Scoping early childhood development (ECD) services in Walmer Township

Final Research Report

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HUMAN SCIENCES RESEARCH COUNCIL (HSRC)

Human and Social Development Research Programme and Population Health, Health Systems and Innovation unit

13 July 2016

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Suggested citation: Groenewald, C., Makusha, T., Petersen, Z., & Mncadi, A. (2016). *Scoping ECD services in Walmer township*: *Final research report.*

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1. Overview

The Centre for Justice and Crime Prevention (CJCP) is running a five year early crime and violence prevention project in Walmer Township, Port Elizabeth, aimed at addressing risk factors for violence. In response to the call for proposals (CFP), the Human Sciences Research Council (HSRC) successfully submitted an application to conduct a scoping study to identify registered and unregistered ECD services- and taverns and shebeens in Walmer Township, Port Elizabeth, South Africa (hereafter referred to as the 'study site'). This particular report will describe the mixed-method approach that we used to scope the ECD services in Walmer and will also present the findings of this study and emerging issues for CJCP to consider in the next phases of the early violence prevention project.

2. Background

Exposure to, and experiences of violence at an early age have adverse behavioural and bio-psychosocial impacts on a child's later development (Moffitt & Klause-Grawe, 2012). These adverse effects have been linked to a wide range of detrimental effects such as depression, anxiety, learning difficulties, low self-esteem, self-blame, abuse-specific shame and guilt, risk of internalizing or externalizing behaviour, stigmatization, and risky sexual behaviour (Krug, Mercy, Dahlberg & Zwi, 2002; Richter et al., 2014; Richter et al., 2015). In addition to these detrimental effects, literature identifies several other risk factors for aggressive and violent behaviours, including low filial and parental connectedness, parental antisocial behaviour, poor academic performance and attitudes towards schooling, and affiliation with deviant peer cultures and physical aggression at an early childhood age (Granic & Patterson, 2006; Byrne & Brian, 2007; Phyfer & Wakefield, 2015). In order to decrease the prevalence of violence, an investigation into the factors that promote and prevent violence and a deeper understanding of the degree to which violent behaviour is linked to other problem behaviours is required (Tolan et al., 1994; Ellickson & McGuigan, 2000).

Early interventions, which recognise that the causes and consequences of violence are complex and occur at various ecological levels, are imperative for the prevention, and possible reduction of crime and violence (Krug et al., 2002; Skeen, Tomlinson, Ward, Cluver, & Lachman, 2015). Early childhood development (ECD) services are considered to be critical points in which crime and violence prevention strategies can be implemented (Phyfer & Wakefield, 2015; Mikton, MacMillan, Dua, & Betancourt, 2014). However, current ECD frameworks, although considered 'holistic', do not adequately recognise and integrate programmes for early crime and violence prevention (Phyfer & Wakefield, 2015). In the current paper, we not only sought to identify the ECD services in the study site, but also to explore how issues related to child and family wellbeing (and its inverse violence) are perceived and practiced amongst ECD service providers in Walmer Township.

3. Study components

As per the CFP, the aim of this study was to produce contextually relevant information that will assist the CJCP with the implementation of the early crime and violence prevention project. The overall study comprised two study components; one of which explored ECD services in Walmer Township and the other focused on scoping shebeens and taverns in Walmer Township. This particular research report discusses the findings of the former component which aimed to:

1. Identify the registered and unregistered ECD services in existence in Walmer Township and map the location of these spaces using reference keys (community mapping)

2. Explore knowledge, attitudes, perspectives and behaviours of ECD service providers (ECDSPs) in relation to: a) the registration process, b) link between ECD services and child and family wellbeing, c) the operational support needs of ECDSP, and d) willingness to partake in community-based crime prevention and safety initiatives

4. Methodology

Study Design and processes

A mixed method, step-wise research design was adopted in this study. Qualitative in-depth interviews and focus group discussions (FGDs) supported by an interactive mapping activity were used to explore the ECDSPs' subjective experiences, perspectives and practices in relation to the study aims. This was followed by a structured survey phase where the breadth of the issues related to the study aims was explored.

