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# Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community

RESEARCH REPORT

**07 AUGUST 2019**

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1145751




A research report submitted to the Faculty of Health Science
University of the Witwatersrand, Johannesburg,
in partial fulfilment of the requirements for the
degree of Master of Science in Occupational Therapy

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**Dedication**

This research report is dedicated to:

My mother, for her love of education, which she instilled in me from a young age.

To my son, for keeping strong in all instances when I could not be there to give him the love and care he deserved.

# ABSTRACT

The research was conducted in a low-socio economic community. The population of the study was the primary caregivers of the children aged three to five that were enrolled at the Early Childhood Development (ECD) Centre which was poorly resourced. Play is the primary occupation in childhood, and the means through which children learn and develop. The situational circumstances in the community and the lack of resources at the ECD centre had prohibited these children from engagement in occupations of meaning. These children were occupationally deprived, thus could not reach their full developmental potential. The study aimed to explore the perceptions of primary caregivers on their roles in the stimulation of normal milestone development for their children as preschoolers in local ECD centre in a low socio-economic status community. The research purpose was to break the negative cycle of occupational deprivation through active involvement of the caregivers. It was therefore vital to understand the caregivers' involvement and their own perceptions regarding stimulation of developmental milestones so as to meet them where they are in the development of context specific interventions for prevention of developmental delays. The methodology used was qualitative research and the design a descriptive study. Methods of data collection were semi-structured interviews with 10 primary caregivers and the ECD practitioner. The interviews were done in the caregivers' home language of Setswana and transcribed in Setswana. The interviews were analysed through thematic data analysis, originally in Setswana. The themes and selected codes were translated into English. Three themes emerged which included the caregivers' perception of their role in stimulation, facilitators and barriers for stimulation and lastly how the caregivers perceived their involvement in the ECD centre where their children were enrolled. The caregivers expressed their willingness to stimulate their children, but the unavailability of educational resources came as a barrier. With regards to their involvement in the ECD centre, they expressed their dissatisfaction over the non nutritious menu served daily as a well as lack of comfortable bedding. The lack of communication between the caregivers and ECD practitioner regarding progress of the children, was the biggest concern for both parties. The ECD practitioner and the caregivers mutually found the meeting as a starting point to discuss matters of concern. Caregiver involvement would be improved through collaboration with the occupational therapist for context specific interventions.

# DECLARATION

I [Malikomo Kometsi] declare that this Research Report is my own, unaided work. It is being submitted for the Degree of [Master of Science in Occupational Therapy] at the University of the Witwatersrand, Johannesburg. It has not been submitted before for
any degree or examination at any other University.

___  _____

(Signature of candidate)

_____07____day of__AUGUST_____2019___in__JOHANNESBURG

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# ABBREVIATIONS AND GLOSSARY OF TERMS

**Child development:**

The stages of change in which a child gets to master more and more difficult levels of physical activity, thoughts, feelings, communication and engagement with people and things. These developmental domains are explained as physical, cognitive, emotional and social development (1)**.**

**Early childhood:**

This is the period between birth and eight years of age during which development takes place (1)**.**

**Early Childhood Development Centre (ECD):**

This is a partial care facility that provides an early childhood programme. The focus of an ECD is on early learning and development for children from ages of birth up to the year they enter Grade R or formal school (2).

*During interviews, the caregivers referred to the ECD centre as crèche and this will be used in the results chapter to refer to the ECD centre.*

**Early intervention:**

Early intervention refers to experiences and opportunities that are afforded to young children with developmental delays, or to those that are vulnerable and at risk of developmental difficulties. It is provided by primary caregivers and/or professional practitioners who enable children to participate meaningfully in their homes and community environments (2).

**ECD practitioner:**

An ECD practitioner is a person that is employed in formal early childhood development programmes to provide early childhood development services. These services include playgroups and family training (2).

**ECD programmes:**

These are programmes that offer diverse forms of daily care, development, early learning opportunities. They also provide care services for children from birth until the year before they enter formal school [2].

**Family:**

This is a group of people united by the ties of marriage, blood, adoption or cohabitation. The unity is characterised by a common residence or household, and the individuals interact and communicate with one another in their respective family roles. They maintain a common culture and are governed by family rules (2).

**Integration:**

This is when policies, laws and programs across and within different sectors become effectively coordinated. This ensures that families with their children get access to early childhood development services that are comprehensive (2).

**Low Socio-Economic Status (SES):**

Low SES is described as a state of poverty experienced by a family with low education, occupational status, or income relative to others in the population (3).

**Primary caregiver:**

This is a person who may or may not be related to the child, who take primary responsibility for meeting the daily care needs of the child. This excludes those who look after children for other purposes like remuneration or reward (2).

**Perception:**

Perception involves the personality of the caregiver, with previous experiences and motivations included (4).

## ABBREVIATIONS

**WHO:** World Health Organisation

**UNICEF:** United Nations International Children's Emergency Fund

**IADL:** Instrumental Activities of Daily Living

# CHAPTER 1: INTRODUCTION

## 1.1 RESEARCH TITLE

Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

## 1.2 INTRODUCTION

Early childhood is a stage in human development where the foundation of many aspects I s laid. This encompasses all areas of development that include physical, cognitive, language, social and emotional abilities (1)**.** Leung et al. (2017) state that development begins prenatally and gets accumulated throughout the life course. Furthermore, the foundation of human development is laid in the early years, which includes physical and mental health, academic attainment as well as economic status (5). The World Health Organization (2004) shares the notion that a human being's mind is a "blank slate" at birth. Indeed human beings acquire behaviour and knowledge through experience (6). The Republic of South Africa (2015) also aligns that learning starts at birth and continues throughout life. Therefore, early learning and development build the fundamentals for lifelong learning which add to the attainment of key outcomes for young children (2). In other words, events in the early years of a child's life affect the child's efficiency and their ability to learn throughout the life course (7).

De Paula et al. (2013) states that the environment in which the child grows contributes to the learning experiences and helps to determine the child's capabilities. As an integral part of the environment, a well- structured family is able to facilitate optimal development of the young child. The psychosocial family environment is where the child forms relationships with people and then with the world. Similarly, learning begins at home, and the set of spaces to which the family exposes the child and the culture in which the child gets inserted, determine the child's ability to live and develop. A stimulating home environment is one that constitutes opportunities for the development of motor, cognitive, language, social and emotional capabilities. These skills are important prerequisites for learning as they provide young children with chances to interact with various environments, such as the social, cultural, physical and socio-moral environments (8). In fact, the Occupational Therapy Practice Framework III (2014) describes occupational

performance as an attainment of selected occupations resulting from the dynamic involvement between the child, the context and the environment, as well as the play activity (9). Consequently, poor person-environment fit leads to poor occupational performance. For children to develop optimally and perform best in their play occupation, there needs to be a good fit between the environment and the children. Murdock and Rounds (2015) expressed environment-fit as a reciprocal and ongoing process whereby people shape their environments and environments shape people" (10) (page 83).

Furthermore White et al. (2008) explain that the environment can influence occupation by either providing opportunities for participation or constraining or limiting participation. Occupational deprivation occurs when occupational performance and participation is constrained due to factors outside the person within the environment, over which the person has limited control. Poverty may impose a form of occupational deprivation by limiting choices in occupations that are different for age and culture (11). Thus children's play opportunities may be constrained by unsafe environments, lack of resources, parenting practices that devalue play, and general limited opportunities for variety in play. Children's participation in meaningful play experiences and opportunities are vital for their health and well-being. Attention should therefore not be drawn to the health benefits only, but to shape play by broader historical, political and socio-economic structures within the society (11). Improvement in meaningful play can enhance the health benefits, which will in turn improve the person-environment fit. Holmeck and Zurenda (2008) highlight that the fit between the person and the environment can affect the person's motivation and physical health, and if the fit is optimal, the person's functioning can be enhanced (12).

De Paula et al. (2013) are of the view that children in under-privileged environments, without stimulation, people, toys or physical space, are at high risk of global developmental delay (8). As a result of their deprived social circumstances, children living in low socio-economic status (SES) communities are at risk of developing poor occupational identities because they have limited opportunities to engage in occupations that are valuable (8). Grantham-McGregor et al. (2007) showed that children younger than five years exposed to multiple risks, including poverty, malnutrition, and poor health have significant long-term adverse outcomes. The review identified unstimulating and unhealthy home environments as factors that detrimentally affect children's developmental domains and lead to poor adult outcomes. This is an indication that these children, who are disadvantaged, are at high risk to perform poorly in school, which will lead to low

incomes, high fertility, and provide poor care for their children, thus making a contribution to the intergenerational transmission of poverty (13). These findings have been backed up by a number of studies that have consistently found children living in poverty are at high risk of cognitive, language, and socio-emotional delays (14–16).

In view of the devastating impact that poverty can have on the development of a child, it is important to identify factors that can mitigate some of the negative outcomes in child development. Studies suggest that caregivers and the home environments they create can be key mitigating factors in preventing this loss of potential and strengthening developmental outcomes in poverty-stricken communities (7) (8) (17). Thus, it is important to strengthen the role of the family, in particular the primary caregiver, in stimulation.

Ackerman (2015) did an extensive review on research related to caregiver involvement in child development concluded that the caregivers' perceptions and their reasons for involvement, are based on their personal choice to become involved. These perceptions are formed by external expectations as well as their beliefs on parenting and are therefore contextual (4). Unfortunately, many of the studies reviewed were focused on formal schooling (i.e. from primary school onwards) and were set in schools with reasonable resources (i.e. not schools where resources are low and parents are poor). Thus, there is limited literature that has explored the shared experiences of caregivers from communities with low socio-economic status regarding their involvement in the stimulation of their children's development, despite caregiver involvement likely being even more important in these communities than in well-resourced ones (7) (8) (17). Furthermore, perceptions of caregivers are very contextually based (4). Therefore it is difficult to generalize findings from previous studies to different communities if the circumstances and characteristics of the communities are different. As a result, there is a gap in the literature on the views of particularly low SES caregivers on their role in the stimulation of child development. Therefore, this study aims to contribute to the literature on the caregivers' involvement in early childhood development through the exploration of their perceptions of their role in stimulation.

## 1.3 BACKGROUND OF THE RESEARCH

As part of community outreach services from Potchefstroom Hospital, community development stimulation services were provided at an Early Childhood Development (ECD) centre once a week, for 18 months during the years 2014 and 2015. This centre enrolled 25 children aged three to five years. The researcher observed that the ECD centre had employed one ECD practitioner and a general worker. In the beginning of both 2014 and 2015, these children were assessed on perceptual development, gross and fine motor skills. The results of the assessment indicated poor performance in these areas and developmental delays were noted. The ECD centre was situated in a low socio-economic community which lacked infrastructure. There were limited play resources both at home and the ECD centre. The physical environment where the children engaged in play was very small, which limited their occupational performance. The environment at home was also small, with reduced space available for play. Most of the houses were shacks built in small yards. The non-stimulatory environment lead to reduced engagement in play, resulting in deficient occupational performance. Considering that poverty was rife in this setting, the centre was thus poorly resourced. It was funded through donations by a local church. The children contributed a monthly fee of R70.00. At large, the community and the ECD centre did not offer a conducive environment to enhance milestone development. It was further observed that there was limited collaboration between the ECD practitioner, and the primary caregivers of the children enrolled. The non-stimulatory physical and social environment of the community offered few opportunities for engagement in play. It was evident that there was a high risk of occupational deprivation.

During the 18 months of outreach in 2014-2015 (prior to commencement of research), the researcher was involved in running stimulation sessions for the children attending the ECD centre. During these sessions, the researcher observed that many of the children were performing below the expected norms for their ages. Despite the age differences, there was only one ECD practitioner employed to teach. Further observations included the lack of involvement of the primary caregivers in the ECD centre. It was identified that the caregivers did not volunteer and become visible to actively participate in the activities of the ECD centre. The environment in which a child grows in, is believed to have a great impact on childhood development. The literature from studies by Leung et al. (2017) and Lynch et al. (2016) clearly states that family involvement is crucial in the stimulation of childhood development. This indicates that the primary caregivers can mitigate the poor development of children growing in low-socio economic households, through the provision of stimulating experiences (5,18) . Within the context of the ECD centre, the

researcher also observed the lack of collaboration between the ECD practioner and the primary caregivers. There were no interactions where the ECD practioner would formally or informally discuss the academic performance of the children with the primary caregivers. There were no programmes that the ECD centre provided for the primary caregivers could engage with the ECD practitioner to acquire skills for child stimulation. During outreach visits, the ECD practitioner shared concerns over the limited involvement of the caregivers regarding activities of the ECD centre. These observed issues prompted the researcher to embark on a research project that could initiate the process of understanding the perceptions of different role players in this particular ECD centre. It was crucial to explore the views of the caregivers in order to establish their understanding on their role in the stimulation of their children's development as there are not enough descriptions of caregivers' perceptions in the literature to allow for generalization to this particular ECD centre.

## 1.4 STATEMENT OF THE PROBLEM

The poor person-environment fit meant that the children enrolled at the ECD centre were at risk for developmental delay and lifelong loss of potential due to poverty and occupational deprivation. Families, more especially the primary caregivers could play an important role in mitigating the influence of poverty on development. However; at this particular ECD centre there were concerns that caregivers were not involved in their children's development. Effective methods in the prevention of poor childhood development would depend largely on the involvement of the caregivers, which would also require a collaboration between the caregivers, the ECD practitioner and the researcher as an occupational therapist. The challenge remained that there was limited literature on what primary caregivers thought their role in the stimulation of early childhood development was, especially in context of poverty or low SES. The existing literature, more especially in the South African context, focusses on the benefits of caregiver involvement in child development (2) (4), but does not look into the caregivers' own views about stimulation of child development. Furthermore, it was impossible to create contextually relevant and sustainable interventions without truly understanding the perspective of the relevant stakeholders, particularly the caregivers of the children attending the ECD centre.

## 1.5 PURPOSE OF THE RESEARCH

The purpose of this study was to understand the perceptions of caregivers of children attending an ECD centre within a low socio-economic community of their role in the stimulation and early development of their children. This research study acknowledges that to solve the problem of poor developmental outcomes, poor caregiver involvement and poor resources at the ECD centre, a good understanding of all stakeholders' perceptions and needs is important for contextual relevance. For purposes of this study caregiver perceptions would be explored to identify key variables related to caregivers that may ultimately be important when considering intervention strategies in the future. Thus, prior to embarking on any kind of intervention strategies, it was critical to understand what caregivers perceived as their role in their children's development in order to understand the potential factors that influence the caregivers' buy-in during the intervention, and to also meet them where they are. This was best done through a qualitative study in order to explore caregivers own perceptions and views.

## 1.6 RESEARCH QUESTION

What do primary caregivers perceive as their role in the stimulation of their children's developmental milestones as preschoolers in a local ECD centre in a low socio-economic status community?

## 1.7 AIM OF THE RESEARCH

To explore the perceptions of primary caregivers on their roles in the stimulation of normal milestone development for their children as well as their involvement in their children's ECD centre in a low socio-economic status community.

## 1.8 RESEARCH OBJECTIVES

**A.** To explore perceptions of primary caregivers on their role in the stimulation of developmental milestones of their children (three to five years of age) in a low socio-economic status community.

**B.** To explore the involvement of primary caregivers in their children's ECD centre in a low socio-economic status community.

## 1.9 JUSTIFICATION AND USE OF THE RESULTS

The results of the research will be significant in developing basis for partnerships between the caregivers, the ECD practitioner and the ECD management. The children will remain central to the collaboration that will be developed, which will incorporate all partners. The researcher believes that if the caregivers understand the views of the ECD practitioner and management, the caregivers will understand the needs of the ECD centre and the importance of stimulation. On the other hand, if the ECD practitioner understands the perceptions of the caregivers, their suggestions to improve the ECD centre will be communicated with the management. The mutual understanding that will be developed, will be to the advantage of all educational entities. There are no local government strategies in place to address the barriers and break the negative cycle of occupational deprivation.

As a health service provider, the researcher cannot change the infrastructure or improve the socio-economic status but can have an influence on the caregivers. Lack of caregiver involvement in the stimulation of development through play, adds to the barriers, but supportive caregivers can be facilitators in overcoming occupational deprivation. Engle et al. (2007) states that stimulation happens through responsive and highly complex, developmentally appropriate engagements between caregivers and children which promotes child development (7). The World Health Organisation (2004) states that improved caregiver-child interactions promote health and development of children that are vulnerable. These interactions enhance the children's resilience to the damaging effects of poverty and deprivation (6). It is against this background that the researcher developed an interest to investigate the perception of the caregivers and to establish their involvement in the stimulation of their children's development. Once the caregivers' perceptions are understood, appropriate and contextually relevant intervention strategies can then be developed.

Intervention strategies are essential in breaking the negative cycle of occupational deprivation and occupational injustice. For effective implementation of integrated intervention strategies, a good understanding of the role players' perception is needed so as to develop occupational

therapy intervention that is appropriate, focused on occupational performance, more child and family centered and broadly community based. The results of the study will assist in building partnerships between the caregivers and the occupational therapists in an effort to remove environmental barriers that discourage children's participation in play occupations. When the caregivers' perception of their role in stimulation has been established, the researcher will be in a better position to develop relevant intervention programs to empower caregivers to stimulate their children. The approach forms part of the preventative and promotional health services which include understanding the importance of stimulation in early childhood and the prevention of poor early child development. Hartinger et al. (2016) mention that hampered early child development could be prevented through the implementation of early childhood stimulation interventions, with the main focus being precisely on disadvantaged children and their families (19). Through specifically designed, context bound strategies, the caregivers will improve their knowledge on child development. The empowerment will encourage involvement in stimulation of childhood development in their home environments.

# 2 CHAPTER 2: LITERATURE REVIEW

This literature review aims to create a rationale for this study by reviewing the impact of poverty on early childhood development and how caregivers can play a role in mitigating this impact. The introduction creates the backdrop for why it is necessary to consider early childhood development in the context of poverty and will introduce the literature to be reviewed.

## 2.1 INTRODUCTION

This research aims to explore the perceptions of primary caregivers and their involvement in the stimulation of children living in low socio-economic communities, where poverty is rife. In a landmark series on childhood outcomes in countries that are developing, Grantham-McGregor et al. (2007) showed that in most developing countries, children below five years are subjected to multiple risks such as poverty, malnutrition and poor health. These unstimulating and unhealthy home environments adversely affect children's interdependent developmental domains which include cognitive, sensory-motor, speech and language as well as socio-emotional development. When children are exposed to early risk conditions, this has significantly long-term harmful effects on children. The difference between the children's current levels of development and what they would have possibly achieved if they werein a more stimulating environment with enough support and nutrition, shows the extent to which potential is lost. As they develop to late childhood, the children will eventually have poor levels of cognition and education. These two directly link to later earnings. This is an indication that disadvantaged children stand a higher chance to perform poorly in school and as a result, earn low incomes, have high fertility, and provide poor care for their children, this contributes to the intergenerational transmission of poverty. This cycle of integenerational poverty should be disrupted to improve health and development of many countries in which early childhood development plays an important role (13)

Grantham-McGregor et.al. (2007) further report that the national statistics on the growth of young children in countries that are developing, is limited. The indicators of poor development are shown in the world-wide data which reflects only two factors being the prevalence of early childhood stunting as well as the number of people that live in poverty. These two indicators have a close association with poor cognitive and educational performance in children. The researchers

estimate that over two hundred million children under five years are not fulfilling their developmental potential. Most of these children live in south Asia and sub-Saharan Africa (13). This loss of potential constitutes an occupational injustice. Children in sub-Saharan Africa in poor communities are being deprived of the opportunity to grow, develop and become valuable contributing members of society due to the inadequacies of their environments (11). Caregivers and home environments have been identified as key mitigating factors in preventing this loss of potential (20), however; caregivers' perceptions are relatively poorly understood and very contextually based (4).

Considering the wide-reaching consequences on the lack of stimulation in children aged three to five years, this literature review focused on occupational science and occupational therapy. The sections reviewed included occupational injustice, which children experience due to non-nurturing environments. In childhood, play is regarded as the core occupation and it forms an integral part in the building blocks for optimal development. The injustices in play as an occupation thus result in occupational deprivation and imbalance. Furthermore, the literature reviewed was on factors that contribute to early childhood development such as availability of formal and informal resources and most importantly caregiver involvement in using the resources and engaging in play. The psychosocial factors showed how the environment, specifically poverty, which characterises low socio-economic status communities, impacted on caregiver involvement in stimulation. It was crucial to also review the preventative and promotional health services which included prevention of poor early childhood development, the role of ECD programs, stakeholder involvement and collaboration between the ECD centre, caregivers and the occupational therapist.

## 2.2 EARLY CHILDHOOD DEVELOPMENT

According to Grantham-McGregor et al. (2007), early child development is regarded as crucial given that the development of all domains takes place during these years. Through this stage of human development, the brain is rapidly growing through neurogenesis, axonal and dendritic growth, synaptogenesis, cell death, synaptic pruning, myelination, and gliogenesis. These ontogenetic processes take place at various times, building on one other. These small agitations in these developments can have long-lasting effects on the structure of the brain and its

functioning capacity. The growth of the brain is highly affected by the quality of the environment. The authors' reviews highlight that many studies show that early undernutrition, iron-deficiency, environmental toxins, stress, as well as poor stimulation and social interaction, can negatively impact on the brain structure and function, and the results have lasting cognitive and emotional effects (13). Hartinger et al. (2017) regard early childhood as a crucial time for the developing brain, and this comprises physical, socio/emotional and language/cognitive development. There are many interacting and interdependent factors which the developing brain depends upon; these include genetic inheritance, health and nutritional status, quality of caregiver–child interaction and environmental characteristics (19) . McCoy et al. (2016) agree that the early years in children's development are critical in the foundation of cognitive and socio-emotional characteristics. Appropriate core cognitive skills develop between birth and five years. These skills allow children to maintain attention, understand and follow instructions, solve difficult problems and also have the ability to communicate with others. In addition, children's early experiences of warm, receptive relationships with their caregivers and peers, assist them in developing social and emotional capabilities. They also enable them to get along well with others and to independently manage negative emotions and aggression. These patterns play a crucial role in achieving subsequent developmental milestones and ultimately developing into economically successful and productive adults (21).

Grantham-McGregor et al. (2007) add that children living in poor, developing countries, who do not achieve their developmental potential stand a greater chance of not developing into productive adults. There are two pathways that have been found to reduce the children's productivity when they are adults, which include fewer years of schooling as well as reduced number of years learning in school. It is thus clear that underprivileged children have a high risk of not only being less educated with lesser cognitive function than their peers but also to be less productive as adults (13). Walker et al. (2011) build on this argument in that developmental deficits that have built up in early childhood, place children on a lower lifetime trajectory with negative implications for adult cognitive and psychological functioning, including educational attainment (22). Taking into consideration the cost implications of poverty (unavailability of resources, funds to meet the basic needs, unemployment) towards a society that has poor early child development, it is crucial to consider that the effects will be passed on to the next generation, keeping these inequities in long existence within society. It is approximated that this loss of human potential is related to more than a 20% deficit in adult income and will therefore have repercussions for national development

(13). Lower income per adult, has a negative effect on the revenue of the country and may mean that these adults will need financial support in the form of grants. The lack of early childhood development and the loss of human potential then contributes to a further perpetuation of the poverty cycle and contributes to the intergenerational transmission of poverty.

Considering that early cognitive development predicts schooling, Grantham-McGregor et al. (2007) further discovered that early cognitive and social-emotional development are strong bases of school progress, more especially in developed countries. It was identified that in countries that have not developed; early years of childhood and later educational progress are closely linked. In Guatemala, preschool cognitive ability determined children's registration in secondary school and achievement scores in adolescence. In South Africa, it was discovered that intellectual abilities and achievement at the end of grade one determined later school progress (13).

The South African government is involved in developmental initiatives that include the Sustainable Development Goals in which early childhood development is key. The government has a responsibility to make provision for condusive conditions to ensure that children are physically healthy, mentally alert, socially competent, emotionally sound and are able to perform learning activities at their full potential (2). For a nation to develop, it is critical for the government to provide the necessary conditions that enable children to develop to their highest potential. These conditions include the provision of resources, conducive environments for learning and support to caregivers who stimulate the children (2).

In summary, this literature review has demonstrated the long ranging consequences of poor early childhood development. Thus it is important to understand what aspects may impact on development as these may be important targets of intervention in the future. The following section will unpack the many factors that impact on children reaching their maximum potential.

## 2.3 FACTORS THAT IMPACT ON EARLY CHILDHOOD DEVELOPMENT

### 2.3.1 Impact of poverty on early childhood development

White et al. (2008) define poverty as the state of having insufficient resources that are a necessity with regards to human needs, which include adequate food, clothing, water, and housing. They add that poverty can also involve a limited amount of nonmaterial resources that an individual owns, with examples being emotional, mental, spiritual, and physical skills (11). Grantham-McGregor et al. (2007) agree that from the different methods that determine poverty, one such evaluation used measures of deprivation of basic needs, the substructure and accessibility of services. Investigations that were made in forty-five developing countries showed that 37 % of children lived in absolute poverty, especially in rural areas (13). WHO (2004) describes poverty as a conglomerate of events and conditions that create prevalent stress and hardship. With poverty, there is an increase in the likelihood of many risk factors being present simultaneously in the caregivers, the child, the support system for the family as well as the neighbourhood. Consequently, poverty limits the presence of protective factors. Over time, there are increasing risk factors for delays in development, leaving fewer opportunities available for children in poverty, more especially in communities that are underdeveloped. These children are unable to escape from these growing effects, even to benefit from interventions that may reduce their effect (6).

The family structure also has an impact on child development. Children of single or separated caregivers are at risk, but those from educationally and economically deprived backgrounds have far more substantial risks, even if they live with one or two parents (23). The difference in single or two-parent households is generally in terms of economic and parental resources. The rate of poverty is three to five times higher in single-parent households than of the two-parent households (23). Even in households where there can be more than one primary caregiver, the children's development is still affected by the poverty status. Chronically poor people transmit their poverty to the next generation, this cycle thus continues with poor caregivers that have poor children who will also become poor adults (24) . Given that the intergenerational cycle of poverty cannot be broken, the caregivers will therefore benefit from empowering skills to mitigate the risks of delayed development.

Lynch et al. (2016) highlight that the circumstances in the home environment and family contexts are highly considered with regards to studies on occupational development in children. The authors emphasize that there is an important connection between the social and physical environment within the home as well as the play processes present in the home (18). According to WHO (2004), children's home environments are described in terms of structural characteristics which include family size and household income; home environment features (presence of books, crowding and noise); characteristics of caregivers (their ages, their health and knowledge) and child characteristics (temperament, health and developmental status). The factors, coupled with limited resources and support systems, are to some degree, inter-related. They have an impact on the extent to which the caregiver and the child behave in commonly rewarding, developmentally appropriate and mutual interactions (6). White et al. (2008) mention that in early childhood, the brain and body are under construction, and these two, need rich environmental experiences and sufficient nutrition in order to develop optimally. Play that provides curious exploration of objects and things in the environment supplements and improves early brain development including neuronal differentiation, or the increase of interconnections between neurons in the brain. An elevated number of interconnections in the brain supports more complicated cognitive and movement abilities and it is also connected with maximum developmental outcomes. Engagement in play that is meaningful also enhances environmental learning which further strengthens key neuronal interconnections while eliminating others. This neuronal pruning is another manner in which the brain becomes more efficient, and this only takes place in the childhood stage as it is a time when the brain is forming in relation to individual's interactions with the environment. Therefore, what may be observed as a simple activity of building blocks or playing an easy game of hide and seek, forms part of the human occupational exposure that play a role in later skills in adulthood (25)

According to WHO (2004), there are many causes that underlie developmental problems in young children, however, poverty is regarded as the most profound and pervasive exacerbating factor. The low status in the social environment puts children at a greater developmental risks as they are exposed to direct physical consequences of deprivation and the indirect results of severe stress on the parent-child relationship (6). Children in low socio-economic communities are often deprived of an opportunity for play. This has been confirmed in a study by White et al. (2008), where one of the core factors of play deprivation in the wake of poverty was simply the lack of choice or opportunity (11). Williams and Hutchings (2015) add that children from poor

backgrounds have the likelihood to start their schooling career lacking important capabilities such as emotional regulation and social skills as well as lower cognitive abilities (16).

Bass et al. (2016) also support the argument that children born into poverty stand a high chance to experience delays in cognitive development. These disadvantages result in low academic and social achievements (14). Mendelsohn et al. (2011) add that children growing up in poverty lag behind when compared to their middle-class peers from the time they utter their first words. During play and shared reading, verbal interactions between the caregivers and the children are crucial for school readiness, however, these were found to be less frequent in families of low socio-economic status (SES) (26). These poverty-stricken families have high incidences of toxic stress which comes from factors that include low levels of education, unavailability of resources and social support. These factors result in home environments that are characterized by irregular cognitive stimulation, caregiver responsivity and limited experience to high-quality language interactions which are important for cognitive and language development and overall success in school (27). Brown and Lee (2017) add that caregivers, as children's first teachers, can afford their children the opportunity to learn the foundational early skills necessary for later school success. However, children born to low SES families lack behind in comparison to other children, more especially in the literacy development. These children have limited access to reading material; books are scarce in their homes and libraries (school and public). The development of language and vocabulary are precursors for enhancing literacy. Children in low-income families do not get exposure to successful reading skills development at home (28). There is a gap in the South African literature as a study by Ackermann (2015) only focused on caregivers of children attending quintile five schools, which are in higher socio-economic communities. Literature on the perceptions of caregivers in low socio-econimic communities is thus missing.

Hartinger et al. (2017) highlight that circumstances of impoverished households usually produce reduced stimulation, caregiver-child interaction as well as stability. This happens mainly due to lack of tangible resources to enable the interaction between the caregiver and the child. The non-stimulatory environment leads to poor childhood development. Furthermore, deprivation during early childhood impacts on cognitive development, which has a bearing on other ECD markers. There is an even higher developmental risk on ECD markers for children that are exposed to poverty, challenging social and physical surroundings that reduce the amount of stimulation being provided by caregivers and as such, the home environment. Thus, the accumulation of risk can

result in poor outcomes for children living in impoverished circumstances. Home-based interventions stand to assist in the devastating effects of poverty for developing children, which reduces the widening gap between rich and poor (19). White et al. (2008) mention that children who are born to caregivers who interact minimally with them, are at a disadvantage from the start, and this means that they are deprived of the rich and playful interpersonal occupations of early childhood (11). Brown and Lee (2017) stated in their review that children raised in low-income communities are exposed to less diverse vocabulary from their caregivers' talking and attention than their peers from higher communities. They found that low-income caregivers' conversations with their young children contained much poorer vocabulary and meaningfully fewer words than their middle-income peers' interactions. At 4 years, children from high SES families have seen up to 30 million more words than children from low SES families. Children from low SES families heard about 616 words per hour, while those from middle-class families heard around 1251 words in an hour, and those from upper middle-class families listened to roughly 2153 words per hour (28).

Low SES communities are characterized by intergenerational poverty which brings poverty of resources in the environment that the child grows in. Limitations in resources available for stimulation, reduces interaction between the caregiver and the child. These children are therefore deprived of rich playful engagements with their caregivers. The deprivation for stimulation results in delays in development as it has been emphasized that play processes interrelate with the social and the physical environments (18). The lack of sensory rich environments in situations that the caregivers have little control over, lead to occupational injustices. These poor contextual circumstances continue from generation to generation, and as the children form part of the poverty cycle, they are occupationally deprived as their play is compromised. Consequently, children that live in circumstances that are deprived due to poverty, have increased risk for developmental delays. These children perform poorly at school or do not complete their schooling career and struggle to secure jobs. As a result they live perpetually in poverty and this cycle starts all over again when they have their own children (24).

### 2.3.2 Poverty leads to occupational injustices

Gerlach et al. (2014) state that historical (intergenerational poverty), political (housing and food securities) and socioeconomic (employment), circumstances promote occupational injustices if children are prevented from participating fully and freely in meaningful play as it is regarded as a

health promoting occupation of early childhood. The occupational justice perspective in this instance considers the unique nature of the child's occupational needs, routines, and potential, as well as the relationship between occupation and the socio-emotional and physical aspects of health and well-being build (29).

In their article on applying an occupational justice framework, Wolf et al. (2010) state that in an occupationally just environment, children have access to resources and are provided with sufficient support to engage in occupations that are necessary and meaningful to them. They describe occupational justice as a term that emphasizes rights, responsibilities, and liberties that enable the individual to experience health and quality of life through engagement in occupations. Occupational deprivation is the most highly reviewed type of occupational injustice in literature. They describe it as a form of occupational injustice which occurs as a result of individuals being denied the opportunity and resources to participate in occupations (30). Ramugundo (2012) agrees that in the event caregivers and children tend not to engage in play within their own homes, a type of occupational injustice takes place (31).

