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**EARLY CHILDHOOD DEVELOPMENT PRACTICES FROM THE PERSPECTIVE
OF CAREGIVERS IN GA-DIKGALE COMMUNITY**

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

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I, Michelle Jan Walford, declare that this research report is my own, unaided work. It is being submitted for the Degree of Master in Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

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Abstract

Background

Early Childhood Development (ECD) practices can shape the outcome of a child's life into adulthood, and caregivers are key in ensuring that proper ECD care is provided. Following the principles of Self-Efficacy Theory as a theoretical framework, the caregivers' perceptions of the care provided can affect the development outcomes of the children in their care.

This was a qualitative study that used Focus Group Discussions (FGDs) and facility-level questionnaires to explore the current ECD practices in the Ga-Dikgale community, Limpopo, from the perspective of the caregivers who provide ECD services. Quantitative data were also collected to give context to the study, through facilitated questionnaires. This research sought to explore how the caregivers at ECD facilities in Ga-Dikgale perceive ECD practices in Ga-Dikgale. The aim of the research was to explore the perceptions of caregivers working at ECD facilities with regard to ECD practices in Ga-Dikgale.

Methods

The study included 32 facilitated interviews with a representative of each ECD facility, and five FGDs with a total of 33 participants. Qualitative data were collected through FGDs and analysed using MaxQDA. Quantitative data were collected on both a facility and participant level to complement the qualitative data and provide context to the responses from the FGDs. The Quantitative data were analysed using Excel.

Results

The deductive themes from the study included: defining ECD; the importance of ECD; ECD activities; ECD infrastructure and equipment; ECD priorities for providing care; and community engagement. The following inductive themes emerged: caregivers' personal lives; relationships with stakeholders; and the needs and requirements for the respective ECD facilities. The results show that experiences vary across the participants with regard to community support and their relationship with stakeholders.

Conclusion

The respondents recognise the importance of ECD in the shorter term, for school readiness and child protection. While a loving and nurturing environment is provided, respondents do not appear to recognise the importance of their own roles in the development of the children in their care. There is a consistent focus on areas of concern or lacking as opposed to the importance of the work being done. A lower sense of self-efficacy among caregivers may have adverse effects on the development outcomes of the children in their care.

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Abbreviations and acronyms

DSD	-	Department of Social Development
DOE	-	Department of Education
ECD	-	Early Childhood Development
ECDC	-	Early Childhood Development Centre
ELDA	-	Early Learning Development Area
FGD	-	Focus Group Discussion
NIP	-	National Integrated Plan
NCF	-	National Curriculum Framework
NPO	-	Non-Profit Organisation
NQF	-	National Qualifications Framework
PPC	-	Partial Place of Care
SASSA	-	South African Social Security Agency
WHO	-	World Health Organisation
ZCC	-	Zion Christian Church

Definitions

The following definitions have been used for the sake of this research.

Early Childhood Development (ECD): *“The process by which children from conception to at least nine years grow and thrive – physically, mentally, emotionally, spiritually, morally and socially.”* (1)(p25).

ECD Facility: *A partial care facility that provides an early childhood programme with an early learning and development focus for children from birth until the year before they enter Grade R/formal school.* (2) (p11) ECD facilities fall under the Children’s Act Amendment 41 (2007), Chapter Five, definition of partial places of care. (3)

ECD Practitioner/ Caregiver: For the sake of this report, the definition includes any person who is involved in the provision of ECD services in any context and with any level of training. The Children’s Act (2005) defines a caregiver as: *any person other than a parent or guardian, who factually cares for a child and includes... a person who cares for a child with the implied or express consent of a parent or guardian of the child.* (4) (p11)

ECD Practices/care: The activities that caregivers undertake with the children in their care, or with regard to the children in their care.

Orphan: *A child who has no surviving parent to caring for him or her.* (4) (p24)

Children may be maternal, paternal or double orphans if their mother, father, or both parents respectively, are no longer alive.

Parent/guardian: The person who is the legal parent or guardian of a child. Literature will sometimes refer to parents as primary caregivers; however, for the sake of this research parental caregivers will be referred to as parents or guardians.

Partial Place of Care: Places where more than six children can spend time and be cared for during the day, away from their families. (3)

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1 Chapter one: Introduction

1.1 Background

Early childhood is a critical stage in life; improper care at a young age affects people long into adulthood and can include effects on future health, behaviour, learning and even the ability to be employed as an adult. (5, 6) Early Childhood Development (ECD) services provide the building blocks for children to thrive in adulthood. (7) Access to ECD services is included as part of the United Nations (UN) Sustainable Development Goals (SDGs) for 2030, Goal Number Four, which speaks to education for all ages. (8)

For children from birth to age five, high quality ECD must provide a nurturing and supportive environment with a focus on the principles of care, play, good nutrition, opportunities for early learning and stimulation. (6) ECD is structured around meeting the needs of children in all respects: intellectual, physical, emotional and social to help them reach their full potential. (3) (Chapter Six) Each day must be planned out with different activities that meet the respective developmental needs of the children through a variety of physical, creative, communication, cognitive or intellectual, imaginative or creative and quiet or restful activities. (9) Shonkoff et al (10) link high quality ECD practices with improved health outcomes later in life.

Caregivers are crucial in ECD facilities in ensuring an environment where children are cared for, protected and stimulated. (6) They provide a sense of security for children, and their effect on children's lives is immense. (6) The level of care they are able to provide is impacted not only by their state of mind, but by their perceived self-efficacy. (11) Self-efficacy is the belief that one holds in their own ability to succeed. (11) Increased perceptions of self-efficacy are also linked to individuals' ability to cope with challenging situations. (12) Bandura suggested that in educational facilities, perceived efficacy on both personal and collective (in this case, facility) levels can directly affect the educational outcomes of the facilities as a whole. (11)

ECD facilities are places where children below school-going age can go during the day on weekdays to be cared for by an adult. The Children's Act (2005), Chapter 20, states that any child care facility must comply with structural, health and safety requirements as mandated by law. (4) ECD facilities are required to have sufficient

infrastructure, space, equipment and educational resources to meet the developmental goals of the children in their care. (3) (Chapter Five) Depending on the number of children attending as well as the services provided, there may be additional area requirements such as a sick bay, office, lockers for staff, and areas for food preparation, cooking and washing up. (3, 9)

The National Integrated ECD Policy mentions that there is a need to develop monitoring and evaluation tools to measure the quality of, and access to, ECD services. (2) While no centralized metrics are in place at present, there are proxies used to measure quality of care, such as the infrastructure, child-caregiver ratio, or the level of qualification held by the caregivers. (2) Due to a lack of funding, ECD facilities often don't meet the standards of physical structure, children's nutritional needs and providing sufficient training for caregivers. (6)

ECD facilities must meet the minimum requirements in order to qualify for funding from the Department of Social Development (DSD). (13) Should facilities meet the requirements, they are eligible to receive a subsidy, but this is by no means guaranteed. (3, 13) Facilities may also charge user fees for the children who attend. The subsidy and fees are not mutually exclusive and facilities may receive both simultaneously. (2)

The Heckman Equation demonstrates that the earlier an investment is made into a child's education, the greater the impact. (14) Comparative to investing time or funds into other social or educational programmes, ECD is regarded as an efficient investment in terms of improving quality of life into adulthood; there is a higher long term economic return from investment into ECD the earlier in a child's life the investment is made. (14) For example, investments into early education have proven to yield greater economic benefit in the long term, than investments into remedial learning for adults who lack sufficient skill sets for the workforce. (15) Girdwood (7) suggests that ECD care increases an individual's chances of breaking the inter-generational cycle of poverty.

Conversely, an adverse experience in early childhood is linked to a higher likelihood of developing a number of chronic conditions including depression, diabetes, heart disease and alcoholism. (10) Traumatic experience in early childhood can cause

chemical and physical changes in the brain that negatively impact both the physical and mental health outcomes into adulthood. (16) Neglect can be just as – if not even more – damaging than physical abuse in terms of cognitive and social development, however, this can be remedied if appropriate treatment and a secure relationship with a nurturing adult are established as soon as possible. (16)

1.2 Statement of the problem

Ackerman (17) suggests that ECD practitioners should have a clear understanding of how important ECD is for children's long-term development. While high-quality ECD care may break the cycle of poverty (14), poor self-efficacy among caregivers may in fact be detrimental to the developmental outcomes of the children in their care. (11)

There is a gap in the literature around exploring perceptions of ECD practitioners regarding their own roles in ECD care. It is not clear, in this case, how caregivers perceive themselves and the services they provide, as this may affect the developmental outcomes of the children in their care. It is important to better understand how the caregivers in ECD facilities perceive themselves and the services they offer within the context of their environments.

1.3 Justification of the study

The importance of nurturing, attentive and responsive caregivers is well established. Attachment theory suggests that the relationship between child and primary caregiver, be it parental or otherwise, sets a precedent for the child's relationships in future and will affect their mental, emotional and behavioural development. (18, 19) Therefore, the quality of ECD care provided can shape an individual's socio-behavioural patterns into adulthood. (18) Among other outcomes, the quality of care provided during early childhood is correlated to an individual's mental and physical health outcomes later in life. (16) Therefore, this study has public health relevance.

This study explored ECD practices from the perspective of caregivers who were actively providing the care. This research sought to understand the current ECD practices in the Ga-Dikgale community from the perspective of the caregivers, who were actively involved in providing ECD services. Applying Bandura's Self-Efficacy Theory as a theoretical framework, it can be seen that understanding the perceptions of caregivers regarding their own roles in the care and development of children may

contribute towards a better understanding of the potential outcomes of those children. (11)

The research presented an additional opportunity to participants; which was that of self-reflection of their involvement, in their own assessment. This was an opportunity that allowed them to learn and grow from the experience. (20)

1.4 Research question

How do the caregivers at ECD facilities in Ga-Dikgale perceive ECD practices in Ga-Dikgale?

1.5 Study aim and objectives

The aim of the research was to explore the perceptions of caregivers working at ECD facilities with regard to ECD practices in Ga-Dikgale.

1.5.1 Specific objectives

The study had three main objectives:

1. To describe the characteristics of the caregivers working at ECD facilities in Ga-Dikgale in 2016
2. To establish caregivers' perceptions of the care provided in ECD facilities in Ga-Dikgale in 2016
3. To establish caregivers' perceived priorities for providing high-quality ECD services in Ga-Dikgale in 2016.

1.6 Literature review

This study aimed to explore the perceptions of caregivers working at ECD facilities with regard to ECD practices in Ga-Dikgale. It was carried out by describing the characteristics of the caregivers, and exploring their perceptions of the care provided in ECD facilities in Ga-Dikgale. This section provides literature that allows for analysis of the data that were collected. This literature review explores the importance of ECD and the current state of ECD in South Africa. It outlines the key elements that make up high quality ECD practices. It explores what influences the quality of ECD practices, as well as the role of caregivers in ECD and how their perceptions can affect the care that they provide.

1.6.1 The current state of ECD in South Africa

Based on statistics including data up to the end of 2016, there are 8.2 million children, or 15% of South Africa's population, aged six years or younger. (21) There are a variety of issues currently facing ECD in South Africa, with regard to the standards of care and safety provided to children attending ECD facilities and particularly those attending rural ECD facilities. (22) In reality; only one in six South African children has access to site-based ECD services and, even then, rural facilities have historically been of poorer quality than their urban counterparts. (23) There is a particular disparity in more traditional black South African communities, where between 31% and 35% of children do not receive stimulation for early learning in the home. (21)

South African rural communities – specifically former homelands – tend to be more impoverished, more poorly developed and less likely to have access to basic services or infrastructure than their urban counterparts. (24, 25) According to the statistics available, an urban child has historically been far more likely to receive any sort of ECD services than a child in a rural setting; in 2001 only 11% of the country's ECD facilities were in rural areas. (25, 26) During the time of the 2014 Nationwide ECD audit, approximately 37% of South Africa's ECD facilities were in rural areas, catering for 45% of the population's children who lived in rural areas. (6, 27) This shows that there has been expansion of ECD in rural areas over time. While the number of facilities available to service rural communities has increased, there is still an issue pertaining to quality; children in rural areas still struggle to access high quality ECD services. (6)

There are South African children who grow up in difficult circumstances, which can severely affect their ability to access high quality ECD and in turn make them vulnerable to compromised outcomes later in life. (6) Girdwood (7) links poor quality ECD to socioeconomic status - children who come from poorer backgrounds tend to enter the system with a disadvantage, due to lack of home stimulation. It is also established that children who enter the formal schooling system with below-average development tend not to catch up: they tend to continue underperforming relative to their peers. (7).

1.6.2 Legislation and policy regarding ECD in South Africa

The Children's Act (2005) and its amendments are used as the guiding documents for all policy and legislation around ECD. (3, 4) The Act (Chapter One) outlines the rights of children to access social services. (4) In the South African context, The National Integrated ECD Policy (NIECDP) has been developed to facilitate access to ECD services. (2) The NIECDP outlines the intent to deliver services to children, train caregivers, educate parents, promote community development, strengthen institutional resources, build capacity and public awareness and increase demand for ECD services. (28)

The Children's Act (Chapter One) states that children have a right to be protected from all forms of abuse, exploitation and neglect. (4) By their nature, the facilities are responsible not just for the care, but also the protection of children who attend, and caregivers should be trained on how to recognise and respond to any signs of neglect or abuse. (9) In a South African context, caregiver training is mandated by law (3)(Chapter Five), and is shown to affect the quality of care provided, and therefore child development in the long term. (29) ECD facilities are classified as partial places of care, as there is a responsibility to keep children in their care safe when a parent is not available to care for their child, usually during the day. (3) ECD practitioners are responsible for providing a safe environment and universal precautions must be taken to do so; if an ECD facility does not meet the requirements for such a facility, it may be considered illegal and the people running the facility may be charged with an offence. (3, 4) In the case of harm coming to a child in the care of an ECD facility, if negligence or illegality can be proven, facility owners and caregivers can be held criminally liable. (4) (Chapter 20)

The South African National Curriculum Framework (NCF) outlines the six Early Learning Development Areas (ELDAs): wellbeing, identity and belonging, communication, exploring mathematics, creativity, and knowledge and understanding of the world. (30) Similarly, the development areas of children can be broken down as: physical, social, emotional, linguistic and cognitive. (6) Children should be developing motor skills during their time in ECD. (30) They must learn how to care for and respect others, as well as themselves through engaging with their peers. (30) They will learn about their own identity, as well as respect for diversity. (30) They must learn to communicate, both verbally and non-verbally. (30) They must learn

problem-solving and introductory mathematical skills that form the foundation for formal education. (30) The learning areas overlap and can affect each other, thus it is key to give attention to the development of a child in each area. (6)

1.6.3 A holistic approach to ECD

ECD is designed to support the holistic development of children in various aspects: physical, social, emotional, mental and linguistic (or communication). (6, 31) Physical development involves the development of gross and fine motor skills through muscle activity to improve movement, balance, coordination and agility. (32) Social development covers the development of skills such as sharing, cooperation, respect and empathy for others, as well as listening to adults. (32) Emotional development covers both intra and extra-personal experience, expression, recognition and management of emotions. (33) It is how a child learns to develop relationships with others that are positive and rewarding. (33) Mental, or cognitive development, refers to a child's ability to reason, solve problems, store and access information, as well as their development of language. (34) Language development is how a child learns to communicate verbally, to express thoughts or feelings. (32)

It is key for ECD practitioners to respect the needs of the children with regard to their holistic development. (9) Children learn at different paces, and they learn best through active play. (9) Activities that assist with the holistic development of children include: exploration of their world; communication and listening; creative exercises; coping skills; developing their independence; respect for self, others and the environment; and enjoying themselves. (9)

Between the ages of three and five years old, a combination of effective parenting and receiving ECD support outside of a home environment significantly increases a child's likelihood of being open to formal learning when they enter the school environment. (6, 35) Children leaving ECD should be mentally, physically, socially and emotionally ready for school. (6) A set of goals and objectives have been developed by for children coming into Grade R. (2) A number of the services at facilities lay the foundation for formal education through active learning and play. (2)