a) **Participant recruitment**

Local organisations working in the study site facilitated the recruitment of fieldworkers who reside in the township and assisted the research team in making contact with prospective participants (ECDSPs). The fieldworkers were familiar with community structures and also spoke the local language, which facilitated community entry and successful recruitment of the ECDCPs. While we intended to recruit between six and eight participants for focus group discussions (FGDs), and 5 individual in-depth interviews with registered and unregistered ECDSPs respectively, setting up the individual interviews proved to be difficult. This activity was especially challenging with the registered ECDSPs who, at the time of the study, were attending meetings with social workers in addition to their ECD caregiving duties. Nevertheless, we conducted one FGD with registered and unregistered ECDSPs respectively and two individual interviews with unregistered ECDSPs (see Figure 1 below).

b) Data collection

Qualitative phase

Data collection commenced with FGDs and in-depth interviews supported by a semi-structured discussion guide (see Appendix A) and an interactive mapping activity. The FGDs and in-depth interviews were conducted in the language that the participants were most proficient in (either in English or Xhosa). The semi-structure discussion guide covered a range of topics including descriptive details on the operating structure of the ECDSPs, perspectives, practices and experiences of the registration process, and perceptions of the role of ECDSPs in promoting child and family wellbeing. The aim of the mapping activity was to identify the locations of the ECDSPs that were operating in the study site. A single map was co-produced by the participants and this map was then presented to the next participant(s) who were asked to add those ECDSPs that they thought were lacking on the map This iterative mapping approach was followed to ensure inclusivity and was conducted until saturation was reached[1] (when no new ECDSPs could be identified). The information collected during this phase was transferred onto an A0 map of the study site using color-coded referencing keys, which facilitated the recruitment of the ECDSPs for the survey component of the study (See Appendix B for the map where yellow circles represent registered ECDSPs, red circles represent unregistered ECDSPs, and blue circles represent those we were not sure of).

Figure 1: Participants

	Total number of ECDSPs identified in mapping activity	Sample size in qualitative phase **N= 16**	Sample size in quantitative phase **N= 30**
Registered ECDSPs	**N= 46**	6 participants in FGD	17 participants
Unregistered ECDSPs (inclusive of those who are in the process)		8 Participants in FGD 2 Participants in interviews	13 participants

Survey phase and directories

A short survey was constructed to assess the ECDSPs perspectives, practices and experiences in relation to ECD provision, physical and operating structures of ECD centres, training background of staff and the role of ECDSPs in promoting child and family wellbeing (Appendix C). Given the small sample size of the ECDSPs that were identified through the mapping activity (N=46), we decided to recruit all the ECDSPs for the survey component of the study. As explained in the table above, thirty participants were recruited and interviewed by the fieldworkers using the structure survey questionnaires.

A further objective of the study was to obtain contact information from ECDPs operating in Walmer township to facilitate the implementation of targeted service delivery in the upcoming phases of the early violence prevention project (which the currently study forms part of). This information is

[1] Notably, we need to acknowledge here that there is likely to be other places that do not classify themselves as ECDSPs but rather offer only day care facilities with no educational care.

currently being collected and will be made available to CJCP only, once this activity has been finalised.

c) **Data Analysis**

All qualitative interviews were audio recorded, transcribed and translated verbatim. The text was analysed line-by-line and started with an open-coding process to understand the meaning of the interviews. The open-coding, structuring of the data and thematic analysis of the interviews was facilitated using the Atlas ti programme. Three investigators (including the person who conducted the interviews) coded the data. Two investigators (excluding the interviewer) did the second level of coding, creating code lists and families, which were then used to facilitate further analysis (development of themes).

The survey data were entered into SPSS and analysed using the data analysis software. The captured data was subject to quality control where it was checked and verified through a process of double data entry. This entailed checking for missing values and inconsistencies in the captured data. Data analysis then comprised both descriptive and inferential statistics. Given the small sample size of the study, the findings of the study are not strictly generalizable. However they do provide context specific information that could inform the development of support initiatives for ECD owners in this community.

d) Ethics

The research process was conducted in accordance with the International Ethical Practice for Research with Human Subjects. These guidelines encompass informing participants of the aims of the study, the benefits or lack of immediate benefits in participating, their rights in participating and the confidential nature of research. All participants gave written consent to participate in the research. Participants who had difficulty reading had the consent form read to them by the interviewer. The study design, instruments used, consent forms and any ethical considerations were reviewed and approved by the HSRC Research Ethics Committee.

