Needs assessment of child health monitoring in early childhood development centers and other child-focused programmes within the Community systems strengthening (CSS) for health pilot, Cape Town.

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1. Definitions

CSS – Community Systems Strengthening

UCT – University of Cape Town

ECD – Early Childhood Development centre; “any building or premises maintained or used for the care of children. It includes a playgroup, crèche, aftercare centre, preschool and nursery school or similar” (City of Cape Town , 2015)

RTHB – Road to Health Booklet; free booklet used by parents and healthcare practitioners for monitoring and education on infant and child illness and development

TFT – Training in Transition

WFP – Women on Farms Project

EH – Environmental Health department

NGO – Non-governmental Organisation

Grassroots – NGO facilitating access to and improving quality of ECD services via training programmes

CPF – Child Protection Forum

DoH – Department of Health

DSD – Department of Social Development

CHW – Community Healthcare Worker

2. Background context

The current needs assessment was conducted by a medical student of the University of Cape Town (UCT) as part of a practicum via the Community Systems Strengthening (CSS) project.

CSS is a capacity development project managed within the UCT Department of Public Health (Health and Human rights) and is funded primarily by the European Union. It is aimed at building the capacity of community members and health committees to develop responses to the social determinants of health within their context (University of Cape Town, 2019). It aims to improve community wellbeing via community development and empowerment. It is a joint partnership amongst UCT, Training for Transition (TFT), Women on Farms Project (WFP) working with community members and Health Committees in Belhar, Gugulethu and Klapmuts.

CSS works within the three areas, via community participation, to assist communities realise their health rights and to promote community owned initiatives. Community members are trained on specific topics with the intention of using this new or updated knowledge to develop their own projects relevant to their communities (University of Cape Town, 2019).

The training topics include: 1) food and nutrition, 2) peace building (violence reduction), 3) health promotion (chronic and infectious conditions) and 4) child protection.

The training programmes allow CSS to build capacity, but also to gather information on people’s experiences, needs and strengths. CSS uses this information to develop models empowering

communities to advance and strengthen governance of their own health systems from within. This takes the form of training, conducting research, testing models currently in use, advocacy with regards to government departments (local and national) and policy, as well as community systems strengthening of health committees, and linkages with clinics, NGOs and other available resources both locally and internationally.

As a result of training provided, particularly with the Child Protection work package, new Early Childhood Development centres (ECDs) emerged during the project as well as other child-focused programmes such as aftercares and soup kitchens aimed at feeding children. The majority of these are unregistered. ECD centres are defined as "any building or premises maintained or used for the care of children. It includes a playgroup, crèche, aftercare centre, preschool and nursery school or similar" (City of Cape Town , 2015). ECDs have a rigorous registration process to ensure suitability of a facility in which children will be cared for; they must adhere to requirements from several City departments including land use and management, health, fire and rescue and social development (City of Cape Town , 2015). These requirements are difficult and, in many cases, impossible for ECDs to achieve, leaving many ECDs unregistered with little support. The needs of these ECDs/child-focussed programmes are numerous, however this assessment was limited to monitoring child health in ECDs which had emerged from the CSS project, with a particular focus on ECD knowledge of the Road to Health Booklet (RTHB), referral systems and links with clinics.

In particular, the RTHB was identified as an existing tool, underutilised in many facilities, that could be an extremely beneficial resource for improving child health screening and wellbeing at ECDs. The RTHB could provide an important link in the referral chain between the ECD/child-focussed programmes and clinics.

The RTHB is a formal booklet compiled and distributed by the Department of Health (DoH) in South Africa. It is the 'passport' to a child's access to health and the essential monitoring thereof. It is provided to every child in South Africa at birth and encompasses a wide range of data pertaining to the mother and child, their health status, immunisation schedules, growth patterns, developmental milestones, clinic/hospital visits and outcomes as well as important health promotion information for parents such as oral rehydration therapy for diarrhoea and breastfeeding assistance (Western Cape Government, 2019). It is regarded as vital to a child's health and development and when used correctly could improve the efficiency and effectiveness of child healthcare across the country, especially in under-resourced settings. The importance of the RTHB is underpinned by the intention that parents and caregivers can use the information to monitor their child's health and development, and take their child timeously for clinic visits.

The current assessment aims to uncover how the CSS pilot sites screen for child health and safety issues and utilise the RTHB. It also investigates the extent of support and referral systems that ECDs are aware of and have access to, and briefly explores the links between clinics and ECDs (within CSS project) and how this can be improved.

The needs assessment report mentions other challenges such as the social welfare of the children in the ECDs, as well as operational challenges at clinics. Although these are highlighted, they are not the main focus of the assessment. As health is multidimensional it is vital we mention the various factors which emerged during the assessment, that impact child health and wellbeing, however these cannot be explored in full detail.

The assessment recommends how communities in the pilot sites; support networks, clinics, DoH and other stakeholders can assist in overcoming the issues identified. As CSS focuses on training and strengthening support networks to empower communities, this was the main intervention explored. The information can also assist the DoH in identifying the successes and areas requiring improvement

within the health systems in the three communities studied, some points may also be useful to other communities.

The needs assessment is not an in-depth research assignment but rather a practical investigation, aiming to use collaborative methods to identify ECD needs, within the confines mentioned. In addition, the report aims to discuss practical ideas to assist, which can be sustained by the community after intervention by CSS or which can be supported by other structures.

3. Methodology

Information was collected using semi-structured, yet flexible questionnaires in focus group discussions as well as 1:1 interviews. This was done in two phases at three sites, namely Klapmuts, Belhar and Gugulethu.

Phase 1 primarily utilised focus groups (although some interviews were also conducted when focus groups were not feasible) with ECDs/child-focused programmes and community stakeholders, in December 2018.

Phase 2 involved interviews with clinic managers, with an additional interview with the Bellville Environmental Health Department in January and February 2019.

Questionnaires were used to guide discussion for focus groups and interviews, and were voice-recorded with permission from participants. Focus groups and interviews were predominantly conducted in English, however at Klapmuts Afrikaans was frequently used. In addition, the Gugulethu coordinator assisted with isiXhosa translation when required.

3.1 Phase 1 – ECDs/child-focused programmes:

The data gathering team comprised the main investigator, Michaela Levy (final year medical student at UCT) supervised and supported by L. Ryan (CSS Project Manager). The team conducted two focus groups with ECD and community stakeholders, in Klapmuts and Belhar. In Gugulethu individual ECDs were visited and interviewed by the research team.

Group participants were invited by CSS partners and coordinators. The groups included people working at or with ECDs/child focused projects in the pilot areas linked with the CSS project, and included members of the health committee and Child Protection Forum. The research team travelled to the communities and held focus groups and interviews locally. Participants signed a register, gave consent and were reimbursed in line with CSS policies.

The process was based on PAR principles (participative action research). The focus groups were guided by the questionnaire developed by the team (appendix A), covering all critical topics, as well as allowing for discussion on unidentified themes, ensuring that participants could also guide the research. Notes were taken during the discussions, however all conversations were also recorded.

In Gugulethu the CSS trainer met with the team to visit each ECD in the CSS programme, as well as assisting with Xhosa translations. Three ECDs were visited and the same questionnaire was used to guide the conversations with ECD staff. The conversations were -recorded.