1.6.4 ECD practices

Children feel a sense of comfort and confidence in routine and take pride in knowing what will happen during a given day. (36) Therefore, it is important that there is a daily routine that is familiar to the children that is more or less the same each day, including options for them to choose from built into the plan. (9, 36) As part of the daily routine, children are signed in every day on a register when they arrive. (9) As part of their daily health check, caregivers must be trained to recognise children's illnesses and how to deal with them, as well identify the early signs of abuse. (9) All staff must be aware of any special medical or health needs of the children in their care. (9)

It is mandated that children must have at least one indoor and one outdoor activity per day. (36) The toys and equipment available for indoor and outdoor play should be safe, provide an array of activities, be sufficient in quantity and be age-appropriate. (9, 36) Since care is more stimulating in a well-resourced, well organised space, the play areas should be well equipped, organised, safe and free of hazards. (9, 37)

Cognitive development is key in ECD and this is achieved in a number of ways, some of which can be incorporated into indoor play activities such as problem solving, construction, creative play or art, make believe, communication, and storytelling. (30) Similarly, outdoor play is essential for a child's development. (38) Draper et al demonstrate that outdoor play caters primarily to physical development but can address multiple development areas. (39) Furthermore, while teachers and caregivers may be aware of the benefits, they lack the practical training, capacity, and often the time to adequately facilitate outdoor play. (39)

The NCF speaks about the importance of having a toilet routine for children as part of the daily routine. (30) It is required that toilets be safe and hygienic for children to use. (3) (Chapter Five) Toilet training is an important developmental milestone that requires a child to be physically, emotionally and socially ready to take responsibility for this routine. (40)

Meals and snacks provided at facilities should meet the nutritional requirements of the children. (9) Babies must be bottle-fed on demand and children must receive food

at least once per day, either from the ECD facility or from the parents. (9) Clean and safe drinking water must always be available. (3) (Chapter Five)

The NCF mentions storytelling and sleeping routines as key in the daily programme of an ECD facility. (30) Storytelling is an important tool for a number of learning areas and, as mentioned above, children require some quiet or restful activities built into their daily programme. (30)

1.6.5 ECD caregivers

This research report refers to ECD practitioners and caregivers interchangeably. The research focused on caregivers or ECD practitioners working at facilities that cater to children from birth to age five, who are traditionally not yet attending school. (6, 41)

1.6.5.1 ECD caregivers trained to nurture and care for children

Caregivers at ECD facilities are responsible for providing an environment for the children in their care that is safe, nurturing, healthy and stimulating. (6) Berry et al (42) suggest that the care that children experience – not only in terms of meeting their needs, but the affection and responsiveness of their caregivers – directly influences their development. Biersteker and Kvalsig corroborate this finding and emphasise the importance of caregivers who are *“healthy, sensitive, loving, warm and consistent in the way they interact with children”* (41)(p165) Caregivers are expected to show an interest in the children in their care and a passion for ECD in general. (9)

ECD programmes can be specifically developed around promoting the bond between adult and child, based on Attachment Theory. (18, 19) Children learn through continuous feedback and for this reason, it is important that caregivers be attentive and responsive when engaging with children. (43) Caregivers should be trained or be receiving ongoing updated training in ECD and management of programmes and facilities. (3) (Chapter Five)

The Harvard University Centre on the Developing Child suggests that when a child develops a secure relationship with at least one nurturing and dependable adult, be it a parent, primary caregiver or otherwise, it can promote the child’s emotional and

social development. (16) In this case, multiple adults can offer a more robust support system for a child and in no way encroach on the parent-child relationship.

(16) For a child to have the best chance of meeting their developmental outcomes, it is imperative that caregivers are trained to provide a nurturing, safe and healthy environment for that child that meets their physical, mental and emotional needs. (43)

The duties of caregivers in ECD facilities include, but are not limited to, providing food at least once per day (either caregiver or parent); providing opportunities for learning through constructive play; creating a safe environment free of danger, discrimination, abuse etc.; protecting children holistically; educating children on their rights; building self-confidence and coping strategies – especially for vulnerable children, such as those who have faced discrimination or death of a family member; and keeping necessary records on all children and activities. (9)

1.6.5.2 Caregivers' perceptions of the care they provide

The emotional state of the caregiver affects the care provided and therefore can affect their relationship with children in their care. (43) Increased perceptions of self-efficacy are linked to individuals' ability to cope with challenging situations. (12) People who have a sense of self-efficacy will visualise their own success and are more likely to achieve it, while those with self-doubt tend to focus on barriers to success and are likely to stand in their own way. (11) This effect is multiplied under stressful conditions. (11) Caregivers and parents who do not realise the importance of their interactions with children are less likely to provide nurturing and stimulating care. (43)

1.6.5.3 The long-term relationship between poverty and self-efficacy

It has been shown that higher self-efficacy leads to better results, and in this case, children's outcomes improve under the care of teachers or carers with high self-efficacy. (11) Similarly, workers who are living in poverty may be at risk of poor productivity due to the effects of poverty on their own lives, and therefore poverty may in itself lead to poor outcomes, all else held constant. (44) People living in poverty or a state of deprivation, report feeling worn down and find it difficult to adequately care for children. (43) In addition, people caring for vulnerable or at-risk children report feeling overwhelmed and tend to have higher levels of emotional

distress. (43) Caregivers in vulnerable communities may be living in poverty themselves. It can thus be suggested that caregivers living in poverty who have lower levels of self-efficacy, may indeed negatively affect the developmental outcomes of the children in their care. Girdwood (7) suggests that children who begin their schooling at a disadvantage tend to underperform relative to their peers over time with a widening gap in performance. Recent research shows that South African children whose performance falls below the benchmark in early schooling tend to stay below average for their entire school career, reflecting the long-lasting damage of poor early education. (45) Furthermore, poorer school performance is linked to falling into a lower income quintile later in life. (45)

1.6.5.4 Relationships with stakeholders in the community

The environment in which a child spends most of their time will have an impact on the development of the child. (46) Risk factors for poorer development; such as abuse, neglect, inadequate complementary feeding, limited stimulation, impaired primary caregiver capability; tend to cluster in households – therefore, children who live in homes with one risk factor are commonly exposed to multiple risks. (47)

While a child's parents will always be the primary caregivers and protectors, children of working parents have a right to access and benefit from childcare services and facilities. (41) DSD states that parents should be actively involved in the functioning of the centres. (9) Parents and communities have a responsibility to work with ECD facilities to provide the necessary care for children. (4) Families must be able to communicate freely with the caregivers and their concerns or queries must be addressed with respect. (9) Similarly, parents are responsible for complementing the learning at facilities to ensure the best development of their children during their time at home. (9)

A famous African proverb says, "It takes a village to raise a child". This is echoed in ECD, where the broader community in which a child lives acts as a network of care. (42) As a key part of their communities, it is important that facilities have a good relationship with the parents and families with whom they work; this is even more important when dealing with vulnerable families, to ensure the safety and sufficient care of the child. (42)

The local municipality is mandated to be involved in community ECD services. (3) Facilities and ECD practitioners are expected to work closely with various public services to meet the needs of children that include the Departments of Home Affairs, Social Development, Housing, Water Affairs, Health and Education among others. (9) Specifically, social workers from DSD are responsible for ensuring that facilities meet the standards set out by DSD. (9) The South African Department of Education (DOE) has identified schools as a key node of support for children. (42) There is a goal to have universal access to Grade R across South Africa. (22) For this reason, schools rely on their feeder facilities to prepare children for school. (22)

1.7 Summary of the chapter

ECD literature has been considered from both a global and more local perspective. South African literature echoes the same principles as global literature. However, the practice of ECD in South Africa may vary from that in developed countries, where the bulk of the global literature comes from.

This was an exploratory study that considered ECD, a highly researched topic, from within the context of an under resourced South African community, lacking in access and financial means. It explored the care provided from the unique perspective of those providing it.

2 Chapter two: Research methods

2.1 Introduction

This chapter provides detailed information on research methods that the researcher adopted to achieve the study. These include the study design, study setting, study population, study sample, demographic information, data collection, data management and analysis, as well as ethical considerations.

2.2 Study design

This was a cross sectional and exploratory study using qualitative and quantitative methods to understand Early Childhood Development (ECD) practices in the rural community of Ga-Dikgale from the perspective of ECD caregivers. Quantitative methods were used to collect data for describing the characteristics of the caregivers working at ECD facilities in Ga-Dikgale. The qualitative methods explored caregivers' perceptions of the care provided and the priorities for high quality care in ECD facilities in Ga-Dikgale.

The collected quantitative data was used to provide contextual information. This was achieved through describing demographic characteristics of the study population including age, gender and educational background. A subset of the study population participated in the qualitative part of the study.

The qualitative study focused on the perceptions of the research participants. Hennick states that one instance where qualitative studies are valuable is when the research is designed to *"understand behaviour, beliefs, opinions and emotions from the perspective of the study participants themselves."* (48)(p10) For this reason, the study followed a predominantly qualitative design.

Caregiver perceptions may vary from person to person, and depend on their individual experience. Some of the themes that the literature review introduced had the potential to lead to sensitive discussions, such as the role of caregivers within family dynamics, or how ECD plays a role in child protection in the case of abuse or neglect. The study included questions that explored perceived weaknesses or shortcomings in the ECD practices in Ga-Dikgale in general.

2.3 Study setting

Ga-Dikgale is a rural community of 29 villages in Limpopo, approximately 40km from Polokwane city at its closest point. The community is split into three municipal wards in Polokwane municipality, Capricorn District. The total population for the three wards is 42 584 as based on census 2011 data. (49, 50)

A large proportion of Ga-Dikgale's population is made up of children, with 42% of the population (approximately 18 000 people) being under the age of 18 years, and 11% (approximately 4 800) children under the age of five years old. (50) The Limpopo Community Survey reports that 8.7% of children in Limpopo are orphaned (51); if this trend can be used as a guideline, we can expect that there are close to 1 600 orphans in Ga-Dikgale.

The 2016 Limpopo Community Survey found that while more males are born than females in Limpopo province, the ratio of men to women decreases after the age of 24 years old. In other words, as the population ages it becomes more weighted towards females as there are more men leaving the area than women. (51) This supports the researcher's observation that the community members who reside in the community permanently were predominantly children and older women.

Employment in the community is low; in the 2011 Census, only 13% of adults reported being employed. (52) The children and elderly people in the community are not economically active, and those who are economically active struggle to find work without leaving the community. (52, 53) The migration of community members of working age has a number of effects on the community at-large.

Under the Apartheid regime, Ga-Dikgale was part of the "homeland" known as Lebowa. (54) The Ga-Dikgale elders recall two forced removals from their lush original land further north in South Africa, resulting in the community's location today. As such, it has historically been under-resourced, lacking in access to basic services and infrastructure. (49) However, work has been done in the last two decades and more infrastructure is being built and accessed with time. (49) At the time of the 2011 national census, 80% of households across the 29 villages used electricity for lighting, while 59% used electricity for cooking. (49, 50) However, it is the researcher's observation that people tend not to use much electricity, because they

cannot afford it. Water runs in most villages one day per week, from municipal taps. 65% of households report that municipal water is their primary source of water, and 12% rely on boreholes. (50) Access to a tap differs from village to village, with some villages having a tap in the yard of most households and other villages relying on communal taps. In 2011, 58% of the population reported having access to piped water on their residential property. (50) In the same year, 88% of households in the community reported using unventilated pit toilets. (49, 50)

Ga-Dikgale is a tribal community, led by Kgosi (King) Solly Dikgale. Each of the 29 villages has a social infrastructure that forms part of the tribal leadership, including indunas (chiefs) from each of the villages who collectively form the authority for the community. Any and all major decisions including new business rights, land allocations, interpersonal conflict (to name a few), are taken to the tribal authority for discussion, facilitation and/or approval. Each community's induna acts as the link between their respective community and the tribal leadership; by playing the role of community representative to the tribal authority (the community's internal policing system) when a community member's actions are unacceptable or against community law. The induna also acts as a mediator for issues between community members. While there is a minimal police presence in Ga-Dikgale, all issues are attended to by the indunas and to the tribal authority before a community member involves the police.

Ga-Dikgale is a Sepedi-speaking community. (52) From conversations with community members, the researcher learned that the community members are predominantly Christian and the Zion Christian Church (or ZCC) appeared to be the most popular church. Traditional values are still in place; teenage boys may attend initiation camps in their teenage years and the men can be seen returning from the camps during the winter months. Other traditional activities in the community include singing and dancing, beadwork and the production of homeware such as bowls using pumpkin shells. There are some community members who can sew or knit and the older men in the community tend to have an artisanal skill (gardening, welding, painting, bricklaying, etc.)

Ga-Dikgale's closest town is Mankweng. Major transport services are operational from there, and limited taxi services are available from points in Ga-Dikgale to

Mankweng. The bus from Mankweng to Polokwane costs R15,00. It is the researcher's observation that subsistence farming is relatively common – the majority of households grow maize in their yards – but there is a heavy reliance on money flowing into the community via working family members outside of the community, as well as social grants such as child care grants, pensions etc.

The South African Social Security Agency (SASSA) social grant system is key in Ga-Dikgale. The SASSA pay points are well known throughout the community and, on payout days, there are groups of people who come into the community to set up an informal “travelling market” that follows the mobile pay points from stop to stop, selling a variety of fresh produce, firewood, clothing, sweets and other items.

There are 40 primary health clinics, one provincial hospital, one district hospital and one tertiary hospital in Polokwane municipality. (55) By South African province, Limpopo has the lowest ratio of medical practitioners to people. (56) Moreover, rural areas are consistently understaffed compared to urban areas. (56) The municipal offices of the Sebayeng-Dikgale cluster report needing upgrades to infrastructure including mobile health services. (55) The researcher has observed three primary health clinics in Dikgale.

The 2016 General Household Survey showed that ECD services in Limpopo tend to be overcrowded in general, with a ratio of between 401-500 children in the Capricorn district to each ECD centre. (21) More specifically, the 2016 Community Survey reported that 52% of children aged 0-4 in Polokwane municipality were not attending any form of educational institution. (51)

Representatives of the Department of Social Development (DSD) – such as social workers – are present in Ga-Dikgale, but it is the researcher's observation that they generally do not feel equipped to assist in any meaningful way. They report being overworked, but the researcher has not had enough interaction with any social worker to draw any meaningful conclusions.

2.4 Study population

The study population were caregivers working at ECD facilities in Ga-Dikgale between August 2016 and March 2017. ECD facilities are defined by the Children's Act Amendment 41 (2007), Chapter Six, as a partial place of care that provides care to children up to school-going age. (3) Therefore, any ECD facility with seven or more children was eligible to take part in the study. The study unit was the ECD caregiver, who was actively working in an ECD facility in Ga-Dikgale at the time of the discussion.

2.5 Study sample

The study used purposive sampling, tapping into the existing social structures within the community. Guest et al (57) suggested that field-oriented studies that are not designed to be generalizable, may use purposive sampling. In regard to focus group discussions, literature suggests that 20 to 30 participants are sufficient. (57, 58) Similarly, Krueger and Casey (59) found that three to six focus group discussions is sufficient to reach data saturation, with an ideal group being between six and eight members.

Makgosi Dikgale took the request to the tribal meeting on behalf of the researcher and asked the Indunas to compile a list of ECD facilities in their respective villages. They were not asked to be selective in any way. The researcher received a list of 30 facilities to start with. The 30 facilities on the list provided by Makgosi and the Indunas were contacted. While these initial contact sessions were happening, Makgosi continued to send the details of additional facilities to make contact with, all of whom were contacted in due course. Once all of the facilities that Makgosi and the Indunas had nominated had been contacted, managers at each facility were asked to suggest any other ECD facilities that they knew of to take part in the respective interviews and Focus Group Discussions (FGDs). A total of 38 facilities were nominated and 32 of these were included in the study. Six facilities were excluded for ethical reasons, as discussed under the ethical considerations below.

Developing a relationship and a level of trust with the community members was necessary to gather meaningful data. (60) For this reason, there were introductory meetings with each facility to ask for permission to include the facility in the study.

Whenever possible, this was with the manager of the facility. Once permission had been granted, the basic facility information was collected using a general facility questionnaire. The facilities were then invited to nominate a participant for the focus group discussions.