5. Findings and discussion

A synthesis of the qualitative and quantitative findings will be provided in this section. The findings will be presented according to three main sections namely:

a) Descriptive findings (ECD provision and programme structure, teacher training, resources and needs)
b) Perspectives and experiences of formal registration
c) Perspectives on the role of ECD services in promoting child and family wellbeing

Descriptive findings: Physical and operating structure

In this section, we provide some descriptive details related to the operating and physical structures of the ECD service providers (ECDSP) that participated in this study. Notably, we generally did not find any significant differences between registered and unregistered ECDSPs in relation to the survey questions.

Operating structure

As is evident in Table 1, a range of variable was used to determine the operating structures of the respective ECD centres. This included ownership of the ECD centre, reasons for establishment, operating period, child enrolment, facilitation of healthcare services, food provision, and number of ECD caregivers and training. Results show that majority of the ECDSPs (83.3%) were owners of ECD centres while only one government owned (Department of Education) ECD centre was found. Twelve of the participants (70%) indicated 'day care' as the main reason they had established their ECD centre, followed by preparing children for school (40%) and 'child protection' (30%). This is further explained by the extended operating times of the ECD centres where all reported that they operate for more than 7 hours per day.

Twenty-seven of the ECDSPs (90%) indicated that they had been in operation for more than three years while only one had been established in the previous year. In relation to child enrolment, seven (23.3%) of the registered ECDSPs, compared to 1 (3.3%) of the unregistered ECDSPs, reported that they currently have between 20 and 30 children enrolled at their ECD centre. Five of the registered ECDSPs (16.7%) and four of the unregistered ECDSPs (13.3%) respectively indicated that they have enrolled more than 40 children. The majority of the ECDSPs provided services to children in the 0-5 years age range (66.6%), while only 16.7% provided services to children in the 3-5 years age range.

Table 2 provides data on the ECDSPs practices in relation to health and nutrition. We found that 63.3% per cent of ECDSPs provided meals for children compared to thirty-seven per cent who did not. Of those ECDs who provided meals, 30% offered one meal per day while the rest averaged at least two meals per child per day. Most of the ECD centres (80.0%) facilitated health care services, such as the provision of Vitamin A supplements, deworming and growth monitoring to children attending their ECD centres. Approximately 67% of these ECD centres reported that they facilitated growth monitoring and 13.4 per cent providing Vitamin A supplements to the children enrolled in their centres.

Table 1: ECD provision

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
ECD ownership						
Department of Education	1	3.3	0	0.0	1	3.3
Employer/Owner	14	46.7	11	36.6	25	83.3
Community organization	2	6.7	0	0.0	2	6.7
Church/Mosque/Temple	0	0.0	2	6.7	2	6.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Reasons for establishment						
School readiness	7	23.3	5	16.7	12	40.0
Day care	11	36.7	10	33.3	21	70.0
Crime prevention/child protection	4	13.3	5	16.7	9	30.0
Operating period						
Less than a year	0	0.0	1	3.3	1	3.3
1 to 2 years	1	3.3	1	3.3	2	6.7
3 to 4 years	9	30.0	3	10.0	12	40.0
5 years and above	7	23.3	8	26.7	15	50.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Operating days per week						
Daily	17	56.7	13	43.3	30	100.0
Operating hours per day						
7 to 8 hours	2	6.7	0	0.0	2	6.7
More than 8 hours	15	50.0	13	43.3	28	93.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Catchment area						
Walmer Township only	14	46.7	11	36.6	25	83.3
Walmer Townships and surrounds	3	10.0	2	6.7	5	16.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Child enrolment						
Less than 10 children	1	3.3	2	6.7	3	10.0
10 to 20 children	3	10.0	2	6.7	5	16.7
20 to 30 children	7	23.3	1	3.3	8	26.6
30 to 40 children	1	3.3	4	13.3	5	16.7
40 children and above	5	16.7	4	13.3	9	30.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Number of teachers						
1	2	6.7	2	6.7	4	13.4
2	9	30.0	6	20.0	15	50.0
3	3	10.0	3	10.0	6	20.0
4	1	3.3	1	3.3	2	6.6
5	2	6.7	1	3.3	3	10.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Child age ranges						
0-5 years	12	40.0	8	26.6	20	66.6
1-5 years	3	10.0	2	6.7	5	16.7
3-5 years	2	6.7	3	10.0	5	16.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Table 2: Practices in relation to nutrition and health

