Jamaica

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2013

Policy Goals	Status
1. Establishing an Enabling Environment The early childhood development (ECD) system in Jamaica has a legal framework that includes policies, regulations, and a National Strategic Plan that protect children and their families and promote high quality service delivery. The Early Childhood Commission (ECC) serves as an institutional anchor and effectively coordinates across sectors. Financing for ECD, while adequate in some sectors, could be better coordinated with measures to ensure sustainable levels of investment in ECD.	Established
2. Implementing Widely A wide scope of ECD programs exists in Jamaica, with essential interventions available across all relevant sectors. Coverage for health programs is adequate, but access to certain nutrition interventions could be scaled to reach all young children and pregnant mothers. There is universal access to preprimary school for 3-6 year olds, but early learning opportunities are not as easily available for children in the 0-3 age group.	Established
3. Monitoring and Assuring Quality Jamaica has an advanced system to monitor levels of access and outcomes in ECD. Rigorous standards exist for ECD service delivery in the health and education sectors. Quality assurance measures have been enhanced in recent years, but compliance with standards could still be improved.	Established

This report presents an analysis of the Early Childhood Development (ECD) programs and policies that affect young children in Jamaica and recommendations to move forward. This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework [1] and includes analysis of early learning, health, nutrition and social and child protection policies and interventions in Jamaica, along with regional and international comparisons.

Jamaica and Early Childhood Development

Jamaica is an upper middle-income country with a total population of 2.7 million. With a land area of 10,991 square kilometers Jamaica is the largest English-speaking island in the Caribbean. The GDP in Jamaica is US$14.4 billion. Jamaica is ranked 85th in the UNDP Human development index. The country has a gross national income of US$4,800 per capita, with 17.6 percent of the population living below the national poverty line. In 2012, 9 percent of the total population was younger than 6 years old (411,055 children).

The Government of Jamaica (GoJ) has recognized the importance of ECD through its support of public policies and programs for young children. In 2003, the Early Childhood Commission (ECC) was established as a body corporate reporting to the Minister of Education and Youth with responsibility to coordinate the various sectors involved in ECD and oversee the quality of early childhood institutions (ECIs). Between 2006 and 2008, the ECC coordinated the development of the GoJ's first National Strategic Plan for ECD (2008-2013). The plan served as a roadmap for improving the quality of ECD in the country. Since 2008, the GoJ has made considerable progress in improving the ECD system; this has included strengthening the ECC as an institutional anchor, creating a system for monitoring child health and development through the Child Health and Development Passport, and enhancing and tracking the quality of ECIs.

As of 2013, the GoJ is in the process of developing a new National Strategic Plan (2013-2017) as well as a national multi-sector ECD policy. The present SABER-ECD analysis is intended to identify achievements, as well as gaps, in Jamaican ECD policies and programs in hopes of informing the development of the new plan. Table 1 presents a comparison of selected ECD indicators in Jamaica and countries across the Latin American and Caribbean region.

Table 1: Snapshot of ECD indicators in Jamaica and other Latin American and Caribbean countries

	Jamaica	Barbados	Brazil	Chile	Colombia	Trinidad and Tobago
Infant Mortality (deaths per 1,000 live births)	**20**	**18**	**14**	**8**	**15**	**25**
Below 5 Mortality (deaths per 1,000 live births)	**22**	**20**	**16**	**9**	**18**	**28**
Births attended by a skilled attendant	**98%**	**100%**	**97%**	**100%**	**99%**	**98%**
Moderate & Severe Stunting (Below 5, 2006-2010)	**4%**	Not available	**7%**	Not available	**13%**	Not available
Gross Preprimary Enrollment Rate (3-6 years, 2010)	**112%**	108%	**Not available**	**106%**	**49%**	**82%** (2007)
Birth registration 2000-2010	**98%**	Not available	**93%**	**100%**	**97%**	**96%**

Source: UNICEF Country Statistics, 2010; UNESCO Institute for Statistics, WHO, 2011; MoH, 2013 (infant and below 5 mortality).

[1] SABER-ECD is one domain within the World Bank initiative, Systems Approach to Better Education Results (SABER), which is designed to provide comparable and comprehensive assessments of country policies.

Systems Approach to Better Education Results – Early Childhood Development (SABER-ECD)

SABER – ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multisectoral information is collected on ECD policies and programs through a desk review of available government documents, data and literature, and interviews with a range of ECD stakeholders, including government officials, service providers, civil society, development partners and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies for young children and their families.

Box 1 presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive, but is meant to provide an initial checklist for countries to consider the key policies and interventions needed across sectors.

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: Establishing an Enabling Environment, Implementing Widely and Monitoring and Assuring Quality. Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of policy levers are identified, through which decision-makers can strengthen ECD. Strengthening ECD policies can be viewed as a continuum; as described in Table 2 on the following page, countries can range from a latent to advanced level of development within the different policy levers and goals.

Box 1: A checklist to consider how well ECD is promoted at the country level

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families?
Health care
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early Learning
• Parenting programs (during pregnancy, after delivery and throughout early childhood) • High quality childcare for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social Protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation/ access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc.)
Child Protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially for young children) • Training for law enforcement officers in regards to the particular needs of young children

Figure 1: Three core ECD policy goals

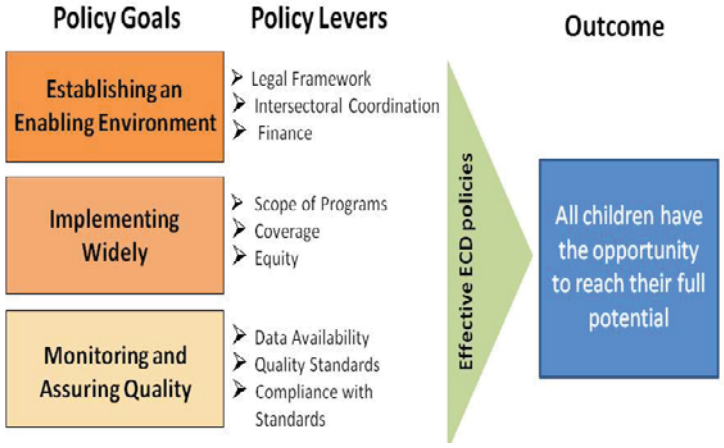


Table 2: ECD policy goals and levels of development

ECD Policy Goal	Level of Development			
	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●
Establishing an Enabling Environment	Non-existent legal framework; ad-hoc financing; low inter-sectoral coordination.	Minimal legal framework; some programs with sustained financing; some inter-sectoral coordination.	Regulations in some sectors; functioning inter-sectoral coordination; sustained financing.	Developed legal framework; robust inter-institutional coordination; sustained financing.
Implementing Widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes.	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes.	Near-universal coverage in some sectors; established programs in most sectors; low inequality in access.	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted.
Monitoring and Assuring Quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement.	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance.	Information on outcomes at national, regional and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance.	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance.

Policy Goal 1: Establishing an Enabling Environment

➢ Policy Levers: Legal Framework • Intersectoral Coordination • Finance

An Enabling Environment is the foundation for the design and implementation of effective ECD policies.[2] *An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD; coordination within sectors and across institutions to deliver services effectively; and, sufficient fiscal resources with transparent and efficient allocation mechanisms.*

Policy Lever 1.1: Legal Framework

Established ●●●○

The legal framework comprises all of the laws and regulations which can affect the development of young children in a country. The laws and regulations which impact ECD are diverse due to the array of sectors which influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young children, parents, and caregivers.

National laws and regulations promote healthcare for pregnant women and young children. In 2009, a gazette to the *National Health Services Act* abolished user fees for public health services. Both antenatal visits and skilled delivery are guaranteed in Jamaica. In addition, standard health screenings for HIV and STDs for pregnant women are free and standard follow-up and referral procedures are provided. The Ministry of Health (MoH) has operational guidelines for prevention of mother-to-child transmission and antenatal care as well as a National Strategic Plan for HIV and Aids in Jamaica (2007-2012).

No official policy exists in Jamaica that sets out a national position regarding maternal and child health. However, in 2007, the MoH produced a comprehensive *Family Health Manual,* which includes detailed objectives and strategies for health service provision for infants and young children. The goal of the ECD section of the manual is to ensure holistic child development through promoting and protecting child wellness in the family, health center, and community settings. The manual outlines specific strategies for structured service provision at each development stage in the early years (through 8 years). To guide child visits, the manual presents norms for growth and various developmental milestones. It also summarizes age-specific clinical procedures as well as key messages for health providers to convey (immunization schedule, breastfeeding, hygiene, early stimulation, etc.) at each well child visit. In addition to age-specific guidelines for immunization outlined in the Family Health Manual, the *Public Health Act* states that young children are required to receive a

[2] Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005.

complete course of childhood immunizations (*Immunization Regulations of 1986)*.

New draft policy will promote appropriate dietary consumption by pregnant women and young children. Voluntary measures, without enforcement mechanisms, are in place [3] to meet the International Code of Marketing of Breastmilk Substitutes, a global health policy framework adopted by the WHO. Jamaica complies with the Innocenti Declaration for the Promotion, Protection, and Support of Breastfeeding. However, according to the MoH, only 40 percent of infants are exclusively breastfed in Jamaica at 3 months [4]. The MoH has recognized the need for increased emphasis on optimal infant and young child feeding practices. It recently drafted a new *National Infant and Young Child Feeding (NIYCF) Policy,* which is being reviewed by Cabinet (April, 2013). The draft *NIYCF Policy* provides an operational framework and guidelines for programs and services that will promote adequate nutritional practices for young children.

While the Nutrition Department of the MoH does not report a specific policy for salt iodization or flour fortification, it reports that all salt is iodized and iron fortified food is encouraged. Additionally, the new *NIYCF Policy* presents guidelines that promote complementary feeding with iron-rich foods for children 6-24 months, including fortified cereals.

Maternity leave and job protection is available, but Jamaican policy could better promote opportunities for parents/caregivers to provide care to newborns and infants in their first year of life. The *Maternity Leave Act* (1979) guarantees 12 weeks of maternity leave with guaranteed pay of 8 weeks. Leave is paid by the employer. Fathers are not guaranteed any paid leave. Table 3 provides a sample of leave policies from other Latin American and Caribbean countries. Compared to Jamaica and other countries in the region, high performing countries like Sweden and the United Kingdom, offer greater protection for parental leave and focus on enhanced economic and social planning. Sweden's approach, detailed in Box 2, is an advanced, flexible policy to ensure adequate care of the child.