Facility-level interviews took place at a total of 32 ECD facilities. Of those, 31 facilities were represented at the five focus group discussions. There were a total of 33 people who took part in the FGDs, because two of the facilities sent two people each. The study was conducted through individual interviews with representatives of each of the 32 ECD facilities, as well as five focus group discussions. Each facility was invited to nominate one person to attend one of the focus group discussions.

There were a total of 33 people who took part in the FGDs. 100% of the participants were female. Their ages ranged from 25 to 62 years old, with an average age of 48 years. Please refer to Figure 2.1 for the age distribution of the participants. The educational background of the participants varied. One person had achieved between Grade eight and Grade 11 education; eight people had Matric certificates and/or a short course qualification; five had ECD Level One training; 15 had ECD Level Four training and two had a full ECD degree or diploma. 28 of the 33 participants were the managers of their respective facilities; two had childcare roles; one had a support role and two are unknown. Please refer to Figure 2.2 for the education and position distribution of the participants. The majority of FGD participants were managers of their respective facilities. They were generally the most educated members of their facilities.

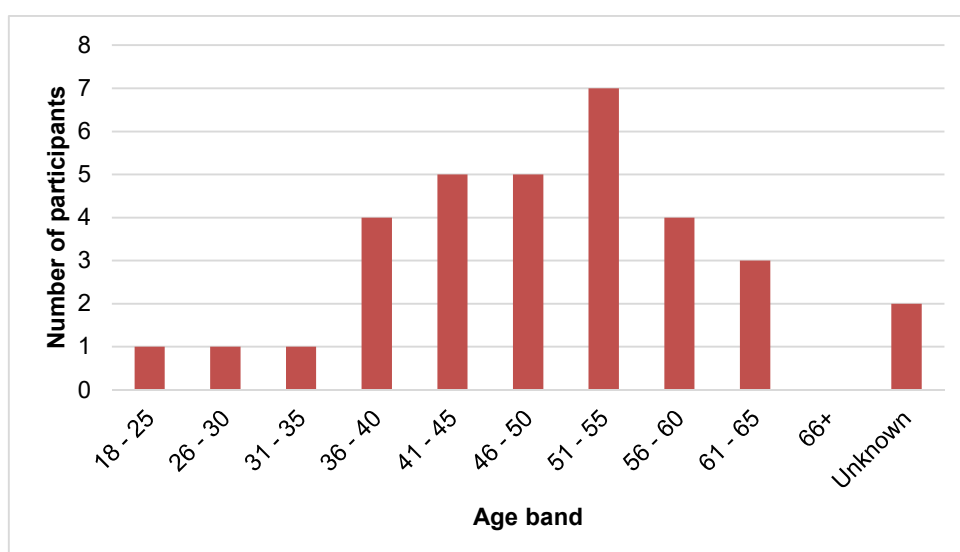


Figure 2.1: Age distribution of the FGD participants

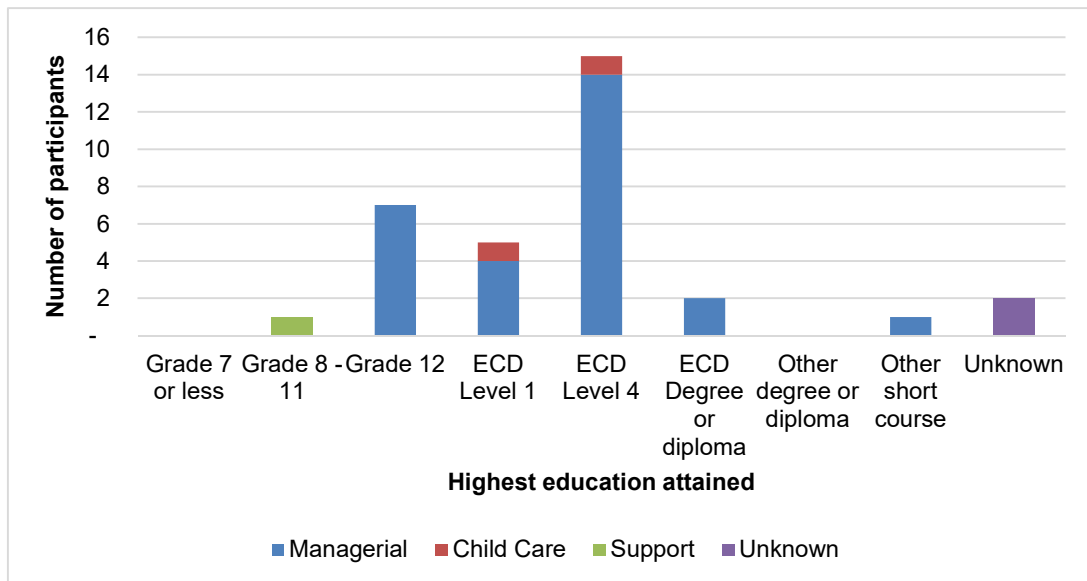


Figure 2.2: Education and position distribution of the FGD participants

2.6 Data collection

Two data collection methods were used: interviews using a facility information questionnaire and the FGDs. Data for Objective One (to describe the characteristics of the caregivers working at ECD facilities who take part in the study in Ga-Dikgale in 2016) were collected using the facility interview questionnaire. By clustering geographically and starting with the more populated areas of Ga-Dikgale (such as Marobala and Titibe villages), initial contact was made with each facility via telephone. Once a suitable meeting time had been arranged, the facility was visited in order to complete a facility-level interview.

All interviews as well as the FGDs were facilitated by a colleague of the researcher, who is a trained facilitator. She is a black, Sepedi-speaking woman in her late thirties. She lives in Gauteng and has travelled regularly to Ga-Dikgale for field work for almost a decade. She had an existing relationship with the tribal authority and was able to conduct all interviews while observing appropriate customs and processes. Before data collection could take place, the facilitator was given a full orientation on the purpose, aim and objectives of the study. She was given time to familiarise herself with the research tools. She facilitated the pilot study and was given feedback before the formal research began to ensure that she was prepared. While the facilitator was trained and experienced to do the job, it is important to note that she was an employee of the same organisation as the researcher, and therefore her

remuneration was covered by the organisation, which played a role in the choice of facilitator.

The manager of each facility completed the facilitated questionnaire, through a face-to-face interview with the facilitator, with the researcher present. There was some input from other individual caregivers where necessary. The questionnaire was presented in English and each question was translated verbally into Sepedi for clarity. 32 facility interviews were completed. Each took between 30 minutes and one hour. The facility questionnaire covered the basic information of the facility (Department of Social Development (DSD) registration, attendance, fees charged) and the demographic information of the caregivers working there (age, gender, experience in ECD, education levels).

Once the facility interview was complete, the manager of each facility was invited to nominate a representative to participate in the FGD that took place closest to their home village. This could be any member of their staff, including themselves. Facility representatives were informed that while they were invited first to whichever FGD was closest to them, they were welcome to reschedule to participate in any of the five discussions, subject to the availability of space, which they checked with the facilitator beforehand.

Data for Objective Two (to establish caregivers' perceptions of the care provided in ECD facilities in Ga-Dikgale in 2016) and Objective Three (to establish caregivers' perceived priorities for providing high-quality ECD services in Ga-Dikgale in 2016) were collected during FGDs. FGDs were chosen as the format for data collection because of their ability to put people within the group at ease, as well as create an additional depth to the discussion introduced by a group dynamic. (61) They are an ideal platform for addressing programme strengths and weaknesses, as well as discussing sensitive subjects by creating a support system. (61) FGDs also allow for social interaction, a level of debate and for the group to learn and be influenced by each other's opinions. (61) This is valuable in a social context for the group, not only to take the pressure off of any individual, but to allow groups to have their opinions challenged and reinforced without the interference of any outside party. (61)

The FGDs took place at various child care facilities through Ga-Dikgale. Participants were invited to sit around a table and were given a participant number, allocated at random. The facilitator led the discussion and referred to participants by their numbers instead of their names (e.g. participant number 2). Each group had between six and eight participants. The participants sat around a table with the researcher and facilitator in a room where they would not be overheard or interrupted. Once consent to take part as well as consent to be voice recorded had been given by each participant in writing, voice recording began. Each FGD was structured as a group brainstorming session that took approximately two hours. The discussions took place in Sepedi.

To facilitate discussion of different aspects of the ECD practice, the FGD guide was designed to cover the following topics: respondents' definitions of ECD; characteristics of an ideal ECD facility; daily ECD activities; and comparison of own facilities with the ideal ones. Discussions centred on the participants' perceptions of ECD and their work, in terms of ECD in general as well as their own facilities. This led to discussion around how caregivers perceived their own roles within their community. Within the context of this study, the term "caregiver" refers to any member of staff at an ECD facility, whether directly involved in childcare or not. The final part of the FGD session explored the relationship between ECD facilities and Ga-Dikgale in general. In order to accommodate the fact that caregivers' experiences could differ according to the different ECD facilities, the FGD guide was designed in a manner that facilitated discussion beyond own facilities but about ECD in general. For example, comparisons were discussed regarding "the community" as opposed to "your facility". Discussions took place in Sepedi. Water and sweets were available during the FGD, and participants received lunch afterwards, in line with Pedi custom.

Saturation is reached when no new ideas or themes emerge during research; in other words, additional discussions yield no new results. (62) After preliminary analysis of the five discussions, the researcher had established sufficient saturation to conclude FGDs and continue with the analysis.

2.7 Data management and analysis

The facility level questionnaire responses were used to provide context and to better understand the study population and sample. The quantitative data were analysed by capturing the results using a Microsoft Excel spreadsheet and reported using basic statistics.

The voice recordings of each FGD were simultaneously translated into English and transcribed for analysis in English by a translator with experience in public health research, who is fluent in both Sepedi as a home language as well as English. For quality assurance purposes, the facilitator back-translated and compared samples of the transcripts to the voice recordings. Analysis followed an iterative process using printed transcripts and later coding the same transcripts using MaxQDA software to explore the themes that emerged.

Each of the five FGD transcripts were printed with a wide margin on the right side of the page for notes. The transcripts were read and perused in detail. In each read-through, notes were made on the transcripts using a different coloured pen, to enable tracking of the progression of themes as they emerged. Quotes that could form part of the research report were noted.

Any recurring words, ideas or phrases were listed on a separate piece of paper and their frequency was counted. These words, ideas and phrases formed the basis of the preliminary codes. By clustering the preliminary codes into themes, the deductive themes of the research emerged. These themes and sub-themes were loaded as a code book onto MaxQDA, and the transcripts were coded again. Please refer to Appendix 1: Code Book from MaxQDA for further information.

The themes were developed through a process of comparing any emerging ideas back against the data set, an approach of constant and iterative comparison of the analysis with the data. (63, 64) Charmaz refers to starting analysis with an inductive approach and comparing iteratively with the data throughout the process of analysis, as well as writing. (64) Therefore, the analysis included repetitive reading of the transcripts and repetitive questioning of both the themes in the data, and the relationships between them.

Harry et al (65) outline their analysis plan in relation to In-vivo coding (using actual words and quotes of participants), axial coding (clustering words and concepts around emerging categories) and selective coding (exploring the relationships between the clusters or categories found in the previous step). Following this structure, the themes emerged from the data available as well as through interpretations of the responses of participants. Strauss and Corbin refer to the importance of exploring each situation to compare its alignment to a theory; and if it does align, how it does so. (63) Once the data had been coded using MaxQDA, the major results emerged based on the frequency of the new themes. These formed the results section of this report.

2.8 Reflexivity

Anderson suggests that some of the limitations of qualitative research can include the researcher's personal bias as well as the effect that a researcher's presence may have on the responses that participants give. (66) This report must consider the influence that the researcher had on the study itself. The researcher is a white, English-speaking female in her late twenties. This presented a cultural misalignment with the black, Sepedi-speaking participants of the research. It was for this reason that a Sepedi-speaking facilitator was necessary.

The researcher and facilitator both have an existing relationship with the Ga-Dikgale community and have worked in ECD. Thus, they did not face tremendous barriers to access community members. Even with – and perhaps in some cases because of – their respective experience and relationships with Ga-Dikgale, the researcher and facilitator would both be perceived as outsiders. This may have affected the manner in which participants chose to respond. Moreover, given the researcher's and facilitator's experience with the Ga-Dikgale community and with ECD, there was potential for pre-existing biases to be transferred onto the study participants. It was critical for the participants to be allowed to speak freely and not be guided by the probes or cues of the facilitator.

2.9 Ethical considerations

Makgosi (Queen) Clarah Dikgale gave written permission for this study on behalf of the Ga-Dikgale tribal leadership (Appendix 3: Approval from Makgosi Clarah Dikgale) on 12 October 2015. The final results will be shared with the tribal leadership in the

form of a hard copy presented to Makgosi Dikgale as well as a verbal presentation to the tribal authority, should Makgosi accept the researcher's offer to present the results.

Ethics clearance certificate number M160681 (Appendix 4: Ethics Clearance) was received from the University of the Witwatersrand Human Research Ethics Committee (Medical) (WHREC) on 24 June 2016.

Prior to conducting facility level interviews, an information sheet (Appendix 5: Information Sheet) was given to and discussed with the manager or a representative of each facility. Thereafter, a consent form (Appendix 6: Informed Consent for Facilities) was distributed for the manager or representative to give permission for the facility to take part in the study. A manager or representative was interviewed using a facilitated questionnaire (Appendix 7: Facility Information Form).

Prior to the FGDs, two consent forms were distributed per participant. One served as an agreement to participate in the study (Appendix 8: Informed Consent for Focus Group Discussions - Participation) and the other as an agreement to voice recording (Appendix 9: Informed Consent for Focus Group Discussions – Voice Recording). The participants were reminded of the voluntary nature of the study and that they could withdraw at any time with no adverse consequences. In addition, they were reminded that confidentiality could not be guaranteed in Focus Groups. The FGDs were voice recorded. The facilitator led each session by following an interview guide (Appendix 10: Interview Guide).

During the translation and transcription process following the FGDs, all participants were de-identified through reference to their randomly assigned participant number. The researcher filed all consent forms, facility information sheets and hard copies of the focus group discussion transcripts in a locked area of the researcher's home. Registers of the participant codes and the digital recordings were stored on the researcher's computer in password protected files, with access only available to the researcher and facilitator.

The research is based on information that was gathered from sites where children are cared for and kept safe. While no child was involved in the research directly, the

team were cognisant of the presence of small children and did not allow children to sit in on any of the discussions. Similarly, permission was granted from the manager of each facility to enter each site beforehand for the protection of any children on the property.

The FGD participants received refreshments during the focus groups and R50,00 toward their transport costs, after the discussion had concluded. The R50,00 was signed for by each individual.

The researcher is employed by an organisation working in Ga-Dikgale and therefore has an existing relationship with a number of childcare facilities and community members, including the staff from six ECD facilities. These six facilities were excluded from the study to avoid any bias based on prior engagement with the researcher.

3 Chapter three: Results

3.1 Introduction

This chapter considers the results of the study. The study objectives were to describe the characteristics of the caregivers working at Early Childhood Development (ECD) facilities in Ga-Dikgale in 2016; to establish caregivers' perceptions of the care provided in ECD facilities in Ga-Dikgale in 2016; and to establish caregivers' perceived priorities for providing high-quality ECD services in Ga-Dikgale in 2016. Quantitative data were collected for Objective One to give context to the study and its participants. Qualitative data were collected for Objectives Two and Three to explore and understand the perceptions of the study participants.

This chapter presents the findings from the study, including both facility-level and individual information from the interviews and Focus Group Discussions (FGDs), respectively. It considers the ECD facilities, caregivers, children at the facilities and the communities surrounding the facilities. It discusses the study respondents as a subset of the total population of caregivers at these facilities. It considers the following key themes that emerged during the study: the importance of ECD; daily activities at facilities, Caregivers' personal lives; community engagement; and caregivers' needs and requirements for their facilities.

3.2 Demographic characteristics of the caregivers at 32 ECD facilities in Ga-Dikgale

During the interviews with each facility, data were collected to explore the age, gender, position, level of education and years of experience of each caregiver. The results in this section are an aggregate of all 32 facilities that took part in the interviews. The characteristics discussed below are based on the facility-level data collected during facility interviews.

