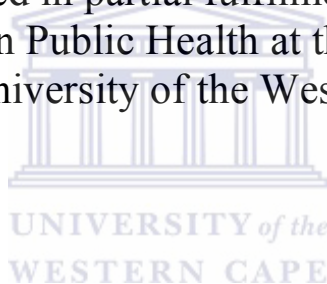


**PARENTAL PERCEPTIONS OF HEALTH AND
CHILD HEALTH NEEDS IN EARLY CHILDHOOD
CARE & DEVELOPMENT CENTRES IN
AMATOLE DISTRICT, EASTERN CAPE,
SOUTH AFRICA**

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A mini-thesis submitted in partial fulfilment of the requirements for the
degree of Masters in Public Health at the School of Public Health,
University of the Western Cape



Supervisor: Dr Ruth Stern

November 2011

“Each one of you is your own person, endowed with rights, worthy of respect and dignity. Each one of you deserves to have the best possible start in life, to complete a basic education of the highest quality, to be allowed to develop your full potential and provided the opportunities for meaningful participation in your communities.”

Nelson Mandela and Graça Machel (UNICEF, 2000 as cited by CSDH, 2008: 50).



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- Ms Corinne Carolissen, UWC SOPH Administrator; for being a role model with her committed, persistent and organized approach to her work
- My children Sophie and Thomas and my husband Ron; for their patience, humour and love

DECLARATION

I declare that *Parental Perceptions of Health and Child Health Needs in Early Childhood Care & Development Centres in Amathole District, Eastern Cape Province, South Africa* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references

Miriam Mitchell

November 2011

Signed.....



KEYWORDS


- Parental Perceptions of Health
- Child Health Needs
- Early Childhood Care & Development
- Social Determinants of Health
- Health Promotion
- Health Promoting Settings
- Social Capital
- Environment
- Focus Groups
- South Africa



ABBREVIATIONS

CEH	Children's Environmental Health
CSDH	Commission on Social Determinants of Health
ECCD	Early Childhood Care & Development
ECDoH	Eastern Cape Department of Health
FAO	Food and Agriculture Organization of the United Nations
FGD(s)	Focus Group Discussion(s)
HPS	Health Promoting Schools
LA21	Local Agenda 21
MDG(s)	Millennium Development Goal(s)
PHC	Primary Health Care
SDH	Social Determinants of Health
UN	United Nations
UNEP	United Nations Environment Programme
UWC	University of the Western Cape
WESSA	Wildlife & Environment Society of South Africa



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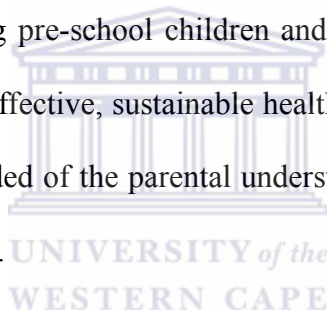
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ABSTRACT

Background

Parental perceptions of health and child health needs have not been explored within Early Childhood Care and Development (ECCD) centres in the Eastern Cape of South Africa. Although the relationship between social, economic and environmental conditions and health status has been well documented in the literature, it is unknown whether parents of children attending rural ECCD centres, share this understanding. Children have the right to a healthy environment. Many children in rural Eastern Cape live in environments that present challenges in regards to water and sanitation, food security and safety. ECCD centres are the daily environment for the attending pre-school children and have a role to play in promoting child health. In order to develop effective, sustainable health promotion initiatives in ECCD centres a baseline recording was needed of the parental understanding of health, their children's health needs and perceived solutions.



Study Design

This study was an exploratory study, which used qualitative research methods to describe the parents' perceptions of health and health needs of their children in ECCD centres in Amathole District, South Africa.

Data Collection

Focus group discussions were the data collection method used to record the parental perceptions of health and child health needs. Because there was limited parental involvement in the ECCD centres, it was hoped that the focus groups would be a suitable method to generate more community involvement. Four focus groups were conducted using a semi-structured

outline. The researcher facilitated the focus group discussions with the assistance of an isiXhosa speaking research assistant. The voice recordings of the discussions were professionally translated and transcribed for analysis.

Analysis of Results

Content analysis of the transcriptions revealed a thick description of parental perceptions of health and child health needs. Participants saw health in holistic terms and identified a complex inter-relationship of various social determinants of health, consistent with Dahlgren and Whitehead's determinants of health model. Parents were aware of the absence of many of these determinants of health and the challenges to child health that this brought. The child health needs perceived by parents were related to nutrition, hygiene, social interaction, safety and protection from disease. Five recurring themes emerged as a result of this study, including individual lifestyle factors, social interaction, environmental challenges to health, safety and lastly poverty. The ECCD centres were considered a resource for child health and suggestions were given as to how to strengthen the ECCD centres' role in further promoting health.

Conclusion

The participants' broad definition of health and depth of understanding regarding the determinants of health, allows for a range of stakeholders to be involved in the promotion of health in the ECCD centres. The majority of the perceived challenges to health existed in the living conditions of the children and families. The Health Promoting Schools (HPS) framework could enhance the current work of the Eco-Schools Programme in the ECCD centres.

STUDY DESCRIPTION

1.1 Introduction

The South African National Health Act of 2003 highlights the constitutional right of every child to basic health services and to an environment that does not contribute negatively to health. The Act also acknowledges the provision of health services in non-traditional health settings such as schools (Government Gazette, 2004). Local Agenda 21¹ identifies that many sectors including education need to be involved in order to meet the health challenges of people living in under-resourced environments (UNEP, Undated).

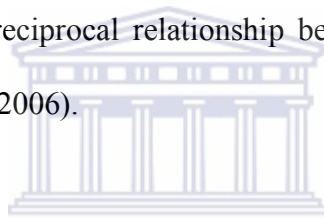
A recent resurgence of interest in early childhood care and development (ECCD) has occurred, particularly in developing countries. Child development refers to the “ordered emergence of interdependent skills of sensorimotor, cognitive-language, and social-emotional functioning.” (Engle et al., 2007:230). The influence of a person’s early years on their subsequent adult health has been documented in multiple studies (Catford, 2000). Crucial brain development that occurs in early childhood (Guldbrandsson & Bremberg, 2005) has justified the importance of ECCD and its impact on health and education outcomes (Committee on Early Childhood, Adoption & Dependent Care, 2005).

The National Integrated Plan for Early Childhood Development in South Africa provides a framework for programmes in health, nutrition, water and sanitation as well as early learning and care. The goal of integration is to create an environment where young children can thrive (UNICEF, 2005). The link between the environment and health in Early Childhood Care and

¹ Local Agenda 21 resulted from the Earth Summit held in Rio de Janeiro in 1992. This action plan towards sustainability has been adopted by many environmental initiatives. There are overlapping priorities between Local Agenda 21 and the Healthy Settings approach of the New Public Health movement (Baum, 2002).

Development (ECCD)² centres is strengthened by the fact that children are more vulnerable than adults to unhealthy environments (deVilliers, Koko-Mhahlo & Senekal, 2005; UNEP, undated). Determinants of health such as social, economic and environmental conditions have been documented to impact health (Brennan Ramirez, Baker & Metzler, 2008).

The Border Kei regional office of the Wildlife and Environment Society of South Africa (WESSA) is currently partnered with a small number of ECCD centres in Amathole District. An environmental education programme has been providing support to establish Eco-Schools. The Eco-Schools programme aims to incorporate curriculum based environmental education and action in order to establish healthy school environments (WESSA, 2009). This ecological approach acknowledges the reciprocal relationship between environmental sustainability and health (McMichael & Butler, 2006).



Unmet health needs at the ECCD centres had been identified by WESSA through site observations of several ECCD centres and an informal survey of some of the staff members' understanding of child health needs. Establishing parent groups and conducting health education sessions at the ECCD facilities had been suggested as a strategy, in order to respond to the general health and nutrition needs of the children. However at the time there had been limited parental involvement in the ECCD centres and no functioning parent groups existed within the centres. Furthermore, no investigation had been conducted of the understanding of health and child health needs held by the parents³ of the ECCD centre children.

² The early learning centres for children under 6 years of age. Other names for the same entity can include Early Childhood Centre, crèche, and pre-school. The researcher will use the term ECCD centre in this study to refer to any of the above.

³ The title of parent may or may not refer to the biological mother or father of the child. This study used the term parent to refer to the primary home caregiver of the child. This could include the biological parent, grandparent or other family member who serves as the child's guardian.

1.2 Problem Statement

It was noted that there was a lack of information regarding parental perceptions of health and health needs in the ECCD centres with which WESSA was partnered. The parents' perceptions of health, perceived health needs of their children, and the perceived role of the ECCD centre in promoting health had not been documented. This information was needed in order to develop a more effective health programme in the ECCD centre. A lack of parental involvement was noted in the ECCD centres.

1.3 Study Purpose

In order to respond to this problem, this research aimed to explore the perceptions of health and child health needs held by ECCD centre parents in Amathole District, Eastern Cape, South Africa. The study sought to examine the parental perception of challenges to child health and opportunities that existed in the ECCD centre. It was anticipated that documenting the parental perceptions of child health and health needs would inform WESSA how to effectively partner with the ECCD centres on health issues. Gathering this information was also sought in order to facilitate further parental involvement in the ECCD centre. It was hoped that the involvement of the parents in the analysis of child health needs would serve as an advocacy strategy by raising their awareness of health issues (Baum, 1998).

1.4 Study Context

The ECCD centres that were selected to be involved in the research project were located in the Amathole District of the Eastern Cape of South Africa. In 2008 Amathole District had a population of just over 1.7 million people. The recorded life expectancy for this population in 2006 was 48.8 years in 2006 (ECDoH, 2008) with Tuberculosis being the leading cause of death (Statistics South Africa, 2007). There was a large youth population, with approximately

32% of the total population aged 15 years or younger. The Eastern Cape of South Africa has one of the country's highest rates of poverty. The percentage of adult residents in Eastern Cape, who are employed in the formal sector, is the lowest for the country. Sub-Saharan Africa has the highest prevalence of disadvantaged children in the world (Grantham-McGregor, Cheung, Cueto, Glewwe, Richter & Strupp, 2007). The youth figures, coupled with the high unemployment rate in adults, meant that the majority of the Amathole population were economically dependant (ECDoH, 2008). In 2008, seven out of ten children in the Eastern Cape were living in poverty⁴ (Children Count, 2011).

The prevalent poverty of the context is accompanied by a lack of basic services for many of the residents. Only 35% of Eastern Cape children have access to a water source on the site of their residence (Children Count, 2011). A large proportion (25%) of Eastern Cape residents source their water supply from public taps. More than one quarter of residents in Amathole District lack any toilet facilities on site. For those who do have on-site facilities, the majority (56%) use pit latrines without ventilation (Statistics South Africa, 2007). Therefore a large number of Amathole District residents do not have access to basic sanitation⁵.

WESSA had been working with a number of primary schools within Amathole District that were participating in the Eco-schools project. Subsequently WESSA expanded their work to a few ECCD centres that were adjoining some of these primary schools. The two ECCD centres chosen for this study were both located in township settlements in rural areas of Amathole District. The residents of these areas were predominately isiXhosa speakers who faced daily

⁴ The poverty line of R350 per month in 2000 South African Rand is linked to per capita expenditure of the 40th percentile of households in 2000. This has increased to the equivalent of R569 in 2008 (Children Count, 2011).

⁵ Basic sanitation is defined as having access near the place of residence to a flush toilet or a ventilated pit latrine. Non-ventilated pit latrines, chemical toilets or bucket toilets are not defined as adequate sanitation (Children Count, 2011).

challenges of inadequate basic services. Electricity service was available to some homes in these township settlements, but many homes and one of the ECCD centres did not have electricity. Pit latrines were located at the local primary school adjoining one of the ECCD centres. Many of the residential homes lacked any sanitation and residents used the bush for toilet purposes. Water was supplied each day in large tanks to one community by the local municipality. The other township had a limited piped water supply.

Both settlements were within easy walking distance to paved roads supplying public transport options to the major city of East London. The limited number of employment options available in the rural area meant that some of the participants left the area during the day, to participate in either informal or formal employment in the urban areas.

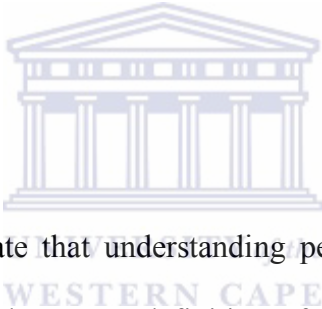


2. LITERATURE REVIEW

2.1 Introduction

This section aims to provide an overview of the issues described in the literature that are related to parental perceptions of child health needs in ECCD settings. A review of the concepts of health and the social determinants of health is given including the role of social capital in promoting health. A comparison of health education and health promotion is offered, followed by a discussion of the health promoting settings movement, including health-promoting schools. Next the debate between healthy lifestyles and healthy environments as determinants of child health is highlighted. Finally some stakeholder perceptions of child health issues are explored.

2.2 Concepts of Health



Naidoo and Willis (2000) state that understanding people's meaning of health is crucial in planning health promotion. The WHO definition of health, which has remained unchanged since 1948, refers to a state of complete physical, mental and social well-being and not simply the absence of disease or illness (CSDH, 2008). Yet despite this holistic definition, many public health practitioners have continued to perceive health using illness terms, including negative style language such as avoiding disease or disability. Talbot & Verrinder (2010) in their book on the Primary Health Care (PHC) approach to promoting health discussed the significance of how health is defined. They explained that if health were defined as the absence of illness, then the response would likely be a medical intervention focusing on the prevention of disease, and subsequently excluding the social determinants of health. Talbot and Verrinder (2010) describe this as selective primary health care. They argue that the medical model of health promotion tends to focus on a specific disease and subsequently ignore the wider context

and the social determinants of health. This limited approach tends to keep control in the hands of the health professional and does not normally work towards equity and social justice. Although there are many health promotion programmes that focus on specific diseases, they tend to avoid the ‘upstream’ cause of the disease and therefore have limited effect, if they are not combined with a broader approach (Jackson, 2007).

The public health literature has transitioned over the last few decades, to a more holistic and positive approach to defining health. This change is evident with health being more recently defined in terms of wellness and a person’s ability to reach one’s full potential (Roden, 2003). The WHO Health Promotion glossary recently included new terms such as wellness and sustainable health promotion action, recognizing the need to address determinants of health (Smith, Tang & Nutbeam, 2006). Health is currently seen as a resource for living and as a result of the interaction between the environment and people in their everyday activities (Kickbush, 1997; Tones & Tilford, 2001). The environment has been described as both the physical and the social environment. Because the ECCD centre is the daily environment where many young children learn and play it has been identified as having an impact on child health and development (Catford, 2000; CSHD, 2008; Jaramillo & Mingat, 2008).

2.3 Social Determinants of Health

There is a well-documented relationship between health and social determinants in the current literature (Raphael, 2006; Wilkinson & Marmot, 2003). Social determinants of health have been defined as “life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life” (Brennan Ramirez et al., 2008: 6). Other authors clarify that the determinants of health are any factors that alter health in positive or

negative ways, and not just life enhancing factors (Keleher & MacDougall, 2011). The social determinants of health discussed in the literature include structural factors in society such as policies and the economy, as well as every day conditions of life present in the living environment (Marmot, Friel, Bell, Houweling & Taylor, 2008; Wilkinson & Marmot, 2003).

Dahlgren and Whitehead (1991) developed a model to represent these determinants of health. Sometimes referred to as the ‘rainbow model’ (Keleher & MacDougall, 2011), this commonly cited model illustrates the multiple determinants of health in the form of expanding layers (Jackson, 2007).

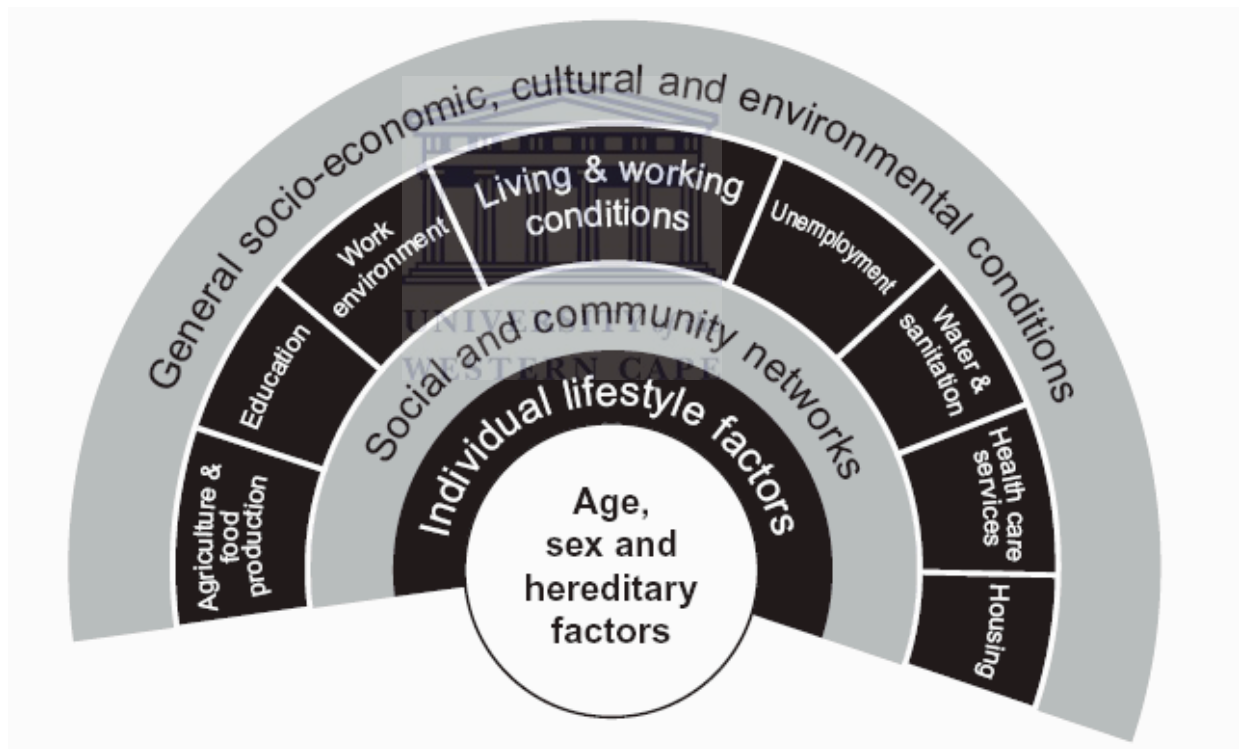


Figure 1. Dahlgren and Whitehead’s Model of Determinants of Health (1991)

At the centre of the diagram lie the unmodifiable determinants of health, such as individual age, sex and hereditary factors. The four layers of the rainbow that move beyond this core represent predominantly modifiable determinants. These layers include individual behaviour or lifestyle factors followed by social and community networks. Supporting the social and community

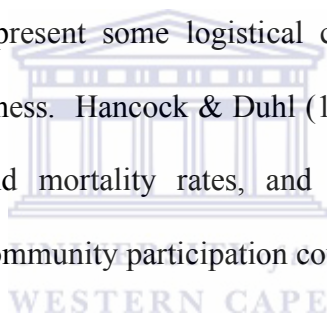
networks are the surrounding living and working conditions, with the outermost layer being the general context or societal conditions. Within these outer layers of the rainbow model lay a broad range of determinants. Factors such as community networks can be classified as a psychosocial determinant, whereas water and sanitation are considered environmental influences on health. It has been noted in the literature how the unequal distribution of these determinants can account for health inequity (Brennan Ramirez et al., 2008; Raphael, 2006).

