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The Role of Support Services for Children (0-5 Years) Growing up in Rural Zimbabwe

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Abstract

The study aimed at identifying forms of support services and service providers for children 0-5 years obtaining in rural Zimbabwe. The study was carried out in the context of the Convention on the Rights of Children (CRC). Both qualitative and quantitative methodologies were employed. Participants included children, parents, teachers and district level administrators. The rural Zimbabwean communities were Hwange, Binga, Zaka, Bulilima and Mangwe. The study found that support services for children 0-5 years included health, hygiene, education, nutrition and protection. According to parents, teachers and administrators; support was satisfactory in health, nutrition and protection. This was through efforts by government and non-governmental organisations (NGOs). Support was relatively limited in hygiene and ECD education services. This was due to lack of resources, limited parental knowledge and negative cultural practices. Consequently, parents required to be conscientised on the practices detrimental to child development and activities that strengthen their capacity to draw upon resources for the well-being of their families. There was need for government to offer holistic ECD programmes that provide high quality integrated care, building on parenting skills and advocacy for children. Such programmes cater for the children's school readiness skills, nutrition, health and psycho-social development.

Background to the study

The child is born into a family in a particular community which can be rural, urban or farming. Great effort goes into the child's upbringing by the parents. Omolayo (2018) states that in African culture, the child is regarded as a blessing and a valued gift that should be well cared for. In research carried out in Zimbabwe by Nyandiya-Bundy, Khani and Chiswanda (2002), it was found that most parents value their children and have high aspirations for them. They hope that their children grow to be disciplined, responsible and capable of leading productive and healthy lives. Amos (2013) argues that in order to realise these aspirations in their children parents are therefore, highly motivated to do the best for their children and to meet their needs. In a study focusing on the traditional parenting and child care practices

conducted by Brudevold-Newman (2018) among Zambian communities, parents said that one of the most difficult and painful experiences of being a parent is when they cannot provide for the basic needs of their children (food, clothing, education and medical care among others). However, parents find themselves helpless when they live in poverty.

Poverty is described as an inability to afford items that are essential in sustaining one's life (Beegle, Christiaensen, Dabalen & Gaddis, 2016). Similarly, it is viewed as lack of basic human needs such as clean water, nutrition, health care, education, clothing and shelter because of the inability to afford them (Jones & Summer, 2011). In a study conducted by Dyanda, Makoni, Mdukuti and Kuyayama (2006), it was noted that children growing up in the Zimbabwean rural communities' encountered pervasive complex challenges that existed in their environments due to poverty. It was pointed out that these children required more than just schooling but regeneration of their families' capacity to educate, care and protect them. However, the study did not supply evidence of who provides these services in rural Zimbabwe where need was identified, and the specific areas of need in which children required support, hence this study.

Several studies submit that poverty as a context for human development; particularly child development is a liability (Bicaba, Brixiová & Ncube, 2015; Jones & Summer, 2011; and Beegle, Christiaensen, Dabalen & Gaddis, 2016). Early Childhood Development (ECD) services to children living in poverty should consider health and nutrition. Families that live in poverty often exhibit helplessness to fend for their children because poverty has disabled their capacity to realise this obligation. In the same vein, current research states that the safeness and richness of the environment provided by parents and communities play a major role in initiating and enhancing good and intellectual skills, physical and emotional health (Ortiz, Daniels & Engilbertsdoóttir, 2012). This study is therefore, legitimate for one who wants to understand challenges encountered by caregivers in raising children living in poverty to enable informed intervention.

The Convention on the Rights of the Child (CRC) (1989), of which Zimbabwe is a signatory, has the following state obligations:

> "…ensure to the maximum extent possible the survival and development of the child" (Article 6 [2])

"…combat disease; through inter alia, the provision of clean drinking water" (Article 24 [2c])

"…recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (Article 27 [1])

"…in case of need, provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing" (Article 27 [3])

It remains to be studied how Zimbabwe, as a signatory to the convention, is realising its obligations, particularly in the poverty-stricken rural areas.

