1	25
Hanover	2	11	4	-	-	5
Westmoreland	1	10	9	1	3	5
St. Elizabeth	-	12	1	2	1	14
Manchester	9	19	8	10	15	16
Clarendon	22	34	30	18	18	30
St. Catherine	41	50	60	77	110	142
Total	389	941	1076	953	1412	1595

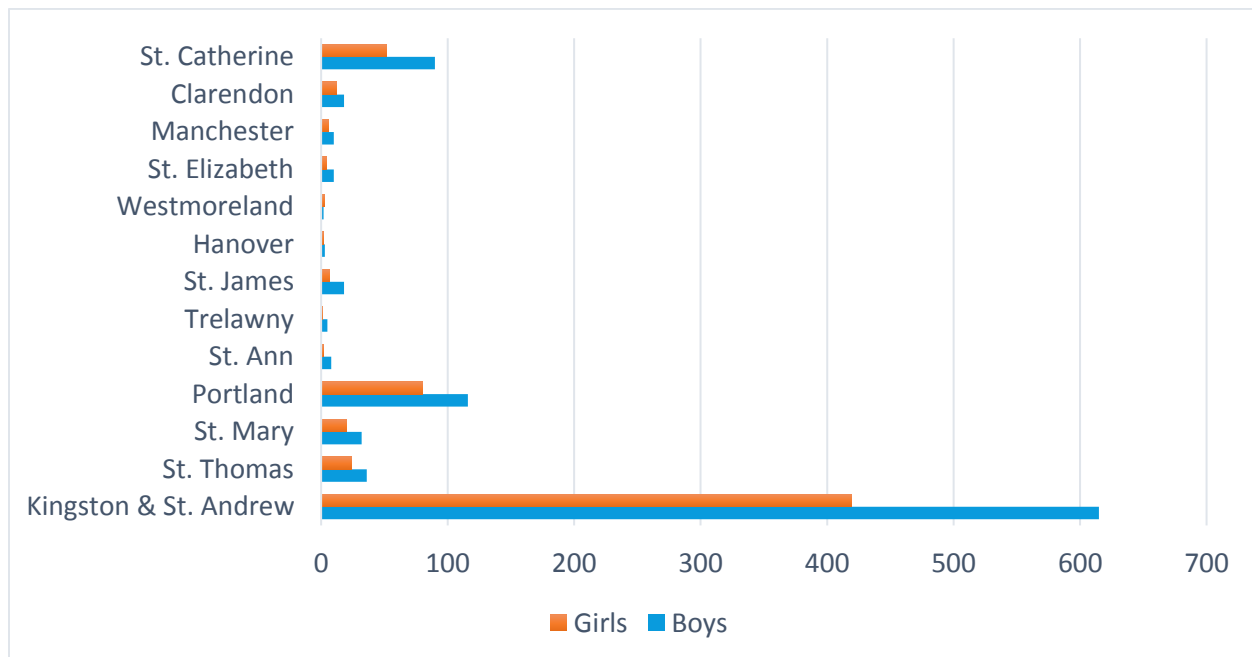


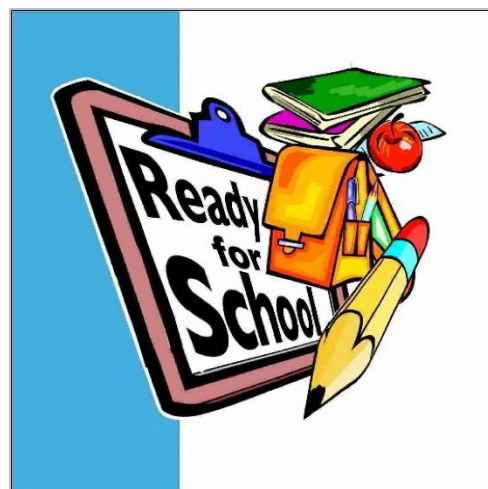
Figure 6: Early Stimulation Programme intervention provision by parish and gender, 2014-2015

Table 5: *Early Stimulation Programme referrals and intervention by parish, 2014-2015. Colour coding represents regional divisions in sequential order from Region 1-6.*

Parish	No. referrals received	No. of new referrals receiving intervention	Total no. of children receiving intervention
Kingston & St. Andrew	425	420	1034
St. Thomas	19	19	60
St. Mary	25	24	52
Portland	68	60	196
St. Ann	5	5	10
Trelawny	2	2	6
St. James	3	3	25
Hanover	2	2	5
Westmoreland	2	2	5
St. Elizabeth	8	8	14
Manchester	15	15	16
Clarendon	20	18	30
St. Catherine	65	65	142
Total	659	652	1595

AGE 4 ASSESSMENT

Several studies convincingly demonstrate that academic performance and even completion of primary education are associated with a child's possession, upon entry, of particular characteristics and skills (physical, social and cognitive) that will enable learning and development (Aiona, 2005; Arnold, Bartlett, Gowani, & Shallwani, 2008; O'Sullivan, 2012). The readiness of Jamaica's children entering primary school has been of concern for a number of years, particularly in light of evidence from various formative assessments administered to students in Grade One consistently showing low levels of competence among our children. While school readiness involves not only responsibilities on the part of the child but of the school as well (Arnold *et al.*, 2008; O'Sullivan, 2012), the quality of ECD offerings play a significant role in the child's preparation. Following the growing global trend, one offering that may provide tremendous gains in the area of school readiness is the screening of children during these pre-primary years.