Health needs and life chances are described as strongly determined by a person's social environment (McMichael & Butler, 2006; Wilkinson & Marmot, 2003). Shorter life expectancy occurs, along with more experience of illness and disability, the lower a person's levels of wealth, power or prestige (Brennan Ramirez et al., 2008; Catford, 2000; Hillemeier, Lynch, Harper, & Casper, 2004; Marmot et al., 2008). Throughout the current literature, numerous examples are given of the correlation between a person's socio-economic standing in society and their level of health (Bambra, Gibson, Sowden, Wright, Whitehead & Petticrew, 2010). According to Sanders and Chopra (2006) South Africa's history of colonization and apartheid has contributed to the ongoing inequity that currently presents a major challenge for health. Poverty levels have been identified as an underlying factor influencing the social determinants of health (Raphael, 2006; Sanders, Todd & Chopra, 2005). Roden (2003) claims that poverty is the most significant threat to a family's wellbeing and subsequently their children's health.

With concern over the contributing factor of poverty to the growing health inequity between and within countries, the WHO established the Commission on Social Determinants of Health (CSDH) in 2005 (Keleher & MacDougall, 2011). The commission's mandate was to gather evidence to promote health equity and work towards social justice (CSDH, 2008). The

establishment of the CSDH signifies a global acknowledgment of the importance of the broader context on health (Sanders, Stern, Struthers, Ngulube, and Onya (2008).

In its final report, the CSDH outlined three recommendations to address health inequity (CSDH, 2008). Firstly, there needed to be a focus on improving daily living. The report highlighted the importance of equity from the start of life, with a major emphasis on ECCD. Secondly, inequitable structures needed to be addressed in society, with empowerment of people playing a key role. Finally, the CSDH recommended further research on the issue of social determinants of health, in order for more effective policies and programmes to be developed (Hillemeier et al., 2004; Marmot et al., 2008). However, research into the social determinants of health can present some logistical challenges for the researcher trying to measure health rather than illness. Hancock & Duhl (1988) advised avoiding illness indicators such as risk behaviours and mortality rates, and suggested that healthy environments, sustainable ecosystems and community participation could be used as indicators of health.



A qualitative study conducted in an urban centre in Kenya, identified a range of social determinants of health present in the environment (Muchukuri & Grenier, 2009). The results of the FGDs, field survey and literature review, showed determinants such as water supply, sanitation, solid waste management, and housing as all being key determinants of health. This study would have been strengthened with the inclusion of examples of the FG participants' responses, however the study did highlight the importance of the physical environment on health.

McMichael & Butler (2006) also stressed the interrelationship between human health and the environment, in their literature review of issues related to the seventh MDG of environmental

sustainability. They describe how environmental changes, occurring due to globalization, climate change and consumer culture can influence human health. Several authors agree with the overlap between health and the environment (Davis & Cooke, 2007; Dooris, 1999) and question if the term ‘health’ may not be any different from the notion of ‘quality of life’ or ‘sustainability’ (Dooris, 1999). The Third International Conference on Children’s Health and the Environment sought to draw attention to children’s environmental health (CEH) issues. One key aspect of the conference’s Busan Pledge was a commitment to inform parents and other key stakeholders in CEH issues (WHO, 2009a).

2.3.1 Social Capital

One of the social determinants of health that has been elaborated on in the literature is the concept of social capital. Social capital has been defined as the “networks between people that lead to cooperation and beneficial outcomes” (Baum & Palmer, 2002:352). Some authors have clarified that social capital does not always result in beneficial outcomes for everyone. For example, high levels of social capital in one population (such as a hate group) may result in negative outcomes for another group (Talbot & Verrinder, 2010). Social capital involves levels of trust, reciprocity and social cohesion. When people in a community trust each other they are more likely to be willing to help each other, which strengthens their sense of belonging (Keleher & MacDougall, 2011).

The meaning of social capital has been hotly debated in the literature since Robert Putnam (1993) defined social capital as invisible glue that binds people together (Talbot & Verrinder, 2010). Kawachi, Kim & Coutts (2004) clarify that some confusion of terms may exist between individual social support and collective social capital. They comment on three accounts of social capital identified in a framework by Szreter and Woolcock. The first type known as

“bonding” social capital is where similar groups develop networks between members. “Bridging” social capital refers to the networking that occurs between dissimilar groups, who share equal levels of prestige or power. Finally the more difficult to achieve “linking” social capital is described as the respect and networking between groups of people interacting across a power or structural gradient.

Child health can be influenced by levels of social capital, as confirmed in a South African qualitative study conducted in a historically disadvantaged peri-urban community. The study’s authors, deVilliers et al. (2005) reported that people’s poverty levels determined their ability to belong to social networks (bonding social capital). According to the study results, poverty and decreased social capital experienced by the participants resulted in their lack of power and ability to gain resources. The study found that poverty and decreased social capital influenced the mother’s accessibility to primary health care (PHC) clinics and subsequently affected child nutrition. These results are consistent with Roden’s (2003) claim that poverty is a key determinant of child health. Bradshaw (2008) further explained the link between poverty and social capital in South Africa with her comment that although the general perception is that African people are well networked, the reality is, that they belong to groups with very little resources. Bradshaw’s observation supports the prevalence of “bonding” social capital and highlights the difficulty for marginalised group to achieve “linking” social capital (Talbot & Verrinder, 2010), which would enable African communities to network across the power gradient with other well resourced communities.

In addition, Baum & Palmer (2002) in their study of social capital in suburban Adelaide Australia found that poorer people had poorer health partly due to their physical environment, which can lead to social exclusion. Decreased bonding social capital was described as

reciprocally related to perceived lack of safety in the community. When people did not know their neighbours, they perceived each other as strangers and potential threats to their child's safety, rather than a source of support. Conversely, the reputation of a particular place being unsafe decreased the use of existing resources such as playgrounds, therefore limiting further community interaction. Baum & Palmer's study involved in-depth interviews of 40 people who were asked open-ended questions such as 'what would make your community healthier'? Participants felt that having safe spaces in the community to meet up with other people would enhance their health. Suggestions included community meeting halls and outdoor recreation areas.

2.4 Health Promotion

The second recommendation in the final report from the CSDH was for empowerment of people, which is consistent with the health promotion framework. Health promotion has been defined as a "process of enabling people to increase control over their health" (Kickbush, 2003: 386). The Ottawa Charter, developed in 1986 following the first international health promotion conference, has become a founding document for health promotion (Roden, 2003; St Leger, 1997). The Ottawa Charter has been credited in the literature as marking a shift in the way health promotion has been defined (Roden, 2003). Numerous authors writing on the concept of health and health promotion refer to the five key action areas of the Ottawa Charter. The action areas include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting the health service (Health Systems Trust, 2000; Kickbush, 2003; St Leger, 1997; WHO, 1986).

Building healthy public policy means that all policy makers, not just those within the health sector, should consider the impact of policy on health. The action area of creating supportive

environments conveys that the social and physical environment where people live, work and play, must be conducive to health. The importance of working with and empowering communities is fundamental to the charter's third action area of strengthening community participation. The fourth action area of the Ottawa Charter, to increase individuals' skills, acknowledges the role health education can play to increase people's ability to make informed choices about their health. Finally, the existing health service must move away from a strictly curative model, to focus services on health promotion appropriate to the health needs of the community. Talbot and Verrinder (2010) point out that health promotion interventions will be more successful if the action areas are used together, rather than individually.

2.4.1 Health Education as a Component of Health Promotion

Prior to the Ottawa Charter, health promotion was often limited to health education. Even in the current literature, there remains confusion over the terms of health education and health promotion (Jackson, 2007) and health education strategies are more commonly discussed as a means of health promotion. Several studies of health needs in ECCD settings have focused on only the health education aspect of the Ottawa Charter for health promotion (Gupta, Shuman, Taveras, Kulldorff & Finkelstein, 2005; Taveras, LaPelle, Gupta & Finkelstein, 2006).

The concepts of health education differ from health promotion, although they are at times incorrectly referred to in the literature as being interchangeable terms. It is important to note that health education is only a part of health promotion (Jackson, 2007). Health education definitions have remained fairly static in the literature for the last few decades (Roden, 2003). According to Whitehead (2004), health education involves the delivery of health information to an audience. This can occur by both structured and unstructured methods. The author explains that health education assumes the delivering professional has the necessary knowledge and that

the recipient wants and needs to improve their health. Mukoma and Flisher (2004) agree with Whitehead that health education has had some success in increasing knowledge and motivation for healthy living. In contrast, a body of literature supports the notion that health education tends to ignore the broader determinants of health (Tones & Tilford, 2001) and needs to be linked with improvements in the social and physical environment in order to bring lasting change (Sherman & Muehlhoff, 2007; Williamson & Drummond, 2000).

Despite its limitations, some writers in the public health literature argue that health education still has an important role to play in addressing health needs. Kemm (2003) advocates strongly for health education as an important means of working towards the Ottawa Charter action areas of increasing personal skills and healthy public policy. Kemm recognises that in order for health education to be effective, more research is needed in which the emphasis is on incorporating qualitative participatory methods to evaluate the effectiveness of health education. The recommendation that Kemm makes is for the evaluation of health education to move beyond measuring mere behavioural change to also include empowerment and awareness of health issues.

2.4.2 Strength Based Approach

Further exploring the notion of community participation, Baum (1998) argues for a community-based approach that focuses on the strengths of the local context. This way of working identifies the positive contributions to health that already exist in the context, and then builds on this foundation. Baum explains that this strength-based approach can be empowering for participants as it highlights existing resources and solutions rather than only focusing on deficits and problems of the context.

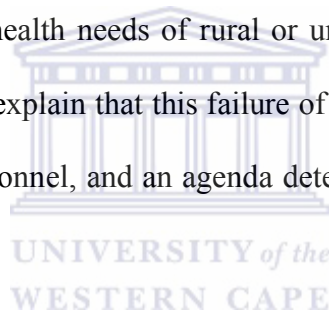
This strength-based approach was used in a health and social needs assessment, conducted in a rural Balinese village (Pepali, Earnest & James, 2007). This study used a rapid participatory asset-focused approach (RPA) to determine community perceptions of health problems and their causes. The results were used to plan effective community radio programming, amongst other strategies, in order to utilize the popular community radio as an existing resource. Open-ended questions were used during the FGDs and in-depth interviews. Participants identified economic issues as a key determinant of health. However when they were asked to rank the major health problems, the ones identified were primarily disease focused. The health clinic staff members were participants in the FGDs, which may have resulted in a medical emphasis on the problem list.

2.5 Implementing Health Promotion Using The Settings Approach

The attempt to implement the action areas of the Ottawa Charter (including health education through the development of personal skills) has been noted in the literature as a catalyst for the healthy settings movement. The Health Promotion Glossary defines a health promoting setting as a “place or social context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and wellbeing.” (Nutbeam, 1998:362). The settings approach evolved out of the WHO Health for All strategy, the Ottawa Charter and the Local Agenda 21 (Dooris, Dowding, Thompson & Wynne, 1998). This has occurred during the shift in Public Health, from an individual disease focus, to a more holistic population-based approach (Hancock & Duhl, 1988). Subsequently, some of the public health strategies employed, have moved from individual focused health education, and towards community focused health promotion strategies, which incorporate the social determinants of health.

Employing non-traditional health sector settings such as an ECCD centre has been described in the settings approach as a vehicle of health promotion (WHO, 2011). The WHO Europe office initiated the settings approach in the late 1980s, with the launch of the Healthy Cities and then the Health Promoting Schools (HPS) projects (Dooris et al., 1998; WHO, 2011). Despite having roots in a European context, health-promoting settings has been identified by Baum (2002) as an appropriate approach for low to middle income countries, such as South Africa.

The settings approach rejects medical models of health (Dooris et al., 1998) because they tend to focus on the prevention of individual illness rather than incorporating a broader view of health. This is consistent with Werner and Sanders' (1997) claim that a Western medical model does not address the health needs of rural or urban marginalized populations. Werner and Sanders (1997) go on to explain that this failure of the western medical model is due to the use of specialist medical personnel, and an agenda determined by professionals and a focus on illness.



In contrast to the medical model, Kickbush (1997) explains that with a health promoting settings model, the health needs of the setting are addressed with the use of a multi-sectoral approach, allowing for a diversity of solutions to health problems. For example, community members, health professionals, local government representatives, education and environment workers can all contribute to the creation of a healthy setting (such as an ECCD centre).

2.5.1 Health Promoting Schools

Traditionally, health education was conducted in schools using a medical approach to health, and focused on teaching children how to avoid illness (Barnekow et al., 2006). Davis and Cooke (2007) acknowledge that learning is crucial for health, yet often education can be a

challenge to health rather than a resource. Instead they suggest, “what is needed is education and learning that transforms rather than replicates existing patterns of injustice and inequality, and unhealthy lifestyles and environments” (Davis & Cooke, 2007:348).

The discussion in the literature regarding health-promoting settings for children has focused primarily on the Health Promoting Schools (HPS) framework. Health promoting schools acknowledge the reciprocal relationship between education and health. It has been argued that children learn better when they are healthy, and improved child health results in improved educational outcomes (Barnekow et al., 2006; Davis & Cooke, 2007). A Health Promoting School has been defined as a place where everyone in the school community works together to promote a healthy setting for living, learning and working (Department of Health, 2011).

The HPS movement has attempted to incorporate the five action areas of the Ottawa Charter into the school setting, therefore using a socio-ecological approach (Barnekow et al., 2006).

In South Africa, the HPS movement has incorporated the action areas of the Ottawa Charter into their whole school approach to health through their use of ‘SPECS’. This acronym refers to the skills, policies, environment, community and services within the school setting that can be health promoting (Department of Health, 2011). These five areas correlate to the five action areas of the Ottawa Charter. According to Davis and Cooke (2007), this whole school approach to health incorporates the overlapping areas of the school curriculum, the environment and the community. They state that the HPS approach shares common values with the sustainable schools movement (known in Europe and Africa as eco schools). Therefore, they suggest that since environmental issues and health issues often overlap, these approaches could be combined in order for schools to be both ‘green and healthy’.

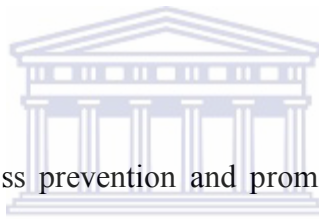
There has been very little literature found related to health promoting schools in South Africa. Mukoma & Flisher (2004) noted the positive outcomes of HPS in their review of evaluations of nine HPS projects located predominately in Europe, with none of the HPS located within South Africa. These studies all evaluated HPS programmes in either primary or secondary schools and did not include any ECCD centres. One example of a HPS programme in South Africa was found in a situational analysis following a HPS intervention in three township schools located near the capital of Pretoria. The themes that emerged from this situational analysis which was conducted in 2005, included poverty, poor physical environment, social isolation, limited hope for the future and leadership issues (Holland & Rendall-Mkosi, 2007).

2.5.2 Health Promoting Settings in Early Childhood

Of the smaller number of studies about promoting health in ECCD settings, the majority have emerged from developed countries in Europe or North America (Guldbrandsson & Bremberg, 2005; Gupta et al., 2005; Taveras, LaPelle, Gupta & Finkelstein, 2006; Williamson & Drummond, 2000). Little has been written about child health needs identified in ECCD centres within developing countries. Some of the studies of ECCD settings in developed countries have targeted families from centres located in low-income areas (Taveras et al., 2006; Williamson & Drummond, 2000), which may be transferable to the South African context. Jaramillo and Mingat (2008) in their World Bank report on early childhood care and education in Sub-Saharan Africa acknowledged the effect of the environment on a child's health and development. This supports the recent findings from the WHO on the importance of the social determinants of health (Marmot et al., 2008).

2.5.2.1 Lifestyles, Childhood Environments and Parental Influences on Health

Health promotion strategies aimed at pre-school aged children have been discussed in various studies. However many studies have ignored the broader context or environment that contributes to health. Instead they have implemented selective health promotion, which has targeted either specific risk factors for illness or the promotion of healthy lifestyle choices, as seen in the following literature. Healthy eating, increased exercise and obesity prevention have been the priority of pre-school health promotion interventions in many developed country contexts such as Australia (Hesketh, Waters, Green, Salmon & Williams, 2005). A cross-sectional study in Brazil evaluated the nutritional status of children attending day care centres and found it to be higher than children not attending (Silva, Miranda, Puccini & Nobrega, 2000).



Roden (2003) discussed illness prevention and promoting healthy behaviour, in her Sydney based FGDs of parental understanding of health behaviour. The study results showed that participants were in agreement that health and safety issues were the responsibility of parents. The parents perceived illness prevention and health promotion as distinct from one another. Some parents saw their role as simply preventing childhood illness. However, other parents discussed illness prevention along with the promotion of healthy lifestyles as a parental responsibility. The study cited health-promoting behaviours as important for child emotional health and included teaching children life skills, reinforcing confidence and talking honestly with children. Other studies of health needs of pre-school aged children have used a medical focus and targeted children with specific diseases or conditions who were not attending ECCD centres.