In their discussion on occupational injustice and deprivation, White et al. (2008) mention that if children lack access to their basic occupations, this leads to occupational deprivation, which they define as "the prolonged preclusion from engagement in occupation of necessity and/or meaning due to factors that stand outside the control of the individual" (11) page-02. Occupational imbalance on the other hand, can happen when children are not given enough opportunities to engage in meaningful play activities, leaving them with too little to do. However, children can also be expected to engage in too many chores around the household, that may be considered as instrumental activities of daily life (iADLs) and work instead of play, leading to an imbalance in occupations. In order to address occupational injustices in children, it is thus crucial to identify the environmental and systems barriers that prevent them from engaging in occupations that promote health and quality of life. These barriers can include a social system which does not provide enough funding for early childhood development centres, whose main focus is to promote children's development (30). Durocher et al. (2014) support the statement above as they report that occupational apartheid may stem from restrictions in occupations at various levels, including economic, social, legal or religious (32).

Poverty greatly impacts on engagement in meaningful occupations, which lead to occupational injustices. If children cannot participate in play as their occupation, then learning cannot take place. If circumstances beyond the caregivers' control impact on their involvement in the play occupation, this means stimulation will be limited and development in children, delayed. It is thus important for caregivers to understand the importance of play as the means through which to stimulate their children's development.

### 2.3.3 Poverty leads to play deprivation

In their study, White et al. (2008) showed the relations between poverty and occupational deprivation. They believe that these terms and the associations between them are difficult and context specific. However, an appreciation of the connections between them provides a specific means of realizing the long-term effects that poverty poses on the skills and competencies of individuals. They used the occupation of play in order to illustrate how poverty has an influence on the developmental abilities of children who are deprived of it. They found that occupational deprivation due to poverty, lays the base for possible skill deficits throughout the children's lifespan (11). There are some occupational injustices involving the childhood occupation that stem from factors that are rooted in wider social structures, which are outside of a caregiver's immediate control. There is also dominant discussion about caregiving in that caregiver-child, play based interactions and opportunities that are created within the home environment, are believed to be a caregiver's choice. Children's play experiences within their homes are characterised by intergenerational occupational injustices considering that caregivers lack the experiences and knowledge in the involvement of childhood play experiences, and they get transferred to the next generation. These form critical points to consider in the reframing of play (29).

Brown (2003), regards play deprivation as the idea that if children do not play, this may deprive them of experiences that are considered to be important for development. Given that play contributes greatly to brain development, play deprivation thus have adverse effects on brain growth. The sensitive period for neurological growth is between birth and the age of seven years. If children are chronically play deprived, this can lead to sensory deprivation, especially if they were unable to play during the sensitive period. Play is actually the sensitive period considering it is not just active during the sensitive period of brain growth. This means that limited play, will

result in limited brain development. This indicates that with play deprivation, children develop smaller than average brains resulting in certain areas of the brain becoming malformed. Brown (2012) reported that children who do not play, develop brains 20-30% smaller than normal for their peers (33).

Gerlach et al. (2014) state that socio-economic inequities shape play through adverse impacts that are created from the distribution of social and economic resources through public policies. Further examples of occupational injustices include single mothers raising children with incomes that are often below poverty lines. This escalates the vulnerability of both the mother and her dependents. Other adverse contributing factors include unsafe and inadequate housing and food shortages, which are increased by current social and welfare policies. Although parents that live in these conditions have the same desires for their children to succeed and reach their full potential, their attention is focused on ensuring their family's survival. When they experience food and housing insecurities, ensuring that their children have active and creative play opportunities, being either indoor or outdoor, is not much of a concern. This results in children having inequitable access to meaningful play opportunities (29).

Furthermore, White et al. (2008) explain that poverty may put at risk the nutrition of children such that they may not be able to sustain any energy to engage in play. In this situation, poverty may have imposed a form of occupational deprivation by limiting choices in occupations that are different for age and culture (11). Gerlach et al. (2014) add that historical, political, and socioeconomic circumstances promote occupational injustices if children are prevented from taking free and full participation in meaningful play as it is regarded as a health promoting occupation of early childhood. The occupational justice perspective in this instance considers the unique nature of the child's occupational needs, routines, and potential, as well as the relationship between occupation and the socio-emotional and physical aspects of health and well-being (29)

Brown (2013) further shares the opinion that there is not a significant connection between play deprivation and other forms of disadvantage. In other words, play deprivation is not necessarily unique to communities living in poverty and can also occur in wealthier environments where play is restricted by structured activities (33).The researcher agrees with Brown (2013) in that

structured activities may limit free play and discourage participation in play if the the caregiver's choice of activities and their presentation are not interesting to the child. The advantage in wealthier environments is that caregivers can afford to provide a wider variety of store-bought toys to encourage participation in play even if it is structured. Furthermore, choices of play are restricted to the toys available, limiting opportunities for free flow play where children can explore their environments further and be able to make independent choices for play. However; there is a lack of literature in this field and future studies need to investigate the extent of play deprivation for children with wealthier parents. Further investigations should include other the different forms of advantage that have not been unpacked in this study by Brown (2013). The author did not elaborate on how play deprivation can connect to other forms of deprivation. The elaboration would have enabled further research to investigate the impact of poverty in comparison to other forms of disadvantage that lead to the deprivation of play (33). What is clear from the literature is that play deprivation is especially devastating when combined with all other risk factors and environmental deprivations associated with poverty. Children living in poverty have inequitable access to meaningful opportunities and experiences for play in comparison to children from middle-class families (29). White et.al. (2008) therefore argues that certain conditions of poverty may leave children occupationally deprived in play (11).

Children residing in low SES communities lack the necessary resources and safe neighbourhoods to engage in play. Their caregivers limit engagement in play as the consider the environment as unsafe. They do not involve their children in play while they are busy with household chores. Play deprivation leaves these children at high risk of developmental delays. Caregiver involvement is thus considered for the alleviation of the impact of poverty on their childrens' development.

### 2.3.4 Early stimulation through play

According to Missiuna and Nancy (1991), play can be defined as an "eager engagement in pleasurable, physical or mental effort to obtain emotional satisfaction" (Missiuna & Nancy, 1991)(p-882). They add that opportunities are created during play, where children learn the effects they possess on objects and people within the space they live in, and this assists them to develop and test their social and occupational roles (34). Gerlach et al. (2014) highlighted that play as a childhood occupation can be shaped by diverse child rearing practices which include family structures, parental values, beliefs and expectations that are connected to childhood and the context (29). Lynch et al. (2016) consider that through childhood stage, occupational engagement

is considered to be important for learning and development. Such engagement happens mainly through play (18). Missiuna and Nancy (1991), add that as they explore the world around them, children gather vital information through their various senses which equips them with skills to know the nature and the properties of objects and further develop rules about their own location in time and space. These skills further allow them to interact and respond to the needs of their environment. The interaction results in the development of perceptual, conceptual, intellectual, language and eventually the integration of cognitive abilities (34)

White et al. (2008) agree that some types of play usually have cultural differences, including participation in house chores. However, as children participate in these activities, they do so in a playful attitude which displays elements of play such as self-direction, enjoyment, and meaningfulness. Thus, poverty itself may not always restrict participation of play (11). On the other hand, children living with families with low income in actual fact, live in mostly unsafe neighborhoods. This means that children are naturally restricted by their caregivers from engaging in outdoor play (11). In addition to the impoverished environment that is not providing enough opportunities for stimulation, Lynch et al. (2016) report that caregivers are at times the gatekeepers of their children's occupational opportunities, giving or refusing them permission to access play environments. The decision often depends on the caregivers' assessment of the risk involved. Children may view the risks as fun and positive while caregivers find them negative and dangerous (18).

On the other hand, Ihmeideh (2017) found that some caregivers regarded play as important for their childrens' development and learning. Physical play was considered as the most common type of play that the caregivers engaged in with their children. Furthermore, there were significant correlations between the caregivers' perceptions of children's' play and their participation with all play types. The differences that were observed in this engagement, were based on the caregivers' socio-demographic variables. These findings therefore showed the significance of extending children's' play across all children's educational levels, at the same time involving the caregivers in children's play activities (35). Milteer et.al. (2011) stated that Philosophers and psychologists, such as Plato, Piaget, and Friedrich Froebel, regarded play as important for healthy child development even before the United Nations High Commission for Human Rights considered play as a right to every child. When the caregivers get involved with their children during playtime, play is then believed to offer opportunities for caregivers to view the world from their children's perspective and to bond with them. Nurturing relationships with consistent caregivers mediate

healthy development in children. When caregivers engage in child-driven play, they can see the world through their child's eyes and therefore offer guidance more effectively. They further added that children require character traits of honesty, generosity, tenacity, decency and compassion. These characteristics are gained at home when caregivers and children interact in a supportive manner and play is regarded as a time-tested way that families have these interactions. The presence of play in schools, communities and homes should be supported in order to preserve play in the lives of economically disadvantaged children. Across the economic spectrum, the caregivers' presence and attention enriches their children as one-on-one play is a time-tested, effective means of stimulation (36).

In childhood, learning happens through play and play is the child's main occupation. It is through play that caregivers get to engage with their children and stimulate their development. However, poverty limits the availability of resources and space for engagement in play. Caregivers also decide if their children should play outside or not, depending on the safety in the environment. This leads to play deprivation as children do not gain the necessary experiences for their development.

## 2.4 CAREGIVER INVOLVEMENT IN CHILDHOOD DEVELOPMENT

The review of the literature so far has determined that early childhood is the time during which the groundwork is established for existence, growth and progress across all domains and capabilities. This critically sensitive period of fast growth and change is during the first and early years and the rate is determined by internal and external factors. The internal factors include the child's individual nature while the external ones are living conditions, gender, family structure, living conditions, care arrangements, cultural beliefs, health and education systems. The children's optimal development is determined by nature of their environment, whether it is supportive and nurturing. It is now important to review how caregiver involvement in early development and play can impact on this important period in a child's life. In order to understand caregiver involvement and how it is interpreted across the world, it was considered important to define it and categorise it into aspects that encompass different domains of child development.

Ackerman (2015) reviewed a number of studies on caregiver involvement in early stimulation and he defines caregiver involvement under four major categories which include caregiver academic

aspirations and expectations for children, their children's participation in school, communication about school as well as a home structure that supports learning. A theoretical conceptualization about caregiver involvement, paid attention to three general factors for involvement:

a) caregiver's beliefs that it is their responsibility to take part in their children's learning
b) caregivers' perception of invitations for involvement from the school, the teacher and the child,
c) other involvement activities that may conflict with the demands on caregivers' time and energy (caring for other children, work schedules that are demanding or inflexible) (4).

WHO (2004) categorised caregiving into primary functions that are interlinked and bind responsibilities for caregivers. These functions include the promotion of biological integrity by providing food and shelter (sustenance), the engagement of attention and provision of experience and information (stimulation), the reinforcement of goal-directed behaviour as well as meeting social and emotional needs (support) (6). Ackerman (2015) further reported on widely used frameworks that divide caregiver involvement into home-based and school-based activities. From these frameworks, six types of caregiver involvement derived, which form basis of many studies on caregiver involvement. The types are as follows:

**Parenting** – supporting, nurturing and child rearing. This means that families create home environments that enable them to provide support their children as students.
**Communicating** – effective forms of communication about school to home and home to school programs and children's progress.
**Volunteering** – supervising and organizing parent help and support.
**Learning at home** – Manage, recognise and reward. Provision of information to families on how to assist children with homework and other curriculum-related activities.
**Decision-making** – contribute, consider and judge. Involvement of caregivers in decisions and development of parent leaders and representatives.
**Collaborating with community** – share and give. Identification and integration of community resources and services to strengthen school programs, learning and development (4).

According to The Republic of South Africa (2015), the South African Government recognizes that the child's caregivers have the responsibility to provide nurturing and caring environments during the crucial early years of life. However, the Government also realizes that the primary caregivers should access and receive the information, support and services which are essential to empower

them to fulfil their responsibilities. This means that early stimulation for childhood development, depends on strong measures for securing both the children's rights and those of the caregivers as this decides on the capacity of the caregivers to ascertain that their children develop holistically and optimally (2). WHO (2004) explains that a person's functioning is derived from the internalization and mastery of social processes that occur between people (6). The caregivers are responsible for framing children's experiences and helping them interpret their experiences both symbolically and culturally. This is crucial in a child's early learning. However; caregivers from a low SES struggle to do this as there is limited social interaction between the caregiver and the child. The caregivers living in poverty-stricken areas do not have access to information regarding child development and stimulation.

American Academy of Family Pediatrics (2003) states that children have basic needs and there are some needs provided for, mainly by family. These are social support, social interaction, coping and life skills. It is believed that schools offer formal education whereas families educate children on how to get along in the world. If the upbringing of children is done in a positive and nurturing environment, they are more likely to have pro-social acquaintance skills, an ability to regulate their emotional responses, and achieve appropriate educational standards. On the contrary, children who are brought up in environments with reduced resources, by caregivers who have health problems, and who use punitive parenting practices, stand a poor chance to achieve good outcomes. The influence of caregivers or other family members is pervasive, whether they are physically present or not. Families are regarded to have the most central and enduring influence in the life of children despite their composition, income, education, or values (23).

Jones et al. (2016) define positive care-giving as the continuous connection between a caregiver and a child, which includes caring, teaching, leading, communicating, and providing for the needs of a child regularly and unconditionally. An association that is positive between caregivers and their children as well as the quality of children's early environment has long-term effects on the development of their cognitive and behavioural components (37). White et al. (2008) add that caregiver education is highly associated with memory, language skills as well as intellectual capabilities in developing children. Consequently, children who are born to parents who interact minimally with them, are at a disadvantage from the start, and this means that they are deprived of the rich and playful interpersonal occupations of early childhood (11). To add to this statement, Gerlach et al. (2014) regard these children as 'at risk' while the caregivers are considered as

'negligent'(29). American Academy of Family Pediatrics (2003) supports the above-said in that families that live in poverty have the likelihood to have lower levels of educational achievements; less social possessions; less stable personal relations; more health risk behaviors, including poor nutrition and substance use; and a higher prevalence of stressful life events (for example, insufficient housing, contact with the police, economic uncertainty, job loss, family illness). Given that single parent, female-headed households fall among the poorest families, it is unclear as to what extent does poverty, family structure, and other factors are responsible for the poorer outcomes of children in these families. It can therefore be concluded that the stresses of poverty take their toll on caregivers and negatively affect their child-rearing behaviors and expectations. Children that come from poor families stand a high chance to be unsupervised, which exposes them to the physical and social dangers of their environment (23).

According to Clarke-Stewart et al. (1979), in WHO (2004), early caregiver-child interactions play a crucial role in how children develop self-regulation, cognitive abilities, language acquisition and socio-emotional adjustment. This was evident from an outcome of a panel study of 14 children and a replication study of 96 children that was conducted in the United States of America. The research methods used, included naturalistic observations, semi-structured situations and interviews. The developmental domains that were measured included cognition, language and social interactions. It was discovered that these developmental domains intercorrelated and associated with stimulating interactive maternal behaviours, with the positive interaction with the child included. These relations were not influenced by socio-economic status or maternal intelligence (6) (38). This means that the socio-economic status and maternal intelligence did not determine improvement in developmental domains. Rather stimulating interactive maternal behaviours yielded positive outcomes.

Hunter (2009) states that the most appropriate definition of caregiver involvement from the voices of the caregivers is "helping" and "actively involved." One caregiver described it in a nutshell, "you have to blend peanuts to produce peanut butter; therefore, you have to blend schools and parents to produce academically sound students" (39) page 99. The views of the carevivers regarded communication, accountability, reliability, responsibility and emotional support as key elements to caregiver involvement. Through communication, they would establish clear expectations and keep them informed. For reliability, the caregiver would need to maintain consistency in the

rearing of the child, which included a structured home routine with weekly schedule and a set bedtime. Consistency meant dedication and commitment from the caregiver. Caregivers also needed to take responsibility of their actions. This required a structured home environment where the child could complete schoolwork. The emotional support was also key to good caregiver involvement (39). Ackermann (2015) added that the perceptions that caregivers share on their involvement, they are based on personal choice, construct from their roles and believes. Caregivers perceived their involvement as an extension of their responsibility of raising their children (4).

Caregiver-child engagements play a critical role in the children's growth in developmental domains. There are many theories around the reasons why caregivers get involved in supporting their children. Their involvement in stimulation has extensive benefis for domain development. Most studies have shown how important it is to create programmes that encourage responsive and playful caregiving, but very few of the studies have actually explored the caregivers' experiences and what they view their roles entail. Occupational identities form during childhood stage and they are influend by caregiver-child interactions.

### 2.4.1 Caregivers' involvement influences occupational identity development

Kielhofner (2008) states that through their own experiences of failure and success in occupations, children gain knowledge, capacity, and feelings of self-efficacy and this in turn form the shape of their occupational identity (40). Phela and Kinsella (2014) add that during childhood, the development of occupational identity is dependent on the skill of mastering self-care occupations, and the participation in leisure occupations may have an influence about who the child becomes (41). Kielhofner (2008) noted that as children participate in occupations, their sense of personal causation, interests, and values begin to develop. The developments enhance the emergence of a child as an occupational being, given that the child establishes his or her specific ways of thinking, feeling and doing (40).

Phela and Kinsella (2014) have also acknowledged that childhood is a stage in human development when occupational identities start to take form. They further add that social relations influence identity development in childhood, as children grow up knowing themselves as

individuals that have the ability to act in the world, and they comprehend that their actions have a social meaning. They further suggest that children's interests are formed and reformed by family, friends and common culture, leading to frequent changes in occupational participation and perhaps how children see themselves from day-to-day. They add that the importance of valued occupations that children are allowed to participate in, as well as the moral commitments shown in the communities and societies, indicate the responsibilities on how forthcoming identities are formed (41). Considering the evolution of the occupational nature of humans, Humphry (2005) is of the opinion that the processes of development that form early childhood occupations are the same forces for change in occupations later in life (42).

It has been highlighted in the literature that the development of occupational identities is dependent on the caregivers' influences on the choice of occupations the children engage in. Who they become in society depends on their interactions with their cagivers, the family and the community at large. It is evident from the literature that caregivers play a much bigger role in the stimulation of childhood development, than family or community. Encouraging caregiver-child interactions thus influence co-occupations which enhance the child's occupations where learning happens.

### 2.4.2 Caregiver – child interactions and co-occupations

Pierce (2009) states that the term co-occupation was invented in the early days of occupational science. It has its grounds in the interdisciplinary play literature, which has awarded it a lasting nature as an original idea in occupational science. Occupational scientists have shown great interest in the interactive social dimension of occupation, more especially those of caregivers and children. The principles imbedded in co-occupation are of a high interactive nature. Therefore; co-occupation can be regarded as a dance between the occupations of one person and another which successively shapes the occupations of the individuals involved (43). Furthermore, Price and Stephenson (2009) add that co-occupation forms a central piece in the development of a child's occupation. Caregiver and child co-occupations originate from a transaction with a wider scenario of family, community, and culture, all of which shape and influence co-occupation. Classic co-occupations vary with cultural beliefs and habits. The majority of caregivers anticipate being able to determine and meet their child's needs, yet the caregiver's cultural view of caring, determines what those needs are and the manner in which they will be met. Should these

expectations not be achieved, caregivers often experience isolation, feeling misunderstood by those with typically developing children. It has been highlighted that caregivers have greatest desires to raise their children such that they are able to fit in socially. In order to create opportunities for their children to develop, caregivers take decisions about organizing the play space, the types of toys to include, and how to create a routine that will enhance occupational development. These are also shaped by the person's situation which includes cultural values and beliefs, finances, the nature of one's neighborhood, and relationships with family and friends. They further report that in a study of activities needed for caregivers raising typically developing pre-school age children, these mothers were however found to be overwhelmed by feelings of lacking knowledge on how to care for their child. These caregivers also realized their responsibility towards the development and eventual success of their child (44)

In summary, the literature from studies by Leung et al. (2017) and Lynch et al. (2016) has shown that caregivers are mitigating factors in the challenges that limit children to reach full potential in their development (5,18). Their interaction and involvement in play enchance co-occupations and develop better occupational identities. There are other strategies that contribute to prevention of delays in childhood development which can be integrated with caregiver involvement. These include stakeholder involvement, ECD programs and the partnership between the caregivers, ECD management and the Occupationa Therapist. These approaches can empower the caregivers on skills and knowledge they require to enhance their involvement in the stimulating childhood development.

## 2.5 THE PREVENTION OF POOR EARLY CHILDHOOD DEVELOPMENT

According to Bayhan and Sipal (2011), effective early stimulation requires early intervention and the justification for early intervention is mainly to prevent cognitive disabilities and poor intellectual development. The focus is on children whose families do not provide sufficient stimulation in the early years of life. Early intervention entails detailed assessments of the child and the family's strengths and needs in order to provide appropriate services including monitoring and evaluating the child throughout the development (45). Early intervention is highly varied as WHO (2004) agrees that Early Childhood Development (ECD) programs that broadly address children's basic needs, including health, nutrition, emotional and intellectual development, create capable and productive adults. Early intervention programs adjust those lifetime trajectories of children born into poverty or deprived of the opportunities for development (6). The Children's Act No.38 of

2005 provides a detailed framework for the provision of social services for South African children. It considers caregiving and family support as key outcomes for the early intervention programs. It recognizes early childhood development services as a type of prevention and early intervention (2).

Engle et al. (2007) state that child development can be improved through stimulation programs which include responsive and increasingly complex developmentally appropriate interactions between caregivers and children. It is now known that both cognitive and social-emotional skills form the basis for later academic and employment success. It is mentioned previously that insufficient stimulation and interactions can have a negative impact on child development as the basic neural circuitry gets disrupted. Early stimulation can therefore promote neurocognitive processing as well as brain functioning (7). Hartinger et al. (2017) add that hampered early child development could be prevented through the implementation of early childhood stimulation interventions, with the main focus being specifically on disadvantaged children and their families (19).

Walker et al. (2011) identified protective mechanisms which are associated with caregiver education, and they add that the quality of child-rearing environment is also regarded as crucial. The benefits of caregiver education include improved knowledge about child development and that the caregivers will be more likely to use developmentally appropriate child-rearing strategies as well as providing more stimulating home environments. They need to be equipped with a broader variety of child-rearing strategies in order to possess educational aspirations that are higher for their children (22). Engle et al. (2007) have proposed caregiving and caregiver-child programs as part of strategies for improving child development. These strategies include working with caregivers to improve their caregiving skills and resources, conducting home visits or group sessions. In their study, they found that caregiving programs that used home visits reported positive results on child development. In Jamaica, caregiving practices showed great improvement when both the caregivers and the children were actively engaged in the home visiting program, and the results were low when the caregiver component involved only information sharing. Group sessions were also used with caregivers in Turkey, where caregivers were involved in play skills with their children, there were both short and long-term effects on childhood development. In Bangladesh, information-based sessions resulted in an improved caregiver's knowledge on childhood development and child rearing. However, there was no effect

on child development; this is perhaps due to the fact that families did not participate in practice or skill-based activities (7).

Walker et al. (2011) report that studies from Bangladesh, China, India, and South Africa have proven that interventions to enhance caregiver–child interactions and increase developmentally appropriate activities produce positive effect on cognitive development if they are carried during home visits or combined approaches. In Chile and South Africa, early interventions to improve caregiver–child interactions promoted attachment and social–emotional development, but there were no gains reported in Bangladesh (22). Brown and Lee (2017) share the fundamental beliefs that education for a young child begins at home. It is of great importance for young children to have a more meaningful and systemic support from their primary caregivers so that they can begin school with the necessary background for future academic success. For many times, low SES caregivers lack knowledge on providing their children with learning and educational opportunities at home. They also do not have access to educational resources at home (28).

The alleviation of poor development in early childhood was highlighted in a study designed by occupational therapists, Parush and Hahn Markowitz (1997) to find the long-term effects of a prevention program intended to improve learned caregiving. The results showed that the intervention program which consisted of providing information (to increase knowledge and develop attitudes) and modeling (to heighten relevant practice) procedures equipped the participants with advanced skills about the developing child. The participants also showed stronger convictions that the human and physical environment can also have an impact on the quality of the child's development. It is thus evident that the heightened knowledge, attitudes, and practices pertaining to development that the participants in the intervention group attained importantly support beliefs that occupational therapy services can contribute to primary prevention of poor stimulation. Providing knowledge, supporting or changing attitudes about the role of nurtuting the child's wellbeing, and mediating the positive practice of caregiving, can all be regarded as primary prevention aspects of occupational therapy pediatric facilities (46)

Prevention of delays in childhood development depends on effective early intervention strategies that complement caregiver involvement. Caregiver-child interactions in low SES communities cannot suffice as the sole approach in the prevention of poor development. Other plans need to be considered to encourage caregivers to play a role in the stimulation of childhood development. Early childhood programs will create platforms for collaboration between caregivers and the ECD

practitioner. This will make it possible to share ideas for stimulation and ensure carry-over of concepts from the ECD centre to home for caregiver involvement.

### 2.5.1 Early childhood development programs

According to The Republic of South Africa (2015), the South African government recognizes early childhood development as a global right and public good. It is its mandate and obligation to provide for early childhood development services as a right. This assists the government to achieve the national developmental results that are necessary to equalize the developmental discrepancies experienced by vulnerable children. This in turn achieves South Africa's two key developmental challenges being poverty and inequality. The government regards early childhood development as a central and wide-reaching human right that all children are entitled to, without any discrimination. This right is acknowledged in a host of policies and laws dating as back as 1995. These include the White Paper on Education and Training (1995), the Interim Department of Education's Policy for Early Childhood Development (1996), the National Programme of Action for Children in South Africa (1996), the White Paper on Social Welfare (1997), the Education White Paper 5 on Early Childhood Education (2001), the National Integrated Plan for ECD 2005–2010 (NIPECD), the Children's Act No. 38 of 2005, and the National Plan of Action for Children (NPAC) in South Africa 2012–2017. These policies and laws seek to effect to the rights of every young child to achieve development at full potential, to be physically healthy, to have sound mental alertness, to be socially capable, emotionally healthy and competent to learn (2)

The Republic of South Africa (2015) highlights that access by young children to early childhood services and support, has a significant impact on numerous areas of development including:

- School enrolment, retention and performance: Improved cognitive development is highly associated with early childhood services and support. These services assist in the prevention and/or early identification of developmental delays as enhancing school readiness. These lead to improved educational results, more especially for the socially and economically marginalized children.
- A better economy: these services are related to higher levels of employment and earning potential, which eventually improve production, the country's gross domestic product (GDP) and increase tax revenue. Studies have shown that participation in early learning and development programs add to increases of 5% and 10% in lifetime labour income.

- Poverty: Access to these programs alleviate deficiencies in the care, stimulation and educational opportunities for impoverished children and improve the development of young children (2).

Hartinger et al. (2017) build on this statement by adding that interventions for ECD are often regarded as cost-effective and promising approaches that can reach these vulnerable children and they also impact on success and productivity up to adult age (19).

ECD programs play a vital role in the prevention of poor childhood development, which include improved cognitive abilities, higher income and alleviation of poverty. They are highly regarded by the South African government in addressing challenges that children experience in their development. They are incorporated in the children's rights. The government considers that effective ECD programs require integrated services from relevant stakeholders since childhood is a crucial stage where all domains develop.

### 2.5.2 Partnerships with relevant stakeholders

The National Integrated Early Childhood Development (ECD) Policy by Republic of South Africa (2015) aims to ensure the global availability and equitable access to early childhood services. This should be achieved through a national collated system which is enclosed in a legal framework that identifies, allows and forces the fulfillment of early childhood roles and tasks of appropriate role players. Considering that the children's early childhood development rights and needs are amalgamated and include many areas like health, nutrition, safe environments, psychosocial and cognitive development, it is crucial to provide a comprehensive service package that does not depend only on one government department. Securing the universal early childhood development rights needs an integrated multi-sectoral plan that involves all government departments, the corporate sector, religious organisations, none profit organisations, caregivers and children (2).

Mccoy et al. (2016) support the integrated approach to intervention. They report that research has shown that the delivery of warm, responsive and stimulating caregiving has proven to promote children's early cognitive and socio-emotional development, even in the presence of poverty. Methods that integrate psychosocial and educational approaches with health and nutrition, can promote ECD as they can target multiple developmental domains (21). Cates et al. (2018) agree that collaborations across health professionals and policy makers will be required in order to

identify mechanisms for stable funding and to ensure population-level implementation of programs that have been proven to be effective (27).

Stakeholders from private and government sectors can contribute greatly in enhancing caregiver involvement and contributing to essential resources for promoting early intervention. Their participation is critical as it will provide a holistic approach to the problem at hand as literature has shown that all domains develop during early childhood. This will require the coordination from all professionals to ensure that services are well integrated with the partners involved.

### 2.5.3 Collaboration between caregivers, ECD practitioner and therapist

Cates et al. (2018) state that at the forefront of approaches to address disparities are interventions that focus on caregivers and early home language environment. These interventions can be delivered as centre-based or at home (27)**.** Mendelsohn et al. (2011) add that early childhood preventive interventions should promote caregiver-child interactions and school readiness. These need to be population-wide and low cost to for easy access and frequent sessions that will reduce additional travelling. This will in turn allow close relationships between the caregivers and the health care professionals (26) as Cates et al. (2018) support that the existing relationship will encourage the caregivers to focus on their child's development and behaviour and be willing to implement the advice (27)

Law et al. (1998) highlight that the uniqueness of the occupational therapy profession lies in its focus of regarding occupation as central in the promotion and maintenance of health and well-being. The foundations in the theory and practice of occupational therapy stem from the belief that occupation and well-being are highly related. For this reason, occupational therapists use unique approaches in health promotion and community health (47). Gerlach et al. (2014) believe that inequalities in health require intervention at both micro and macro levels as that will promote meaningful early play experiences and opportunities, which will in turn bring equal access to possible health promoting benefits that play brings (29). Considering that in their preschool years, children spent most of their time at home with their caregivers, it is crucial to provide these opportunities. The experiences that take place in higher income homes can be reproduced with high quality intervention programs for disadvantaged children in low SES communities (28).

## 2.6 CONCLUSION OF THE LITERATURE REVIEW

Low SES communities are characterized by poverty, which leaves the children at risk of limited stimulation. Literature has proven that caregiver involvement in the stimulation of childhood development mitigates the effects that poverty have on stimulation of children. Caregivers that reside in poverty-stricken communities lack the necessary knowledge and skills for engagement in play, through which children learn and develop. Literature has shown that the involvement of stakeholders and the upliftment of ECD programs, can improve child development and enhance the caregivers' knowledge and skills. However, these services will require coordination and involvement of the community at large, which the occupational therapist can provide. For this intervention to be effective, caregiver involvement is key, which has been proven by the literature. It was not evident in the literature, how caregivers view their involvement in the stimulation of their children's development. Literature has extensively described the benefits caregiver involvement has on child development, but it is limited on the perceptions of caregivers on their role in the stimulation of child development. This study will thus contribute to understanding the perceptions and experiences of caregivers before attempting to create intervention programmes that require caregiver buy in to work.

# 3 CHAPTER 3: RESEARCH METHODS AND DESIGN

## 3.1 TYPE OF STUDY

For this study, the research design that was employed was desscriptive qualitative research. This approach aims to address questions concerned with developing an understanding of the meaning and experience dimensions of humans' lives and social worlds (48). It was this method of research that permitted the researcher to explore the perceptions of the caregivers and provide them an opportunity to share experiences of their lives as role players in the stimulation of milestone development within their context. Qualitative research takes place in the natural setting (49) (Creswell, 2003), and in this regard the researcher went to the participants' site to conduct the study.

## 3.2 RESEARCH DESIGN

### 3.2.1 Descriptive study

A qualitative descriptive study provides a valid representation of the factors that are relevant to the research question (50). From the experience of providing services at the ECD centre, it was identified that the children enrolled were at high risk of developmental delays and there was a lack of caregiver involvement. Due to the complexity of the issue identified, it was deemed crucial to understand all aspects of the problem before developing an intervention program. There was a need to first describe the aspects of the problem and to develop an understanding of the role players' perspective before attempting to design an effective intervention. The descriptive study provided essential tools that enabled the researcher to understand the topic being researched and to deliver a clear description of the observed problem.

## 3.3 DESCRIPTION OF THE SETTING

The study was conducted at an ECD centre that was situated in a low socio-economic community located in Sonderwater, an informal settlement in Ikageng location in Potchefstroom, North West Province, South Africa. The type of housing was mainly informal structures and this area lacked in infrastructures such as tarred roads, plumbed toilet facilities and easily accessible running water

supply. This research area was a known site in which the researcher provided services. This ECD centre was founded by a local church as part of their Mercy Ministries. The funding and resources for the running of the centre were donated by the church. There was one ECD practitioner who conducted teaching for the 25, three to five-year olds that were enrolled at the ECD centre at the time of the research. There was only one classroom where these children were grouped in their desks according to their age groups. The ECD practitioner presented a single topic across all age groups. Although she would not grade the tasks according to the children's age groups or level of cognitive ability, in their feedback discussions she would take their ages into account.