To this end, the ECC initiated the development of the Jamaica School Readiness Assessment for four year olds. Assessing children's readiness to access primary education from as early as age four provides the opportunity to not only identify those who may be at a developmental disadvantage, but to also implement additional support mechanisms during the year preceding entry to the primary school environment. The assessment tool is comprised of three measures: 1) a measure of development; 2) a measure of learning and; 3) a measure of behaviour. Westmoreland was chosen as the parish in which the assessment tool would be piloted, with funding provided by UNICEF. In June 2014, twenty-two (22) ECC staff members participated in train-the-trainer sessions in preparation for their training of 264 EC practitioners representing 147 ECIs in that parish. The pilot proceeded in the same month with EC practitioners administering the assessment to 2,379 four year olds. A final project report with recommendations for a national roll-out is expected in the upcoming financial year.

To improve the quality of services offered by early childhood institutions

Jamaica has 2,685 ECIs spread across the fourteen parishes existing in the form of a: basic school; day care centre/nursery; government supported day care centre; infant school/department; kindergarten & preparatory school; mixed pre-school & nursery or; pre-school (see Box A for descriptions). While there is no legal obligation for pre-primary children to attend an ECI, local custom has long had a strong leaning towards having children aged 3-5 years enrolled in some form of educational institution. Universal enrolment among this age group continues to be maintained, with 94.4% being enrolled in an ECI, and the remaining 5.5% attending primary school (PIOJ & STATIN, 2014). In contrast, only 11% of children under 3 attend an ECI (World Bank, 2013), reflecting the tradition of most young children remaining home until age 3 (see Tables 6 and 7 for enrollment). Overall enrollment figures consistently show girls outnumbering boys in all age groups except the age 5 and older groups. Also, the vast majority of students (73.6%) attend a basic school as opposed to the other ECI types.

In light of the fact that the majority of children will benefit from early childhood education and that high quality EC programmes can have enduring impact on a child's social development and academic achievement, ensuring these facilities create this enabling environment is central to the mandate of the ECC. The ECC is able to do this chiefly through the Early Childhood Commission Act (2003) and Early Childhood Regulations (2005) which stipulate that no ECI is to be in operation if not registered with the ECC.

Box A – Definitions of early childhood institution facility types

Basic school: a school that offers a course of educational training for students under the age of 6 years; usually community-based.

Day care centre: any premises used for the provision of non-residential day care service to more than four children up to 6 years of age for at least six hours per day and at least four days per week.

Government supported day care centre: a day care centre funded by the GoJ.

Infant school: a government-owned school that offers a course of educational training for children aged 3 years and 9 months to 6 years.

Infant department: a department of a government-owned school (usually All-Age or Junior High) that offers a course of educational training for children aged 3 years and 9 months to 6 years.

Kindergarten & Preparatory School: a privately-owned school that offers a course of educational training for children from age three to twelve.

Pre-school: a privately-owned school that offers a course of educational training for students under the age of six years.

Table 6: *ECL enrollment for 2014-2015 by parish, gender and age. Colour coding represents regional divisions in sequential order from Region 1-6*

Parish	Under 3 yrs.		3yrs.		4yrs		5yrs.		Over 5 yrs.		Total
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	
Kingston	283	322	773	872	984	1005	1085	1065	57	59	6505
St. Andrew	953	1111	2772	2906	3170	3332	3436	3789	1251	1037	23757
St. Thomas	152	155	586	510	607	663	545	523	72	68	3881
St. Mary	175	174	677	701	848	880	788	704	20	17	4984
Portland	232	224	507	528	533	563	450	420	7	2	3466
St. Ann	287	309	1099	1199	1196	1261	1166	1081	15	3	7616
Trelawny	291	440	494	469	535	533	666	713	21	3	4165
St. James	433	421	1373	1352	1800	1688	1681	1568	39	31	10386
Hanover	52	54	495	501	544	604	602	571	10	7	3440
Westmoreland	132	122	1044	1014	1219	1192	1236	1221	33	9	7222
St. Elizabeth	162	178	868	860	994	1012	960	901	182	130	6247
Manchester	181	234	815	859	973	942	902	768	41	35	5750
Clarendon	373	397	1514	1585	1739	1693	1593	1484	145	119	10642
St. Catherine	687	739	1923	1867	2079	2055	1992	1958	105	84	13489
Total	4393	4880	14940	15223	17221	17423	17102	16766	1998	1604	111550

Table 7: Enrollment for 2014-2015 by parish, ECI type and gender. Colour coding represents regional divisions in sequential order from Region 1-6.