Jamaica follows some, but not all, guidelines in accordance with the ILO Maternity Protection Convention. The *Maternity Leave Act* protects against discriminatory dismissal of pregnant women; employers are required to give employees the same job when they return from maternity leave. However, employers are not required to provide breaks for nursing mothers.

Table 3: Comparison of maternity and paternity leave policies in Latin America and Caribbean

Jamaica	Colombia	Brazil	Trinidad	Barbados
12 weeks maternity, at 100% for 8 weeks, paid by the employer. No paternity leave.	14 weeks maternity, 10 days paternity at 100% of salary, paid by state and employer	17 weeks maternity, 1 day paternity at 100% of salary, paid by state	13 weeks, 100% for 1 month and 50% for 2 months, paid by employer. No paternity leave.	12 week maternity at 100% of salary, paid by state. No paternity leave.

Source: ILO, 2012.

Box 2: Relevant lessons from Sweden: The Swedish Parental Insurance Benefit

Summary: The *Swedish Parental Insurance Benefit* is the international exemplar for parental leave policy. Parental Insurance in Sweden is designed to benefit both men and women. In total, the leave includes 480 days of paid leave, 60 days of which are earmarked for the mother, 60 days for the father, and the remainder to be divided as the couple chooses. It commences up to seven weeks prior to the expected birth, and also is available for parents adopting a child. The compensation rate can vary; as a minimum, however, 80% of the employee's salary is provided during leave. In addition, each parent is legally entitled to take unpaid leave until a child is 18 months old. Addition benefits include: temporary parental leave, which entitles a parent 120 days of parental leave annually to care for children under the age of 12 with illness or developmental delay (child requires a doctor's certificate); a pregnancy benefit, payable for a maximum of 50 days to expectant mothers who are unable to work because of the physically demanding nature of their jobs; and, pension rights for childcare years, which partially compensate the loss of future income during the period when the parent is at home with the child.

Key considerations for Jamaica:

- ✓ Mandated parental leave for fathers
- ✓ Adequate, sustainable financial support to families during early stage of child's life
- ✓ Additional benefits for families with children who have special needs

Jamaican law guarantees the provision of free preprimary education. In 2011, the GoJ added a constitutional amendment called the *Charter of Fundamental Rights and Freedoms.* The charter declares that every child has a right to publically funded tuition

[3] International Baby Food Action Network (IBFAN), 2006. *State of the Code by Country: A survey of measures taken by governments to implement the provisions of the International Code of Marketing of Breastmilk Substitutes.*

[4] Mothers should exclusively breastfed until 6 months. Updated data does not exist for this period.

at preprimary (and primary) level. It should be noted that while free provision of preprimary school is mandated by law, the Government currently provides free public preprimary education for only approximately 10 percent of the population of children between 3 and 6 years old[5].

Child protection policies and services, including birth registration and protection from violence, are established in Jamaica. The *Registration of Births and Deaths Act* states that parents or caregivers of children are required to report a child's birth within five days to local district registrars. Since 2007, Civil Bedside Registrars work in public and private hospitals to facilitate this registration process.

The GoJ promotes the reduction of family violence across relevant sectors. The Child Development Agency (CDA), the organization primarily responsible for Jamaica's child protection system, has established several services to prevent violence. This includes home visiting programs, child abuse tracking and reports activities through the Office of the Children's Registry. In addition, the ECC (discussed in detail in the following section) promotes training provision for early childhood care and education (ECCE) teachers so that they are equipped to identify situations of child abuse and neglect. Additionally, under the Ministry of Justice (MoJ), several important interventions are in place to protect children, including training for judges, lawyers, and law enforcement officers on children's rights. An Office of the Children's Advocate and specialized Children's and Family Courts also exist in the national judicial system to protect the rights of children.

Social protection policies and services are established in Jamaica to protect vulnerable young children. The *Childcare and Protection Act* guarantees all children, including orphans and vulnerable children and children with special needs, a range of ECD services. The Act is designed to protect the best interests of all children, including each child's right to safety, continuity of care, development of physical and emotional needs, quality relationships, and education. The CDA and several non-governmental agencies provide services to orphans and vulnerable children, including those affected by HIV/AIDS.

[5] Public preprimary schools, known as Infant Schools and Infant Departments have traditionally been for 4 and 5 year olds but a few schools have 3 year olds.

The *Early Childhood Act and Regulations* (2005) promotes inclusive education for children with disabilities. It also outlines the roles and responsibilities of ECIs and parents. The GoJ supports non-governmental community-based programs that cater to disabled children who cannot access mainstream preprimary education. The *National Policy for Persons with Disabilities* provides a framework for the GoJ to provide equal opportunities for people, including young children, with disabilities.

Box 3: Key laws, policies, and regulations governing ECD in Jamaica

Key ECD Laws

- *Early Childhood Commission Act* (2003)
- *Child Care and Protection Act* (2004)
- *Early Childhood Act and Regulations* (2005)
- *National Parenting Support Commission Act* (2012)

Other Policies/Regulations Protecting Women & Children

- *Public Health Act (1974)*
- *Maternity Leave Act (1979)*
- *Registration of Births and Deaths Act (1981)*
- *National Policy for Persons with Disabilities (2000)*
- *Family Health Manual (2007)*
- *National Strategic Plan for HIV and AIDS in Jamaica (2007-2012)*
- *National Health Services Act (2008)*
- *National Strategic Plan for Early Childhood Development (2008-2013)*
- *Charter of Fundamental Rights and Freedoms (2011)*
- *National Parenting Support Policy* (2012)
- *National Infant and Young Child Feeding Policy* (DRAFT, 2013)

Policy Lever 1.2: Intersectoral Coordination

Established

Development in early childhood is a multi-dimensional process.[6] In order to meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, non-state actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with non-state actors are also essential.

The ECC serves as the national institutional anchor to coordinate ECD across sectors. In 2003, the ECC was established as an official agency to govern the administration of ECD in Jamaica (*Early Childhood Commission Act*). Operating under the Ministry of

[6] Naudeau et al., 2011; UNESCO-OREALC, 2004; Neuman, 2007.

Education (MoE) and reporting directly to the Minister of Education, the ECC is responsible for advising the MoE on ECD policy matters. It assists in the preparation as well as monitoring and evaluation of ECD plans and programs, acts as a coordinating agency to streamline ECD activities, manages the national ECD budget, and supervises and regulates ECIs. The ECC includes a governance arm comprised of the officially appointed Executive Director, a Board of Commissioners, and seven sub-committees representing governmental and non-governmental organizations. It also has an operational arm that implements the policies and programs as determined by the Board and its technical subcommittees. As displayed in Figure 2, the ECC is designed with representation from all relevant sectors, including education, health, local government and community development, labor, finance, protection, and planning. Each ministry or government agency nominates a representative to serve on the Board of Commissioners. The seven sub-committees which provide technical support to the ECC board are comprised of 50 governmental and non-governmental agencies.

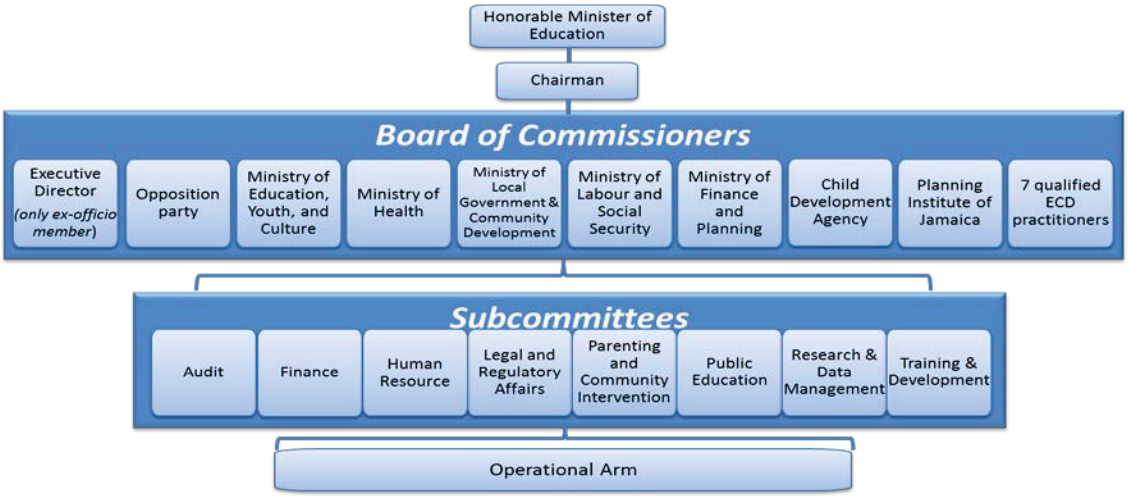
The Government is in the process of drafting a new explicitly-stated multi-sectoral ECD strategy. In 2008, with the support of the World Bank, the GoJ developed the *National Strategic Plan (NSP) for Early Childhood Development 2008-2013* to improve the ECD system in Jamaica. The NSP includes strategies for internal processes, including effective parenting, healthcare, screening and early identification and referral for at-risk children, quality early childhood facilities, and curriculum delivery. It also includes strategies for working environment processes, including a results-oriented framework for relevant sector agencies and timely and appropriate information availability.

As of June 2013, the GoJ is in the process of drafting a new NSP (2013-2017) as well as a new ECD policy, which will be known as the *Early Childhood Development Policy of Jamaica.* The national policy will be applied sub-nationally and cover education, health, nutrition, and child and social protection. To complement this new policy and NSP, the Government is encouraged to include a costed implementation plan.

Mechanisms exist for collaboration with local and non-state stakeholders. In addition to national-level coordination, the ECC coordinates with the local-level early childhood actors. The ECC holds monthly coordination meetings for ECD implementers at the service delivery level. In addition, the ECC board has had a representative from the Jamaica Early Childhood Association (JECA) since its inception. JECA, a non-state entity, is comprised of management bodies of all community-based ECIs. The ECC arranges for both training and information sharing meetings with local service providers and practitioners from JECA.