Sonderwater is a settlement located within the Ikageng Township, on the periphery of the town of Potchefstroom, which is the second largest city in the North West Province of South Africa. Potchefstroom, together with its surrounding suburbs has a population of 43 448, of which 69.94% are white, 25.4% African, 2.8% coloured and 1.3% Asian. It covers an area of 162.44 square kilometers. Ikageng is a township that borders Potchefstroom with a population of 87 701, of which the racial makeup is 98% black African. Ikageng is a Setswana name that means "built yourself". During the apartheid era, this township was designated as a 'black only' settlement. It rapidly expanded into three other informal settlements, resulting in poorly developed infrastructures and sub-sections like Sonderwater, which was started in 1989. Sonderwater means "without water" in Afrikaans (51).

At the time of the study, the majority of the dwellings were shacks and there were a few houses for community members that benefitted from the Reconstruction and Development Programme (RDP) of the South African Government. The infrastructure and the socio-economic conditions in this area were very poor. The main roads joining Sonderwater and other sub-sections of Ikageng were tarred but narrow. The roads within Sonderwater were mainly gravel. The mode of transport used by this community was public transport, mainly taxis. The provisioning of basic municipality services like running water, sewage disposal and electricity was lacking in the shacks. Sanitation was also poor as a lot of households used pit-latrine toilets which were built outside the shacks. RDP houses had toilets with a flushing system. Most of the residents used paraffin stoves for cooking in their shacks. The residents of Sonderwater travelled long distances to access the nearest primary healthcare services in the neighbourhood of Ikageng. The rate of unemployment in this setting was very high and most households depended entirely on social grants for income..

### 3.3.1 Language, culture and beliefs

The residents of Sonderwater are *Batswana. Motswana* (singular) or *Batswana* (plural) are a Bantu-speaking people of South Africa.. Setswana, as spoken by the community of Sonderwater, is one of the eleven official languages in South Africa, and it is recognized by the country's constitution (52).. *Lobola* negotiations take place before the traditional wedding to determine the amount for the bride-wealth payment (53). It isassumed that because of the low socio-economic status of Sonderwater, the majority of couples in this area opted to cohabitate as they could not afford the lobola payments.

### 3.3.2 Research site

The research was conducted at an Early Childhood Development (ECD) Centre which was situated in Sonderwater, a low socio-economic community within Ikageng. Considering that poverty was rife in this setting, the centre was thus poorly resourced. The resources for the running of the centre were financed by a church based in another suburb within Potchefstroom. There was one ECD practitioner and a general worker employed at the ECD centre. The church also funded the salaries for the ECD practitioner and the general worker. Each child contributed R70.00 per month for fees. The ECD centre also received donations from the North West University (Pukke) students, as part of their community service projects. The building was constructed from steel and corrugated iron. It had an outside tap that had various uses including water for meal preparation. There was one pit-latrine toilet which was shared by the children, the ECD practitioner and the general worker. The outdoor play area was small and only had a swing and a slide.

This ECD centre had a capacity of enrolment for 25 children with age ranges from three to five years. The primary caregivers of these children were interviewed to establish their role in the stimulation of their children, including their involvement in this ECD centre. The ECD practitioner taught these 25, three to five-year-old children that were enrolled at the ECD centre. There was only one classroom where these children were grouped in their desks according to their ages.

During teaching, the practitioner presented a single topic across all age groups. She then graded the tasks and the discussions according to the children's age groups or levels of performance with regards to educational tasks. The language of instruction at the ECD centre interchanged between Setswana and English as the ECD practitioner was IsiXhosa-speaking but able to speak Setswana. The general worker was responsible for preparing porridge for the children in the morning and a snack at midday, which was often bread and cool-aid drink. Her other duties included cleaning of the ECD centre. The general worker also collected water in a basin and added dishwashing liquid. The children took turns to wash their hands in that one basin before they could be served a meal or after using a toilet

## 3.4 SAMPLING

### 3.4.1 Sample size, selection and criteria

The study used non-probability sampling, given that it investigated specific problems at a particular place. It aimed to establish the perceptions of caregivers of children enrolled at a specific ECD centre so as to address their problems accordingly. All the caregivers of the children enrolled at the ECD centre at the time of research, qualified as participants as they had knowledge over the phenomena of interest. Qualitative sampling is purposive (or purposeful) when it aims to select appropriate information sources to explore meanings (48). Purposive sampling is used to identify and select information-rich cases for most effective use. Individuals or groups that get selected are knowledgeable and experienced about the phenomena of interest. They are also available and willing to participate and to communicate their opinions in a reflective manner (54). The caregivers at the ECD centre were considered as information rich sources as they would best be able to describe their own experiences, ideas and perceptions about their children's development.

The study population consisted of all the primary caregivers of the children attending this ECD centre. There were 25 learners enrolled in 2015, aged three to five years. The inclusion criteria were a primary caregiver of a child enrolled at the ECD centre volunteering to participate and giving consent for an audio-recorded interview. All caregivers that were willing to participate were given the opportunity, regardless of age or gender. The only exclusion criteria was that only one caregiver per child would be interviewed. Thus, if a mother and a father volunteered only one of these volunteers would be included in the study.

The researcher held a meeting with all the caregivers and the ECD practitioner to explain the research and to allow caregivers to volunteer participation (discussed again under research procedure). From this meeting, eight caregivers volunteered to participate. After the meeting, the ECD practitioner assisted the researcher in identifying the primary caregivers according to the required age-group of the children. In order to have a fair representation of the population, the researcher wanted to ensure that all three the age bands (three-year-olds, four-year-olds and five-year-olds) were represented. Therefore, with the help of the ECD practitioner, a further two caregivers were actively recruited in order to represent the five-year-old age band adequately. No father and mother pairs volunteered for the study so the exclusion criteria did not need to be applied. The final sample size, therefore, consisted of 10 caregiver participants between the ages of 21 and 46 years. The gender included one male and nine females. Three caregivers for three-year-olds, five caregivers for four-year-olds and two caregivers for five-year-olds were included in the study.

The ECD practitioner was also invited to participate in the study in order to provide an alternative view from the caregivers and to provide the opportunity to triangulate data collected in the caregiver interviews. The ECD practitioner was female.

Thus, in total, 11 interviews were conducted.

## 3.5 DATA COLLECTION INSTRUMENTS USED

### 3.5.1 Demographics questionnaire (Addendum G)

All participants completed a demographics questionnaire before commencing with the semi-structured interview. This form collected information on the partipant's gender, level of education, source of income and means of earning the income. Information on the size and type of housing was asked and this included the number of occupants in the household. Further questions included the number of children that the caregiver was looking after, how many were attending the ECD centre and their ages.

### 3.5.2 Semi structured interviews (Addendum A)

An existing developmental checklist was downloaded from a paediatric occupational therapy website (55). The criteria used was a checklist for each age group, covering all domains of development.

The checklists that were validated for the South African context did not provide sufficient details under the domains. The questions of the checklist were translated by a language professional into Setswana (Addendum J) and kept as notes by the researcher. This allowed uniformity in explaining areas that were difficult for the participants to understand. The translated questions were checked by the researcher and the Setswana-speaking supervisor to ascertain that meaning was not lost. The developmental checklist (Addendum C) was used to introduce the caregivers to the concept of developmental milestones, as it was considered that the concept of developmental milestones might be an unfamiliar to them. The developmental checklist provided context for the interview questions on development and it also provided a way of opening the interview and building rapport with the caregivers. Thus, the checklist was utilized as a springboard for the interviews with the caregivers. The developmental checklist items were discussed with participants and the researcher demonstrated with pictures on areas that the participants were not familiar with. The children were not assessed during the interviews with the caregivers.

The caregivers were Setswana-speaking therefore the interview guide (introductory, two key and probing questions, which included description of daily routine (Addendum A) was developed in English then translated into Setswana and the interviews were conducted in Setswana. The translated questions were verified by a Setswana competent supervisor. One interview with a caregiver was piloted, recorded and transcribed. The transcription was discussed with the supervisor to ensure that the questions were probing enough to obtain rich data. The ECD practitioner was interviewed in English (Addendum B) as her home language was IsiXhosa. The information sheet for the participants (Addendum L) as well as the consent forms (Addendum M) for participation and audio recording (Addendum N) were translated into Setswana so that they could be read out to participants considering their low levels of education. The Setswana participants' demographics forms (Addendum O) were completed prior the interviews.

Face to face, semi-structured interviews with ten caregivers and one ECD practitioner were conducted at the homes of the interviewees. The interviews were audio-recorded and transcribed verbatim in Setswana to ensure protection against bias and to provide a permanent record of the interview (56).

## 3.6 DATA COLLECTION PROCEDURES

Permission to carry out research at the ECD centre was obtained from the management at the local church that funded it (Addendum H). The ethics approval to conduct research using human subjects, was awarded by the Human Research Ethics Committee (Medical), with clearance certificate number: M150916 (Addendum I). Authorisation to utilize the ECD centre for a meeting venue was granted by the ECD management. A meeting was then held to inform the caregivers and the ECD practitioner about the study. The research aim and procedures were discussed in that meeting. All caregivers that met the criteria were invited to participate. At the end of the meeting, the participants that volunteered to be interviewed completed the demographics questionnaire (Addedum G) and signed the forms for informed consent (Addendum E) and consent for audio recording (Addendum F). Arrangements were made with the participants for interviews to be conducted in their homes. Appointments were then scheduled for interviews with the ECD practitioner and the participants that signed the consent forms. Each interview (Addendum A) was scheduled to take thirty minutes to an hour, which included discussion of the developmental checklist and completion of demographic forms prior the session. The recording device from the occupational therapy information technology department was signed out for the duration of the data collection. During the interview, the seating plans differed for each household, but the interviewer and interviewee sat next to each other and placed the recording device discreetly between them. The seating arrangement was less formal, which put the interviewee at ease and allowed maximum participation.

In order to promote good interview practice, the researcher began with the introduction, outlined the purpose of the interview and its intended format and structure. The interview started with the participants discussing the developmental checklist with the researcher. This provided the caregivers with an opportunity to explore the concept of developmental milestones and to provide a springboard for the main interview. In order to increase the quality of the interview and obtain rich data, a rapport was established by starting the interview with questions that the interviewee could answer easily then proceeded to more difficult ones. During the semi-structured interviews, the interviewer used an interview guide with specific questions that were organized by topics but were not necessarily asked in a specified order. The order of the questions was determined by the flow of the interview. Probing and follow-up questions were asked in order to gain additional information. The interviews lasted 20 to 40 minutes.

The ECD practitioner was interviewed in order to obtain her views on the involvement of caregivers on stimulation of milestone development and to provide detailed information about the context. The ECD practitioner was also interviewed at her home, as with the caregivers, the auido recording device was positioned in the middle.

Field notes about observations, reflections and ideas were taken during and immediately after each interview. Observation that were made included the body language, the household structure, and interaction with the interviewer. These were noted at the back of the interview schedule for each participant. These observations made during the interviews were summarized in the results chapter Reflections were made during and after the interveiew and a reflexivity statement was compiled, which summarized the reflections of each interview. When all question areas had been covered, the interview drew to a close to provide an opportunity for the interviewer to paraphrase or share the main points that had been discussed. The interviewee was allowed further to add information or correct inaccuracies in the interviewer's interpretation of responses. Interviews from the primary caregivers and the ECD practitioner, field notes, as well as the literatuere review are regarded as a form of triangulation. Bailey (2007) states that data from multiple sources of information can be triangulated. The purpose of multiple sources of data is corroboration and converging evidence (57).

To manage the data, the researcher listened to the audio records to make sense of the data from the interviews. The data was transcribed by a transcriber from audio to text. For the cleaning process, the researcher compared the audio recordings with the text. The errors were then identified, and the transcripts were modified before the data was analysed. The data was stored on the researcher's computer hard-drive, which is password protected.

## 3.7 DATA ANALYSIS

### 3.7.1 Thematic analysis for semi-structured interviews

Braun and Clarke (2006) describe thematic analysis as a technique for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and gives a description of data set in detail. Themes encapsulate something important about the data, in relation to the research question, and represent some level of patterned response or meaning within the data set. Themes

can be identified in an inductive or 'bottom up' way. An inductive approach means themes recognized are strongly linked to the data themselves. Inductive analysis is therefore a process of coding the data without trying to fit it into a pre-existing coding frame (58). The initial analysis of the data was done in Setswana and reviewed by Setswana-speaking supervisor. The inductive approach was followed in this research where themes had a direct link to the data from the interviews.

Erlingsson et al. (2017) elaborated the phases that were followed in the analysis of data (59). Verbatim transcriptions of interviews were prepared from the audio-recordings by a professional transcriber. The field notes from interview observations as well as a summary of reflections (reflexivity statement) were typed and presented at the end of the results chapter. A general sense of the results was obtained by finding trends across all transcriptions. At this step the researcher gathered the general impression of what the participants reported. Through the use of an Atlas.ti8 software, codes were developed by taking the text data into categories and labeling the categories with a term. A list of topics was then formulated, and similar topics were clustered together. The number of categories was reduced by grouping those that related to each other. At the description phase, codes were sorted into themes, becoming the major findings of the research. These were given headings which were supported by diverse quotations and specific evidence.

During the analysis process, information was further grouped around participants' demographics (obtained from the demographic questionnaire), the description of daily routines (obtained from the first question of the interview) and the results that answered the objectives (obtained from the rest of the interview).

Themes and codes were translated from Setswana to English by the researcher. The Setswana supervisor reviewed the translations to ensure that the meaning has been retained. The English translations were back translated into Setswana by an independent consultant (recruited from the Occupational Therapy Department) to ensure accuracy. The final English version was then reviewed by the English supervisor. In the end, the headings were represented into tables. The interpretation phase allowed meaning of the data to be derived and the findings compared with information from the literature.

## 3.8 RELIABILITY AND VALIDITY: TRUSTWORTHINESS

Data trustworthiness can be evidenced by transferability, dependability, confirmability and credibility (60). For increasing transferability of the study, the data analysis provided detailed descriptions which allowed 'fit' with other contexts. Purposive sampling permitted a deeper understanding of a specific problem as the participants that were selected, possessed qualities that included extensive knowledge and experience in the phenomena being researched. These caregivers had the best knowledge gained from their own experience as caregivers in a low-resourced community. They could therefore offer the best information regarding their own perceptions as people are considered as experts of their own experiences and thus perceptions. The use of the information-rich participants within their context, provided a platform for other researchers to decide if the findings can be generalized.

The credibility of the study was enhanced by ensuring that the procedures implemented included methodology triangulation from different data sources used, which included interviews from the caregivers and the ECD practitioner. The literature review also formed part of the triangulation. The credibility of the research was enriched by involving the Setswana-speaking supervisor as a co-coder during the analysis of the data. The English-speaking supervisor confirmed the interpretation of the Setswana coding process.

Field notes were kept throughout the interviews to ensure reflexivity. Reflections were continuously maintained by the researcher and the summary of the reflection was provided in the results chapter. The researcher also had numerous reflective supervision sessions with both supervisors, who questioned and probed the researchers own thoughts and biases regarding the study and guided reflection on results.

The dependability of the study was also enhanced through triangulation. Synthesised member checking, where the results were discussed with the participants, confirmed the accuracy of the findings. Bert et al. (2016) confirms that synthesized member checking takes into account the constructed nature of knowledge by giving the participants opportunities to engage with and comment on the interpreted data, some months following their semi-structured interviews (61). The primary caregivers and the ECD practitioner were invited to the ECD centre where the research findings were presented. The themes, categories and subcategories were presented in a table form with a brief description of each theme, category and subcategory. The particpants were given an opportunity express their opinions on the interpretation of the results and to confirm whether this did indeed represent their

views and opinions.

Contrary, negative or discrepant information that countered to the themes was presented in the discussion chapter.

For confirmability, the research report was viewed by a peer for the control of researcher bias.

## 3.9 PROCEDURES TO ENSURE ETHICAL CONSIDERATIONS IN RESEARCH WITH HUMAN

The permission to conduct the research was obtained from the leadership of the church that managed the ECD centre. The approval of the research protocol was attained from the Health Science Faculty. Ethics clearance code - M150916 was acquired from the Human Research Ethics Research Committee (Medical). Informed consent was obtained from all participants prior to the interviews. The information sheet was discussed with the participants and they were made aware that the method of data collection would be face to face interviews and that participation in the research was voluntary and refusal to participate or withdraw at any time would lead to no foreseeable consequences. Consent to audio-record the interview was obtained from the participants that had volunteered to participate. At the start of each interview, the interviewer verbally explained to the interviewee that the reason for recording the interview was for data collection. Information provided by the research participants was treated with confidentiality and anonymity in respect of their rights to privacy, was maintained by using pseudo names when reporting the results.

# 4 CHAPTER 4: RESULTS

## 4.1 SUMMARY OF PARTICIPANTS' DEMOGRAPHICS

Ten primary caregivers and the ECD practitioner were interviewed as research participants. The demographics are outlined in table 4.1 (a) and 4.1 (b). Each participant has been assigned a pseudonym to ensure confidentiality and to protect the participants' identities.

**Table 4.1 (a)**

| Pseudonym | Gender | Age (years) | Age (in years) of child at ECD | Education level |
|---|---|---|---|---|
| **Kagiso** | Male | 35 | 5 | Grade 11 |
| **Neo** | Female | 25 | 5 | Grade 4 |
| **Disebo** | Female | 39 | 4 | Grade 6 |
| **Lerato** | Female | 26 | 4 | Grade 9 |
| **Thato** | Female | 23 | 4 | Grade 7 |
| **Dimpho** | Female | 42 | 4 | Grade 10 |
| **Boitumelo** | Female | 21 | 4 | Grade 9 |
| **Tebogo** | Female | 40 | 3 | Grade 2 |
| **Mpho** | Female | 24 | 3 | Grade 12 |
| **Dineo** | Female | 26 | 3 | Grade 12 |
| **Zizo** | Female | 46 | None | NQF Level 4 (ECD) |

**Table 4.1 (b)**

| Pseudo name | Type of employment | Other type of income | Housing type | Number of rooms | Household members |
|---|---|---|---|---|---|
| **Kagiso** | No employment | Child support grant | Shack | 2 | 4 |
| **Neo** | No employment | Child support grant | Shack | 2 | 3 |
| **Disebo** | No employment | Child support grant | Shack | 3 | 6 |
| **Lerato** | Self-employment | Child support grant | Shack | 2 | 11 |
| **Thato** | No employment | Child support grant | Shack | 2 | 5 |
| **Dimpho** | Paid employment | Child support grant | RDP | 4 | 5 |
| **Boitumelo** | No employment | Child support grant | RDP | 5 | 8 |
| **Tebogo** | No employment | Child support grant | Shack | 4 | 6 |
| **Mpho** | Self-employment | Child support grant | Shack | 5 | 7 |
| **Dineo** | No employment | Child support grant | Shack | 1 | 3 |
| **Zizo** | Paid employment | None | Shack | 2 | 3 |

All the primary caregivers interviewed were Batswana, while the ECD practitioner was Xhosa. The primary caregivers' ages ranged from 21 to 40 years with seven from the ten, in their 20s, while the ECD practitioner was 46 years old. Out of the 11 interviews conducted, there was only one male. The participants' highest level of education ranged from Grade two to 12. Four of the caregivers had primary level education, the other four did not complete high school and only two of them completed matric. The ECD practitioner had level four ECD training post high school. Out of ten, seven of the participants were unemployed, two were self-employed as vendors and one had paid employment as a domestic worker. The child support grant was the only income for those that were unemployed and supplementary income for those in the category of self/paid employment. Nine of the participants, including the ECD practitioner, lived in shacks, and only two owned RDP houses. The number of family members in the household ranged between three and eleven, with children included.

## 4.2 DESCRIPTION OF DAILY ROUTINE

The caregivers described their daily routines from the start of the morning to the evening. They shared that their mornings were occupied with their caring duties, getting their children ready to attend the ECD centre. These included co-occupations in performing activities of daily living such as bathing, dressing, meal preparation and eating.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, ra tsoga, ke beye metsi, ke mo tlhapise, and then ha ke fetsa go mo tlhapisa ke be ke mo jesa instant porridge, ke be ke mo khapa, ke mo ise ko sekolong……"* **Neo** | *"We wake up, I heat up water then bath her and when I am done bathing her, I feed her instant porridge, then I walk her to school..."* ***Neo*** |

The afternoons were mainly for collecting the children from the ECD centre. Most of the caregivers did not include structured time for stimulation or carry over of activities from the ECD centre. In their view, their responsibilitity was mainly to make sure that the children had food to eat before they could go out to play.

| SETSWANA | ENGLISH |
|---|---|
| *"Fa re fithla ko ntlong, o fitlha a ja a ba a ithoballa, sometimes a bo a fitlha a sa robale, a tsaya dithoye a bapale……"* **Neo** | *"When we get home, she eats then she sleeps, sometimes she does not sleep, she takes her toys and play."* ***Neo*** |

Some families carried out the school-related tasks in the evening. The caregivers reportedly assisted the children with homework then allowed them to share what they had done at school before going to sleep.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, ha re fetsa go etsa di homework maitseboa, before re ja, ra go tswalela dikoko, ra phutha, tse di tsenang mo ntlong di tsena mo ntlong, ra tswala monyako, gongwe re bo re tsholela, ra ja, ra go etsa dirasiteishene gongwe ko kamoreng ya bone, kgotsa mo kamoreng ya rona, re tlotlelana disetori, ba a rapela ba le babedi, dithapelo tsa ko sekolong, ra robala."* ***Kagiso*** | *"When we are done with homework in the evening, before we eat, we close the chicken coup, we tidy up- the stuff that belongs in the house, we put inside the house. We close the door (lock the door) and then we dish up to eat. We then go and recite poems either in their bedroom or mine, and then we tell each other stories, they say their prayer that they have learned at school. Then we sleep."* ***Kagiso*** |
| *"Ke a mo apola, ene ha a tswa kereche o hitlha a tsena hela nako e nngwe o ya go tshameka a ise a batle le dijo ha a sena go tshameka e be nna gone a batlang dijo."* ***Disebo*** | *"I change her clothes as soon as she comes from creche. Sometimes she goes to play and does not want food. After playing then she comes and ask for food."* ***Disebo*** |

## 4.3 RESULTS

This chapter presents the findings of the ten interviews that were conducted with the primary caregivers of the children enrolled at the Living Waters ECD centre. For the purpose of presenting the results, the primary caregivers (parents / guardians / grandparents) are referred to as caregivers. The ECD practitioner at the creche is referred to as the educator. ECD centre refers to the creche where the primary caregivers have enrolled their three to five-year-old children. Pseudo-names have been used for the participants.

The study had two main objectives:

1. To explore the perceptions of primary caregivers on their roles in the stimulation of normal milestone development for their children as preschoolers in local ECD centre in a low socio-economic status community.
2. To explore the caregivers' involvement in their children's ECD centre

Three themes emerged from the data analysis summarized in Table 4.3.1.:

1. Caregivers' perception of their role in stimulation
2. Facilitators and barriers for involvement in stimulation
3. Caregivers' perception of the ECD centre

The first and the second themes will answer objective 1 and include the perceptions of the caregivers of their role in stimulation, as well as their views on contributing factors that act as facilitators and the barriers. The third theme, which focuses on the caregivers' perceptions of the ECD centre, will answer objective 2.

**Table 4.2: themes, categories and subcategories**

| THEMES | CATEGORIES | SUBCATEGORIES |
|---|---|---|
| **1. Caregivers' perceptions of their role in stimulation** | **Yes, it is my responsibility, I involve my child in activivities** | **Caring activities<br>Home activities<br>Educational activities<br>Play activities** |
| | **No, it is not my responsibility, I involve my child in nothing** | **Home activities<br>Educational activities<br>Play activities** |
| **2.** Facilitators and barriers for involvement in stimulation | Facilitators | Willingness<br>Time |
| | Barriers | Time<br>Money<br>Resources for play<br>Awareness of development |
| **3.** Caregivers' perceptions of the ECD Centre | Positive perceptions | Learning observed in a child |
| | Negative perceptions | Time<br>Resources<br>Nutrition<br>Communication |
| | Suggestions for change | Time<br>Resources<br>Nutrition<br>Communication<br>Improved teaching<br>Improved caregiver participation<br>ECD centre fees<br>Caregiver support |

Since the interviews with the caregivers were conducted in Setswana, the original quotes will be presented in Setswana to maintain the participants' voices. Alongside each quote is the English translation of the participant's words.

Two themes emerged from the data that relate to objective 1. These themes will be reported individually below:

## 4.4 THEME 1: CAREGIVERS' PERCEPTION OF THEIR ROLE IN STIMULATION

Theme 1 explores the perception of the caregivers on their role in the stimulation of their children. In expressing their perceptions on their role in stimulation, the majority of the caregivers regarded stimulation of child development as their responsibility. A few of the caregivers did not consider stimulation as their responsibility.

Category 1 encompasses the majority of the caregivers, who regard it as their responsibility to stimulate their children and they do so by involving them in various activities being; care, home / house chores, educational / school-related tasks. They also interact with them during play.

Category 2 represents the minority of the caregivers who do not see it as their duty to stimulate their children. As a result, they do not engage their children in any activities.

### 4.4.1 CATEGORY 1: YES, IT IS MY RESPONSIBILITY, I INVOLVE MY CHILD IN ACTIVITIES

The majority of caregivers felt that it was their responsibility to ensure the development of their children and that they did this by including their children in a number of different types of activities. Their expression of responsibility was through the activities they did with their children. Thus the subcategories of caring, home, education and play activities contributed to the caregivers understanding of what their responsibility entailed in ensuring that their children grew and developed.

#### 4.4.1.1 Caring activities

Some of the caregivers found the parenting role of caring for their children as the major responsibility in their upbringing. The participants felt that the parenting occupations, which gave them meaning, included preparing their children for school in the morning and assisting them with their personal management activities such as bathing and dressing.

| SETSWANA | ENGLISH |
|---|---|
| *"Oho, ga a ya sekolong, ke a tsoga vroeg ka mo tlhapisa, ka mo jesa breakfast each and* | *"Ohh when she goes to school, I wake up early to bath her and then give her breakfast each and every day and take her to crèche, she* |

| | |
|---|---|
| *everyday, ke mo isa ko kereche, ka one oclock ngwana o tswa ko kereche."* ***Dineo*** | *comes home from school at one o clock."* ***Dineo*** |
| *"Mme, ke mo bankanya sentle hela ha a ya sekolong."* ***Disebo*** | *"Ma'm, I only prepare him properly when he goes to school."* ***Disebo*** |
| *"Mole, ha a bona gore ke mo shebile hela, o tla bo a re: "mama ntlhapise ke batla go ya sekolong". Ke mo tshelele metsi ke mo tlhapise a ye sekolo……..."* ***Lerato*** | *"Later, when he realizes that I am just looking at him, he would say "mom, please bath me I want to go to school." I would run him water and bathe him then take him to school."* ***Lerato*** |

A few of the caregivers' occupational roles continued after they had fetched their children from the ECD centre. Their caring activities included meal preparation to ensure that their children had food before they could engage in play.

| SETSWANA | ENGLISH |
|---|---|
| *"Ke hitlha hela ke cleaner ke mo apela ka gore nako e nngwe ngwana le ha ba jele ko sekolong o fitlha a batla dijo….."* ***Disebo*** | *"When I arrive I go straight into cleaning (tidying up) and preparing him food because at times even if they ate at school, children would want to eat when they get home."* ***Disebo*** |

#### 4.4.1.2 Home activities

A large number of caregivers reported that they involved their children in household tasks including cleaning, sweeping and washing the dishes. As co-occupations, these activities were performed within the same spaces where the caregiver physically engaged the child in the same chores they were busy with.

| SETSWANA | ENGLISH |
|---|---|
| *"Wa nthusa, ha ke tshwere lefielo mole ke fiela le ene wa fiela ko ntle, ha ke tlhatswa dikotlolo o batla go nthusa go phimola….."* ***Dineo*** | *"She helps me, when I am sweeping in the house she also takes the broom to help me sweep. When I wash the dishes she wants to help me dry them..."* ***Dineo*** |
| *"Fa ke tlhatswa dikotlolo mo ntlong o tla bo a nthusa go tlhatswa dikotlolo le ha ke kolomaka o tla bo a tsaya lefielo a kolomake."* ***Mpho*** | *"When I wash the dishes she would help me with cleaning the dishes, when I clean she would take the broom to help me sweep."* ***Mpho*** |

| | |
|---|---|
| "*Le go tlhatswa dikotlolo. Ha ke ga metsi, o tla bo a re: "Mama, ke go thuse go ga metsi."* ***Lerato*** | Even to wash dishes, when I fetch water, he would say, "mama, can I help you to fetch water?" **Lerato** |

One of the caregivers expressed challenges in her attempts to involve her child in home activities, as the child was not interested in participating in house chores.

| SETSWANA | ENGLISH |
|---|---|
| ***"****Ga a rate go thusa mo ntlong……o botswa."* ***Mpho*** | *"He does not like helping out in the house……..he is lazy."* ***Mpho*** |

Another caregiver shared that she got discouraged to involve her child in home activities as the child did more harm than good. Instead of playing her role in the co-occupation, the child rather played with the objects.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, go bua nnete fela nna ha ke mo tsenye, bo obuti ba gagwe ba rata go mo tsenya. Jano yena o rata go dira dilo tsa bo stout, ke ka moo ke sa mo tsenyeng mo go tlhatsweng bo dikotlolo. Ga a tshwanetse a tlhatswe dikotlolo yena o tshameka ka metsi."* ***Dimpho*** | *"To tell the truth, I do not involve him, his brothers involve him. But he likes being naughty, that is why I do not involve him in washing dishes. When he is supposed to wash the dishes, he plays with the water."* ***Dimpho*** |

#### 4.4.1.3 Educational / school-related activities

The caregivers indicated that they assisted their children in school-related tasks when they had identified the areas where the children struggled. This included stimulating the children in improving their abilities such as pencil grips, scissor skills, colouring-in, rote counting, writing their names as well as naming basic colours.

| SETSWANA | ENGLISH |
|---|---|
| *"O na le go tshwara pensele jaana, ra mo ruta gore pensele e tshwariwa jang. Ee, tlhola ke mo ruta gore ha a tshwere sekere o khata jang and o kgona go khata. Le boloko ha e le jaana o kgona go e khata smart a bo are ke mo tshasetse ka moo a matarise. Ee."* ***Disebo*** | *"He tends to hold the pencil this way, we teach him how to hold the pencil. I always teach him how to cut when he is holding the scissor, and he is able to cut. Even when the block is like this, he can cut smartly, then he will ask me to smear so he can paste, yes."* ***Disebo*** |

| | |
|---|---|
| *"Ke mo ruta mebala ko ntlong jaaka a itse gore o itse mebala e meraro, o tshwanetse a bo a itse mebala e metlhano, ke kgotlelela gore ke mo rute e mebedi e ke sa e itseng."* ***Mpho*** | *"I teach her colors at home as she only knows three, she is supposed to know five colors. I continue to teach her the other two colors."* ***Mpho*** |
| *"Ha ke kwala o batla ke mo rute go kwala gore ke mmontshe gore koloi e dirwa jang le sekele le gore ke mo rute gore lebitso la gagwe le kwadiwa jang."* ***Dineo*** | *"When I write, she wants me to show her how to write and how to draw a car and a circle. She also wants me to show her how to write her name."* ***Dineo*** |

The majority of the caregivers reported that they initiated the discussion with the educator about the performance of their children, they carried over the responsibility to stimulate the children on the areas that either the educator or themselves had identified as lacking.

| SETSWANA | ENGLISH |
|---|---|
| *"……Mamiseterese a ntlhalosetse gore ee, o ntse a dira sentle le ha a sa kgone go kwala sentle bo mabitso a gagwe, wa ntlhalosetsa miseterese. Re heta re kena mo ntlong ha sekolo se tswa, be ke mo kwadisa lone lebitso la gagwe."* ***Kagiso*** | *"The teachers informed that yes he does it correctly, even though he is till not able to write his name, the teacher explains to me. When we get home after school, I help him how to write his name."* ***Kagiso*** |
| *"Ka gore ke a mmontsha mo diphosong, ka bona mo dipampiring tsa gagwe gore o 'lack" kae, le gore ke a mmotsa gore se ke eng, wa tlhaloganya, mo a sa tlhaloganyeng teng ka mo bontsha, gore se ke jaana, le go bala ke ntse ke mo rotloetsa go ya ko pele, gore o go felela mo go 10 ga se mo go felelwang teng o tshwanetse go balela go ya pele."* ***Dineo*** | "*Given that I show her where mistakes are, I can see from her papers where she lacks, and also that I show her what things are, she understands. Where she does not understand I explain to her, even counting, I encourage her to do better, that stopping at ten is not where it ends, she has to count on."* ***Dineo*** |
| *"Ee. Like go tla le dibuka le dipampiri tse ba tlholang ba ba fa tsone ko sekolong ba sa mo ruta go khalara, ke mo ruta go khalarela sentle."* ***Neo*** | *"Yes, like to bring the books and the papers that they give them at school, I teach him colouring-in if they did not teach him."* ***Neo*** |