Parish	Basic School		¹ Day Care		² Gvt. Day care		³ Infant		⁴ Kinder/Prep		⁵ Mixed		Pre-school		⁶ Special Ed.		Total
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	
Kingston	2165	2196	61	60	0	0	722	822	60	60	174	185	0	0	0	0	6505
St. Andrew	7870	8296	150	165	2	1	312	355	1487	1558	1424	1481	330	312	7	7	23757
St. Thomas	1598	1542	5	0	0	0	66	83	164	170	46	40	83	84	0	0	3881
St. Mary	1994	1986	0	0	0	0	255	241	76	95	154	128	29	26	0	0	4984
Portland	1266	1305	5	12	12	15	302	284	39	29	103	91	2	1	0	0	3466
St. Ann	2653	2779	24	18	5	7	351	321	254	242	369	359	100	120	7	7	7616
Trelawny	1438	1480	0	0	0	0	297	396	32	43	240	239	0	0	0	0	4165
St. James	2863	2624	128	114	49	29	1002	985	690	721	290	304	300	275	4	8	10386
Hanover	1241	1305	12	9	0	0	255	223	52	57	84	80	59	63	0	0	3440
Westmoreland	2755	2684	17	13	7	7	378	367	244	244	94	81	169	162	0	0	7222
St. Elizabeth	2956	2871	14	10	3	2	83	98	20	14	65	58	25	28	0	0	6247
Manchester	2384	2397	55	49	0	0	258	196	77	79	138	117	0	0	0	0	5750
Clarendon	4332	4288	19	12	0	0	536	485	219	238	217	213	41	42	0	0	10642
St. Catherine	5443	5399	58	41	0	0	311	312	79	84	442	455	453	412	0	0	13489
Sub-Total	40958	41152	548	503	78	61	5128	5168	3493	3634	3840	3831	1591	1525	18	22	111,550
Total	82,110		1,051		139		10,296		7,127		7,671		3,116		40		111,550

¹Day Care/Nursery; ²Government Supported Day Care; ³Infant School/Department; ⁴Kindergarten & Preparatory School; ⁵Mixed Pre-school/Nursery; ⁶Special Education

REGISTRATION/CERTIFICATION

The Early Childhood Act (2005), which governs the regulation and management of ECIs in Jamaica, states clearly that “no person shall operate an early childhood institution unless that institution is registered [...].” Central to the purpose of registration are: 1) ensuring there is no threat to children’s health and safety and; 2) ensuring appropriate facilities are in place to enhance the social and cognitive development of each child enrolled. An often overlooked benefit of registration is that it places ECIs in a position where their operational needs can be identified and appropriate aid provided by or through the ECC. During this and previous years, aid has taken the form of salary subsidies, staff development, facility improvement, and provision of learning materials, among others. Not being registered, then, is not only a legal infraction but prevents the ECI from accessing available support mechanisms.

Registration is a process that requires collaborative effort between an ECI and the ECC. To initiate the process, ECI operators must submit a complete application to the ECC which leads to a host of collaborative activities, the end goal of which is to have the ECI being certified – that is, being issued a certificate of registration. Unfortunately, despite the legal framework being in place for ten years, registration compliance remains challenging.

Application for Registration/Certification

For the last three years, ECI compliance in applying for registration with the ECC seems to have peaked at around 94%-95%. By the end of this financial year, 94.2% (2,529) of ECIs applied for registration, compared to 94% and 95% in the previous two years. The most regularly cited challenge among the remaining 5.8% (156) that have not submitted an application is the associated expense, particularly in relation to the acquisition of essential documents from external agencies (e.g. Police Record, Food Handler’s Permit). Pre-schools have consistently had the lowest compliance rate (81.3% for this period) while government supported day care centres continued to maintain full (100%) compliance (see Table 8). This may indeed be indicative of the role of access to funding as well as governance in complying with registration, bearing in mind the distinct financial structure and levels of accountability of these two ECI types. At the parish level, St. Mary had the highest compliance rate of 99% while St. Ann had the lowest with 88% (see Table 9).

Notwithstanding the high rate of application compliance, the ECC is yet to certify any ECI as the financial year ended with none achieving the required 100% score on all legal components of the 12 standards (see Box B for standards). As Development Officers maintain collaboration with ECIs to raise the quality of institutions, the goal of certification will be attained, incrementally, in the coming years.

Table 8: *Number and percentage of ECIs that applied for registration by ECI type from 2012-2013 to 2014-2015 financial years*

ECI Type	2012-2013			2013-2014			2014-2015		
	No. ECIs	Applied	%	No. ECIs	Applied	%	No. ECIs	Applied	%
Basic School	1938	1879	97%	1949	1879	96.4%	1923	1861	96.8%
¹ Day Care	89	85	95.5%	90	82	91.1%	85	76	89.3%
² Gvt. Supported	12	12	100%	12	12	100%	13	13	100%
³ Infant	130	122	93.9%	130	124	95.4%	136	125	91.9%
⁴ Kinder & Prep.	184	157	85.3%	187	160	85.6%	194	165	85%
⁵ Mixed	207	191	92.3%	228	204	89.5%	234	207	88.5%
Pre-school	91	71	78%	94	72	76.6%	91	74	81.3%
Special Education	10	8	80%	10	9	90%	9	74	81.3%
Total	2661	2525	95%	2700	2542	94%	2685	2529	94.2%

Data for previous years (2009-2011) unavailable.