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
No of times children are fed per week						
None	6	20.0	5	16.7	11	36.7
2 days per week	1	3.3	0	0.0	1	3.3
5 days per week	10	23.4	8	26.6	18	60.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Meals provided						
No meals	6	20.0	5	16.7	11	36.7
1 meal	3	10.0	6	20.0	9	30.0
2 meals	5	16.7	2	6.6	7	23.3
3 meals	3	10.0	0	0.0	3	10.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Facilitation of health care						
Yes	13	43.4	11	36.6	24	80.0
No	4	13.3	2	6.7	6	20.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Health care services facilitated						
Nothing	4	13.4	2	6.7	6	20.0
Vitamin A only	1	3.3	3	10.0	4	13.4
Growth Monitoring only	12	40.0	8	26.6	20	66.6
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Availability of children with disability						
Yes	2	6.7	4	13.3	6	20.0
No	15	50.0	9	30.0	24	80.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Does ECD require use of steps?						
Yes	1	3.3	0	0.0	1	3.3
No	16	53.4	13	43.3	29	96.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Furthermore, the number of teachers employed at the ECD centres ranged from 1 to 5 teachers, with the majority reporting that they currently employ between 2 and 3 teachers (70.0%). The ECDSPs were also asked about the training backgrounds of the caregivers they employ at their ECD centres. Surprisingly, Table 3 shows that more registered ECDSPs (7 (23.3%)) than unregistered ECDSPs (3 (10%)) reported that their caregivers do not have any ECD training. Inversely, less registered ECDSPs (7 (23.4%)) than unregistered ECDSPs (9 (30%)) reported that at least one of their caregivers have attended an ECD training course. We further found that 73% of the ECDSPs reported that the caregivers at their centres do not have any form of child protection training. This finding advocates for the provision of child protection training to equip ECD caregivers to adequately respond to situations that threaten child wellbeing.

Table 3: Staff member training

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
Training received						
None	7	23.3	3	10.0	10	33.3
ECD training	7	23.4	9	30.0	16	53.3
ECD and First Aid training	1	3.3	1	3.3	2	6.7
ECD, First Aid and TB, HIV/AIDS training	2	6.7	0	0.0	2	6.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Teachers who attend ECD training						
None	11	36.6	8	26.7	19	63.3
1 Teacher	5	16.7	4	13.4	9	30.0
2 Teachers	1	3.3	1	3.3	2	6.6
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Child protection training						
None	11	36.7	11	36.7	22	73.4
1 Teacher	4	13.4	2	6.6	6	20.0
2 Teachers	1	3.3	0	0.0	1	3.3
4 Teachers	1	3.3	0	0.0	1	3.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
How long ago did training take place						
Not Applicable	11	36.7	11	36.7	22	73.4
This year	2	6.6	0	0.0	2	6.6
More than a year ago	4	13.4	2	6.6	6	20.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Physical structure

To assess the physical structure of the ECD centres, the participants were asked about the building material and the availability of doors and windows at their respective ECD centres. Table 4 shows that approximately fifty-six percent (56.7%) of the participants reported that their ECD centres have brick walls while 43.3% indicated that their ECD centres were shacks. Most of the ECD centres (70%) were reported to be attached to the private homes of the participants while only four participants reported that a freestanding ECD centre. All of the participants indicated that their ECD centres had roofs, windows and doors, and the majority had easy access to a water source on their premises. The participants were also asked about the play materials (dolls and puppets, crayons, paper, clean toys etc.) that they had access to at their ECD centres. Results (see Table 5) indicate that majority of the ECDSPs had access to materials like dolls, puppets and crayons, and 60% indicated that they had a safe place to store these materials.