In another instance, a caregiver was the one that involved the child in educational activities. However, the child often resisted and preferred to engage in other play activities with peers or siblings.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, ha ke tshameka ke a mo bitsa le ene, go re, ga o batle go tshameka le nna, ke paka di-puzzle, ke a teroya, ke a khalara. Ee o tla mpolelela gore ee papa, re tlo go khalara, of ke santse ke tshameka le bomokgotsi ba ka bolo. Ka nako ya go etsa di-home work tsa ga ausi wa ka, le nna ke tla be ke le teng."* ***Kagiso*** | *"When I play, I call him to come play with me. We play with picture puzzles, we draw, we color in pictures. He will tell me yes dad, we will color, or I am still playing soccer with my friends. When it is time to do my sister's homework I will be home too."* ***Kagiso*** |

Some of the children initiated the engagement with their caregivers when they struggled to complete their educational activities. The caregivers in this instance reported that they contributed to their learning by engaging the children and showing how the task needed to be done. When the children got home from creche, some of the caregivers made time to listen to their children as they reported on the activities they had done for the day at the creche. They went over the same activity in order to re-enforce the knowledge the children had acquired from the ECD centre.

| SETSWANA | ENGLISH |
|---|---|
| *"Maybe ha a batla go teroya katse, wa mpotsa mama tla o mpontshe gore katse e diriwa jang, ke a mo bontsha ke bo re tsaya le wena o ko o dira jaana o bo o dira jaana."* ***Disebo*** | *"Maybe when he wants to draw a cat he asks, mama, please show me how to draw a cat. I show him then I say you too should do the same."* ***Disebo*** |
| *"…….Le ga a kwala o tlhola a tla go mpontsha, le ga a sa ngwala dilo tse di tlhakileng, wa mpontsha a re mama bona ke teroile motho, bona ke teroile eng. Wa mpotsa gore a ntshelle tee, ke be ke re ee, akere ke ngwana."* ***Dimpho*** | *"…….Even when she writes, she would often show me, even though her writing is not clear, she would come and show me and say Mama look, I have drawn a person, look at what I have drawn. She would ask if she can pour me tea, then I would agree, she is just a child, is it not so?"* ***Dimpho*** |
| *"Ene ha a tshameka ka tsone, o di tsaya tsotlhe a di fodisa fa fatshe. A bo a mpotsa gore mama colour e e jang, be ke mo bolelela, e e jang, be ke mo bolelela. Ha a fetsa a bo a di bua tsotlhe a sa mpotse."* ***Disebo*** | *"When he plays with them (toys), he takes them all and lines them on the floor. Then he would ask me to name the colours, I would tell him what the colour is, I tell him. At the end he names them all without asking for my help."* ***Disebo*** |

A few of the female caregivers expressed that the fathers of the children got involved in stimulating school-related activities. They further added that the children often shared the tasks that they had

done at the ECD centre with their fathers. The fathers also played a role in stimulating other developmental areas like gross motor skills.

| SETSWANA | ENGLISH |
|---|---|
| *"Ka one o'clock ngwana o tswa ko kereche, ka dula le ene hatshe ka mo botsa gore o dirile eng, ke cheka dipampiri tsa gagwe ka di saena. Later papa wa gagwe wa chaisa o tla mo bolelela gore Papa ke dirile one, two, three, four, five, papa wa gagwe a shebe, le ene wa saena mo godimo ga moo."* ***Dineo*** | *"She comes home at one o'clock from school and we sit down and I ask her what she did at school, I check her papers then sign her papers. Later when her father comes home from work, she will tell him daddy, we did this and that. Her father will check and then he will also sign."* ***Dineo*** |
| "Ntho e a sa e rateng thata ke di-sport mare bolo le baesekele ke tsone tse a di ratang thata and le papa wa gagwe thata o mo ruta go tshameka bolo. Ee, le ka tlhogo wa e betsa. Ke papa gagwe a mo rutang dilo tseo. Papa wa gagwe ene o mo ruta dilo tse ngata thata……." ***Disebo*** | *"The thing that he does not like a lot is sport, but he does like riding his bicycle and playing soccer. His father teaches him how to play soccer. He can even hit it with his head. His father teaches him that, his father teaches him a lot of things."* ***Disebo*** |

#### 4.4.1.4 Play activities

In this sub-category, the caregivers shared that they interacted with their children during play. The children invited the caregivers to join them in their play and this granted them opportunities to stimulate the children. The caregivers also took the initiative to invite their children, so they could interact in these stimulating activities. The co-occupations they engaged in included activities like skipping rope, playing 'hoola hoop', soccer, and building puzzles.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, jaaka bo kgati jalo, re bo re e tshwarisana, re tlole, ke mo rute le go tlola jaana, le bo hula hoop, wa itse gore hula hoop e dirwa jang a tshikinye letheka."* ***Dineo*** | *"Yes, just like skipping rope, we hold it together and skip. I show her how to skip, as well as hoola hoop, she knows how to play a hoola hoop, moving her waist."* ***Dineo*** |
| *"Ee, o tlhola a tsaya dikopi tsa gagwe le diketlele tsa gagwe tsa go tsameka, mo mosong a re o re tshella kofi. Le ga a kwala o tlhola a tla go mpontsha, le ga a sa ngwala dilo tse di tlhakileng, wa mpontsha a re mama bona ke teroile motho, bona ke teroile eng. Wa mpotsa gore a ntshelle tee, ke be ke re ee, akere ke ngwana. O tlhola a tsaya pampers a re o phamphasa ngwana. A kuka ngwana a tla* | *"Yes, she often takes her play cups and kettle, in the morning she makes us coffee. Even when she draws, she would come and show me, even though the drawings would not be clear, she would show me and say mama, look I have drawn a person, look what I have drawn. She would offer to make me tea, and I would accept, she is just a child, isn't it? She often takes a diaper, saying that she is* |

| | |
|---|---|
| *go mpha, a re ke mo fe letsele. Ke be ke mo fa yena ke re a mo pepe."* ***Dimpho*** | *changing the baby's diapers. She picks up the baby(doll)to give to me, asking me to breastfeed. I would give her the baby(doll) back asking her to carry it on her back."* ***Dimpho*** |

One of the caregivers reported that their child did not often involve them in play; neither did they involve their child in house chores. Co-occupations took place rarely, when the caregiver had created time.

| SETSWANA | ENGLISH |
|---|---|
| *"Hangata ena o bapala a le mong, ha a nke a tlaletlale mo setareteng mo, ke mo fe dintho tsa hae ke di beye fatshe hore a bapale mare nako e nngwe ha kena le nako ke ye ke bape le ena re bapala re le babedi."* ***Teboho*** | *"He often plays by himself, you will not find him playing in the streets. I usually give him his toys, I put them down and allow him to play. And sometimes, when I have time I sit next to him and play with him."* ***Teboho*** |

The male caregiver highlighted that there was good interaction initiated by the children if his child was involved in play with other children. The children were often on the lead and they decided on the rules of the games and they were always eager to show the adult how the games were to be played. The caregiver allowed the children to make rules, which encouraged good interaction and participation in the play activity.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee, ha ke hitlha ba tshameka bolo, ra tshameka bolo. Se ke sa se itseng le bone se ba se tlhaloganyang ke gore nnyaa re tshameka bolo jaana, le wena o tshwanetse o tshameke jaana. Nna ha ke itse mpontsheng, ba bo ba mpontsha tse dingwe tsa metshameko ya bone e ke sa e itseng gore e tshamekiwa jang. Tse dingwe ke a ba bontsha, a re beyeng dipala jaana, re tshamekeng jaana bolo."* ***Kagiso*** | *"Yes, when I find them playing soccer, we play together. When there is something that I am not doing correctly, I would ask for assistance and they would show me how to do it. When they are playing games which I do not know how to play, they would orientate me. I do the same with games that they do not know how to play."* ***Kagiso*** |

One of the caregivers shared that in her view, her main responsibility was to ascertain that her child played on safe grounds. As her child participated in play with other children, her roles in the

co-occupation included supervision and observation but not physical involvement in the play activity.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke na le gore ke tswe ke shebe gore ba tshameka ka dilo tse di ntseng jang, le gore ha ba tswile ba ile ko kae, ke available all the time gore ke kgone go bona safety ya ngwana, gore ngwana o tshameka mo mannong a a siameng or jang."* ***Dineo*** | *"I sometimes go out to observe the kind of things they play with, and also where they have gone to. I am available all the time to oversee the safety of the child, and the type of surrounding that the child is playing on."* ***Dineo*** |

The caregivers observed their children during play. One of the caregivers reported that the children engaged in rough play.

| SETSWANA | ENGLISH |
|---|---|
| *"Ke motho ya rofo, ke hore ntho e nngwe le e nngwe e a etsang, o e etsatsa borofong, re phela ka ho kgalema"* ***Teboho*** | *"He is a rough person, he plays rough, he does everything in a rough manner. We are constantly reprimanding him."* ***Teboho*** |

A few of the caregivers shared that their children often played in the streets (outdoor play) without supervision or involvement of the caregivers during their play time. However, the caregivers highlighted the importance of supervision during outdoor play as they felt that the children were inclined to engage in rough play.

| SETSWANA | ENGLISH |
|---|---|
| *"Ijoo o rata seterata thata. Mare o se rata hela ha go ka tshamekiwa dibolo or a bona bana bangwe ka dibaesekele or disekuta jaana, le ene o tla ba tsenya sekuta sa gagwe mo tseleng."* ***Disebo*** | *"Yoh! He enjoys playing outside in the streets. But he enjoys it more when they play soccer or when he sees other children with bicycles or scooters, then he would take his scooter into the road too."* ***Disebo*** |
| *"Verdere ke mabile a dibaesekele, tse a etsang dikoloi ka tsone ko ntle, a tshameka ka tsone ko ntle"* ***Teboho*** | *"Furthermore, we have bicycle wheels, he drives them like cars when playing outside."* ***Teboho*** |

### 4.4.2 CATEGORY 2: NO, IT IS NOT MY RESPONSIBILITY, I INVOLVE MY CHILD IN NOTHING

Category 2 is derived from the group of caregivers that did not regard stimulation as their responsibility. These caregivers did not involve their children in any activities in the home, educational or play and left the responsibility of stimulation to the ECD practitioner.

#### 4.4.2.1 Home, play and educational / school – related activities

A minority of the caregivers expressed that they did not involve their children in play and home activities. They added that in their daily routine, they did not take time aside to follow up on what the children did at the ECD centre. In their view, all was well with regards to educational / school-related tasks, therefore there was no need for further stimulation at home.

| SETSWANA | ENGLISH |
|---|---|
| *"Nnyaa, ha ke le busy o tla bo a le ko ntle kwa. Ha ke apaya o tshamekela ko ntle, ha ke mo tlhapisa o dula stele till ke fetsa go mo tlhapisa."* ***Thato*** | *"No, when I am busy he be would outside. When I am cooking, he plays outside, when I bath him, he sits still I finish bathing him."* ***Thato*** |
| ***"…..****Re bo re sa etse niks re itulela fela"* ***Disebo*** | *"……Then we do nothing, we just sit."* ***Disebo*** |
| *"…..Nnyaa, nna ke bona hela go le shapo hela, go le right."* ***Disebo*** | *"…….No, to me it is just ok, it is alright."* ***Disebo*** |

One of the caregivers shared that they got involved with the children during outdoor play. The games that they played with their children included soccer and skipping rope. When the children had gone away to play with their peers, then the caregiver would get busy with house chores and engage the child in play when they were home.

| SETSWANA | ENGLISH |
|---|---|
| *"Ha re feditse, ra itshamekela, bo di-puzzle, bo bolo, bo dithini, bo go tlola bo kgati, re phehe, bone ha ba ya go tshameka le bomokgotsi ba bone ke sala ke pheha. Ga ba boa koo, ba a ja, ga re fetsa go ja ke bo one, ra ja, ha re fetsa go ja, ka bo ma two, three, ke nako ya gore re tshameke di-puzzle."* ***Kagiso*** | *"When we are done, we play with puzzles, soccer, tins, skipping rope, then cook. When they go out to play with their friends, I stay behind to cook. When they come back, they eat, when we finish eating, it is already around two, three, that is the time to play with puzzles."* ***Kagiso*** |

A few of the caregivers conveyed that they did not often engage the children in play. Some of the children preferred playing alone outside if they were not playing in the neighbourhood with peers.

| SETSWANA | ENGLISH |
|---|---|
| *"Hangata ena o bapala a le mong, ha a nke a tlaletlale mo setareteng mo, ke mo fa dintho tsa hae ke di beye fatshe hore a bapale mare nako e nngwe ha kena le nako ke ye ke bape le ena re bapala re le babedi."* **Teboho** | *"Often he plays alone, he does not roam around the streets, I give him his things, put them on the floor for him to play but at times when I have time, I sit next to him and we play together."* ***Teboho*** |
| *"Ee o tshameka a le nosi."* ***Dineo*** | *"Yes, she plays alone."* ***Dineo*** |

On the other hand, one of the caregivers expressed that the did not show interest in play and the caregiver got discouraged to initiate play as the child would only participate for a short while then reported to be tired.

| SETSWANA | ENGLISH |
|---|---|
| *"Ha ke mmona a tshameka ko ntlong o rata go tshameka ka dikoloi bikinyana fela, ha a go bolelela gore o kgathetse, o kgathetse. Wa tlogela."* ***Disebo*** | *"When I see him playing in the house, he likes playing with cars just for a short time, then he would report that he is tired then stop."* ***Disebo*** |

## 4.5 THEME 2: FACILITATORS AND BARRIERS FOR INVOLVEMENT IN STIMULATION

**Table 4.2: themes, categories and subcategories**

| THEMES | CATEGORIES | SUBCATEGORIES |
|---|---|---|
| 1. Caregivers' perceptions of their role in stimulation | Yes, it is my responsibility, I involve my child in activities | Caring activities<br>Home activities<br>Educational activities<br>Play activities |
| | No, it is not my responsibility, I involve my child in nothing | Home activities<br>Educational activities<br>Play activities |
| **2. Facilitators and barriers for involvement in stimulation** | **Facilitators** | **Willingness**<br>**Time** |
| | **Barriers** | **Time**<br>**Money**<br>**Resources for play**<br>**Awareness of development** |
| **3.** Caregivers' perceptions of the ECD Centre | Positive perceptions | Learning observed in a child |
| | Negative perceptions | Time<br>Resources<br>Nutrition<br>Communication |
| | Suggestions for change | Time<br>Resources<br>Nutrition<br>Communication<br>Improved teaching<br>Improved caregiver participation<br>ECD centre fees<br>Caregiver support |

This theme describes the facilitators and the barriers that influence the involvement of the caregivers in the stimulation of their children. Category 1 examines the aspects that make it possible for the caregivers to get involved in stimulation. These include their availability and preparedness to stimulate the children. Although limited, they have resources available to facilitate play. Category 2 explores the drawbacks that discourage the caregivers from involving

their children in stimulation. These barriers include funds, time, resources for play and the caregivers' awareness of developmental abilities.

### 4.5.1 CATEGORY 1: FACILITATORS

The facilitators that enabled the caregivers to stimulate their children included willingness and time. The caregivers expressed that they were willing to stimulate their children and considering that the majority was unemployed, they had the time available to stimulate their children.

#### 4.5.1.1 Willingness

A large number of caregivers expressed willingness to stimulate their children. They added that although they did not have have access to resources or the funds to purchase them, it was their desire to engage their children in play as they understood its importance in their development.

| SETSWANA | ENGLISH |
|---|---|
| *"Maikarabelo a me ke a gore le nna ha ke le mo gae ke nne le dilo tse ke mo ruteng tsone fano e seng fela fa go tliwa ko kereche, le nna ke tlamegile ke mo thuse, ke shebe gore wa kgona go tshwarella. Nna bothata ba me ke gore ha nka mo kereyela fela bo di-colour le buka e spare ke nne ke mo rute go kwala ntho e nngwe le nngwe, like ha a tswa sekolong ba mo ruteng se itseng, ke mo bontshe gore se dirwa jaana le jaana. Ha sekolo se tswa ke tla nna ke ya go botsa mam ke mmotse gore ba ne ba etsa eng, a ntlhalosetse ene gore ke mo rute eng le eng mo ke sa itseng teng, ke thusane le ene and then ha ke mo gae ke bo ke ruta ngwana."* ***Boitumelo*** | *"My resposibility should be to teach her other things at home, she should not only learn when at crèche, I should also help her and check if she can grasp what she is learning. My challenge is, if I can just get her crayons and a spare book to teach her writing everything, like when she comes from school, when they have taught her something, I should show her how it is done. When school comes out I will ask the educator and find out what they did, she will tell me what to do, when I do not understand, I will work together with the teacher and find a solution."* ***Boitumelo*** |
| *"Ee, gone ke mo godisitse and ke ntse ke rata go mo godisa and ke ntse ke rata gore a ye ko pele, a kgone go itse tse dingwe, a tseye karolo le mo sekolong le ha go etsiwa metshameko e e ntseng jalo. Nna ga ke bone go na le bothata go mo ruta ka gore ke se ke ipoleletseng sone."* ***Kagiso*** | *"Yes, actually I raised him and I would like to raise him. I have wishes for him to progress, to learn more, to take part in school activities as well as sport activities. I do not have any problem to teach him since it is what I have decided."* ***Kagiso*** |

| | |
|---|---|
| *"Ke gore, like, fa a tlhaga sekolong go be na le sengwe se, like, ke re ba ba ruta go kwala ka matsogo a bone ke be ke kgona go mo ruta, efela go thata and o rata ho bapala."* ***Neo*** | *"It's like when she comes from school there should be that I teach her like how to write with her own hands, so I can be able to teach her, although it is difficult since she likes to play."* ***Neo*** |

#### 4.5.1.2 Time

The caregivers reported that they had ample time available to stimulate their children. The majority were home each day to fetch or receive their children from the ECD centre and then to involve them in play.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee nako e ke na le yone. Ha ke bereke akere."* ***Dineo*** | *"Yes, I do have the time. I am unemployed."* ***Dineo*** |
| *"Ke na le nako but ha ke na didiriswa."* **Boitumelo** | *"I have the time, but I do not have the resources."* ***Boitumelo*** |

### 4.5.2 CATEGORY 2: BARRIERS

This category explored the barriers that discouraged the caregivers to provide structured stimulation for their children. These barriers included time, money and resources for play. The caregivers that were employed expressed that they did not have time after work to stimulate as they had to prioritise household task. A large number of caregivers expressed that they did not have money to purchase the resources for stimulation. The resources for play included store-bought toys that if they had, could have encouraged them to involve their children in stimulation. Their limited knowledge/awareness of development discouraged them to provide stimulation for their children.

#### 4.5.2.1 Money

In this sub-category, the caregivers reported money as being their biggest challenge in acquiring the resources needed to stimulate the children. They shared that even at times when they could

access funds, they would not have enough to spare for the purchase of toys for stimulation purposes.

| SETSWANA | ENGLISH |
|---|---|
| *"….. Ee ke mathata a madi."* ***Boitumelo*** | *"…..Yes, it is financial problems."* ***Boitumelo*** |
| *"Madi ga a yo, a na le nako ya gore ke a kokoanye, ha a nna teng, a nna a shota, be ke sa kgone go ka mo rekela tsa gagwe, bo di-puzzle, bo dilo tse a di tlhokang for go tshameka."* ***Kagiso*** | *"There is no money, there are times when I am able to collect some, and when it is available, it is not enough then it does not allow me to buy him things, like puzzles and other things that he needs to play with."* ***Kagiso*** |
| *"Nnyaa, ga go na madi."* ***Mpho*** | *"No, there is no money."* ***Mpho*** |

#### 4.5.2.2 Time

The caregivers expressed that they did not have sufficient time to involve the children in stimulating activities. When the caregivers got busy, they requested their older children to stimulate the younger siblings. The caregivers indicated that they often had to juggle their time between house chores and working. This left them no time to engage the children in stimulating activities. They added that due to time constriants, co-occupations within households were not considered a priority as the caregivers hurried to complete tasks.

| SETSWANA | ENGLISH |
|---|---|
| *"Nako e nngwe ke bo se na nako a bo a nkiwa ke ausi wa hae, e nne ene a mo rutang."* ***Teboho*** | *"At times when I am busy, his sister takes the responsibility to teach him."* ***Teboho*** |
| ***"****Nnyaa, ga go na nako ka gonne nako e intse ke bo ke le busy ke kolomaka. Ha ke santse ke re ke feditse go kolomaka ke nna busy ke a rekisa, ga ke na nako ya gore nka mo ruta."* ***Mpho*** | *"No, there is no time, most of the time I'm busy cleaning. As soon as I am done cleaning, I get busy selling, I do not have time to teach her."* ***Mpho*** |
| ***"....****O tsholla matlakala ao o a kokantseng, o dira gape fail, mare a re wa kolomaka****.....****Nyaa, ke berekela go fetsa."* ***Dimpho*** | *"….She spills the garbage that I have collected, she makes the house dirty again and claims that she is cleaning…..No, I work with the aim to finish"* ***Dimpho*** |

#### 4.5.2.3 Resources for play

The caregivers reported that they had limited resources for stimulation. There were some caregivers that mentioned to have only one to two toy items available. These included balls, cars and dolls.

| SETSWANA | ENGLISH |
|---|---|
| *"Di teng mare ga di enough dithoyese tse tsa gagwe ka gore tse dingata o di ntshitse mabili."* ***Disebo*** | *"The toys are there but not enough for her, since many of them are broken and without wheels."* ***Disebo*** |
| *"O na hela le dikoloi. Ee, le bo bolo, hela qha!"* ***Thato*** | *"He only has cars. And a ball, just that"* ***Thato*** |

#### 4.5.2.4. Knowledge / awareness of development

**"Ke mo ke iseng ke mo tsotella teng" ("I have not taken notice of him doing that")**

The caregivers expressed for their first time that they became aware of developmental skills through the checklist discussed during the interviews. Many of the developmental domains were new concepts to them and they felt that they did not know how to support their children because they did not know enough about what their children should be doing, even though most of the caregivers were very willing to be involved in stimulation. They shared that they had never observed their children participate in some activities including riding a tri-cycle / bicycle and playing in the jungle gym as these were not resources they had access to.

| SETSWANA | ENGLISH |
|---|---|
| *"Dilo tse mme a ntseng a di bua tse dingwe di mphile kelello tse ding ke a qala go utlwa dilo tse mme a mpotsang tsona. Ke dilo tse eleng gore o ne o ntse o sa itse gore ngwana o tshwanetse a bo a ne a di dira ka dijara tsa gagwe."* ***Teboho*** | *"Some of the things that you are mentioning have opened my mind, there are some that you have asked that I hear for the first time. These are some of the things I did not know that a child has to be able to do at his age."* ***Teboho*** |
| *"Ke dilo tse di neng di seyo mo kelellong ya ka."* ***Teboho*** | *"These are things I never thought of."* ***Teboho*** |
| *"Nnyaa, ha ke so mo bone."*<br>*"Ga ke itse nna."* ***Boitumelo*** | *"No. I have never seen (him) do that"*<br>*"I don't know."* ***Boitumelo*** |

Some of the caregivers shared that they gained knowledge that arose from the interaction with the developmental checklist. They became aware that there are certain abilities that a child should be able to perform during their development. They felt that before this discussion of development, they did not fully understand or know what their children should be doing and therefore could not always encourage development fully.

| SETSWANA | ENGLISH |
|---|---|
| *"…that is why nna ke re ke motlotlo ka se mme a mpulang kelello ka sone for saeteng ya ngwanake, ee gore e tshwanetse gore e be e le gore ngwana o bo a dira dilo tse di rileng"* ***Dineo*** | *"…that is why I say I am happy that you opened my mind from the side of my child, yes, it must be that the child is able to do certain things."* ***Dineo*** |
| *"Mme, ntho e jwaloka ena, o motho wa botlhokwa yo a kgonang go re bula dikelello, that is why ke reng mme tiya o se ka wa etsa fela mo rona o etse le batho kaofela, ka gore ha a yo motho yo o kgonang go etsa matsapa a mme a a nkileng."* ***Teboho*** | *"Something of this nature, you are an important person who can open our minds, hence I say, be strong and not just do it for us but for others as well, because there is no one who can put the same efforts as you have done."* ***Teboho*** |

## 4.6 THEME 3: CAREGIVERS' PERCEPTION OF THE ECD CENTRE

**Table 4.2: themes, categories and subcategories**

| THEMES | CATEGORIES | SUBCATEGORIES |
|---|---|---|
| 1. Caregivers' perceptions of their role in stimulation | Yes, it is my responsibility, I involve my child in activities | Caring activities<br>Home activities<br>Educational activities<br>Play activities |
| | No, it is not my responsibility, I invove my child in nothing | Home activities<br>Educational activities<br>Play activities |
| 2. Facilitators and barriers for involvement in stimulation | Facilitators | Willingness<br>Time |
| | Barriers | Time<br>Money<br>Resources for play<br>Awareness of development |
| **3.** Caregivers' perceptions of the ECD Centre | Positive perceptions | Learning observed in a child |
| | Negative perceptions | Time<br>Resources<br>Nutrition<br>Communication |
| | Suggestions for change | Time<br>Resources<br>Nutrition<br>Communication<br>Improved teaching<br>Improved caregiver participation<br>ECD centre fees<br>Caregiver support |

Objective 2: To explore the caregivers' involvement in their children's ECD centre

Theme 3 answered the second objective which explored the caregivers' perceptions of the ECD centre. Three categories that emerged include the positive perceptions, the negative perceptions and the proposed suggestions for change. This theme emerged when the participants were asked about their involvement in the ECD centre. When answering these questions, participants

elaborated on both their positive and negative perceptions of the centre as well as spontaneously discussed how they could get more involved or suggested changes to address their negative perceptions.

Category 1 explains their positive insights, which emerged when the caregivers' observed that their children were learning to do new things.

Category 2 illustrates their negative perceptions, where they express their dissatisfaction over the aspects such as lack of basic resources like sleeping mattresses, the menu that lacks variety in the food, the operating times of the ECD centre and lastly the lack of structured communication between the educator and the caregivers.

In category 3, the caregivers' suggestions for changes that could be implemented in the ECD centre, are explored. These envisioned improvements include time, resources, nutrition, communication, improved teaching, improved parental participation, increase in the school fees as well as peer/caregiver support.

### 4.6.1 CATEGORY 1: POSITIVE PERCEPTIONS

The caregivers expressed that they noticed that their children were learning and growing since their enrolment at the ECD centre. They applauded the ECD practitioner on the good work she did in teaching their children.

#### 4.6.1.1 Learning observed in children

A few of the participants expressed their satisfaction over the learnings that they had noticed in their children's learning. They reported that there were certain developmental activities that the children could not perform, but since they had been attending the ECD centre, they were able to show improvements in certain developmental areas. Theses included colouring-in, as well as showing a good concept of colours and basic shapes. The caregivers were grateful for the good teaching from the educator as the children also shared their feedback over their positive experiences of the ECD centre and the skills they gained.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ausi ke bona since a tsena kereche jaana ke bona a dira dilo tse dingata tse di kgatlhisang. O itse le go khalisa, o itse le go buisa maina a gagwe, o itse le gore dijara tsa gagwe di kae. Last di ne di mo palela mare since a tsena kereche o itse ntho e nngwe le e nngwe. Huu! ha e sale a tsena kereche o itse di-colour tota."* ***Disebo*** | *"Ma'm, since he started going to this* ***crèche****, I have observed that he can do a lot of impressive things. He is able to colour in, he can say his names, he knows how old he is. Last time he could not do those things, but since he started attending this crèche, he knows everything. Huu! Since he started attending this he really knows how to identify colours."* ***Disebo*** |
| *"Ha ke tswa mo ntlong moo, ke a ya ko sekolong, ke fitlhe ke ba tlhalosetse, ke fitlhe ke ba leboge, ngwana ke a bona gore wa impruva, ke a bona gore se ngwana a se tlelang mo kereche ke eng. At least go na le sengwe se se, di –improvement tse dingata tse ke di bonang since a kena ko sekolong sele, ka ba latela vroeg mamisiterese ke hitlha ke ba tlhalosetsa, gore ke a itumela ebile ka leboga ka tsela e ba nthutelang ngwana ka teng, ka kgotsofala."* ***Dineo*** | *"When I leave the house, I go to school and thank them (the teachers) because I can see that the child is improving, I see what the child gets to do at the crèche. At least there are lots of improvements that I've noticed since the beginning of the year. I go to the school early so that I can express my gratitude to the teachers for the manner in which they teach my child, I am satisfied."* ***Dineo*** |
| *"Nnyaa, nna ga ke bone, le ha go na le tse di shotang mare nna ke bona ba nthutela bana ba ka sentle, bana ba ka ba rutega sentle fa ba ile teng koo. Ka gore, tse dingwe dikereche ga di rute bana. Bana at least ha ba tswa ko sekolong ba kgona go mpontsha gore "papa bona misiterese o re rutile go khalara, bona misiterese o re rutile go kwala sekele, o re rutile di-triangle misiterese and le nna ke bona gore ba kgona go di tshwarelela sebaka se setelele. Ba nkgotsofatsa the way ba rutang bana ka teng."****Kagiso*** | *"No, I don't see it that way, even if there may be things that may be left out, but I see them teaching my children well, my children gets well educated when they attend there. Since other* ***crèches*** *do not teach children, with this one, when they come from school, they are able to report to me and say, dad, look, teacher taught us coluring-in, look, teacher taught us to draw a circle, she taught us triangles and I can also see that they are able to retain the information for a long time. They satisfy me with the manner in which they teach the children."* ***Kagiso*** |

One of the caregivers expressed amazement and satisfaction in their child's competence in activities that they, themselves had not taught them, such as colouring-in without veering out of the borders of the picture.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke a itumela ka gore dilo tse ngwana a mpontshang tsone, ke dilo tse dingwe tse di* | *"I am impressed given that, the things that the child report to me, are things that are* |

| | |
|---|---|
| *makatsang, ka gore ngwana yo, ga se ngwana yo o rutilweng and o itse go khalara sentle ha a tswe le mo meleng, o itse le go teroya motho, ha re itse gore ngwana yono o rutilwe ke mang. So ke bona ngwana yono a impruva, ga ke itse gore ke ka mabaka a a ntseng jang. Ke a itumela nna ha ke bona dilo tse di ntseng jalo."* ***Dineo*** | *amazing, as this child was not taught, and he is able to colour without going outside the lines, he can draw a person, we don't know who taught this child. So I have noticed improvements in this child, I cannot state the reasons why. I get excited when I see things like that."* ***Dineo*** |

### 4.6.2 CATEGORY 2: NEGATIVE PERCEPTIONS

Despite the learning that the caregivers noticed in their children there were many negative perceptions of what was happening at the ECD centre that influenced their children's growth and that they felt made it difficult for them to participate or be involved. The biggest issue raised was that of communication between the ECD centre and the caregivers themselves, and this contributed to their apparent non-involvement. Other issues raised were those of time, nutrition and resources. The ECD practitioner also contributed to the understanding of the perceptions of the caregivers by describing what happened at the ECD centre on a daily basis. Her descriptions are added as a counterpoint against which to compare the caregivers' perceptions.

#### 4.6.2.1 Time

The caregivers conveyed their dissatisfactions over the operating times of the ECD centre, where they felt that a 13:00 closure was too early and should be extended. They had a shared concern over the safety of their children. This is because they were reliant on their neighbours to pick the children up from the ECD centre as they would still be at work. Furthermore, they expressed difficulties in running errands such as going to town as they always had to be conscious of the closing time of the ECD centre in order to collect the children on time.

| SETSWANA | ENGLISH |
|---|---|
| *"Ke gore yone e tswa vroeg and ha o tsamaya, ha o tsamaye monate. Go tshwana le ha o re o ya toropong ga o kgone go tsamaya o phutologile ka gonne o naganne ngwana fela gore kana wa tswa ka one. Ee, and ha go safe gore o ka tlhola o ya toropong maybe one e chaya o sa itse gore ngwana o hakae, o sa raya motho gore tsamaya o ye go ntseela* | *"It is because it comes out early, and when you have somewhere to go, you cannot be free. The same as if you go to town, you cannot do so freely given that you have to consider that the child gets released at one. Yes, and it is not safe to go to town as maybe it gets to one and you have no idea where the child might be as you would not have asked somebody to fetch the child on your behalf.* |

| | |
|---|---|
| *ngwana. And ya bone ha e chaile, e chaile."* ***Disebo*** | *And with them, when the time has come, it has come!"* ***Disebo*** |
| *"Maikarabelo a ke tshwanetseng gore ke a oketse ke gore ba hafola nako ya bana ya sekolo, e kare ba ka oketsa nako ya bana ya sekolo. Ee, re ba bontshe mabaka a go re jaaka bana ba rona ba bangwe ba batsadi ba a bereka, jaanong fa ba bereka jalo, ba tshwanetse gore ba kope batho ba di next-door gore ba ba shebele bana ba ye go ba tseela bana ko kereche. Ka dinako tse dingwe ha go safe, wa tlhaloganya."* ***Mpho*** | *"My responsibility is to make sure that that they do not half the children's schooling time, It is my wish that they could increase the children's schooling time. Yes, we shoud communicate our reasons as some of the parents work, as they work, they have to ask the neighbours to look after their children, to go fetch their children from crèche. At times it is not safe, you understand?"* ***Mpho*** |

The ECD practitioner described that her ordinary day at work started around seven in the morning. When the children arrived at the ECD centre, they were served soft porridge (made from mealie meal) and after eating they would engage in free play. Their routine included prayer, theme discussion and then an activity for the day. They took a break at 11:00 to play outside, washed their hands to have lunch at 12:00. Story time followed immediately after they had a meal, then they would take a nap and go home at 13:00.