On completion of focus groups and interviews, written and recorded information was summarised and analysed by the medical student. Gaps in the knowledge were identified and further follow up questions were drafted for facility managers and EH (Environmental Health) for part two of data collection.

3.2 Phase 2 – clinic facility managers and environmental health

Meetings with clinic facility managers were approved by DoH City of Cape Town who were supportive in allowing access to the clinics. Interviews were arranged with NY1 and Vuyani Clinics in Gugulethu and St Vincent Clinic in Belhar as well as Belville Environmental Health Department. A new guiding questionnaire (appendix B) was used in the interviews to explore the relationship between ECDs and clinics, including questions developed as a result of ECD focus groups. Although the interviews were guided by the questionnaire, open discussion allowed for the exploration of a variety of themes and ideas from the facility managers, promoting participation.

The interviewers met with the facility managers for one on one interviews. The relationship between ECDs and clinics was discussed and were voice recorded.

It was the team's intention to meet with all facility managers however this was not possible with the Klapmuts Clinic manager. This was multifactorial due to difficulties in communication and resource and time restraints.

3.3 Data analysis:

Data collected after each of the two phases was transcribed and summarised. This information was analysed to extract generative, common and diverting themes amongst the ECDs/child-focussed programmes and clinics at each pilot site. These themes were used to develop recommendations that could be implemented at different levels i.e. ECD, clinic, NGO and DoH levels.

3.4 Limitations/barriers:

Focus groups are a small sample intended to represent a community's viewpoint. In reality, this cannot always be extrapolated to provide an accurate representation; however, since the CSS ECD and related clinics, were the main target of this analysis, the groups interviewed can nonetheless provide valuable insight into the current situation in resource poor areas which relates to ECD knowledge on the RTHB, referrals/ relationships between clinics and ECDs, and the like .

Rationale for the assessment was to explore needs with regards to the RTHB, referrals and clinic relationships specifically within CSS pilot sites however, these are issues faced by many ECDs/child-focused programmes in other poorly resourced areas.

Some site-specific issues were uncovered e.g. in Klapmuts and Belhar focus groups were held, however in Gugulethu it was not possible for ECD managers to leave their place of work due to being understaffed/under-resourced, thus the project team met at their facilities. This allowed for in-depth interviews and observation of three ECDs for analysis.

Additionally in Klapmuts, Afrikaans was the main language of choice and the research team was not fluent, thus conversation was harder to follow and information harder to gather. However, a CSS partner from the Women on Farms Project assisted in translation. In Gugulethu the CSS trainer assisted with translations.

4. Discussion:

A number of generative themes were identified from the focus groups and interviews with ECDs and facility mangers/EH. These are discussed in the sections below, the first covering themes identified from ECD/child-focused programme data and the second describing themes from health service providers, .i.e. facility managers and EH.

4.1 Section 1 – ECD/child-focused programme perspectives:

In discussion with ECD staff and community members the following themes emerged: services provided by ECDs, their enrolment and assessments of children, RTHB knowledge and use; as well as referral and support systems utilised. Additionally, several important success stories are highlighted. The themes are discussed below.

4.1.1 Services provided:

Overall ECDs saw their services and community role as follows: to provide education and basic skills learning, including literacy and numeracy, as well as holistic child development. All ECDs mentioned that an important aspect of their work is to monitor the children's safety and wellbeing and involve parents and other services when needed/if available. The ability to screen, observe and refer children is discussed in greater detail later in the assessment. "I try to keep them safe and busy" said one ECD manager from Belhar.

When comparing the three communities, Belhar appeared able to provide a broader range of services due to ECD-specific training provided by a formal ECD training institution and its subsequent ongoing support. In addition, Belhar is supported by an active Child Protection Forum (CPF), whose role is elaborated on in the support systems section below. The communities of Klapmuts and Gugulethu appeared to lack support from a formal ECD training provider. However, they were supported by the Women on Farms Project and Gugulethu CSS coordinators, respectively.

It was clear that registered ECDs in the pilots sites were able to provide greater services to their communities than their unregistered counterparts, due to the larger support network and services accessed via Department of Social Development (DSD).

4.1.2 Enrolment, assessments and observations of the children:

Enrolment: Each ECD had an enrolment process for children entering their facility, including, at the most basic: personal details about the child and parent/family which were either recorded or photocopied and kept at their facilities. It was evident that areas which had received training, either on Child Protection from CSS or ECD training from a training provider such as Grassroots NGO, had more detailed and structured enrolment systems and a better understanding of the information required in the process. This was the case in Belhar, where many ECDs requested further details on the health and social circumstances of the child and family during the enrolment process (appendix C - enrolment form).All ECDs, mentioned requesting RTHB information at enrolment, however some were only able to receive copies of the personal details page and with limited information on immunisations, growth charts or the child's health status. This was particularly the case in Gugulethu, where some parents refused to bring in their actual booklets for fear of disclosing their HIV status. "The parents don't want to bring the clinic card [RTHB] … page 6 and 7 have the [HIV] status of the parents so it's not easy for them to bring the card" – ECD manager in Gugulethu. In Belhar and Klapmuts the booklets, if available, were photocopied in their entirety by the ECDs and used for monitoring the child's health and clinic visit dates. The reasons for the varying use of the RTHB is explained further in the RTHB section below.

Assessment and Observations: Assessment and observation of the child's safety and wellbeing was carried out at most ECDs. For physical health all ECDs mentioned "keeping an eye out" to see if the child "looked right". This concept of the child "looking right" was a common term used at each site, the definition differing at each facility depending on the extent of knowledge and referral options. Signs mentioned included fever, flu symptoms, coughing, rashes, obvious illnesses and changes in weight.

Observations varied from site to site and depended on the ECD staff knowledge, training and experience on the topic. Once again, those having received Child Protection training from CSS were better equipped for identifying and following up on issues. Additionally, the Belhar Child Protection Forum (CPF), initiated by community members subsequent to CSS training, provided further information and assistance specifically surrounding child safety and abuse. A CPF member said "It's difficult because the kids have a lot of problems, but they are not able to speak out at school… sometimes the kids want to speak to a mommy figure. I tell kids that after school we have a facility where you can come to and talk about this whole thing".

ECDs mentioned monitoring/ looking out for unexplained bruises, fractures and destructive, withdrawn or changing behaviour and language. In Gugulethu, creches with infants and younger children, highlighted nappy changes as an important way of checking for any sexual abuse by looking for discharge or swollen/damaged genitalia.

If issues regarding the child's physical health or safety were identified, all ECDs mentioned speaking to the parents as the initial step and thereafter making use of referral systems, if any were at their disposal. This is discussed in further detail in the referral and external support section below.

Sites did not show that documentation was necessarily taken each day; however, there were examples such as an ECD in Belhar, where referral forms were filled in when issues arose and referral/follow up was required (appendix D). This was designed by ECDs after training received from Grassroots.