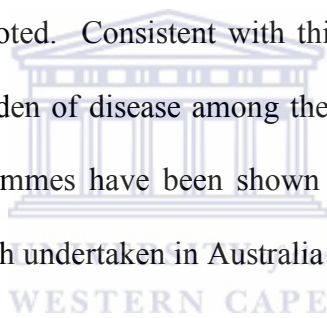
Understanding health needs of disabled children in a South African township was the focus of a descriptive study by Saloojee, Phohole, Saloojee and IJsselmuiden (2007). Using a mixed method design, the study noted that the majority of these children were not attending pre-schools and there was a general lack of coordinated care for this specific pre-school population. This study was limited by its snowball sampling method, as many disabled children may not have been included because they were hidden away in the community, due to the stigma of their condition. This study did acknowledge the added challenges that the social and economic environment presented to parents who were caring for their children.

Challenges in the environment may limit a parent's ability to choose a healthy lifestyle for their child. Williamson and Drummond (2000) cited this in the results of their parent focus group discussions with Canadian low-income families. Parents participating in the study viewed recreational activities as being important for their child's health. Physical activity was perceived as a major determinant of physical and mental health. But the expense of organized sporting and recreational activities, along with a lack of transport, were considered barriers for participating in this perceived healthy lifestyle. The study noted that parents with higher income levels were more likely to mention social determinants of health, as compared to a more narrow perception of health. It is important to note that parents who participated in this study were already active in existing parent groups at the Head Start pre-school and this may have affected their sense of empowerment and subsequent responses.

Factors in the living environment have been cited as challenges to child health. Sanders and Chopra (2006) claim that children from rural and predominantly black communities in the Eastern Cape of South Africa are more likely than children from more urban and racially mixed

areas, to experience malnutrition, food security issues, lack safe sanitation and be exposed to indoor pollutants⁶.

In their report of South African's historical roots determining health, Coovadia, Jewkes, Barron, Sanders & McIntyre (2009) argue that public health programmes need to address the social determinants of health such as poverty and violence in order to address the increasing child mortality rate in South Africa. The authors explain that in rural communities in South Africa, it is often common for children to be raised in the absence of their fathers. Coovadia et al. (2009) elaborate that this can lead to challenges for children (and boys especially) in developing into responsible adults; and therefore programs that encourage non-violent masculinity need to be promoted. Consistent with this explanation, is Sanders and Chopra's (2006) claim that a large burden of disease among the poor in South Africa, is due to trauma and violence. ECCD programmes have been shown to help prevent addictive and criminal behaviour in adults, in research undertaken in Australia (Catford, 2000).



2.6 Stakeholder Perceptions

Study results show differing groups of stakeholders will hold differing perceptions of determinants of health. Baum (1998) acknowledges the tension and differing priorities between the professional person and the community members, that may occur when assessing needs and determining health priorities in a setting. The main focus in the literature of health needs of ECCD centres is from the perception of the professionals, rather than the views of the family or

⁶ Indoor pollutants caused by cooking smoke has been cited in news reports as contributing to the pre-mature death of 1.9 million people a year, as well as contributing to climate change. The Global Alliance for Clean Cookstoves coordinated by the UN Foundation is a partnership with the US government and other charitable foundations. The proposed clean stoves program aims to prevent eye and lung disease, cancer as well as to reduce deforestation, black carbon and CO₂ emissions (Harrabin, 2010)

community members. Parental perceptions of challenges in promoting their child's health are often not explored, as seen in a quantitative study based in Boston, USA.

This Boston study focused on the perception of professionals, rather than the views of the family or community members. The study surveyed pre-school directors and visiting health consultants on their attitudes and barriers to incorporating health promotion activities in their ECCD centre (Gupta et al., 2005). The goal of the proposed health promotion activity was to prevent emergency hospital admissions and to develop healthy behaviours in children from the centre. Directors and consultants identified time and money as barriers to health promotion. This study assumed that the task of health promotion lay with both the education and health professionals. The multiple choice survey used in the study did not give parents the opportunity to voice their concerns regarding their child health needs or possible solutions in their own words. The parents were only asked to rate their preference for specified health education strategies and pre-defined health topics. This implied that the professional researchers involved in the study perceived parents role in health promotion as simply recipients of health information. Gupta et al., (2005) suggested that health education handouts were the preferred health promotion strategy for the majority of parents. However these results are not consistent with other studies using a more participatory approach.

An interesting study conducted in Mississippi, cited as the poorest state of the United States, attempted to explore community perceptions of community nutrition and health needs (Yadrick et al., 2001). Despite the study acknowledging the importance of community participation, only a small portion of lay community members were enrolled as participants. The majority of the purposively selected participants, although resident in the community, were educated professionals and community leaders.

The study results identified high blood pressure as the leading health problem in the area. According to the Mississippi study, individual health and lifestyle choices were perceived to be the cause of the populations' nutrition and health problems. Responses from participants who identified themselves as African American were an exception to the overall results. In contrast to the study's Caucasian respondents, African American respondents were more likely to report community level issues such as food access and food insecurity as determinants of health. Overall, the results of the Yadrick et al., (2001) study confer with other research of professional perceptions of health, which emphasise individual health choices as determinants of health and subsequently health education as a strategy for health promotion (Gupta et al., 2005).

In contrast to the findings of the Mississippi study, another North American Public Health researcher, Freudenberg, criticises the health promotion view that ill health is based primarily on individual lifestyle choices. He argues, "individuals make choices in a social context" (2007: 1). Freudenberg's argument that individual choices occur within a context, builds on the earlier work of Chambers. The 'reality' of the context according to Chambers (1997) is determined not just by the physical environment, but instead is constructed by people within their context, based on what these people perceive, know or believe.

Findings consistent with Freudenberg's views were confirmed in a South African study of determinants of non-communicable diseases in adults who had migrated to peri-urban settlements. Community perceptions were recorded using qualitative methods conducted in the context of study. The authors Stern, Puoane & Tsolekile (2010) identified that access to healthy food, safe environments and levels of social capital all determined a person's susceptibility to non-communicable diseases. Based on these results the authors conclude that

strategies are needed which move beyond individual behaviour change, in order to address the underlying determinants of ill health.

2.7 Taking Action Based on Parental Perceptions

According to Freeman (2009) hearing parent voices is the first step in health promotion. The author stresses the value of community participation in health research. There has been little research into the role of the ECCD centre as a setting for health promotion, incorporating the roles of advocacy and community participation. However, some other studies based in African countries offer some lessons learned on the importance of community participation and advocacy.

An evaluation of an integrated nutrition programme in primary schools in Zambia, acknowledged the importance of parental perceptions for the success of a nutritional education programme (Sherman & Muehlhoff, 2007). In this study, funded by the FAO of the UN, an evaluation was conducted of a curriculum-based nutrition program that had been taught in Zambian primary schools. In class, students were educated on the importance of a balanced diet and hand washing. However the study found that there were challenges in the application of this health education. Parents did not see the link between health and nutrition, so children were not supported at home in applying their new knowledge. In addition, other challenges existed in the home environment such as lack of water in homes to implement hand washing; and protein foods grown by the family were sold as a cash crop rather than used for family nutrition. The report concluded that educational lessons needed to be complemented by food security and sanitation interventions. Sanders et al. (2008) also conclude that initiatives that focus only on healthy behaviours such as hand washing, will have limited effect if there isn't the environment to support the desired behaviour.

Several other authors agree with the need for advocacy in health promotion, as stated in the Zambian study. Baum (1998) described the importance of understanding parental perceptions of health as this can serve as an advocacy strategy by raising parents' awareness of health issues, and providing an opportunity for their involvement in the process of determining health needs. Williams & Drummond (2000) concluded that addressing perceived barriers to health was as important as developing health education sessions. They suggested that policy advocacy and social action to promote health were important roles for public health workers.

Recording parental perceptions of health can allow for community participation. Community participation is described as important because "for a community-based intervention to be effective and sustainable perceptions of community members must be determined and then used to plan and tailor interventions" (Yadrick et al., 2001:267). Sanders & Chopra (2006), claim that community participation can lead to empowerment of the participants. This process of empowerment can be a way of working towards advocacy. Several authors explain that community participation allows for solutions to be created from within the community rather than imposed from outside of the community (Chapman & Davey, 1997; Harris, Wise, Hawe, Finlay, & Nutbeam, 1995). Sanders et al. (2005) challenged the international community to create conditions in which African people can develop their own solutions to their problems.

The process of gaining an understanding of the factors a community perceives as being healthy can enable people to determine their own health priorities. This was the conclusion of Cameron (2005), who outlined an empowering model of qualitative research through the use of health impact assessments and vision workshops. Although this research was conducted with a small sample in an Indian community, rather than an ECCD centre, the participatory approach offers

some useful lessons. Cameron's conclusion reinforces the earlier recommendation by Kemm (2003) of using participatory methods in qualitative research on health education.

2.8 Summary of the Literature Review

The literature review sought to provide an overview of the broad range of issues related to parental perception of health and child health needs in ECCD settings. The dynamic concept of health was defined and noted to have various meanings, according to the context. The social determinants of health were explored and the influence of the social and physical environment on health was detailed. The development of health promotion as an approach to respond to health inequity was strongly influenced by the Ottawa Charter. The review of health promotion literature stressed that health education alone is insufficient to address the existing health inequalities. In order to be effective, health education focused on increasing personal skills must be accompanied by the other four health promotion actions of the Ottawa Charter. The health promoting settings movement has endeavoured to utilise this comprehensive approach. Very little has been documented in the literature, regarding health promoting schools in South Africa and the influence of the social and physical environment of the ECCD centre in promoting child health. Sustainable health promotion within an ECCD setting needs to incorporate the parental perceptions of health and child health needs. The focus of this research endeavours to be a starting point in that direction.

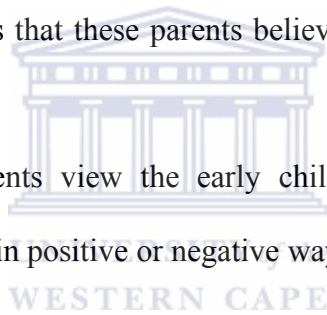
3. METHODOLOGY

3.1 Aim

To explore the perceptions of health and child health needs held by parents of children enrolled in ECCD centres partnering with WESSA, in Amathole District, Eastern Cape, South Africa.

3.2 Objectives

- i. To explore the perceptions of health held by parents of children enrolled in selected ECCD centres in Amathole District.
- ii. To explore the perceived child health needs identified by these ECCD centre parents.
- iii. To identify the factors that these parents believe either contribute to or challenge their children's health.
- iv. To explore how parents view the early childhood centre in Amathole District as contributing to health in positive or negative ways.



3.3 Study design

This study was a qualitative exploratory study. An exploratory study was appropriate for this research, because the parental perceptions of health and specific child health needs of the ECCD centre in Amathole District were not yet known. Therefore the research aim focused on identifying them. It was hoped that the study would be valuable in exploring these parental perceptions and therefore contribute to the proposed establishment of effective parent groups to promote the health of the ECCD centre children.

Qualitative research methods were used to describe the parents' perceptions of health and the health needs of their children. This allowed for the collection of subjective data, which can

give a greater understanding of what people consider important. Qualitative research methods therefore allow for participants to describe their experiences and perceptions in their own words, within their own contexts (Freeman, 2009) in order to acknowledge the unique reality for each participant. The emphasis of qualitative research is on the experiences of people within their context, which in this study was the ECCD centre.

Focus group discussions (FGDs) were the data collection method used to record the parental perceptions of health and child health needs. FGDs can capture information-rich data, which was useful in the Amathole District setting in order to include people with a strong oral tradition. The method is useful for helping to clarify the research focus by using open-ended questions to explore broad topics (Baum, 2008) such as perceptions of health and child health needs. FGDs have been cited as a useful approach, in assessing health needs in school settings, in order to develop health education resources (Secker, Wimbush, Watson & Milburn, 1995).

FGDs are an economical and efficient way of gathering information from a number of sources (Baum, 2008). They can be a stimulus for interaction between the research participants. Therefore, because there was limited parental involvement in the ECCD centres, it was hoped that the FGDs would be a suitable method to generate more community involvement.

3.4 Study Population and Sampling

The study population consisted of the parents of children enrolled in WESSA associated ECCD centres in Amathole District. A purposeful sample from this population was chosen. The participants included parents from two different rural ECCD centres in Amathole District. The WESSA Border Kei Manager advised the researcher on the selection of a suitable ECCD centre with an established relationship with WESSA and the eco schools programme. This centre

served as the site for three of the four FGDs. An additional FGD was conducted in an ECCD centre which had a less formal association with WESSA. The senior staff member from each ECCD centre was responsible for the selection of suitable research participants to form the FGDs held at their centre.

The FGDs were heterogeneous and comprised of parents of varying ages and backgrounds. Participants selected were all adults, with no upper age limit. Child headed households were excluded from the study. The adult participants had one or more dependent children who had been enrolled in the selected ECCD centre for at least six months prior to the study. The participants had been the primary guardians of the enrolled child for at least one year. Four FGDs were conducted. Two FGDs each included one male participant in the group, while the other two FGDs were composed entirely of women.

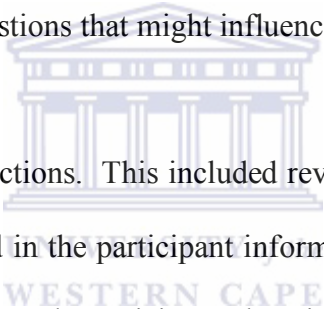
3.5 Sample Size

It was expected that each of the four FGDs would be comprised of approximately six to eight participants. However these groups were formed from the available parent population, based on logistical considerations. Due to the fact that the FGDs were conducted in ECCD centres located in the rural community, varying numbers of participants arrived at the agreed interview time. The FGDs consisted of nine, four, five and eleven participants respectively.

More than four participants had been recruited for the second FGD, but several potential participants were away from the rural area collecting their monthly grant when the FGD was scheduled. It was decided to go ahead with the discussion despite the small number of participants, as the meeting time had already been rescheduled more than once. It was felt that worthwhile information was elicited from all of the FGDs.

3.6 Data Collection

The facilitator of the FGDs followed a semi-structured outline (see Appendix 4), which guided the discussion. The outline contained only open-ended questions, which did not require a yes or no answer, thus allowing for participants' views to be expressed in their own words (Baum, 2008). The researcher served as the primary facilitator of the FGDs. Because the researcher was not an isiXhosa speaker, and the FGDs were conducted in isiXhosa, it was necessary to utilize a research assistant. The ECCD head teacher from the first centre and the previous manager from the second centre each served as the research assistant for the respective FGDs. The researcher trained the isiXhosa speaking research assistants on how to ask open-ended questions. This training included how to avoid asking closed questions requiring a single word answer, and avoid leading questions that might influence the participants' responses.



The FGDs began with introductions. This included reviewing the purpose of the study and the ethical considerations outlined in the participant information sheet and informed consent form. The researcher, assistant and each participant then introduced themselves to the group and talked briefly about their own children. As the aim of the study was to understand parental perceptions, the researcher felt it might be helpful to highlight the fact that everyone attending the FGD shared in common their role as a parent. The introductions appeared to help relax the participants and gave each person the opportunity to speak in front of the group, before the recording of the discussion. The participants were reminded that they could discuss issues regarding child health for children in the ECCD centre community and did not need to share specifically about their own children.

A debrief session was held at the end of each FGD between the researcher and assistant to briefly review the session. Any change to the format or focus of the FGDs was communicated

before the subsequent FGD. The sessions were recorded using a digital voice recorder. They were then concurrently translated and transcribed into English by an external professional translator, for analysis by the researcher. The original isiXhosa voice recordings were kept during the research process.

3.7 Data Analysis

The first step of the analysis was to gain a thick description of the perceptions of health and health needs emerging from the FGDs. A preliminary analysis was conducted using the framework of the semi-structured FGD questions such as the participants' understanding of health, child health needs, challenges to health, resources for health and the role of the ECCD in child health. This initial analysis occurred concurrently with the data collection.

The qualitative methodology allows for concurrent analysis of data during the data collection (Strauss & Corbin, 1994). This approach was suitable for this study in order to further clarify the research question and adapt the research focus according to the participants' responses. The written mini-thesis report includes translated examples of the participants' responses to illustrate the analysis.

The data were then coded using content analysis to see how the participants classified their perceptions and understanding of health and child health needs (O'Leary, 2004). The codes were first hand-recorded in the margins of the printed transcripts, and then entered into the electronic version of the same transcripts as additional comments by the researcher.

Next, the transcripts of the FGDs were read and re-read to elicit reoccurring themes. This involved organizing several different codes around a common theme. This was conducted by

using a cut and paste method to move the data into different documents organized around themes. The thematic analysis highlighted the common themes and the shared experiences of the participants of the FGDs. Finally connections were made between repeated codes and themes, as well as variances in the data (Gifford, undated).

3.8 Rigour

Triangulation of viewpoints strengthened the validity of the study. Triangulation is the process of comparing data from different sources or points of view (Gifford, 1996; Mays & Pope, 2000). The researcher's views of the FGDs were compared with feedback from the isiXhosa speaking assistants, and the findings in the literature. The research supervisor also commented on the categories and analysis of the data.

The FGDs concluded with a summary of the ideas discussed, and an opportunity for participants to ask final questions or provide comments. This allowed for confirmation that the participants' perceptions had been accurately recorded, and for any necessary clarifications to be made. The researcher kept a research diary detailing her experience of the research process. This enabled the researcher to reflect on her role and acknowledge her impact on the research process (Rice & Ezzy, 1999).

Qualitative research does not allow for generalizations, as the results are specific to the context. The themes that emerged from the research may be transferable, with the provision of a thick and rich description of the research context and a reflection on how this relates to the literature (Mays & Pope, 2000). The small sample size limits the extent of the transferability of this study. In spite of this, the parental perceptions of health and child health needs that emerged

from the rich data collected in the Amathole ECCD centres FGDs, may offer some understanding which can be applied to other similar contexts.

3.9 Ethical Considerations

Ethical approval was first sought from UWC. Before proceeding with the research, permission was also requested from WESSA. The research idea was presented to the working group of the WESSA eco-schools project, during their annual planning meeting. The researcher and the WESSA manager met with the staff of the primary ECCD centre and other key stakeholders to introduce the study and gain verbal approval.