Research questions

The present study endeavours to answer the following questions:

i. What type of support services are found in rural Zimbabwe?

ii. Who are the service providers?

iii. In what areas of need are children supported?

Methodology

This study employed both quantitative and qualitative approaches. The quantitative approach was in the form of questionnaires which were close-ended. These questionnaires were for children, parents, teachers and administrators. Children included those enrolled at a preschool and had acquired verbal language. Parents included biological parents, grandparents, kinsmen and non-relatives who provided care to children. Teachers included ECD district trainers, the primary school head, teacher-in-charge [TIC] and ECD teachers. These complement parental care for children that are enrolled at the ECD centres and those that participate in their community outreach programmes such as infants and toddlers. Administrators comprised district administrators, education officers, nursing officers, and welfare officers. These singly or in collaboration, provide support services to families within areas of their jurisdiction. Chiefs and headmen were covered under the questionnaires for administrators. Questionnaires provided information to determine how many of the participants' attitudes and perceptions.

To complement data collected through the questionnaire, the qualitative approach was used. The qualitative approach focuses on the process of social interaction and is holistic in that it attempts to provide conceptual basis for understanding complex issues (Cohen, Manion & Morrison, K., 2018), in this case personal issues such as interaction of culture with child health, hygiene, nutrition, education and protection. This approach seeks insights rather than statistical analysis (Chih-Pei Hu & Yan-Yi CHANG, 2017). Hence interviews as follow up to questionnaires were carried out with administrators and teachers. Focus group discussions (FDGs) were conducted with parents to probe on information collected through the questionnaire. Observation of the physical environment of the study sites and implementation of support programmes which the researcher came across was done. Different sources of data and instruments for collection of data enabled triangulation. Triangulation is based on the argument that the best way to ensure that data collected provides the researcher with a valid picture of what is being measured are to cross-check data with that collected through another source or method. By focusing on the need to validate results and cross-check information from alternative sources with information collected through different methods, the researcher was assured that the results obtained are valid.

Location of the study

The study was carried out in rural districts of Hwange, Bulilima, Mangwe, Zaka and Binga. The rural population survives on subsistence agriculture and the majority of the rural populace are not or have never been formally employed (Beegle, Christiaensen, Dabalen & Gaddis, 2016). Nyandiya-Bundy, etal (2002) point to the problem in health access, hygiene, access to protected water and nutrition in rural communities. Consequently, rural Zimbabwe falls into the category of impoverished communities.

The sample

Purposive sampling was employed to come up with the sample. The researcher targeted the 'rich' source of data. Children were targeted because they are the ones who receive support. Parents and teachers have practical experiences with 0-5 year old children under their care. The administrators are the ones who authorize implementation of support services in their

districts and are directly involved in support programmes for the care of children, 0-5 years, in their respective districts.

Participants of the study included 200 children (3-5 year olds enrolled at preschools), 200 parents (100 biological parents, 2 chiefs, 3 headmen, 95 caregivers which included grandparents, aunts, uncles and other kinsmen), 200 teachers (50 primary school heads, 5 ECD district trainers, 100 ECD class practitioners and 45 teachers-in-charge) and 20 administrators (5 district education officers, 5 district administrators, 5 district nursing officers, and 5 district social welfare officers). The sample is representative as it reflects the characteristics of the target population. All participants were from the rural community and directly or indirectly involved in the care of children, 0-5 years. Because they are all part and parcel of the Zimbabwe rural community, their knowledge and experiences of support services for children in the age range, 0-5 years are considerably similar. The 5 districts represent 14% of the target population. As a result, findings can be generalized to the target population.