4.1.3 RTHB knowledge and use:

Knowledge on RTHBs varied amongst the three sites. The most informed community members/participants on the RTHB was Belhar. It appeared that many had received formal training on the RTHB during Grassroots ECD courses. Therefore, all the ECDs asked for the booklets upon enrolment for continued monitoring of the child in their care. Important areas documented included: immunisations, growth (especially weight for age), overall development of the child and future clinic dates. This information was also used to remind parents about clinic visits, missed immunisations and any red flags advising parents to seek further care. This notably greater knowledge of the RTHB was clear evidence of the value of the ECD training and the potential opportunity to train ECDs on RTHB use and referrals. This will better empower staff through increased knowledge of child health and their ability to identify issues which could either be handled internally or referred appropriately.

In Klapmuts, no formal RTHB training has been conducted and most knowledge on the booklet was gained from personal/family use. "We have had no training, nature trained us" said one ECD manager at Klapmuts. Discussions highlighted a limited understanding of the RTHB and how to interpret important sections, such as growth charts. One participant explained these as "zig zag lines" making no sense. Despite this, some Klapmuts child focused projects, were still utilising the RTHB to remind parents of immunisations and clinic dates. However, this lack of Road to health knowledge means they cannot properly motivate parents to overcome the barriers preventing them from keeping up to date with their child's immunisation schedule. Examples of these barriers include the financial strain of parents missing a day's wages which in turn causes frustration for clinic nurses who have to deal with missed appointments. Registered ECDs are supported in a myriad of ways which allows them to use tools like the RTHB more effectively. For example in a registered ECD, Klapmuts clinic nurses and therapists (speech was mentioned) visit and check the booklets.

In Gugulethu there are multiple barriers to using the booklets. Some parents are not willing to provide more than a photocopy of the personal details page due to the booklet including confidential health information, including their HIV status. Additionally, ECD staff had no training on the booklets,

resulting in little understanding of the contents. Immunisations, growth or any developmental milestones were not checked adequately. One ECD staff member mentioned not understanding the booklet with her own children and cannot confidently explain contents to parents of children attending the ECD. “I don’t want to lie I don’t look at it [RTHB]… I don’t understand it… Starting from me, I want the training [on the RTHB]” – ECD practitioner in Gugulethu.

In contrast, another creche owner for infants in Gugulethu had a greater understanding of the booklet and had received training from multiple institutions including Grassroots. As a result the ECD owner insists that all parents provide their booklets to be checked each weekend, this allows for reminders regarding the immunisations in the upcoming week, clinic dates and monitoring of the child’s growth.

A dominant theme at all sites regardless of training received, was a lack of confidence in the ability to educate parents on this key tool (RTHB). Even individuals who were knowledgeable on the RTHB did not feel capable of cascading this information to parents effectively, nor answering questions adequately. ECD managers at Klapmuts said “I try to explain why the dates of immunisations are important… I don’t have the proper medicine information about the injections to explain it” and “I can see that the child is falling below the line for weight [on the RTHB growth charts] but I don’t know how to tell the parents because I haven’t done the training”.

It is evident that if ECD staff can explain the importance of having access to the RTHB and its value in child health and development, parents may be more willing to share it despite barriers to providing them.

4.1.4 Referral systems and external support:

Belhar had the most established referral system and related mostly to child protection. This stems from a broad support network involving importantly, the Child Protection Forum (CPF), mentioned previously. The CPF is one of the first points of referral for many of the ECDs within CSS Belhar, for assessment and counselling of the child. On further evaluation, referrals are made to a broader network via CPF such as social workers, SAPS and various affiliated NGOs and fora. These include Grassroots, Belhar Health Forum, Police Forum, The Pink Ladies, Life Choices and school governing bodies. CPF provides guidance and advice on issues ECDs are unsure of in relation to child protection. “Our main aim is to empower the kids [and parents], instead of just giving to them; we now help the parents to gain the confidence to depend on themselves” – CPF member describing how they assist parents in accessing support systems in the community.

ECDs describe starting the referral process by informing parents of the issues and encouraging them to seek further care from clinics, social workers, SAPS etc, and then, accessing CPF services if required. Belhar ECDs receive no visits from clinic nurses, social workers, DSD workers or other therapists, but describe a good relationship with the clinics and clinic nurses who are willing to help with information or when visiting with a child. “The [clinic] sisters don’t come visit us but they are very supportive when we go to them… the [clinic] supervisor’s door is always open she will assist at any time” – ECD manager at Belhar.

Klapmuts ECDs described a poor referral system and support network. ECDs occasionally refer to social workers, however this process was deemed ineffective as many cases were not followed up or dealt with correctly. Similar points were raised with respect to SAPS, where some participants felt they were apathetic and did not support important community events. “The Child Protection group had a big community dialogue and SAPs was invited and didn’t come… they never come to anything… they don’t take [child] issues seriously”, said a Klapmuts stakeholder. At the registered ECD in Klapmuts, as mentioned previously, clinic nurses and therapists are sent by DSD, and if any issues arise regarding certain children, these are raised in those visits. However, once a child is referred or seen by visiting clinicians, ECD staff are ill informed on the child’s progress or follow up.

Informal ECDs in Klapmuts feel powerless, with few referral options and frequently have to deal with issues themselves if parents are not willing to take issues further. In some cases, clinic staff are not always supportive of parents and ECD staff, particularly when clinic visits are missed. This further perpetuates the common practice of parents not following up on missed appointments. Rural and semi-rural areas like Klapmuts are under-resourced with fewer NGOs to support them. A few organisations such as Women on Farms, Family in Focus and Child Protection training from CSS were mentioned, but require additional support to improve child wellbeing and safety.

In Gugulethu no referral system could be described. Their options are to inform parents if an issue is identified or, in severe circumstances, they may be able to take the child to the clinic themselves. This seldom occurs due to the need for ECD staff to be attending to other children at their facility, frequently a 'one woman show'. There are instances of healthcare visits to ECDs to weigh children and check their immunisations, but this is difficult without the RTHB on hand, and ECD staff are unable to motivate parents to bring the booklets. "There was the health workers that came here… I wrote a letter to the parents to bring the clinic cards [RTHB] but they didn't bring… so the ladies [healthcare workers] were here but it didn't work" – Gugulethu ECD manager.

Overall, Gugulethu members describe little consistent direct clinic support, but are visited by Community Healthcare Workers sporadically. There was also no continuous support from a formal ECD forum at the time of the needs assessment. CSS has been providing support via various programmes, in particular their Child Protection training, mentoring and the like.

4.1.5 Success stories:

There are instances where NGOs, communities or individuals have acted to improve the systems and wellbeing of the children in their care.

Belhar's CPF is a significant example of a successful source of support and information for the ECDs in the area. They are an important step in referral for ECDs, and function as a mediator between the community and the different NGOs, social workers and SAPS in the area. CPF provides counselling and holds events with themes of child protection, child counselling and empowering parents and children to assist themselves with their financial and social difficulties. Through CSS and partners, ECDs have contact with organisations like Grassroots, whose training has empowered them with the knowledge and assurance to properly care for and protect the children in their care.