Parents who were interested in participating in the study were given a Participation Information Sheet (see Appendix 2) outlining the study in a summary format. These were translated into isiXhosa. The isiXhosa speaking research assistant read through the detailed information (see Appendix 1) with each participant in a group setting, to ensure they understood despite varying levels of literacy.

Participation in the study was voluntary. The participants were advised that they were free to withdraw from the study at any time without any penalty. The FGDs were held in the rural ECCD centre location within walking distance of the participants' homes, so no transport costs were reimbursed. The participants were given a jar of peanut butter as a small gift, on completion of each FGD.

Each participant was asked to sign an informed consent form (see Appendix 3) before the FGDs. Again these forms were translated into isiXhosa by the research assistant and relayed verbally. During the first FGD there was a reluctance to sign the written consent forms, but verbal consent was given to participate and proceed with the voice recording of the discussion.

All the participants at the completion of the FGD then signed the consent forms. The participants acknowledged their initial hesitation in participating, but stated they soon felt relaxed and free to participate. The general consensus was that the participants enjoyed the FGDs and found them beneficial.

Participants were assured of confidentiality as outlined in the Participant Information Sheet. They were asked to keep the information shared in the FGD confidential. The discussion of parental perceptions of health and health needs was not a particularly controversial or sensitive topic, and as anticipated, it did not result in any known trauma or harm to the study participants. However, had the need arisen as a result of the research study; professional counselling would have been arranged by the researcher for these participants.

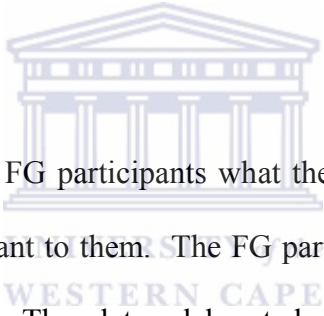


4. RESULTS

The FG participants' recorded perceptions of health and child health needs are explored in this chapter. The chapter begins by looking at the parental understanding of health. Next, their views about the determinants of child health are explored, followed by both the perceived challenges and the resources available for child health. An overview of the perceived role of the ECCD centre in promoting child health is then provided. The chapter concludes with the participants' suggestions for how the centre could contribute further in promoting child health.

4.1 Parental Understandings of Health

4.1.1 Cleanliness



The facilitator first asked the FG participants what the word 'ezempilo' (the Xhosa word for matters relating to health) meant to them. The FG participants were quick to respond and say that health meant cleanliness. They later elaborated on this rather limited view of health, to include cleanliness of the child as well as their environment at home and at the ECCD centre. When the FG participants were asked what would happen if there was a lack of cleanliness, one FG participant replied that there would be germs.

Personal hygiene was viewed as an important component of health. Many FG participants discussed the need for bathing the body. As one participating parent noted:

“You can try to explain to him [your child] this matter [health]. You as the parent must explain that when you bath, you must do it hygienically. When he has bathed, he will have improved his health. He will not be dirty anymore.”

In addition to personal cleanliness, environmental hygiene was also viewed as a component of health. FG participants spoke of the importance of cleanliness during food preparation. As one FG participant stated:

“And the food that is cooked and the people that cook the food must be clean. And the utensils that they use to cook the food for the children must be clean.”

Many parents were aware of the value of keeping food clean and not eating food that had been contaminated by dirt. The participants agreed with one another, that in order to stay healthy, children must avoid picking food or other items up off the ground and putting them into their mouth.

4.1.2 Feeling Healthy

Health was also described by some participants in more general terms such as “how they must live” or “how you feel in your body”. Participants alluded to a more holistic view of health with a connection between physical and emotional health. It was agreed in the FGDs that the concept of health included emotional or mental health status. Participants spoke of ‘feeling right’ or ‘feeling free’ when they were healthy. One participant made a direct connection between health and happiness as noted below:

“When you are healthy, you feel right. You are happy.”

Other participants actually substituted the word ‘happy’ for ‘healthy’ as if they were interchangeable concepts. As illustrated with the following:

“It’s varied, the health of the children here in the community. With one child, you will see that he is not completely well. With another child, you will see that he is not happy. With another, you will see that he is happy. They are all different. They aren’t all happy, the children here in the location.”

4.1.3 Active and Playing

A repeated theme discussed in relation to the concept of health, was activity and energy levels. Participants perceived that when you are healthy you have energy to do whatever you want to do. A child was perceived as healthy when they had the energy to play. Healthy children were described by participants as being interested in their surroundings, able to play with toys, being active, lively, jumping and playing outside on playground equipment. The participants in the FGDs described health as something that could be observed outwardly on the body by another person. Several participants compared a healthy child who was active, with an unhealthy child that was ill and lethargic. This is evident in the words of one respondent:

“You can see a healthy child by his liveliness. He is fresh. When a child is sick, he has no energy.”

4.1.4 Safety

A surprising but recurring response to the question of what the word health meant to the participants, was the theme of safety. In all of the FGDs, parents gave examples of their concern over the safety of their children. Participants agreed that abuse of a child could include both emotional and physical abuse. Parents perceived the community as potentially unsafe for their children. One parent spoke of the dangers that could occur if their child left the confines of their parental home and went away to play without parental supervision. The participant spoke of a child being physically and emotionally traumatized after being threatened by a man with a knife. The parental advice this parent would give their child on how to remain healthy is given below:

“Even if you just leave my yard, you will come into contact with somebody who will make you less healthy, who will abuse you [and demand of the child] ‘Give me a certain part of your flesh’ and he threatens the child with the knife, the child will spend all his life in fear. Health is to stay at home and listen to your parent to what she is telling you to do, and she will keep you safe in her home.”

4.2 DETERMINANTS OF HEALTH

As the parents explored their definitions of health, various determinants of health were identified. The facilitator asked the FG participants what factors they felt were necessary for health to occur. The responses noted below have been organized into levels, starting with individual determinants and moving towards more broad determinants of health. This includes responses grouped around the themes of healthy behaviour, supportive social environments, living conditions and finally broader socio-economic conditions, which may determine child health.

4.2.1 Healthy Behaviour

4.2.1.1 Personal Hygiene

As noted in the previously discussed definitions of health, personal hygiene was viewed as a contributing factor to a child's health status. The participants agreed in order for a child to be clean, it was important for them to bath daily. In addition, they also commented that the child's personal belongings such as clothing, lunch box and drink bottle needed to be clean. One participant added that children must use soap when they wash their hands after using the toilet or before eating. It was not sufficient to use only water in order to remain healthy.

4.2.1.2 Protection from Body Fluids

Hygiene and safety concerns were perceived as being interrelated when participants expressed their concern over the risk of exposure to body fluids. As one respondent commented:

“If maybe a person is stabbed, and he [the child] touches his blood, he [the child] will catch germs that way as well.”

The FG research assistant elaborated on this comment to clarify that, due to the prevalence of HIV in the community, a child must be careful not to touch blood from a stab wound with bare

hands in order to prevent exposure to HIV. The participants agreed with this clarification. However, it is interesting to note that in all of the FGDs HIV/AIDS was not directly discussed by the participants themselves.

4.2.1.3 Sleep

It was agreed by the participants that children needed to have sufficient sleep in order to be healthy. Some parents perceived children to be lacking in the necessary amount of sleep when they went to bed late at 9 o'clock in the evening. The link between sleep and the perceived definition of health as being active was made in the following response:

“If my child goes to bed early, and gets enough sleep, she is active [she is energized the following day]. She isn't lethargic all the time.”



4.2.1.4 Recreation

Because parents perceived health in terms of activity levels, they felt that children needed the opportunity to play in order to maintain their health. Participants described children as happy and healthy when they were playing. Parents stated that when children were able to play with toys, their minds were stimulated. Outdoor play was also perceived as stimulating to a child's mind. Parents spoke about the reciprocal relationship between playing and health. Parents thought for the child to be healthy they needed to play, and when a child was healthy, it was able to be observed in their ability to play, as explained in the following example:

“And for the child to be happy, he must always be playing, like here at the school, at the crèche, there are swings. So, they play, and if a child is not happy, he will not play.”

Playing sports such as soccer was seen as helpful in protecting children from disease. Parents viewed exercise as helping children to feel 'fresh' and 'right'

4.2.1.5 Nutrition

In all of the FGDs, nutrition was perceived as a vital determinant to child health. One participant who was currently breastfeeding a younger child also spoke of the importance of nutrition on her health, and subsequently that of her infant. Food that parents viewed as healthy included vegetables such as spinach and carrots, as well as fruit such as apples and bananas. The only protein foods mentioned as important for a child's diet were eggs and milk. The emphasis on the discussion of healthy food was on fresh fruit and vegetables. Participants agreed that some children did not receive the benefit of a varied diet and ate predominantly maize meal. As one participant explained:

“And his appetite will not be satisfied if you feed him things that are not up to standard, like feeding him porridge all the time, if he eats porridge night and day. Porridge is fine for breakfast. So, you need to vary his food as well, so that he can be happy”.

Eating a varied diet including fresh produce was perceived as important for the child's physical and mental wellbeing. Parents gave the example that when a child is given healthy food they are more interested in learning. Participants also explained how a child with a varied diet was seen as being a more active participant in recreational activities such as soccer training. This reinforced the perceived correlation between nutrition and health, since activity levels had previously been described as a definition of health.

4.2.2 Social Environment

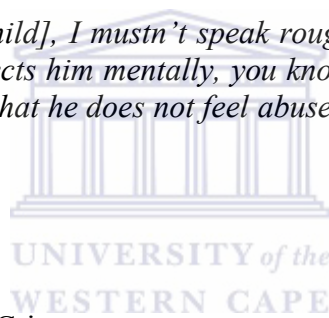
The parental perceptions of the environmental effects on child health included the notion of illness and a medical model of health. Yet throughout the FGDs, it was clear that the participants viewed health and health needs in a holistic way that also encompassed the social and emotional environment of the child. Considering that health was perceived as 'being free' 'happy' 'feeling right' and 'safe', factors in the social environment were viewed as significant

determinants of health. Participants identified the issues of conflict, substance abuse and parenting practices as influencing child health as outlined in the following results.

4.2.2.1 Conflict and Communication

Parents admitted that at times they might be stressed and therefore might shout at their children. One mother joked with the group, that they must not antagonize their children when they were frustrated at their fathers, as the children do not understand the cause of the maternal frustration. Although this was commented on in a light-hearted manner, it was acknowledged with immediate agreement from the group. Another parent in a different FGD also spoke of the importance of communicating in a peaceful manner with children, in the following response:

“When I speak to him [the child], I mustn’t speak roughly to him. Because his health depends on how we talk to him. It affects him mentally, you know? He can become victimized. We must not speak roughly to him, so that he does not feel abused mentally. We must give them health in the way we talk to them.”



4.2.2.2 Substance Abuse and Crime

The participants were asked by the facilitator what they would most wish or dream for their child’s health, in order for it to be very good. The responses all focused on the parents’ wish that their young children would grow up being free from the dangers of smoking, alcohol abuse, crime and time in jail. These responses illustrated the participants’ ability to think long-term as they spoke of health issues typically related to youth and young adulthood. They did not give any examples of what they would wish for in their pre-school child’s immediate future.

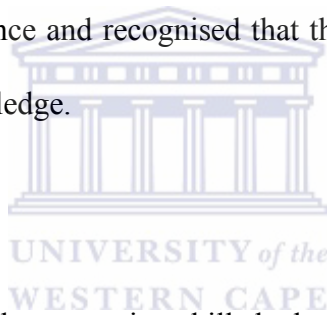
Parents felt that drugs and alcohol affected young people’s behaviour and social relationships. It was agreed that substance abuse could lead to conflict and violence as evidenced in the following participants’ words:

“The child just ends up saying anything to the parent [when he smokes or drinks], and he ends up not knowing his place in the home, for example, he will want to hit you when you are talking.”

Another parent echoed this concern when she stated:

“And when she has been drinking, she can kill somebody, and tomorrow not remember.”

One parent suggested that her child might avoid smoking, drugs and alcohol abuse through attendance at church and subsequently following the teachings of the church. Another parent disagreed and felt that her child would be pressured to smoke by her friends attending the church. Peer pressure was perceived to strongly impact child health. Parents were aware of the limits of their parental influence and recognised that their children might be engaging in risky behaviour without their knowledge.



4.2.2.3 Parenting Practices

Parents discussed the impact that parenting skills had on the health of their child. It was seen to be important for parents to communicate with children, provide for them and set boundaries. Participants shared their aspirations of wanting their children to succeed at school academically and gain the life-skills needed to be responsible adults. One participant suggested that parents should be honest with their children and to explain their own educational background and perhaps why they hadn't achieved to the level that they wished for their children as noted:

“Those things that she wants to do, you help her to do them ... but only right things. And if you were not able to do a certain thing [such as finishing school], you must tell her that you were not able to do it because of such-and-such. I mean, you must tell her about your life, that if you went to a certain place [school], you were not successful. Then she mustn't do what you did. She must choose another way, and go to school and learn, and finish school.”

A parent's ability to recognize signs of illness was perceived as a determinant of health. Because children may not be able to articulate when they were feeling unwell, it was seen as important for parents to closely monitor a child. This implies the importance of a parent being present and actively supervising children. Another participant explained that it was easy to miss early signs of illness in their child and only notice illness when it was more advanced. She reminded the other participants:

“That is why we must remain vigilant over our children, so that they can be healthy.”

4.2.3 Healthy Physical Environment

4.2.3.1 Environmental Cleanliness

Elaborating on their earlier definition of health as consisting of cleanliness, participants agreed that a clean environment was a determinant of health. Parents identified a range of environments that needed to be clean. This included the child's home environment with particular emphasis on their place of sleeping. Other parents spoke of the importance of a clean environment where the child was learning or playing, such as the ECCD centre.

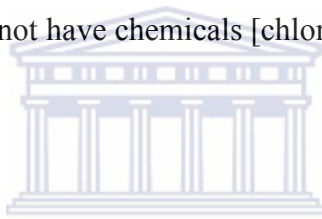
Environmental pollution was perceived as a determinant of health. Parents were concerned about people smoking in the children's environment and the detrimental effect on the child's health. Participants felt that the rubbish that was littered around the environment caused offensive odour and could affect health. Several participants talked about the increase in vehicles driving on roads in the community and the damage that resulting road dust and carbon monoxide in the air could cause. The perception was that these factors could result in what one participant described below as a 'dirty wind':

“Perhaps sometimes when the children are playing, a dirty wind blows past them. Perhaps one of them will get sick quickly from that wind.”

4.2.3.2 Water and Sanitation

Participants perceived water, or the lack of it, as a key determinant for the health of the children. Parents were aware of the importance of clean water for hygiene, food preparation and drinking purposes. Dirty water was thought to be the cause of illness such as sores on the body. Parents saw that dirty water and unclean cooking utensils as the cause of infections of the stomach causing diarrhoea.

The participants considered wastewater in the community a source of disease. One parent explained that stagnant water such as sewage water might attract mosquitoes, which they felt affected the children's health. Another parent perceived that the water in the rural villages was not completely clean as it did not have chemicals [chlorine] added to it and therefore it might be bad for their bodies.



The communities in which the two ECCD centres were located lacked sufficient sanitation for the members of the community. Many of the homes were lacking any type of toilet. The parents viewed this lack of proper sanitation as being detrimental to health. As one participant stressed:

“And it is also necessary that when he relieves himself, he not relieve himself just anywhere, such as in the yard. Seeing that we do not have toilets, there are bushes some distance from the houses. He must go and relieve himself there. Because excretions such as faeces and urine cause problems. They cause germs”

4.2.3.3 Heating

The FGDs were conducted during the South African winter. Perhaps as a consequence of the timing of the interviews, the cold weather was perceived as a determinant of health. Parents stressed the importance of keeping their children warm.

Some participants who lived in the informal settlement did not have electricity and therefore lacked access to heaters in their homes. Consequently they kept their children warm by dressing them in layers of warm clothing and footwear. One parent thought it was best to keep their child indoors during the cold season, especially later in the day when it was cooler. Parents recognized that a child might not always know when to dress warmly, or be aware of the changing weather during the day. Therefore they perceived it was the parents' responsibility to monitor the child and dress them appropriately.

If the child became cold then the participants thought illness might occur. The effects of cold weather on child health was explained by a participant in the following scenario:

“When he gets cold, you know, the child gets flu, and you find that he is sick. And when he is sick, you will see that he is not ... he doesn't even want food, because he is coughing. And when he is coughing, he will infect the other children at the crèche. We must keep them indoors when we see that a child is coughing, especially seeing that coughing can cause others to become infected... all the other children here at the crèche. So, those things are caused by the cold [cold conditions].”

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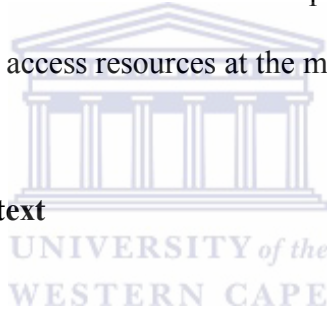
The cold weather was also perceived as being the cause of other illness such as arthritis, TB and pneumonia. One participant emphasized that the cold can kill and therefore parents must protect children from the cold weather.

4.2.3.4 Access to Medical Care

Parents felt that the level of access to medical care determined a child's health. A travelling clinic visited one of the ECCD communities once a month. The other community had a permanent medical clinic across the road from ECCD centre. Apart from administering vaccinations, parents generally viewed the role of medical care given at clinics as providing treatment in times of illness or injury, as seen in the following:

“And when he is sick, you must take the child to the clinic... so, you must go and buy some medication for the child. Then you will notice that the child will be healthy, and he will start to play again.”

Vaccinations were seen as a valuable intervention, which contributed to a child being healthy. However, participants felt that some parents did not utilize the available immunization service for their children, despite the clinic and ECCD centre reminding parents of the need for child vaccines. One participant felt that children of grandparents were less likely to access the medical clinic, due to difficulties elderly caregivers experienced with mobility. Other participants disagreed with the perception that aging parents were a risk factor for not accessing services. Instead they perceived that the level of parenting skills and parental motivation determined a child’s ability to access resources at the medical clinic.



4.2.4 Socio-Economic Context

4.2.4.1 Poverty

Many of the previously discussed determinants of health were dependent on the income levels of the parents. Throughout the FGDs the underlying determinant to the child’s health was the existing poverty in the community. The participants were asked what accounted for the differences in health between children. “Why did some children appear to be healthy and others not?” One respondent summed up the key determinant of health in the following way:

“With some of the children, it’s a case of the mothers not caring. With others, it’s a case of poverty.”