At the time of the study there were a total of 109 caregivers working at the 32 facilities, or an average of 3.4 members of staff per facility. 102 of these members of staff (94%) were female. The ages of the caregivers spanned a difference of 65 years (the youngest was 20 years old, while the oldest was 85 years old); they ranged in their experience from none at all, to over 40 years; their education ranged from Grade seven or lower, up to those with university degrees.

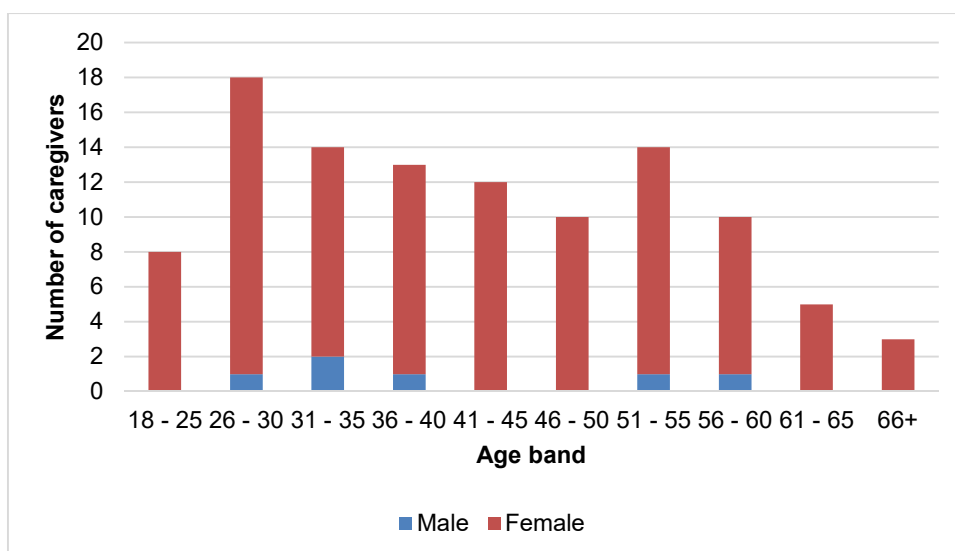


Figure 3.1: Age and gender distribution of caregivers across 32 facilities in Ga-Dikgale

When listing positions, nomenclature differed between the facilities. There did not appear to be any standardised set of positions across the facilities. For this analysis, those who listed their positions as manager, principal, assistant manager or vice principal were clustered into “Managerial”. Those who listed caregiver, practitioner or teacher were clustered into “Child Care”. Those who listed cook, gardener or cleaner were clustered into “Support”. There are 35 people in Managerial roles (32%); 48 people in Child Care roles (44%); and 26 people in Support roles (24%).

The highest level of education attained was given across the 109 caregivers. 33 people (30%) reported having completed between Grade eight and Grade 11; and 19 people (17%) reported that they completed Grade 12. A total of 46 respondents (42%) reported having received ECD training through an accredited training organisation – 18 members of staff had a National Qualifications Framework (NQF) Level One certificate; 22 had an NQF Level Four certificate; and six had an ECD degree or diploma.

Of the Managerial cluster, 34 of the 35 people (97%) had a Grade 12 education or higher; and 24 of the 35 (69%) had ECD training. Of the Child Care cluster, 29 of the 48 people (60%) had a Grade 12 education or higher; and 19 of the 48 (40%) had ECD training. Of the Support cluster, eight of the 26 people (31%) had a Grade 12 education or higher; and three of the 26 (12%) had ECD training. There appears to be a loose relationship between the level of education and the position held by individuals, where those with relevant ECD education hold more of the managerial

roles, while those with lower or less relevant education hold more of the support roles.

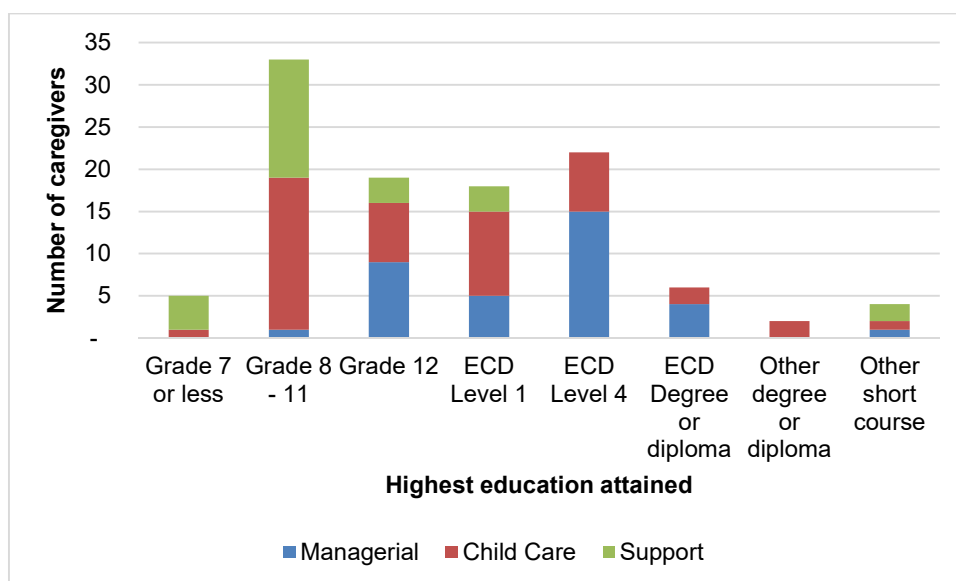


Figure 3.2: Education and position distribution of caregivers across 32 facilities in Ga-Dikgale

Facilities may be registered with the Department of Social Development (DSD) as Non-Profit Organisations (NPOs) and registered Partial Places of Care (PPCs), or both. Of the 32 facilities that were included in the study, 26 facilities (81%) are registered NPOs and 12 of the 32 facilities (38%) are registered PPCs. 16 of the 32 facilities (50%) reported having a social worker from DSD who works with them.

There is a total of 1 189 children registered at the facilities in the study. The children at the facilities are 52% male and 48% female. Children are eligible to attend ECD facilities from birth to age five. Facility sizes range widely, from eight children at the smallest facility up to 142 children at the largest. The lowest ratio of caregivers to children is one adult to four children (1:4). The highest is 1:20.

3.3 Caregivers' perceptions of ECD care provided in Ga-Dikgale

The results presented in this section represent the views and opinions of the caregivers that took part in the FGDS. The FGDS were labelled from Focus Group A to Focus Group E. Participants were randomly assigned a Participant number. Wherever possible, responses have been labelled to show which focus group and/or which participant they came from.

The deductive codes from the FGD guideline included: defining ECD; the importance of ECD; ECD activities; ECD infrastructure and equipment; ECD priorities for providing care; and community engagement. The following inductive themes emerged: child protection; caregivers' roles and skills; caregivers' personal lives; relationships with parents; relationships with the children in their care; relationships with DSD; funding and income streams; feelings of inadequacy with regard to the services the respondents are able to provide; and caregivers' legal liability.

3.3.1 ECD activities

The participants were tasked with outlining what a normal day would look like at an ideal facility. The purpose of this group task was to stimulate discussion among participants as they engaged with each other on the operations of their respective facilities, which later led to discussions about their perceptions of ECD care provided in the community and the priorities of facilities in general. The discussions addressed holistic development; school readiness; play and socialisation; routines; daily activities; and child protection.

Holistic Development

A theme that emerged was that of holistic development, referring to the respective key areas of development that make up ECD: *"I see the big role in childhood development, being to develop a child holistically. That meaning we develop them physically, socially, mentally and... I forgot the other one."* (C7) Another reason that arose was the longer term benefits of high quality ECD. Participant B3 said that ECD is: *"...to afford kids the opportunity to learn because this is the beginning of learning. This is so that they can be accomplished and get good jobs in the end."* (B3) The areas of holistic development overlap, as can be demonstrated by some of the examples below.

When speaking about mental development, one participant focused on cognitive ability for formal schooling, saying *"When a child leaves preschool, they develop attention and reasoning... they are able to have reasoning capacity."* (B3) They spoke about children learning to socialise with other children, and learning language or other cognitive skills through their interaction with the caregivers and other children: *"...But when they engage with other kids... this reminds me of one particular child. I have a child in our crèche, who could not speak. The other day, I*

ran into her mother and she told me that she heard her daughter call out [Anna's] name. She then asked me who [Anna] was because my child can call out that name. That helped me realise that this thing is important because when a child is placed in the midst of other children, language is learnt." (A5)

The respondents spoke about gross and fine motor development by referring to the development of large and small muscles respectively: *"When we refer to physical development that is when we are going to develop a child's large muscles and small muscles. In terms of the large muscles we might take them outside, playing outside to develop the whole body... They can ride on tires. They can play on the jungle gym and so forth. In terms of the small muscles we can come inside and do colouring, drawing and whatever and even puzzles using fingers."* (C7) One participant spoke to the importance of play for a child's development: *"I think it's the games. A child has to play. I regard them as important because a child is able to grow. Some parts of their bodies get developed. For example, when playing indigenous games that involve hands, their tiny fingers get developed. When they play soccer, their feet get developed."* (A5)

Social development speaks to a child's ability to empathise and interact successfully with their peer group, manage their emotions and relate easily to adults. (67) The caregivers spoke about how children learn through play and how by playing with them they are able to understand the children in their care: *"My answer is also linked with games and things like that. Indeed, you are able to better know a child through playing."* (A6) In addition, they noted that children made friends and learned to play together. They also learned from each other: *"...when a child is at home they won't be able to form friendships. But when they are with a lot of children they are able to create friendships with other children even when they have to go to school they will not be shy."* (E2)

The response below is an example of how social development was linked to emotional development: *"They touched on the social aspect of things. I can tell when a child didn't have a particularly good morning at home. Just by how they approach playing games that day. You can also tell if they left home very emotional. So that's where we step in and ask them how they feel that day. They will speak out and say "I feel a*

certain way,” or “my mother did such and such a thing to me.” You are able to tell what the condition at home is even through those activities we play with them.” (A6)

School readiness, play and socialisation

The participants spoke about school readiness. The focus fell on getting children ready for Grade R, specifically with regard to socialising (both with adults and other children) and toilet training. ECD caregivers identify part of their role as preparing children for formal schooling, saying: *“When they get to school, they won’t encounter a lot of problems.” (B5)* They felt that children who have gone through ECD care are better prepared for school compared to those who have not: *“the difference is evident when they start going to school. And you can see that this kid has not been anywhere.” (B4)* The caregivers in Focus Group E spoke about their relationship with feeder schools in their communities and how their work assists Grade R teachers, saying, *“I see the importance being that in preschool, we teach children, when they get to Grade R, the teachers in Grade R don’t have a problem because we taught them how to go to the toilet, another one to write, we taught them a whole range of things.” (E3)*

The discussions circled around play and communication. There was a feeling that children who stay home are not comfortable around other people and ECD is key in socialising children. Participant E4 spoke about children being able to converse with them and then their teachers in Grade R, which children who did not attend an ECD facility could not do: *“I think what we are doing is big because when a child gets to Grade R, if they did not start with preschool, there is a huge difference because when they get to Grade R they still have to socialise with the other kids... they still need a lot of support whereas they are supposed to get there and go on but they delay them.” (E4)*

The respondents felt that ECD addressed the need for children to be socialised, saying for example, *“By the time they start going to school, they are not afraid of people and they are able to speak. When a child hasn’t been to crèche, the first thing they do when they get to school is cry because they are not familiar with people” (B1)* The idea of children being socialised referred both to adults and to other children: *“We are making a difference in a sense that when a child gets to school, they are not*

surprised at the environment. They are already accustomed to multiple people and they've grown socially. Their ability to share is also improved.” (A5)

A participant linked ECD with toilet training: *“In fact some others who haven't been to preschool and just went straight to Grade R still [wet] themselves and other things. They are so behind.” (E4)* Another also linked the idea of socialisation with toilet training, in how children are able to communicate their needs once they get to formal schooling: *“When they get to school, that environment does not come as a surprise. There are other kids at our crèche who are even afraid to ask to go to the bathroom. But because they are used to the idea of a teacher, when they get to school, having an adult around doesn't surprise them. Their minds mature when they are here and nothing much seems to be a surprise when they get to school level.” (A5)*

Routines

Routine is an important part of ECD. The predictability and structure of routine gives children a sense of belonging and ownership of their environments. (68) As part of their discussion around daily activities, there were a number of key routines that came up. These included a daily ring, toilet routine, indoor play, outdoor play, meals, storytelling and nap time. The activities were categorised according to the discussion, for example; registration and health check was identified as the first activity when the children arrive in the morning, followed by a daily routine of other activities.

The participants spoke about their respective ways of signing children in for the day, referring to their practices broadly as registration and health check. While practices varied between facilities, the common themes reflected that when children arrive, it is required that they be signed in by a parent or guardian. In Focus Group B, one participant mentioned that in her facility, *“We use a book that parents sign in when they bring a child... After the parent signs the book, you check if the kid has any problems like a fever.” (B)*

During the conversation that followed, it was discussed that in order to protect themselves, caregivers must insist that children be signed in by a guardian upon arrival at a facility, which indemnifies the facility and its staff. However, this is often overlooked because of familiarity or even just if the guardian or parent is running late. Another participant in Focus Group B said, *“Now, our problem is that indeed a*

caregiver might not have training. The first thing is, whoever brings the child in, has to sign so that you don't get in trouble. So and so brought them in and so and so checked them out. Sometimes we start being lazy and you bump into a young girl who brought their child in and is late for school. They no longer sign. When something happens to the child, I don't have a witness. That's why we always encourage each other to sign. Make sure that whoever brings the child and takes them afterwards has signed... "Oh you're my cousin's child, just come here." Or they send different people every time to come pick up the kids." (B)

Once the child has been signed in, they are checked to ensure that they are in good health, and their bags are checked for any notes from parents or medication etc. This is important as caregivers are responsible for the children in their care. In Focus Group A, one participant noted that *"Health check is very important for us to write [on the list of daily activities] because we have to know the condition that the child arrived in"* (A) The respondents alluded to instances of neglect that might be picked up during health check and dealt with: *"Pertaining to babies, you find that a kid's last nappy change was the previous night. They just bring them to the crèche in that state and you notice that they have burn marks and haven't been changed. So we make sure to resolve those kinds of issues as well."* (A)

Daily Ring is where children are welcomed and the children go through the plan for the day. The participants discussed their respective routines, which included activities related to children's news, weather, emotions, date and time, birthdays, names, themes for the day, song, dance and prayer: *"It is an all-inclusive session. So, following the health check, they will have prayer. After prayer there'll be some who have performances who are given the opportunity to perform."* Another participant responded, *"We don't do it the same hey."* (A) In Focus Group A, each facility took turns to report a slightly different style of morning ring. The order of events differed, as did the time spent on morning ring. *"...Alright so we start with the attendance. After the attendance we figure out with the kids what day of the week it is. Say for instance its Wednesday, we then give our kids stickers that they put up on the wall next to Wednesday with some Bostik. And then they put the date according to their month. That's our morning ring."* (A)

One respondent went into more detail around special occasions such as birthdays, and how they go out of their way to make a child feel special: *“Since these kids don’t really know when they were born, I speak to their parents beforehand and so I know that today is so and so’s birthday. I know, because I spoke to their parents. The kid doesn’t know anything. And maybe their parents brought a little something. So we sing for them and eat whatever the parents brought later. If I have a flower, I just put it on them so that they feel special and that they know that today they are unique.”* (A)

The respondents expressed the importance of a toilet routine in the daily activities at an ECD facility, saying *“My understanding is that the biggest purpose that we serve for children who attend crèches is that when the child starts to go to school, they are know that they need to go to the toilet.”* (C3) Within each of the FGDs, there was the inclusion of a regular toilet routine in the daily plan for the children. Depending on the age of the children, this differed slightly from changing nappies to assisting with toilet training, to simply supervising and making sure children washed their hands.