> "*In the morning we…the children arrive at 7:30 and then I give them toys to play with and after that they eat their porridge, after that they do a circle, we play, and pray and after praying we do the morning ring, and after the morning ring, we do the register and after the register we do discuss our theme, after theme discussion we start our classes. After that they go out for the break at 11:00."* ***Zizo***

### 4.6.2.2 Resources

Another concern raised by the caregivers was the lack of resources at the ECD centre. Examples cited included children sleeping flat on the cemented floor without the mattresses, carpets or pillows. Moreover, the children would come home, complaining of the sore necks as a result of poor sleeping conditions.

| SETSWANA | ENGLISH |
|---|---|
| ***"****Mo samenteng, mo mmateng o plata, plat, ha go na mosamo, ha go na niks, ha go na kobo, ha go na sepe. So ngwana altyd ha a tlhaga* | *"On cement, on the flat, flat mat, there is no pillow, there is nothing, there is no blanket, there is nothing. So, a child always comes* |

| | |
|---|---|
| *ko sekolong o mpolelela gore thamo e botlhoko."* ***Dineo*** | *from school reporting that the neck is sore."* ***Dineo*** |

One of the caregivers had the opinion that the creche fees were too low to cover the expenses for the resources needed for the sleeping routine. They highlighted that they had a fear to voice this worry as the educator might explain that they could not afford to buy the resources considering that the fees were low.

| SETSWANA | ENGLISH |
|---|---|
| ***"****Ha re gane, school fees se bikinyana mare ha re nagane gore... ha se rona re tlhophileng go ntsha di R70 tse tsa school fees. Ke bone ba re beetseng, jaanong ekare ha re ripota, ba tla re bolelela gore chelete e bikinyana go etsagalang, go etsagaleng."* ***Dineo*** | *"We do not disagree; the school fee is low but if we think that….it was not us that chose to pay R70 for the school fees. They are the ones that decided on the price, therefore it is possible that if we may report, they will tell us that the money is too little, this and that, this and that."* ***Dineo*** |

The ECD practitioner reported that the ECD centre had basic educational materials like scissors, blocks, paint and crayons. She added that the parents did not contribute financially towards these materials, they received donations from the church

"*There is no contribution from the parents*." ***Zizo***

#### 4.6.2.3 Nutrition

With regards to nutrition, the caregivers felt that the menu at the ECD centre did not change, the children ate the same food all week.

| SETSWANA | ENGLISH |
|---|---|
| *"Ka gore vandaga ba ja….elke… each and every morning ke motogo eo e obvious, afternoon go jewa borotho, so each and every day ke borotho le motogo, borotho le motogo on top of that soet aid."* ***Dineo*** | *"Considering that today they eat…. every…. each and every morning it is soft porridge, that one is obvious, in the afternoon they eat bread, so each and every day it is bread and porridge, bread and porridge, in addition to that sweet aid."* ***Dineo*** |
| *"Ba fa bana borotho thata. So re tlwaetse bana ko kereche ba ja dijo tse di siameng. Jaanong* | *"They serve the children too much bread. It is common practice that children at* ***crèches*** *get* |

| | |
|---|---|
| *bone ba fa bana borotho right through, borotho. Le wena o le mogolo ha o ja borotho right through ha bo go natalele sentle. Ke gore borotho bo batla gore ha o bo ja, o bo je o bo lakaditse, e seng o bo je hela, vandaga, kamoso o bo je nnyaa."* ***Disebo*** | *served the right food. So they serve the children bread right through, bread. Even you as an adult when you eat bread right through you do not enjoy it much. It is like, one needs to eat bread only when they feel like it, not to eat it today, tomorrow you eat again, no."* ***Disebo*** |

Furthermore, the caregivers shared that they would have preferred to pack their child more nutritious food but this was against the policy of the ECD centre. They expressed their concerns over the health of their children. They felt that the inadequate nutrition was contributing to the illnesses and allergies in their children.

| SETSWANA | ENGLISH |
|---|---|
| *"And nna ke buile ngwanake mo godimo ga moo gore o sickleke, qho ha ngwana ha a tlhaga sekolong o tlhaga a se monate, ha ke itse gore ngwana ya bo e le gore o jele eng, jang ko sekolong ga ke itse gore sentle sentle allergy ya gagwe e mo kae."* ***Dineo*** | *"And I expressed that my child, on top of everything else, is sickly, often when the child comes from school, she is not well, I would not know what it would be that the child ate, how, at school. I do not know presicely wthat she is allergic to."* ***Dineo*** |
| ***"****Ba ba fa borotho thata. Ee, ha a batla go ithusa, wa sokega ke borotho."* ***Lerato*** | *"They get served too much bread. Yes, when he wants to relieve himself, he constipates because of the bread."* ***Lerato*** |
| *"…ke maketse ngwana each and every day ngwana wa "gapa" se neng neng go yellow, go green go orange, ngwana o jele soet aid, nna mo ntlong ga ke mo fe soet aid. Ke ile, ha ke ba tlhalosetsa gore ha ke a kgotsofala, ne ke ba tlhalosetsa fela gore ngwanake wa kula kula and e kare ke bona gore, o mpoleletse gore ba ja soet aid and ga ke kgotsofalele soet aid e ba e nwang.."* ***Dineo*** | *"….I get shocked each and every day seeing the the child vomiting subtances that are at times yellow or green or orange, the child had sweet aid, yet in the house he does not drink sweet aid. I went to crèche'and expressed my dissatisfaction, simply explaining that my child is sickly and it's like I see that, he told me that they drink sweet aid and I am not satisfied with the sweet aid that they drink….."* ***Dineo*** |

There was a general worker that was employed to assist the ECD practitioner to prepare food for the children. The ECD practitioner shared that the children were served mainly bread at lunch.

> *"Sometimes they eat bread with eggs, or sometimes they eat bread with jam or peanut butter and then they drink the juice."* ***Zizo***

#### 4.6.2.4 Communication

The majority of the caregivers indicated that there was inadequate communication between themselves and the educator, with lack of formal communication regarding the performance of their children at the ECD centre. Some of the caregivers did not see the importance of communicating with the educator regarding progress of the children. They were not concerned, therefore they indicated that they did not make any means to meet with the educator or initiate the discussions regarding their children's performance.

| SETSWANA | ENGLISH |
|---|---|
| *"Nnyaa, ga nke ke ya."* ***Thato*** | *"No, I don't ever go."* ***Thato*** |
| *"Nnyaa, re ya fela ha re lo monka."* ***Teboho*** | *"No, we only go when we have to fetch him."* ***Teboho*** |
| *"Nnyaa, ga gona ripoto, ga ke ise ke bone ripoto."* ***Dineo*** | *"No, there has not been a report, I have never seen a report."* ***Dineo*** |

Regarding caregiver involvement, the ECD practitioner indicated that upon request, not all caregivers participated in the activities. Those that volunteered to assist, did so rarely. In a space of three months there had never been a single caregiver that went to ECD centre to offer assist ance.

> *"Some they do come, some they don't come. Sometimes some parents they do come at school to help voluntarily, sometimes."* ***Zizo***

> *"Not even one parent came."* ***Zizo***

Furthermore, the caregivers viewed communication with the educator as one-sided as they felt that they were the ones who often initiated it.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke nna hela ke fitlhang ke botsa, ha ke sa botse ha go na motho yo o ntlhalosetsang, ke nna ke leng "concerned" ha ke tsena ke a dumedisa, "he batho o tlhotse a le jang, a wa khoupa," dilonyana tsa go tshwana le tseo, ha* | *"I am the only one that comes to enquire, if I don't ask, there is no one that explains anything to me. It is me that is concerned, when I get there I greet and ask, good people, how has he been, is he coping, things like that.* |

| | |
|---|---|
| *ke sa botse ga gona motho yo o mpolelelang."* ***Dineo*** | *If I don't ask, there is no one that tells me."* ***Dineo*** |
| *"Ee o ne a bua le nna e le nna ke mo boditseng pele le gore a re ka kgona gore ha a di khalarile jalo ke bo ke mo setatisa na, a bo a dumela a re ee, nka kgona e bile ntho e e tla mo etsa fast gore a tle a tlhaloganye ke mo rekele paint book"* ***Neo*** | *"She only spoke to me when I had initiated the conversation and asked if the child had coloured-in like that, will it be alright to trace for her, she agreed and said yes, I can. She then advised me to buy her a paint book as that will assist her to learn faster."* ***Neo*** |
| *"Ke bo ke fitlha koo ke botsa mamisiterese gore a o ntse a dira sentle……"* ***Kagiso*** | *"I get there and ask the teachers if he is doing well…"* ***Kagiso*** |

One of the participants expressed the need to know the progress of the child, but since there was no formal communication from the ECD centre, this important interaction took place informally.

| SETSWANA | ENGLISH |
|---|---|
| ***"****Nnyaa, nkile ka kopana le o monosi, le teng mare e ne e se ko sekolong e ne e le mo tseleng, a bo a mpolela gore, nnyaa, ha a sokodise o rata go tshega hela, o itirela dilo tsa gagwe sentle hela ko sekolong, ha a rate le go betsa bana ba bangwe."* ***Lerato*** | *"No, I once met with one of them, but that was not at school, it was on my route somewhere. She told me that he is not troublesome, he just likes laughing and he does his things well at school, he does't like hitting other children."* ***Lerato*** |

The ECD practitioner shared that some of the caregivers that came in the mornings individually to find out what they did the previous day or the activities for that specific day. She revealed that not all the caregivers wanted to hear progress about their own children. Other caregivers just dropped their children, or the children would go to the *crèche* on their own.

> *"Some usually come in the morning when they bring their children, they usually ask what did we do yesterday, and what are we going to do that day."* ***Zizo***

The caregivers shared that they found out about the creche activities from their children. The majority reported that the children showed them what they did at the creche for the day, and they sometimes brought homework to be completed at home. The caregivers added that they got to determine their children's progress depending on what the children communicated when they got home.

| SETSWANA | ENGLISH |
|---|---|
| *"Ebile ke ene, ha a tswa ko sekolong o hitlha a bua a re mama re dirile jaana ko sekolong, re opetse eng re ne re dira jang, a bue dilo tse tsotlhe tse."* ***Disebo*** | *"Actually, it's him, when he comes home from school he would say, mum, we did this at school, we sang that, did that, he would explain all these things."* ***Disebo*** |

While other caregivers had children who were able to provide feedback concerning activities of the ECD centre, some indicated that the children did not come with homework that needed to be completed, nor did theyshow them what they did for the day. They only shared about their play and the fun they had playing at the creche.

| SETSWANA | ENGLISH |
|---|---|
| *"Mme ha ke re ha e sale a kena ko kerecheng ha ke soka ke utlwa a bua iets ya ko teng. Se se leng teng fela ke ho utlwela fela hore o ne a le ko diswinking, ke yona fela. Ho bina, bo diresiteishene, dipuonyana tseo, ha ke so mo utlwe."* ***Teboho*** | *"Ever since he started crèche, I have not heard him report anything from crèche, all that he does is to tell me that he was playing at the swings, that's all. I have never heard him sing or do those recitations and poems."* ***Teboho*** |

Furthermore, the ECD practitioner had an opinion that there were only a few caregivers that showed desire to be involved in the activities that their children were doing at the ECD centre. Those that showed interest in the activities, also appreciated the work that the ECD practitioner did with their children.

> *"Some of the parents I think they are willing to help but some of them I think they are shy, I don't know what they are shy of, what can I say, you see, because some they come and they appreciate the work we are doing at school."* ***Zizo***

> *"There are few that are interested."* ***Zizo***

### 4.6.3 CATEGORY 3: SUGGESTIONS FOR CHANGE

While caregivers had negative perceptions of the ECD centre and felt that this influenced their apparent non-involvement at the ECD centre, they spontaneously suggested many changes that could be made at the ECD centre that would encourage their participation and be beneficial for their children. In this category the issues surrounding communication were addressed again,

however participants also had a number of suggestions of how they as caregivers could get involved at the ECD centre that were unprompted by their negative perceptions. The other concerns of time, resources and nutrition were also addressed.

#### 4.6.3.1 Time

The operating times of the creche were regarded as a concern, especially the time that the children got sent home. The caregivers expressed the need for the home-time to be changed from one o'clock to at least three o'clock. They stated that their reasons for that request would be to accommodate working caregivers who often had to ask the neighbours to assist with picking up their children from creche.

| SETSWANA | ENGLISH |
|---|---|
| *"Nnyaa, ba ntse ba tsena ka eight ba tswa ka one. Jaanong nna nka kgotsofalela fa ba ka tsena ka eight ba tswe ka bo three.* ***Mpho*** | *"No, they start at eight and finish at one. So, I would be satisfied if they can start at eight and finish at three."* ***Mpho*** |
| *"Nna ntho e ke neng ke re ba e etse ko kereche, ba sa tlhole ba ntsha kereche vroeg." Ke tla nagana sentle gore ra go dira jang gore re kgone go bona gore kereche e tlamegile gore e tswe at least ka nako e e beterenyana e seng ka one."* ***Disebo*** | *"With me, the thing that I want to bring to their attention at the* ***crèche****, is to stop sending the children home early. I will think it through what we will do to to see to it that the children should be released at least at a later time and not at one."* ***Disebo*** |

#### 4.6.3.2 Resources

In keeping with the shortage of supplies particularly for the sleeping routine, one of the caregivers conveyed that she would be willing to supportthe creche with the necessary resources. She would be willing to bring pillows and towels for the children to sleep comfortably.

| SETSWANA | ENGLISH |
|---|---|
| *"Ee ka tlhaloganya, mare nna ke ne ke re, at least ha ba ka re letla rona batsadi gore re kopa le tleleng bana ge le mesamo le ditoulonyana, di towel, tsa gore ba ale mo fatshe, ba kgone go nna comfortable. Ha ke nagana gore ke nna hela ke batlang gore ngwanake a robale monate, ke nagana gore rotlhe batsadi re concerned….."* ***Dineo*** | *"Yes, I do understand, but I am actually saying, at least, if they can allow us as parents to bring pillows and small towels for the children to put on the floor, so that they can be comfortable. I don't think that I am the only one that wants my child to sleep confortably, I think we are all concerned as parents."* ***Dineo*** |

#### 4.6.3.3 Nutrition

As the nutrition was the caregivers' biggest concern, they highlighted that they were prepared to do all it takes to make sure their children were served nutritious meals at the creche. They considered that the creche could increase their monthly fees so that they could buy healthier food. The caregivers could individually donate ingredients like sugar and mealie-meal to make the porridge as well as a better type of juice to replace the drink-o-pop. Ideally, they would prefer to pack their children a snack with fruits included.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke sajesta gore go betere ha motho a ka tsenyetsa ngwana wa gagwe snack sa gagwe, di-fruits, o mo tsenyetsa sekhafethine sa gagwe sentle hela, le juice. Rather than gore bana ba je soet aid, eo ga ke e kgotsofalele totally. Ee, jaaka le mo tabeng ele ya di drink, ke ke disaedile go bitsa batsadi gore batsadi a once re doneiteng juice for bana ka gore ga re kgotsofalele di soet aid at all. So eo ga go thata gore re ka e etsa."* ***Dineo*** | *"I suggest that it might be better if one can pack a snack for their child, fruits, or simply put in their own lunch packs and juice. Rather than the children drinking sweet aid, I am totally dissatisfied with the children drinking sweet aid. Yes, as with that issue of of the drink, I find it best to call the parents, to suggest that we all donate juice for the children given that we are not at all satisfied with the sweet aid. So that one is not difficult to do."* ***Dineo*** |
| *"Go tla fetoga madi, ee, and then bana ka dinako tse dingwe ba ja borotho ka drink, so maybe ha batsadi ba ka doneita gore at least ona a reke sukiri ona a reke mabele, ona a reke eng, then le chelete."* ***Mpho*** | *"The money will be different, yes, at times, the children eat bread with cool drink. Perhaps if the parents can donate towards buying sugar and sorghum, each buying something different, also the money."* ***Mpho*** |

#### 4.6.3.4 Communication (meetings)

To heighten communication between the parties involved in the stimulation of the children, the caregivers suggested that most of theor concerns could be addressed through the introduction of formal meetings. Other caregivers emphasized that they would give their full participation if the meeting could be arranged by the creche. This meeting would allow interaction between the educator and the caregivers where issues including creche times, nutrition, resources, creche fees and how they could participate in the development of their children.

| SETSWANA | ENGLISH |
|---|---|
| *"Ra bitsa dikopano jaaka batsadi botlhe ba bitse dikopano gore ba ntshe maikutlo a bone, gore ba kgotsofalela gore bana ba bone ba tsene ka nako e ba e tsenang and then ba tswe ka nako e ba tswang ka yone."* ***Mpho*** | *"To call meetings for all parents. To call meetings where they can express their opinions and suggestions for the proposed times that their children can start and finish."* ***Mpho*** |

| | |
|---|---|
| *"Re bona gore re kopantsha jang, bone ha ba ka bitsa di-meeting."* ***Disebo*** | *"See how we collate things, if they can call a meeting."* ***Disebo*** |

Some caregivers would like to initiate this meeting to enable them an opportunity to discuss issues among themselves first before requesting a meeting with the educator or the management of the creche.

| SETSWANA | ENGLISH |
|---|---|
| *"Ke zame, leka ganosi fela, ke kopa batsadi ba bangwe gore re tsenye meeting, ke utlwe gore batsadi ba tla nkaraba ka goreng.Ha ke nagane gore ke nna hela ke batlang gore ngwanake a robale monate, ke nagana gore rotlhe batsadi, re concerned, but nna ke ne ke nagana gore go ne go le mosola gore re kopane as rona batsadi rotlhe, re kgone go bua taba e nosi, re dumelane ka ntho e nosi, then re kgone go bitsa matichere re kenye meeting, gore rona re ye go bua ditletlebo tsa rona gore ga re kgotsofalele sa gore le sa gore."* ***Dineo*** | *"I should try, even if it is just once, to ask other parents to hold a meeting, to hear the parents' opinions. I do not think that I am the only one that desires that their child sleeps comfortably, I believe we all are concerned as parents and I consider it important that we all meet as parents, so we can talk from one voice, and agree on one thing. Then we will be in a better position to request a meeting with the teachers, to allow us an opportunity to voice our concerns and express what we are not satisfied with."* ***Dineo*** |

The ECD practitioner found a meeting with the caregivers to be the best suggestion in addressing matters like the lack of communication, their involvement and the progress of their children. She added that in previous year when the caregivers participated in such meetings, improvements were noticed in the children's performance. However, she mentioned that the ECD management (principal) bore the responsibility to arrange such a meeting at least once a term.

> *"The best way I can think of for my side, I think if I call them for the meeting, I think that is the best way we can do, because there is no other alternative that I can think of."* ***Zizo***

> *"Yes, our principal called the meeting last year then the previous principal usually did that and called the parents and tell them about the progress of the children. She usually did that."* ***Zizo***

### 4.6.3.5 Improved teaching

The caregivers suggested areas within which they felt teaching could be improved in keeping with their children's level of development. These included aspects such as colouring-in, writing their own names, knowing their ages as well as their parents' contact details.

| SETSWANA | ENGLISH |
|---|---|
| *"Nka rata gore ba ba tsibese dijara tsa bone ha ba ithuta le go kwala mabitso a bone. Ee, and like ba ba rute go kwala mabitso a bona because go thata, le dijara tsa bone ga ba di itse, o fitlhela ngwana a sa itse, o imisa menwana fela a sa itse."* ***Neo*** | *"I would like them to teach them their ages when they learn, and also to write their names. Yes, and like teaching them write their names because it is difficult, and they don't know their ages. You would come to a point where the child does not know, she would just lift the fingers without any knowledge."* ***Neo*** |
| *"Ke bo ke re nnya le ka bo le ba ruta maina a bone tlelare hela go tswa mo kereche. Ke ne ke botsa gore jaaka a dira ko sekolong gongwe wa bala wa khalarisa, ntho e ke batlang a e etse, tlamegile ba mo rute go kwala leina la gagwe ka gore ke yone ntho e ba sa ba ruteng ya gore ba kgone go kwala maina bone ko sekolong. So tlamegile ba mo rute go kwala leina la gagwe le sefane sa gagwe le maina a ga papa gagwe le mama gagwe le di-phone number tsa rona jalo, tsa ga mama gagwe le papa gagwe le kwa a dulang teng."* ***Disebo*** | *"I then said, no, you could be teaching them their names already at the crèche'. I was under the impression that since at school he reads, he coulours-in. My wishes for him, is for them to teach him to write his name as they do not teach them at school. So, they are supposed to teach him to write his name and surname, his father's and mother's names as well as our phone numbers, his mother's and his father's and also where he resides."* ***Disebo*** |
| *"Maikutlo a ka ke gore ke latelele … ko kereche kwa, ko sekolong sa gagwe, ke leke go ba tlhalosetsa tse ke sa di kgotsofaleleng, tse ngwana a sa kgoneng go di dira, tse e leng gore mo seemong se a leng mo go sone ko kereche, o ne a tshwanetse a be a di dira."* ***Dineo*** | *"My opinion is to follow it up with the crèche', at his school. I should try to express my dissatisfaction and tasks that the child is unable to do, which he is expected to do in his development, in the crèche'."* ***Dineo*** |

With regards to the teaching themes, the ECD practitioner covered mostly 'my body', 'my family', and 'my senses'. She reported that she accommodated the age differences by grouping the children, giving them tasks and rotating the teaching. If the groups were split, then the different groups would have to wait for their turn for the teaching. For some activities, the children received the same teaching as a larger group, and the instructions were not differentiated.

*"I put them in groups first. The 3 to 4 years I combine them and then I put them in one group and then I give them the blocks to play, or else I give them the magazines to page on and then I took the 5 to 6 years I teach them. They take the turns."* ***Zizo***

*"I combine them on my body."* ***Zizo***

#### 4.6.3.6 Improved caregiver participation: "Ngwana ke sejo wa tlhakanelwa"

In improving caregiver participation, the suggestions that were raised by the caregivers encompassed aspects such as better involvement on the part of the caregivers in not only encouraging their children to go to creche but also in the development and growth of the creche. Moreover, participation in the classroom as well as the carryover of what was taught in the classroom into the home environment were also expressed. This is evidenced in some caregivers being willing to physically assist the educator in the calssrom.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ja ke le mme, go tlhotlheletsa, tiro e mme a tlileng ka eona mo ntlung, ya ka ga ke le mme wa ngwana, ngwana ga a tshwanela gore ha a le mo sekolong, se se potlana, morutabana ga a tshwanela gore e nne yena fela ya tsayang karolo. Ga a bowa koo le rona re tshwanetse re tsaye karolo mo ngwaneng. Ngwana ke sejo wa tlhakanelwa."* ***Dimpho*** | *"As a mother, to encourage the teachings that the lady has brought into the house. As I am a mother, for a child that attends a good school, the teacher is not supposed to the only role player. When he comes back from there, we need to play our part as a child is like food to be shared."* ***Dimpho*** |
| *"Se re ka se fitlhelela fa re ka buisana re le batsadi le batsadi ba bangwe, gore a re rotloletseng bana ba rona gore ba ye ko dikerecheng ba ye go ithuta. Ee, re tswelediseng kereche, e tswelele. Le ba bangwe ba nne ba ye ko teng ba ye go ithuta ko teng. "Ehh, nna ke setse ke le ready tlelare gore sengwe le sengwe se se ka tlhagang. Go tseyeng karolo ga ngwanaka ke tla nna teng."* ***Kagiso*** | *"This we can achieve if we can talk as parents to encourage our children to go to* ***crèches*** *to learn. Yes, we need to build the* ***crèche*** *to improve. Others should go to acquire knowledge. Yes, I am ready for anything that may arise. I will be available for my child to play my part."* ***Kagiso*** |
| *"Nnyaa ke ikutlwa gore nka tswelela pele, ka gore ke batla kgolo ya ngwanake e nne betere, e bile e gaise e nna ke fetileng mo go yone. Ee ke a tswelela pele. Ga se hela gore re sheba dilo tsa ko kereche but re tshwanetse gore re gopole gore ngwana wa gola, o tlhoka gore le ene a nne le batsadi ba ba ntseng ba mo thusa mo kgolong ya gagwe."* ***Dineo*** | *"No, I feel I can make progress as I would like to see an improvement in my child, even to surpass the one I have experienced. Yes, I will continue. It is not only about matters of the crèche but it is about realizing that as the child grows,* |

| | |
|---|---|
| | *he needs parents that will assist him in his development."* ***Dineo*** |

#### 4.6.3.7 ECD centre – fees

An increase in the creche fees was suggested by the majority of the participants as they felt it could enable the management of the creche to obtain the resources required for the running of the creche. They expressed that a portion of the child support grant that they received from the government, could be used towards creche fees.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke ne ke re ba bue gore re patale school fees bokae, ka gore re ntsha R70 kgwedi le kgwedi."* ***Lerato*** | *"I would like them to suggest the school fees amount, as we only pay R70.00 per month."* ***Lerato*** |
| *"Ee, ba ka di kgona ka gonne go na le madi a bana ba a kreiyang a mmuso. Ke nagana gore ke one a a ka thusang bana bano go kreiya sengwe le sengwe."* ***Mpho*** | *"Yes, they can manage given that there is government money that the children get. I think that is the money that can assist in obtaining anything for these children."* ***Mpho*** |

#### 4.6.3.8 Peer / caregiver support

The caregivers considered that a peer support group could be ideal in creating a platform where they would meet as caregivers to discuss issues concerning the creche. This support group would also allow them to support one another so that they would gather strength to develop their children as well as the creche.

| SETSWANA | ENGLISH |
|---|---|
| *"Nna ke bona e le ntho ya botlhokwa, e botlhokwa haholo fela, e bile re tla kgothala re tla ema ka maoto re tla batla le ba bang ka ntle hore re tle re tsebe ho ema re le bomme. Ntho e ke e labalebelang gore e ka tswela pele ke gore rona re le bomme re kopaneng re kopantsheng puo ya rona hore re be le maatla a go kgothalla bana ba rona ba tswele pele. Ke tla leka ka bojotlhe gore ha ke kopana le* | *"I think it is important, it is highly important, and I think we will take courage and we will stand up and look for others in the community, so we can take a stand as mothers. My desire in moving forward is that we meet as mothers, to put ideas together so that we can have strength to encourage our children to progress. I will do my utmost best when I meet with any woman, to encourage her to progress."* ***Teboho*** |

| | |
|---|---|
| *mme o feng kapa o feng ke nne ke mo kgothatse go ya ko pele."* ***Teboho*** | |

## 4.7 SUMMARY OF RESULTS

The caregivers indicated that they regarded stimulating their children's developmental milestones as their responsibility. They indicated that they had time available and they were willing to involve them in activities. However, their lack of resources, especially the financial means to purchase educational toys, came across as their biggest challenge in enabling the involvement with their children. They expressed their views over service delivery at the ECD centre and suggestions on how they could be improved. Their recommendations included the need for open communication with the ECD practitioner to allow them to track progress on development of their children. They indicated their willingness to get involved at the ECD centre so to encourage child-centred approaches that would ensure stimulation information got carried over to them. This would in turn assist them to be more involved in stimulation at home. The ECD practitioner expressed that the caregivers did not participate in the activities of the ECD centre. She suggested that a meeting that would be held in conjunction with the ECD management would create a platform where issues like nutrition, resources and caregiver inlvolvement would be discussed. The perceptions of the caregivers regarding their involvement in the stimulation of their children's development, were explored, therefore; the research objectives were reached.

### 4.8 SUMMARY OF FIELD NOTES

The semi-structured interviews were conducted in the participants' homes. This created an opportunity for the researcher to observe the extent of the poverty status in the households. This also created a relaxed atmosphere as the participants were interviewed in comfort of their own homes. The researcher lived the experiences of the participants for the duration of the data collection. The majority of the households were shacks without electricity connections and running water. Hygiene was thus compromised. Some of the families had only one bed and the one-room shacks were divided with curtains to make a second room. The light from outside could be seen through the holes in the roof. This raised concerns over children being exposed to adverse weather conditions. Most of the roads within the community were not tarred. The checklists revealed that the caregivers were not familiar with the details of the developmental domains. Pictures were provided for some of the items they were not

familiar with. When asked about the resources for play, they shared that they did not have the educational toys that were referred to in the checklist. For the duration of data collection, no caregiver was observed engaging in any stimulating activity with their child. This raised concerns over their involvement in stimulating the children.

## 4.9. THE REFLEXIVITY STATEMENT / SUMMARY OF REFLECTIONS

The personal characteristics that I reflected on included that I am a black female who experienced poverty in her upbringing, although it was not to the extend of the research context. The thoughts that came to mind as I went into the homes of the caregivers included their struggles in putting food to the table. It was humbling to observe how the caregivers welcomed the researcher into their homes, without the embarrassment of a stranger seeing their poverty status. This showed their willingness to participate in the study, to express their views and have an ear to express their challenges with their children. It was not a challenge to structure the interview with what was available in each household. This helped with the rapport and the caregivers were at ease to be interviewed in the comfort of their own homes. The children were observed playing outside their homes and in the streets, and the reality that they did not have access to toys, motivated the researcher to complete the researcher so that the children could be helped in providing stimulation.

The researcher was saddened by the poor home circumstances and the injustices in their environment. The thoughts that came to mind included concerns over the caregivers' limited awareness over the importance of stimulation. If intervention strategies are to be developed to limit the risks of developmental delays, the approach would need to take into consideration the home circumstances so that the implementation can be effective. The caregivers showed their desires and willingness to mitigate in the poor environment the children live in and that was motivating to develop strategies that they can easily buy in. There were many instances during contact sessions with supervisors where it seemed the appropriate interventions dominated the discussions. It was difficult to keep to the focus of the study to first explore the caregivers' perception in order to get their buy-in as the desires of the researcher were more on stimulating the children.

# 5 CHAPTER 5: DISCUSSION

## 5.1 SUMMARY OF FINDINGS

The findings showed that the majority of the caregivers regarded it as their responsibility to stimulate their children for milestone development. A few of the caregivers did not share this view. Those that regarded stimulation as their responsibility, involved their children in home, educational and play activities. They specified the barriers and facilitators for effective involvement in the stimulation of their children, with time and resources reflected in both. The caregivers expressed their willingness to stimulate their children considering that they have time available as they are unemployed. They indicated that if they could have the necessary resources and the knowledge, then they would effectively stimulate their children. The study revealed that the primary caregivers are to some extend, involved in the stimulation of their children.

The participants voiced both positive and negative perceptions of the creche. Their positive views highlighted their satisfaction with regards to the improvements they observed in their children's development. Their negative perceptions included their concerns over the management of the ECD centre, these being; time, nutrition, limited resources and unstructured communication with the ECD practitioner regarding their children's performance. The low socio-economic status of the community has led to paucity of resources for the ECD centre. The concerns that the caregivers expressed over the management of the ECD centre could be emanating from the poor economic status of the community. Considering that the status of the community cannot be changed, the suggestions the caregivers proposed stemmed as possible changes that can be considered to uplift the ECD centre. If the caregivers work in collaboration with the ECD centre management, and the intervention strategies from the occupational therapist get implemented, there is hope for great improvement towards the stimulation of the children.

## 5.2 DESCRIPTION OF DAILY ROUTINE / STRUCTURE IN STIMULATING DEVELOPMENT

During the interviews, the caregivers expressed that each morning they take the full responsibility to prepare their children to attend the ECD centre. This was regarded as the most important activity especially by the caregivers who did not involve their children in developmental or play activities. These caregivers regarded their mothering role as their key responsibility and all that the children needed for optimal development. Although these caregivers regarded their caregiving role as most important, they did not share a daily routine that they followed or structured activities that they engaged the children in, when they came home from the ECD centre. A few of the caregivers that shared how they involved their children, left structured stimulation for later in the evening. Many of the caregivers shared a daily routine through which the children played in the streets when they came home or took part in house chores. This is supported by Brown and Lee (2017) in stating that low-income caregivers may have the desire to support their children's future academic success. They however lack the skills and educational resources needed to impact on their children's readiness for school. Brown and Lee (2017) discovered that poverty was linked to negative characteristics including poor maternal warmth, lack of cognitive stimulation as well as family stress. Moreover, children born in low-income families have a high likelihood to experience daily routines that are inconsistent and less predictable (28). The participants in this study expressed their willingness to stimulate their children but lacked the necessary skills and resources. Due to their poverty status, their inconsistent daily routines were determined by their needs for survival. The caregivers' survival needs like providing food for their children, superseded provision of structured stimulation for their children. Their daily routines were inconsistent as they would spend a large amount of time to source food and other resources for their families. This led to lack of structured stimulation, more especially on educational activities.