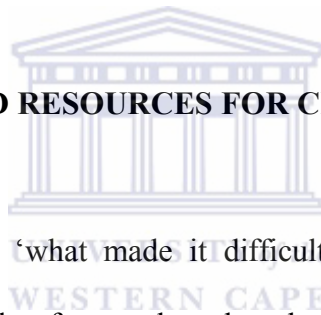
Some parents saw a connection between providing materially for her child and preventing undesirable behaviour. They felt that it was important to provide the necessary clothes, entertainment options and snacks that a child might want, in order to prevent the child from

going to take these things from their friends. Another parent agreed that a child should be given small change from the parent so that they would not steal from others as explained below:

“A child must not struggle. I must try by all means to have a 50-cent coin or a R1 coin available, and I give it to her. Because if I don’t give her that money and I tell her, ‘I don’t have any money,’ she will go and steal money from another house. ... that child is naughty, because of struggling [being impoverished], because of being hungry ... she doesn’t have food, so she ends up going and doing things in the houses, breaking into the houses, stealing food, and sneaking up on other children. What makes the children sneak up on each other like that is hunger. They are hungry.”

The participants mentioned that when they were able to provide material goods for their children, they reminded the child of the reality that they might not always have money available in the future.

4.3 CHALLENGES AND RESOURCES FOR CHILD HEALTH



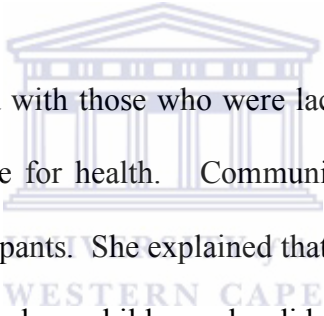
The participants were asked ‘what made it difficult for the children to be healthy?’ The facilitator also asked them what factors they thought already existed in their community that ‘made it easier for the children to be healthy’. Their responses regarding the perceived challenges and available resources for child health followed similar themes that had been previously identified as determinants of health. It is significant to note that although the participants were aware of broad social determinants of health, they also perceived their community to be lacking many of these necessary factors that could promote child health. Therefore they were concerned about these daily challenges to child health.

4.3.1 Food Security

Based on the expressed value of good nutrition in improving child health, parents were concerned with the challenges they faced in the area of food security. They felt that many

children did not have a varied diet that provided sufficient nutrition for their health needs. The perception was that it was difficult to provide adequate nutrition to their children when faced with challenges in either growing their own food, or affording purchased food items.

Several participants thought a home garden was a valuable resource for health. Some participants did have vegetable gardens to supplement their nutrition. This confirmed the earlier view that eating fresh vegetables and fruit was a health promoting behaviour. The output from the gardens was seen to vary depending on a participant's ability to purchase seeds for planting, motivation to maintain the garden, and the availability of water. One participant saw that it was important to share the produce from the garden with others who did not have a garden.



Other initiatives to share food with those who were lacking were also being implemented and seen as a community resource for health. Community support for vulnerable children was discussed by one of the participants. She explained that in the weekends some parents prepared food at a community centre, where children who did not have food could go to receive free meals. The participant explained how this initiative provided for the child's safety and nutrition needs, in situations where the biological parents were neglecting their children as the following participant elaborated:

“There are parents in some homes that do not have time to spend with their children, especially over weekends, when they are busy and eating nice things. They forget to make provision for the children. The children need to be kept safe. That is why we want places that care for the children, so that, like at the craft centre over the weekend, there are parents there that are looking after the children, who go without anything to eat, because the biological parents of the children are keeping their children in a place that is not right. They were not able to look after their children. That is why we like that ... there be homes that continually ensure that the children receive something to eat so that they can be healthy.”

4.3.2 Water Shortage

Related to the perception that health meant cleanliness, the shortage of available water was of great concern for all of the participants. One of the ECCD centres did not have piped water or rainwater tanks. The local municipality supplied JoJo's (water tanks) to which water was delivered by the truckload. The water then needed to be hand carried in buckets to the ECCD centre.

It was generally agreed by that there was insufficient water to meet the needs of cooking, drinking, bathing and laundry. Participants relied on rainwater to some extent to supplement their water supply. One participant noted that the local dam was dry due to lack of sufficient rain. The gardens that were perceived as beneficial to health, suffered during times of drought. Participants were concerned that the gardens were currently withered as explained by the following participant's comment:

“The rain is not falling in the soil. So, then the soil is always hard, you understand? So, you will plant vegetables in the soil, but the water runs out here by us in the former Ciskei.”

4.3.3 Lack of Sanitation

Based on the participants' perception that sanitation was a determinant of health, they were understandably concerned about the lack of adequate toilets in the community. Due to the fact that many participants did not have toilet facilities and used the neighbouring bush, they perceived the lack of sanitation as a daily challenge to health. One participant wished for clean safe toilets for the children. It was seen to be unsafe to use the bush at night. During the day time there were not always enough bushes to hide behind so people often relieved themselves close to the houses. One participant spoke frankly about her concern over the lack of sanitation in her following comment:

“It’s scary. You can tramp on fresh faeces – faeces that have just been deposited – even if you go right next to the houses.”

Another participant agreed and expressed concern about diseases such as diarrhoea that could occur due to the lack of sanitation.

4.3.4 Heating and Cooking Sources

Given the perception that keeping children warm was a determinant of health, sources of heating and cooking were seen as a challenge. Those participants with electricity in their homes faced the challenge of affording electric heaters to provide warmth in the cold season. The participants without electricity used either open fires or paraffin stoves for cooking and heating. Both methods were perceived as challenging for child health. Open fires were not used as frequently as in the past. One participant spoke about the children complaining of sore eyes from the smoke from open fires. The paraffin stoves were seen as a safety hazard as they could easily cause unintentional fires. One participant explained her concern regarding the use of paraffin stoves in the following response:

“It is not OK, because we’ve got Beatrix⁷ in our houses. Those stoves smoke a lot. So, that paraffin smoke affects the children’s throats, and they get sore chests. And even you, the adult, end up getting a sore chest if you have been sitting in that smoke.”

4.3.5 Traffic and Transport

Both ECCD centres were located on relatively busy unsealed roads in the community. The roads were perceived as dusty and dangerous. The participants felt that the frequent traffic stirred up the dirt on the road resulting in increased dust in the air. One participant gave an example of how at times, she observed a child would begin coughing after chasing after a car while playing on the side of the dusty road, as described in the following response:

⁷ Beatrix is a type of flame stove commonly used in informal settlements in the Eastern Cape

“To explain, sometimes when a car drives past, the children sometimes like to play outside, sometimes when they see a car turning, they like to follow it. And then you will see a child coughing, but he was not coughing before. You find that that dust, when the child inhales it, he starts to cough.”

Another participant shared that she was afraid of cars because the children would chase after them or the children might cross the road without seeing a car coming. Other participants agreed with this concern and stated they also felt anxious about the potential risk of vehicles hitting pedestrian children.

Some children had to walk quite a distance to reach the ECCD centre. In response to the expressed challenge to keep children safe, one participant suggested that children who lived in the outlying areas could be escorted to the ECCD centre each day by another adult, rather than walk alone, as expressed in the following response:

“So, I was wishing, even though I’m not working, that we could get together and talk somewhere, that we could arrange that I could always wait for them somewhere and then accompany them and then fetch them from here [the ECCD centre] and take them home.”

Another participant added that some children who were not dressed warmly could become chilled walking such a long distance. Because there was not electricity in one of the centres, it was seen as difficult for the children to become warm again when they arrived. Another parent commented that some children might miss out on attending the ECCD centre during wet weather in order to avoid walking in the rain. The participants saw the themes of warmth and transport as being inter-related challenges to child health.

4.3.6 Medical Resources for Health

Participants spoke about the challenges they experienced when their child was unwell. The disease management measures that were described in the FGDs focused on accessing medical care. Parents did not describe any home remedies that were practiced when their children were unwell. Participants perceived that the lack of a permanent medical clinic in one of the communities was a major challenge to child health. Because the mobile clinic visited the community only once a month, the participants felt that many times there was a lack of available medical resources. If the mobile clinic was not available, parents described other measures such as obtaining medicine from a pharmacy, borrowing medicine from another family, or taking the child to the nearest city for medical treatment.

Several participants expressed their wish for a permanent clinic in the community that only had a mobile clinic. Another participant suggested a compromised solution of having the mobile clinic visit the ECCD centre routinely as stated below:

“Even if the mobile clinic could just come for the children at the school ... the crèche and the school – and not go to serve the needs of the people in the community [it would be better].”

4.3.7 Access to Consumer Goods

Participants stated that the lack of commercial shops in their community meant it was difficult for them to purchase healthy food or pharmaceutical products, which they perceived as necessary for health. Some participants who had paid employment stated they were able to access shops in the near-by urban area. One participant clarified that there were a few local shops within walking distance of the ECCD centre, but *“those expensive little shops”* were targeting the middle class residents or tourists.

4.3.8 Unemployment

A lack of regular employment posed challenges for many participants to provide what they felt were necessary elements to keep their children healthy. Participants agreed that work opportunities were limited, as noted below:

“There is no work. Work is scarce.”

A shortage of cash flow meant parents were not always able to purchase items to provide sufficient nutrition, warm clothes, medication or recreation options that they viewed as important for child health needs. Disparity existed within the rural community. A few participants had regular employment, some were unemployed, and many relied on government grants to supplement their income. One participant explained how the different income levels within the community resulted in varied health status amongst the children:

“Sometimes our homes here in the former Ciskei are not the same. So, in one home, for instance me, I make a garden every year. In one particular year, I will not cultivate my garden. I will be in financial difficulty and not have money to buy vegetables. It will be difficult for me to buy eggs, things that will be nutritious for me. So that person doesn’t get those things, so she will end up not being right [not being healthy]. You will see a child that is always right [healthy]. All of those things [vegetables, eggs, and nutritious food] she is getting. So, they [healthy children and unhealthy children] differ in that way.”

Another participant perceived that some parents might have a regular income, but chose to spend their money on other commodities, rather than on items that could promote their child’s health. Abuse of alcohol was cited in several FGDs as a factor that participants perceived as influencing some community members to spend their money on alcohol, leading to shortage of available income for child health needs.

4.4 CONTRIBUTION OF ECCD CENTRE TO CHILD HEALTH

The ECCD centre was perceived as a major resource for child health. Many participants spoke in great detail about the influence of the ECCD centre on their child's health. Based on their perceived definitions of health as being when children were safe, feeling happy, nourished and active, the centre was seen as contributing to the children's needs related to safety, life skills, nutrition and recreation. In some areas the ECCD was perceived to be potentially detrimental to child health.

4.4.1 Safety

The ECCD centre was generally perceived as a place of safety for the attending children by keeping them away from the potential dangers of child abuse and road injuries.

4.4.1.1 Protection from Child Abuse

One female participant felt that the centre kept the children safe from being molested. She was reluctant to elaborate further, however a fellow participant in the same FGD spoke candidly about the ECCD safety role, when he cited the following example:

“To borrow from what you are saying, you will remember that there was a time when a person my age would not be ashamed to do shameful things like having sexual intercourse with a child. A child of five years old! A man my age! He would molest the child when the mother was at work. So, concerning safety, now that there is a place like this centre, and children are coming to this centre, men cannot do things like molesting the children anymore. The children are guarded [protected] when they are here at the centre, and the mothers will come and collect their children in the afternoon, [knowing that their children were kept safe].”

This view of the ECCD centre as protecting children from potential child abuse was confirmed in subsequent FGDs and reinforced the parental perception that to be healthy was to be safe.

4.4.1.2 Road Safety

One participant felt that the ECCD centre provided a safe place for children to play, away from the potential dangers of playing in the road. Several other participants agreed with this view. Another participant, however, highlighted the supervision challenges that existed with so many children, and the potential for children to still be exposed to road accidents while at the ECCD centre. This participant saw how road safety at the ECCD centre could easily be improved with the following suggestion:

“Another thing, and the yard I don’t think is right. I think that the children that get through the fence are going to be run over by the cars. And when the teachers are busy inside, the children like to go outside the fence. If it could happen, I wish a new fence could be erected. And wire netting and a gate.”

4.4.1.3 Other Safety Hazards

When the participants were asked how the ECCD centre contributed negatively to child health, one participant identified the lack of building maintenance of the ECCD centre as an issue. She explained that the skirting boards were not fitted well and felt that frogs would enter the classroom through the gaps in the building. The participant stated poison was placed for the frogs, which although not identified as such, could also be a potential health hazard for the children. The main concern for the participant was the risk of injury to children from snakes that naturally co-exist when there are frogs present, as described in one participant’s response:

“Our crèche ... there is no building that is well built. We wish that this building could be rebuilt, because these skirting boards are fitted badly there. There are always frogs coming down through those skirting boards [!] and chasing the children, and then we have to put poison down. If there are frogs that means there are snakes as well. They [the snakes] are going to bite us and the children one day.”

4.4.2 Teaching and Learning Life Skills

In keeping with the participants’ perception that succeeding in school, and gaining life skills helped to determine health, they were enthusiastic regarding the learning they saw taking place

at the ECCD centre. They felt that the ECCD centre staff valued learning and passed this on to the children. Participants saw the value of ECCD centres in preparing children for more formal education. Examples were given of academic learning that occurred in the centre such as increasing numeracy or literacy skills. However, the majority of the examples of learning given by the participants related to the acquiring of life skills by the children in the area of social skills, personal hygiene and confliction resolution.

4.4.2.1 Social Skills

Parents perceived social skills as an important determinant of a healthy social environment. The parents subsequently described the valuable contribution to child health of teaching social skills in the ECCD centre. Being able to communicate clearly helped a person to “feel free” or healthy. The participants stated that the children at the ECCD centre were taught how to communicate with each other as well as with adults. One participant felt that it was apparent which children attended the ECCD centre, and which did not, by the nature of their interactions with others. Participants spoke of children at the ECCD centre being taught values, manners, and respect for their elders. Another participant agreed and thought that children who did not attend the ECCD centre were rude in comparison. Several participants gave examples of their children having increased confidence, improved social skills and increased independence as a result of attending the ECCD centre. As seen in the following:

“And even my child is different now that he is at the crèche. It used to be that whenever you gave him something, he would not be able to say thank you. But now the difference is big. If he gives you something and you don’t say thank you, he will say, “Say thank you, Mother.”... So, I see a big difference now. He is teaching ME now. And being insulted ... he doesn’t want [people] to be insulted. He will say ‘No insulting [of people] is allowed here.’ ...And he used to be very quiet. So, now he is talking, and showing me things that his Miss [his teacher] taught him.”

4.4.2.2 Personal Hygiene

Building on the perceived importance of cleanliness for health, the participants gave many examples of how children had learnt personal hygiene skills as a result of attending the ECCD centre. Again, the participants felt they could see a difference in behaviour between children who attended the ECCD centre and those who did not. The ECCD centre children were more likely to practice personal hygiene such as washing hands or rinsing food. Other participants stated that children now avoided touching blood with bare hands if someone was cut, due to learning they could catch germs. The children also reminded their parents to practice some of these newly acquired life skills, as seen in the following comment by a participant:

“So, he tells us that ... that we must wash our hands before we eat. Yes, we know these things, but he tells us again and again to do them.”



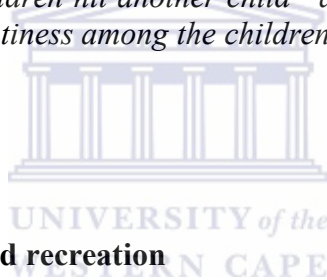
4.4.2.3 Conflict Resolution

Based on the parental perception that the social environment was a determinant of health, there was a lot of discussion around the issue of conflict resolution. The ECCD centre was viewed as both a source and a solution for health issues related to conflict. Some participants felt that their children might be exposed to more conflict by interacting with other children at the centre. One participant shared her concern that a child might quarrel with another and hit another child. Another participant explained that children might act aggressively while at the ECCD in response to their prior exposure to alcohol misuse and conflict at home. As identified in the following comment by a participant:

“I want to say that perhaps a child comes from a home where the parents like to fight or to have drinking parties. Then, when he leaves home and comes here to the crèche, he arrives at the crèche and does exactly what was happening at his home. If maybe at home his parents were drunk and were fighting with each other, he comes to the crèche and wants to fight with the other children, you understand? He ends up not behaving well towards the other children at the crèche. The child ends up acting out what he saw happening at home.”

The research assistant from one of the FGDs, who was also a staff member at the ECCD centre, was quick to point out that she tried to mediate between the children and to teach them to resolve any conflict. This clarification may have limited further discussion regarding existing conflict at the centre. However the participants readily agreed with the facilitator, that the children were taught to resolve conflict at the ECCD centre. Several participants agreed that their own children had learnt to interact with other children, to communicate with others and to share, all as a result of attending the ECCD centre. The majority of the participants gave examples of how fighting amongst the children generally decreased when they attended the ECCD centre as described in the following participant's words:

“And even if a child has been naughty at home, when he comes to the crèche, he appears to stop being naughty, because the miss [teacher] is there. She doesn't want them to be naughty. The children say, “One of the children hit another child” and the miss [teacher] runs to the scene and intervenes. So, any naughtiness among the children comes to an end, and they go home and are well behaved.”



4.4.3 Promotion of play and recreation

4.4.3.1 Development of Social Roles

Parents considered their children to be healthy when they were active and playing so therefore recreational facilities at the ECCD centre were considered to directly impact on child health. Both ECCD centres had some outdoor play equipment and a limited number of toys for children to play with indoors. Participants used words such as “active”, “happy”, “healthy” to describe how a child appeared after playing at the ECCD centre. Participants perceived that an environment conducive to play allowed for development of social roles and encouraging health, as one participant described:

“When they play, you can see the things that they wish they could be when they grow up. They play with the cars. They do everything. So, you find now that they are free, and they are happy.”

4.4.3.2 Child Development

Participants felt that the ECCD centre stimulated children in their social and physical development. One participant attributed the increased physical development in her child, to the role modelling received from other children at the centre. This mother shared how her child was delayed in learning to walk and the mother was encouraged by other parents to enrol the child at the ECCD centre. Within a week of her child beginning to attend the ECCD centre her child was walking. The mother attributed this development in her child to the role modelling received from other children at the centre.