Procedure

A pilot study was carried out to test instruments, assess methodology and approaches, establish trends and adjust them accordingly. Five children from each of the three preschools visited participated in the study. The pilot study was conducted in Seke rural district at 3 ECD centres from which five children from each centre took part. Ten parents from each village in which the 3 ECD centres were located were involved in the pilot. The government district offices included the District Administrator (DA), District Social Welfare (DSWO), District Nursing Officer (DNO) and District Education Officer (DEO). Data were collected over 4 days. The results of the pilot revealed that support services were significant in areas of health, hygiene, nutrition, education and protection. It turned out that interviews with parents were time consuming as parents were in large numbers. As a result FDGs were employed. Unlike ECD teachers and administrators, parents could read and write but were not proficient with the English language. As a result FDGs with parents used the first language. Five days were spent collecting data in each district.

Data analysis

Both quantitative and qualitative methods were used to analyze data. Data collected through questionnaires were organised into categories and quantified into number [N] and their respective percentages [%] and presented in tables and bar graphs. A qualitative analysis of observed phenomena as well as statements and comments made during interviews and FDGs was made. Analysis of qualitative data was done at two levels. The first level was the coding and extraction of trends from interviews and FDGs, and the second level involved putting of noted trends into categories and giving meaning to the information.

Results

The study explored forms of support services and service providers for children 0-5 years obtaining in rural Zimbabwe. Tables 1 to 3 and Fig 1 to 3 show frequencies and trends of participants' views respectively. Data is presented as per research questions.

Research question 1: ***What the types of support services are?***

Table 1: Types of support services

Types of support services	Parents						Teachers						Administrators					
	Not Provided		Provided		Total		Not provided		Provided		Total		Not provided		Provided		Total	
	N	%	N	%	N	%	N	%	N	%			N	%	N	%	N	%
Health	11	5.5	189	94.5	200	100	21	10.5	179	89.5	200	100	-	-	20	100	20	100
Hygiene	14	7	186	93	200	100	30	15	170	85	200	100	-	-	20	100	20	100
Nutrition	9	9.5	181	90.5	200	100	32	16	168	84	200	100	-	-	20	100	20	100
Education	40	20	160	80	200	100	61	30.5	139	69.5	200	100	-	-	20	100	20	100
Protection	52	26	148	74	200	100	120	60	80	40	200	100	-	-	20	100	20	100
Material	174	87	26	13	200	100	146	73	54	27	200	100	13	65	7	35	20	100
Financial	190	95	10	5	200	100	163	81.5	37	18.5	200	100	15	75	5	25	20	100
Social	200	100	-	-	200	100	193	96.5	7	3.5	200	100	17	85	3	15	20	100
Emotional	200	100	-	-	200	100	188	94	12	6	200	100	18	90	2	10	20	100

Parents, teachers and administrators were requested to indicate types of support services for children 0-5 years obtaining in their community [Ref: Table 1]. According to parents, types of support services included: health 189 (94.5%), hygiene 186 (93%), nutrition 181 (90.5%), education 160 (80%) and protection 148 (74%). As far as teachers were concerned scores were: health 179 (89.5%), hygiene 170 (85%), nutrition 168 (84%), education 139 (69.5%) and protection 120 (60%). According to adminisrators, health, hygiene, nutrition, education, and protection scored 20 (100%). However, material, financial, social and emotional types of support scored less than 50% as per submissions of all participants. Overall, the results reveal general consensus among participants that there was support in health, hygiene, nutrition, education and protection. Other types of support services such as material, financial, social and emotional were limited.