A newly established commission creates links between Jamaican parents and the GoJ. In 2012, the MoE introduced the *National Parenting Support Policy* (2012). The Government recognized that parents should serve an important role to promote and coordinate organizational efforts and resources for positive parenting practices and optimal opportunities for young children. In conjunction with the policy, the *National Parenting Support Commission Act* (2012) established an official coordinating body to ensure effective streamlining of GoJ activities related to parenting. The National Parenting Support Commission (NPSC) is responsible for monitoring and evaluating the implementation of the *National Parenting Support*

Figure 2: Intersectoral composition of Early Childhood Commission



Policy and recommending budgetary allocations for parenting programs for the MoE.

The Parenting Strategy promotes the establishment of *Parents' Places,* centers that provide parenting information, support, and training for both parents and practitioners. In 2011, 7 Parents' Places were successfully piloted. In the past year, Parents' Places have been expanding and a new USAID parenting project is supporting the establishment of 60 new Parents' Places. Found in each parish, the ECC's Resource Centers that support practitioners in a number of ways, including curriculum support, will also become Parents' Places. Two of the 7 established Parents' Places are already in Resource Centers.

ECD goals have been established in all sectors and the new strategic plan should serve as a common plan of action. The current NSP outlines integrated ECD services that all Jamaican children should receive. Additionally, each sector has put forth its own specific ECD goals. For example, the Ministry of Labour and Social Security (MLSS) has designed a conditional cash transfer program called PATH (Program of Advancement through Health and Education). PATH (which has benefits for families living below the poverty line and other vulnerable individuals) includes a specific conditionality for children younger than 6 years old to access preventative healthcare. For the education sector, the MoE has outlined specific education goals, including quality ECIs and effective curriculum delivery. In the health sector, the MoH disseminates Child Health & Development Passports to all babies born in Jamaica or who move to the country before they are six months old. Law mandates the use of all Passports by all health centers and well-child clinics. The Passport is an innovative tracking tool to track immunizations, growth, and development, as well as provide anticipatory guidance to parents. The passport is focused on health interventions and outcomes, but also tracks several education and nutritional outcomes. While the Passport serves as a valuable mechanism for collecting information on holistic development for individual children, there is currently no integrated service delivery manual or common plan of action for all practitioners delivering services to young children.

The Child Health & Development Passport may serve as a useful foundation for developing a cross-sectoral manual with guidelines for integrated service provision. In considering the inclusion of a menu of integrated services in the new strategic plan, the ECC may learn valuable lessons from Colombia, a country which has also recently developed a new multisectoral ECD strategy. Box 4 describes how the national ECD strategy includes an integrated service delivery scheme known as the *Ruta Integral,* which presents a common plan of action for implementation at the service delivery level[7].

Box 4: Relevant lessons from Colombia: *Ruta Integral*

Summary: The Government of Colombia has recently developed the *De Cero a Siempre,* or "From Zero to Forever" strategy to promote comprehensive ECD system across relevant sectors. A major component of the new strategy is the *Ruta Integral de Atenciones,* or the "Scheme for Comprehensive Services," which is an established list of specific ECD services that should be delivered to all young children. This *Ruta Integral* provides an operational framework which spans from the prenatal period to 6 years of age and includes interventions related to the health, nutrition, socio-emotional development, cultural understanding, and protection of the child. The strategy emphasizes implementation at the local level. Each municipality is expected to establish a municipal ECD committee that are responsible for coordinating interventions at the level of service delivery to ensure that children receive all essential services outlined in the *Ruta Integral.*

Key considerations for Jamaica:

✓ Because policy decisions and interventions in ECD span across multiple ministries in Jamaica, it is important to have a common plan of action, not only at the policy level, but at the service delivery and local level.

Policy Lever 1.3: Finance

Emerging

While legal frameworks and intersectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensure that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns, but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits[8]. Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.

In some sectors, explicit criteria are used to decide ECD spending. In the education sector, funding is based on

[7] For more information see: SABER-ECD Colombia Country Report.

[8] Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek & Luque, 2003.

specific criteria, including the number of children enrolled and historical precedent. The ECC requires that ECIs meet certain criteria in order to be registered and receive materials, nutrition grants, or stipends for teachers. In the health sector, the vaccination budget is based on the number of targeted children and doses. The Nutrition Unit within the MoH (and works with the MoE's School Feeding Unit) also has a budget for meals provided in ECIs according to the number of children. In the social protection sector, the MLSS uses children's characteristics to determine PATH funding.

The ECC monitors spending across sectors for activities related to the National Strategic Plan, but overall planning and reporting of ECD budgets across other ministries could be better coordinated. The ECC monitors the amounts spent across sectors for activities related to the National Strategic Plan, but all ECD spending is not coordinated with the other ministries. Table 4 displays the ECC's reported expenditures in education, health, and nutrition.

Table 4: ECC budget allocations (2012-2013)	
Education	JA$2.4 billion
Health	JA$17.5 million
Nutrition grants	JA$ 32 million

The ECC holds an annual planning meeting with the Ministries of Education, Health, Labour and Social Security, and Finance to share budgets related to NSP activities for the upcoming year. However, no explicit coordinating mechanisms exist to ensure that overall ECD budget planning is truly a coordinated effort. It would be beneficial to establish improved coordinating mechanisms and accurately report ECD-specific budgets. For example, in the nutrition sector, the ECC manages JA$ 32 million of nutrition grants for ECIs. Additionally, the Nutrition Unit of the MoH has a budget for children's growth and nutrition; and the MLSS has a budget for PATH Nutritional Support and Feeding grants (however, ECD-age specific expenditure data are not readily available for either). Similarly, in the health sector, while the ECC reports JA$17.5 million for the NSP ECD-specific health budget, which includes implementation of the Child Health and Development Passport, the MoH reports that it does not disaggregate its overall spending specific to ECD-aged children.

In the protection sector, the CDA does not disaggregate expenditures for child protection services specifically for ECD-aged children. Within the MLSS, ECD expenditures go towards two programs, PATH and the Early Stimulation Program (an early intervention program for young children with developmental disabilities, see Policy Lever 2.2). The MLSS allocated $JA 18.2 billion in 2012-2013 for the Early Stimulation Project (excluding salaries). However, the MLSS budget for PATH, which targets children 0-18 years, cannot be disaggregated by specific age group.

There is no national law establishing a minimum level of public funding for ECD services. Currently, financing for ECD takes place with a relatively voluntary nature. No official mechanisms exist to ensure sustainable investments of ECD in Jamaica. Jamaica could turn to OECD countries, such as Australia, which ensure sustainable ECD financing with a more streamlined system. Box 5 explains Australia's system to ensure sustainable financing for ECD.[9]

Box 5: Relevant lessons from Australia: sustainable financial investments in ECD

Summary: In 2008, through the Council of Australian Governments, all state and territory governments in Australia jointly agreed to *the National Partnership Agreement on Early Childhood Education*. Prior to the National Partnership, Australia's investment in ECD was only 0.1 percent of GDP, which ranked 30th out of the 32 OECD countries. To achieve quality, universal coverage, all levels of government agreed to increased, sustained financial investment, which was partially aided though additional funding of $970 million (AUD) by the Commonwealth of Australia over a five-year period.

The Australian strategy calls for streamlined mechanism for management and finance at all levels. It requires effective accountability mechanisms, with clearly defined roles and responsibilities at each respective level. The Best Start Program in the State of Victoria is an example of a comprehensive ECD program with sustainable financing mechanisms. The program uses a decentralized approach and is co-financed by local governments and regional stakeholders. The program's multi-pronged funding approach is effective largely due to strategic mapping, constant monitoring, and extensive evaluation methods at the local level.

Key considerations for Jamaica:

- ✓ Accountability measures for financing and allocating funding across sectors and between sectors and the national and provincial governments
- ✓ Improved availability of expenditure data and a unified information system to monitor the NSP across ECD indicators in order to track and sustain adequate financing.

[9] *For more information, see Australia's National Partnership Agreement on Early Childhood Education:* *http://www.deewr.gov.au/Earlychildhood/Policy_Agenda/ECUA/Pages/EarlyChildhoodEducationNationalPartnership.aspx.*

In the education sector, the level of ECD finance may not be adequate. According to UNESCO, Jamaica spends 1 percent of total government expenditures on preprimary education[10]. Table 5 compares Jamaica's distribution of preprimary spending with other countries in Latin America and the Caribbean that spend a greater proportion of government expenditures towards preprimary.

Table 5: Public expenditures on preprimary in selected Latin American and Caribbean countries

	Jamaica	Brazil	Chile	Costa Rica	Guyana
Distribution of public education expenditure on preprimary	9.0%	7.0%	12.0%	6.0%	11.0%
Preprimary expenditure as percentage of GDP	0.6%	0.4%	0.5%	0.4%	0.4%
Preprimary expenditure as percentage of total government expenditure	1.0%	1.3%	2.1%	1.4%	1.5%

Source: UNESCO Institute of Statistics, 2010.

The burden of finance for ECCE is not equitably distributed across various segments of society. While law guarantees free preprimary education for all, approximately 10 percent of children currently have free preprimary education. In community ECCE centers (*Basic Schools*), which represent the large majority of ECIs, parents are expected to pay school fees. In public ECCE centers (*Infant Schools and Departments*), which represent less than 5 percent of ECIs, no school fees are levied, but parents are expected to pay for uniforms and transportation.

In the health sector, the level of ECD finance allows for free healthcare for young children and mothers. The MoH does not report ECD-specific expenditures. However, all health services in the public sector, including antenatal check-ups, labor and delivery, immunizations, growth-monitoring and promotion, and well child visits, are officially free. Table 6 compares selected health expenditure indicators in Jamaica with other countries in Latin American and the Caribbean.

The GoJ does compensate community health aids and public ECCE providers; however for the majority of service providers who work in Basic Schools, remuneration is not adequate. Community health aids, who visit homes and promote healthy caregiving and help identify high-risk situations, are paid an annual salary of JA$445,856 to JA$504,445 per year by the GoJ. In public Infant Schools and Departments, teachers are paid using the same compensation scale as those in primary and other levels of the public school system on a scale agreed upon by the Jamaica Teachers' Association.

Table 6: Regional comparison of select health expenditure indicators, 2010

	Jamaica	Barbados	Brazil	Chile	Colombia
Total health expenditure as a percentage of GDP	5%	7%	9%	7%	7%
Out of pocket expenditure[11] as percentage of private health expenditure	71%	81%	58%	69%	68%
General government expenditure on health per capita (adjusted for purchasing power parity)	USD 220	USD 998	USD 474	USD 562	USD 304
Routine EPI vaccines financed by government	100%	100%	100%	Not available	100%

Source: WHO Global Health Expenditure Database, 2013; UNICEF, 2013.