Other stories of success come from individuals within Gugulethu. For example, an ECD owner in Gugulethu, is also providing support to four children with autism; having no formal training in autism but learning from her own experience with her autistic son. The lack of knowledge within the community and amongst some clinic staff; often leads to stigmatisation of children with autism – telling them "they're crazy", "they need to be disciplined", and they need to be "hidden away". The ECD owner has developed techniques by trial and error on how to care for her son, by keeping him stimulated and loved. Subsequently community members have heard about her experience and successes with her child, and have sought her help with their own children. However, she still feels there is a limit to her knowledge and resources, and wishes to receive further training and support in order to better assist and educate her community on autism, reducing the stigma associated with it. CSS is trying to assist by linking the ECD with Autism Western Cape

4.2 Part two - Clinic Manager Perspective in Creche and Clinic Relations:

Discussions with clinic managers explored the following themes: relationships between clinics and ECDs, RTHB use and training within clinics, referrals between ECDs and clinics target requirements for clinic managers. These are elaborated on below.

4.2.1 Relationships between ECDs and clinics:

The relationships between the clinics and ECDs vary per site. In Gugulethu, both NY1 and Vuyani Clinics have contact with the ECDs, both registered and unregistered in their areas, using a list accessed via Environmental Health. Both Gugulethu clinics aim to do six-monthly visits to the ECDs providing vitamin A, deworming medication and checking the RTHB to remind about immunisation clinic visits. Clinic staff also occasionally visit ECDs for specific vaccination campaigns run by the provincial department, depending on current outbreaks, e.g. measles. Both clinics tried their utmost to assist ECDs but also contend with internal challenges such as labour turnover, transport and logistical issues involved with travelling to ECDs and the like. At Vuyani, Community Healthcare Workers are provided by Philani an NGO, who visit homes and ECDs to track and refer children for immunisations.

Facility managers have also been proactive. For example, one manager has attempted to build relationships with the local ECD forum but was met with resistance when attempting to initiate and maintain such relationships. This is, in addition to the internal capacity challenges which negatively impact the clinics ability to reach city required targets in vitamin A, deworming and immunisations.

Relationships between ECDs and clinics were not always strong - one of the facility managers felt that ECDs had lost faith in their clinic, as they have not been able to provide support services at ECD sites due to the many challenges mentioned. “I know we have lost so much faith [from ECDs] because we promised we would make it but we couldn’t come due to operational problems… you see it was just me running this place… we want to rebuild this [relationship] this year…” – clinic manager from a facility in the pilot areas. However, there are numerous efforts to improve these services and relationships, as well as utilising the trust Environmental Health has developed with the ECDs, by joining them on visits to the centres in the community.

4.2.2 RTHB use and training:

All clinics have some form of RTHB training for parents. This mostly takes place in the waiting room of the children’s clinics by the triage nurses and occasionally during consultation time with the nurse or doctor. The topics highlighted by clinic managers, include the importance of keeping the booklet at hand, immunisation and clinic visit schedules, oral rehydration for diarrhoea and breastfeeding. Their intention is to familiarise parents with the page numbers for specific information, notably those with preventable and common issues, as opposed to going into the detailed importance of each aspect of the book. These sessions are informal and unstructured training, impacted by the capacity of the individual clinics.

All clinics admitted that this attempt at promoting the booklets has limited success. “We do our bit and hope that at least some will catch on” – facility manager in pilot site. The booklets are not always seen as very user friendly and are overloaded with information which can be challenging in areas of high illiteracy and innumeracy. Additionally, the growth charts are complicated to explain and occasionally even staff require time and training to understand them. It appears these issues with the RTHB have not been solved by the release of the new RTHB which includes more written information than the previous edition. A facility manager said, “you get so many people that can’t read and now need to read all this”, “the thicker the book the more they won’t open it”.

Facility managers agree unanimously, that clinics are not able to provide enough education and promotion of the RTHB to parents. Internal challenges and resource constraints make practical learning opportunities difficult at the clinics. Additionally, many staff are still waiting to receive training on the new RTHB and sometimes, themselves struggle to provide parents with accurate information on it.

4.2.3 Referrals:

The clinics are not aware of any formal referrals received from the ECDs. Visiting nurses to ECDs may fill out referrals for identified issues, referring children to the clinic for immunisations, illness, growth faults or other problems. Vuyani clinic receives referrals from Philani Community Care Workers (CCW) who visit the ECDs but the CCWs are only monitoring the child; that is, not providing any healthcare themselves.

All clinics supported the idea of formal referrals from ECDs and subsequent follow up slips provided by the clinics in return. It is seen as a potentially good tool to assist in providing the clinic with the appropriate details of the child's health problem as the parent/caregiver is mostly not present at the ECD and not always knowledgeable on their child's health problem. "There is supposed to be a referral system… with a follow up slip at the bottom so we know what each person in the [healthcare] system has done… but it is not done [filled out]." – facility manager at one site. "It [a referral system] would be very useful because remember the mother is mostly at work so the person bringing the child to the clinic is a caregiver… they don't know the child and what is wrong with them… at least then we know some information about them" – another facility manager. This is done by primary schools in the St Vincent area, apparently with good outcomes. It would also reduce the resource burden, with fewer phone calls, nursing staff and CCWs required to monitor children outside of the clinic. St Vincent clinic did emphasise that ECD staff should be properly educated on appropriate monitoring and referrals, and should not attempt to diagnose the children.

4.2.4 Targets:

A common theme amongst facility managers is the emphasis placed on targets, despite being greatly overburdened and understaffed. These targets mainly include vitamin A and deworming campaigns, but also immunisations. This is a great motivation for managers wanting to improve their relationships with ECDs to attempt to meet these requirements, which they clearly are unable to reach at clinic level.

5. Recommendations

Recommendations have been summarised by groups providing the suggestion. This is a result of the participative research process, allowing interviewed participants to recommend actions. The heading "Recommendations made by the Research Team from overall analysis" is specific to reflections of the primary interviewer (student) and supervisor.

5.1 Recommendations made by ECDs:

Overwhelmingly ECDs believed they required further training in a few areas. These were most importantly surrounding RTHB and warning signs of child illness and abuse – some of this training has been delivered by CSS already. All communities, but specifically Gugulethu and Klapmuts, expressed the need for this training for themselves initially but then subsequently to allow them to further educate parents on the use and importance of the RTHBs. The information ECDs recommended for this training is integrated into the section, *5.3.2 RTHB Training,* below.

Additionally, ECDs wished for a more comprehensive list and explanation of support systems available to them in their areas and the implementation of referral systems which would allow them to make use of these services. ECDs in the Gugulethu and Klapmuts communities expressed the need for a central body that would be able to guide them as to these training opportunities and support systems. This existed in the form of the CPF for the Belhar community, as mentioned throughout this report.

In Gugulethu, ECDs recommended more formal follow up visits from Community Healthcare Workers for immunisations and growth monitoring of the children in their care. They wished for a more streamlined communication between themselves and their clinics, which was confirmed by clinic facility managers in the area.

5.2 Recommendations made by Facility Managers:

Facility managers agreed that increased RTHB knowledge and general child health amongst ECDs/child-focused programmes would greatly enhance their ability to provide healthcare to the children in their area. It would reduce the burden on clinics, allowing them to prioritise the sickest and neediest children. Additionally, cascading this information from ECDs to parents, would assist the clinic staff in parent training surrounding the RTHB – repetition being the key to educating the parents.