Another participant described how she felt that children were helped at the centre in their language development. Participants perceived the staff as attentive to the development needs of their child and subsequently advised parents of any concern as described by a participant:

“Another thing, when a child is growing up – sometimes you will notice that the child isn’t talking properly (the children here at the crèche can talk) – and when the teacher sees that the children is lacking in a certain area, perhaps he is developmentally challenged – he can’t pronounce certain sounds properly – so you will tell me that the child can’t pronounce certain sounds.”

4.4.4 Child Nutrition

Consistent with the participants’ perception of nutrition as a determinant of health, they were enthusiastic in their support of the ECCD’s contribution to child nutrition. One ECCD centre provided a meal for the children each day. A participant used the word ‘delighted’ to describe how she felt about her child receiving food from the ECCD centre. The other ECCD centre in the study did not cook for the children each day. Instead, children brought lunch boxes from home as their main source of food for the day, and some meals were supplemented by outside donors each week.

Children were encouraged to share contents of their lunch box with a classmate who did not have food from home as described in the following participant's response:

“Those that don't have prepared lunchboxes ... endeavours are made at the school [ECCD centre] that there be provisions and that a meal be cooked, so that the poor ones that don't have food at home can eat. And if it is seen that there is a child that is not suffering [that has lots of food], that he be encouraged to share with other children [that have less food]. The person in charge will share the child's food with the other children, so that the child that had less food doesn't go home upset and tell his parents that he never had anything to eat at school.”

There was a difference of opinion in the FGDs regarding this practice of sharing food. Some participants thought it was wrong for children to share their food and subsequently have less to eat themselves. One of the facilitators clarified that children were never forced to share with others, although it was encouraged. Other participants thought that teaching children to share their food was beneficial for the children who came to school without food, and also was a valuable life skill for all the children to learn at a young age because:

“It becomes like second nature to share when a child has been taught to share.”

One participant suggested that it would be better if the ECCD centre could cook for the children each day. Another participant expressed a wish that breakfast could be provided at the ECCD centre to ensure that all children ate in the morning. The participants explained that sometimes a parent did not provide breakfast for their child. Some participants saw the ECCD centre as a distraction to child nutrition. The perception was that many times a parent may have prepared a hot breakfast of mealie-meal porridge, but the child refused to eat in their eagerness to go to the ECCD centre. Due to the fact that participants saw nutrition as important for a child to be healthy and active, they sometimes forced their children to eat breakfast. Participants were concerned when their children skipped breakfast as seen in the following comments by participants:

“Sometimes they don’t want food. They rush to school to go and play.”

“Yes, he’s in a hurry to get to school. He comes into the classroom and he’s hungry.”

4.4.5 Disease Management

Participants perceived that the ECCD centre had a role to play in the disease management of their children. Participants from both centres felt that the physical space was small and often crowded with many children. This was viewed as being unhygienic and a risk factor for spreading illness. One parent suggested that the centre could better serve child health needs if there was a separate facility for unwell children who came to the ECCD centre, as described below:

“For example, he might be coughing, and I might be talking to him, and then all those germs are coming out and being exposed to others. You see, they [the children] are all in the same place, and that place is hot and steamy, and it is easy to pick up an infection. But if there was a separate place [sick bay] that could be started by a teacher, it would be much better for the children, and they would be healthier.”

Participants perceived the ECCD centre provided the opportunity for some children’s health to be more closely monitored. Participants stated that they appreciated the occasions when a member of the ECCD staff noticed a child was unwell and subsequently notified the parent.

4.4.6 Access to Resources

The ECCD centre was perceived as a source of further resources for child health. Participants spoke of ECCD centre children receiving donations of clothing and food from groups in neighbouring areas. These donations assisted the parents in their efforts to keep their children warm in the cold season and sufficiently nourished. One participant added that she encourages parents of needy children to enrol them in the ECCD centre so that they can also benefit from having access to further resources as she describes in the following statement:

“We think that we are safe when we hide our child [keep our child at home] when we don’t have resources to look after the child. They [the parents] must come [to the centre], so that they can see the children. And we, as we are working in the school, can ask for help from them. Like the white parents that come here that bring help – they get to see that [the teacher] is struggling, and then they bring more help. There is even a parent that brings porridge for the children, when she sees the difficult circumstances of the children. She loads it in her bakkie⁸ and brings it.”

Other participants also agreed that children benefited from these donations and stated that the children were eating more regular meals than they had done so in the past.

4.5 FUTURE CONTRIBUTIONS OF ECCD CENTRE TO CHILD HEALTH NEEDS

Ideas for future improvement to the ECCD centre to further contribute to child health were discussed in the FGDs. Several suggestions have already been outlined in the study results. Additional suggestions made by the participants included: improving the water supply; building repairs; additional equipment and provision of health related workshops.

4.5.1 Improved Water Supply

Because the lack of water was seen as a major concern for the participants, they felt that having water tanks at the centre to collect rainwater could improve the quality and consistency of the water supply. As one participant described:

“These tanks will help us a lot, because the water in the taps likes to dry up. So, if we have tanks, there will always be water, and the children, when they are at the crèche, will not have a problem with the availability of water.”

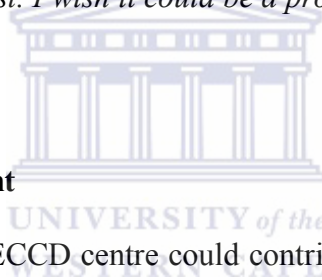
⁸ Bakkie is the South African term to describe an open back motor vehicle also known as a pick up truck or utility vehicle

The perception was that the improved water supply would support the participants' ability to provide the cleanliness, sanitation, cooking, and nutritional gardens to meet the children's health needs.

4.5.2 Building Repairs

Repairs to the ECCD centre buildings were mentioned including repairing the roof guttering and increasing the number of toilets available to the children. The environment outside the ECCD centre was considered dusty and one participant felt that an open lawn area would improve child health by reducing the children's exposure to dust, as she explained:

"I wish we could have a wide open space that is clean, with properly mowed grass and no dust to settle on the children, because the preschool is next to the road. Every time a car drives past, the children become full of dust. I wish it could be a proper place."



4.5.3 Additional Equipment

Participants thought that the ECCD centre could contribute further to health by acquiring more items of equipment. One participant wanted the number of toys to be increased as she felt that children fought over the limited supply. It was perceived that increasing the availability of toys would help prevent conflict and provide further opportunities for play, both of which were considered determinants of health.

Participants from two different FGs felt the children could benefit from cot mattresses. One participant explained that when the teacher was away from the centre for professional development and volunteers were busy cooking food, then the children were forced to lie on the floor to sleep rather than play outside unsupervised. The participant was concerned that without mattresses the children would become cold and more likely to become sick with the flu. In another FGD a participant confirmed the importance of sleep for child health, and felt that

young children who still needed a day time nap would benefit from having a mattress to sleep on as seen in the following suggestion from one participant:

“Sometimes these children at the crèche ... they are still small ... so, sometimes they have a sleep at a certain time. So, I wish they could each have their own little bed, so that when the children are told to go and sleep, they can each go and sleep in their own bed. But we don’t have beds.”

Referring back to a medical model of health, several participants felt that the addition to the ECCD centre of a first aid kit or a supply of over-the-counter medications would be useful. Because there was no medication in some homes it was suggested that the ECCD centre stock supplies of medications to give children when they were coughing, had body aches or stomach ailments, as described in the following response:

“There is no medication at home, and the parent wants the child to come to school. The child will come to school coughing. Other children will come to school with a part of their body being sore or aching, and here at the school we don’t have any medication to give the child to treat the problem that he might have and to alleviate it, so that his cough can be alleviated, or so that his stomach ache can be alleviated, or so that we can treat whatever he has. We’ve got nothing to help such children.”

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4.5.4 Health Related Workshops

One participant expressed a desire for the ECCD centre to provide further opportunity for children to develop their English language skills to promote emotional and social wellbeing. Many participants agreed that acquiring English language skills improved the child’s ability to progress with their education and gain additional social and life skills.

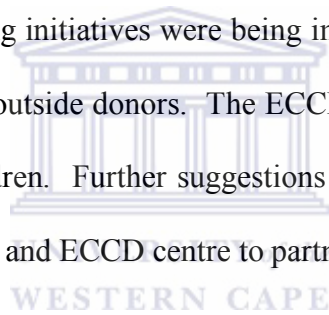
One participant felt that parents could benefit from further health education as noted in the following suggestion:

“And I wish we could have another place here at the crèche that helps us in health-related matters, to give us advice, so that we can have greater knowledge. Because maybe some things we know, and other things we don’t know”.

4.6 SUMMARY OF RESULTS

The study results show that participants viewed health in broad terms. Initially the responses described health in a somewhat narrow medical model. However, on further discussion the broader social determinants of health quickly emerged. Determinants of child health in the ECCD centre included healthy behaviour, the social and physical environment and the broader community context. Many of these determinants of health were seen as lacking in the community, therefore they were also perceived as challenges to health.

The inter-related challenges to health were dependent on the economic vulnerability of the community. Health promoting initiatives were being implemented in the ECCD centre by both the participating parents and outside donors. The ECCD centre was perceived as playing a key role in the health of the children. Further suggestions were given as to how to strengthen the ability of the family members and ECCD centre to partner together in promoting child health.



5. DISCUSSION

In order to develop effective health promotion initiatives within an ECCD centre, the perceived health priorities of the parents must be considered. Listening to parent voices encourages community participation in the health promotion project and may lead to empowerment of the participants if their views are heard and acted upon. This participatory process can also incorporate a strength-based approach, building on effective strategies and resources already present in the home and community environment. This is in keeping with Freeman's (2009) claim that the process of eliciting parental perceptions is the foundation for any health promotion plan. The purpose of this research was to explore the perceptions of health and child health needs held by parents of children in underserved ECCD centres in rural South Africa.

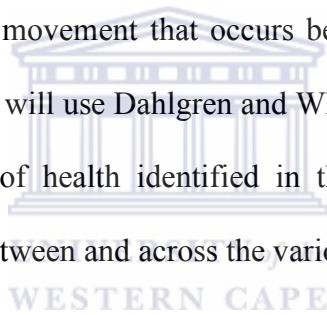
5.1 Holistic Definition of Health

This study found that parents defined health in holistic terms consistent with the WHO definition of health being a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1986). Participants identified physical, mental, social and emotional aspects of health, which according to Davis and Cooke (2007) have formed the basis of a more holistic, ecological approach to health promotion work in schools. More recent definitions of health in the literature describe health in terms of reaching one's full potential (Roden, 2003). The participants of this study spoke of the ECCD centre contributing to health by encouraging a child to develop fully in all aspects of life.

In this study, five recurring themes emerged as a result of exploring the perceptions of health and the health needs held by the ECCD centre parents. These themes included individual lifestyle factors, social interaction, environmental challenges to health, safety and lastly poverty. The results demonstrated a parental understanding of the broader determinants of

health, and were generally consistent with the determinants featured in the layers of Dahlgren and Whitehead's (1991) rainbow model (see figure 1).

Bradshaw (2008) notes that Dahlgren and Whitehead's simple model may suggest that the relationships between the determinants are linear, with the relationships existing in only two directions. Whereas, she argues that the determinants of health are in fact, much more complex and the layers inter-related. This study also serves to confirm the inter-related nature of the determinants of health. A journal editorial on models of the social determinants of health agrees with the complexity of these relationships. In the article an alternative metaphor of cascading bubbles is given, to highlight the dynamic nature of the determinants. The bubbles represent the interaction and movement that occurs between determinants of health (Wilcox, 2007). However, this chapter will use Dahlgren and Whitehead's (1991) model as a framework to discuss the determinants of health identified in this study, with the understanding that complex interactions occur between and across the various levels of determinants.



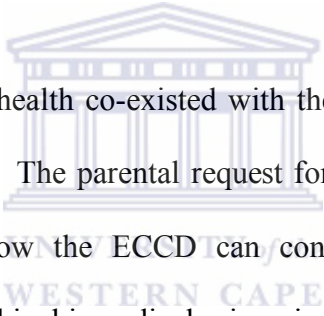
5.2 Biomedical Model of Health

The Biomedical model of health is not clearly identified in Dahlgren and Whitehead's diagram of the determinants of health. However since the biomedical model focuses on promoting health as an absence of disease, then it could be incorporated in the inner layer of unmodifiable risk factors for disease, such as age, sex and hereditary factors. Physiological factors include measurable levels of health as noted by Labonte (1997, as cited in Talbot & Verrinder, 2010).

This study showed that parents initially described health in terms consistent with a medical model. The participants were aware of the concept of germs that can cause illness, as seen in their description of some diseases being contagious and transmitted through coughing. They

spoke of the benefits of physically isolating ill children in the ECCD setting to prevent the spread of disease. Avoiding body fluid contact was also perceived to be important to health. The avoidance of body fluid contact is a significant concern in the South African context with a high prevalence of HIV infected persons.

The current study found parents were aware of their role in detecting and preventing illness which is consistent with the findings of Roden (2003), following her FGDs of parents' understanding of health behaviour. The ECCD centre was seen to have a role in preventing illness with the parents' suggestion of the mobile clinic visiting the ECCD centre, as a way to prevent communicable diseases through better immunisation services for the children.



A clear biomedical focus to health co-existed with the parents' understanding of the broader social determinants of health. The parental request for a sick bay to isolate sick children is a highlights an example of how the ECCD can contribute to health by focusing on the containment of illness. This biomedical view is contrasted with the participants later discussing in detail the underlying social determinants of health. Participants suggested some other medically focused improvements to the ECCD centre, such as equipping it with first aid boxes and a supply of over-the-counter medication. Sanders et al. (2008) point out that the focus of a lot of health promotion has been on the marketing of health goods to treat individual illnesses. They explain that this bio-medical approach is popular with donors. The requests from the participants in this study for additional supplies may have been prompted by the presence of the researcher as a white foreigner. Participants spoke of other white foreigners who donated clothing, educational supplies and food to the ECCD centres. The participants, who are already accustomed to receiving donations from outside donors, may have therefore suggested tangible improvements to the ECCD centre such as the requests for medical supplies.

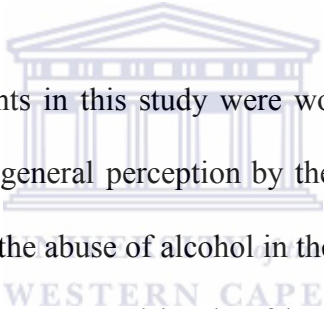
However, it is important to note, that these suggestions from the participants are all in keeping with four of the eight PHC activities identified at Alma Ata, namely; immunisations, preventing locally endemic disease, treating injuries and the provision of essential drugs (Talbot & Verrinder, 2010).

5.3 Individual Lifestyle Factors

Much of the literature regarding parental perceptions of health has focused on individual lifestyle factors or healthy behaviour (Roden, 2003; Yadrick et al., 2001). Consistent with previous research, this study found that participants perceived individual lifestyle factors as one of the influences on child health. However they demonstrated a deeper understanding of the influences on health and identified a range of social determinants of health (which will be discussed later in this section). The behaviours that were viewed in this study as promoting health for children included maintaining personal hygiene, adequate sleep, participating in recreation and being provided with a balanced diet. The ECCD centre was seen to be contributing to healthy behaviour in the children (and subsequently their families) by teaching personal hygiene skills, providing opportunity for recreation, and providing supplemental nutrition. ECCD centres have been found to have a positive impact on child nutrition levels in a study in Brazil. The Brazil study compared nutritional levels amongst children attending day care, with children not attending day care, and found the nutritional status was higher in the group of children attending day care (Silva et al., 2000). Like South Africa, Brazil is a country with extreme income disparity (OECD, 2010).

Several lifestyle factors were identified by participants in this study as either harmful or a challenge to health. Interpersonal violence and alcohol use have been linked in the literature (WHO, 2009b) and noted by Bradshaw (2008) as lifestyle factors occurring in South Africa,

which adversely affect health. This study also found that the prevalence of alcohol abuse in the community was viewed as detrimental to health. The community alcohol abuse was viewed as increasing the risk of crime and child abuse, which subsequently affected the perception of safety in the community. Children in the community were more likely to be subsequently exposed to violence as either victims or witnesses to family violence. The abuse of alcohol also impacted on issues related to child safety and the quality of parenting. Participants spoke about cases of child neglect that commonly occurred over the weekends when parents were distracted by drinking alcohol. A connection between parental alcohol abuse and poor childhood nutrition was identified in the current study when participants spoke of some community members spending their limited money on alcohol rather than family nutrition.



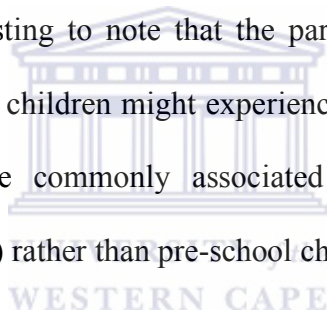
The majority of the participants in this study were women, who spoke of alcohol misuse by men in the community. The general perception by the participants was that, as women, they lacked the power to influence the abuse of alcohol in their community. This result illustrates the relationship between personal power and levels of health identified in the literature (Brennan Ramirez et al., 2008). WHO (2009b) notes in a fact sheet on violence against women, that women are more at risk for violence when factors such as lower socio economic status and alcohol use amongst their partners is present. The threat of violence could account for why some of the female participants felt that the alcohol abuse in their communities was out of their control.

5.4 Social Interaction

Dahlgren and Whitehead (1991) labelled the second layer on their determinants of health model as social and community networks. In this study, parents perceived the social environment as both a source of strength and at times a challenge, in their choice of providing a healthy

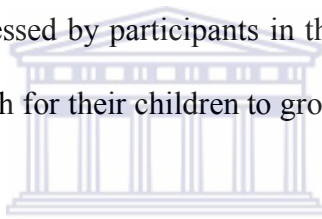
lifestyle for their children. This understanding is consistent with Freudenberg's (2007) notion that individuals make choices from within the constraints of their social context.

Social capital has been widely discussed in the literature as a key determinant of health (Baum & Palmer, 2002; deVilliers et al., 2005; Stern et al., 2010). The participants in this study did not discuss social interaction as a specific component of their perceived definition of health. However, several elements of social interaction were discussed such as feeling free and happy or being active and engaged in play. Participants were aware that the social environment influenced individual lifestyle factors such as smoking and alcohol use. They expressed their concerns that peer pressure could potentially influence their children to be involved in these risk behaviours. It is interesting to note that the participants were able to anticipate future challenges to health that their children might experience later in life, considering peer pressure over substance use is more commonly associated with adolescence and young adults (McMurray & Clendon, 2011) rather than pre-school children.