In Focus Group A, one participant gave her explanation as follows: *“Oh so for the older ones, I have a teacher accompany them. “Toilet time-toilet time” they are singing, “toilet time-toilet time”. Then they leave with their teacher so that she can help those who haven’t yet learnt how to wipe themselves. We usually place soapy water right outside the toilet so that they can wash their hands before they come back in. The teacher left inside is left with the task of changing the little ones’ nappies.”* (A) There was a sentiment that toilet training children in ECD is important to – and appreciated by – the teachers at feeder schools: *“Another difference is that we also become important when it comes to the school. Teachers in schools are not strained like they were before ECD was around. The kids’ minds are opened up by the time they get to school and they’ll know to ask their teacher anytime they want to go to the toilet.”* (B6)

The participants spoke about indoor play activities. The activities that were discussed included education, fantasy or make believe, art, reading, construction and puzzles or games. The participants in Focus Group C spoke about how they will have smaller groups doing different activities at the same time, and rotate them through the day so that they all get a chance to do each activity: *“Let’s say we have 20 kids like you said*

[referring to an earlier comment]. *I put three kids there and I give those a task to cut, and I give the others colouring, these other ones use clay and the others do something else. They are all in a group and at the end of the day all these kids would have rotated around all four of those tables. When they leave cutting they go to moulding, when they leave moulding they go somewhere else. And then some play with toys on the floor.*" The participants spoke about the importance of working with small groups of children to give them the necessary attention: *"We do the small group, let's say for instance during indoor when you have kids colour in and you take them in small groups to help them understand and also so that you can see whether they are doing the right thing. You can't take a large group and conduct those activities aimed at developing a child."* (C)

Focus Group A referred to different areas in their facilities that were for different activities: *"What we have at our centre is that, we have an educational area, a fantasy area, an art area where they can mould their sculptures."* They referred to both facilitated play and free play during indoor activity time: *"Educational activities are also done during this period where a child is given free choice to go to the art area or education area. When the child wants to go to the make believe section they can go there, blocks section if they wish or even the books section."* (A)

The participants spoke about outdoor play, both in terms of facilitated and free play activities. They spoke about activities such as swings, balancing on tyres or balance beams, outdoor make believe games, water play, sand pits, skipping games, balls games and others. The participants in Focus Group B had a conversation where one participant said, *"After this we have outdoor. They play on swings and balance on tyres."* Another added, *"We also have make believe outside."* Another mentioned, *"Water play"* and someone else added, *"Sand pit"*. (B)

Other participants spoke about activities that the children at their respective facilities enjoyed, which included drumming, Diketo [a traditional game], water play, sports and swings: *"I'd say our kids love outdoor. For instance, you can hear drumming, it's heritage..."* (B) Another participant said, laughing, *"Kids like to play on swings, joh! [Exclamation]"* (C)

The participants understood the importance of not only feeding the children, but providing the correct nutritional balance, noting that *“We want the food they eat to be nutritional. There should be protein, a vegetable and starch.”* (B) However, some mentioned that they could only provide simple meals because of a lack of resources, saying: *“We give them soft porridge”* (A) or *“...and then after that, snack, if we have it.”* (B)

Respective groups gave different plans for feeding the children. They spoke about providing breakfast, snacks and lunch, as well as meals being age-appropriate: *“Ideally there should be a section specifically dedicated for eating where we’ve placed tables and chairs and organised the kids into age groups and so forth, but because our facility is small, we put the kids and place the food on their laps as they put their legs in a specific manner to ensure that they don’t spill. I don’t know how to describe it.”* (A)

There were discussions about the correct way of feeding children, regarding frequency and type of meal. During Focus Group B, a respondent supported her choice of routine during the discussion about providing a snack to the children, saying *“That’s what the law says.”* (B) Others differed in how they structured their daily feeding routines and the conversation went back and forth with various respondents wanting their way to be recognised: *“I see up there we haven’t written morning snack.”* (B) Another participant responded, *“Morning snack, we don’t have a snack then. It goes back to how we do things differently.”* (B) When discussing the differences and similarities between their facilities, one respondent in Focus Group D said: *“Those with two snacks eat health food but if you are an independent crèche I don’t think you can afford that.”* (D)

Participants spoke about storytelling time and how much the children enjoy it, as well as how important it is. For example, one respondent in Group B said: *“For me it’s the story. Even if I don’t feel like telling a story today they’ll start singing the song ‘it’s time for a story.’”* (B) A respondent mentioned, *“Another purpose of storytelling is to improve a child’s listening skills. It develops them mentally because when you tell them a story you have to help them be part of the learning experience. For instance, say “what did he do?” And they will try and put it in their own way and say “Masilo did this.””* (A)

The discussion in Group A about storytelling was generally linked to nap or rest time for the children. *"We put a blanket or mat flat on the floor, and we put them in a semi-circle... so they are on the floor in a semi-circle, you sit down with them so that you're on the same level as them. You can even stretch out your legs so when you are going to tell them the story... that will put them to sleep. I'm under the impression that a child is supposed to be sung to so that they can sleep."* (A) In Group C, someone mentioned that *"...they fall asleep during storytelling."* (C)

Other activities that were discussed included washing hands and faces, tidy up time, cleaning and preparation that the staff must do, as well as administration for the facility staff to complete. One example of this, was talking about preparation for each day: *"Open toilet, open windows, and lay down the mattress. Boil the water, all this is part of preparation."* (C)

Child protection

The participants spoke about facilities being places where children could be kept safe, saying, *"We protect them as well as caring for them."* (C7) They mentioned that children who stay home may be neglected, get injured or abused: *"Working parents and school pupils... can't leave a child at home because some of them are abused."* (D5) Participant E4 mentioned that *"...maybe if they are left at home they could get burned or be raped or something else."* (E4)

3.3.2 Caregivers' personal lives

The participants spoke about how working at ECD facilities relates to their personal lives. They referred to how working in an ECD facility allows them to focus their energy on something other than their home lives if there are problems at home. *"What I've seen is that... I won't hide this because we are women... sometimes it's not nice at home. But when you are with those kids, those things go away. The stress goes away. And by the time you go back home you are all better because of all those little kids."* (C5)

They spoke about how being a caregiver allows one to manage one's own family better, such as Participant A1 saying: *"From my side, I've seen it affording me enough time with my family. For instance, I have a little one who goes to crèche and*

you find that we'd be busy with crèche related activities even after hours. And so you find that the mood in my home is pleasant and I'm seldom impatient. I seldom scold my child complaining of this and that because I spend time with the community's children and I get to understand what children can be like. So when my child acts in a way that would otherwise frustrate me, I become more lenient. I can socialise with my child at home because of the crèche." (A1)

The participants spoke about how working with children improves their own emotional wellbeing: *"Spending time with children reduces my stress. I am also able to express my love to my own children at home and be in a better position to communicate with them appropriately. If you only spend time with your kids at home, you get impatient quite a lot. However, when you get out and spend time with the kids here, you engage with them in various activities and that helps refresh your mind. You essentially feel re-energised when you get home."* (A4)

They spoke about how working with children improves their own physical wellbeing. Following on from the conversation in Focus Group A, a participant said, *"I would like to add onto what participant number 4 said. Even your health is affected because you dance around with the kids and go up and down with them. All those ailments and lifestyle related health issues are brought to a minimum."* (A5)

The respondents spoke about caregivers supporting each other and helping each other through difficult times: *"It is true when you are stressed and you have domestic issues, when you get there, they all go away. We are also able to sit down, there is a support group for caregivers."* (C2) They spoke about using their skills to counsel each other: *"We are able to give ourselves time and talk about our problems and counsel each other and things return to normal. We are even able to go outside to the community and call them and say, kindred come, there is a support group at [name of Facility] ... Then they come and we all sit down and help each other with ideas."* (C2)

3.3.3 Community engagement

The study considered what the participants perceived their own roles in their community to be, as well as the skills that they offer. They were asked why they

thought ECD is important and what was required of them as ECD practitioners. The respondents considered their roles regarding the children in their care. They also discussed how part of being an ECD practitioner was engaging with different structures in the community such as schools; the children's families or parents; the community authority; DSD and social workers; as well as other community members. This section explored the dynamics of this role, from the perspective of the caregivers.

Caregivers' roles with regard to the children in their care

The discussion touched on what ECD meant to the participants, and why it was important. There was a focus on ECD being the foundation for a child's future: *"I think ECD is a place that I would regard as a child's foundation. Where a child starts learning multiple things from ECD."* (A6)

Participant D2 spoke about the work of facilities adding value to the lives of their communities: *"Ever since we opened our centre, the crèche, we've noticed a huge difference. There were a lot of complaints about how kids who stay at home are being raped. Kids are being hit by cars. You find that there was no progress here in Ga-Dikgale. But since we opened the crèche, we see happy people."* (D2) There was a fondness with which participants spoke about the children in their care: *"We have love for the kids and they love us as well... When they go to Grade R they still talk about us."* (E2)

Community support

During the conversations, respondents mentioned a number of other community members or groups, such as health services; churches and church members; and the surrounding community in general. The participants' feedback with regard to community relationships varied based on their individual experiences. Some experienced support, some did not. Some had never asked for community support because of an assumption that they would not receive any. There is a perception that the facilities should not try to ask the community for support, apart from the parents of the children in their care, because they would not support them. However, some mentioned that the community at large had helped when they had asked.

When discussing their relationships with health services, Participant E7 spoke about taking the children to access the mobile clinics in Ga-Dikgale: *"When we gather them together with those in the [mobile clinics], they are able to find them because at times when they are in their homes, their families aren't able to take them to the clinics"* (E7) They spoke about interactions with churches for special occasions at their facilities. For example, Participant E4 said, *"Sometimes we work with pastors, they come when the children graduate and they pray for the children."* Later in the conversation, she gave a specific example where someone from their local church helped her facility: *"In the other Dikgale section where I'm from, there was a ZCC [church] woman who burned the old sacks and she made new beautiful ones and she gave them to the children to sit on. She also took all those blankets on the mattresses which the children sleep on and she went to wash them with her own washing machine at home and she brought them back."* (E4)

The relationships between participants and their respective communities differed depending on their respective experiences. Some participants reported that their local community (i.e. the people in their village) had supported their facility financially, saying, *"With us the community paid for the installation of the fence."* (D) Later in the conversation, Participant D2 responded that community members close to her facility will help in different ways but that all community members support them: *"Our crèches are community based organisations... and everyone in the community has somehow contributed, from making a fence and building the shack."* (D2) One participant noted that her facility receives no support at all from their community: *"There is no one to help... We are on our own."* (B3) When discussing access to resources, one participant spoke about how her facility relies on her local community for water and cannot always depend on their local community to provide it: *"We use the community water right? ... The one they open for us. When they do not open we do not eat."* (C)

Some participants had never tried to get general community assistance and spoke about the assumption that it would not be feasible, such as Participant A5: *"In terms of the community, we haven't tried it. Our understanding is that; they are aware that there are many crèches in the community. Being well aware that their child does not go to that crèche, they will not go and help clean the yard...I mean, during holidays, there's a lot of rain and the parents have to come spade down the grass or pop out a*

little something so that we can pay someone to do it for us. They will never agree to pop out money in that crèche and my crèche as well. So we saw that this is something that they won't be able to do.” (A5)

Relationship with feeder schools

As discussed above, the respondents considered part of their role in ECD to be preparing children for school. One respondent noted the difference that ECD makes in a child's ability to engage with a teacher or another adult, saying, *“You find that indeed a child is able to say “can I go to the toilet”, and can interact with the other kids. They don't think I can't speak to this woman... Being afraid of people. So I think that is the biggest difference that we make.” (C3)*

There appears to be a strong relationship between the facilities and the schools in Ga-Dikgale. Participant C7 mentioned being thanked for the work that they do: *“I was once thanked by our feeder school here in [name of village] because the kids go there with a very mature mind... they brought feedback to us and said we thank you because you have a huge task. The kids are not troublesome, they just started off in a focused manner and their work was quick.” (C7)* One participant spoke about how teachers will ask caregivers for advice: *“With the Grade R teachers, sometimes they would come to us and ask, if a child behaves in this manner, how would you deal with them?” (E4)*

Relationship with parents

When the group discussed the purpose of ECD, one of the responses that came up in each group was ECD being a means to assist parents with caring for children. Participant E7 spoke about parents who need to work, or look for food, or study, saying that because of the ECD facilities, *“...parents are able to go to school and attend their studies.” (E7)*

The relationship between caregivers and parents varied between facilities, with some reporting healthy relationships and support systems, and others no support at all. There were varied emotions attached to the references. Participant C6 reported that *“...actually, their parents get happy. When they get home, the child comes back full and well fed, beautiful and clean. You can almost hear them say what makes us happy the most is that our kids are clean and they eat.” (C6)* They spoke about the

importance of trust: *"We do have a good working relationship with the parents. They were able to give us their children, which means that trust is there."* (C3) Another participant replied and illustrated that there is a direct acknowledgement of the care that was received: *"We have meetings with them and we actually hear them saying that they are thankful. They thank us."* (C2) Later in the same conversation, a participant mentioned that the parents of the children at her facility will volunteer their services: *"Another one that I think shows a good working relation is that you see people volunteering even though they can see that you cannot pay them."* (C7) Another participant added to this, saying *"when I want a committee from them they agree, they choose a committee to stay with the school."* (C1)

However, some of the participants spoke about their negative experiences of interactions with parents. One participant in Group B spoke about a lack of support from the parents of the children in her care, saying, *"Not all the parents support us. When we call a meeting, they don't show up or do as we request."* (B) The respondents spoke about how parents are not willing to assist with the education of their children: *"Some of them are understanding and you can explain to them that this child has a problem. But some of them... if you ask them to please help their kids with school work at home... for example if you give a piece of paper as homework, when you follow up on it, they'll tell you that their parents threw it in the dust bin."* (B2)

The respondents spoke about parents blaming them for a child's poor performance, despite not wanting to assist in any way, such as Participant B4: *"They are different. When you tell some parents that their child is not receptive when you tell them to do something, they pin it on us and say it's because we don't teach. We experience that problem at the end of the year – we have graduations you see. Now, there are some kids who just don't want to do anything – and the law says no one should be forced to do anything they don't want to. Since we are going to promote the one who participates, the parent of that other child starts fuming."* (B4) They spoke about teenage parents who needed to go back to school. There were a number of references to teenage parents who sent their children to the facilities. Participant B6 said, *"We are of great help because our young teenagers bear children at a young age and still have to go to school. You find instances where the infants are brought in as young as three months because the mother has to go to school – she can't stay at*

home.” (B6) Later in the same FGD, Participant B6 noted a generally negative attitude towards teenage parents because of a perception that they do not invest much time or interest in their children. “Some of them are school kids. They just toss the children in here. They don’t care how their child slept. They just bring them to the crèche. When you try to tell them about problems that their child is having, they don’t even want to know. These are the instances that lead to unfortunate cases. That’s why I wanted to know where we could get protection. A lawyer perhaps. We are going to be arrested and who will speak on my behalf because this parent brought their kid in their sick state. When they pass away, she doesn’t say the child has been sick for some time now. She just says she passed away in the crèche therefore they must have given her something.” (B6)

Relationship with tribal authority

The participants spoke of their dealing with the tribal authority. They mentioned that in order to start an ECD facility, one must approach the tribal leadership: *“Other women, if you started a crèche at your own home... you can go to the royal house, speak to the chief and ask for a site... and they will give you one... and that will be her place to start building her crèche.” (E5)* The respondents in Focus Group E also spoke about any activities in the facilities being communicated to the tribal leadership: *“Everything we do, we take it to the chief [induna or village elder] first because they are the nearest to us... and the chief will take it to the king.” (E)*

Relationship with DSD and social workers

The respondents spoke about DSD in a tone that showed frustration. An example of this is the requirement to attend mandatory meetings with no provision for transport money: *“When they call you to come to their offices, you use the money you’re supposed to earn or use to buy the children electricity for cooking.” (B)* The tone of the discussion reflected a feeling of resentment towards DSD from some participants. In Focus Group B, one participant said, *“They did not give us anything. They didn’t fund us. They check! They ask to see the children’s sponges [mattresses]. Where will you get them if you don’t have money?” (B)* Group B participants also expressed frustrations about not being able to reach the DSD standards due to what they perceived to be a shifting goalpost: *“They tell you to fix something but you don’t have the money to. I can register with few kids. But if I get more kids, they’ll take them out and tell us to build more rooms.” (B)*

Some respondents reported positive experiences of DSD. One example was given where DSD provided support: *“We call the community around us and social workers to come and teach children about abuse”* (D2)

Feelings of inadequacy

The caregivers expressed a feeling that they were ill-equipped to fully meet the needs of the children in their care. Although they felt proud of their contribution to the community, like being able to take kids from the streets and teach them, they felt that they could be doing more if they had the necessary resources and skills, saying: *“we lack a lot of things but we do work.”* (E4)

Legal indemnity

In Focus Group B, one participant spoke about a fear of being held liable for the injury or death of a child. She said: *“Something just happened recently here in [name of village]. A child left home sick and was brought to crèche as usual. I don’t know if it was a case of them not noticing or if it was one of those cases where the caregiver just tells the parent they’ll look after the child as a favour until they finish running their errands. So the parent took forever to come back. The child started acting up and so was taken to the clinic. It turned out that this kid was dead on arrival. Now, who’s to blame in that case? ... I mean in this kind of a situation the caregiver is in a lot of trouble. To make things worse they might not even have training. Or first aid. Who is going to speak on her behalf? She’ll be arrested.”* (B)

3.3.4 Needs and requirements

The study considered the physical aspects of facilities. The respondents were asked to outline the infrastructure and equipment that would be present in an ideal facility, regardless of whether or not they had access to any of those things at the time. In addition, the participants were asked to define what is necessary for any ECD facility to have, be, or do; and make a list of anything that they thought was important for an ideal facility. Once they had created what they felt was an exhaustive list, the participants were asked to debate and agree upon their top ten priorities for an ECD facility.