## 5.3 **OBJECTIVE 1:** To explore the perceptions of primary caregiver on their role in the stimulation of developmental milestones for their children (three to five years of age) in a low socio-economic status community.

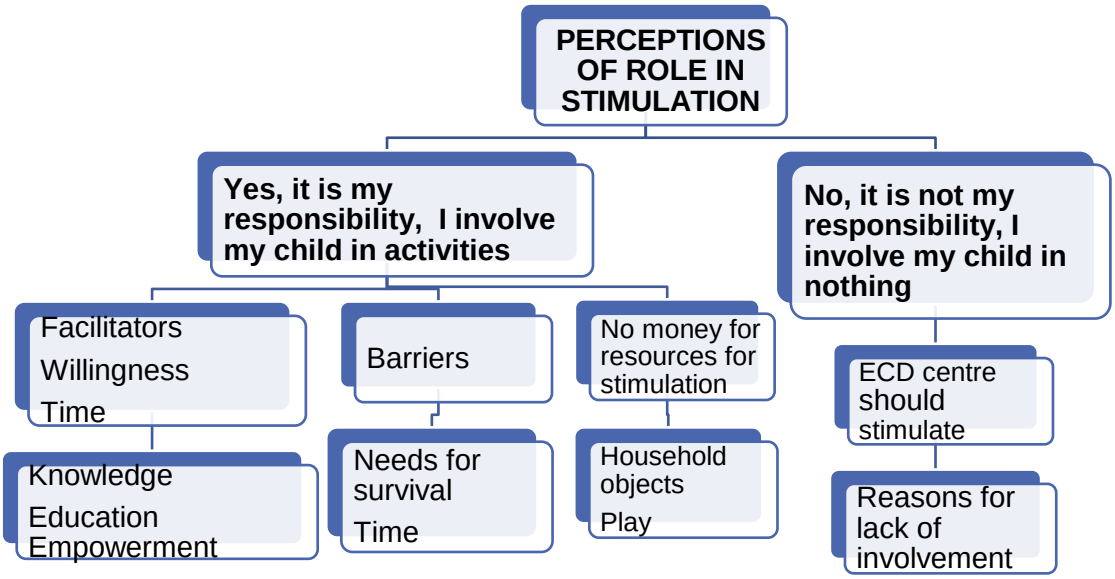
The first objective was answered by the first two themes that emerged from the data as shown in table 4.2

**Table 4.2: Themes, categories and subcategories**

| THEMES | CATEGORIES | SUBCATEGORIES |
|---|---|---|
| **1. Caregivers' perceptions of their role in stimulation** | **Yes, it is my responsibility, I involve my child in activities** | **Caring activities**<br>**Home activities**<br>**Educational activities**<br>**Play activities** |
| | **No, it is not my responsibility, I involve my child in nothing** | **Home activities**<br>**Educational activities**<br>**Play activities** |
| **2. Facilitators and barriers for involvement in stimulation** | **Facilitators** | **Willingness**<br>**Time** |
| | **Barriers** | **Time**<br>**Money**<br>**Resources for play**<br>**Awareness of development** |
| **3.** Caregivers' perceptions of the ECD Centre | Positive perceptions | Learning observed in a child |
| | Negative perceptions | Time<br>Resources<br>Nutrition<br>Communication<br>Play |
| | Suggestions for change | Time<br>Resources<br>Nutrition<br>Communication<br>Improved teaching<br>Improved caregiver participation<br>ECD centre fees<br>Caregiver support |

This discussion will first explore the perceptions of those caregivers who said “yes, it is my responsibility” and will discuss the facilitators and barriers to being involved in their children’s development. The minority viewpoint, “no, it is not my responsibility”, will then be discussed. The perceptions that emerged are summarized in diagram 1.

**Diagram 1: Caregivers’ perception of role in stimulation**




### 5.3.1 YES, IT IS MY RESPONSIBILITY, I INVOLVE MY CHILD IN ACTIVITIES

The majority of the caregivers felt strongly that it was their responsibility to involve their children in stimulating activities. They expressed their desires to really want to be involved in the children’s stimulation. The greatest facilitator identified was willingness to be involved in their children’s development. The caregivers acted on this responsibility in the best way they knew how, which included involving their children in household chores, play and educational activities. This study supports the findings by Brown and Lee (2017) who reported that low-income caregivers have the desire to support their children’s future success (28). Ackermann (2015) also reported in his study that caregivers care about their children’s future and have the desire to be involved in their education and growth (4). Furthermore, Lynch et al. (2016) identified household learning as an important place where caregivers support and encourage development of their children (18).

Thus, it is clear from literature and this study that a low SES does not influence the desire to be a good caregiver who gets involved in a child's stimulation and development.

In this study, many of the caregivers reported that they involve their children in household tasks such as sweeping, washing, and doing dishes. Indeed, this was the most common form of involving children in activities. While some caregivers did this in a factual way, many caregivers allowed their children to participate in household chores in a playful manner and reported "playing along" with their children. Thus, the children in these households had the opportunity not only to observe their caregivers getting busy in the house, but also engaging in the same activities themselves while playing. By engaging in the same activities together, the caregivers and children in this study were involved in co-occupations, which Lynch et al. (2016) defined as the doing of things together. The authors suggested that co-occupations offer spaces in which children can learn about daily life and culture and considered occupational engagement to be important for learning and development throughout the childhood stage. Co-occupations also offer opportunities to develop occupational identities within the family unit while stimulating developmental skills and the development of healthy relationships (18). In this study co-occupation in household chores created the one common space identified by all the caregivers in which they could confidently interact with their children and promote learning. It is therefore important for occupational therapists to consider the opportunities that participation in household tasks can offer in terms of stimulation.

Many factors may play a role in the choice of household chores as the main activities in which caregivers involve their children. The majority of the caregivers in this study were single parents raising their children alone. This situation enforced them to juggle household chores while coordinating play and ensuring the safety of their children. In addition, for the few caregivers that were employed, balancing time and responsibilities with the play needs of their children was even more difficult. For this reason, involving their children in household chores was a way of engaging with their children while still completing other important responsibilities as caregivers. The demographic information reflect that the majority of the participants were females. In the context of the South African societies, women have many responsibilities in the household, which include meal preparation and caring for the children. In this underprivileged community, most of the female participants were unemployed, single parents. As described by Ross (1995), paternalism

is a Greek and Latin word for father hence the paternalistic societies of South Africa reflect on social hierarchies where males are the heads of families and are responsible for the welfare of the subordinates and dependents (62). In this particular study, the absence of male figures in the majority of the families that were interviewed, indicate that these women participants spent a significant amount of time finding resources to provide for the families' basic needs. As a high percentage of their time was spent sourcing the basic resources, this left them with limited opportunities to provide stimulation for their children.

While co-occupations are most often described as occurring in a shared space and time, Lynch et al. (2016) also described another form of co-occupations which does not necessarily occur in the same shared space. This often results from multiple factors within families, which include the need to maintain routine within equally demanding family responsibilities as demonstrated by the caregivers in this study. These include taking care of the household like providing food and clothing, washing the dishes and sweeping the floors. Lynch et al. (2016) further reported that caregivers make decisions over these factors depending on what is regarded as important at the time. Some families could engage in play occupations during mealtime, while others could orchestrate play while the parent is cooking. The caregiver and the child may not physically engage in an occupation together. In this scenario, family occupations would not only be about doing things together but also about doing apart (18).The caregiver can provide instructions and guidance in an activity that the child is engaged in, at the same time be involved in another activity. While the caregiver washes the dishes, the child can pack away the toys. In other words, co-occupations in the form of household chores affords the caregivers flexibility to involve their children in different learning experiences at different times, especially when cargivers do not have a lot of time to spend on stimulation activities.

Finally, caregivers in this study perceived household chores and activities as a good way to engage with their children and to promote learning. This finding is similar to findings from a study by Ackermann (2015), who reported that caregivers perceived that monitoring and supporting in the household did not lessen the meaning of their involvement with their children, but it was as vital as volunteering at, and attending school involvement opportunities. Caregivers had the perception that their involvement at home showed that they were supporting their child as they created a positive environment for their children (4).

From this discussion it is clear that co-occupations enhance caregiver-child interactions, and through this involvement, learning and development of milestone take place. During participation in household chores, children can develop skills such as sorting, colour stimulation and counting, while developing their occupational identities by taking part in the routines and daily activities of the family. As previously discussed, caregivers are the mitigating factors in preventing poor childhood development, co-occupations and engagement in play therefore promote caregiver involvement.

However, despite household activities being common co-occupations undertaken by the caregivers and their children in this study, these were not the only activities they were involved in. Caregivers attempted to play with their children and also tried to involve them in some educational activities such as building puzzles, identifying colours, and colouring in. Sjaak (2011) reported that the home environment and the caregiving style determined the development of cognition in early childhood (17). The caregivers who participated in the study by Sjaak (2011), shared their views that children do not learn in their first years of school, their main activity was play, which they did not regard as learning. Three caregivers that had low levels of education, reported stress after work and, if they engaged in play, it was mainly for amusement and showing affection. They relied more on the teacher to stimulate their children's cognitive development. On the contrary, highly educated caregivers regarded play as an activity in which children acquired knowledge. The caregivers in the study by Sjaak (2011), kept many kinds of toys at home to stimulate learning like reading and counting. A highly educated caregiver uttered "…children learn a lot by playing. I play memory games with cards, that is to help him to learn figures…..Well things like this, they learn a lot just by playing'' (17) page 7. Playing is a co-occupation that requires the engagement of two people who are closely involved in the creation of the occupation (44). The caregivers with low levels of education engaged in co-occupations that involved their children in some educational activities, but they were more reliant in the teacher for stimulation. It is thus evident that the level of caregiver education determines the type of stimulation the child receives as educated caregivers perceive the outcomes of play differently. The majority of the caregivers in the current study had low levels of education and they expressed their willingness to stimulate their children, but they did not know how. They were happy to receive homework activities from the ECD practitioner and that guided them on areas of development to stimulate.

In conclusion, it is clear that the majority of caregivers in this study did consider it their responsibility to be involved in their children's growth and development and were attempting to involve their children in a number of activities. The question remains whether the types of activities that caregivers described were most effective in supporting their children's development and whether a variety of activities or enough time was spent in different activities. What is clear is that caregivers were eager to involve their children in activities and cared about what their children were able to do. A number of facilitators and barriers to this involvement were identified by the caregivers and will be discussed in the next section.

#### 5.4.1.1 FACILITATORS

##### 5.4.1.1.1 Willingness and time

The group of caregivers who identified it as their responsibility to be involved, also showed willingness to implement interventions if they just knew how. This group of caregivers did not consider involvement in child development as a difficult task, the only challenge they expressed was a gap in knowledge on strategies of how to actively encourage normal developmental milestones. They shared that they value stimulation, they have the desire to be involved but they did not know what was important to stimulate.This finding linked with the study by de Paula et al. (2013) who reported that the caregivers commented that they "don't find it difficult". Despite their engagement in household chores and other activities, it was common practice for the caregivers in the study by de Paula (2013) to change their routines to allow more active participation in the normal development of their children. A caregiver reported: "I have no difficulty in doing it, because I make a huge effort" (8) Page 6. This indicates that caregivers in general feel that the effort required to be involved in their children's development did not translate into difficulty because they too possibly recognized the importance thereof. The caregivers in the current study need to be empowered with skills for stimulation of child development as they showed the will power and regarded involvement in stimulation of development, to be their responsibility. Given that they also reported involving their children in household chores, empowerment in the correct strategies and use of available resources, could positively impact on their engagement in stimulating child development.

For some caregivers, time was also identified as a facilitator. Time was an interesting factor in this study as it figured as both a facilitator and barrier to involvement in children's stimulation. Some caregivers felt that as they did not work, they had time to be with their children, while others felt that the many responsibilities of being a single parent and managing a home with very limited resources, left them with limited time to engage their children in play or stimulation activities. This statement was supported by Sjaak (2011), where a caregiver reported: ''I would like to do more things with my child if I had more spare time. I'm just too tired for those things. I just don't have the energy after my work'' (17) page 7. Co-occupations and household chores have already been discussed as ways of mitigating time, but it is worth noting that in some cases the fact that caregivers have the time to spend with their children may be an opportunity for intervention. In these cases there were other reasons, such as money and knowledge that limited involvement in play and stimulation activities.

In conclusion caregivers showed a willingness to engage with their children and to support their development and learning, while some caregivers also identified the fact that they had time to do this. However, there were a number of barriers identified that hindered their involvement in their children's stimulation and will be discussed next.

#### 5. 3. 1.2 BARRIERS

The number one barrier identified by caregivers in this study was the lack of money, which directly impacted on their ability to provide resources for their children. Caregivers' perceptions of what they needed for their children to do well was to have the financial means to buy educational or shop-bought toys. Caregivers did not appear to value household objects as toys, but rather regarded "specialtiy" toys as what their children needed to develop well. Bradley and Putnick (2013) describe toys as tools that children use to learn about themselves, their environment, and to develop the necessary skills needed in life. They can be categorized into household objects, outside objects, homemade toys, and store-bought toys (63)**.** All of these objects can provide opportunities for play and learning, yet in the current study, caregivers appeared unaware of the possibilities for play outside of store-bought toys. For them the indication of their poverty was the fact that they could not buy toys for their children.

While caregivers in this study expressed the issues with money and resources specifically in terms of purchasing toys, the intergenerational quality of poverty observed in these households clearly affected all aspects of life and played a role in the other barriers identified such as time and knowledge. The struggle for survival meant that caregivers often felt they had neither the time nor the resources to be involved in the stimulation of their children. This is supported by a study by Ihmeideheh (2019) in that caregivers who cannot afford store-bought toys may feel disempowered to actively engage in play with their children using the most effective known tools – themselves (64). In this sense, these caregivers view play as requiring a store-bought toy as opposed to playing readily available in the house.

The caregivers therefore need empowerment to understand that they can use themselves as tools for stimulation as their poverty status will not be changed soon. Max-neef (1989) states that a good quality of life is dependent on possible things that people have that fully satisfy their fundamental human needs (65). Survival needs therefore took priority over other responsibilities for the caregivers as explained in the theories by Abraham Maslow and Max Neef that physiological needs supersede other human needs. Jerome (2013) highlights that according to Maslow's Hierarchy of Needs, which has five levels, the individual cannot fulfil the second need until the demands of the first have been met. In the hierarchy, the physiological needs are followed by safety needs. Self-actualisation, which is in the apex of the hierarchy, gets activitated when all foregoing needs are satisfied. The caregivers' responsibility to stimulate their children, can be classified as self-actualization, which is the need to do what a person was "born to do". The caregivers' involvement in structured stimulation is thus left to the end in the daily routine as they struggle with basic needs for survival and these preceding needs should first be satisfied (66). In his theory of 'A Matrix of Needs and Satisfiers', Max-neef (1989) explains that there is a permanent and dynamic interrelationship between needs, satisfiers and economic goods. A need is expressed through a satisfier while goods are a means through which people empower the satisfier to meet their needs. Similar to Maslow's Hierarchy of Needs, Max-neef (1989) highlights that needs that are regarded as deprivation, are often restricted to physiological. Food and shelter are hence the satisfiers of the fundamental need for subsistence (to remain alive). Education and early stimulation are satisfiers of the need for understanding (65). The need for subsistence precedes the need for understanding, hence the caregivers prioritised survival needs over time and resources for structured stimulation.

The poverty state in the households in this study greatly influenced the involvement of the primary caregivers in stimulation as they could not provide sufficient stimulation materials/environments. Due to the low SES of the community, the majority of the households where the research was conducted, did not own radios and/or television sets and some did not have electricity, which were also material resources identified by Bradley and Putnick (2013) as providing enriched experiences. These researchers found that children that had access to electricity had opportunities to learn from radio and television. It also provided the light for reading and engaging in other learning activities (63). The lack of even basic material resources such as electricity or a radio meant that there were no external sources for stimulation, and therefore that the children in this study depended entirely on the caregivers' initiative. This also confined exposure to stimulation to occurrences within their area, limiting their knowledge of the outside world. As a result, there were less opportunities available for learning because of the lack of money and resources.

The current research revealed the negative impact that low socio-economic conditions had on stimulation of development, which interrelated with studies that were conducted in other parts of the world. All the caregivers in this study identified some developmental delays in their children when using the checklist. The research by Bradley and Putnick (2013) confirmed that the situation in poor South African communities was not unique. They reported that a socio-economic status difference was observed in a study of the home environments of three to six-year-old children from socially advantaged and disadvantaged families in India. Extreme low levels of materials and enriching experiences for children, were observed in lower castes of India (63). In a review by Leung and others (2017), they found a socioeconomic difference in attainment scores of the 22 months old children. Those from higher socioeconomic status achieved higher scores. The achievement scores at 22 months were used to predict academic qualifications when the children were 26 years old. The children from high SES families that had attained low scores at 22 months had better chances to improve later on as compared to children of families of low socioeconomic status (5). Considering that most of the caregivers in this study showed a willingness to play and be involved in their children's stimulation, it is important to address the lack of resources that prevents these caregivers from providing the kind of stimulation that would support their children's optimal development. Interventions strategies specific to the setting are needed to close the SES gap in providing stimulation opportunities similar to high SES families.

The poor social circumstances of the children enrolled at the ECD centre limited them to the availability of resources for stimulation. Despite their disadvantaged backgrounds, these children still had opportunities for play. The participants' children used their imagination to make play things out of the material they had available. Regardless of their disadvantaged backgrounds and the unavailability of resources for play, these children still engaged in play with the objects they could access outside. Their caregivers shared that they engaged in outdoor play, making use of available material for play. Their creative activities included hopscotch, playing with tins, using soil to build/draw, pushing tyres, using bricks as poles during soccer play. Through engagement in play, these children were still able to develop in many areas, including socially. Thus, a lack of formal play materials does not mean a complete lack of development as supported by White et al. (2008) that children's engagement in outdoor play such as in public parks can have a positive effect on their physical development such as strength, endurance, motor skills and coordination (11). Gerlach et al. (2014) explains that children's play has been greatly defined, categorized and decontextualized by adults who are mainly from urban and middle-class clusters. They suggest that what may be defined as play, should actually be regarded as 'western play' (29). In poor communities like Sonderwater, resources are not available for engagement in 'western play'. This is significant to consider in future intervention strategies as the children make use of the available resources to participate in play. It may be important to focus on 'non-western play' so as to develop interventions that are context specific and make use of materials that the children are familiar with as this might encourage the caregivers' buy-in.

In conclusion, the lack of resources, identified as a lack of money to buy toys, is a major barrier for caregivers in this study. It is also the major factor that influenced the two other barriers identified, namely time and knowledge which will be discussed below.

#### 5.3.1.2.1 Time

The second barrier which was identified was time. Although some caregivers identified time as a possible facilitator, considering that they were at home and had the time to spend with their children, most caregivers felt that they were very busy trying to provide for their families. Caregivers that were employed or self-employed, were overwhelmed by the house chores such as cooking and cleaning. They had limited time to stimulate their children in addition to looking after the families' needs. Despite their time constraints, they still showed their willingness to

stimulate their children and regarded it as their responsibility. House chores and caring for other family members took more time such that little time could be dedicated for engagement in stimulation. De Paula et al. (2013) supported the findings in reporting that on average, children of working caregivers did not spend a lot of time with them, compared to children of unemployed caregivers. The authors further commented that time for unpaid work was relatively rare. During their home visits, they verified that the caregiver did not get help from the family for activities relating to home care. These caregivers expressed the burden and limited time to implement the recommendations relating to cognitive and sensorial stimulation. If caregivers participated in paid workforce, it resulted in time for unpaid work being scarce. Children then lost valuable attention from their primary caregivers (8). If the availability of time could not be regarded as the causal factor for less engagement in stimulation, then lack of knowledge due to low education levels and low SES, could be the bigger cause for limited exposure to stimulation.

#### 5.3.1.2.2 Lack of knowledge

This barrier was particularly identified as the caregivers interacted with the checklist of developmental milestones. Before the interview, none of the caregivers in this study had an understanding of child development, but all became increasingly aware of what developmental miletsones entailed after the discussion of the checklist. Many of the caregivers had never seen or heard of some of the activities on the checklist. While there is debate around the validity of using imported developmental checklists and subjecting all populations to the standards of Western milestones, it is worth noting that the caregivers in this study had little idea before the interview, what the domains of normal development were.

Poverty has already been identified as a major factor in influencing caregivers' abilities to provide adequate stimulation for their children. Poverty is often linked to low levels of education amongst caregivers which in turn has been identified as a risk factor for poor developmental outcomes (4,39,64). In this study half of the caregivers only had primary school education, while only two completed high school. The caregivers indicated that they became aware of their children's development, when the developmental checklists were discussed. They commented that they were not aware of some activities that the children needed to be able to perform as they develop... It was thus evident that the caregivers' lack of knowledge and skills for the involvement of children

in stimulation correlated with their low educational standards. White et al. (2008) agreed that the maternal education was highly associated with memory, language skills as well as intellectual capabilities in developing children (25).

Furthermore, de Paula et al. (2013) added from their findings that caregivers with low literacy levels, shared the perception that educated caregivers had an influential role on the development of their children. Within the same study, half of the study population expressed their wishes to encourage development but were unable to do so because of their illiteracy (8). This finding was similar to the finding in this study where caregivers expressed a willingness and a responsibility to be involved in their children's development, but that they did not really know how. In a review of the literature, numerous studies showed that caregivers with high educational levels, were more likely to spend time with their children than those that had lower education levels. Higher levels of education appeared to allow caregivers to realise the impact that an investment of time had on the developing child. For this reason, they put in an extra effort to spend more time engaged in activities with their children (8). Thus, it can be noted that time itself does not appear to be the main factor influencing caregivers' involvement with their children, but rather whether caregivers have the necessary knowledge and skill. It can be concluded that knowledge and education levels of caregivers play a bigger role in the involvement of stimulation for childhood development.

Many of the caregivers in this study expressed their limited knowledge with regards to the importance of stimulation and its benefits in child development. This finding was supported by the World Health Organization (2004) in that knowledge of the caregivers about child development, caregivers' beliefs about their children as well as their expected milestones of development, had a great impact on the behaviour of caregivers. If the caregivers did not realise the importance of their interaction with their children and its impact on their development or they lacked the awareness for the need to support their children's emerging capabilities, they were less likely to provide caregiving that was responsive and stimulating (6)**.** Pierce and Stephenson (2009) agreed with this finding, as they reported in their study of activities needed for caregivers raising typically developing pre-school age children, where caregivers were however found to be overwhelmed by feelings of lacking knowledge on how to care for their children. After interventions, these caregivers then realized their responsibility towards the development and eventual success of their child (43). In the current research, the involvement of primary caregivers was regarded as

crucial in stimulating early childhood development. The caregivers' perception in their role for efficient early childhood stimulation therefore developed basis onto which education on the importance of early child development could be specific to their socio-economic status and living conditions.

In conclusion, intergenerational poverty, combined with low levels of education, poor resources, and poor knowledge appear to be the main factors influencing caregivers' participation in stimulation activities with their children. While time is also a factor, it could be described as both a facilitator and a barrier and depended on what caregivers prioritized as most important.

It is important to note that despite the vast majority of the caregivers in this study indicating that it was their responsibility to be actively involved in their children's stimulation and development, there was a minority that felt it was not their responsibility. This minority view will now be discussed.

### 5.3.2 NO, IT IS NOT MY RESPONSIBILITY, I INVOLVE MY CHILD IN NOTHING

Some of the caregivers reported that they did not involve their children in any stimulation activities. This group of caregivers viewed their role in caring practices and did not regard it as their responsibility to stimulate their children. The demographics for this minority group included unemployed female caregivers who lived in informal structures with educational levels below high school. They considered the function of stimulating children as the sole responsibility of the ECD centre. The caregivers explained that they worked to obtain money needed for their survival and house chores took a more important role than involving the children in stimulation. The caregivers in this category chose not to involve the children even when busy with home errands. The search for money for survival took priority over everything due to their intergenerational poverty status. This indicated that there were some occupational injustices regarding the childhood occupation that stemmed from factors that were rooted in wider social structures, which were above the caregivers' immediate control. This category of caregivers shifted the responsibility of stimulation to the children's older siblings who also lacked the relevant skills for stimulation. If the caregivers were too busy finding survival means, it left little or no time to even supervise the older siblings in the co-occupation, which clearly indicated poor levels of stimulation that the children got exposed

to. Pierce (2009) stated that in a developing child, play was considered a co-occupation because the stimulation process required the interaction or communication between the caregiver and the child that engaged in a play occupation (43). The concept of co-occupations was not practiced with the primary caregivers that did not involve their children in any activity. Considering poor co-occupations between the caregiver and the child, the children's occupations were poorly shaped, which lead to poor occupational identities. The demographics of this group of caregivers were not different from some caregivers in the group that regarded stimulation as their responsibility. The reasons for their lack of involvement would not relate to their demographics as there were some caregivers with even lower education levels that considered stimulation as their responsibility. However, the researcher did not probe this group of participants sufficiently to explore their viewpoint in more depth and to be able to truly understand and represent it. This was a limitation in the interviewing process and would be a point of interest in future research. Despite this limitation, there are a few possibilities reported in literature for why caregivers might not consider developmental stimulation as important. These are discussed below and could form the basis for future research into these viewpoints.

#### 5.3.2.1 Possible reasons for lack of involvement

Considering that it was a minority group of caregivers that did not involve their children in stimulation activities, the researcher did not probe further to establish the underlying reasons. The assumptions that were made included their low literacy levels which impacted on their knowledge on the importance of stimulation as well as skills required for proper stimulation. Their roles as primary caregivers included the responsibilities for ascertaining survival for all their family members. This could burden them with duties that leave limited time for stimulation. It was observed that most families depended on one caregiver for their survival needs. The reality of day-to-day life of many low SES families is surrounded by stressors that recur often, which are largely uncontrollable. Low SES children have family lives that are unpredictable and at times chaotic. Their day-to-day routines are less stable, partly because of demands that families have little control over, which disrupt the routines (13,67). Some of the low SES caregivers have to manage multiple jobs with late shifts that at times impact on the time available to be at home with their children. In addition, unanticipated events like leaking roof may change the daily routine given that the caregivers may not have resources to remedy the problems, which lead to negative consequences that change their children's day-to-day lives (13). Children in low SES

environments also get exposed to interpersonal aspects of family life, which they have very little control of. They unfortunately experience more frequent conflict and poorer family interactions. They are recipients of harsh and punitive parenting strategies. However, these types of family environments may stem largely from the tough life circumstances with many demands and constraints that the low SES caregivers face, instead of being intentional parenting styles (3). De Paula et al. (2013) alluded to these presumptions in reporting that among the limitations perceived in caregivers for their role in the stimulation of their children, it could be highlighted that they were overburdened due to their own difficulties, discrimination, and social reaction to the child, and often due to little or no support from the family (8). It is highly recommended that further research should be conducted so as to establish the perceptions of caregivers that do not regard it as their responsibility to stimulate their children.

## 5. 4 OBJECTIVE 2: To explore the involvement of primary caregivers in their children's ECD centre in a low socio-economic status community.

The second objective was answered by the last theme that emerged from the data. This is highlighted in table 4.4 below.

**Table 4.2: Themes, categories and subcategories**

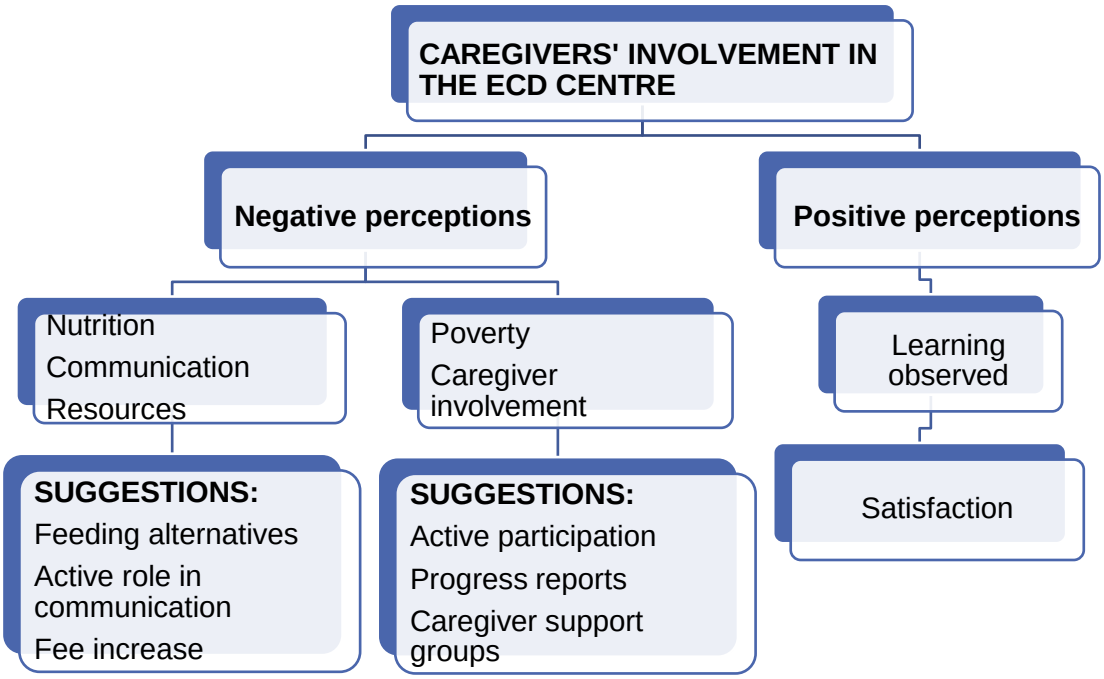
| THEMES | CATEGORIES | SUBCATEGORIES |
|---|---|---|
| 1. Caregivers' perceptions of their role in stimulation | Yes, it is my responsibility, I involve my child in activities | Caring activities<br>Home activities<br>Educational activities<br>Play activities |
| | No, it is not my responsibility, I involve my child in nothing | Home activities<br>Educational activities<br>Play activities |
| 2. Facilitators and barriers for involvement in stimulation | Facilitators | Willingness<br>Time |
| | Barriers | Time<br>Money<br>Resources for play |
| | **Positive perceptions** | **Learning observed in a child** |
| | **Negative perceptions** | **Time** |

| | | |
|---|---|---|
| 3. Caregivers' perceptions of the ECD Centre | | **Resources**<br>**Nutrition**<br>**Communication**<br>**Awareness of development**<br>**Play** |
| | **Suggestions for change** | **Time**<br>**Resources**<br>**Nutrition**<br>**Communication**<br>**Improved teaching**<br>**Improved caregiver participation**<br>**ECD centre fees**<br>**Caregiver support** |

From the interviews with caregivers and the ECD practitioner, it was clear that caregivers were not very involved at the ECD centre itself. However, when asked, caregivers highlighted a number of perceptions of the centre that covered their interactions with both the management and the ECD practicioner. While the caregivers thanked the ECD centre after noticing that their children were learning new things, , their perceptions of the ECD centre were mostly negative. Caregivers had a number of issues or concerns regarding the centre, although it seemed they had not previously acted on these concerns. One of the greatest issues appeared to be the lack of communication between both the ECD practitioner and the ECD centre's management. On the other hand, the ECD practitioner reported that she kept the parents informed on the progress of their children and thus there is some discrepancy between the caregiver perceptions and the ECD practitioner's perceptions. The ECD practitioner reported inviting the caregivers to meetings but also shifted the responsibility of formal communication invitations to the ECD management. She regarded informal feedback to the caregivers as sufficient to discuss the children's progress. The caregivers were concerned that they initiated the chidren's progress discussions with the ECD practitioner and management did not send invites for structured sessions. This showed that the ECD practioner and the caregivers shared different views over communicaton regarding children's progress and the management of the ECD centre. The caregivers blamed the ECD practitioner for not inviting them formally, while the ECD practitioner reported that the invitations were not honoured by the caregivers. Despite their negative perceptions, caregivers came up with a number of strategies or suggestions for their concerns, which they believed could improve their involvement in their children's education at the ECD centre. The following discussion will focus on caregivers' positive perceptions, their negative perceptions then finally possible solutions

to these challenges as a way forward to increasing involvement at the ECD centre. These are summarized in diagram 2 below:

**Diagram 2: Caregivers' involvement in the ECD centre**




## 5.4.1 POSITIVE PERCEPTIONS

### 5.5.1.1 Learning observed in a child

The caregivers commended the ECD practitioner for her hard work in stimulating their children. The ECD practitioner sent home with the children, tasks that they had completed. The caregivers noticed many changes in their children since they enrolled with the ECD centre. They expressed their gratification over the improvements they observed in their children's developmental abilities. They were very happy that they could perform many of the activities that they could not do before. The caregivers noticed growth and were amazed at some of the activities that the children could do. They added that the children came home to share positive experiences at the ECD centre and what they learned. These findings were supported by Konstantina et al. (2014) who reported that, according to caregivers' perceptions, willingness of staff from an early intervention centre to

provide caregivers with useful and clear information about their children's development, increased their self-confidence in their ability to support their children (68). The gratification that the caregivers in the current study, showed towards the improvements in their children's development, indicated that they had confidence in the ECD practitioner over the hard work in stimulating their children. The improvements they noticed in their children's work, boosted their self-confidence to stimulate their children.