Research question 2: ***Who are the service providers?***

Table 2: Service providers for support of children

Service Providers	Health				Hygiene				Nutrition				Protection				Education			
	Not provided		Provided		Not provided		Provided		Not provided		Provided		Not provided		Provided		Not provided		Provided	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
NGOs	18	90	2	10	5	25	15	75	4	20	16	80	15	75	5	25	15	75	3	15
Churches	10	50	10	50	18	90	2	10	16	80	4	20	8	40	12	60	10	50	10	50
Central Government	4	20	16	80	5	25	15	75	6	30	14	70	5	25	15	75	4	20	16	80
Local Government	10	50	10	50	16	80	4	20	17	85	3	15	10	50	10	50	8	40	12	60
Individuals	19	95	1	5	19	95	1	5	19	95	1	5	18	90	2	10	19	95	1	5

Administrators provided information on service providers obtaining in the community [Ref: Table 2]. Only administrators were engaged because they are the most informed in the aspect since they are the ones who sanction implementation of support services for children in their respective districts. Items assessed were those which participants said that children were getting support in. These were health, hygiene, nutrition, protection and education [Ref: Table 1]. According to administrators service providers for health included NGOs 16 (80%), churches 4 (20%), central government 14 (70%), locai government 3(15%) and individuals 1 (5%). As for hygiene the scores were: NGOs 15 (75%), churches2 (10%), central government 15 (75%), local government 4 (20%) and individuals 1 (5%). Scores for nutrition were: NGOs 16 (80%), churches 4 (20%), central government 14 (70%), local government 3 (15%) and individuals 1 (5%). As for protection, scores were: NGOs 5 (25%), churches 12 (60%), central government 15 (75%), local government 10 (50%) and individuals 2 (10%). Education service providers were given as: NGOs 3 (15%), churches 10 (50%), central government 16 (80%), local government 12 (12 (60%) and individuals 1 (5%). Overall therefore, it was noted that central government was active in providing support to children in all areas save for limitations on the part of resources. Churches provided support in health, protection and education. Hygiene and nutrition support provision were dominated by NGOs, whereas health, protection and education were dominated by central government. Support provision by individuals was insignificant.

Research question 3: ***In what areas of need are children supported?***

Administrators, teachers and parents provided information as these are involved in the care of children at district, school and family levels respectively. Items focused on were those that participants said children were getting support. These were health, hygiene, nutrition, education and protection.