They spoke about not having the resources, requirements or funding to do the work that they would like to be doing. The conversations were skewed towards the needs and shortcomings of facilities, as opposed to what was important to contribute towards the impact of their work. They appeared to feel the need to explain themselves and their shortcomings, or perhaps were just looking for an outlet for their frustrations. They did not appear to recognise the impact of their work or what they were doing well. When discussing priorities for facilities, the participants did not differentiate between what is important for an ECD facility in general, and what they themselves were lacking. The prioritisation exercise often became an exercise in “we don’t have...”

DSD compliance

As discussed in the literature review, there are legal requirements that ECD facilities are required to meet to qualify for DSD funding or support. Discussions around infrastructure and equipment were repeatedly linked to a lack of funding. When the participants listed the priority areas of need for facilities, it was based around their perceptions or experience of what funders or social workers from DSD would want them to prioritise. For example, one conversation in Group B went as follows.

[Speaker 1]: *“Let me tell you here, for those who don’t understand. The first thing that we look at is for social to help us. Now when social gets there, they want to find a building, a fence, water, toilet...”*

[Speaker 2]: *“But training is also important.”*

[Speaker 1]: *“No we are not disagreeing with training, what we are doing here is putting them in order. We do want training. But, we also have to look at what social requires a facility to have before they can come in here.”* (B) When asked about why it was so important for the facilities to meet the DSD standards, one respondent in Group B spoke about her facility receiving support from DSD on an ad hoc basis: *“They do give a little something. When they get there... They can help us. They can give us food. When you are registered with them, they give you food.”* (B) Another respondent in Group B added that her facility had never had any engagement with a social worker, saying *“We don’t know because we don’t have social development. All we know is just hearsay. They only visit you when your things are in order.”* (B)

Funding in general

When the participants were asked about the needs of their respective facilities, the conversations tended to circle around funding as their primary need: *"We need funding, that is the first thing [laughs]."* (D) When probed, it was explained in the conversations that when respondents spoke about funding or money, they were not all talking about the same thing. Some meant charging higher school fees, some referred specifically to monetary donations, over and above the school fees paid by parents. An example of this was in Focus Group A. One participant said, *"Money... let me explain it this way. We depend on a school fund. That amount is too little. For instance, if a child pays R150, some of the money goes to the staff and another portion goes to food. Can you see that it would not really be enough?"* (A)

When the need for funding came up in the FGDs, the facilitator probed further, asking why the respondents felt they needed money, and what they needed to use it for. The responses varied by participant. In Focus Group B, one participant said, *"Sometimes we take the fee and use it to fix the school because there's a lot of damage. Nothing is really coming together. Even the fence as well. It's not safe."* (B) The same question posed in the respective focus groups gave different answers. Focus Group A had responses such as, *"So we can buy these kids the equipment that they need... so we can give them a proper diet."* Another response was simply, *"hiring teachers."* (A) In Focus Group B, the facilitator asked, "What does money mean?" One participant responded *"Salary."* Another said, *"Food."* (B) In Focus Group D, one participant said, *"I thought funding includes food."* Another said, *"We need funds for the building."* (D) Some did not specify the source of the funds but focused on salaries or stipends for the staff. One example of this in Focus Group C was a participant saying, *"When you take this money and buy food for the kids, at the end of the month you don't have a salary."* (C)

Prioritisation exercise

The items on the priority list were given a weighting between one (if an item was in 10th position on the priority list) and 10 (if an item was in first position on the priority list). This score was summed to find an overall score per item. The top five priorities for an ECD facility (building, food, training, fence, and water) were consistent across all five Focus Groups, with at least four of the five priorities listed above featuring in every group's top five list of priorities. There were three items that each of the five

Focus Groups consistently listed in their top five priorities: a building, food and training. Also included in the top five were fences, water, salaries and funding. A building overall ranked most highly with 43 of a possible 50 points, followed by food with 39 points and then training with 35 points. There were differences of how each group categorised their needs, but the results were interpreted as follows in Table 3.1: List of priorities from each FGD.

Table 3.1: List of priorities from each FGD

	Group A	Group B	Group C	Group D	Group E
1	Water	Building	Salaries	Food	Training
2	Building	Salaries	Food	Building	Fence
3	Salaries	Fence	Water	Fence	Building
4	Training	Food	Building	Funding	Food
5	Food	Training	Training	Training	Water
6	Toilet	Toilet	Fence	Computer	Office equipment
7	Kitchen equipment	Water	Educational/ Indoor equipment	Office equipment	Tables and Chairs
8	Stationery	Mattresses/ Blankets	Office equipment	Mattresses/ Blankets	Educational/ Indoor equipment
9	Outdoor equipment	Outdoor equipment	Water Tank	Educational/ Indoor equipment	Outdoor equipment
10	Cleaning equipment	Stationery	Income Generating project	Outdoor equipment	Educational/ Indoor equipment

Formal facility structure

As illustrated above, a building was the highest ranked priority across the five focus groups. When asked to elaborate, participants mentioned that they referred to a formal structure, since some facilities currently operate from informal structures, saying for example, *“The building is not enough... it is a shack. [Informal structure]”* (D) One respondent spoke about how having a formal building was not enough, and

that it was important to have sufficient space for the children to play and do their activities, saying: *“A lack of [space and adequate equipment] make it hard for me to attend a child individually.”* (A)

There was a feeling that if a facility had a building, it would have a knock-on effect for greater things to come, especially for their capacity to provide for the children in their care. For example, one participant said, *“Honestly, if we improve on a building, a lot of things on our side will improve as well. If you give us things, we don’t even have a place to put them... The kids have nowhere to attend. They feel cold, they get sunburned.”* (B)

In Focus Group D, one respondent opened up about feelings of shame for not having a building, and her colleagues provided comfort.

[Participant]: *“It’s a shame on us who don’t have a building. Those who have buildings are way better than us.”*

[Facilitator]: [asking another participant] *“Do you have a building?”*

[Participant]: *“Yes we do,”*

[Participant]: *“They even have a fence.”*

[Participant]: *“You will get there too, with the funding you will get.”*

[Participant]: *“Yes we will.”*

[Participant]: *“Our crèche is only 2 rooms which is very small for a crèche.”*

[Participant]: *“That is true.”* (D)

Food

The importance of feeding children came up in all five focus group discussions.

When comparing it to training for example, one participant said that *“Training is the last thing, as long as the children have food.”* (D) While food was ranked highly

across all five focus groups, it was a contentious issue. Some respondents reported they felt that parents should be sending their children to the facilities with food to eat, as they could not afford to feed them from the school fees they were receiving:

“Some pay school fees and take money for school fees and go and buy food. And they suffer. At the end of the month you don’t have anything to go with at home...”

(C)

Training

As illustrated in Figure 2.2 above, 22 of the 33 participants reported having ECD certifications. The participants spoke about the importance of being trained in order to meet the needs of the children. When discussing resources and equipment, one respondent reiterated that training should come first, saying that *“Without being trained, you might have all these things, but not know how to use them.”* (E) One person felt that training was the most important of any need, saying: *“...Between water and training. You’ll go for training without water. You’ll go for training without eating. Let’s think twice.”* (B)

There were discussions about responsibility and apportioning blame when things go wrong. The participants expressed feeling that training might expose them to criticism from their respective communities. An example of this was in Group A: *“As stuck as we are now, someone might say that if we get training, and have a uniform and when people come they are able to recognise the errors we commit because everything will be listed on the time table...”* (A) As discussed above, the respondents reported feelings of inadequacy. One of the main reasons for this, was a feeling of not being sufficiently trained. One respondent said, *“Something that we need is training. Okay. If we had training, I would know that when a child comes to the crèche I am supposed to use a thermometer and what what... The big one is training because you might just admit a child and check them without any know-how.”* (C)

Fencing

Three of the five focus groups chose fencing as part of their top five priorities. This was for a number of different reasons. The connection was made between fencing and the requirements set out by DSD, with one respondent saying, *“We don’t even have a fence. We might get into trouble with the Social Development. The fence we have is very weak.”* (D) Another reason for wanting fencing was linked to food gardening: *“When we mentioned that we want a fence, we want to plant so that the children get some spinach... this cannot be done without a fence. Water as well.”* (B)

Water

Water was a topic that was debated. In Focus Group B, there was a disagreement between participants when deciding between water, food and training for their order

of priority. Some of the points that were raised were statements such as, *“What will you cook this grocery with if you don’t have water?”* Another was, *“It’s hard to get food. You can always ask someone to donate water.”* However, another participant felt that it was not so easy to access water, saying, *“We can always afford training if the parents pitched in. Water on the other hand... Don’t you struggle? Do you know how hard it is to get water?”* Another mentioned that *“You’ll see what to do. You eat first and drink water before you go for training. In fact, you bath first.”* (B) In Focus Group C, water was mentioned as a way that parents could assist: *“...parents could volunteer, the way we struggle with water, they could bring water here to help their children.”* (C)

Salaries for the caregivers

While the need for money was spoken about openly, some of the participants shied away from stating that they would like to be earning more. In Focus Group C, one participant spoke about how proud she was to add impact in her community, regardless of families’ ability to pay their fees, saying: *“You find that they say they do not go to the crèche because they are poor. Those of us who have opened crèches have seen that it is better that we take them as well because we are not after money.”* (C)

One participant in Focus Group A argued for salaries to be higher up in the group’s prioritisation list, saying: *“You know, this is a job fellow workers. I’m fully aware that we all want to teach these kids but at the end of the month there needs to be a salary. Salary comes first.”* (A) Later in the discussion, another participant mentioned a shortage of staff, saying: *“At the moment we often only have 2 people working because we don’t have enough money but if we have more money, we’d be able to get [more staff].”* (A) In Focus Group B, one participant spoke about not having been paid at all that year and that she had been working as an unpaid volunteer. She said, *“The money they [the parents] pay [school fees] with, we take that and apportion it. Some is used for food, some for soap. With us this year we just take the money and buy food with it. It’s just a matter of coming there to help out really.”* (B)

Play equipment

In Focus Group E, one participant mentioned that a lack of resources is a problem for their outdoor play time, saying *“Sometimes the outdoors...We still struggle with that.”*

The outdoor [equipment] we have is boring. They just push tyres, or push a rock. They don't have toys. They even know that when I leave here I am going to push tyres and there are only four of them. We can count them." (E)

The respondents mentioned various games and activities that they would like to be doing with the children, but do not have the resources required. When discussing outdoor play in Focus Group B, three participants responded as follows:

[Speaker 1]: *"Water play."*

[Speaker 2]: *"Sand pit. "*

[Speaker 3]: *"As if we have them."* (B)

The participants spoke about the need not just for equipment, but also making sure that there is sufficient equipment for all of the children. One participant mentioned that at her facility, *"We have toys and swings but they are not enough."* (D)

Resources and supplies

Participants spoke about the difficulty of teaching children well, without the resources that they require. One participant mentioned her *"Lack of resources... maybe for counting. For laying out the classroom. Let's say I don't have blocks that the kids could use, say during the free choice activities... it limits the kids and you find that during free choice activities, they only play one activity."* Later, in that same discussion, another participant highlighted that educational aids would complement their work: *"Whenever you tell a kid a story, they always want to see what you are talking about. When you say the cow is... or the lion is... you must show them. What ends up happening is we have kids who think goats live in taxis, because they don't know them."* (A)

Support from parents

Each of the five focus group discussions covered the participants' desire for the parents of the children in their care to support their facilities. Some spoke of successfully working with parents to provide for the kids, such as in Focus Group A: *"Alright. I would like to tell them about the kids, first of all, the school fund. Just how little it is and how we can work together to raise funds here at the crèche. Or so we can work together if, say for instance, a parent has a mattress or sponge at home, they can bring them over to the crèche so that there is development."* (A1) Another

participant chimed in, saying, *"I would like to add on what participant number one said. When you involve parents, we are able to identify... maybe if one of the parents works at a kitchen, they usually get toilet rolls... resources, we can get them when we involve the parents. In cases where we have meetings, we can also work together by sitting down and talking about teaching aids."* (A5)

The participants in Focus Group C discussed how parents could support them. Volunteering time came up, with one person saying: *"Parents could volunteer, the way we struggle with water, they could bring water here to help their children. When there is water, you find that it is very far."* Another participant agreed, saying: *"Even in our yard, sometimes we don't have time to take spades and clean up for their children. Parents should just come and help us clean up. Where there are thorns, they should gather them and be burned so that when those children play, they shouldn't get hurt."* A participant spoke about parents not doing what she considered to be the bare minimum, saying: *"Hei [exclamation], I would like parents to include Pampers [nappies]. They don't insert Pampers [into their children's bags to take with to Crèche], they just have two for the whole day. They make our job difficult."* Participant C6 added, *"They should pay because this is where we suffer."* (C6) Another participant agreed, saying, *"Like [participant C6] was saying, when the month ends and you know that you took your child to crèche, pay the school fees."* Not everyone agreed, with one participant saying that at her facility, *"They do work with us because for example when we say you should give your children tissues, give your children wipes, give your children this, they do help. They don't just sit around."* (C)

In Focus Group B, the conversation about support from parents had a tone of sadness and even hopelessness. One participant said, *"Not all the parents support us. When we call a meeting, they don't show up or do as we request."* (B) Another participant agreed, saying, *"They just shove their kids to preschool and say we'll see what to do with them. We don't actually have the right to chase them away. The year ends with a single cent not being paid. I don't know how we can receive protection."* (B)

3.4 Summary of the chapter

The study explored how caregivers defined ECD and what they identified as important aspects of this care. Their responses revealed that they define ECD as caring for children holistically, which they defined to mean care in mental, physical, emotional, and spiritual respects. The respondents believe that they are meeting the needs of the children through these areas of care. Caregivers also highlighted preparing children for school, as well as assisting parents and protecting children as important aspects of their role.

The focus groups offered insight into community life for ECD practitioners. The discussions were set up in a way that people spoke with no hesitation. An overarching theme in all of the FGDs was that of limitations felt by the participants. The participants struggled to articulate what they felt was going well. They would say something they were proud of, and then revert back to why they weren't doing what they would like to be doing.