It is difficult for clinics to provide more training on RTHB, and as such the best level to target would be the ECDs. This could be done at individual ECDs or at evening forums involving parents, as these could be better attended after work hours. Some clinics were willing to attend ECD fora after hours if necessary, to promote knowledge transfer and build relationships.

It was suggested that the training currently rolled out for health professionals be simplified, to ensure there is no conflicting information and that it is accessible and appropriate for ECD staff, parents and caregivers. Environmental Health reiterated this point, as it is important that the training be aligned to current DoH RTHB training to prevent miscommunication.

5.2 Recommendations made by Environmental Health

The meeting with Environmental Health (EH) in Belville was an additional discussion supplementing information from clinics as well as providing an understanding of the structures and processes ECDs are required to adhere to. EH's relationship with ECDs mainly involves the registration process, inspections and information sharing at ECD fora. EH inspections, of both registered and unregistered ECDs, focus on the safety and health of the facility environment. This includes food hygiene, smoking exposure, overcrowding and fire safety amongst other criteria. They assured the research team that only in severe cases, where children are at risk, do they shut down ECDs, preferring rather to assist and guide them to improve their facilities.

EH tries to collaborate with other health professionals, e.g.as dieticians, to provide information at ECD fora specifically regarding diarrhoea and oral rehydration therapy – an important aspect of the RTHB. At these fora they are able to update their ECD lists so clinics can continually meet their vitamin A and deworming targets. An issue identified by EH, is the small numbers of unregistered ECDs that attend these meetings for fear of being closed down – "[it's] almost like there's a negative stigma around being unregistered". This will affect the numbers of unregistered ECDs on EH's database as well as the dissemination of key information provided at the fora and access to important support services linked to child safety and health.

Recommendations from EH around improving RTHB knowledge and use were:

- to ensure there is no conflicting information being spread about the booklets - "we would really appreciate it if there was one message"
- to make the RTHB training more interactive so ECD and community members can discuss issues and solutions they have found without fear of judgement

5.3 Recommendations made by the Research Team from overall analysis

This includes recommendations on RTHB training, potential referral systems, community support systems and finally recommendations to the Department of Health.

5.3.1 RTHB Training

It is clear from the investigation at both ECD and clinic levels in the three communities that RTHB is believed to be a powerful tool that is not utilised to its full capacity and thus further training is required. This training would aim to facilitate knowledge of the content and importance of the booklet for both ECD staff and parents. The outcome thereof will greatly improve ECD and clinic relations and ultimately child health in these areas.

From discussion with ECD and clinic staff the following should be considered when developing and implementing this training: The target population, location, most effective time for training to take place, the process of the programme (including structure and content of the training), the sources of information and the medium of communication. These points are discussed below.

1. *Target population*

There are two main target groups, the ECDs and related fora, and parents/caregivers. The ECDs include the staff working at the facilities, ECD fora, Child Protection fora and health fora members. The parents and caregivers include any person making use of the ECDs for childcare.

2. *Location*

The assessment highlighted that it is appropriate to provide training in a space not intervening in clinic services and is easily accessible by ECD staff and parents. This could include certain ECD centres or at ECD forum meetings.

3. *Time*

Parents and ECD staff work during the day and are therefore unable to attend training; hence classes in the evenings would likely be most well attended.

4. *Process*

Training should cover the structure and content and should target different levels of RTHB knowledge.

The sessions should be structured in a manner which allows information to be integrated and practiced. Therefore, most appropriate would include:

- Shorter sessions occurring over some weeks
- Less detail with focus on understanding basic key aspects
- Activities to reinforce information
- A space for reflection and questions.

Content covered should include:

- Pages where important information can be found
- Main themes/chapters of the new RTHB i.e. nutrition, love, protection, healthcare and extra care
- Key health promotion content relating to preventable and common issues ie ORT for diarrhoea, breastfeeding and warning signs of serious problems
- Growth charts should be explained as simply as possible
- Importance of each immunisation and their timeous administration including vitamin A and deworming.

Different levels of training should be available to community members. This should be divided into basic and advanced levels.

Basic level training would be aimed at those who have little to no understanding of the booklets. Those attending basic training would most likely be parents/caregivers and community members in the process of starting an ECD. The training would only aim to educate those attending the training and not include facilitation skills training for the cascading of information.

Advanced level training will further educate those who may have, for example, already received ECD training or other similar ECD courses. It would look at training content of these other courses and supplement them with further details to facilitate deeper understanding of the RTHBs. Additionally, facilitation skills training should be included after advanced training so ECDs can cascade RTHB information to parents with children attending their facilities. ECD staff should also be guided on how to use this information to motivate parents to provide ECDs with their child's RTHB.

5. Sources of information

It is important that information conveyed in the RTHB training is aligned with current DoH, clinic and NGO (e.g. Grassroots, Early Learning Research Unit) RTHB training. These departments and organisations should be contacted to discuss important training points and to seek guidance on effective methods.

With respect to the rollout of training on the new RTHB, some clinics have received training on the updated version, and some are still awaiting it. It would be useful and important to understand the changes made to the updated RTHB and align with this training, so no confusion occurs between old and new editions. Essentially training given by the different entities should not be conflictual and should highlight the same vital information.

6. Medium of communication

Due to current issues with the RTHB being too language heavy and in English; it was suggested by ECDs, clinics and EH to utilise visual and interactive material. The methods used should encourage discussion amongst participants allowing learning from each other's successes and failures.

Visual media such as video or cartoon pamphlets and posters may assist in retaining important information. These may be supplementary to the training sessions and could be distributed in clinics and other facilities and shown on screens in waiting rooms, especially for those who cannot access the training. This may also assist in alleviating the burden on nurses having to provide RTHB training at clinics under time and staff constraints. It should be explored if provincial RTHB training also includes these kinds of visual aids to prevent a duplication of effort.

Electronic sources could be distributed online or via WhatsApp on cell phones. This dissemination of information by the communities themselves may spark discussion amongst members rather than creating a hierarchical approach to obtaining the information.

5.3.2 Referrals

Discussion with ECDs and clinics revealed that there is little to no referral system existing between the two facilities. Although some ECDs e.g. Belhar, have attempted producing their own referral forms, there is no formalised system recognised by the clinics or ECDs. It is clear from ECDs and clinics that having a formal system in place with appropriate follow up, would greatly assist both facilities in caring for children. This would empower ECDs to act on issues identified by use of the RTHB or other screening/monitoring tools that require referral and would relieve the burden on clinics to have to seek out sick and defaulting children.

Further discussion with clinic managers is required to establish which information would be useful to clinics to include on an ECD-to-clinic referral form. It may be useful to contact schools in the areas to see what is included in their forms as well as contacting ECD training/service providers for input.

In this project's discussions with the communities and clinics, the information which appeared important are:

- the details of the child
- the problems identified
- services already accessed by the child
- a follow up section with information for the ECDs and parents about therapy given and any further follow up required.

5.3.3 Community support systems

An important outcome for CSS is developing the capacity of community members and strengthening the systems to promote support and sustainability. An example of this is the Child Protection Forum (CPF) from Belhar. This forum is a key support system to its community, providing services for child wellbeing and safety as well as a database to guide community members to the appropriate support structures. This has provided ECDs with invaluable support, empowering them to provide appropriate and effective care to the children at and outside of their centres. Such a model can be explored in other communities.