Health Support

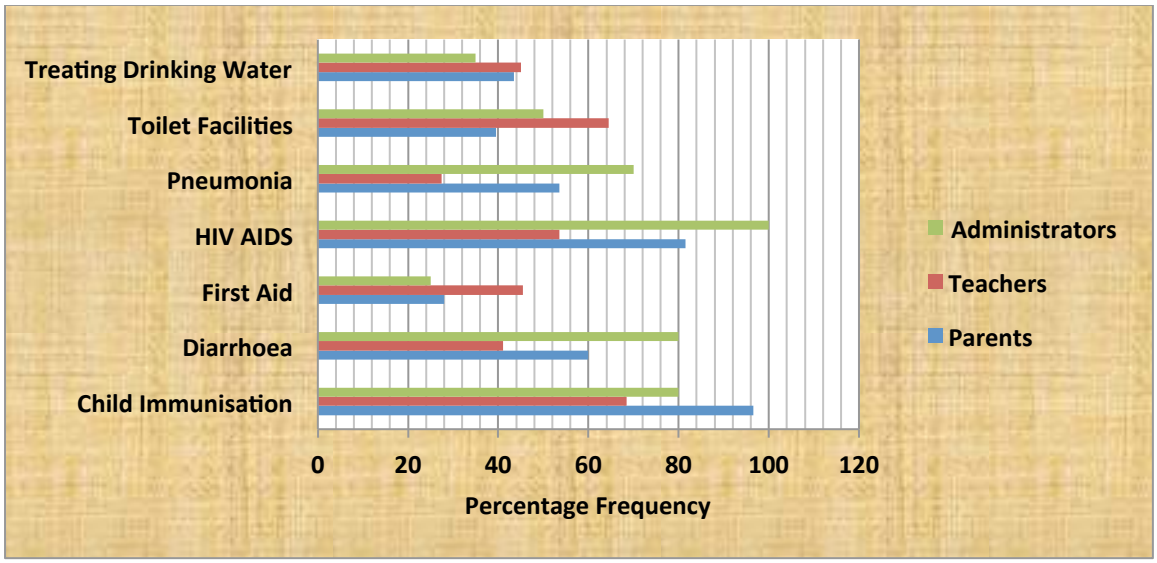

Figure 2: Health support for children

Fig 2 contains information on participants' responses about health support provided for children 0-5 years. According to parents, areas in which children were given support were: pneumonia 100 (50%), HIV and AIDS 164 (82%), diarrhoea 120 (60%) and child immunization 196 (98%). Items such as treating drinking water, toilet facilities and first aid scored less than 50%. As far as teachers were concerned, the scores were: toilet facilities 132 (66%), HIV and AIDS 108 (54%) and child immunization 14 (70%). However, provision for treated drinking water, pneumonia, first aid and diarrhoea scored less than 50%. According to administrators, there was support in the following: toilet facilities 10(50%), pneumonia 14 (70%), HIV and AIDS 20 (100%), diarrhoea 16 (80%) and child immunisation 19 (98%). Items that scored less than 50% as noted by administrators include treating drinking water and first aid. Overall therefore, there was general consensus among all participants that children got support in aspects of HIV and AIDS and immunisation. Parents and administrators submitted that support was provided for pneumonia and diarrhoea. However, according to teachers and administrators there was support in terms of toilet facilities.

Hygiene support

Table 3: Hygiene support for children

Item	Children						Parents						Teachers					
	Not always		Always		Total		Not always		Always		Total		Not always		Always		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Washing HbE	55	27.5	145	72.5	200	100	39	19.5	162	81	200	100	50	25	150	75	200	100
Washing HaE	37	14	172	86	200	100	39	19.5	162	80.5	200	100	50	25	150	75	200	100
Treating WbU	64	32	136	68	200	100	51	25.5	149	74.5	200	100	74	37	126	63	200	100
ToothB	130	65	70	35	200	100	46	23	154	77	200	100	156	78	48	24	200	100
Toilet use	30	15	170	85	200	100	54	27	146	73	200	100	66	33	134	67	200	100
Regular CB	28	14	172	86	200	100	48	24	156	78	200	100	50	25	150	75	200	100
Ironing CC	175	87.5	25	12.5	200	100	51	25.5	150	75	200	100	103	51.5	97	48.5	200	100
Cutting N	112	56	88	44	200	100	48	24	152	76	200	100	107	53.5	93	46.5	200	100
Cleaning H	120	60	80	40	200	100	48	24	153	76	200	100	123	61.5	77	38.5	200	100
Changing CR	115	57.5	85	42.5	200	100	44	22	156	78	200	100	112	56	84	44	200	100

Key: Washing HbE - Washing hands before eating, Washing HaE - Washing hands after eating,

Treating DW - Treating drinking water, ToothB - Toothbrushing,

Toilet use - Toilet use Regular CB - Regular child bath, Ironing CC - Ironing children's clothes, Cutting N -

Cutting nails, Cleaning H - Cleaning hair,
Changing CR - Changing clothes regularly

Information for hygiene support was obtained from children, parents and teachers [Ref: Table 3]. Children responded to this question because they are the ones who receive the support and parents are the primary caregivers of children, complemented by teachers. Administrators were not asked this question because they do not interact with children on a day-to-day basis. According to children support in hygiene activities was in: washing hands before eating 154 (73.7%), washing hands after eating 136 (68%) and treating drinking water 172 (86%), toilet use 170 (85%) and regular bath 181 (90.5%). As far as parents were concerned, all items scored more than 50%. According to teachers, items such as washing hands before and after eating, treating drinking water, toilet use and regular child bath scored more than 50%. Overall, therefore, hygiene support was given in aspects that include washing hands before and after eating, treating drinking water, toilet use, and regular child bath. However, there was consensus between children and teachers that there was limited support in hygiene aspects such as tooth brushing, ironing children clothes, cutting nails, cleaning hair and changing clothes. On probing teachers and children cited lack of resources like toothpaste, firewood or paraffin for use in ironing clothes, nail cutters, soap and clothing due to poverty.