Table 4: ECD physical structure

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
ECD Structure						
Brick	9	30.0	8	26.7	17	56.7
Shack	8	26.7	5	16.6	13	43.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Roof material						
Tiles	1	3.3	0	0.0	1	3.3
Zinc	14	46.7	11	36.6	25	83.3
Asbestos	2	6.7	2	6.7	4	13.4
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Windows and doors available						
Yes	17	56.7	13	43.3	30	100.0
ECD situation						
Freestanding site	2	6.7	2	6.7	4	13.3
A private home	12	40.0	9	30.0	21	70.0
Multipurpose building	3	10.0	2	6.7	5	16.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Distance to water source						
At the ECD Centre	14	46.7	11	36.7	25	83.4
Less than 100m from ECD Centre	3	10.0	1	3.3	4	13.3
Less than 200m from the ECD Centre	0	0.0	1	3.3	1	3.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Water source						
Tap	17	56.7	12	40.0	29	96.7
Borehole	0	0.0	1	3.3	1	3.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Table 5: ECD play materials

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
Play materials (Dolls, puppets etc)						
Yes	15	50.0	13	43.3	28	93.3
No	2	6.7	0	0.0	2	6.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Pens and crayons availability						
Yes	15	50.0	12	40.0	27	90.0
No	2	6.7	1	3.3	3	10.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Paper availability						
Yes	15	50.0	11	36.6	26	86.6
No	2	6.7	2	6.7	4	13.4
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Clean toys availability						
Yes	11	36.7	13	43.3	24	80.0
No	6	20.0	0	0	6	20.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Can children reach toys?						
Yes	15	50.0	13	43.3	28	93.3
No	2	6.7	0	0.0	2	6.7
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Safe storage of toys						
Yes	11	36.7	7	23.3	18	60.0
No	6	20.0	6	20.0	12	40.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Language of instruction on toys						
English	5	16.7	4	13.3	9	30.0

English and Xhosa	12	40.0	9	30.0	21	70.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Perspectives and experiences of registering: Necessity versus economic abilities

This section reports on the participants' experiences and perspectives on the process of formally registering their ECD centres. All of the participants in the qualitative phase agreed that registration is important for the social and lawful protection of the ECD centre should any of the children fall ill or become injured while in the care of the ECD centre staff. A secondary reason that emerged here, related to the support that some registered ECD centres receive to better implement their ECD services in the community. These could include subsidies from the Department of Social Development (DSD) which could contribute to staffing costs, as well as the provision of stationary like crayons and pens for the children. While these benefits were recognised, the participants' decisions and actions towards registering appeared to be swayed by the challenges associated with the registration process. The challenges that emerged in our discussions will now be discussed under two subthemes: macro-level challenges and administrative delays.

Macro-level challenges: "the requirements are insane"

Evident in the narratives of some of the unregistered ECD service providers (ECDSP), was the socio-economic challenges that place ECDSPs in Walmer Township at a predisposed disadvantage in the registration process. This is best explained in the extracts below:

> "The requirements are ridiculous! They should be changed because of the nature of this community! So many of us are living in wooden rooms and the taverns are all over the place so how can the government expect us to have bricks and bigger places as if they haven't seen our environment?" (II1, unregistered participant)

> "I am not registered and I am neither in the process of registering simply because I do not qualify in their checklist. I mean I am in a wooden structure, so I was given a checklist that listed a brick house as one of the requirements. I operate in an informal settlement so I cannot have a brickhouse in a place that has not been surveyed in any way. I do not have funds that can allow me to have fire extinguishers. I don't have funds to fulfil the checklist that I have been given. So I have a very thick checklist […] There is no use for me to even submit the form for me to be registered for ECD [as] I know that I do not have everything that they want. I don't have it and I don't even have any other means for me to have it" (FGD, unregistered, P1)

The socio-economic challenges experienced by the unregistered ECDSPs produced feelings of disempowerment and resistance to registering their ECD centres. The underlying issue here was that, while ECDSPs are provided with some information on why they do not meet the requirements, many do not have accessible funds to attend to these requests. What further complicates the ECDSPs decisions to register or not, is that the ECD centres are the only source of income for majority of the

participants. Some ECDSPs thus opt to refrain from registering as their centres would be found to fall short of the requirements and likely be closed down.