Issues related to social interaction were also often discussed as a determinant of health. In this study, the perception was that exposure to emotional stress and inter-personal conflict within families was detrimental to child health. According to Wilkinson and Marmot (2003), a rise in stress levels can lead to a decrease in health. In this study it was acknowledged by participants that the ECCD centre was at times a source of inter-personal conflict, by exposing children to other children who may have experienced violence within their respective homes. However, the dominant perception was that the ECCD centre was a resource for positive social interaction. This study's results showed that the parents saw the ECCD centre as teaching children social skills and conflict resolution skills.

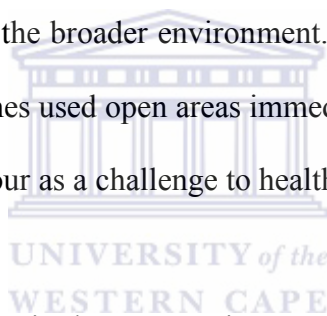
These results may offer some explanation to Catford's (2000) view that ECCD centre programmes can help prevent addictive and criminal behaviour in adults. These benefits may be due to the social interaction that occurs in the ECCD setting. Wilkinson and Marmot (2003) claim that the foundation for adult physical, mental and emotional wellbeing is set in place in early childhood. They explain that reduced stimulation in childhood and poor emotional attachment of children to primary caregivers, can lead to behaviour problems and risk of social exclusion in adulthood. In comparison, by offering increased child stimulation at the ECCD centre and providing parenting support to encourage strong emotional attachments between children and primary caregivers, this may help prevent such social problems in adulthood. Therefore, supporting the positive social interaction within the ECCD centre may be useful in addressing the concerns expressed by participants in this study regarding conflict and crime in their community and their wish for their children to grow into responsible adults.



The importance of play and recreation for child health has been cited in various studies (Baum & Palmer, 2002; Williamson & Drummond, 2000). In keeping with the literature, this study found that parents identified the physical benefits to child health from play and recreation. Parents viewed the opportunity for outdoor recreation provided by the ECCD as beneficial for health. They felt that it contributed to their child's physical development and enabled them to 'feel fresh', and 'active' which were terms parents used as both a measure and determinant of health. The participants also associated play with their child's social development, as they saw that children learnt to interact with one another through playing together. Utilising more intentional play as a means to explore the issues of gender roles and conflict resolution may be useful to encourage the development of non-violent masculinity discussed by Coovadia et al., (2009) and subsequently reduce the incidence of socially unacceptable behaviour. Developing pro-social behaviour is also recommended by Wilkinson and Marmot (2003).

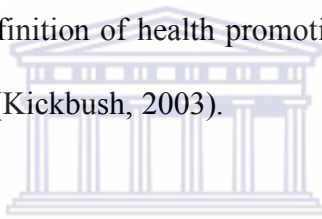
5.5 Environmental Challenges to Child Health

The results of this study moved beyond a medical model of health and incorporated a socio-ecological model. Consequently, the social determinants of health, including environmental challenges to health, were clearly evident. These findings support Talbot and Verrinder's (2010), explanation of the significance of how health is defined, and notion that a broad definition of health allows for broad ecological based solutions. Although some of the challenges to health in the community were initially identified as caused by individual behaviours, they were readily associated with broader challenges in the environment. Muchukuri and Grenier (2009) noted the effect of the environment in their study of social determinants of health in Kenya. In this study the challenges were viewed as being external to the participants and linked to the broader environment. For example, participants recalled that community members sometimes used open areas immediately outside their homes for sanitation purposes and saw this behaviour as a challenge to health and a potential source of disease.



Although this lack of sanitation in the community was perceived as a challenge to health, and a cause of illness, it was clarified that this behaviour occurred because of conditions in the environment, such as a lack of latrines leading people to use the bush. This environmental factor influencing health was intensified by the perception that the bush was not safe at night, as well as a decreasing area of bush due to deforestation. Harrabin (2010) in his news report of the global bid to tackle cooking smoke, explains that the reliance on wood for cooking (also identified in this study) increases pressure on a person's natural habitat. The outcome of this for the participants of the current study was the concern over raw sewage in and around houses. These findings which show the overlap between the sustainability of the forest and child health needs, reinforce the interrelationship between health and environment already noted in the literature (Dooris, 1999; McMichael & Butler, 2006; Talbot & Verrinder, 2010).

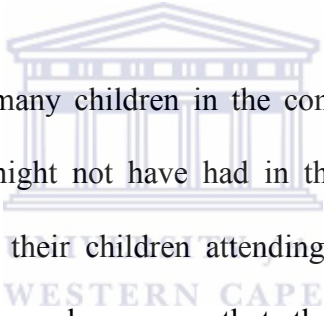
This study found that parents perceived that they participated in unhealthy behaviours because there were few other options, not because of their lack of understanding of the risks. These results support Williamson and Drummond's (2000) findings that parents' ability to choose a healthy lifestyle for their children was limited by challenges in their environment. Although it was not discussed, this conflict may have increased participants' stress levels, as they were aware they were participating in behaviours that they viewed as unhealthy, but over which they felt they had little control. According to Jackson (2007), many of the factors determining health are often outside a person's level of control. Wilkinson and Marmot (2003) acknowledge that stress and a lack of control over a person's work or home life can be detrimental to health. This further highlights the need for health promotion in the ECCD community, given that the definition of health promotion is to encourage people to have more control over their own health (Kickbush, 2003).



The living and working conditions in this study were definitely perceived by the participants as key determinants of the health of their children. The participants were also aware that these elements in the living and working conditions were either lacking or under resourced, so they perceived them more often as challenges to health (as opposed to resources). The physical environment was referred to briefly in the participants' definition of health when they discussed the importance of a clean environment. Throughout the FGDs other elements of the living conditions or physical environment were repeatedly discussed. In this study, most of the perceived challenges to child health were found in the living and learning environment.

Access to sufficient clean water was a key concern for the participants in this study. They saw this presented challenges to meet their child's health needs in terms of cleanliness, sanitation and nutrition. Many of the challenges to child health found in the physical environment were

inter-connected. Water was needed in order to maintain a clean environment. Participants were aware that access to water and a clean environment were needed in order to support healthy behaviours such as engaging in personal hygiene practices and clean food preparation for their children. These results were similar to the challenges identified in a study of a school based nutrition and health education programme in Zambia. Sherman & Muehlhoff (2007) found that school children were unable to implement the hand-washing behaviour taught at school, due to a lack of water at home. The same study also noted that parents did not see the link between health and broader determinants. However, in contrast to Sherman & Muehlhoff's (2007) results, this study found parents displayed great insight into the social determinants of health and made links between healthy behaviour and environmental influences on health.

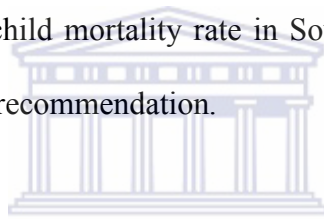


The ECCD centre provided many children in the community access to basic sanitation and hygiene facilities that they might not have had in their homes. However, parents saw an increased risk for illness for their children attending the ECCD due to overcrowding. In addition, some parents expressed concern that their children could become cold and subsequently unwell due the lack of electricity and sufficient heating in one of the centres.

Other environmental determinants of health identified in this study included pollution, exposure to indoor cooking smoke, and inadequate home heating. Bradshaw (2008) identified fossil fuel and traffic related air pollution as key concerns for health in South Africa. This study's results give further evidence to Sanders and Chopra's (2006) claim, that children from rural, predominately black communities in the Eastern Cape, were more likely to experience malnutrition, food security issues, a lack of safe sanitation and exposure to indoor pollutants. It is noteworthy that participants in this study cited all of the above examples from Sanders and Chopra (2006) as perceived challenges to child health in their own community.

5.6 Safety

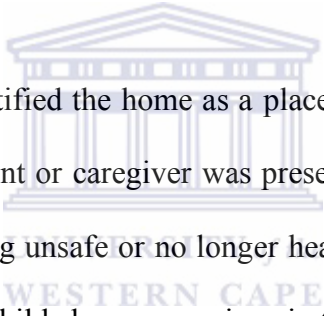
The theme of safety emerged very strongly in this study, from the data regarding both the definitions of health and the contribution of the ECCD centre to child health. The current study identified threats to child safety that included physical, emotional and sexual abuse. The level of insight displayed by the participants with regards to the influence of safety on health, was an unexpected inclusion in this study's results. However, a safe environment has been identified as a determinant of health in other studies conducted in South Africa (Stern et al., 2010). Safety concerns identified in this study support Sanders and Chopra's (2006) claim that the burden of disease among the poor in South Africa is largely due to trauma and violence. Coovadia et al., (2009) recommend that health promotion needs to address violence in the community, as it contributes to an increasing child mortality rate in South Africa. The concerns raised in this study are consistent with this recommendation.



The increased perception of violence in the community may be due to changing community demographics. According to a primary school teacher in one of the communities, the population of the settlements surrounding the ECCD centres have become more transient in recent years. The teacher indicated that this was due to people moving in and out of the community in search of work. Those that are transient are generally poor and unemployed, like many of the longstanding residents. However, they often do not stay long enough in the community to establish meaningful connections with other community members. Subsequently, there are an increasing number of residents who are not known to the longstanding community members (Personal communication with Nomhle, July 2010). Baum and Palmer (2002) found that when people did not know each other in the community they were more likely to be perceived as a threat to safety rather than a resource. They further explained

that limited social interaction between community members due to safety concerns resulted in decreased social capital, which further decreased the perception of safety in the community.

This study found that the presence of community spaces (such as the ECCD centre and the community centre), were perceived to be positive contributors to child health. This is consistent with Baum and Palmer's (2002) findings that a safe place to meet with community members increased their social capital and subsequently their perceived state of health. Davis and Cooke (2007) take this idea further by suggesting that these social spaces could be outdoor 'green' spaces. In addition to the benefits of social interaction and improved mental health, such 'green' spaces would also provide for physical activity and may increase the community members' connection with nature and their support for environmental issues.



Participants in this study identified the home as a place of safety for children. This was on the condition that the child's parent or caregiver was present and attentive to their needs. Parents spoke about children becoming unsafe or no longer healthy when they left the home or ECCD centre. Explicit examples of child abuse were given in this study and parents spoke about abuse occurring outside of the home, or when an adult did not actively supervise children. Interestingly, there was no discussion of any abuse that might occur within the home, or involving a parent or caregiver. This perception of safety in the home seemed to contradict the previously discussed examples of alcohol abuse and domestic violence that was noted to occur within homes of families in the community. In contrast, the co-existence of injuries and alcohol use has been noted in Raphael's (2006) review of the social determinants of health. According to his review, materially deprived living conditions and stress, increase the occurrence of physical injuries as well as alcohol use.

A lack of maintenance of the ECCD physical environment was identified in this study as increasing the children's risk to safety hazards. These hazards included inadequate fencing of the ECCD centre, which could potentially expose children to traffic injuries. Participants also noted that holes in the buildings allowed frogs to enter into the centre and could subsequently attract snakes, exposing children to risk of injury from snakebites.

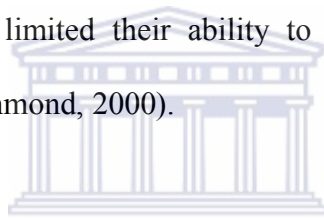
5.7 Lack of Resources.

Participants felt that as parents they needed additional resources to fully provide for their children and promote their health within the home. The study found that parents perceived the ECCD centre lacked sufficient resources and could be better equipped in order to further promote child health. For example the ECCD parents thought it was important to encourage sleep in order to promote good health in their children. The parents felt that it was particularly important for the toddler-aged children to maintain their daytime naps, even while at the centre. But they felt that this behaviour was difficult to facilitate at the ECCD centre due to a lack of cot mattresses for the children to sleep on.

Parents perceived that educational resources and toys were important for child development. Parents expressed concern that although educational resources were available at the ECCD centre, they were limited in number. The study participants' awareness of the importance of providing educational resources at the ECCD centre is consistent with the significance of brain stimulation noted in the literature, in order to encourage early childhood development (Guldbrandsson & Bremberg, 2005; Wilkinson & Marmot, 2003).

5.8 Poverty

Throughout the literature, poverty is cited as a structural determinant of ill health, which contributes to other determinants of health evident in the social and physical environment (Raphael, 2006; Roden, 2003; Sanders et al, 2005; Wilkinson & Marmot, 2003). The participants in this study identified factors such as nutrition and sanitation as a challenge to child health. However, for each of these identified challenges, the presence of poverty was an expressed underlying cause. Other studies using participatory research methods have also found that participants identified poverty as a determinant of health, such as the study conducted in a rural village in Bali on community perceptions of health (Pepali et al., 2007). Participants in the Canadian focus groups on low-income families' ability to promote child health thought that poverty limited their ability to practise healthy behaviours with their children (Williamson & Drummond, 2000).



The parents in the current study also regarded poverty as contributing to their perceived lack of resources. It was felt that this affected parents' ability to provide for their children, which they saw as potentially leading to undesirable behaviour in their children such as stealing, smoking and alcohol use and the fear that their children would engage in crime in later life. These findings support Wilkinson and Marmot's (2003) findings that poverty increases the risk of addiction, social exclusion and violent crime. Bradshaw (2008) also notes that unemployment leads to a higher risk for behaviours such as binge drinking and substance use.

As discussed previously, the participants in this study perceived poverty as one of the factors contributing to social isolation. As a result of this isolation, there was a decreased level of social capital experienced by some in the community. This current perception of poverty affecting social capital gives further evidence to similar ideas that Wilkinson and Marmot

(2003) present in their book on the basic facts of the social determinants of health. According to the literature, this perceived social isolation could consequently perpetuate the cycle of poverty and therefore ill health (Hillemeier et al., 2004, Marmot et al., 2008). Wilkinson and Marmot (2003) suggest that government should support families with young children, encourage community participation and reduce the effects of social isolation.

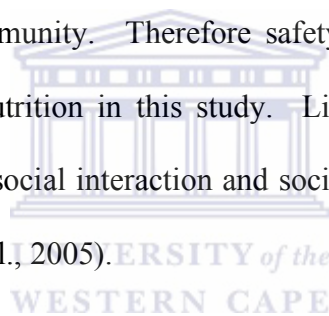
5.9 Inter-relationship of Determinants of Health

Referring back to the model by Dahlgren and Whitehead (1991) of the determinants of health, it was noted that the multiple layers intersect and influence each other. Other authors agree that the relationship between various determinants of health tends to be complex and inter-related (Jackson, 2007; Talbot & Verrinder, 2010; Wilcox, 2007). This was evident in this study; for example participants perceived that poverty impacted living conditions, which then subsequently posed challenges to nutrition and child health. In contrast to Sherman and Muehlhoff's (2007) evaluation of school based nutritional education in Zambia, parents in this study saw the links between health and nutrition. Study participants saw that for children to be active they needed adequate nutrition, which is a common parental perception (Roden, 2003). The broader determinants for healthy eating were also identified.

Parents viewed fruit and vegetables as healthy food. However, access to food was a perceived challenge to health in this study, likewise with the historically disadvantaged participants in the Mississippi based study of community perceptions on health (Yadrick et al., 2001). The current study participants felt that they often lacked money to purchase these healthy food items or to purchase gardening supplies in order to grow their own produce. This again highlights the influence of poverty on health (Bambra et al., 2010; Roden, 2003; Sanders et al., 2005). Some participants were able to provide their children with produce grown in home or community

gardens. But parents were aware that the crops were dependent on sufficient water. The community had experienced periods of drought and there was typically an insufficient water supply either by piped water, municipality tank water supply or rainwater tanks. Therefore there were broader challenges in the environment, which made it more difficult to implement healthy behaviours such as eating adequate fruit and vegetables. Sanders et al. (2008) remind us that the environment needs to be supportive for health, in order for healthy behaviour to occur.

The supportive environment includes the social environment, which also intersects with the other determinants of health. In this study the participants identified a reciprocal relationship between social interaction and the sharing of food within the ECCD centre and the local community centre. However, social interaction was both dependent on, and influenced by, the perceived safety of the community. Therefore safety and social capital were perceived to indirectly determine child nutrition in this study. Likewise, in another qualitative study of parents in the Eastern Cape, social interaction and social capital were perceived as influencing child nutrition (deVilliers et al., 2005).



Williamson and Drummond (2000) found that higher income parents were more likely to mention social determinants of health. In contrast this study revealed that parents living in impoverished rural areas with limited income were able to identify the social determinants of health. Furthermore, they were able to describe the complexity of the connections between these determinants of health. Parents used broad and holistic terms to define health, which included more than the absence of disease. Consequently, their suggested responses to the challenges for health were also broad and included aspects of both the social and physical environment in the ECCD centre.

5.10 The ECCD Centre as a Health Promoting Setting

Complex issues related to health have been identified in this study. Research has shown that issues that have not traditionally been associated with health have found effective solutions with a health promoting school approach (Davis & Cooke, 2007). The ECCD as a health promoting setting can allow for creative solutions to the broad health concerns expressed by participants. The HPS framework looks at the setting (such as the ECCD centre) as a whole and how it can be healthy (Department of Health, 2011). This is in contrast to the traditional health education approach, which would select one aspect of child health, such as nutrition, and then plan health education strategies to teach children about healthy eating (Barnekow et al., 2006).

Investing in the ECCD centres in rural Eastern Cape to create a health promoting setting is consistent with the recommendations of the CSDH (2008), which stressed the importance of equity from the start of life. The ECCD centre is the daily 'working' environment of the children. It is also the work environment for the staff and parent volunteers who assist with childcare duties. The settings approach identifies both a health promoting school or ECCD centre, and a healthy workplace as examples of a healthy setting (WHO, 2011). Providing professional development for staff is an important part of the HPS approach (Davis & Cooke, 2007). The ECCD centre as a HPS setting has an opportunity to promote the health of all its members, including children, families, staff and wider community.