The GoJ pays 4,000 early childhood practitioners a salary subsidy determined by qualifications and experience, which ranges from JA$177,600 to JA$307,743 per year. Approximately 2,400 of these practitioners with vocational training at Level 2 and above received salary subsidies in 2013;[12] the others being at Level 1 and below. Teachers in Basic Schools should be paid on the same salary scale based on their training qualification. However, many of them do not receive Government subsidies. More than 4,600 teachers have vocational certification (3,635 from Basic Schools). This means that many teachers that comply with minimum teaching qualifications (See Policy Lever 3.2) are still not adequately compensated. In addition to government salary subsidies, teachers and practitioners from Basic Schools rely on compensation from school fees. Unfortunately, in Basic Schools, parents do not always pay the fees, and therefore salaries are often inadequate.

[10] According to the ECC Finance subcommittee, the total public expenditure on ECCE as a percentage of government expenditures was 0.43 percent.

[11] Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups.

[12] Source: World Bank Jamaica ECD Project Results Monitoring

Policy Options to Strengthen the Enabling Environment for ECD in Jamaica

Legal framework:

➢ **Consider providing better protection for new parents to promote opportunities to care for newborns and infants in their first year of life.** The GoJ could improve its parental leave policies to expand the guaranteed paid leave for mothers and/or add paternity protection. Sixty countries around the world mandate between 14 and 25 weeks of paid leave. The benefits of paid parental leave policies extend beyond the individual benefits for young children and their families. Research shows that women are more likely to return to the same employer when they have access to better family leave policies, which reduces the lost investment for employers who might lose employees following the birth of a child. In addition, improved child health outcomes and reduced healthcare costs for children benefit the government. [13] Jamaica could consider turning to high-performing countries like Sweden to improve its parental leave policies (See Box 2).

Intersectoral Coordination:

➢ **Ensure that the new strategic plan includes a common plan of action for integrated service delivery**. The Child Health & Development Passport already outlines a comprehensive list of essential interventions for young children, which is commendable. The new strategic plan could expand on this to ensure that ECD interventions are not only tracked, but also that all children have access to them. The upcoming national strategy for ECD should continue to provide and expand upon explicit mechanisms to promote sustained coordination across health, education, and protection. An integrated service delivery manual within the strategic plan would be an important step for the GoJ to not only guarantee holistic ECD services on paper, but also establish mechanisms to ensure that children, particularly the most disadvantaged, actually have access to these interventions. Box 4 provides an example of Colombia's integrated service delivery manual, *Ruta Integral.*

Finance:

➢ **Ensure the level of ECD finance is adequate to meet the needs of the population.** Jamaica spends 0.6 percent of its GDP on preschool (UNESCO, 2010) and could consider a higher level of ECD financing to ensure the needs of young children are met. Evidence suggests a public investment of 1 percent of GDP is the minimum required to ensure provision of quality early childhood care and education services.[14] Jamaica could turn to countries like Australia, where sustainable financial investment mechanisms exist (Box 5).

➢ **Improve budget coordination and accurate reporting of ECD-specific spending across ministries.** OECD governments spend an average of 2.36 percent of GDP on a broad range of services for young children and their families (including preprimary expenditures).[15] If the GoJ can report and coordinate all ministerial expenditures for ECD-specific interventions, it can better capture the entire picture of ECD financing. Recent research on ECD financing suggests that sustainability and administrative simplicity are two of the key characteristics in ECD finance strategies[16]. A unified information system that tracks both expenditures and ECD indicators will be of utmost value for the Government in tracking and sustaining ECD investments across sectors. With improved availability of expenditure data and a unified information system to monitor the implementation of all ECD activities in the country, the GoJ will be able to better track its investments and identify areas where increased finance levels are necessary.

➢ **Create mechanisms so that all ECCE providers have the opportunity to receive salary subsidies from the Government.** While Jamaica has reached nearly universal coverage for preprimary, inadequate compensation for ECCE service providers is likely to have implications to the quality of services received. The existing qualification-based teacher pay scale is a good measure to incentivize ECCE providers to be adequately equipped with the skills and knowledge to deliver quality care and education. However, this payment mechanism is still not reaching many teachers who meet minimum qualifications. The GoJ should consider a) requiring that ECIs adequately compensate those that meet minimum requirements; and b) ensure that those teachers that do not have adequate training have the opportunity to attain affordable tertiary education training opportunities (See Policy Options in Policy Goal 3).

[13] Heymann & McNeill, 2012.

[14] This figure is supported by studies from the Consultative Group on Early Childhood Care and Development (2008); the OECD's *Starting Strong II* Report (2011).

[15] OECD, 2006.

[16] Garcia & Valerio, 2012.

Policy Goal 2: Implementing Widely

➢ Policy Levers: Scope of Programs • Coverage •Equity

Implementing Widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population) and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, and social and child protection, and should target pregnant women, young children and their parents and caregivers. A robust ECD policy should include programs in all essential sectors; provide comparable coverage and equitable access across regions and socioeconomic status – especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

Established ●●●○

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 3 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

Programs cover a wide range of beneficiary groups and are established across all relevant sectors to meet the holistic needs of children. As demonstrated in Figure 4 (on the following page), Jamaica has an excellent scope of programs available to address the health needs of pregnant women, mothers, and young children. A wide scope of health interventions are available, including parenting programs, antenatal visits, skilled delivery, immunizations, and regular tracking of growth and development are available. In the education sector, programs for parents and children 0-6 years old are available. In child and social protection, anti-poverty, birth registration, and domestic abuse prevention programs are available for both parents and young children. Finally, in the nutrition area, breastfeeding and school feeding programs exist, but no structured food supplementation program for pregnant women or micronutrient support program for young children exist.

It is commendable that the majority of the essential interventions are listed within the Child Health & Development Passport or the Maternal Record Book, a tracking tool for healthy risk-free pregnancies. These two documents serve as tools to ensure that pregnant women, children, and caregivers access the wide scope of essential ECD interventions in Jamaica.

On the following page, Table 7 displays the range of programs across sectors available and provides the available coverage data for each intervention. Policy Lever 2.2 will review the extent to which the population has access to these interventions.

Figure 3: Essential interventions during different periods of young children's development