Nutrition support

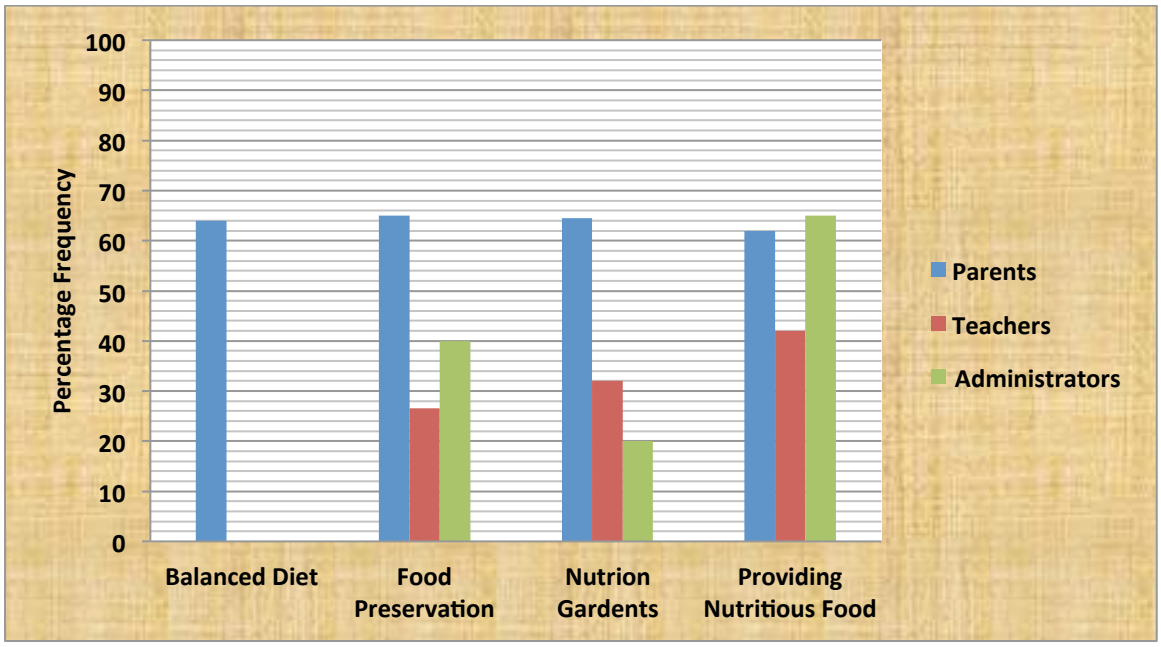

Figure 3: Nutrition support for children

Information on nutrition support was solicited from parents, teachers and administrators and is presented in Fig 3. Items about which information was collected were: balanced diet, food preservation, nutrition gardens, and providing nutritious food. According to parents all items scored more than 50%. As far as teachers were concerned, nutrition support was in the form of: food preservation 56 (28%), nutrition gardens 64 (32%) and provision of nutritious food 84 (42%). According to administrators, nutritious food scored 13 (65%) whilst food preservation and nutrition gardens scored less than 50%. After probing it was noted that most support services were external and they would not focus on preservation and nutrition gardens because the community has nothing to preserve and no sustained nutrition gardens. Provisions like "Zunde ramambo" (a communal production and storage of food presided over by the chief) has been abandoned due to limited agricultural inputs as a result of poverty. Both teachers and administrators were of the view that there was no support in terms of balanced diet.