¹Day Care/Nursery; ²Government Supported Day Care; ³Infant School/Department; ⁴Kindergarten & Preparatory School;

⁵Mixed Pre-school/Nursery

Table 9: *ECIs that have applied for registration and given Permit to Operate by parish from 2009-2015*

Parish	No. ECIs	No. & % of ECIs applied for registration		No. & % of ECIs given Permit to Operate	
Kingston	101	96	93%	40	39.6%
St. Andrew	455	441	97%	231	50.8%
St. Thomas	115	107	93%	59	51.3%
St. Mary	125	124	99%	73	58.4%
Portland	92	90	98%	45	48.9%
St. Ann	202	178	88%	73	36.1%
Trelawny	82	76	93%	63	76.8%
St. James	211	191	91%	148	70.1%
Hanover	79	76	96%	77	97.5%
Westmoreland	163	150	92%	114	69.9%
St. Elizabeth	173	163	94%	126	72.8%
Manchester	176	172	98%	128	74%
Clarendon	254	235	93%	123	48.4%
St. Catherine	457	430	94%	268	58.6%
Total	2685	2529	94.2%	1568	58.4%

Box B – The 12 Standards for Early Childhood Institutions

Standard 1	Staffing	Standard 7	Nutrition
Standard 2	Developmental/Educational Programmes	Standard 8	Safety
Standard 3	Interactions and Relationships with Children	Standard 9	Child Rights, Child Protection and Equality
Standard 4	Physical Environment	Standard 10	Interactions with Parents and Community Members
Standard 5	Indoor and Outdoor Equipment, Furnishing and Supplies	Standard 11	Administration
Standard 6	Health	Standard 12	Finance

INSPECTION

Inspection of ECIs is a core function of the ECC. It is a crucial means by which it can be determined whether an institution is providing quality services or acting as a threat to children's development. Inspection of an ECI is an ongoing process that is initiated upon the receipt of an application for registration. The results of an inspection may lead to one of three possible recommendations:

1. Permit to Operate to be issued:- if all critical health and safety requirements are met
2. Certificate of Registration to be granted:- if all legal standards (i.e. EC Act, Regulations and other relevant national laws) are met
3. Closure of the ECI:- if critical health and safety requirements are not met and the children are considered to be at risk in that setting

Since beginning inspections in April 2008, a total of 8,098 have been conducted, covering all ECIs known to be in operation. This figure includes initial inspections as well as repeat inspections of ECIs with some institutions being inspected as many as six times.

In 2014-2015, a total of 1,216 inspections were completed despite severe staff attrition that left the Inspectorate with only 26 inspectors by the end of the year – a depletion of 35% from an initial complement of 40. The impact was felt not only in the reduced number of inspections that were possible during the year, but in the travel demands which necessarily included cross-parish journeys with 3 parishes (Portland, St. Elizabeth and St. Thomas) no longer having an assigned inspector. Despite these challenges, staff remained committed to ensuring ECIs are safe and learner-centred, making recommendations as the inspection results showed to be appropriate.

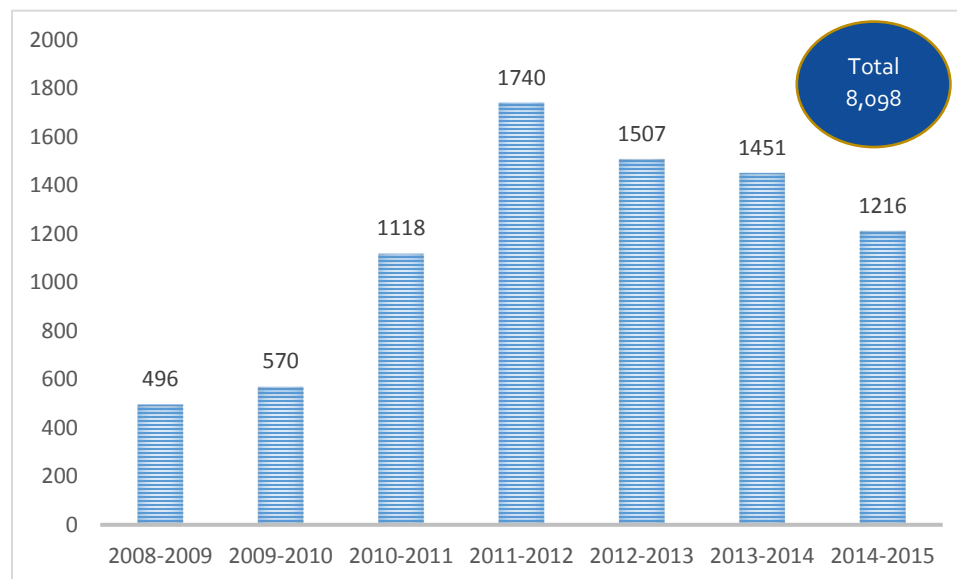


Figure 7: Number of inspections conducted each financial year

Table 10: *Number of inspections conducted in each parish for the financial year 2014-2015*