In this study parents expressed a variety of child health needs including safety, social interaction and physical activity. An intervention that has been cited in HPS literature, which may be useful in addressing these expressed needs, is the use of a walking school bus. Children walk to school with adult supervision along a designated route, stopping to collect additional children along the way (Talbot & Verrinder, 2010). Such an initiative can have benefits for the

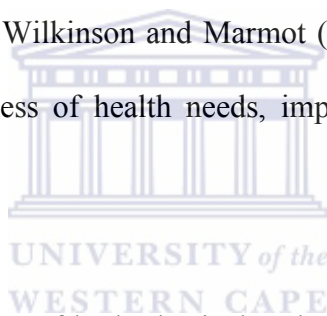
children, parents, and environment. Children have the opportunity to participate in exercise and social interaction and receive a safer route to school, all of which were expressed child health needs in this study. Parents gain opportunity for social interaction as well as physical exercise through participating in the walking school bus by supervising children. In situations where the alternative would be to drive a child to school, the walking school bus results in environmental benefits of less vehicle pollution issues (Davis & Cooke, 2007; Talbot & Verrinder, 2010).

The walking school bus initiative has been suggested in the literature as a way of incorporating health and environmental sustainability (Davis & Cooke, 2007; Talbot & Verrinder, 2010). This initiative could be a useful addition to the health promoting work of the ECCD centre. The ECCD centres involved in this study are already engaged in some environmental projects such as school gardens, environmental education and improving access to water. Further partnership between various stakeholders and service providers can provide for the dual focus of health and environmental sustainability to be addressed. As Davis and Cooke (2007) remind us, health-promoting settings such as the ECCD centres can be both healthy and green.

5.11 The Effects of the ECCD Centre on Parents

In addition to the beneficial role of the ECCD centre in promoting child health, this study found that parents felt they also benefited from belonging to the ECCD community. Wilkinson and Marmot (2003) acknowledge that a sense of belonging improves health. The increased social capital that resulted from parents being involved in the ECCD centre was also identified in this study. The perception was that parents had increased access to supportive networks when their children were enrolled in the ECCD centre. Increasing the parents' capacity to promote the health of their children is consistent with the second recommendation of CSDH (2008), which is empowerment of people.

The researcher in this study noted that participants were generally enthusiastic in their involvement in the FGDs and the isiXhosa speaking research assistant confirmed this observation. In two of the four FGDs, more participants than expected, arrived and were willing to participate in the discussion. At the conclusion of the FGDs, the participants mentioned that they had enjoyed the discussion and felt they had learnt more about health as a result. Baum (1998) discusses the fact that parental involvement in a health promotion initiative can be a useful advocacy strategy. This can occur as a result of the participatory process by raising participants' awareness of relevant issues and involving them in the decision-making process of a health promotion initiative. The enthusiasm and participation of the FG participants enrolled in this study might be a catalyst for the formation of parental support groups in the ECCD centre. Wilkinson and Marmot (2003) note that parental support groups can increase parental awareness of health needs, improve parenting confidence and prevent social exclusion.



The ECCD centre was a source of both physical and social resources. The physical resources included donations of used clothing and supplemental food for the children. Because parents identified poverty as limiting their ability to provide for their children, these donations were viewed as supporting them in their parenting role. Some participants were concerned about other parents who were 'not seen' and had their children 'hidden away' because of being embarrassed about their poverty. Subsequently these families did not benefit from the supplemental clothing and nutrition that children enrolled in the ECCD centre received. deVilliers et al. (2005) also found that decreased social capital resulted in participants being less likely to access resources.

6. LIMITATIONS

This study is limited by the small sample size. The researcher was restrained by the scope of a mini-thesis, which limit the number of focus groups. Therefore the theoretical saturation point normally recommended in qualitative research was not reached.

The focus groups required advanced facilitation skills and language skills. Because the group interviews needed to be translated during the discussion time for the benefit of the English-speaking researcher, this lengthened the process of the group interview. The translation could have been a distraction for the participants and limited the flow and flexibility of the FGDs (O'Leary, 2004). At times, the isiXhosa speaking research assistant may have given additional prompts during the translation, which may have influenced the participants' responses. The research assistant's English translation of the participants' responses, at times, used different words than those uttered in the original isiXhosa. This may have influenced subsequent responses in the focus group discussion for the participants who had the ability to comprehend English.

In addition, the researcher is both white and foreign born, which may have influenced the FGDs. There may have been some reluctance on the part of the participants to trust the researcher as an outsider, assuming that the researcher may not understand the context or might be judgemental of participant responses.

The researcher anticipated some of these limitations and ensured that the research assistant who was well known and trusted by the community first introduced her to the participants and highlighted her connection with other key stakeholders in the ECCD centre. Time was spent at the beginning of each FGD allowing each participant (including the facilitator and assistant

facilitator) to be introduced to the group. The commonality of all participants being parents was stressed in order to foster understanding and acceptance between participants. It was discussed in the FGDs that the researcher was living in the province rather than merely visiting for the purpose of completing the research. The researcher made further use of the isiXhosa speaking assistant to highlight the nuances of language, body language and cultural aspects that may have been overlooked.

In both focus group locations, the participants knew the research assistant, as a current or past ECCD educator of their children. This could have influenced the participants' responses either positively or negatively. It could be argued that the participants may have given answers that they thought would be approved of by the educator. On the other hand, the fact that the assistant facilitator was known and trusted by the participants could have enabled them to speak more freely. The feedback from one of the assistant facilitators following the FGDs suggested that the participants were participating more actively than she expected and appeared to be sharing freely. The participants were not informed of the professional role of the researcher as a primary health care nurse, in order to avoid influencing the discussion of definitions of health in either a medical or non-medical manner.

7. CONCLUSION AND RECOMMENDATIONS

The exploration of the perceptions of health and child health needs held by parents of children enrolled in ECCD centres revealed a complex range of inter-related factors. Parents described health in holistic terms, including physical, emotional and mental wellbeing. Health was viewed as more than the absence of disease and incorporated a state of feeling free and safe. In contrast to the professional view that the general public are not aware of the determinants of health, this study found that the parents' holistic view of health did, in fact, include them. This surprising depth of parental understanding of the determinants of health was a worthwhile outcome of the study.

Parents perceived the child health needs to include child nutrition, hygiene, social interaction, safety and protection from disease. Parents identified a range of determinants of health including a combination of lifestyle and living conditions. Healthy lifestyle choices were viewed as being limited by the socio-economic context of the participants. The living conditions of children enrolled in the ECCD centre were perceived as the major challenges to child health. These results were represented amongst all the layers of Dahlgren and Whitehead's rainbow model of health determinants. Overall, parents viewed the early childhood centres in Amathole District as a resource for health, and offered suggestions to further strengthen the centres role in promoting health.

Recommendations

Due to the complex inter-related nature of the determinants of health, a collaborative multi-sectoral approach is needed. Based on a strength-based approach (Baum, 1998), it is recommended that existing resources within the ECCD community be further utilised to promote child health. WESSA, as an environmental focused NGO is already working with

several ECCD centres in the area of environmental education. The HPS framework used in the health promoting schools approach could be useful in building on the environmental work of the eco-schools projects (Davis & Cooke, 2007) that WESSA is currently implementing. The SPECS model currently used by HPS projects in the Western Cape of South Africa (Department of Health, 2011) could be useful within the ECCD settings of the Eastern Cape. The five action areas of the Ottawa Charter forming the acronym SPECS, namely; skills, policy, environment, community and services are elaborated on below.

Skills

A focus on increasing personal skills of members of the school community is suggested (Department of Health, 2011). This focus includes not only the children, but also parents, teachers and caregivers in the ECCD centre, as well as the wider community. In order to facilitate the education and social support aspects described in this study, a parental support group involving parents and ECCD workers could be established. One function of this support group could be the implementation of the parenting education classes initially suggested by WESSA. These classes could be conducted at the ECCD centre and incorporate issues related to nutrition, hygiene and parenting. But it is important to keep in mind that parents are generally aware of the determinants of health, and therefore this depth of understanding can be utilised as an existing resource. According to Barnekow et al. (2006), health education is one of the ways to increase empowerment. As the participants in the parental and caregiver support group become more empowered, the group may evolve into an advocacy group for the ECCD centre to lobby for improved facilities and resources.

In planning health education, it would be useful for corresponding improvements to be made in the environment (Sherman & Muehlhoff, 2007; Williamson & Drummond, 2000). For example

health education on hygiene could be linked with initiatives to improve water supply to the ECCD centres, and nutrition classes need to be supported by initiatives such as strengthening the community-feeding programme and community gardens. Stern et al. (2010) conclude that health promotion strategies need to focus on more than mere behaviour change.

Training of parents and staff in issues related to water and sanitation and environmental sustainability may help to increase their own understanding and skills in environmental education, and encourage them to reinforce children's learning. Keeping parents informed on child environmental health issues was a commitment of the Busan Pledge, which came out of the 3rd International Conference on children's Health and the Environment (WHO, 2009a).

Policy

Creating healthy policy in the ECCD setting would be useful in order to clearly identify the centre's commitment to health promotion. These policies would give guidance to the centre and focus the activities towards health (Department of Health, 2011). A starting point in creating healthy policy would be to address some of the issues raised in this study, such as child nutrition at the centre, child safety and supervision, hygiene practises, maintenance of buildings and provision of water. It is important to involve both staff and parents in creating these policies that advocate for health. Children and parents could be asked to participate in 'vision' exercises (Cameron, 2005) where opportunity is given to draw or talk about ideas which would make their community and ECCD centre healthier (Baum & Palmer, 2002).

Environment

A safe and healthy school environment is crucial for the care and development of the enrolled children. The parenting groups could again be involved through education and action. Projects

that address the supply of water to the centre, adequate toilets, the establishment and cultivation of a school garden, and maintenance of ECCD buildings, could address some of the parental concerns raised in this study. Parents identified the need for secure fencing to the ECCD centre, which has also been given as an example of an entry point into a HPS project in the Western Cape (Department of Health, 2011). WESSA is in an ideal position to take the lead in supporting the ECCD community with some of these initiatives.

Community

Strengthening the interaction between the ECCD centre and community is the fourth aspect of the recommended SPECS model (Department of Health, 2011). One such initiative that could be implemented without requiring additional funding or resources, is the example in the literature of the walking school bus (Davis & Cooke, 2007, Talbot & Verrinder, 2010), This is recommended as a response to parental concern expressed in this study over road safety and personal wellbeing of children enrolled in the centre. Parents from the ECCD community could take turns to escort children to the ECCD centre, particularly from the far end of the informal settlement. The initiative would increase the visibility of the work of the ECCD centre within the community, as well as increase social interaction and social capital for the participating parents. Other such initiatives could evolve from the strengthening of networks between the ECCD centre, the parent support groups, the local community centre, sports groups and primary schools.

Services

The ECCD centre can advocate for the access of appropriate external services for the children and families. It is recommended that the mobile health clinic make scheduled regular visits to the ECCD centre. Health clinic staff could be involved in conducting health education sessions

for parents and ECCD staff on topics chosen by the participants. The clinic staff should conduct health and development assessments for children aged five years who are completing their learning at the ECCD centres and before they transition to the local school. Other local government departments and community-based organisations could be encouraged to accept an element of their responsibility towards health. Various sectors responsible for providing services for child welfare, nutrition, water and sanitation, transport, and housing can all be lobbied for more improved access and accountability to the ECCD community.

Further Research

The third recommendation from the CSDH (2008) was to raise public awareness of the social determinants of health. The commission also advocated for an expanded knowledge base and understanding of the social determinants of health in the health workforce. This study may offer some lessons to the health workforce in the Eastern Cape on the significant understanding of the social determinants of health displayed in the parental perceptions of health and child health needs. This study has not incorporated the views of attending children at the ECCD centre, and could be the focus of further research.

This research serves to strengthen the link between the perception of health and the social determinants of health, specifically in an ECCD centre setting. As Bambra et al., (2010) highlight, most of the research on social determinants of health is focused on the association between determinants and health. There is however, relatively little research regarding effective interventions to address the social determinants of health. Bradshaw (2008) has noted that further research is required to evaluate the effectiveness of interventions that respond to the social determinants of health. Further research could be conducted in the ECCD centres, to assess the effectiveness of the above recommended SPECS model.

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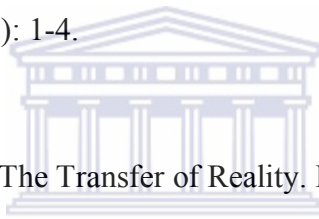
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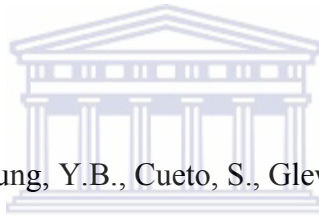
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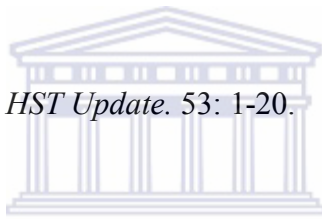
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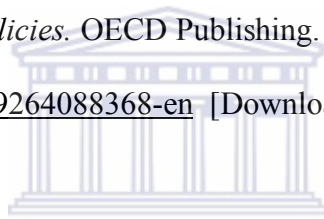
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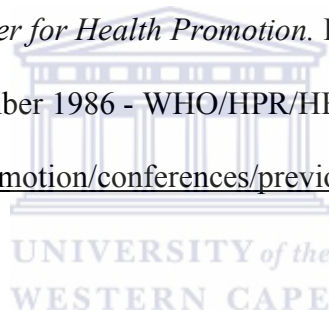
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PARTICIPANT INFORMATION SHEET

Dear Research Participant:

Thank you for taking the time to learn more about the research project that will take place in your early childhood centre/preschool. This letter is to give you more information about what is involved in joining the study.

Research Title: *Parental Perceptions of Health and Child Health Needs in Early Childhood Care and Development (ECCD) Centres in Amathole District, Eastern Cape Province, South Africa.*

Study Purpose: The research will form a mini-thesis. This is part of my requirement for a Master's degree in Public Health from the University of the Western Cape (UWC) in Bellville, South Africa. The research may be used in future published or unpublished material. The purpose of the study is to understand how parents' of children in early childhood centres in Amathole District, view the health and health needs of their children. It is hoped that the study will give a deeper understanding of the health needs in the centre and the role the early childhood centre can play in promoting the health of the children.

Confidentiality: Participating in the study will involve being a part of a group interview (focus group) with myself, and a research assistant. The interview will be recorded and transcribed. Your identity will be kept confidential. You will not be required to use your real name during the group interview. If you choose to participate in the study you will need to sign an informed consent form. This form along with any other study records will be kept in a locked storage box in my home office. The documents will be destroyed after the study is completed. You will be expected to keep the information discussed in the focus groups confidential.

Costs/Benefits: You may not experience any specific benefits personally from the study, but it is hoped the results will be helpful for the ECCD centre, in which your child is enrolled. Apart from giving your time to attend the focus group, there is no cost for you to join the study. The initial interview will take up to two hours of your time. You are free to decline to answer any question you are not comfortable with. If you choose to participate, you may withdraw from

the study at any time. No penalty will occur for you or any family member, should you decide not to participate in the research study.

Contact Details: Please feel free to contact myself, or my supervisor regarding any questions or concerns.

Miriam Mitchell – Researcher
078 623-1305
2816289@uwc.ac.za

Ruth Stern - Supervisor
021 959-2809 (School of Public Health)
rstern@uwc.ac.za





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PARTICIPANT INFORMATION SHEET

Research Title: *Parental Perceptions of Health and Child Health Needs in Early Childhood Care and Development (ECCD) Centres in Amathole District, Eastern Cape Province, South Africa.*

This research project at your early childhood centre: -

- Aims to understand the health needs of the children as described by parents
- Will be used for a mini-thesis for a Masters of Public Health degree
- May be used for further publications or presentations
- Involves a group interview with other parents to be conducted and recorded by myself and an assistant
- Will not result in any personal cost or benefit from participating in the study
- Is optional for you to join and you are free to leave the study at any time
- Will not require you to answer any question you are not comfortable with
- Will not penalize you or any child at the centre if you refuse to join, do not want to answer a question, or decide to leave the study
- Your name and identity will be kept confidential
- All recorded information regarding the study will be kept locked in my home office and then destroyed after the study is complete

Please feel free to ask any questions or concerns to myself, or my supervisor:

Miriam Mitchell – Researcher

078 623-1305

2816289@uwc.ac.za

Ruth Stern - Supervisor

021 959-2809 (School of Public Health)

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RECORD OF INFORMED CONSENT TO CONDUCT A FOCUS GROUP

Date:

Interviewer:

Researcher's UWC Student Number: 2816289

Telephone: 078-623-1305

Email: 2816289@uwc.ac.za

Institution: University of the Western Cape (UWC), Bellville, South Africa

Interviewee's pseudonym:

Place of interview:

Thank you for allowing me to interview you as part of the study *Parental Perceptions of Health and Child Health Needs in Early Childhood Care and Development (ECCD) Centres in Amathole District, Eastern Cape Province, South Africa*.

Please read this consent form and the attached Participant Information Sheet. If you wish to participate in the study, then your informed consent is required. Please give consent by signing this form at the interview. You will also be asked to give your verbal consent to the study on the tape recording of the group interview (focus group discussion).

Agreement

Interviewee's Agreement: I have read and understood the Participation Information Sheet. I have had any questions regarding my participation in the study explained. I freely consent to participate in a group interview as outlined by the Participation Information Sheet. I agree to keep the information shared in the focus group confidential.

Name:

Signature:

Date:

Place:

Interviewer's Agreement: I shall keep the contents of the above research interview confidential. The pseudonym noted will be used in any further documentation regarding the interview. The contents of the focus group discussions will be used for the purposes stated on the Participation Information Sheet, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with the interviewee.

Name:

Signature:

Date:

Place:





FOCUS GROUP GUIDE

Focus groups will be composed of six to eight participants.

1. The focus group facilitator will provide a welcome. This will include an introduction of participants and researcher
2. Explanation of focus group logistics, collection of signed consent forms, tape recording of session
3. Explanation of purpose of focus group
4. Group discussion following semi-structured outline. The isiXhosa speaking facilitator will translate the following questions into isiXhosa during the process of the group interview:
 - What is your understanding of health?
 - What do you think your child needs to be healthy?
 - What makes it easier for your child to be healthy?
 - What are the challenges to your child's health?
 - How does the ECCD centre affect the health of the children?
 - *Explore both positive and negative contributions to above*
 - What changes would you like to see at the ECCD centre in regards to meeting the health needs of your child?
 - How do you think these could be achieved?