Overall, therefore, nutrition support was satisfactory in terms of provision for nutritious food, and relatively limited in aspects such as balanced diet, food preservation and nutrition gardens. It was verified through observation that some nutrition gardens were not satisfactorily operational. Pieces of land were set aside and fenced, but most of these had no crops. Seed and water were cited as problems. Nutritious foods in the form of porridge and barley wheat (commonly referred to as 'bulgur') were provided by NGOs under feeding schemes targeting children under 5 years. It was also verified through observation that some nutrition gardens were not satisfactorily operational. Pieces of land were set aside and fenced, but most of these had no crops. Seed and water were cited as problems, as parents lacked the financial resource to procure agricultural inputs and drill boreholes at their homesteads and ECD centres.

Education support

Table 4: Education support for children

SA	Parents						Teachers						Administrators					
	Not provided		Provided		Total		Not provided		Provided		Total		Not provided		Provided		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
PLM	124	62	76	39	200	100	107	53.5	93	46.5	200	100	9	45	11	55	20	100
PLPC	132	66	68	34	200	100	153	76.5	47	23.5	200	100	16	80	4	20	20	100
ECS	61	30.5	139	69.5	200	100	83	41.5	117	58.5	200	100	2	10	18	90	20	100
CHS	64	32	136	68	200	100	79	39.5	121	60.5	200	100	7	35	13	65	20	100
AECDc	150	75	50	25	200	100	97	48.5	93	46.5	200	100	13	65	7	35	20	100
ABC	110	55	90	45	200	100	128	64	72	36	200	100	19	95	1	5	20	100
HRP	142	71	58	29	200	100	165	82.5	35	17.5	200	100	12	60	8	40	20	100

Key: SA – Support Aspect PLM – Providing learning materials
PLBC – Preparing lunch box for the child ECS – Encouraging children to do sport
CHS – Child homework supervision AECDc – Access to ECD centres
ABC – Access to birth certificates HRP – Human Resource provision

Table 4 contains information on support for children in the area of education. According to parents, children got support in terms of encouragement to do sport 139 (69.5%) and child supervision of homework 136 (68%). As far as teachers were concerned, the scores were: encouragement to do sport 117 (58.5%) and child supervision of homework 121 (60.5%). According to administrators scores were: encouragement to do sport 18 (90%) and child supervision of homework 13 (65%). Other items scored less than 50%. All respondents were agreeable that support was limited in the provision of learning materials and lunch box for the child, access to ECD centre, access to birth certificates and human resource provision. The

main overall pattern was consensus among parents, teachers and administrators that children were encouraged to do sport and that their homework was supervised.

It was also noted that there was lack of education support in aspects such as provision of learning materials and lunch box for the child, access to ECD centre, access to birth certificates and human resource provision. Through probing during interviews, it was discovered that communities did not provide children with lunch boxes because they believed that this was catered for through NGO feeding programmes. As for the other aspects such as provision of learning materials, access to birth certificates and human resources, communities lacked the financial resources to pay for such support services though they were available.

Child Protection

Table 5: Child protection support

Protection Aspect	Parents						Teachers						Administrators					
	Not provided		Provided		Total		Not provided		Provided		Total		Not provided		Provided		Total	
	N	%	N	%	200	100	N	%	N	%	200	100	N	%	N	%	N	100
Child Abuse	36	18	164	82	200	100	34	17	166	83	200	100	-	-	20	100	20	100
Gender Discrimination	25	12.5	175	87.5	200	100	13	6.5	187	93.5	200	100	-	-	20	100	20	100
Road Safety	20	10	180	90	200	100	9	4.5	191	94.5	200	100	1	5	19	95	20	100
First aid	174	77	46	23	200	100	184	92	16	8	200	100	16	80	4	20	20	100

Child protection covered issues such as reporting child abuse, preventing child abuse, gender discrimination, road safety and first aid [Ref: Table 5]. According to parents children got support in areas such as child abuse 164 (82%), gender discrimination 175 (87.5%), road safety 180 (90%) and first aid 46 (23%). As for the teachers, scores were: child abuse 166 (83%), gender discrimination 187 (93.5%), road safety 191 (94.5%) and first aid 16 (8%). According to administrators scores were: child abuse 20(100%), gender discrimination 20

(100%), road safety 19 (95%) and first aid 4 (20%). The overall pattern is that all the participants were of the opinion that to a large measure, children were protected. Scolding and corporal punishment were observed as on the rise. It was noted through probing that caregivers adopt such practices as disciplinary measures without realising that they are abusing the children under their custody.