The ECD forum in Belhar and Klapmuts started by CSS participants is another example of how capacitated community members can support each other and strengthen their communities and child health. More ECD fora should be established in pilot site communities as they would already have contact with other CSS ECD networks. The services they currently provide to the ECDs and the community at large should be understood in lieu of support, training, meetings, information sharing etc. If these forums could extend their services to house databases of support available to ECDs and provide ongoing guidance, ECDs may feel encouraged when child health and safety problems are identified at their facilities. These services may include clinic contacts, social workers, SAPS, NGOs as well as other ECDs in the area that may be able to provide guidance to more vulnerable ones.

An essential part of strengthening these systems is assisting unregistered ECDs who are specifically vulnerable due to the lack of support and services provided to them. However, as the assessment highlighted, such formalised fora are also plagued by internal conflict and politics which can impede joint working towards holistic child health, development and safety.

Lastly, the ECD in Gugulethu has the potential to become a hub of knowledge on autism. Such vital information and services are not easily accessible in communities and providing support and further resources to this ECD would strengthen the greater community and child well-being.

5.3.4 Suggestions to Department of Health

In discussion with ECDs and clinics it became evident that there are opportunities for improvement at city or provincial level. Issues of understaffed clinics, lack of resources such as vehicles for ECD visits and nurses to do health promotion, are well known systemic problems faced by public healthcare facilities. These cannot be rapidly changed, however, some challenges can be resolved locally with little resource requirements.

City Health requires clinics to reach their child health targets, specifically those for vitamin A and deworming rates. ECDs are an effective place to access the age group requiring these medicines, and if done so would improve target numbers significantly. Thus, if City can assist clinics with staff,

resources, vehicles and contacts to facilitate this, it would improve these numbers and child health in the areas.

With regards to RTHB training, greater impact can be achieved if a form of training/awareness was available to parents from the start of their journey with the booklet i.e. at Midwife Obstetric Units, hospitals or clinics at the child's birth or first visits. If this was formalised, it would alleviate pressure on clinics to develop their own training on the booklets.

However, clinics and ECDs could reinforce learning whenever parents come across the booklet in different environments. Understandably there cannot be a nurse at the bedside of each new parent explaining the booklet, however other methods of communication such as pamphlets, online sources or videos would emphasise the booklets importance and use from the start. This could be accessed by the parent at any point and shared with community members, spreading the knowledge effortlessly.

6. Conclusion

Children's health requirements of the CSS pilot sites are numerous. The current needs assessment uncovered multiple areas encompassing child wellbeing which require support, as well as areas of success. The needs assessment, under the CSS topic of Child Protection (CP), aimed to explore the areas specifically where child health monitoring, existing referral systems and community support, could be improved. This was done with specific focus on the RTHB as an effective tool in child health monitoring. The results of this assessment have led to recommendations of practical and sustainable ideas to achieve the desired level of care

The needs assessment found that ECDs and other child-focussed programmes were important stakeholders in realising the health rights of children within the pilot sites. They provide access to children who may otherwise fall between the cracks; they are a space where information can be offered and disseminated to parents and communities and they are a starting point in the referral chain for a child in need of care.

With regards to RTHB, ECDs in the pilot sites had varying knowledge and use of the booklets. Communities and ECDs who have received CP training from CSS and ECD training from Grassroots, have a better understanding of the RTHBs. However, both ECDs and clinics expressed a need for more RTHB focussed training. The needs assessment goes into detail as to how this could be done, based on recommendations from ECDs, clinics, Environmental Health and observations, and ideas generated by the research team.

Additionally, the assessment revealed how CSS training has empowered participants to develop their own projects and fora in their communities. This has provided greater support to ECDs and the like in these areas. The Child Protection Forum in Belhar was a great example of this, leading to the recommendation that CSS explores similar models in the other communities. This will lead to a stronger link between ECDs and various referral options such as clinics, social workers and NGOs working in child wellbeing and safety.

Department of Health may make use of this health needs assessment to make changes to their own existing structures relating to child health in these and similar communities. They may also review their own training and dissemination of information with regards to the RTHB. Most importantly this needs assessment has provided insight into how CSS can develop further training for their pilot sites and realise their project goal of developing the capacity of community members to strengthen their systems from within.

7. Appendix

Appendix A:

Focus Group Questions for Situational Analysis of Early Childhood Development Centres use of the Road to Health Card in Monitoring Child Safety and Wellbeing

Themes:

These will not be asked directly but will guide each section.

1. What issues surrounding child wellbeing and safety are picked up at ECDs?
2. What assessment is done of the child upon entry and whilst at the ECD?
3. What knowledge do ECDs have of the RTHCs?
4. Do ECDs make use of the RTHCs?
5. What referral systems do the ECDs have access to?
6. What external support do the ECDs receive?
7. Additionally: What kind of training have you received in the past?

Questions:

What issues surrounding child wellbeing and safety are picked up at ECDs?

1. What issues of safety and health of the children in your care do you notice?
   - Physical health i.e. growth issues, malnutrition, sicknesses, poor feeding, disabilities
   - Developmental health i.e. milestones, not interacting, communicating, intellectual disability
   - Social wellbeing i.e. physical, emotion, sexual abuse, alcoholism, bullying, poor access to food and nutrition etc
   - Any others…?
2. Do you notice these issues whilst working with the children or are you looking for them?

What assessment is done of the child upon entry and whilst at the ECD?

1. When children enter your centre what do you ask for?
   - What is the process/enrolment protocol?
   - What documentation/information do you ask for?
   - Do you have any legal requirements of parents/children/other role players? E.g. forms of consent, indemnities, codes of conducts etc
2. Do you do a formal assessment of the child?
   - What specifically are you looking for?
   - Do you look for any signs of the issues we mentioned before (social, physical, developmental wellbeing) on arrival?
   - Do you look for any danger signs/red flags?
3. Do you continue assessing the children whilst they are in your care?
   - Is this done formally, or do you just pick up on things whilst playing/looking after the kids?
   - How do you look out for/deal with bullying at your facility?
4. Do you write down/record this information?
   - Where do you store it? Try uncover safety/confidentiality of information
   - Do you come back to it – following up on children etc?
5. Have you received any training on assessing children?
   - From whom?
   - What is it?
   - Do you find it possible/easy to do this at your centre?

6. Do you think the assessment you do of the children is uncovering the issues discussed above?
    - What improvements could be made?
    - What makes it difficult? I.e. resources, skills, training
    - What kind of changes would help?

What knowledge do ECDs have of the RTHCs?

1. What do you know about Road to Health Cards?
2. Where have you come across them?
    - Personal, family/friends, training, works i.e. ECDs
3. Do you think RTHC are useful?
    - What have you used them for before?
    - What uses do they have?
    - Cue immunisations, growth charts, danger signs, developmental steps dental hygiene if needed
    - Show growth charts, immunisation schedule examples etc

Do ECDs make use of the RTHCs?

Questions may have been answered already in previous questions, use answers to guide this area.