4 Chapter four: Discussion

4.1 Introduction

The aim of the study was to explore the perceptions of caregivers working at Early Childhood Development (ECD) facilities with regard to ECD practices in Ga-Dikgale, by describing the characteristics of the caregivers working at ECD facilities in Ga-Dikgale in 2016; by establishing caregivers' perceptions of the care provided in ECD facilities in Ga-Dikgale in 2016; and by establishing caregivers' perceived priorities for providing high-quality ECD services in Ga-Dikgale in 2016. This chapter will consider these objectives, and how the results of the study compare to the literature available in this regard.

4.2 The importance of ECD

The respondents recognised the importance of ECD and spoke about holistic development, school readiness and keeping children safe. One participant spoke about children getting "good jobs in the end". Their focus was primarily on immediate areas of impact rather than the longer-term potential impact of high quality ECD. Berry et al demonstrate that the benefits of ECD in the long term are made possible through the combined focus on care, stimulation, play, nutrition and opportunities for early learning. (6) Furthermore, the World Health Organisation (WHO) suggests that in order to provide the best possible care that they can, caregivers or parents should be aware of just how impactful ECD care is. (43) While the respondents believed in the importance of their work, it is not clear whether they understood the potential long term impact their work could have.

4.3 ECD activities

The order of events in a facility's daily routine and importance given to each activity varied by group and even by the individuals within the group. Examples are given, in the results above, of the back and forth discussions that happened between participants. Each of the five focus groups covered each of the key activities that should occur in a daily routine at an ECD facility: registration and health check; indoor play; outdoor play; a toilet routine; meals and snacks; as well as restful activities. Berry, Dawes and Biersteker (6) refer to the above activities as part of the essential package of services required for early childhood. Furthermore, the activities are generally aligned with the South African National Curriculum Framework (NCF).

(30) This could be linked to the participants' level of education, since the majority of participants reported having received ECD training.

4.4 Needs and requirements

During the focus groups, conversations would repeatedly lead back to the areas of lacking that the participants felt at their facilities. Shah et al suggest that a sense of not having enough of something causes people to focus with urgency on the areas where they perceive scarcity to be the greatest. (69) This theory lends itself to the finding that, regardless of how well or poorly a facility appears to be functioning from an outsider perspective, the participants drew attention to what they don't have and who could get it for them, as opposed to what they did have or could achieve on their own.

The respondents' perceptions of lacking may indicate poor self-efficacy in terms of the care they are providing to children in Ga-Dikgale. This may be due to the difficulties faced by caregivers in their own situations, such as living and working in resource-constrained environments. (43)

4.4.1 Infrastructure and equipment

The results show that the top five ranked priorities across the five focus groups included a formal structure (building), fences and water, with other infrastructure and equipment needs coming up in the top ten list, including toilets, indoor play equipment, outdoor play equipment, office equipment, kitchen equipment, computers, furniture, mattresses and blankets. ECD facilities in South Africa, specifically those in rural communities, fall short of the requirements to be compliant with the Department of Social Development (DSD) guidelines and other regulations. (6) Draper et al (39) outline the importance of proper nutrition, outdoor play and physical activity for children's development and link it not only to physical, but also to cognitive development. This is aligned with the findings in Ga-Dikgale, where the participants prioritised the need for infrastructure and equipment consistently across all five focus groups. There were resources listed such as food, stationery and cleaning supplies. Other needs and requirements that were highly prioritised included funding or salaries, and caregiver training.

4.4.2 Funding and social support

Discussions around DSD and those of funding or financial issues were consistently linked. When the participants discussed social workers or DSD, it was with frustration. As Giese et al pointed out, there is a gap in funding policies from DSD: facilities cannot get funding if they do not meet the minimum standards of care as laid out by DSD, therefore they cannot improve the facility as there is no funding available to them. (6, 13) This was reflected in the Focus Group Discussions (FGDs) when the subject of DSD came up. Caregivers reported wanting to improve their facility but needing funding to do so, and that they cannot get funding because they need to improve their facility in order to qualify. To unpack this further, it may indicate that the facilities in this study are trapped in the cycle described by Giese et al above. There may be social and emotional implications for the wellbeing of caregivers if they feel locked into a cycle that they perceive to be out of their control. It may be interesting to consider how this cycle might be broken in the context of South African policy, and/or policy implementation in the future.

4.4.3 Training for caregivers and legal liability

The participants focused on the importance of being properly trained. They focused on their feelings of inadequacy. This discussion linked with conversations about the legal implications of not being properly trained. The participants spoke about being worried that if some harm came to a child in their care, they would be held liable. According to South African law, caregivers are responsible for the care and protection of the children who attend their facilities and as such, not being sufficiently trained is considered illegal. (4) Therefore, it could indeed be the case if that caregiver is not qualified to provide ECD care they can be held liable by law.

Global literature demonstrates the importance of caregivers being qualified to provide ECD care. Vu (18), for example, links various ECD interventions and the training required for each, with improved long term personal and family outcomes. However, Atmore et al indicate that training alone is not a direct indicator of the quality of ECD care provided in South African ECD facilities. They suggest that a lack of practical training or on-site support may be the cause. (22) Given that the level of education was generally high amongst the focus group participants, it may suggest that Bandura's theory of self-efficacy (11) is at play and that despite being sufficiently

trained, the participants' perceptions of inadequacy could be negatively impacting their work.

4.5 Community engagement

4.5.1 The relationship between caregivers and the children in their care

When discussing their relationships with the children in their care, the respondents spoke with warmth toward the children. They spoke about having a loving relationship with them, even after they have left ECD and gone on to formal schooling. However, when asked about their role as caregivers in the children's lives, they focused on the child protection aspect, and did not address the importance of a loving or nurturing relationship for a child's development. As Berry et al have suggested, the relationship between a child and the adult or adults in their life shapes their relationship patterns into adulthood and it is crucial for this reason that children have a stable, nurturing adult relationship in early childhood. (42) The findings suggest that while a loving relationship is present, the respondents may not have a formal understanding of its importance for the development of the children in their care.

4.5.2 Relationship with parents

The participants spoke about their own experiences with parents, which varied across the groups. Some mentioned parents who lack any interest in their child's education; some mentioned parents who were happy to assist where they could. Harrison suggests that relationships with one or more adults is formative and necessary for a child's healthy mental and emotional development. (46) That they were disturbed by parents who appeared not to care very much about their children – and encouraged by parents who supported and cared for their children – may indicate that the respondents understand the necessity of an engaged and caring parent in a child's upbringing.

4.5.3 Relationships with community at large

The results show varied feedback regarding the respondents' experience of their community engagement. Some had had positive experiences with state services

such as the local clinics or mobile clinics; some had not. When mentioning schools, the respondents generally spoke to a healthy and functional relationship with mutual respect. The respondents generally spoke about their relationship with the tribal authority in terms of a working relationship where they report to the tribal authority, or approach them for permissions for specific activities or events. The respondents spoke about having a support system within the network of caregivers to provide support to each other. The experience of support from their local communities varied between respondents. In the South African context, communities at large are responsible and active in the raising of children. (42) This includes relationships with social or state services, schools, the tribal authority, and other facilities in the area and community members in general. (9, 42) The results show that some of the villages within the Ga-Dikgale community may mirror these findings and requirements, whereas others may not to the same extent.

4.5.4 Providing quality ECD services in under-resourced facility

The respondents focused on their areas of lacking throughout the FGDs. They spoke about working hard but needing assistance that was not forthcoming. The WHO reflects on the difficulties that workers face who are themselves living in poverty, such as feeling worn down and feeling unable to meet the needs of the children in their care. (43) The results show that this may indeed be the case in Ga-Dikgale, where the respondents find themselves living in poverty while still trying to care for children in resource-constrained circumstances and perceive the quality of the care that they are providing as poor.

4.6 Summary of the chapter

The respondents have an understanding of what is required of them as ECD practitioners and from ECD facilities. They are focused on their shortcomings and gaps, and do not appear to fully understand the positive impact of the work that they are already doing. Since the perceived efficacy of care provided can affect the developmental or educational outcome of the children in their care, this perceived shortfall may be detrimental to the long-term developmental outcomes of the children attending facilities in Ga-Dikgale.

5 Chapter five: Conclusion

5.1 Introduction

This qualitative study explored Early Childhood Development (ECD) practices in Ga-Dikgale, from the perspective of the ECD practitioners or caregivers themselves. It explored the characteristics of the caregivers, their perceptions of the care provided, and what they considered to be their highest priorities for providing high-quality ECD services. The findings showed that respondents see the importance of ECD and the role they play as caregivers in the community. There is a general understanding of the technical aspect of ECD on the part of the focus group participants, but with limited focus on the longer-term benefits of high quality ECD services. The experience of being a caregiver in Ga-Dikgale varied between respondents, with regard to the support received and relationships with community stakeholders.

There was a consistent focus on the inadequacies, shortfalls or areas of lacking from the perspective of the participants. These findings serve as a reminder of the risk of living in scarcity and how it affects the lens through which one views their own world. A sense of inadequacy – regardless of the level of training received by participants – may indicate poor self-efficacy (11) which may adversely affect the learning outcomes of the children at the ECD facilities, thereby playing into the cycle of poverty that high-quality ECD services are designed to break. (45) This is a concern that may have implications for policy and implementation of ECD.

5.2 Limitations

There were issues raised above that needed further exploration. Due to limitations of time and funding, there was minimal iterative research. This is a risk associated with qualitative research. (66) Other risks include the researcher's own influence on responses; the difficulty in maintaining and demonstrating academic rigour; and the difficulty in preserving anonymity when presenting findings. (66)

The use of FGDs as a means for data collection comes with limitations. The group dynamic may mean that a participant who disagrees with general opinion may not voice their feedback, or may be shut down by other members of the group. (70) Once again, there is a limitation in how participants may choose to respond, given that confidentiality cannot be guaranteed from other participants. (70)

Participation was voluntary, but each facility was nominated to participate in this study by the Ga-Dikgale tribal authority. Therefore, there are limitations to the study with regard to purposive sampling. While every effort was made to create an exhaustive list of facilities in Ga-Dikgale, over and above those that were provided by the tribal authority, it is possible that facilities were left out. This could potentially skew responses that were collected.

Research was conducted by a trained facilitator, with the researcher present. While the facilitator was qualified to do this job, there is a risk when bringing in an external facilitator that the facilitator may not have a deep enough understanding of the study and may not probe enough, or appropriately. (71) Due to the language barriers, this may indeed have been the case, since the researcher does not have a deep enough grasp on the Sepedi language to interject. At the time of conducting the research, the facilitator was an employee of the same organisation as the researcher. Therefore, the cost of her services were covered by the employer and this contributed to the decision to choose her as the facilitator.

Both the researcher and facilitator have a prior relationship with the Ga-Dikgale community in connection with a development organisation that supports ECD facilities. It is likely that there was a perception that should someone say the correct thing, they would receive support and/or funding in the future. This may have skewed the feedback from participants.

5.3 Recommendations for future research

Further research is required to fully explore caregivers' level of understanding with regard to the long-term benefits of ECD, including the long-term benefits of a healthy relationship between a child and a nurturing adult. In addition, further research is required into the implications of working at an ECD facility that does not meet the required standards.

When considering the quality of ECD care, one requires a standard set of metrics against which practices can be measured. At this time, none exists in the South African context, per the national ECD Policy. (2) While some proxies of care were measured as part of Objective 1, they were used only to provide context and not to measure the quality of care provided. This can be explored further.

5.4 Recommendations for Rural Health Policy and Practice

The National Integrated ECD Policy speaks to the gaps in the system at present, specifically to those regarding the health of mothers and children. It mentions that focus and funding is skewed towards urban facilities, and that the quality of care is often insufficient. (2) Furthermore, the Policy suggests a need to measure programmes and their impact on child outcomes. (2) It is necessary to consider the effect that caregivers' self-efficacy will have on the health outcomes of children in their care; and how policy – and thereby, funding – can be channelled to ensure that caregivers are not just trained, but believe in their own ability to provide care.

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7 Appendices

7.1 Appendix 1: Code Book from MaxQDA

Code System	Memo	#
Defining ECD/Reasons for ECD	Refers to what ECD is, why it is important in the community, why is it beneficial for children.	0
Safety/Care/Nurturing/Love		27
Prep/Foundation for school		24
Socialisation/ friendships/relationships		19
Assist parents		16
Growth		12
Holistic development		10
Child protection		10
Unsupervised children		9
Routine		6
Foundation for life		6
Belonging/Social Capital		3
Children's legal rights		2
Daily Activities	Refers to the activities that happen in an ECDC on a daily basis	0
Toilet Routine		43
Meals and nutrition		34
Indoor Play		31
Hygiene and bathing		21
Story telling		19
Morning Ring		18
Prayer		19
Knowledge and Understanding of the world		12
Educational Charts		9
Introductions, names and greetings		2

Outdoor Play		17
Health Check		16
Nap or rest time		16
Preparation and cleaning		10
Sign-in or registration		9
Tidy up		7
Age-Appropriate Activities		6
Formal teaching		5
CG discussion and debriefing		1
Learning Methods	Refers to the ways in which children learn in ECD	4
Learning through song/dance/rhythm		10
Learning through imitation/mimicry/repetition		7
Sensory/experiential learning		5
Early Learning Areas	Refers to the areas of learning that are linked to ECD	2
Social/Behavioural Development		16
Physical/Motor development		10
Mental/Cognitive development		8
Language and communication		7
Culture/tradition		3
Emotional development		1
Concerns or Worries	Refers to areas flagged by participants as problems or that could be problems in the future; negative experiences; concerns for themselves or others	0
Feeling ill-equipped or inadequate		16
Needs Based Approach/ "lack of..."		13
Financial Strain		10
Teenage parents		6

Disabled or special needs children		6
CG's legal rights		5
Helplessness/hopelessness		4
Lack of training, understanding or knowledge		4
Being understaffed		2
Weather		2
CG Personal Circumstances	Refers to the lives of participants outside of their work	0
Sense of Purpose or passion		9
CG Home lives		6
Support between CGs		5
CG Wellbeing		5
CG own family relationships		3
Children's Home Lives	Refers to the lives of children attending the ECDCs when they are at home or in their communities (i.e. not at the ECDC)	3
Abuse/Problems at home		14
Parents involvement in child's education		7
Lack of stimulation/support at home		7
Neglect		5
Child wellbeing		4
Relationship between ECDCs and community	Refers to the dynamic between participants and the communities in which they live and work.	1
General community support		22
Social workers/DSD		13
Schools		10
Health care/Mobile clinics		2
Relationship between CGs and children in their care	Refers to the dynamic between participants and the children who attend their respective ECDCs	1

Understanding children		15
Affirmation		4
Behavioural patterns		4
Patience		1
Relationship between CGs and parents	Refers to the dynamic between participants and the parents of the children who attend their respective ECDCs	8
Feedback between CGs and parents		18
Parents' assistance or support with time		16
Parents' assistance or support with resources		10
Parents' responsibilities		6
School fees		3
Placing blame		3
Trust		3
Feeling appreciated		3
Feeling unappreciated		2
Priorities for CGs	Refers to specific resources or other items that participants have flagged as a priority for an ECDC	0
Building/Infrastructure/Space		30
Educational Resources		27
Outdoor Play resources		25
Food		24
Indoor Play Resources		24
Water		20
Office Equipment		19
First Aid		18
Mattresses or blankets		18
Training		18
Fence		15

Stationery	14
Cleaning Resources	12
Stipends or Salaries	12
Kitchen Resources	11
Toilets	9
Computer	8
General funding	8
Tables and Chairs for children	8
Uniforms for caregivers	8
Toiletries	7
TV	5
Water Tank	5
Outings	4
Fire Extinguisher	3
Food Garden	3
Income Generating project	3
Tippy Tap	3
Uniforms for children	3
Music	2
Electricity	0
	1159

7.2 Appendix 2: Plagiarism Declaration



PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I _____ (Student number: _____) am a student registered for the degree of _____ in the academic year _____.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: _____ Date: _____

7.3 Appendix 3: Approval from Makgosi Clarah Dikgale



LONELY ROAD FOUNDATION

12 October 2015

To Whom it May Concern

Approval for study at Child Care Facilities in Ga-Dikgale

On behalf of the community of Ga-Dikgale, I hereby give permission for Michelle Walford, a student at the University of the Witwatersrand to conduct a study at the Early Childhood Development (ECD) facilities in Ga-Dikgale during 2016.