> "I just want to add that it is not easy to get registered because when we have completed filling the forms, before it can be processed there must be a health inspector who has to assess. The inspector will point at negative things. The first thing she or he will tell you is that the place is not conducive for my 30 children. He or she will say that the place is only adequate for six children. Then that is not good for my business let alone inconveniencing the children and parents who will now have to change the school because of that" (FGD, unregistered, P1).

Administrative delays: "Waiting! It's not easy"

A second registration challenge that emerged in both the registered and unregistered groups related to the several administrative challenges that delay and complicate the registration process. These challenges generally included completion of application forms, obtaining the "correct" person's signature and the extended waiting period. Below, some of the participants describe their experiences:

> "If you make mistakes it does not get processed until you fix it. I experienced that when there was a number I did not write, the application was returned back to me to fix it. It takes a lot of time but I was lucky because my application was approved in less than a year. There are people who have been in this field for many years, some have 20 years but they are not registered. Yet I applied in 2009 and it got approved in that year. This is because there are so many things that are required so you keep on going back to fix certain things or submit certain documents" (FGD, registered, P1).

> "P4: They can also return the forms and say that a certain contact is not going through. They return it just so that you look for one person's new number after all the things that you would have done.

> R3: Exactly, it gets returned without being processed" (FGD, unregistered, P4 and P3).

This extended back-and-forth process appeared to be extremely frustrating for the participants. Importantly, some of the participants highlighted that information on the registration process and requirements is needed in Walmer Township to support ECDSPs to register their centres successfully. Formative support on, for example, how to complete the application forms is likely to decrease the unsupportive back-and-forth process and decrease the waiting period. This could mean a smoother transition from unregistered ECDSPs to registered ECDSPs which could also encourage others to register their ECD centres.

A final issue that emerged, that could compromise individuals' decisions to register, was that some of the unregistered participants indicated that there are social conversations, with other unregistered ECDSPs, that "we should stop opening those [registered ECD centres]" which to them meant that there are "enough" registered ECD centres. This, together with the aforementioned challenges, is

likely to discourage registration and points to the importance of addressing social attitudes and perspectives in relation to registration.

Perspectives on the role of ECD services in promoting child and family wellbeing

In this section we discuss the participants' perspectives on the role of ECDSPs in promoting child and family wellbeing. For some of the participants, ECD centres were considered safe spaces for children where they are monitored, protected and receive information especially about inappropriate sexual conduct. The survey data provides an indication of the perspectives and practices related to child and family wellbeing in ECD centres. Table 6 shows that the vast majority of the ECDSPs (93.4%) reported that they do incorporate lessons on the child and family wellbeing into their daily programs. Approximately 86% indicated that they teach children about the importance of protecting themselves from strangers, and 90% reported that they educate children on the importance of reporting if someone has harmed, or tried to harm, them in any way. However, only 26.7% of ECD centres provided HIV and AIDS awareness to children enrolled in their centres.

The strong focus on reporting child harm is perhaps linked to a finding that emerged in the qualitative data where the ECDSPs generally agreed that "child abuse is very common in the township". Several ECDSPs recounted occurrences of child abuse, of which sexual abuse were discussed more so than other forms of abuse. The ECDSPs reported that they often recognise the 'signs' of child abuse because they "are quite observant of the different characters that children present. So you know that a certain child is bubbly and energetic and the child suddenly changes to being a very anxious and withdrawn person, or when that child is playing with dolls, you realise that she is acting out what she saw or experienced on the doll."[2].

Table 6: Child and family wellbeing education

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
Home language use						
Yes	17	56.7	13	43.3	30	100.0
Teachings about importance of child and family well-being						
Yes	16	53.4	12	40.0	28	93.4
No	1	3.3	1	3.3	2	6.6
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
Child protection lessons						
Yes	15	50.0	11	36.6	26	86.6
No	2	6.7	2	6.7	4	13.4
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

[2] FGD, registered, P1.