Although the caregivers noticed improvements in their children's abilities most of them commented that they were not aware of some of the activities that were discussed through the checkilist. Despite the awareness of developmental delays that was identified by the checklist, the caregivers still remarked the growth they noticed in their children. Konstantina et al. (2014) reported that the caregivers' high levels of satisfaction over the care of their children in an ECD, were not influenced by their education levels and lack of knowledge of developmental markers. The researchers confirmed that there were no statistically significant differences that were found when comparisons were made between the levels of education and caregiver satisfaction. This proved that satisfaction was not related to caregivers' educational level (68). These results supported the findings of the current study in that caregiver satisfaction was high despite their awareness of developmental delays. Although they previously expressed their limited knowledge in involving their children in stimulation, they were satisfied with the learning and growth they noticed in their children. As literature suggests, their high levels of satisfaction over their children's improvements, are not because of their low levels of education, which means they highly regard the work of the ECD practitioner.

Despite their appreciation of the work the ECD practitioner had been doing with their children, caregivers still had many negative perceptions of the centre. However, caregivers suggested solutions to many of the problems they raised, and so the negative perceptions and the suggested solutions to these perceptions will be discussed together.

## 5.4.2 NEGATIVE PERCEPTIONS

### 5.4.2.1 Communication

"Ngwana ke sejo wa tlhakanelwa" (a child is like food to be shared). This expression came from the caregivers as they considered that it is not the sole responsibility of the ECD practitioner to stimulate the child, they would also like to play their part. However, the caregivers expressed that this could only be possible if there were open communication lines between themselves and the ECD practitioner. The only communication that the caregivers reported as positive, was the daily tasks that were sometimes sent as homework for the caregivers to assist their children. The ECD practitioner responded to the caregivers' concerns over lack of communication by shifting the responsibility to the management of the ECD centre. The responsibility of arranging meetings with the caregivers, also lay with the management. This could be confirmed by the researcher as arrangements for meeting with caregivers had to be made through the management of the church. Nevertheless, these findings were in congruence with Ackermann (2015) as he found out that communication was perceived as an important factor for the basis of caregiver involvement. In almost every division - literature, policies, interviews and questionnaires, in his study, communication came to the fore ground (4). There were issues that both the caregivers and ECD practitioners did not communicate about. One example was that the caregivers expressed their concerns over the operating times of the ECD centre. They felt that the time that the ECD practitioner released the children to go home, was too early. This was a concern predominantly of those who were employed and found it difficult to fetch their children as well as those who felt it was the ECD centre's responsibility to stimulate their children. Proper communication lines would have made it possible for the caregivers to bring this concern to the attention of ECD practitioner and management.

Caregiver-teacher sessions were regarded crucial as Engle et al. (2011) described characteristics of successful early child development interventions to be including caregivers and families working in partnership with teachers or caregivers with the aim of supporting children's development (20). Ackermann (2015) supported this aim in that both parties were to collaborate and share similar perceptions regarding the involvement in the child's stimulation and further development. In order to see each other's view, the teacher had to accept that supporting at home was as much crucial as attending and volunteering at school (4). Caregiver-teacher sessions were

not practiced at this centre. The ECD practitioner was not aware of the caregivers' perception of their involvement in the ECD centre, the caregivers also had no knowledge of the ECD practitioner's views. Collaboration between the caregivers and the ECD practitioner, would encourage participation of caregivers in educational aspects of stimulation as well as supporting the ECD centre.

This research revealed that there were no structures in place that allowed open communication between the ECD practitioner and the caregivers regarding progress on development. The caregivers expressed that there were no formal meetings/sessions that allowed one-on-one interaction between the caregiver and the educator. They expressed their frustrations in that there was no formal feedback given to the caregivers by the ECD practitioner on the progress of the children. They added that they had never seen a report from the ECD centre. According to the ECD practitioner, the management had not given her the mandate to issue reports to the caregivers. The ECD practitioner indicated that most of the caregivers did not show interest in the activities that their children engaged in at the ECD centre. On the other hand, the caregivers indicated, they only got to hear about their children's performance when they would informally ask the ECD practitioner. There were no structures in place for correspondence between the management, the ECD practitioner and the caregivers. This clearly indicated that there was no carry over of stimulation tasks from the ECD centre to home.

Lack of communication appears to be the major factor influencing the perceptions of involvement in children's development both for the caregivers and the ECD practitioner. Caregivers want to be involved and see it as their responsibility to stimulate their children, yet they are not involved at the ECD centre predominantly through lack of communication like Ackermann (2015) emphasized the need for communication, he also reported that breakdown in communication could hinder involvement of caregivers in stimulation. He reported that teachers had the perception that caregiver involvement had to be managed. In his research, he discovered that the teachers' focus was more on visibility with regards to caregiver involvement (4), and did not necessarily on the importance of support at home. Facilitation of a reporting structure would enable a child-centred involvement from both the caregivers and the ECD practitioner / management. It must be noted that there was a small group of caregivers who did not find it necessary to communicate with the ECD practitioner. This was the same group of caregivers that

did not regard stimulation as their responsibility. They were not concerned about their children's progress and did not appeared worried by thet performance of the children on developmental tasks.

### 5.4.3 SUGGESTIONS FOR CHANGE

#### 5.5.3.1 Meetings, involvement at the ECD centre and peer support

The caregivers proposed a number of suggestions that would enable them to play an active role in communication. Their desires did not only consider structured meetings for involvement in financial matters, they were extended to regular sessions to discuss progress on development, assisting at the centre from time to time and creating peer support between caregivers. Caregivers' wish to be involved in the ECD centre, corresponded with their willingness to stimulate. This showed that they did not only find it their responsibility to provide stimulation at home, they had an understanding that the partnership with the ECD centre was crucial in providing carry over information to further enhance stimulation at home. Ackermann (2015) reported that the caregivers in his study indicated that involvement at school opened a door of communication between the caregiver and the school as well as the caregivers and other caregivers (4). In the current study, the caregivers also showed their desires to meet with others in order to develop support structures. This support group of caregivers would assist them to present their issues to the ECD centre, in a united form and also empower them to share ideas for stimulation. They expressed their wishes to get the community involved in uplifting the ECD centre. This wish is supported by Rivard et al. (2011) who stated that in order to provide full support in the children's education; school-family relationships connections should encompass a bidirectional flow of information such that the caregivers would be aware of the educator's practices and similarly the educator knows the caregivers' needs, interests and practices. The partnership could extend outside the school into the community to make sure that the school, caregivers and the community developed a shared vision of what would being done (69).

The Republic of South Africa (2015) reports on limited data available for caregiver support and capacity development programs. In the South African context, a huge number of families live in

poverty and other conditions that weaken caregiving capacity. This highlights the urgent need for caregiver support. The caregiver support programs that have been reported are provided mainly by the non- profit sector with an urban bias. In 2011, in the Eastern Cape Province, there existed only 4 group-based caregiver programs with the province's population of 2.7 million. Some of the programs on offer seem too low to acquire their full potential early childhood development benefits. Caregiver support programs are proven intervention for developing effective caregiver-child relationships. Good caregiver practices are essential for caregivers that are raising children in the context of high levels of poverty and other social risk factors (2). The caregivers expressed their desires to open structured communication lines, which as literature suggests, would make it possible for them to be aware of the ECD practitioner's practices, have information on progress of their children and as a result, enhance stimulation.

#### 5.5.3.2 Nutrition

The second biggest concern caregivers had regarded nutrition. Caregivers expressed their frustrations that the ECD centre continued to give the children the same menu of food every day. They shared their perception that they were aware of a sponsorship from the local university (North West University/Pukke) yet the children were served bread with cool-aid drink daily. As expressed by the caregivers, the children were provided food with poor nutritional status. The health risks they stated, included constipation and refluxes. Unfortunately; caregivers' views of the support received from North West University did not completely reflect the reality. The ECD practitioner confirmed that students from North West University visited the ECD centre, but that they did so as volunteers and focused specifically on providing weekly stimulation for the children. They donated educational toys and learning materials, but there was no monetary support that could supplement the menu at the ECD centre. This misconception further reinforces the problems with communication and the lack of transparency between the ECD practitioner and the management, and the caregivers. Caregivers did not have the correct information regarding the involvement of students from North West University with the children.

Research has shown that sufficient nutrition together with rich environmental experiences are needed in order to ensure optimal development. (11). Just (2014) supported that higher diet was associated with better scholastic performance and positive behavioural outcomes. Deficiencies in other minerals like zinc and thiamine inhibited cognitive function and mental concentration.

Supplementation of carbohydrates and amino acids were believed to improve perception, intuition and reasoning (70) It was highlighted in the review by Grantham-McGregor et al. (2007) that there were many researches that showed that early undernutrition, iron-deficiency, environmental toxins, stress, as well as poor stimulation and social interaction, could negatively impact on the brain structure and function, and the results have lasting cognitive and emotional effects (13). In this study, there was a double issue: the environment did not provide stimulating experiences for the children in addition to providing non nutritious food. Indeed, some of the developmental delays identified through the checklist may be due to poor nutrition in addition to a non-stimulating environment.

To remedy the problems regarding food, caregivers showed a preparedness to pack their children nutritious food daily. Despite their socio-economic status, they showed their commitment to providing the best for their children. They were even prepared to volunteer as cooks or donate food if the ECD centre would not consider increasing the monthly fees. They mentioned that the child care support grant would be used for its intended purpose. These suggestions indicated their level of commitment and their desires to give their children the best support irrespective of their financial challenges. Considering that other government departments like Social Development have a role to in ECD centres, their involvement was never discussed with the ECD practitioner and the management. The involvement of this stakeholder could benefit the ECD centre by subsidizing financial costs for meals.

#### 5.5.3.3 Resources

The caregivers only showed concerns over the painful necks that the children got from sleeping on the floor. However, on probing it seemed that caregivers were only concerned about the fact that children slept on the cement floor and did seem to worry about other resources in the centre. On their suggestions for change, they proposed sending towels with the children to use at nap time as well increasing fees for more nutritious food. They did not show concerns over the lack of educational resources at the ECD centre, which confirmed their low levels of involvement regarding the quality of stimulation the ECD centre provided. The impact that poverty of resources had on stimulation, was in line with the findings by Brown and Lee (2017), who reported that in examining school-readiness skills of beginning kinder-garteners, they found that 85 percent of kindergarteners in the highest SES bracket could recognize letters of the alphabet versus 39 percent of kindergarteners in the lowest SES bracket. Only ten percent of these children could

identify the beginning sounds of words compared to 51 percent of the highest SES kindergarteners (28). The caregivers' poor circumstances and their own poor knowledge of development and stimulation meant that they did not see the lack of resources at the centre apart from poor nutrition and lack of comfortable bedding.

During the interview with the ECD practitioner, she expressed that she taught the three to five-year-old children enrolled at the ECD centre, in one group, giving them instructions and tasks that had not been graded according to their age-groups. Veeman (1995) defined multi-age classrooms as the type of classrooms in which students from different age groups were taught by one educator (71). The ECD practitioner expressed that it was a challenge to structure the class activities to accommodate the different age groups in addition to being inclusive and providing support to those children that experienced barriers to learning. The scarcity of resources added to this problem as often the children had to share the materials for learning, which was only practical if the children shared the available resources in groups. Veeman (1995) conducted studies in which the cognitive or achievement effect of multi-age and single-age classes were compared, and they showed no differences between these two types of grouping. On the other hand, studies of the non-cognitive effects of multi-age and single-age classes showed results of inconsistent effects. The conclusion from the studies was thus; there were no empirical evidences for the assumption that child's learning may suffer in multi-age classrooms (71). The ECD practitioner shared that the caregivers did not participate in the activities of the ECD centre, which confirmed the limited involvement of the caregivers in their children's stimulation.

## 5.5 CONCLUSION OF THE DISCUSSION CHAPTER

The low socio-economic circumstances of the children enrolled at the ECD centre exposed them to occupational deprivation. Poverty in low socio-economic communities can also be regarded as a cause for occupational deprivation, as families lacked resources to purchase toys that would enable their children play at a developmentally appropriate level. Occupational apartheid was a form of occupational injustice which was experienced by these children living in low socio-economic communities. Their social status was the personal characteristic through which opportunities for occupation had been restricted. The non-nurturing environment in the low socio-economic community exposed these children to occupational injustices as that limited participation in meaningful occupations. The circumstances which were beyond the control of the

caregivers and the ECD practitioner, lead to play deprivation for the children enrolled at the ECD centre.

The discussions on the developmental checklists reflected a lack of knowledge and awareness of development among caregivers which indicated that limited opportunities for play had impacted on the children's brain growth. Given that they were in the sensitive period of brain development and at risk for chronic play deprivation, it could be deemed crucial that these children needed to receive the necessary stimulation through the engagement of their primary caregivers. The involvement of primary caregivers was discussed as key to alleviating poor development in early childhood. As a result of intergenerational cycle of poverty and lack of knowledge, poor caregiving skills were considered to greatly impact on their role in the stimulation of early child development. The caregivers regarded the involvement in the stimulation of their children's development, as their responsibility. The characteristics of this group of caregivers were similar to those who considered the stimulation of development to be the responsibility of the ECD practitioner. What was common in these two groups was the barriers and the facilitators, as well the low SES community. It can be concluded that the lack of awareness and knowledge of development, was resulting from lack of involvement in stimulating the children, even if the caregivers regarded that as their responsibility or not. The ECD practitioner confirmed attempts to invite the caregivers to the ECD centre, but their participation was poor. The ECD practitioner and the caregivers mutually found the meeting as a starting point to discuss matters of concern and implementation of the suggested changes for improvement Perhaps this could be considered as the starting point for the therapist to collaborate the two parties, with the ivolvement of the ECD management.

The perceptions of the primary caregivers have been established through this study, and they have guided the specific intervention strategies that can be developed to enhance their involvement, including caregiver education on the benefits of different types of play. As play is the main occupation in childhood, stimulation of play thus has benefits for health and well-being. The involvement of the caregivers in shaping play is considered as the occupational therapist's approach to enhancing community health. For the implementation of effective health programmes, it is deemed crucial to promote the importance of early stimulation in childhood so as to develop relevant intervention strategies to prevent poor early childhood development

Literature is limited in terms of the perceptions of caregivers on their involvement. This study shows that caregivers do think it is their responsibility and want to be involved but that the biggest challenges relate to poverty, knowledge and communication with the ECD centre. Thus; interventions need to take these needs and barriers into consideration.

## 5.6 LIMITATIONS OF THE STUDY

- The developmental checklist used in the study as a springboard should have been complimented by thorough developmental assessments for the children of the participants. The formal assessments would have provided tangible proof that could be related to the caregivers' perceptions of the actual developmental levels of their children.

- The management of the ECD centre was not included in the study to provide their views on the caregivers' involvement in the stimulation of their children. For triangulation, interviews with management would have established the extent of their involvement with the daily operations of ECD centre, given the concerns raised by the caregivers which included resources, fees and meals.

- There was only one male participant in the group of ten primary caregivers and with families that had a father figure, the mother was interviewed. While this reflects common gender roles (it is predominantly women who are primary caregivers for children in this community), the lack of men or fathers in the sample means that it was not possible to compare and discuss the involvement in stimulation of the children by male and female participants.

- The group of caregivers that did not consider stimulation of child development as their responsibility, was not probed further to establish the reasons for lack of involvement. These reasons could be valuable if the study aims to change the perspectives of the caregivers or those of the community at large.

- Finally, this study aimed to explore perceptions of a very specific group of people in a very specific geographical location with children attending a specific ECD centre. As such these findings are limited to this specific population. While the findings of this study have

supported literature on caregivers living in poverty, the design of this project means that findings may not be generalizable to all populations of caregivers living in poverty.

# 6 CHAPTER 6: CONCLUSION

This study set out to explore the perceptions of caregivers who live in low socio-economic conditions regarding their role in the stimulation of their children as well as how this influenced their involvement in the local ECD centre. It can be concluded through this study that the involvement of primary caregivers is crucial in the stimulation of early childhood development. Literature has shown that caregivers in low socio-status communities do not involve their children in stimulation due to poverty of formal resources. The bulk of the caregivers in this study regard stimulation of their children's developmental milestones as their responsibility. They have the time and willingness, but they lack the necessary resources. They indicated that they use informal resources to involve their children during household chores.

However, the caregivers' perception remains that scarcity of formal resources contributes to a lack of structured stimulation. The impact of the environment and their low socio-economic status contribute greatly to their lack of funds to purchase the resources needed to enhance stimulation. They also acknowledge that they lack the awareness of age-appropriate developmental skills for their children. With regards to the local ECD centre, they perceive that their involvement can assist the management in improving the conditions. Communication channels will allow collaboration between the management, the ECD practitioner and the caregivers. Their perception on their role for efficient early childhood stimulation has thus developed basis onto which education on the importance of early child development, can be made specific to their socio-economic status and living conditions.

It is shown in the literature that caregivers have a crucial role to play in facilitating co-occupations as they are the shapers of the child's play. Their perceptions on their role in this regard, has determined the relevant and specific intervention programs they need in order to improve their skills in shaping the children's occupations. As their perceptions on their roles have been established, the specific intervention programs can thus improve their knowledge and involvement in the stimulation for their children's readiness for school. There is limited literature on the perception of primary caregivers on their involvement in the stimulation of developmental milestones of their children, more especially in low socio-economic status community. This research has added to the body of knowledge by reporting on the perception caregivers have on their role in the stimulation of child development.

## 6.1 RECOMMENDATIONS TO THE ECD STAFF AND MANAGEMENT

- The first recommendation is regarding strengthening communication strategies at the centre with the first step setting up regular teacher-caregiver type meetings to discuss progress and needs of children is recommended. This can be done either in the mornings when children are dropped off or in the afternoons when they are collected. Within the community at large, there are no programs running that equip the caregivers with essential parenting skills needed to enhance early child development. Peer support groups can be formed through involvement of active caregivers. They will build a cohesive group that will eventually empower them to be more involved in the ECD centre.

- The children enrolled at the ECD centre should be assessed formally for perceptual skills development. This will guide the therapist on the specific information to include in the development of the intervention program for stimulation.

- Considering that this is the only ECD centre in this area, it will be beneficial to equip the practitioner with skills for multi-age approach in providing stimulation. The approach should not only focus on direct learning for the children, they should be given opportunities to interact with other children in order to enhance social skills, turn taking and sharing.

- The management of the ECD centre should consider registration with Social Development as a Non-Profit Organisation in order to access funding that they can use for running costs and purchasing nutritious food. Alternatively, the management can draw up a policy on provisioning of own food. This will allow the caregivers to pack nutritious food for their children.

## 6.2 RECOMMENDATIONS FOR CLINICAL PRACTICE

- In the profession of Occupational Therapy, occupation is regarded as central in promoting health and well-being. The involvement of the caregivers in shaping play, is considered as the Occupational Therapist's approach to enhancing community health. For the implementation of effective health programmes, it is deemed crucial to develop intervention strategies that are relevant to the community being served in order to prevent

poor early childhood development. Intervention strategies to be developed should be specific to the needs of the community to enhance caregiver involvement in the stimulation of development. These interventions should incorporate caregiver education on knowledge about child development and the benefits of play as a means of stimulation. The development of these community specific intervention strategies should allow collaboration between the ECD practitioner, the caregivers and the Occupational Therapist for effective implementation.

- Low SES communities are characterized by unavailability of learning materials for children, which leads to poor stimulation. These types of communities also lack in programmes that equip the caregivers with essential parenting skills needed to enhance early child development. Suggested interventions include caregiver training in the use of home-made / low cost toys and household objects to challenge the barriers. Promotion of responsive caregiving behaviours is crucial as this improves children's development, maternal mood and quality caregiver-child interactions.

- The Occupational Therapist should be a mediator for the ECD centre in facilitating the involvement of other relevant stakeholders that can provide the necessary support for the better functioning of the ECD centre.

- The caregiver-child programmes need to incorporate home visits or group sessions to encourage caregivers and children to actively engage in play skills. The caregivers also require guidance on developing structured daily routines that integrate stimulation of developmental milestones. Ideas can be shared through information-based sessions

## 6.3 RECOMMENDATIONS FOR FUTURE RESEARCH

- In the future, research can be conducted to investigate how aspects such as parenting skills and access to educational resources at home, affect development in children living in low socio-economic communities.

- Further research should include a longitudinal study that will explore the effectiveness of the intervention programme that will have been developed specifically for the ECD centre.

The children will need to be assessed at the start of the intervention and when they exit the ECD centre, in order to determine the effectiveness of the intervention. This should include the intervention and the control groups in order to allow a comparison post implementation of the intervention.

- Literature is limited on the precise extent and specific areas of cognitive abilities that are affected by the absence of a father-figure in a developing child. Further research in this field is needed to establish if the absence of the father-figure affects intellectual development directly or it bears more weight in the socio-emotional development which is also needed in support for the mother that stimulates the child. The Batswana nation regards the father as the financial provider in the household, research may determine if his absence, heightens the effects of poverty alone, or has an influence on cognitive development.

# REREFENCES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## ADDENDUM A: INTERVIEW SCHEDULE FOR PRIMARY CAREGIVERS

Research Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

Participant code: _____

Date: _____

Time: _____

Duration of interview: _____

**Introduction:**

Today we're going to talk about how your child grows and develops and what you think is your role in helping your child grow. Please remember I would like to know what you think and feel so please try and be as honest as possible. Whatever you say today will be kept confidential and I will only be sharing it with my supervisor. To start off I would like you to look at this checklist and try to fill it in. You need to look at how many of these activities your child is able to do. If you have any questions, please ask me.

1. Let's talk about this checklist.
    a. Are these activities familiar to you? What do you see your child doing?
    b. Let's talk about any activities that are unfamiliar to you.

2. What are your views on your role in the stimulation of developmental milestones for your child?
    a. What do you believe are your responsibilities as the caregiver in the stimulation of the growing child?
    b. How does your child involve you in play or participate in something that you are doing?
    c. What kind of things or toys do you have available that you use to help your growing child?
    d. What do you find as difficulties in helping your child to develop?

3. How would you describe your everyday life and your involvement in the life of your child?

a. How would you describe your involvement in your child's education at the ECD centre?
b. How would you describe your satisfaction with your involvement at the ECD centre? Would you like to be more involved or less involved in? What can be done to facilitate this?

## ADDENDUM B: INTERVIEW SCHEDULE FOR THE ECD PRACTITIONER

Research Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

Participant code: _____

Date: _____

Time: _____

Duration of interview: _____

### Introduction

This interview will involve the discussion about the ECD centre and the involvement of the caregivers in the activities of the centre.

Today we're going to talk about your work at the ECD centre and specifically your interactions with the children's caregivers. Please remember I would like to know what you think and feel so please try and be as honest as possible. Whatever you say today will be kept confidential and I will only be sharing it with my supervisor.

1. For how long have you been in this type of job (teaching)? How long have you been working at this specific ECD Centre? Please take me through your typical day in the classroom.

2. Let's talk about the ECD centre.
    a. What type of materials and resources are available at the centre?
    b. How do the caregivers contribute to the materials you use for learning?

3. Let's discuss the involvement of the caregivers with the activities of the ECD centre.
    a. What are your views about the involvement of the caregivers in their children's development and education?
    b. How do you communicate with the caregivers regarding activities that you do with the children? Do they call or visit the centre? What kind of things do they call or visit about?
    c. What would you consider as effective ways for the centre to involve caregivers in

the development and education of their children?

d. Have you ever attempted to implement these strategies at this centre? If so, how was your experience?

**ADDENDUM C: DEVELOPMENTAL CHECKLIST - 3-5 YEARS** www.childrenstherapies.co.uk

## 3 YEAR OLD CHILD

| Posture and Large Movements | |
|---|---|
| □ Walks up/down stairs – alternating feet and can carry large toy<br>□ Jumps from bottom step with 2 feet<br>□ Climbs nursery apparatus agilely<br>□ Can turn corners and obstacles while running<br>□ Walks forward, backward, sideways confidently<br>□ Rides tricycle using pedals, steering round wide corners | □ Stands and walks on tiptoes<br>□ Can stand momentarily on 1 foot when shown<br>□ Sits with feet crossed at ankles<br>□ Throws ball overhand<br>□ Catches large ball on / between extended arms<br>□ Kicks forcefully |
| **Vision and Fine Movements** | |
| □ Build tower of 9-10 blocks<br>□ Threads large wooden beads onto lace<br>□ Can close fist and copy wiggling of thumbs on either hand<br>□ Copies circle, also 'V H and T', cross.<br>□ Draw a person – head + 1-2 other features | □ Matches 2-3 primary colours, usually red and yellow. May confuse blue and green.<br>□ May know names of colours<br>□ Enjoys painting – usually names pictures during or after production<br>□ Cuts with toy scissors |
| **Hearing and Speech** | |
| □ Large vocabulary<br>□ Starts to combine 3-4 words in sentences<br>□ Speech intelligible to strangers<br>□ Gives full name, gender and perhaps age<br>□ Uses personal pronouns and plurals correctly, also most prepositions e.g."in, on, under"<br>□ Talks to self in long monologues, mostly about immediate present, especially during make believe play<br>□ Simple conversations held | □ Describes briefly present activity and past event<br>□ Asks many questions 'what, where, who'<br>□ Listens eagerly to stories and demands favourites repeatedly<br>□ Knows several rhymes to repeat, maybe sing<br>□ Enjoys TV and will join in songs<br>□ Counts to 10 but little actual number correspondence beyond 2 or 3 |
| **Social Interaction and Play** | |
| □ Spoon and fork feeding<br>□ Washes hands but needs help drying<br>□ Pulls pants down and up, help needed with buttons and fastenings<br>□ May be dry through night<br>□ Likes helping with domestic activities, gardening, shopping etc.<br>□ Tries to keep environs tidy<br>□ Vivid make-believe play with invented people and objects | □ Enjoys playing on the floor with toys, alone or with siblings<br>□ Joins in make-believe with other children<br>□ Understands sharing toys<br>□ Affectionate to younger siblings<br>□ Appreciation of difference between present and past and need to defer satisfaction to future |

# 4 YEAR OLD CHILD

| Posture and Large Movements | |
|---|---|
| □ Walks or runs up / down stairs in adult fashion<br>□ Navigates locomotion skillfully<br>□ Climbs ladders and trees<br>□ Can stand, run and walk on tiptoe<br>□ Confident tricycle rider and sharp u-turner | □ Stands on 1 (preferred) foot up to 5 seconds and hops on it<br>□ Bends from waist to pick up toys<br>□ Sits with knees crossed<br>□ Increasing ball game skill: catching, throwing, bouncing, kicking, batting |
| **Vision and Fine Movements** | |
| □ Builds several 3 block bridges from model on request or spontaneous | □ Builds tower of 10+ blocks<br>□ Builds 3 steps of 6 cubes after demo |
| **Hearing and Speech** | |
| □ Can follow a 2 part instruction e.g.“Fetch your coat and give it to daddy”<br>□ Grammatically correct and intelligible<br>□ Gives connected account of recent events<br>□ Gives full name, address and usually age<br>□ Questions include: Why, when, how meaning of words | □ Listens to and tells long stories, may confuse fact/fantasy<br>□ Rote counts up to 20+<br>□ Counts objects by word and touch in 1-1 correspondence up to 4 or 5<br>□ Enjoys jokes<br>□ Knows several nursery rhymes, repeats and sings correctly |
| **Social Interaction and Play** | |
| □ Eats skillfully with spoon and fork<br>□ Washes and dries hands, brushes teeth<br>□ Dresses and undresses bar laces, ties and back buttons<br>□ Sense of humour shown in talk + activities<br>□ Dramatic make-believe & dress-up play<br>□ Complicated floor games<br>□ Constructive out-door building with any available material<br>□ Needs companionship of other children: can alternately cooperative / aggressive<br>□ Understands need to argue with words not blows<br>□ Understands taking turns as well as sharing<br>□ Shows concern for younger sibling and sympathy for distressed playmates<br>□ Appreciates past, present and future | □ Eats skilfully with spoon and fork<br>□ Washes and dries hands, brushes teeth<br>□ Dresses and undresses bar laces, ties and back buttons<br>□ Sense of humour shown in talk + activities<br>□ Dramatic make-believe & dress-up play<br>□ Complicated floor games<br>□ Constructive out-door building with any available material<br>□ Needs companionship of other children: can alternately cooperative / aggressive<br>□ Understands need to argue with words not blows<br>□ Understands taking turns as well as sharing<br>□ Shows concern for younger sibling and sympathy for distressed playmates<br>□ Appreciates past, present and future |

## 5 YEAR OLD CHILD

| Posture and Large Movements | |
|---|---|
| □ Walks narrow line easily<br>□ Runs lightly on toes<br>□ Skips on alternate feet<br>□ Stands on either foot 8-10 seconds<br>□ Can usually stand on preferred foot with arms folded<br>□ Can hop forward 2-3m on either foot<br>□ Moves rhythmically to music<br>□ Grips strongly with either hand | □ Bends to touch toes without flexing knees<br>□ Plays ball games with ability, including rule bound games□ Can hop forward 2-3m on either foot<br>□ Moves rhythmically to music<br>□ Grips strongly with either hand<br>□ Bends to touch toes without flexing knees<br>□ Plays ball games with ability, including rule bound games |
| **Vision and Fine Movements** | |
| □ Picks up and replaces minute objects<br>□ Builds elaborate models when shown, sometimes 4 steps from 10 blocks<br>□ Good drawing / writing control Copies square and at 5.06yrs copes triangle<br>□ Also copies: V;T;H;O;X;L;A;C;U;Y'<br>□ Writes a few letters spontaneously | □ Draws recognisable man: Head; trunk; legs; arms and features<br>□ Draws house: door, windows, roof; chimney<br>□ Other pictures may have background environment<br>□ Colours within outlines<br>□ Counts fingers on 1 hand with index<br>□ Names 4+ primary colours<br>□ Matches 10-12 colours |
| **Hearing and Speech** | |
| □ Fluent, grammatically conventional speech<br>□ Delights in reciting rhymes and jingles<br>□ Loves stories read – acts out details later alone or with peers | □ Gives full name, address, age and usually birthday<br>□ Defines concrete nouns by use<br>□ Asks meaning of abstract words<br>□ Enjoys jokes and riddles |
| **Social Interaction and Play** | |
| □ Uses knife and fork<br>□ Undresses and dresses alone<br>□ Washes and dries hands alone, needs supervision for rest<br>□ More sensible behaviour<br>□ Understands need for order and tidiness – but needs reminders<br>□ Domestic and dramatic play continued alone or with peers<br>□ Complicated floor games | □ Plans and builds constructively<br>□ Chooses own friends<br>□ Co-operates with peers most of the time<br>□ Understands need for rules and fair play<br>□ Definite sense of humour<br>□ Appreciates meaning of time in relation to daily routine<br>□ Tender and protective of younger children<br>□ Comforts distressed peers |

## ADDENDUM D: INFORMATION SHEET FOR INFORMED CONSENT PROCEDURE

Research Title: Perceptions of caregivers on their role in stimulating child development in a low-socio economic community.

Good day,

I, Malikomo Kometsi, am a master's student in Occupational Therapy at the University of Witwatersrand. I am doing research on the perception of primary caregivers of their role in the stimulation of developmental milestones within a low socio-economic community. Research is the process of learning the answer to a question. In this study I want to explore your perception of your role in the stimulation of developmental milestones with your child. This will help me to understand your needs when I plan specific intervention programmes at the ECD centre.

I am inviting you to take part in this research project by allowing me to interview you.

**What is involved in the study:** In order to answer the research question, I would like to conduct a face-to-face interview with you. This interview will take place at the ECD centre in the afternoon and will last about 1 ½ hours. During this interview I will ask you questions about what you think and how you feel about your child's development. The interviews will be tape-recorded to help me remember what you have said. Everything you say will be kept confidential and will not be shared with other caregivers, or anyone at the ECD centre.