The study, titled "Early Childhood Development Practices from the perspective of Caregivers in Ga-Dikgale Community, Limpopo" will take place across Ga-Dikgale during 2016 and will contribute towards her Master's in Public Health qualification. I confirm that I have received a draft protocol for the study.

I look forward to receiving the results of the study in the form of a report.

Kind regards

Makgosi Clarah Dikgale
Ga-Dikgale

12/10/2015

7.4 Appendix 4: Ethics Clearance



R14/49 Miss Michelle Jan Walford

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160681

NAME: Miss Michelle Jan Walford
(Principal Investigator)
DEPARTMENT: School of Public Health
Early Childhood Development Facilities, Limpopo
PROJECT TITLE: Early Childhood Development Practices from the
Perspective of Caregivers in Ga-Dikgale Community
DATE CONSIDERED: 24/06/2016
DECISION: Approved unconditionally
CONDITIONS:
SUPERVISOR: Abigail Dreyer and Daphney Conco

APPROVED BY:



Professor P Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 05/08/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004, 10th floor, Senate House/2nd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in June and will therefore be due in the month of June each year.

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

7.5 Appendix 5: Information Sheet

INFORMATION SHEET (English Version)

School of Public Health Building
University of the Witwatersrand (Education Campus)
27 St Andrews Road
Parktown 2193
South Africa
Tel: 27 11 717-2543
Fax: 27 11 717-2084

Good Day,

My name is (researcher) and this is (facilitator). I am doing a study, which will explore Early Childhood Development Practices in Ga-Dikgale Community. I would like to invite you to participate in this study in order to understand how the people who work in crèches and preschools in Dikgale feel about Early Childhood Development. I will leave a copy of this information sheet with you in case you would like to read it later.

I am a student at the School of Public Health, University of Witwatersrand in Johannesburg, and I am doing this study in partial fulfilment of the requirements for the degree Master of Public Health. We would be most grateful if you would agree to participate in this study.

The study will take place during 2016 and we will visit and organize meetings when it suits you, the participants. There will be facility visits and focus group discussions over this time. The facility visits will take no more than an hour and the focus group discussions will take half a day.

Why am I doing this?

I am doing this study because I would like to understand how caregivers who work in ECD facilities feel about Early Childhood Development, in general but also how you feel that you are doing at the facilities in Ga-Dikgale. I would also like to understand a bit better what is it like to work in a crèche or a pre-school.

What do we expect from the participants in the study?

I would like to invite you to take part in a group discussion with your team members and possibly caregivers from a nearby facility. This consent form (displays the form) confirms that I have explained the study to you and that you have voluntarily agreed to participate in this study. I will be asking some general questions about your facility and about each caregiver, like your age, gender, or about any training you have received. The focus group discussion is about how you and the other caregivers feel about early childhood development and how your facility operates.

Are there benefits to the participants?

No. There are no direct benefits to you. You are welcome to see the results and if you want to make any changes or learn from the results in any way, I will be glad to talk to you about what other facilities are doing.

May I withdraw from the study?

Certainly, you may do this at any time without having to give a reason. Your responses will be confidential and you will not be victimized in any way by not participating or by withdrawing from the study. During the interview your answers will be recorded on a tape recorder if everyone gives us permission to do so. The only people with access to the transcripts will be the two of us (indicate researcher and facilitator). You are not required to mention your name so no one will be able to trace the recordings back to you. Furthermore, in case you experience any form of discomfort, please let us know and we will refer you for appropriate treatment.

What about confidentiality?

Confidentiality will be maintained at all times during individual interviews and questionnaires. At the top of the questionnaires, which only the facilitator and myself will have access to, will be a code to help us order and identify the interview. Your name will be on a list with codes that will be stored separately and will be password protected. Any paperwork and my tape recordings will be kept at my home that will be locked or password protected at all times. In addition, the findings will be reported as group and not individual results, in order to protect any identifying information.

Please take note, for discussions with other people, we cannot guarantee total confidentiality because the discussions will be with groups of caregivers and not just

you and we cannot control whether other participants will disclose any information from the discussions.

It is important for me to stress to you that if any information is disclosed that is of a criminal nature, I will have to report it by law.

If you have any queries, more information may be obtained from me on this telephone number 082 444 8841. If you would like to check the validity of what I have told you, you are welcome to phone the Wits School of Public Health on 011 717 2543, or speak to any of the people listed below:

- Prof P Cleaton-Jones (peter.cleaton-jones1@wits.ac.za)
- Ms Zanele Ndlovu, Mr Rhulani Mkansi. Mr Lebo Moeng, Administrative Officers:
011 717 2700 or 011 717 2656 or 011 717 1234 or 011 717 1252
(zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za; Lebo.moeng@wits.ac.za)

Should you wish to participate, please read and sign the attached consent form and complete the questionnaire and return it to the facilitator, who will be receiving the questionnaires. Thank you!

7.6 Appendix 6: Informed Consent for Facilities

INFORMED CONSENT FOR FACILITIES (English version)

As the manager of _____ (name of facility), I give permission for the staff at this facility to participate in the study entitled: “Early Childhood Development Practices from the perspective of Caregivers in Ga-Dikgale Community, Limpopo” as outlined in the information sheet.

The goals, methods and the purpose of the study have been explained to me and are clear. I understand that the study will involve participating in a focus group discussion. I also understand that general information about this facility and demographic information about the staff at this facility will be collected. I understand that confidentiality cannot be guaranteed during focus group discussions.

I understand that I have the right to refuse participation in the study. I agree to participate in the study on condition that:

1. I can withdraw from the study at any time voluntarily and that no adverse consequences will follow on withdrawal from the study.
2. I reserve the right not to answer any/or all questions posed in the survey.
3. The Human Research Ethics Committee at the University of the Witwatersrand has approved the study protocol and procedures.
4. My name will not appear anywhere on this interview guide. All results will be treated with the strictest confidentiality.
5. Only group results, and not individual results, will be published in the final report, scientific journals and in any presentation related to this study
6. The Researcher is committed to treating participants with respect and privacy throughout the procedure.
7. The researcher is required by law to disclose any information of a criminal nature to the relevant authorities

I, _____ confirm that I have been fully informed about the nature, conduct and benefits (service delivery improvement) of the study, entitled “Early Childhood Development Practices from the perspective of Caregivers in

Ga-Dikgale Community, Limpopo” outlined in the information sheet. I hereby give permission for this facility to take part in the study.

ON BEHALF OF FACILITY:

_____	_____	_____	_____
Name	Position at Facility	Signature	Date and Time

RESEARCHER:

_____	_____	_____
Printed Name	Signature	Date and Time

Human Research Ethics Committee (Medical), University of the Witwatersrand, Johannesburg

- Prof P Cleaton-Jones (peter.cleaton-jones1@wits.ac.za)
- Ms Zanele Ndlovu, Mr Rhulani Mkansi. Mr Lebo Moeng, Administrative Officers:
011 717 2700 or 011 717 2656 or 011 717 1234 or 011 717 1252
(zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za; Lebo.moeng@wits.ac.za)

7.7 Appendix 7: Facility Information Form

Facility Form (English Version)

Facility Name: _____

Village: _____

GPS Coordinates: _____

Manager name: _____

Manager contact number: _____

The above information is for data collection process in case more information is needed from the facility but will not be part of the analysis and the write up. The questions below are for us to understand your facility a little better. Please answer every question as best as you can.

Are you a registered NPO? Yes No

Are you registered as a partial place of care? Yes No

Do you have a social worker from the Department of Social Development who works with you? Yes No

In what year did your facility open? _____

How many children are currently attending? _____

How many are boys, and how many girls? Boys: _____ Girls: _____

Do you charge school fees to the children who attend? _____

If so, how much do you charge? _____

What happens if parents cannot pay for their children? _____

Please tell us about your staff, but do not write their names on this sheet.

Staff Member	Year of Birth	Gender	Year that they began work here	Position	Any training received that relates to your work at this facility
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

[illegible]

7.8 Appendix 8: Informed Consent for Focus Group Discussions - Participation

INFORMED CONSENT FOR PARTICIPANTS IN FOCUS GROUP DISCUSSIONS - English version

I agree to participate in the study entitled: “Early Childhood Development Practices from the perspective of Caregivers in Ga-Dikgale Community, Limpopo” as outlined in the information sheet.

The goals, methods and the purpose of the study have been explained to me and are clear. I understand I will be taking part in a focus group discussion. I understand that as part of a focus group discussion, my confidentiality will not be guaranteed.

I understand that I have the right to refuse participation in the study.

I agree to participate in the study on condition that:

- I can withdraw from the study at any time voluntarily and that no adverse consequences will follow on withdrawal from the study.
- I reserve the right not to answer any/or all questions posed in the survey.
- The Human Research Ethics Committee at the University of the Witwatersrand has approved the study protocol and procedures.
- My name will not appear anywhere on this interview guide. All results will be treated with the strictest confidentiality.
- Only group results, and not individual results, will be published in the final report, scientific journals and in any presentation related to this study.
- The Researcher is committed to treating participants with respect and privacy throughout the procedure.
- The researcher is required by law to disclose any information of a criminal nature to the relevant authorities.

I, _____ confirm that I have been fully informed about the nature, conduct and benefits (service delivery improvement) of the study, entitled “Early Childhood Development Practices from the perspective of Caregivers in

Ga-Dikgale Community, Limpopo” outlined in the information sheet. I agree to participate in the above-mentioned study.

PARTICIPANT:

Signature/Mark or Thumbprint

Date and Time

RESEARCHER:

Printed Name

Signature

Date and Time

Human Research Ethics Committee (Medical), University of the Witwatersrand, Johannesburg

- Prof P Cleaton-Jones (peter.cleaton-jones1@wits.ac.za)
- Ms Zanele Ndlovu, Mr Rhulani Mkansi. Mr Lebo Moeng, Administrative Officers:
011 717 2700 or 011 717 2656 or 011 717 1234 or 011 717 1252
(zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za; Lebo.moeng@wits.ac.za)

7.9 Appendix 9: Informed Consent for Focus Group Discussions – Voice Recording

INFORMED CONSENT FOR PARTICIPANTS IN FOCUS GROUP DISCUSSIONS (VOICE RECORDING) - English version

I agree to participate in the study entitled: “Early Childhood Development Practices from the perspective of Caregivers in Ga-Dikgale Community, Limpopo” as outlined in the information sheet.

I hereby give permission for voice recording of the focus group discussions.

I understand that I have the right to refuse participation in the study.

I agree to participate in the study on condition that:

- I can withdraw from the study at any time voluntarily and that no adverse consequences will follow on withdrawal from the study.
- I reserve the right not to answer any/or all questions posed in the survey.
- The Human Research Ethics Committee at the University of the Witwatersrand has approved the study protocol and procedures.
- My name will not appear anywhere on this interview guide. All results will be treated with the strictest confidentiality.
- Only group results, and not individual results, will be published in the final report, scientific journals and in any presentation related to this study.
- The Researcher is committed to treating participants with respect and privacy throughout the procedure.
- The researcher is required by law to disclose any information of a criminal nature to the relevant authorities.

I, _____ confirm that I have been fully informed about the nature, conduct and benefits (service delivery improvement) of the study, entitled “Early Childhood Development Practices from the perspective of Caregivers in Ga-Dikgale Community, Limpopo” outlined in the information sheet. I agree to participate in the above-mentioned study.

PARTICIPANT:

Signature/Mark or Thumbprint

Date and Time

RESEARCHER:

Printed Name

Signature

Date and Time

Human Research Ethics Committee (Medical), University of the Witwatersrand,
Johannesburg

- Prof P Cleaton-Jones (peter.cleaton-jones1@wits.ac.za)
- Ms Zanele Ndlovu, Mr Rhulani Mkansi. Mr Lebo Moeng, Administrative Officers:
011 717 2700 or 011 717 2656 or 011 717 1234 or 011 717 1252
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7.10 Appendix 10: Interview Guide

Focus Group Interview Guide (English version)

Focus Group Reference Number: _____

Scripted Start

(Greetings)

“Thank you to you all for agreeing to be part of our conversation today. Sisi Pheladi (researcher) and I (facilitator) are learning about Early Childhood Development in Ga-Dikgale. We wanted to speak to you today to hear about what you think about Early Childhood Development.

All of our questions are to understand how you feel as a caregiver. There are no right or wrong answers. Your responses will not be shown to anyone.”

Research Question 1: What is the role of ECD in general?

Interview Questions

1.1. How would you describe Early Childhood Development?

(Probes: How do you define ECD? What ages do you think need ECD services? When you say Development, what does that mean? What services do you think are important for ECD?)

1.2. How does ECD make a difference in Ga-Dikgale?

(Probes: What are some of the services that you provide for the community? How does ECD help the community in general? How does it help the children at the centres? How does your facility help the families in your village? How does working here help you personally, or your family?)

Research Question 2: Brainstorming exercise

a. “We would like to do an exercise with you. We would like to understand what happens during a normal day in what you think is an ideal facility. We would like to

understand what would happen during a normal day here, and what everyone's different roles are."

The group is given a piece of paper and pens, and asked to brainstorm the activities that happen in a day, using a spider diagram. The facilitator can assist by starting the process, but should try to hand over to a member of the team to take over the exercise. (Probes: Who would get here first? What time would that be? Ok, what happens then? Does everyone do that together, or are there other activities happening at the same time? And then? What next? What other services do the children need? What other services do the children like? What other services do you offer? What do the caregivers need? What is something you would like to do in the future? What is your favourite activity?)

b. "Thank you for showing us what a day looks like at your ideal facility. Now we would like to do an exercise with you. We would like to make a picture of what you think is important for any ECD facility to have, or do, or be. All of the activities you spoke about just now are very important, and we would like to see if there are any other activities, or things, that you think are important for a facility."

Respondents are provided with a different colour pen and asked to write anything that they think is important onto the spider diagram. Do not exclude any ideas at this point – keep all ideas as important.

(Probes: What else? What equipment/rooms/resources/skills would they need for that activity (from the timeline)?)

Research Question 3: How are ECD facilities in Ga-Dikgale meeting the needs of the children?

Interview Questions

3.1. If we look at this ideal facility, how do the facilities here in Dikgale compare to the ideal?

(Probes: What are some of the things that your facility does for the children? What do they like? What do you do very well? Which of the things above do you do at the moment? What are some of the needs of the children? What are some services are

you not managing to provide? Which services would you like to improve? How would you want to take better care of the children?)

Use the services/equipment etc. on the wall if you need to probe further

Research Question 4: Prioritisation exercise

“Thank you so much for your answers. We would like to work with you to learn what is most important of all of things you have mentioned before. Let’s go through all of these services and take turns to pick what is most important to you”

Provide as little guidance as possible to begin with – allow for the team to work out a system for themselves.

If the process is not moving forward, suggest that each person choose one or two items that they think is the most important and move them to a separate space. Allow them to debate which are the most important – Choose a top ten. If possible, order those ten items from 1 to 10.

(Probes: What is most important for the children to be healthy? What is most important for the children to be happy? What is most important for the children to be safe and cared for? What do the caregivers need most to care for the children? What is something you would like to do in the future? What is your favourite activity? What is the children’s favourite activity?)

Research Question 5: How can the community in general collaborate with ECD facilities to improve the outcomes of their children?

“Thank you very much for your time. You have mentioned that some of the services that you would like to offer the children are not being offered yet/you have had difficulty in XXX area/XXX service is very important to you. We would like to learn about how the community can work with you all at the ECD facilities to make sure that the children in the community are looked after as well as possible.”

Interview Questions

5.1. How does your facility work with the community at the moment?

(Probes: Which community members do you deal with the most? How do community members help you or support you? Can you tell us about your relationship with the parents of the children who attend?)

5.2. How else can the community support you to look after the children?

(Probes: You mentioned X service that you would like to offer... what are some of things that would make that possible? Where can you get those things from? How can the community help you to offer X? Who could help you? Who are some of your partners in the community? What sort of things could be useful to you??

Closing

“Thank you all very much for your time today. We have learned so much. Once we have spoken to some more facilities, we will report back to you all about what we have learned from everyone. Is there anything else that you would like to tell us before we finish?”