	Registered ECD Centres (N=17)		Non-registered ECD Centres (N=13)		Total	
	n	%	n	%	N	%
Children taught about reporting abuse						
Yes	16	53.4	11	36.6	27	90.0
No	1	3.3	2	6.7	3	10.0
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**
HIV and AIDS Awareness						
Yes	5	16.7	3	10.0	8	26.7
No	12	40.0	10	33.3	22	73.3
Total	**17**	**56.7**	**13**	**43.3**	**30**	**100.0**

Participants were then asked to describe how they respond to these challenging situations. Survey results indicate that most of the participants (96.7%) reported that they involve families through parent meetings which are often convened as a way to provide feedback to the parents on the development of the child. The qualitative data corroborates this and found that all of the participants agreed that they first report their observations to the child(ren's) parents. While the importance of informing the parents is certainly recognised, the ECD caregivers' narratives suggest that they rarely report these cases to social workers. For some of the unregistered ECDSPs, this underreporting was associated with two main concerns. First, because they are not registered, they do not have strong relationships with the social workers. Second, the caregivers indicated that they fear being victimised by the parents should they report them given that they reside in the same community:

> R1: "You talk to the parent sister because you can't just go to a social worker because we stay with these people here in the neighbourhood. The person will swear at you while children are watching! Even when a parent sees the problem, they stand there and swear at you. When a problem requires a social worker, you can't go there! You have to go to the parent. The parent will tell you the child has no problem whatsoever and what are you going to do? Yet you can see that there is a problem. The main problem is that we live with these people here in the neighbourhood. Sometimes it will happen this week and usually it will be repeated to the same child.
>
> R2: You won't live in peace (.) Until you report it to the parents because if you report to social workers first people will disown you and they will not bring their children to your ECD=
>
> R1: =Or the parent will take the child away where the child won't say anything about the matter" (FGD, unregistered).

What is further evident in the extracts above is the frustration and despondence that the ECD caregivers feel towards some of the parents. The phrase "parents just don't care" resonated with many of the ECD caregivers, and majority of them blamed the high levels of alcohol misuse that is apparent in Walmer Township. What this finding suggests is that interventions to promote child and family wellbeing should target parents/caregivers and parental factors like substance misuse and parenting approaches, in addition to ECD service providers.

The ECD caregivers further reported a need for support workshops or trainings on how to best respond to these issues. In this regard, all of the ECD caregivers expressed interest in participating in violence prevention and family wellbeing initiatives to better prepare themselves should these challenges occur in future.

6. Research implications and conclusion

The findings of this study hold several implications for the implementation of target service delivery efforts in the upcoming phases of the early violence prevention project. First, we found that for many of the ECDSPs, ECD centres are their only source of income and are, for the majority, established as day care services. This, paired with the lack of formal training in both the registered and unregistered centres, highlights the need for easily accessible trainings to equip ECD caregivers to implement holistic services that are, to some extent, uniform. This uniformity could assist stakeholders to assess the processes and impact of these ECD services in future.

Second, two main challenges in relation to registrations of ECD services were mentioned namely socio-economic disadvantages and administrative delays. The socio-economic challenges highlight the macro-level contextual factors that act as hindrances in the registration process. Effort to address this structural challenge will need to incorporate concerted inputs from various stakeholders like NGOs, government (e.g. Department of Social Development) and ECDSPs in order to determine how best to facilitate successful registration of (financially and structurally) unregistered ECD centres who are, in some way, already disadvantaged to meet the requirements. On a smaller scale, workshops on accurately completing the administrative tasks that accompany the registration process could also facilitate a smoother registration process. As indicated earlier, there also appears to a need for advocacy efforts that attends to social attitudes and perspectives in relation to registration.

Third, the ECDSPs identified child sexual abuse as a specific issue of concern in their ECD centres and Walmer Township as a whole. Alarmingly, the ECDSPs explained that they receive very little support from parents to address cases of child abuse. The ECDSPs also do not report these cases because they fear being victimised and stigmatised in the community and in this way lose out on 'business'. These findings suggest that the topic of child sexual abuse should be identified as a key priority in violence prevention and intervention efforts in Walmer Township. It also points to the importance of parent interventions that aim to strengthen parental awareness and responses to child sexual abuse. Given that ECDSPs generally seem to have some interaction with parents, through

parent meetings, these platforms could be utilised to promote violence prevention and intervention services.

Lastly, although most of the ECDSPs reported that they do incorporate topics related to child protection into their daily activities with the children, a large proportion of ECDSPs reported that the caregivers at their centres do not have any form of child protection training. In this regard, we advocate for the provision of child protection workshops and trainings to strengthen the practices and responses of ECDSPs in relation to child protection.

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