Parish	No. of ECIs	No. of Inspections
Kingston	101	54
St. Andrew	455	181
St. Thomas	115	61
St. Mary	125	98
Portland	92	11
St. Ann	202	56
Trelawny	82	32
St. James	211	79
Hanover	79	45
Westmoreland	163	91
St. Elizabeth	173	35
Manchester	176	77
Clarendon	254	93
St. Catherine	457	303
Total	2685	1216

Permit to Operate

The issuance of a Permit to Operate represents an ECI's progressive step towards certification. With receipt of a Permit to Operate comes the opportunity for an ECI to improve the quality of its facility and services, guided by recommendations provided in the inspection report and supported by ECC's Development Officers. In addition to the Inspector's recommendations, the minimum health and safety documentation that must be presented for every ECI worker are:

- Medical Certificate
- Food Handler's Permit
- Police Record

A Permit to Operate is valid for only 1 year, which means that those ECIs that do not meet the requirements for certification within the year must make a submission for renewal. During the financial year, 124 permits were issued, bringing the total number of ECIs that have ever been issued a permit to 1,568 or 58.4% of all ECIs known to be in operation as at the end of the financial year (see Tables 9 and 11). This translates to a small majority of approximately 68.7% (76,587) of enrolled children, attending ECIs that have met the minimum health and safety standards. The most common failing preventing ECIs from receiving a Permit to Operate is the submission of an application that is complete, with all necessary documentation included. Despite this, the ECC pursues sustained interaction with the ECIs to encourage and support successful application for registration while ensuring institutions do not pose a threat to children's wellbeing. Occasionally, there is need to recommend the closure of an ECI.

Table 11: Number and percentage of each type of ECI receiving a Permit to Operate from 2012-2015

ECI Type	2012-2013			2013-2014			2014-2015		
	No.	Permits	%	No.	Permits	%	No.	Permits	%
Basic School	1938	81	4.2	1949	180	9.2	1923	84	4.4
¹ Day Care	89	5	5.6	90	11	12.2	85	3	3.5
² Gvt. Supported	12	0	0	12	0	0	13	4	30.8
³ Infant	130	4	3.1	130	3	2.3	136	4	2.9
⁴ Kinder. & Prep.	184	4	2.2	187	6	3.2	194	8	4.1
⁵ Mixed	207	8	3.9	228	25	11.0	234	21	9.0
Pre-school	91	4	4.4	94	11	11.7	91	3	3.3
⁶ Special Ed.	10	0	0	10	0	0	9	0	0
Total	2661	106	4.0	2700	236	8.7	2685	124	4.6

Data for previous years (2009-2011) unavailable.

¹Day Care/Nursery; ²Government Supported Day Care; ³Infant School/Department; ⁴Kindergarten & Preparatory School;

⁵Mixed Pre-school/Nursery; ⁶Special Education

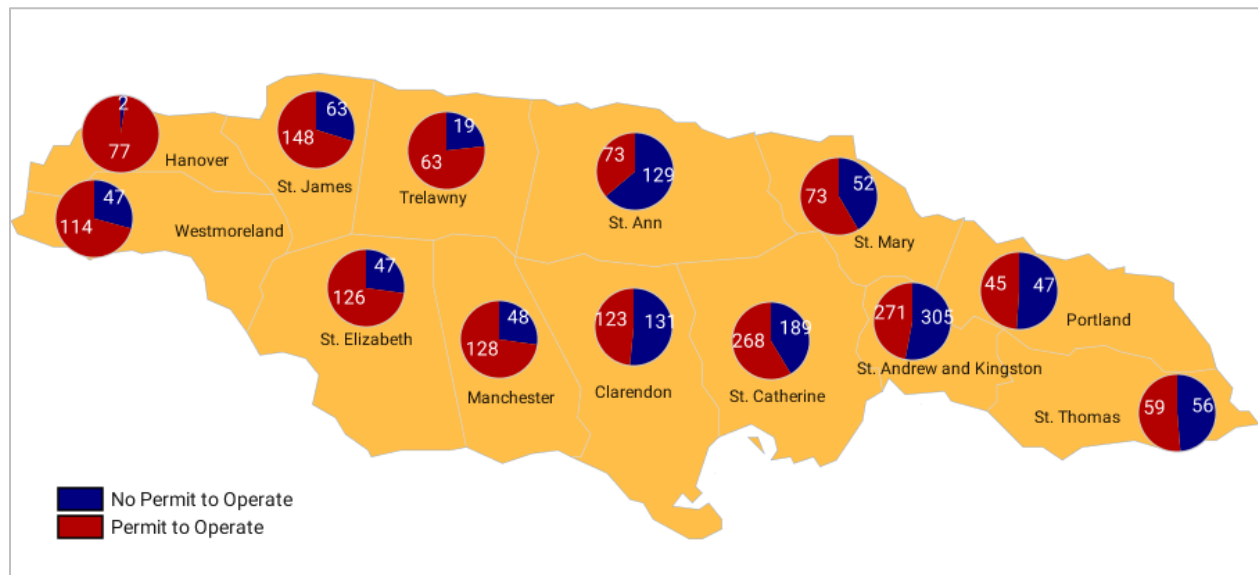


Figure 6: Number of ECIs in each parish with and without a Permit to Operate as at end of 2014-2015 financial year