1. Do you use RTHCs at your centre?
    - When do you ask for them?
    - What do you use them for?
    - What specifically do you look for in them?
    - Are there any problems to using them?
    - Do you record any information from RTHC in your own records?
2. If not, what is the reason you don't use them?
    - If it's parents not wanting to produce them – uncover why not if possible
    - If it's because not part of their process– ask if they believe it could be useful
    - If not known about – ask if they would be open to training on RTHC
3. Do you think RTHC have a use in your centre(s)?
    - What is the use?
    - How do they believe they could be integrated into their system/care? At which point?

What referral systems do the ECDs have access to?

1. If you uncover an issue (referring to ones discussed previously) what is your process for dealing with it?
    - Do you have authorities you can report to?
    - Is there a formal process? E.g. forms, reports etc
2. Do you have facilities/services that you can refer parents/kids to?
    - What are these? Informal vs formal?
    - SW, clinics, healthcare facilities, SAPS, churches/other places of religion, counselling
3. Does the system of referring people work?
    - Do you use them regularly?
    - Do you trust them?
4. Are you able to follow up on children after you have referred them?
    - Do you keep record of children who have been referred or have returned to your care?
5. If no/poor referral system, what kinds of services would be helpful to have access to?
    - SW, clinics, healthcare facilities, SAPS, churches/other places of religion
    - How would this help?

- How would you like this to work?

What external support do the ECDs receive?

1. Does anyone visit you to help care/monitor the children's safety and wellbeing?
   - Who are they? SW, healthcare workers, SAPS, feeding schemes, training programmes
   - Government, NGO, formal, informal?
   - Is it helpful?
   - What services do they provide?
   - How often do they come?
2. What kind of support from outside your ECD would be useful to you?

What kind of training have you received in the past?

1. Have you or anyone in your centre received any training of any kind in the past?
   - What has it been?
   - Who was it from?
   - Specifically ask about child protection policy training from TFT
2. Can you tell me what kinds of things you learnt from this training?
3. Have you been able to use these skills at your facility?
   - What has worked?
   - What has made it difficult to implement?
4. What kind of training would you like in the future?
   - Suggestions on how to make using this training in your setting/facility easier

Appendix B:

Clinic Manager Meetings:

1. What is CSS? What is their purpose?

CSS is a joint in partnership w/Training for Transition, Women on Farms and Health Committees in Belhar, Gugulethu and Klapmuts. It is funded by EU.

CSS aims to look for opportunities in communities specifically via community participation to accomplish health rights of the people within it.

The information comes from gathering experiences of people's access to healthcare in the particular communities – i.e. via focus groups, interviews, dialogues (anything else?)

After the health problems and opportunities have been understood, next step in CSS is to develop models empowering communities to advance their health equity and strengthen governance of their own health systems

This takes the form of training, testing current models used, advocacy to higher powers and within communities and network strengthening of **health committees**

Work packages: participants in all 3 sites

1. Food and nutrition
2. Peace building
3. Health promotion
4. Child protection

CSS also provides communities with links to assistance both locally and internationally

CSS plans to use information gathered from the various projects involved to advocate for changes in policy and regulations aimed at empowering health committees in specific areas and in the broader health systems

2. What is this project? How does it tie in with CSS?

The current project under the banner of CSS is aimed at uncovering how ECDs and similar facilities working with children, screen for child health and safety issues. How/if ECDs make use the RTHC for this and the referral and support systems they have access to. This is being conducted in the areas of Belhar, Gugulethu and Klapmuts.

From gathering this information we will create a needs assessment and hope to understand how each community uniquely and collectively is able to overcome certain inequities in providing care for children as well as the barriers preventing them from doing so. Ultimately, we are trying to understand the needs of the community when addressing child health and safety. These needs may involve further training for ECDs on RTHC, assisting in strengthening networks already existing between ECDs, NGOs, clinics, health committees etc and creating new relationships if needed.

This information will also inform higher powers of the successes and areas requiring improvement within the health systems in the 3 communities.

3. Who am I? Who is CSS Manager and contact?

I am a final year medical student at UCT, assisting in this project. I am meeting with various community stakeholders i.e. ECDs, health committee members, clinic staff/management etc and gathering this information. I will be writing up the needs assessment. I am doing this with the

assistance and supervision of Miss L. Ryan, project manager of CSS. CSS would like to keep relationships with as many stakeholders in the community as possible, and the clinic is very important part of this. If you have any questions please contact her (email, number etc)

4. What have we done already? What was the feedback?

CSS Manager and I have met with various ECDs, health committee members and NGOs working with children in Belhar, Gugulethu and Klapmuts. We sat in focus groups with them and asked the questions regarding their screening tools, RTHC use, referral systems and support from other stakeholders in the community.

We have understood from these sessions that there are many different challenges when it comes to child health and safety – we have understood this from an ECD perspective and now we wish to understand from a clinic level. i.e. What kind of relationships do ECDs and clinics have? How are they able to support each other? What opportunities are there to use this relationship to improve future child health?

5. Questions for clinic manager?

What type of relationship do you have with ECDs in the area at the moment?

- Are you in communication?
- How do you communicate?
- What do you believe is the quality of the relationship?
- Formal vs informal? **Database** support?

Do ECDs make use of you as a place of referral?

- Any form of referral slips?
- Would you find this useful?
- What kind of barriers do you think are in the way of this?
- What makes this easier to do?

How are you supporting ECDs in your area?

- Visiting clinicians, CHW
- Advice and information
- Awareness sessions, campaigns? At clinics, at ECDs, at public space? Do they even know how to find them?
- Well attended, who attends?
- ECD members struggling to attend events in the week
- Immunisations, weighing etc
- Point of contact specifically for ECDs
- Special assistance at clinics – fast tracking

What are some of the barriers preventing better relationships with ECDs?

- What are some of the challenges you've noticed when working with ECDs/children being brought from ECDs?

How do you think the clinic could better support ECDs in the area?

What opportunities do you think exist to improve relationship between ECDs and clinics?

- What opportunities do both sides have?

How important is the RTHC in the clinic?

- Does the RTHC provide access to services at the clinic?
- How important is it that parents present it?
- What happens if there is no card?
- Are staff knowledgeable about content or RTHC? Do staff understand its value beyond the content?

Bigger picture - how can RTHC help improve child wellness and safety and future health?!