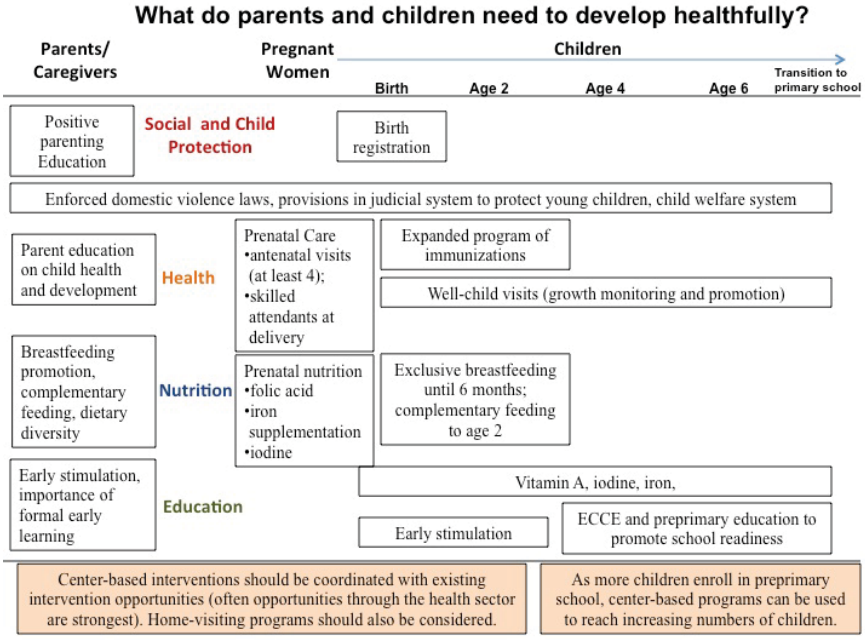


Figure 4: Scope of ECD interventions in Jamaica by target population and sector

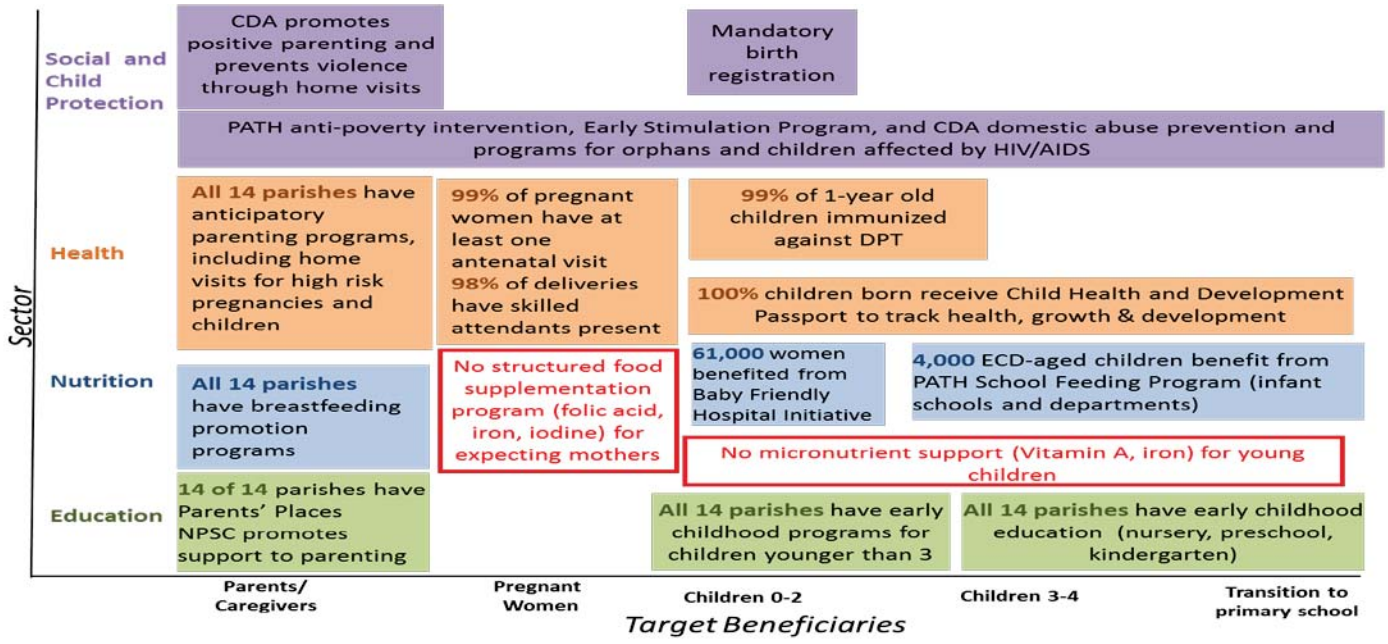


Table 7: ECD programs and coverage in Jamaica

ECD Intervention	Scale		
	Pilot programs	Number of Regions Covered (out of 14)	Coverage (if available)
Education			
Non-state ECIs	-	14	119,282
State ECIs (Infant schools, infant departments)	-	14	12,893
Health			
Antenatal and newborn care	-	14	40,000-60,000 (100%)
Integrated management of childhood illnesses and care for development	-	14	200,000
Childhood wellness and growth monitoring: *Child Health & Development Passport*	-	14	11,273 (100%)
National immunization program	-	14	80,000 (100%)
Nutrition			
Micronutrient support for pregnant women *(MoH)*	-	14	40,000-60,000 (100%)
Food supplements for pregnant women (*done at local level- Food for the Poor)*	Yes	-	-
Micronutrient support for young children: *IDB-supported* Sprinkles *distribution*	Yes	-	-
Food supplements for young children (*done at local level- Food for the Poor)*	Yes	-	-
Breastfeeding promotion programs *Baby Friendly Hospital Initiative*	-	14	61,000
Anti-obesity programs encouraging healthy eating/exercise	-	-	-
Feeding programs in preprimary schools *School Feeding/PATH Nutritional Support*	-	14	Not available
Parenting			
Parenting integrated into health/community programs: *Parents' Places*	Yes	**4** (expanding)	Not available
Home visiting programs to provide parenting messages	-	14	Not available
Special Needs			
Programs for OVCs *Child Development Agency*	-	14	Not available
Interventions for children with special needs *Early Stimulation Program*	-	5	1,412
Programs for HIV/AIDS Prevention *Elimination of MTCT of HIV/Syphilis*	-	14	600
Anti-poverty			
Cash transfers conditional on ECD services (*PATH*)	-	14	400,000

Source: ECC ECI Database,2012; SABER-ECD Program and Policy Instruments.

Policy Lever 2.2: Coverage

Established

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage and reach the entire population equitably–especially the most disadvantaged young children–so that every child and expecting mother have guaranteed access to essential ECD services.

Pregnant women have adequate access to prenatal healthcare, but it is unclear whether they have adequate access to essential nutrition interventions. Table 8 displays selected indicators for heath interventions for pregnant women in Jamaica and other Latin American and Caribbean countries. UNICEF country statistics reveal that pregnant women in Jamaica have nearly universal access to prenatal care and skilled deliveries. An estimated 32,000 people are living with HIV (1.7 percent of the adult population) and the GoJ is continuing to intervene with pregnant women and newborns to prevent mother-to-child transmission (MTCT). In 2011, the GoJ provided anti-retrovirals (ARVs) to 87 percent of pregnant women who were HIV positive (an increase of more than ten-percentage points since 2005). Additionally, 97 percent of newborns receive ARVs. [17] Since 2000, the transmission rate for HIV has reduced from 25 percent to less than 5 percent.

While data show excellent access to health interventions for pregnant women, the level of coverage of essential nutrition interventions for pregnant women is not as well monitored. The latest data available for prevalence of anemia in pregnant women was in 2006, when 41 percent of pregnant women had anemia, a level rated severe by the WHO. As demonstrated in Table 8, this level of prevalence also exceeds the levels of other countries in the region. The MoH reports that 60 percent of anemic pregnant women are adequately treated and has agreed with regional health authorities to achieve a target of 100 percent coverage by 2013. The MoH also reports that 82 percent of anemic pregnant women receive iron and folic acid and has agreed on a target of 95 percent coverage by 2013[18]. The MoH is encouraged to continue working with regional health authorities to meet these targets.

Table 8: Regional comparison of access levels to essential health and nutrition interventions for pregnant women

	Jamaica	Barbados	Brazil	Colombia	Chile	Trinidad
Skilled attendant at birth	98%	100%	97%	98%	100%	98%
Pregnant women receiving antenatal care (at least four visits)	87%	100%	91%	89%	Not available	96%
Percentage of HIV+ pregnant women receiving ARVs for PMTCT	84%	96%	50%	49%	72%	82%
Prevalence of anemia in pregnant women	14%	23%	29%	31%	28%	30%

Source: UNICEF Country Statistics, 2010; UNAIDS, 2012; WHO Global Database on Anemia, 2006; MoH, 2013 (prevalence of anemia in pregnant women).

Young children in Jamaica may not receive adequate care when they are sick. Table 9 displays UNICEF country statistics[19] of selected indicators for access to essential health interventions for young children. The Child Health & Development Passport serves as an effective tool to encourage routine health check-ups. Coverage for growth monitoring and immunization is nearly universal. However, when a child is sick, they may not always be accessing adequate medical attention. As displayed in Table 9, according to UNICEF, in Jamaica when children younger than five years old have an acute respiratory infection, only approximately half of them are treated with antibiotics. The MoH reports that all children with diarrhea are treated with oral rehydration salts.

Table 9: Regional comparison of access levels to essential health interventions for ECD-aged children

	Jamaica	Barbados	Brazil	Colombia	Chile	Trinidad
1-year-old children immunized against DPT (corresponding vaccines: DPT3ß)	99%	91%	96%	85%	94%	90%
Children below 5 with suspected pneumonia receive antibiotics	52%	Not available	Not available	Not available	Not available	34%

Source: UNICEF Country Statistics, 2007-2012.

The level of access to essential nutrition interventions for young children is inadequate. Table 10 presents a regional comparison of selected nutrition indicators for young children. While stunting prevalence in Jamaica is quite low, young children may not be receiving the adequate nutrients for proper development. Only 40

[17] UNAIDS Country Progress Report for Jamaica, 2012.
[18] MoH, 2012. Service Level Agreement Indicators.
[19] UNICEF, *State of the World's Children,* 2013.

percent of infants are exclusively breastfed at 3 months[20]. The WHO reported that in 2006 (last year with available data), 48 percent of preschool aged children were anemic. The coverage level for Vitamin A supplementation is not available. In its service level agreement with regional health authorities, the MoH did not report the current percentage of pregnant women receiving breastfeeding education or the percentage of caregivers receiving education on appropriate infant and young child feeding practices. However, the MoH has set a target of 80 percent coverage for both of these nutrition promotion interventions. The MoH and UNICEF partnered to implement an exclusive breastfeeding pilot project in two parishes (Clarendon and St. Catherine) and successfully increased the rates of exclusive breastfeeding. The MoH is encouraged to expand this program at the national level.

Table 10: Regional comparison of access levels to essential nutrition interventions for ECD-aged children

	Jamaica	Barbados	Brazil	Colombia	Chile	Trinidad
Children below 5 with moderate or severe stunting	4%	Not available	7%	13%	Not available	Not available
Infants exclusively breastfed until 6 months of age	*See footnote 19*	Not available	41%	43%	Not available	13%
Infants with low birth weight	12%	12%	8%	6%	6%	19%
Prevalence of anemia in preschool aged children (2006)	48%	17%	54%	28%	24%	30%

Source: UNICEF Country Statistics, 2007- 2011; WHO Global Database on Anemia, 2006; MoH, 2013.

There is nearly universal birth registration in Jamaica. 98% of births are registered in Jamaica. Table 11 displays the birth registration rate across the region, which is nearly universal.

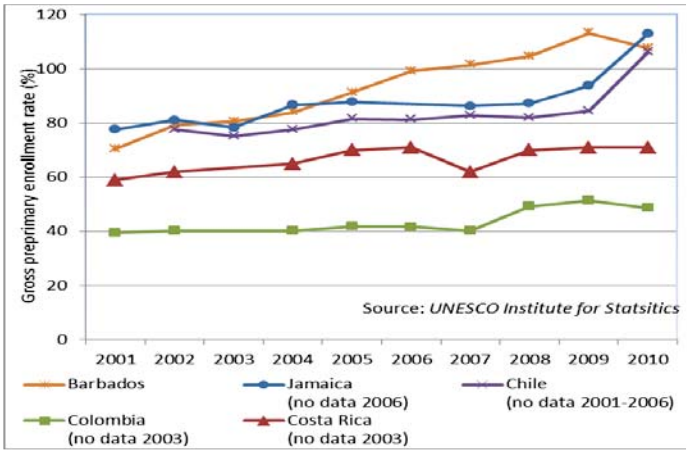
Table 11: Regional comparison of birth registration rate

	Jamaica	Barbados	Brazil	Colombia	Chile	Trinidad
Birth registration 2000-2010	98%	Not available	93%	97%	100%	96%

Source: UNICEF Country Statistics, 2007- 2011

The gross preprimary enrollment rate for children age 3-6 years old is over 100 percent. Figure 5 displays the most recently reported gross preprimary enrollment ratios for selected Latin American and Caribbean countries (UNESCO). In 2010, the gross enrollment ratio in Jamaica was 112 percent. This rate is high by international standards. It will be worth considering the next step of ensuring universal coverage of *quality* preprimary education.

Figure 5: Gross enrollment rate (age 3-6) in selected Latin American and Caribbean countries



While children 3 years and older have adequate access to ECCE, only 12 percent of children younger than 3 have access to early childhood care.

Children **younger than 3 years generally have fewer stimulating resources at home.** In addition to having less opportunity to access center-based care, children younger than three years old have fewer stimulating resources at home. Figure 7 illustrates data from the Jamaica Survey of Living Conditions (2010) (JSLC) regarding the percentage of children in different age cohorts with stimulating resources at home. More children aged 3 to 5 years old have stimulating resources at home (with the exception of musical instruments) than children aged 0 to 2 years. Additionally, significantly more 3- to 5-year-olds engaged in stimulating activities with their caregivers than 0- to 2-year-olds (See Figure 8).