Closures

With the implementation of a regulatory framework governing the operation of the EC sector has come the closure of ECIs for reasons including:

- Critical health and safety issues
- Inability to meet health and safety standards
- Insufficient enrollment
- Financial challenges
- Rationalisation/Merger process

To date, 407 ECIs have closed their doors, 46 of which did so in this financial year. Although the Rationalisation of Basic Schools Project resulted in the closure of some basic schools, it simultaneously created greater access to quality publicly-funded EC education through the establishment of 135 infant schools/departments. The Project is intended to boost the number of government operated institutions by merging select basic schools to create infant departments and infant schools across the island, thereby increasing access to more affordable education provided by trained teachers within the sector. Of the 200 basic schools targeted, 158 were rationalised/merged by the end of the financial year, leaving 42 to be completed by August of the upcoming financial year.

PARTNERSHIPS FOR FACILITY IMPROVEMENT

One of the benefits of applying for registration with the ECC is that it places ECIs in a position where their needs can be highlighted, enabling donor agencies to more readily identify institutions to which meaningful contribution can be made to their development, not only for the purposes of certification but for optimal benefits to the children.

Project for the Advancement of Childhood Education (PACE) Canada – Adopt-a-School Project

During 2014-2015, the Project for the Advancement of Childhood Education (PACE) Canada committed C\$11,000 (over JA\$13 million) for the improvement of ECIs across the island. This sizeable contribution aided 330 ECIs in the acquisition of equipment and material needed to improve the quality of service provided to children. These ECIs were identified by Canada-based donors (Jamaican and Canadian) seeking to give back to the EC sector in Jamaica. Those institutions whose inspection reports revealed areas of significant deficiency were specially targeted in a bid to have them achieve and maintain the established standards. Through a working relationship with ECC's Development Officers, PACE Canada were also able to extend financial aid to an additional 29 ECIs under their Adopt-a-School Project.

ECC Projects

In May 2014, two ECIs received special attention from ECC staff and volunteers who gave the institutions a much needed facelift. On Labour Day, J's Heart Ease Day Care and Pre-School (St. Mary) and the Bright Minds Nursery Pre- and Kindergarten School (Hanover) became the ECC's project, made possible

through funding from ECC staff and 13 corporate sponsors. Work involved the painting and decorating of buildings, landscaping, sanitizing toys and educational supplies, and repairing the driveway at J's Heart Ease Day Care and Pre-School. Books and other supplies were also donated to the schools.



ECC staff giving an ECI a much needed facelift



To ensure that teachers are highly trained in early childhood development

Few will dispute the now firmly established association between high quality ECD programmes and positive outcomes that extend into adulthood – outcomes that impact academic performance, social adjustment, employment, income generation, and risk of teenage pregnancy, incarceration or drug use (Burger, 2010; Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002; Schweinhart *et al.*, 2005). Less definitive is the relationship between teacher qualification and child outcomes. In a statistical analysis summarising the results of seven studies that examined the relationship between EC teacher education, classroom quality and child academic achievement, Early *et al.* (2007) found contradictory associations. For example, of the seven studies included in the analysis, one indicated lower quality when teachers had a bachelor's degree or higher, two indicated the opposite, and four studies found no significant association. Additionally, only one study found a significant association between degree type and academic performance, where students of teachers with a bachelor's degree in early childhood education (ECE) or child development performed better than those whose teachers had a degree in another discipline. In contrast, a more extensive analysis of thirty-three studies found that, overall, student outcomes (e.g. cognitive and social development) for teachers with a bachelor's degree (whether in ECE or otherwise) were significantly higher than those for teachers with only a high school diploma (Kelley & Camilli, 2007).

Despite the contradictions, these and similar studies inadvertently bring to the fore the matter of the quality of teacher preparation. Specifically, more important than the question of whether EC teachers are qualified at degree level is whether they have received the kind of training and developed the skills needed to optimise the quality of their interactions with children, which, may or may not be the result of a degree education.

According to the EC Regulations (2005), a qualified teacher within the Jamaican EC context is “a person who has, at minimum, been issued a diploma by a recognized teacher training college” (s6). The EC sector in Jamaica currently has approximately 35% of its teaching cohort being trained at the tertiary level (i.e. education diploma, bachelor's or master's). While the ideal remains to have all teaching personnel trained at least to the diploma level, financial limitations dictate that other means of improving teaching quality must be pursued. Currently, this involves having more persons with vocational training (referred to as practitioners) and providing opportunities for existing teaching staff to engage in continuing professional development. During the 2014-2015 financial year the ECC, along with its multiple donor partners, invested heavily in providing training opportunities at all levels to practitioners and qualified teachers in a bid to increase the number of those with the requisite skills to optimise child learning and development. These investments took the form of financing and sponsorship agreements, targeted training programmes, and a special recruitment drive.