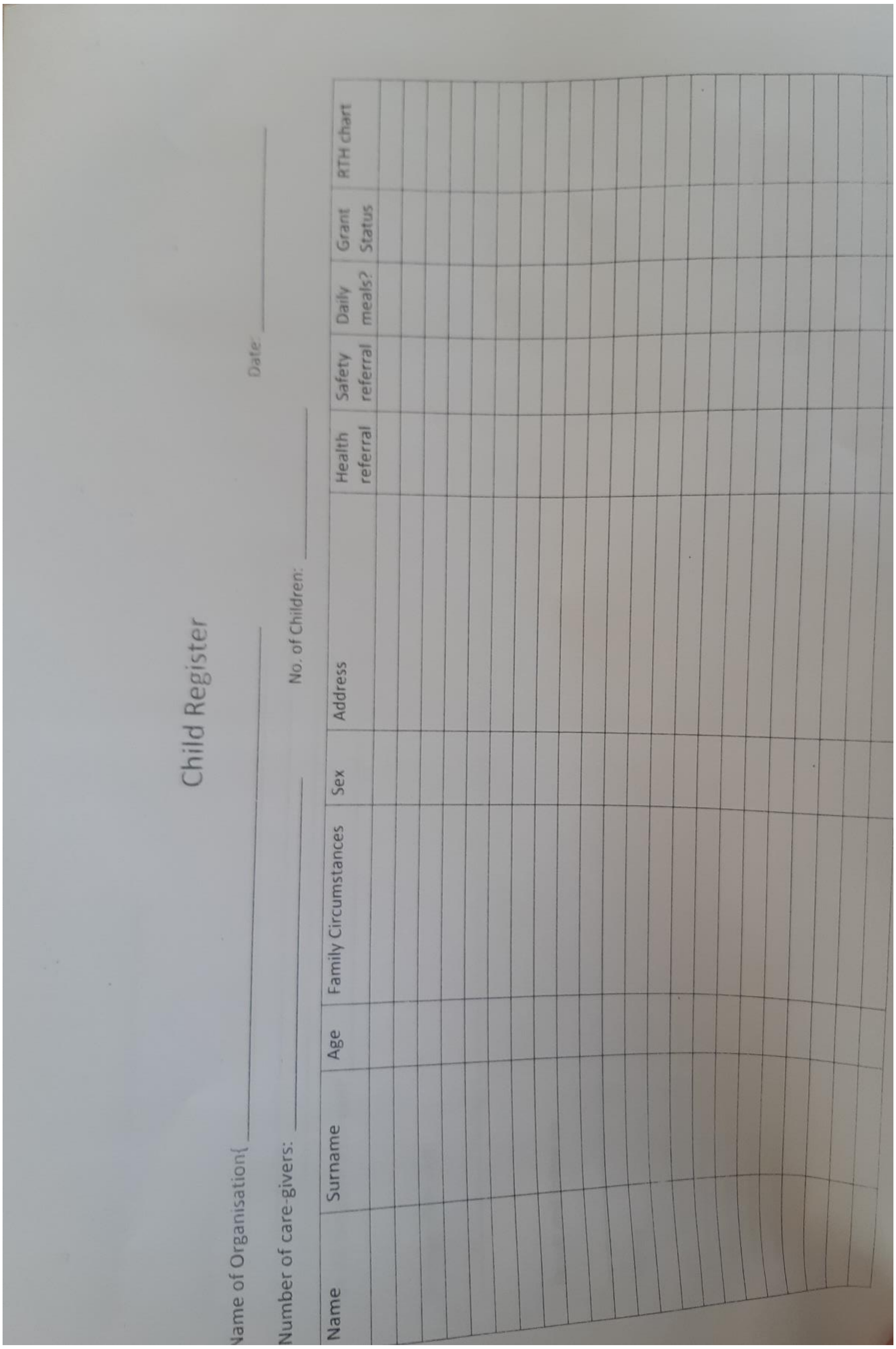
Is any **training** on RTHC done at/for the clinic staff/parents?

- How is this done?
- Where is this done?
- Who is it aimed at?

Do you think that ECDs have the knowledge about RTHC?

- Do you think this could assist them in providing better care to children?
- How do you think better RTHC knowledge could be provided to ECDS?
- Do you think the clinic could play a role in cascading this knowledge to parents and ECDs?

Appendix C: Enrolment form example



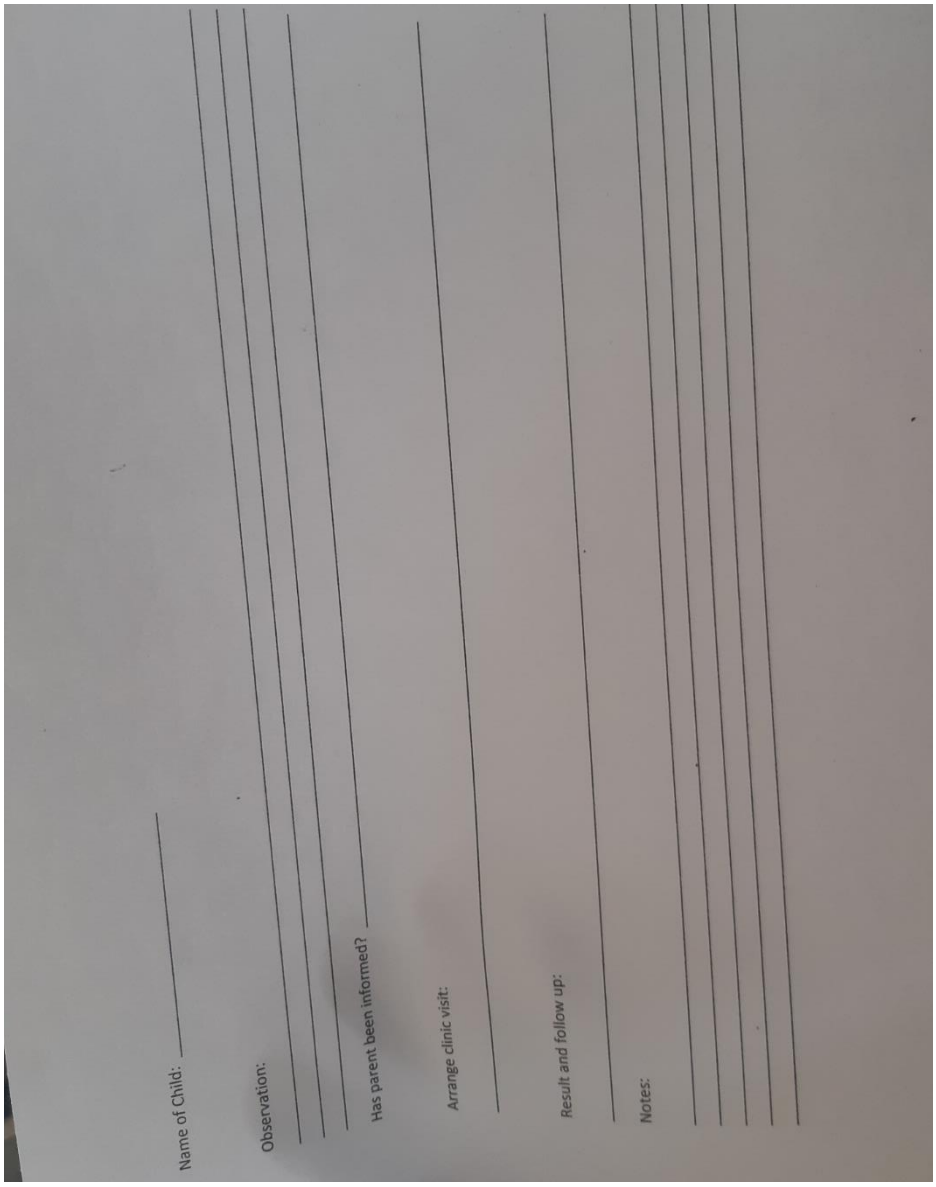
Child Register

Name of Organisation ______________________________ Date: ______________

Number of care-givers: ______________ No. of Children: ______________

Name	Surname	Age	Family Circumstances	Sex	Address	Health referral	Safety referral	Daily meals?	Grant Status	RTH chart

Appendix D: Referral Form Example



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