Figure 6 compares the level of coverage for children younger than 3 with that for children age 3-5[21]. The majority of Jamaica's youngest children are not accessing center-based ECCE interventions. Table 13 displays enrolment by age group for state and non-state

[20] According to the MoH, 40 percent of children are exclusively breastfed at 3 months and 96 percent of mothers report early initiation of breastfeeding. Updated data not available on exclusive breastfeeding <6 months.

[21] The Statistical Institute of Jamaica reported that in 2012, there were 119,695 children younger than 3 and 127,070 ages 3-5 years old. The ECC reported that in 2012, 13,661 children younger than 3 attended ECCE, and 115,265children 3-5 years old attended ECCE.

ECIs. Children younger than 3 years old are concentrated in non-state ECIs. For private ECIs (other than community schools), 25 percent of the children enrolled are younger than 3 (8 percent in community schools and less than 2 percent in public schools).

Children younger than 3 years generally have fewer stimulating resources at home. In addition to having less opportunity to access center-based care, children younger than three years old have fewer stimulating resources at home. Figure 7 illustrates data from the Jamaica Survey of Living Conditions (2010) (JSLC) regarding the percentage of children in different age cohorts with stimulating resources at home. More children aged 3 to 5 years old have stimulating resources at home (with the exception of musical instruments) than children aged 0 to 2 years. Additionally, significantly more 3- to 5-year-olds engaged in stimulating activities with their caregivers than 0- to 2-year-olds (See Figure 8).

Figure 6: Levels of coverage for children 0-2 versus 3-5 in Jamaica (2012)

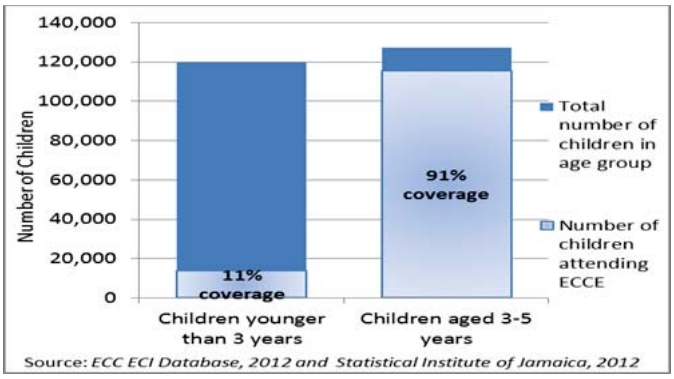
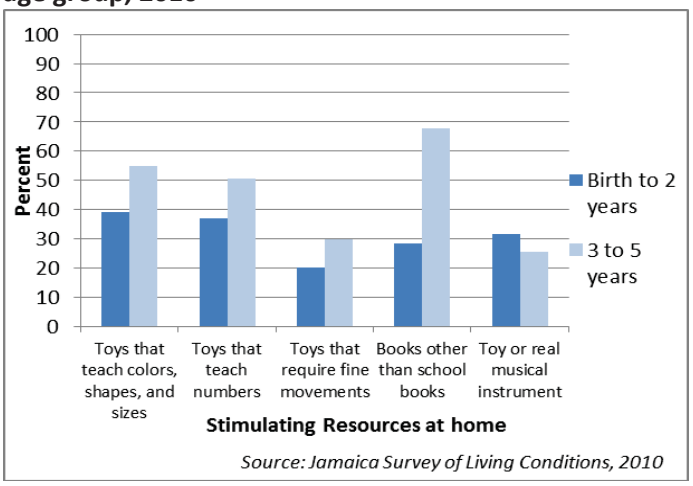


Table 12: ECI Enrolment by age group and facility

	Children less than 3 years	Children 3-5 years old	Children older than 5 years	Total enrolment
State ECIs *Infant schools & departments*	190	12,083	620	**12,893**
Community ECIs *Basic Schools/ Pre-schools*	7,286	85,526	2,021	**94,833**
All other private ECIs[22]	6,185	17,656	608	**24,449**

Source: ECC ECI Database, 2012.

Figure 7: Stimulating resources at home for 0-2 and 3-5 age group, 2010



Policy Lever 2.3: Equity

Established

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services[23]. One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

There is equitable access to ECCE for 3-5 year olds by gender and socio-economic status. Girls and boys have equitable access to preprimary school, with marginally more males than females enrolled. According to the ECC, in 2012, 59,093 boys and 57,552 girls in the 3-5 age group were attending ECIs. There are no major differences in enrollment rates by wealth quintile: both the poorest and richest quintile have 100 percent enrolment, with all five quintiles more than 98 percent (JSLC, 2010).

ECCE services accommodate children's special needs and promote access for all children. An estimated 4 percent of children in Jamaica live with a disability[24]. As discussed in Policy Lever 1.1, *Early Childhood Act* (2005) promotes inclusive education for children with disabilities. The ECC reports that 60 children were enrolled in special education in 2012. Additionally, the MLSS's Early Stimulation Program provides services for young children with developmental disabilities and their

[22] Includes preschool, kindergarten, preparatory school, nursery, daycare, special education.

[23] Engle et al, 2011; Naudeau et al., 2011.

[24] 2009 UNICEF estimate in *Comprehensive Assessment of Existing Service Delivery Options within the EC Sector.*

families. Child Development Officers currently receive in-service training in childhood disabilities, intervention and rehabilitation, and early childhood development. Officers visit homes and public and private ECIs. As of 2013, there were 1,412 direct beneficiaries of the program. The ECC has recently developed and approved a child development screening tool and countrywide identification process for at-risk households in Jamaica. In addition, children are now screened for developmental delays in the Child Health & Development Passport and subsequently referred for intervention, some receive intervention within the MLSS Early Intervention Program. The GoJ's comprehensive ECD policy, currently under development, will include strategies for screening, diagnosis and early intervention for at-risk children and households.

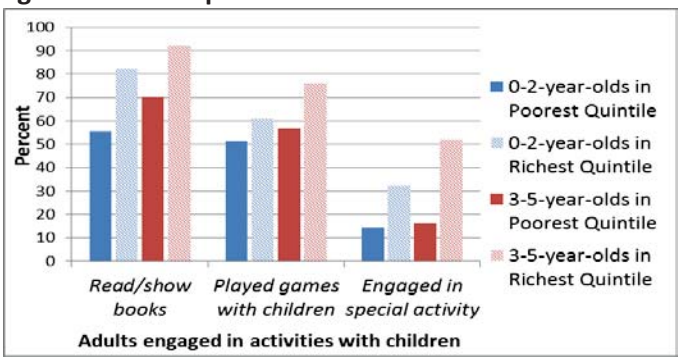
As part of the National Strategic Plan for ECD, the University of the West Indies has developed an Associate Degree in Child Development Therapy, with courses in child health, development and behavior, as well as basic speech therapy, occupational therapy, and early intervention. Many officers from the MLSS Early Stimulation Program are enrolled in this degree program. This will ensure a higher level of service provision to children with disabilities. In addition, UNICEF is supporting the development of a curriculum with practitioner certification for children with special needs. UNICEF is also working with the MoE to develop a curriculum for children with moderate to severe disabilities for specialized preprimary and primary institutions.

In rural and urban areas, there is equitable access to services and learning opportunities for young children. Access to improved sanitation facilities is relatively equitable: in urban areas, the rate of access is 82% and in rural areas, it is 84%. Skilled deliveries are also equitably available by geographic area: in urban areas, the rate of skilled attendants at birth is 99 percent and in rural areas, the rate is 98 percent.

According to the JSLC (2010), children in Kingston Metropolitan Area (KMA), other urban areas, and rural areas all have equitable opportunities for the majority of stimulating activities for children, including stories, songs, games, counting, and drawing.

Poor children do not have the same opportunities to early learning as children from the richest quintile. As illustrated in Figure 8**,** children from the poorest quintile are proportionately less engaged in activities with adults than children from the richest quintiles (JSLC, 2010). Figure 8 also displays, as discussed under Policy Lever 2.2, children younger than three years old are less likely to be engaged in activities with adults than children aged 3 to 5 years old.

Figure 8: Adults engaged in stimulating activities, by age and wealth quintile



Policy Options to Implement ECD Widely in Jamaica

Coverage

➢ **Improve coverage to essential nutrition interventions for pregnant women.** The MoH is encouraged to meet its targets to reduce anemia prevalence in pregnant women. Iron-folate supplements during pregnancy can prevent anemia for the mother and neural tube defects for the fetus. Reducing anemia prevalence in pregnant women can prevent intellectual and physical impairment in children.

➢ **Expand coverage to essential health and nutrition interventions for young children.** The WHO reports that in 2006, nearly half of preschool aged children had iron deficiency anemia, which can significantly impede a young child's development. Less than half of mothers are exclusively breastfeeding their babies. Exclusive breastfeeding until 6 months can reduce infant mortality and promote healthy development. The MoH should continue to encourage local health authorities to meet the target of improved nutrition education interventions. It will also be important to seek out updated data on anemia in pregnant women and preschool aged children to determine whether women and young children have adequate access to foods enriched with iron.

The GoJ should consider how to expand access to care for diarrhea and pneumonia, two of the leading causes

of death in children younger than five.[25] The Child Health & Development Passport should serve as a useful tool and could be possibly expanded to encourage caregivers to take children to seek healthcare when their children show signs of illness.

➢ **Consider providing additional opportunities for early childhood care for children younger than 3 years.** Roughly 9 out of 10 children less than 3 are not attending center-based ECCE programs. Evidence suggests that the strongest cognitive benefits for center-based ECD programs are experienced by younger children (ranging from 9 months to <3 years).[26] Even if the youngest cohort of children are not going to center-based ECCE, the GoJ should consider strategies, including expanding parenting support programs as indicated in the National Parenting Policy and Strategy, home visiting programs[27] or play groups, to ensure that children younger than three years old have adequate opportunities for early stimulation. The JSLC revealed that compared to 3- to 5-year-olds, children in the birth to 2 year cohort tend to have fewer stimulating resources at home and their caregivers engage with them less. The first 1,000 days is an essential period for child development and quality interaction and stimulation is essential to ensure cognitive and social-emotional development.[28]

Internationally recognized research from Jamaica has revealed that home visits and better parenting programs are both feasible and have the potential to impact the development of the youngest age cohort. Jamaica should be commended for both the surrounding research and expansion of these interventions. However, it will be important to place increased emphasis on continuing to scale up these programs for parents and their children from 0 to 2 years of age.