FINANCING/SPONSORSHIP

Financial constraints constitute, arguably, the greatest barrier to the pursuit of formal training and education. Fortunately, several organisations that recognise the significant impact of having highly trained teachers in the EC system continue to contribute to making this possible for EC practitioners, teachers and aspiring teachers.

Food for the Poor – NVQJ Level 2 Scholarships

A tripartite collaboration involving Food for the Poor, the ECC and HEART Trust/NTA produced the establishment of a scholarship programme for practitioners to attain the National Vocational Qualification of Jamaica (NVQJ) certification in ECD Level 2. Extended over a 5-year period, this scholarship enables practitioners with any NVQJ certification to upgrade to the ECD Level 2 qualification and receive certification within their field. Level 2 training covers key areas of ECD such as: the provision of support for children's physical, nutritional and learning needs; facilitating language and cognitive development; and maintaining children's safety and well-being (National Qualifications Register, 2016). Valued at \$32.5million in total, the scholarship provides each recipient \$65,000, inclusive of tuition fees (\$17,000) and travelling/meal allowance (\$48,000) for needy beneficiaries for up to 48 weeks. In 2014, eighty-three (83) practitioners completed training and received their certification.

PACE Canada – NVQJ Level 2 Scholarships

Another set of scholarships to practitioners seeking to attain NVQJ certification in ECD Level 2 was made available by PACE Canada, providing \$750,000 to a cohort of 50 practitioners. At the start of 2015, there were 50 practitioners enrolled in a PACE-sponsored Level 2 programme and an additional 5 practitioners enrolled in the Level 3 programme following special request. This is the second year of PACE Canada's sponsorship of the NVQJ Level 2 certification.

Culture, Health , Arts, Sports & Education (CHASE) Fund ECE Scholarships

Scholarships provided by the Culture, Health, Arts, Sports and Education Fund (CHASE) are designed specifically for practitioners wishing to pursue studies at the undergraduate and post-graduate levels. In 2014, forty-eight (48) new applications for the scholarship were approved. This brought the total approved applications for the upcoming academic year (new and returning students) to 133. At the undergraduate level, scholarships are valued at \$100,000 per student, while postgraduate scholarships cover the cost of tuition only and is calculated based on a review of individual programme costs. Thanks to the CHASE fund scholarship, there is opportunity for an annual increase in the number of trained teachers practicing in the sector.

TRAINING PROGRAMMES

In addition to the provision of funding to facilitate access to formal training and certification, support in professional development is provided in the form of targeted training initiatives ranging from tailored workshops to an associate degree.

ECC Resource Centres – Curriculum Support

ECC Resource Centres were specially set up to provide an additional level of support to teachers and practitioners in their provision of ECD services. Located in several parishes across the island, Resource Centres are centralised locations in which teachers and practitioners are able to access relevant training, materials and guidance from trained ECC staff. During the course of the financial year, 134 seminars focusing on integrated curriculum development and implementation were delivered to 690 EC practitioners at several Resource Centres. The curriculum age cohort of emphasis were birth to three, and four to five year olds.

Advancing Childhood Education Programme (ACEP) – Training for Practitioners and Parents

Two years ago, Jamalco and the Alcoa Foundation entered into partnership with the ECC to develop and fund the Advancing Childhood Education Programme (ACEP) – a programme that targets illiteracy and underachievement among basic school children through training of practitioners and parents. Using results of the Grade One Individual Learning Profile (GOILP) as a guide in selecting schools in Manchester and Clarendon for intervention, ACEP focuses on ensuring that children who are about to transition to primary school are sufficiently prepared to do well in Grade One and beyond. In 2014-2015, two hundred and twenty (220) EC practitioners who participated in ACEP enhanced their literacy and numeracy teaching skills, as well as their behaviour modification techniques. Recognising the role of the parent in student success, a complementary aspect of the programme focused on training parents using the parenting manual *Pathways to Parenting: A Caribbean Approach* (Davies & Brown, 2006). Eighty (80) parents benefitted from the training which emphasised: strengthening skills in coping with children's differences and behavioural styles; promoting positive parent-child communication and; improving self-esteem in basic school children before they transition to Grade One.

INSIGHTS into Children's Temperament

Originating from research conducted in the United States of America, INSIGHTS into Children's Temperament is a culturally adapted intervention to support children's socio-emotional development and academic learning. The intervention takes a two-pronged approach. One component focuses on helping parents and teachers in understanding and recognising children's individual differences and the relationship between individual differences and personality. The intervention builds on this foundation, helping parents and teachers to replace negative patterns of interaction and maladaptive disciplinary measures with those that are responsive and individualised, matching each child's unique personality. The second component, which takes place in the classroom, gives attention to building children's

empathy and problem-solving skills in order to enhance their ability to self-regulate. Self-regulation is a key skill for managing and overcoming learning and behaviour challenges which have the potential to interfere with success in school, work and life in general (Florez, 2011). During 2014-2015, the intervention impacted 6 schools from urban and rural areas at the infant, primary, all age, and junior high school levels. In total, 639 students, 18 parents and 11 teachers benefitted from the intervention.