**Risks:** There are no risks involved in taking part in this research.

**Benefits:** There are no immediate benefits to you for taking part in this research. However, the information from this research will be used to create an intervention programme at the ECD centre that specifically addresses your needs.

**Participation is voluntary:** You may choose to participate or not participate in this research. If you choose not to participate, there will be no consequences for you or for your child. I will not disclose your refusal to anyone, including the people at the ECD centre. You can also choose to withdraw (change your mind) once the research has started. If you choose to withdraw, all your information will be destroyed immediately, and there will be no negative consequences for you or

your child. I will not disclose your withdrawal to anybody, including the people at the ECD centre. I will share my final results with you as a participant when I am finished with my research.

**Costs:** You may have transport costs to get to the ECD centre for the interview. I will reimburse your transport costs for the day of the interview.

**Confidentiality**: Every effort will be made to keep your personal information confidential, but I cannot guarantee absolute anonymity. When I report on your information. I will use codes and I will remove any identifying information. However, personal information may be disclosed if required by law.
Organizations that may inspect and/or copy my research records for quality assurance and data analysis include groups such as the Research Ethics Committee and the Medicines Control Council (where appropriate).
I will publish my findings in a peer-reviewed journal and will make every effort to keep your identity confidential.

**Contact details of researcher/s** – for further information or if you have any questions you can contact me. Please feel free to ask me any questions that will help you to make this decision.
Email: agomie@webmail.co.za
Tel: 073 699 3348

**Contact details of REC administrator and chair** – If you would like to report a problem or a complaint, you may contact the administrator and chair of the Human Research Ethics Council:

Ms Zanele Ndlovu and Mr Langutani Masingi, Medical School, Parktown, Phillip Tobias Building, 2nd Floor, Cnr York Road and Princess of Wales Terrace, Mon-Fri 08h00-17h00 Tel: 011-717-1234/1252/ 2700 or Room SH1005, 10th Floor Senate House, Emails: zanele.ndlovu@wits.ac.za or Langutani.Masingi@wits.ac.za

Thanking you in advance for your assistance in completing this study, your time and willingness to participate is highly appreciated.

Malikomo Kometsi

## ADDENDUM E: INFORMED CONSENT FORM

Research Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

I, the undersigned, confirm that (please tick box as appropriate):

| | | |
|---|---|---|
| 1. | I have read and understood the information about the research, as provided in the Information Sheet. | ☐ |
| 2. | I have been given the opportunity to ask questions about the research and my involvement. | ☐ |
| 3. | I voluntarily decide to take part in the study. | ☐ |
| 4. | I understand that I can pull out at any time without giving reasons and that I will not incur any penalties for withdrawing nor will my withdrawal be questioned. | ☐ |
| 5. | The procedures regarding confidentiality have been clearly explained (e.g. use of pseudonyms) to me. | ☐ |
| 6. | I understand that the researcher and the supervisor will have access to this data and they will preserve the confidentiality of the data. | ☐ |
| 7. | I, along with the Researcher, agree to sign and date this informed consent form. | ☐ |

**Participant:**

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Signature | Date |

**Researcher:**

| _____ | _____ | _____ |
|---|---|---|
| Name of Researcher | Signature | Date |

## ADDENDUM F: CONSENT TO AUDIO-RECORDING AND TRANSCRIPTION

Research Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

This study involves the audio recording of your interview with the researcher. Your name or any other identifying information will not be used in the audio recording or the transcript. The recordings will only be accessed by the researcher and the supervisor. The recorded tapes will be erased once the transcriptions are checked for accuracy. Transcripts of the interview may be reproduced in whole or in part for use in presentations or written products that result from this study.

By signing this form, I give consent to be audio-recorded by the researcher as part of this study.

Participant's name:_____

Participant's Signature: _____ Date:_____

**ADDENDUM G: PARTICIPANT DEMOGRAPHIC FORM**

Research Title: Perceptions of caregivers on their role in stimulating child development in a low socio-economic community.

**Today's Date:** ____ ____ / ___ ___ / ___ ___ ___ ___
Day Month Year

Name of participant _____ Age _____

**Gender:** Male _____ Female_____

Have you been to school? Yes _____ No_____

What is the highest grade you passed? Grade_____
Other_____

Do you currently earn an income of your own? Yes_____ No_____

How do you earn an income? Formal employment_____

Self-employed _____

Other, specify_____

What is the type of housing that you live in? Shanty_____ House_____ Number of rooms_____

How many people live in the household with you? _____

How many children do you have or that you are looking after? _____

How many of your children attend the Living Waters Early Childhood Development Centre? _____

What are the ages of your children attending the centre? _____

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**ADDENDUM H – PERMISSION FOR RESEARCH SITE**

LITTLE SAINTS NURSERY SCHOOL
✉ 671,POTCHEFSTROOM,2520 ☎(018) 294 6690 Fax:(018) 293 0239

20 July 2015

ATT: Ms. L. Koch
University of the Witwatersrand
School of Therapeutic Sciences
Johannesburg

Dear Ms. Koch

With this letter permission is granted to Ms. Malikomo Kometsi to do her research project at Living Waters E.C.D. Centre in Sonderwater. We will support her in any possible way. Living Waters E.C.D. is supervised by the Christian Fellowship Church and Little Saints Nursery School.

Kind regards

R. SERFONTEIN
PRINCIPAL

PST. B. MARKS
EXECUTIVE SECRETARY
CHRISTIAN FELLOWSHIP

## MAMETLELELO J: THULAGANYO YA POTSOLOTSO YA BATLHOKOMEDI BA KONOKONO

**Setlhogo sa Patlisiso:** Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

Khoutu ya motsayakarolo: _____

Letlha: _____

Nako: _____

Nako e e tla tsewang go dirwa potsolotso: _____

**Ketapele:**

Gompieno re tlile go bua ka ga kafa ngwana wa gago a golang le go tswelela ka teng le gore o akanya gore seabe sa gago ke sefe mo go thuseng ngwana wa gago go gola. Tsweetswee gakologelwa gore ke batla go itse se o se akanyang le gore o ikutlwa jang jalo tsweetswee leka go bua boammaruri kafa go kgonegang ka teng. Sepe fela se o se buang gompieno se tla bolokwa e le khupamarama mme ke tla se abelana fela mokamedi wa me. Fa re simolola ke batla gore o lebe lenaanetshwao leno mme o leke go le tshwaya. O tshwanetse go leba gore ke dife tsa ditiro tseno tse ngwana wa gago a kgonang go di dira. Fa e le gore o na le dipotso dipe, tsweetswee mpotse.

4. A re bue ka lenaneotshwao leno.
    c. A o tlwaelane le ditiro tseno? O bona ngwana wa gago a dirang?
    d. A re bue ka ditiro dipe tse o sa tlwaelanang le tsone.

5. Dipono tsa gago ke dife mabapi le seabe sa gago malebana le go tlhotlheletsa ditiro tsa phetogo malebana le kgolo ya ngwana wa gago?
    e. O dumela gore maikarabelo a gago ke afe jaaka motlhokomedi malebana le go tlhotlheletsa ngwana yo o golang?
    f. Ngwana wa gago o go tsenya jang mo motshamekong wa gagw kgotsa go tsaya karolo mo go sengwe se o se dirang?
    g. Ke dilo tsa mofuta ofe kgotsa dithoye tse o nang le tsone tse o di dirisang go thusa ngwana wa gago yo o golang?
    h. Ke eng se o bonang e le mathata mo go thuseng ngwana wa gago go tswelela?

6. O ka tlhalosa jang botshelo jwa gago jwa tsatsi le letsatsi le go tsaya karolo ga gago mo botshelong jwa ngwana wa gago?
    c. O ka tlhalosa jang go tsaya karolo ga gago mo thutong ya ngwana wa gago kwa senthareng ya ECD?
    d. O ka tlhalosa jang go kgotsofala ga gago malebana le go tsaya karolo ga gago kwa senthareng ya ECD? A o ka rata gore o tseye karolo thata kgotsa o seka wa tsaya karolo thata? Ke eng se se ka dirwang go rulaganyetsa seno?

**MAMETLELELO K: LENAANETSHWAO LA GO TIYA GA BANA BA DINGWAGA TSE 3-5**

**NGWANA WA DINGWAGA TSE 3**

**Setlhogo sa Patlisiso:** Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

| **Kemo ya Mmele le Tsamaisomesifa e Megolo** | |
|---|---|
| □ O palama/fologa ditepisi - a gata ka leoto le sele morago ga le lengwe mme o kgona go tshola thoye e kgolo<br><br>□ O tlola go tswa kwa setepising se se kwa tlase ka maoto a le 2<br><br>□ O palama didirisiwa tsa botshamekelo bonolo<br><br>□ O kgona go fapogela go sele fa a filha fa dikhutlong le go fapoga dikgoreletse a ntse a siane<br><br>□ O tsamaela kwa pele, kwa morago, kafa thoko a sa tlhomamisega<br><br>□ O palama teraesekele a dirisa diphetlele, a e tsamaisa go dikologa dikhutlo tse di sephara | □ O ema le go tsamaya ka ditsetsekwane<br><br>□ O kgona go ema ka nakwana ka leoto le le lengwe fela fa a bontshiwa<br><br>□ O nna a fapaantse maoto fa mangenaneng<br><br>□ O latlhela bolo a tsholeditse seatla a se kobiseditse kwa morago.<br><br>□ O kapa bolo e kgolo ka / a tsholeditse mabogo<br><br>□ O raga ka maatla |
| **Pono le Tsamaisomesifa e Mennye** | |
| □ O aga tora ya diboloko tse 9-10<br><br>□ O fololela dibaga tse dikgolo tsa legong mo kgolenyaneng<br><br>□ O kgona go dira feise le go etsisa go tshikinya menwana ya kgonope ya diatla ka bobedi<br><br>□ O kopisa sediko, gammogo le sefapaano,'V, H le T'.<br><br>□ O thala setshwantsho sa motho – tlhogo le dipopego tse dingwe di le 1-2 | □ O tsamaisanya mebala ya motheo e le 2-3 ,gantsi bohibidu le serolwana. O ka nna a tsietsega ka botala jwa loapi le botala jwa tlhaga.<br><br>□ O ka nna a itse maina a mebala<br><br>□ O rata go penta – gantsi o kgona go bua maina a ditshwantsho fa di ntse di tshwantshiwa kgotsa di se na go tshwantshiwa<br><br>□ O kgona go sega ka sekere sa dithoye |

| Go Utlwa le Puo | |
|---|---|
| □ Mafoko a mantsi<br><br>□ O simolola go kopanya mafoko a le 3-4 mo polelwaneng<br><br>□ O bua ka botlhale le batho ba a sa ba itseng<br><br>□ O kgona go bua leina la gagwe ka botlalo, bong gongwe le dingwaga<br><br>□ O dirisa maemedi le bontsi sentle, gammogo le matlama, ka sekai, “mo teng, mo godimo, kafa tlase”<br><br>□ O bua a le nosi a tshwere motlotlo o moleele, gantsi a bua ka dilo tsa nako eo, bogolo jang fa a dira motshameko wa maitirelo<br><br>□ O tshwara motlotlo o o sa raraanang | □ O tlhalosa tiro ya nako eo ka bokhutshwane le tiragalo e e fetileng<br><br>□ O botsa dipotso tse dintsi 'eng, kae, mang'<br><br>□ O reetsa ditori ka tlhoafalo le go batla gore tse a di ratang di boelediwe<br><br>□ O itse meribo e le mmalwa e a e boeletsang, gongwe e a e opela<br><br>□ O rata TV mme o opela a tsamaisana le pina e e opelwang mo go yone<br><br>□ O bala go fitlha kwa go 10 mme ga a kgone go tsamaisanya dipalo go feta 2 kgotsa 3 |
| **Go Dirisana le Batho le go Tshameka** | |
| □ Go ja ka leswana le foroko<br><br>□ O tlhapa diatla mme o tlhoka thuso fa a iphimola<br><br>□ O kgona go apara le go tsola borokgwe, o tlhoka thuso ka dikonopo le go di kopela<br><br>□ Gongwe ga a tlhapologele mo dikobong bosigo<br><br>□ O rata go thusa ka ditiro tsa mo ntlong, go dira mo tshingwaneng, go reka kwa mabentleleng<br><br>□ O leka go boloka ditikologo di le phepa<br><br>□ O tshameka metshameko e e tlhaloganyesegang sentle ka batho le dilo tsa maitirelo | □ O rata go tshameka a ntse fa fatshe ka dithoye, a le nosi kgotsa le bomogolowe le bomonnawe<br><br>□ O tshameka le bana ba bangwe metshameko ya maitirelo<br><br>□ O tlhaloganya gore bana ba bangwe ba ka dirisa dithoye tsa gagwe<br><br>□ O rata bomonnawe<br><br>□ O tlhaloganya pharaloganyo gareng ga pakajaanong le pakapheta mme o ipeela se a se ratang gore a se itumelele mo nakong e e tlang |

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**Setlhogo sa Patlisiso:** Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

## NGWANA WA DINGWAGA TSE 4

| Kemo ya Mmele le Tsamaiso mesifa e Megolo | |
|---|---|
| □ O tsamaya kgotsa o siana a tlhatloga / a fologa ditepisi jaaka mogolo<br><br>□ O kgona go dirisa mmele wa gagwe ka botswerere<br><br>□ O palama dilere le ditlhare<br><br>□ O kgona go ema ka dinao, go siana le go tsamaya ka ditsetsekwane<br><br>□ Ke mopalami wa teraesekele yo o itshepang le yo fapogang ka bonako | □ O ema ka leoto le le 1 (le a ratang go ema ka lone) go fitlha go metsotswana e le 5 a ba a tlolatlola ka lone<br><br>□ O inama go tswa fa lethekeng go tsaya dithoye fa fatshe<br><br>□ O nna a tlhatlagantse mangwele<br><br>□ O oketsa bokgoni jwa go tshameka ka bolo: go e kapa, go e latlhela, go e itayaitaya fa fatshe, go e raga, go beta |
| **Pono le Tsamaisomesifa e Mennye** | |
| □ O aga maborogo a le 3 ka diboloko a dirisa<br><br>sekao se se dirilweng fa a kopiwa kgotsa ka boene fela | □ O aga kago e telele ya diboloko tse 10+<br><br>□ O dira dikgato tse 3 tsa dikhiubo tse 6 fa a se na go bontshiwa |
| **Go Utlwa le Puo** | |
| □ O kgona go latela taelo ya dikarolo tse 2 ka sekai, "Eya go tsaya baki ya gago o bo o e naya papa"<br><br>□ O dirisa thutapuo sentle le<br><br>ka botlhale<br><br>□ O bolela ditiragalo tse di diragetseng bosheng ka go tlhomagana ga tsone | □ O reetsa ditori tse ditelele le go di bolela, o ka nna a tsietsega fa go buiwa ka dilo tsa boammaaruri/dikinane fela<br><br>□ O bala go fitlha go 20+ ka tlhogo fela<br><br>□ O bala dilo ka go bitsa lefoko le go di kgoma a tshwantshanya dilo ka 1-1 tse di tsamaelelanang go fitlha go 4 kgotsa 5<br><br>□ O natefelelwa ke metlae |

| | |
|---|---|
| □ O kgona go bua leina la gagwe ka botlalo, aterese mme gantsi le dingwaga<br><br>□ Dipotso tsa gagwe di akaretsa: Goreng, leng, jang + tlhaloso ya mafoko | □ O itse meribo e le mmalwa ya bana,<br><br>o e boeletsa le go opela sentle |
| **Go Dirisana le Batho le go Tshameka** | |
| □ O ja ka botswerere a dirisa leswana le foroko<br><br>□ O tlhapa diatla le go iphimola, o tlhapa meno<br><br>□ O bofa le go bofolola dikgole tsa ditlhako, dithai le dikonopo tse di kafa morago<br><br>□ O na le go tshegisa fa a bua + ka ditironyana tsa gagwe<br><br>□ Metshameko e e e tlhaloganyesegang ya maitirelo le e e aparelwang<br><br>□ Metshameko e e raraaneng e e direlwang fa fatshe<br><br>□ O aga dikagonyana kwa ntle ka<br><br>matheriale ope o o leng teng<br><br>□ O rata go nna le bana ba bangwe: fa gongwe a dirisana sentle le bone / fa gonwe a ba galefela<br><br>□ O tlhaloganya gore o tshwanetse go ganetsana ka mafoko eseng ka go itaya ba bangwe<br><br>□ O tlhaloganya go refosana gammogo le go abelana<br><br>□ O bontsha a tshwenyega ka bomonnawe le go utlwela botlhoko ba a tshamekang le ene fa ba hutsafetse<br><br>□ O tlhaloganya pakapheta, pakajaanong le nako e e tlang | □ O ja ka botswerere a dirisa leswana le foroko<br><br>□ O tlhapa diatla le go di phimola, o tlhapa meno<br><br>□ O bofa le go bofolola dikgole tsa ditlhako, dithai le dikonopo tse di kafa morago<br><br>□ O na le go tshegisa fa a bua + ka ditironyana tsa gagwe<br><br>□ Metshameko ya maitirelo le e e aparelwang<br><br>□ Metshameko e e raraneng e e direlwang fa fatshe<br><br>□ O aga dikagonyana dilo kwa ntle ka<br><br>matheriale ope o o leng teng<br><br>□ O rata go nna le bana ba bangwe: fa gongwe a dirisana sentle le gone / fa gongwe a ba galefela<br><br>□ O tlhaloganya gore o tshwanetse go ganetsana ka mafoko eseng ka go itaya ba bangwe<br><br>□ O tlhaloganya go refosana gammogo le go abelana<br><br>□ O bontsha a tshwenyega ka bomonnawe le go utlwela botlhoko ba a tshamekang le ene fa ba hutsafetse<br><br>□ O tlhaloganya pakapheta, pakajaanong le nako e e tlang |

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**Setlhogo sa Patlisiso:** Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

## NGWANA WA DINGWAGA TSE 5

| Kemo ya Mmele le Tsamaisomesifa e Megolo | |
|---|---|
| □ O tsamaya mo ditselaneng tse ditshesane bonolo fela<br><br>□ O siana a nanabela ka ditsetsekwane<br><br>□ O tlolatlola a refosanya maoto<br><br>□ O ema ka leoto lepe fela metsotswana e le 8-10<br><br>□ Gantsi o kgona go ema ka leoto le a batlang go ema ka lone a phuthile mabogo<br><br>□ O kgona go tlolatlolela kwa pele sekgala sa 2-3m ka leoto lepe fela<br><br>□ O kgona go tsamaisana le moribo wa mmino<br><br>□ O tshwara ka thata ka sepe sa diatla | □ O inama go tshwara menwana ya maoto a sa obe mangole<br><br>□ O kgona go tshameka metshameko ya bolo sentle, go akaretsa le metshameko e e nang le melao<br><br>□ O kgona go tlolatlolela kwa pele sekgala sa 2-3m ka lepe la dinao tsa gagwe<br><br>□ O kgona go tsamaisana le moribo wa mmino<br><br>□ O tshwara ka thata ka sepe sa diatla<br><br>□ O tshameka metshameko ya bolo sentle, go akaretsa le metshameko e e tshamekiwang ka melao e e riling |
| **Pono le Tsamaisomesifa e Mennye** | |
| □ O tsaya dilo tse dinnye thata fa fatshe le go di busetsa<br><br>□ O aga ditshwano tse di raraaneng fa a bontshiwa, fa gongwe dikgato tse 4 a dirisa diboloko di le 10<br><br>□ O kgona go tshwantsha sentle / o kwala sentle. O kopisa disekwere mme fa a le dingwaga tse 5.06 o kgona go tshwantsha dikhutlotharo | □ O kgona go tshwantsha setshwantsho sa monna a bonala sentle: Tlhogo, letheka; maoto; mabogo; le dipopego<br><br>□ O kgona go tshwantsha ntlo: setswalo, difensetere, marulelo, tšhimini<br><br>□ Ditshwantsho tse dingwe di ka nna tsa nna le tikologo ya lemorago<br><br>□O tshasa mebala mo setshwantshong a sa tswele ka kwantle ga melelwane ya sone |

| | |
|---|---|
| □ Gape o kgona go kopisa: V;T;H;O;X;L;A;C;U;Y’<br><br>□ O kwala ditlhaka di le mmalwa ka boene fela | □ O bala menwana ka seatla se le 1 ka monwana o o supang<br><br>□ O bua maina a mebala ya motheo e le 4+<br><br>□ O tsamaisanya mebala e le 10-12 |
| **Go Utlwa le Puo** | |
| □ O bua puo e e tlwaelegileng, a dirisa<br><br>thutapuo<br><br>□ O natefelelwa go bua meribo le<br><br>dipinanyana<br><br>□ O rata ditori tse di buisitsweng – kwa morago o etsisa dintlha tsa tsone) a le nosi kgotsa a na le bankane ba gagwe | □ O kgona go bua leina la gagwe ka botlalo, aterese le dingwaga mme gantsi le letsatsi la matsalo<br><br>□ O tlhalosa maina a mmatota ka go a dirisa<br><br>□ O botsa tlhaloso ya mafoko a dilo tse di sa tshwarweng<br><br>□ O rata metlae le malepa |
| **Go Dirisana le Batho le go Tshameka** | |
| □ O dirisa thipa le foroko<br><br>□ O kgona go ikapola le go ikapesa diaparo<br><br>□ O kgona go itlhapisa diatla le di phimola, o tlhoka thuso ka tse dingwe<br><br>□ O itshwara ka tsela e e botlhale<br><br>□ O tlhaloganya gore dilo di tshwanetse go bewa ka thulaganyo le ka bothakga – lefa go ntse jalo o tlhoka go nna a gakololwa<br><br>□ O tshameka metshameko ya mo gae le ya diterama a e tsweletsa a le nosi kgotsa a na le bankane<br><br>□ Metshameko e e raraneng e e direlwang fa fatshe | □ O dira dipolane tsa dikago a ba a aga se se bonalang<br><br>□ O itlhophela ditsala<br><br>□ O dirisana le balekane ba gagwe gantsi<br><br>□ O tlhaloganya gore o tshwanetse go tshameka go ya ka melao a sa tsietse ba bangwe<br><br>□ O rata go tshegisa tota<br><br>□ O tlhaloganya bokao jwa nako malebana le ditiro tsa tsatsi le letsatsi<br><br>□ O bonolo ebile o sireletsa bana ba bannye<br><br>□ O gomotsa bankane ba ba hutsafaetseng |

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**MAMETLELELO L: PAMPIRI YA TSHEDIMOSETSO YA TSAMAISO YA TUMELELO KA KITSO**

Setlhogo sa Patlisiso: Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

Dumela,

Nna, Malikomo Kometsi, ke moithuti wa yunibesithi wa Masters mo Occupational Therapy kwa University of Witwatersrand. Ke dira patlisiso malebana le kafa batlhokomedi ba konokono ba bana ba tlhaloganyang seabe sa bone sa go tlhotlheletsa ditiro tsa botlhokwa tsa kgolo mo metseng ya batho ba itsholelo e e kwa tlase. Patlisiso ke tiro ya go ithuta ka karabo ya potso. Mo thutopatlisisong eno ke batla go itse ka botlalo kafa o tlhaloganyang seabe sa gago ka teng sa go tlhotlheletsa ditiro tsa botlhokwa tsa kgolo ya ngwana wa gago. Seno se tla nthusa gore ke tlhaloganye se o se tlhokang fa ke loga leano la manaane a a tlhomameng a tharabololo kwa senthareng ya ECD.

**Go bega tse di bonweng:** Thutopatlisiso eno e a tlhokega gore ke kgone go fetsa dithuto tsa me tsa yunibesithi. Tse di bonwang ka nako ya patlisiso le pego ya yone di tla bonwa ke mookamedi le komiti ya patlisiso e e okametseng go tshwaya ditlhatlhobo.

Ke go laletsa go tsaya karolo mo porojekeng eno ya patlisiso ka go ntetla go go botsolotsa.

**Ke eng se se akarediwang mo thutopatlisisong eno:** Gore ke arabe potso ya patlisiso, ke batla go go botsolotsa re lebane. Potsolotso eno e tla direlwa kwa senthareng ya ECD mo maitseboeng mme e tla tsaya diura di ka nna 1 ½. Ka nako ya potsolotso eno ke tla go botsa dipotso ka se o se akanyang le kafa o ikutlwang ka teng kaga kgolo ya ngwana wa gago. Dipotsolotso tseno di tla theipiwa gore di nthuse go gakologelwa se o se buileng. Sengwe le sengwe se o se buang se tla bolokwa e le khupamarama mme ga se na go bontshiwa batlhokomedi ba bangwe, kgotsa ope fela kwa senthareng ya ECD.

**Dikotsi:** Go tsaya karolo mo patlisisong eno ga go na dikotsi dipe.

**Ditsholegelomolemo:** Ga o na go solegelwa molemo ka yone nako eo ka baka la go tsaya karolo mo patlisisong eno. Lefa go ntse jalo, tshedimosetso e e bonweng mo patlisisong eno e

tlile go dirisiwa go tlhama lenaneo la thuso kwa senthareng ya ECD le le diragatsang ka go toba se o se batlang.

**Go tsaya karolo ga go patelediwe:** O ka nna wa tlhopha go tsaya kgotsa go sa tseye karolo mo patlisisong eno. Fa o tlhopha go sa tseye karolo, wena kgotsa ngwana wa gago ga le na go diragalelwa ke sepe. Ga ke na go bolelela ope gore o ganne, go akaretsa le batho ba kwa senthareng ya ECD. Gape o ka tlhopha go ikgogela morago (wa fetola mogopolo wa gago) fa patlisiso e se na go simolola. Fa o tlhopha go ikgogela morago, tshedimosetso yotlhe kaga gago e tla senngwa ka yone nako eo, mme ga go na go nna le ditlamorago dipe tse di maswe tse di tla amang wena kgotsa ngwana wa gago. Ga ke na go bolelela ope gore o ikgogetse morago, go akaretsa le batho ba kwa senthareng ya ECD. Ke tla go bontsha dibonwamorago tsa me tsa bofelo jaaka motsayakarolo fa ke sena go fetsa patlisiso ya me.

**Dituelo:** O ka nna wa duelela dipalangwa gore o tle kwa senthareng ya ECD go tla potsolotsong. Ke tla go busetsa madi a o duetseng dipalangwa ka one mo letsatsing leo la potsolotso.

**Khupamarama**: Go tla dirwa boiteko bongwe le bongwe go boloka tshedimosetso kaga gago e le khupamarama, lefa go ntse jalo ke ka se tlhomamise gore ga o na go lemogiwa gotlhelele. Fa ke bega ka tshedimosetso kaga gago, ke tla dirisa dikhoutu mme ke tla phimola tshedimosetso epe e e go supang. Lefa go ntse jalo, tshedimosetso kaga gago e ka nna ya lotlegwa fa molao o batla gore go dirwe jalo.

Ditheo tse di ka nnang tsa tlhatlhoba le/kgotsa tsa kopolola direkoto tsa me tsa patlisiso go tlhomamisa boleng jwa tsone le go sekaseka tshedimosetso eo di akaretsa ditlhopha tse di tshwanang le Research Ethics Committee le Medicines Control Council (fa go leng maleba).

Ke tla gatisa se ke se boneng mo jenaleng ya go tlhatlhobana ga balekane mme ke tla leka ka thata gore ke boloke boitshupo jwa gago e le khupamarama.

**Dintlha tsa go ikgolaganya tsa babatlisisi/mmatlisisi** – go bona tshedimosetso e nngwe kgotsa fa e le gore o na le dipotso dipe o ka ikgolaganya le nna. Tsweetswee gololesega go mpotsa dipotso dipe tse di ka go thusang go dira tshwetso eno.

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Mogala: 073 699 3348

**Dintlha tsa go ikgolaganya tsa motsamaisi wa REC le modulasetulo** – Fa e le gore o batla go bega ka bothata kgotsa ngongorego, o ka nna wa ikgolaganya le motsamaisi le modulasetulo wa Human Research Ethics Council:

Ms Zanele Ndlovu le Mr Langutani Masingi, Medical School, Parktown, Phillip Tobias Building, 2nd Floor, Cnr York Road and Princess of Wales Terrace, Mon-Fri 08h00-17h00 Mogala: 011-717-1234/1252/ 2700 kgotsa Room SH1005, 10th Floor Senate House, Diimeile: zanele.ndlovu@wits.ac.za kgotsaLangutani.Masingi@wits.ac.za

Ke go lebogela thuso ya gago go sa le pele malebana le go fetsa thutopatlisiso eno, nako ya gago mme go batla go tsaya karolo ga gago go anaanelwa fela thata.

## MAMETLELELO M: FOROMO YA TUMELELO KA KITSO

Setlhogo sa Patlisiso: Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

Nna, yo ke saenneng fa tlase fa, ke tlhomamisa gore (tsweetswee tshwaya lebokoso kafa go leng maleba ka gone):

| | | |
|---|---|---|
| 1. | Ke badile le go tlhaloganya tshedimosetso kaga patlisiso, jaaka e neetswe mo Pampiring eno ya Tshedimosetso. | ☐ |
| 2. | Ke neilwe tshono ya go botsa dipotso kaga patlisiso le go tsaya karolo ga me. | ☐ |
| 3. | Ke dira tshwetso ya go tsaya karolo mo thutopatlisisong eno ke sa patelediwe. | ☐ |
| 4. | Ke tlhaloganya gore ke ka tswa ka nako epe fela mme ke sa neye mabaka le gore ga ke na go atlholelwa go ikgogela morago le gone ga ke na go bodiwa gore ke ka ntlhanyang ke ikgogela morago. | ☐ |
| 5. | Ke tlhaloseditswe ka phepafalo tsamaiso malebana le polokodiphiri (ka sekai, tiriso ya tlhokaina). | ☐ |
| 6. | Ke tlhaloganya gore mmatlisisi, mokwalodi le mookamedi ba tla bona tshedimosetso eno le gore ba tla boloka tshedimosetso eno e le khupamarama. | ☐ |
| 7. | Nna, gammogo le Mmatlisisi, ke dumalana go saena le go kwala letlha mo foromong eno ya tumelelo ka kitso | ☐ |

**Motsayakarolo:**

_____ _____ _____

Leina la Motsayakarolo Mosaeno Letlha

**Mmatlisisi:**

_____ _____ _____

Leina la Mmatlisisi Mosaeno Letlha

**MAMETLELELO N: TUMELELO YA GO REKOTIWA GA SE KE SE BUANG LE GO KWALOLOLWA GA SONE**

Setlhogo sa Patlisiso: Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

Thutopatlisiso eno e akaretsa go rekotiwa ga potsolotso ya gago le mmatlisisi. Leina la gago kgotsa tshedimosetso nngwe e e go supang ga e na go dirisiwa fa go rekotiwa kgotsa go kwalololwa se o se buileng. Direkoto tseno di tla bonwa fela ke mmatlisisi, mokwalolodi wa se se rekotilweng le mookamedi. Ditheipi tse di rekotileng di tla phimolwa morago ga kwalololo ya se se rekotilweng le go netefadiwa ga sone. Kwalololo ya potsolotso e e rekotilweng e ka nna ya newa yotlhe kgotsa bontlhanngwe jwa yone gore e dirisiwe kwa dipontshong kgotsa dikwadiweng tse di thailweng mo go se se bonweng mo thutopatlisisong eno.

Ka go saena foromo eno, ke dumelela gore se ke se buang se rekotiwe ke mmatlisisi e le karolo ya thutopatlisiso eno.

Leina la motsayakarolo:_____

Mosaeno wa Motsayakarolo: _____ Letlha: _____

**MAMETLELELO O: FOROMO YA MOTSAYAKAROLO YA MOFUTA WA BATHO**

Setlhogo sa Patlisiso: Kafa batlhokomedi ba bana ba tlhaloganyang ka teng seabe sa gone sa malebana le go tlhotlheletsa kgolo ya bana mo metseng ya batho ba itsholelo e e kwa tlase.

**Letlha la gompieno:** ____ ____ / ___ ___ / ___ ___ ___ ___
Letlha Kgwedi Ngwaga

Leina la motsayakarolo _____ Dingwaga _____

**Bong:** Monna _____ Mosadi_____

A o kile wa tsena sekolo? Ee _____ Nnyaa_____

Mophato o o kwa godimo o o o falotseng ke ofe? Mophato_____O mongwe_____

A mo nakong eno o amogela madi manwe a lotseno? Ee_____ Nnyaa_____

O bona lotseno jang?

Tiro e ke e thapetsweng_____

Ke a ipereka _____

E nngwe, tlhalosa_____

O nna mo ntlong ya mofuta ofe? Mokhukhu_____ Ntlo_____ Palo ya diphaposi_____

O nna le batho ba le kae mo ntlong? _____

O na le bana ba le kae kgotsa ba o ba tlhokomelang? _____

Ke ba le kae ba bana ba gago ba ba tsenang kwa Living Waters Early Childhood Development Centre? _____

Bana ba gago ba ba tsenang kwa senthareng eo ke ba dingwaga dife? _____