Equity

➢ **Ensure equitable early learning opportunities for the poorest children starting from birth.** While poor 3- to 5-year-old children have equitable access to preprimary education, poor children younger than 3 do not have the same learning opportunities (see Figure 8). Lack of appropriate early experiences places children at a disadvantage before they even start school. Targeting home visits or parenting support interventions towards the poorest families could be useful to ensure that the most vulnerable children have equitable opportunities.

Policy Goal 3: Monitoring and Assuring Quality

➢ Policy Levers: Data Availability • Quality Standards • Compliance with Standards

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children, standards for ECD services and systems to monitor and enforce compliance with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible, or even detrimental.

Policy Lever 3.1: Data Availability

Accurate, comprehensive and timely data collection can promote more effective policy-making. Well-developed information systems can improve decision-making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards and efforts to target children most in need.

Jamaica has advanced availability of relevant administrative and survey data. Table 13 displays Jamaica's availability of common ECD indicators. The relevant ministries in Jamaica collect excellent administrative data on important indicators related to access to ECD services. UNICEF MICS data also contributes to the rich data available regarding Jamaica's young children and mothers.

Table 13: Availability of data to monitor ECD in Jamaica

Administrative Data:	
Indicator	**Tracked**
ECCE enrollment by region	✓
Children enrolled in ECCE by sub-national region (#)	✓
Children enrolled in ECCE by socioeconomic status (%)	✓
Special needs children enrolled in ECCE (#)	✓
Children attending well-child visits (#)[29]	✓
Children benefitting from public nutrition interventions (#)	✓
Women receiving prenatal nutrition interventions (#)	✓

[25] In 2011, out of 1,000 children born in Jamaica, 18 died before their fifth birthday (UNICEF).
[26] Loeb et al, 2007; Armecin et al, 2006; NICHD, 2003.
[27] Several home visit program already exist in Jamaica, such as the Rural Family Support Organization's *Rovers* program and the visitation program by Community Health Aides
[28] Black, et al, 2008.
[29] The MoH plans to collect this for 2012-2013 (Service level agreement indicator).

Average per student-to-teacher ratio in public ECCE	✓
Is ECCE spending differentiated within education budget?	✓
Is ECD spending differentiated within health budget?[30]	X
Survey Data	
Indicator	**Tracked**
Population consuming iodized salt (%)	✓
Vitamin A Supplementation rate for children 6 -59 mo. (%)	X
Anemia prevalence amongst pregnant women (%)	✓
Anemia prevalence amongst preschool-aged children (%)	✓
Children below the age of 5 registered at birth (%)	✓
Children immunized against DPT3 at age 12 months (%)	✓
Pregnant women who attend four antenatal visits (%)	✓

The Jamaica Survey of Living Conditions provides an excellent picture of the status of young children in Jamaica. The JSLC, a joint publication of the Planning Institute of Jamaica (PIOJ) and the Statistical Institute of Jamaica (STATIN) monitor social indicators, including an entire section on ECD. The ECD section was developed, implemented and analyzed by the ECC to monitor ECD and to guide interventions. Indicators include: parenting, activities engaged in with children by an adult, stimulating resources at home, disciplinary practices, and safe environment. Specific child development outcome indicators are also collected to capture the developmental competencies and readiness skills, including both socio-emotional and cognitive development, for Jamaican children age 4 and 5 years old. The 2010 JSLC examined an ECD age cohort sample of 860 children. In 2014, the survey will collect data on every child at the age of 4 years old.

Policy Lever 3.2: Quality Standards

Ensuring quality ECD service provision is essential. A focus on access – without a commensurate focus on ensuring quality – jeopardizes the very benefits that policymakers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children[31].

The ECC has established a legal framework that sets forth clear standards for all public and private ECIs. Box 6 outlines the three documents that comprise the ECC's framework for ECCE service delivery standards. The *Early Childhood Act* and *Early Childhood Regulations* specify legally-binding minimum levels for ECD service delivery. According to these documents, ECIs that do not meet the minimum standards of health and safety are not provided with a Permit to Operate, an interim status towards full registration. The *Standards for Operation, Management, and Administration of ECIs* include clear indication of standards that are recommended minimum level of quality and those that are legally binding. The standards include guidelines for staffing; developmental/education programs; interactions and relationships with children; physical environment; indoor and outdoor equipment, furnishing and supplies; health; nutrition; safety; child rights, child protection and equality; interactions with parents and community members; administration, and finance.

Box 6: Legal framework for ECI standards[32]

- ***The Early Childhood Act (2005):*** Requires operators of ECIs to apply for registration with the ECC and to facilitate the process of inspection. Significant legal consequences exist for failure to comply with the Act.

- ***The Early Childhood Regulations (2005):*** Provides provisions to the Early Childhood Act, including procedures and requirements which may evolve over time. Legal consequences (less severe than the Act) exist for failure to comply with the Regulations.

- ***Standards for the Operation, Management, and Administration of ECIs (2007):*** Includes (i) legally-binding standards (stemming from the Act or Regulations) and (ii) standards to serve to improve practice voluntarily.

Both legal and voluntary standards are rated on a 3 point scale: "Needs Improvement" which indicates a status below that required, "Acceptable" which indicates status at the required level and "Good" which indicates status above the required level.

Clear learning standards are established for ECCE in Jamaica. The national Early Childhood Curriculum, endorsed by the MoE in 2008, provides specific guidance for ECCE providers for caregiving and teaching in ECIs. The curriculum is evidence-based and aligns with the *Learning Outcomes for ECD in the Caribbean.*[33] Relevant stakeholders from the primary education sector were involved in design of the curriculum,

[30] The MoH did not provide in the SABER-ECD Policy Instrument.

[31] Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et al, 2011V; Victoria et al, 2003.

[32] While the *Act* and *Regulations* are technically legally-binding, the GoJ has not yet acted upon the consequences in order to allow time for adjustment to the new standards.

[33] Child Focus II Project, (2005). Caribbean Child Development Centre, University of the West Indies, Mona, Kingston, Jamaica.

ensuring coherence and continuum of the curriculum into primary education. The curriculum includes a scope and sequence for both children aged 0-3 years and children 4-5 years old and is comprised of skills development in the cognitive, affective, creative, and psychomotor domains. An associated curriculum guide for ECCE teachers allows for planning, preparation, and implementation of daily activities in ECIs. While endorsed by the Government, the use of the national curriculum is not mandated; the *Standards* state that ECIs may use any curriculum approved by the ECC.

ECCE professionals are required to meet pre-service training standards. The *Early Childhood Act* mandates by law that ECI operators must be trained by an institution that is approved by the ECC. The *Regulations* and *Standards* expand upon this, stating that in ECIs that provide care for children above 3 years, at least one teacher (*Lead Teacher*) must be "qualified." "Qualified" teachers are required to have, at minimum, a tertiary diploma issued by a recognized teacher training college. Minimum standards exist for other teachers (who work with Lead Teachers) in ECIs: at least 50 percent should be trained and certified with a Level III vocational degree (*Associate Teachers*) and at least 50 percent must be trained and certified with a Level II vocational degree.

The Jamaica Teaching Council, operating under the MoE, is responsible for professional teaching standards and certification. The Joint Board of Teacher Education (JBTE), which operates within the School of Education of the University of the West Indies has a Bachelor's degree in Education program offered by the Teachers Colleges of Jamaica. The University of the West Indies delivers this program and also supervises the quality of delivery of the JBTE Degree by several other teacher training colleges which deliver the program on a franchise basis. Education degrees require students to complete a pre-service practicum which consists of a variety of aspects, including school visits and a 3-month student teaching program.

Professional development opportunities for ECCE providers are available. The *Standards* recommend that ECCE providers attend in-service training to improve service delivery. The ECC provides training once a month for public and private ECIs, focusing on child development, curriculum, and other areas of ECCE service delivery. The ECC tracks whether providers complete training, but it is not mandated by law. The JBTE program of the University of the West Indies also provides ongoing professional development for current teachers.

Established service delivery and infrastructure standards for ECIs exist. The *Standards* outline acceptable guidelines for teacher-to- child ratios for all public and private centers: 1:5 for children 0-12 months; 1:8 for children 1-3 years; 1:10 for children 3-6 years. The *Act* defines a daycare center as one that operates at least six hours per day four days a week, but the definition of a basic school does not include opening hours. The *Regulations* and *Standards* provide specific guidelines to ensure that ECIs have adequate infrastructure and play areas for young children. ECIs are required to have functional hygienic facilities, potable water source, roof, floor, structural soundness, windows, building materials, and connection to electricity.

Established registration procedures for both state and non-state ECIs exist. The *Act* states that all ECIs must register with the ECC to operate and are to be inspected to determine compliance with minimum acceptable standards. The ECC inspects each registered ECI to determine whether it complies with the *Act* and *Regulations.*[34] The *Regulations* state that ECIs should be inspected twice per year. However, in reality, this is not manageable due to resource constraints and high enrollment rates. The ECC plans to revise the legislation to call for inspections annually or every two years. As of 2013, there were 29 inspectors and 4 senior inspectors trained at the ECC.

The ECC acknowledges that some institutions may exceed minimum requirements and promotes the highest standards of practice. It not only monitors the minimum requirements (outlined in the *Act* and *Regulations)* but also monitors the standards that are not legally binding (the *Standards* document classifies performance as "needs improvement," "acceptable," or "good").

Rigorous standards for ECD service delivery in the health sector ensure quality healthcare. An accreditation system for well child clinics has been developed and approved conjointly by the MoH and ECC. The system will cover specific guidelines that well child and child health clinics should meet, including

[34] Legislation allows the ECC to conduct unannounced inspections, but in practice, inspections tend to be announced.

infrastructure and equipment, data management, level of training of health staff, health promotion, and safety. In addition, several standards are specifically targeted towards ECD-aged beneficiaries to ensure processes for access and effective delivery of services for children 0-3 years old.

All community health aides receive training in ECD and how to deliver messages about development milestones. Additionally, in the Child Health & Development Passport, the schedule of child health check-ups includes important messages for health workers to deliver regarding child development, milestones, and safety in the home. The MoH has recently finalized a flip chart to deliver certain messages about breastfeeding, safety, hygiene, and immunizations that will be used by primary healthcare providers in health centers and communities.

Policy Lever 3.3: Compliance with Standards

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

Quality assurance measures are progressing in Jamaica, but improvements are still needed. As of 2013, 48 percent of ECIs have submitted a complete application for registration to the ECC. The ECC reports that 92 percent of ECIs have received at least one complete inspection (57 percent in the last year). As of 2013, 52 percent of ECIs have been issued a permit to operate.