UNICEF – NVQJ Special Needs Education Level 3

In order to boost the cadre of teachers within the ECE sector with specialised skills in special needs education, the HEART Trust/NTA developed and is currently piloting an NVQJ programme in Special Needs Education Level 3 for EC practitioners. Forty (40) practitioners entered the pilot programme in February 2015 at two locations – Petersfield Vocational Training Centre in Westmoreland and Beechamville Vocational Training Centre in St. Ann. The training programme is expected to continue for 18 months, made possible by UNICEF’s Curriculum Development Articulation Project.

Associate Degree in Early Childhood Education

As of September 2014, four (4) teacher’s colleges and 1 community college have been offering a newly developed associate degree in ECE. Programme development was made possible through collaboration between the ECC and the Joint Board of Teacher Education. The associate degree functions as an intermediate qualification for persons wishing to matriculate to a bachelor’s degree.

RECRUITMENT & DEPLOYMENT

While much continues to be invested in upgrading EC practitioner and teacher qualifications, it is clear that attention also needs to be given to recruitment, strategic deployment and retention, working in conjunction with training initiatives. A 2013 ECC survey of ECI teaching staff revealed uneven distribution and a low proportion of trained teachers across the fourteen parishes. St. Mary had the lowest proportion of trained teachers (15.6% of its teaching staff) while Clarendon had the highest proportion (34.2% of its teaching staff). A strategic approach to teacher deployment along with ongoing recruitment would not only increase children’s access to higher quality ECE, but would also help to alleviate the strain experienced in classroom settings that have greater than the targeted teacher-student ratio of 1:10. In 2013 the average ratio stood at 1:13 with infant departments and infant schools having the highest ratios of 1:20 and 1:21, respectively.

The inclusion of the EC sector in the Jamaica Emergency Employment Programme (JEEP) over the last 3 years has served as a means of addressing some of these matters. Under this phase (Phase 3) of JEEP, trained teacher volunteers were each assigned to 2 ECIs for the academic year, providing much needed support in several areas including curriculum delivery, classroom management, and drafting of development plans. Approximately 200 of these volunteers were employed for the year, serving 386 ECIs across the island, providing support to 436 EC practitioners. This is the largest number of ECIs to benefit

from the programme since its commencement. Among the volunteers were those with a diploma in Primary Education to whom sensitisation and training sessions in the Jamaica EC Curriculum were provided to ensure their adequate preparation for the 3 to 5 year old age cohort.

Positive feedback was received from principals and EC practitioners who noted marked improvement in classroom management and the application of developmentally appropriate teaching strategies, the increased use of engaging teaching resources, and a general boost in student motivation. The accomplishments under this small-scale recruitment programme demonstrate the impact that can be made across the ECE sector if conducted on a wider scale.

CONCLUSION

The financial year under review saw steady progress. Through the five (5) strategic areas of the NSP 2013-2018, the EC sector experienced noted growth, notwithstanding a few challenges, as the projected targets were achieved under the World Bank Early Childhood Development Project for 2014-2015.

Under Parenting Education and Support, parenting programmes were assessed and recommended for certification. Additional assessment of parenting programmes is projected for the 2015-2016 financial year with a target of 10% of parenting education and support programmes.

Parents' Places were also established as key focus was directed to the development of a support system for parents, with the intent to impact the lives of children within the early childhood age cohort for their optimal development. Further improvement is projected for 2015-2016 through partnership between the National Parenting Support Commission (NPSC) and the ECC in providing a platform for positive engagement between parent and child.

The inclusion of preventive healthcare as a strategic area within ECD impacted the services offered to children in the health centres through the monitoring of child health and development using the CHDP. Though distribution of this tracking tool has proved successful, the transfer of information from the CHDP to the MOH MIS System was not achieved as projected. It is expected to be completed in two years' time during the 2016-2017 financial year.

As the monitoring and regulatory body for ECIs in Jamaica, a critical thrust of the ECC is to have all ECIs certified as a means of not only safeguarding against our nation's children being exposed to dangerous environments, but to also secure parity of service. The continued collaborative effort among all stakeholders is critical to accomplishing this feat. Over the course of the year, improvements to ECIs – infrastructure and human capital – were made possible through sponsorship from both local and international partners. It is our aim that by the end of the upcoming financial year, a total of 65% of all ECIs will have received a permit to operate, bringing them that much closer to gaining full certification status and to our daunting yet achievable goal of universal certification.

To further improve the sector, importance is placed on the quality of EC practitioners who are employed to ECIs. Though the percentage of qualified persons employed in the sector was not significant for the year under review, the ECC continues to work with training institutions and funding agencies in ensuring practitioners possess the requisite skills and qualifications.

The past year has proven that with the strengthening of existing partnerships between key local ministries and agencies, local and international donors, the ECD sector is better positioned to meet and exceed its ideals, ultimately leading to all Jamaican children fully actualising their full potential.

"Nothing you do for children is ever wasted." (Garrison Keillor)

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