The ECC quality assurance system is transparent and reveals that not all ECIs comply with quality standards. Inspection reports for ECIs are accessible to the public[35] and provide detailed information on each ECI's compliance with the 12 standards (outlined in the *Standards* document, see Policy Lever 3.2). There is still not 100 percent compliance with all standards. For example, of the 2,261 ECIs in Jamaica (state and non-state), the ECC reports that 78 percent comply with floor standards: 1727 receive an "acceptable" rating (flooring is solid throughout, with no cracks or holes) and 37 receive a "good" rating (acceptable plus flooring surface allows children to move easily from place to place). Additionally, 64 percent of ECIs comply with wall/ceiling standards: 1,449 receive an "acceptable" rating (walls and ceilings are clean, painted with light colors, good condition) and 5 receive a "good" rating (acceptable plus regular scheduled painting).

ECCE professionals from public ECIs report higher compliance with pre-service training standards compared to those from non-state ECIs. Table 14 displays the reported teacher qualifications for state and non-state ECIs. Based on guidelines for a Lead Teacher, only 27 percent of all teachers comply. Conversely, 73 percent of teachers do not meet the minimum training standard, holding either a primary secondary, or vocational degree or not reported.

Table 14 also reveals that compliance is higher in the minority of state ECIs (Infant Schools and Infant Departments), 77 percent of all teachers holding a tertiary degree (28 percent with bachelor's degree, 46 percent with education diploma, and 3 percent with master's degree). On the other hand, in Basic Schools, only 24 percent of teachers hold a tertiary degree and 64 percent hold a vocational degree.

Table 14: ECCE teachers' highest level of education obtained in state and non-state ECIs

	Not reported	Primary	Secondary	Vocational	Tertiary[36]	*Total Teachers*
State ECIs						
Infant schools & departments	2.8%	9.8%	1.7%	9.2%	76.5%	*541*
Non-state ECIs						
Community ECIs *Basic Schools/ Pre-schools*	1.3%	7.1%	3.7%	64.3%	23.6%	*5,653*
All other private ECIs[37]	6.5%	18.7%	4.6%	46.3%	24.0%	*2,028*
TOTAL	**2.7%**	**10.1%**	**3.8%**	**56.2%**	**27.2%**	***8,222***
73% No compliance/unknown for Lead Teacher[38]					*27% meet standard for Lead Teacher*	

Source: ECC ECI database, 2013.

[35] As of 2013, 1,750 inspection reports were posted on the ECC's website: http://www.ecc.gov.jm/ecc/ECIReports/index.php?dir=

[36] Tertiary includes Bachelor's degree, education diploma, and Master's degree.

[37] Preschool, kindergarten, preparatory school, nursery, daycare, special education.

[38] Based on guidelines for Assistant/Associate Teachers (dictating a minimum of vocational degree), 83 percent of teachers comply. However, there are currently very few, if any, ECIs with two teachers in one room.

State ECIs do not comply with child-to-teacher ratios. Table 15 displays average child-to-teacher ratios, as reported by the ECC.[39] The average state ECI has one teacher for every 18 children, which does not meet compliance for the *Standards* guideline of a 1:10 ratio for children 3-6 years old[40] (the majority of children enrolled in state ECIs are in this age group- see Table 12). Community schools also exceed the maximum child-to-teacher ratio guideline. The average ratio for all other private ECIs meets with the standard for children 3-6 years old, but not for younger children (one-fourth of children enrolled in all other private ECIs are younger than 3- see Table 12).

Table 15: Average teacher-to-child ratios in ECIs

	Average teacher-to-child ratio
State ECIs *Infant schools & departments*	1:18
Community ECIs *Basic Schools/ Pre-schools*	1:16
All other private ECIs *(see footnote 37)*	1:9

Source: ECC ECI database, 2013.

Policy Options to Monitor and Assure ECD Quality in Jamaica

Quality Standards & Compliance with Standards

➢ **Improve compliance with teacher qualification guidelines for current ECCE practitioners by incentivizing tertiary education.** Currently 73 percent (5,988) of teachers do not have a tertiary degree. The options available to teachers for tertiary level degrees in early childhood is a commendable achievement in Jamaica and should be made more accessible to current ECCE teachers who do not yet meet teaching qualifications. Since affordability is often a barrier to tertiary degrees, the GoJ may consider strategies to incentivize untrained practitioners to pursue tertiary education. This could include better student loan arrangements, encouraging more organizations to provide scholarships, or work study programs.

➢ **Encourage new students to enter the ECCE teacher workforce.** It would be valuable to make the pre-service opportunities and tertiary level programs available to new students interested in becoming ECCE teachers. With universal enrollment in preprimary, there is a need to serve the large preschool population with qualified ECCE teachers. Increasing the number of ECCE teachers could contribute to reducing overcrowding in ECIs. Additionally, ECCE teachers will also be needed to cater to children in the 0-3 age group, who are currently underserved.

➢ **Continue to inspect ECIs on a regular basis and work to improve outcomes based on results of standards.** While progress has been made in recent years with ECI inspections, approximately half of ECIs still do not have a permit to operate. It is advisable to increase the capacity of the ECC to regularly monitor standards compliance. Furthermore, the ECC should target ECIs that need to improve outcomes. This could include an increase capacity of development officers and/or targeted in-service training for ECIs that do not comply with quality standards.

Comparing Official Policies with Outcomes

The existence of laws and policies alone do not always guarantee a correlation with desired ECD outcomes. In many countries, policies on paper and the reality of access and service delivery on the ground are not aligned. Table 16 compares ECD policies in Jamaica with ECD outcomes. Some policies reflect the reality for some ECD interventions, such as availability of preprimary school, immunizations, and birth registration. On the other hand, the low rate of exclusive breastfeeding and access to free preprimary education do not seem to align with the respective policies.

Table 16: Comparing ECD policies with outcomes in Jamaica

ECD Policies	Outcomes
Draft *National Infant and Young Child Feeding Policy* complies with the International Code of Marketing of Breastmilk Substitutes →	Exclusive breastfeeding rate (3 months): **40%**
Policy guarantees the provision of preprimary school →	Gross preprimary school enrollment: **112 %**
GoJ mandates the provision of free preprimary school →	3-6 year olds with free preprimary access: **10%**
Young children are required to receive a complete course of childhood immunizations →	Children with DPT (12-23 months): **99 %**
Policy mandates the registration of children at birth in Jamaica →	Completeness of birth registration:

[39] These are only average ratios and do not reflect the reality of overcrowding, an issue in many ECIs.

[40] State funded ECIs do not meet ratios as they are more heavily subscribed by parents due to the absence of fees.

	98%

Preliminary Benchmarking and International Comparison of ECD in Jamaica

On the following page, Table 17 presents the classification of ECD policy in Jamaica within each of the nine policy levers and three policy goals. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges. Table 18 presents the status of ECD policy development in Jamaica alongside a selection of OECD countries and regional comparators. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers.

Table 17: Benchmarking Early Childhood Development Policy in Jamaica

ECD Policy Goal	Level of Development	Policy Lever	Level of Development
Establishing an Enabling Environment	*Established*	Legal Framework	
		Inter-sectoral Coordination	
		Finance	
Implementing Widely	*Established*	Scope of Programs	
		Coverage	
		Equity	
Monitoring and Assuring Quality	*Established*	Data Availability	
		Quality Standards	
		Compliance with Standards	

Legend:	*Latent*	*Emerging*	*Established*	*Advanced*

Table 18: International Classification and Comparison of ECD Systems

ECD Policy Goal	Policy Lever	Level of Development					
		Jamaica	Australia	Chile	Colombia	Sweden	Turkey
Establishing an Enabling Environment	Legal Framework						
	Coordination						
	Finance						
Implementing Widely	Scope of Programs						
	Coverage						
	Equity						
Monitoring and Assuring Quality	Data Availability						
	Quality Standards						
	Compliance with Standards						

Legend:	Latent	Emerging	Established	Advanced

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities for further development of effective ECD systems. This Country Report presents a framework to compare Jamaica's ECD system with other countries in the region and internationally. Each of the nine policy levers are examined in detail and some policy options are identified to strengthen ECD are offered.

Table 19 summarizes the key policy options identified to inform policy dialogue and improve the provision of essential ECD services in Jamaica.

Table 19: Summary of policy options to improve ECD in Jamaica

Policy Dimension	Policy Options and Recommendations
Establishing an Enabling Environment	➢ Consider providing better protection for new parents to promote opportunities to care for newborns and infants in their first year of life. ➢ Ensure that the new strategic plan includes a common plan of action for integrated service delivery. ➢ Ensure the level of ECD finance is adequate to meet the needs of the population. ➢ Improve budget coordination and accurate reporting of ECD-specific spending across ministries. ➢ Create mechanisms so that all ECCE providers have the opportunity to receive salary subsidies from the Government.
Implementing Widely	➢ Improve coverage to essential nutrition interventions for pregnant women. ➢ Expand coverage to essential health and nutrition interventions for young children. ➢ Consider providing additional opportunities for early childhood care for children younger than 3 years. ➢ Ensure equitable early learning opportunities for the poorest children starting from birth.
Monitoring and Assuring Quality	➢ Improve compliance with teacher qualification guidelines for current ECCE practitioners by incentivizing tertiary education. ➢ Encourage new students to enter the ECCE teacher workforce. ➢ Continue to inspect ECIs on a regular basis and work to improve outcomes based on results of standards.

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Acronyms

ARV	Anti-retroviral
CDA	Child Development Agency
ECC	Early Childhood Commission
ECCE	Early childhood care and education
ECD	Early Childhood Development
ECI	Early Childhood Institution
GoJ	Government of Jamaica
ILO	International Labor Organization
JBTE	Joint Board of Teacher Education
JECA	Jamaica Early Childhood Association
JSLC	Jamaica Survey of Living Conditions
KMA	Kingston Metropolitan Area
MLSS	Ministry of Labour and Social Security
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
MTCT	Mother to child transmission
NPSC	National Parenting Support Commission
NSP	National Strategic Plan
NIYCF	National Infant and Young Child Feeding (policy)
OVC	Orphans and Vulnerable Children
PATH	Program of Advancement through Health and Education
WHO	World Health Organization

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This report focuses specifically on policies in the area of Early Childhood Development.

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