Discussion

The results of the study are discussed following themes drawn from the research questions. These are: types of support services, service providers and areas of need in which children are supported.

Types of support services

The results show that support services were in health, hygiene, nutrition, education, protection, material, financial, social and emotional. However, areas with significant support services were health, hygiene, nutrition, education and protection. It was noted that central government was active in providing support to children in all areas save for resource constraints. However, hygiene and nutrition support services were dominated by NGOs whereas health, protection and education were dominated by central government.

Areas of need children get support

According to the results areas of need in which children got support were health, hygiene, nutrition, education and protection. It was noted that support was satisfactory in aspects such as health, nutrition and protection and this was due to collaborative efforts between government and non-governmental organisations (NGOs). Support was relatively limited in hygiene and education services due to lack of resources, government policy on corporal punishment, parents' limited knowledge and negative cultural practices on care of under-fives. What is obtaining on the ground is not in line with current trends which advocate for need for government to offer holistic ECD programmes that provide high quality integrated care, building on parenting skills and advocacy for children. Such programmes cater for the school readiness skills, nutrition, health and psycho-social development of the children (Jones & Summer, 2011).

Health support

The study found that children got support in HIV and AIDS and immunisation. This can be explained by country-wide programmes mounted by the government and its partners on the need to combat HIV and AIDS and reduce child mortality. This goes a long way in improving the quality of parenting of the 0-5 year old children. This move by government and its partners is in line with MDG 4 (Reduce child mortality) and MDG 6 (Combat HIV/AIDS, malaria and other diseases). Parents and administrators were of the view that there was support for pneumonia and diarrhoea. The contradictory view of teachers in this aspect can be attributed to the fact that they interact more with 3-5 year olds enrolled at the centre and have a limited idea on what obtains at home among infants and toddlers. Parents and administrators are more informed on support services for this age group through participation in service provider community outreach programmes which teachers do not normally take part.

Contrary to parents' view, teachers and administrators said there was support in terms of toilet facilities. This difference in perceptions can be explained by the fact that all ECD centres have toilet facilities save for the appropriateness to ECD age groups, but in the villages, majority of parents could not afford construction of toilet facilities due to poverty. Alternatively, parents and their children used the bush as a toilet. Absence of properly constructed toilets exposes children to diseases such as typhoid and cholera among others. Jones and Summer (2011) state that contraction of such ailments by children in the formative years retards their physical and intellectual developments, which undermine their education prospects, and in some cases, lose their lives.

Hygiene support

The results of the study reveal that hygiene support was given in aspects that include washing hands before and after eating, treating drinking water, toilet use, and regular child bath. However, distances involved in fetching safe water were a constraint and families resorted to unprotected water sources like the river or well. This is consistent with findings by Nyandiya-Bundy etal (2002) on parenting practices in Zimbabwe. There was also lack of support of ECD centres and the home environment in terms of construction of appropriate and adequate toilets, hence reliance on 'bush toilet'. At the ECD centres, toilets were available save for the fact that two or three squat holes were shared among eight to nine classes of 45-50 children each. This has implications for children's health and hygiene. Frequency of use of toilets did

not match the cleaning intervals and when one messed up, Nyandiya-Bundy etal (2002) submit that children are susceptible to diseases such as bilharzia since most of them did not have shoes due to poverty. Bush toilets, particularly in the rainy season make children susceptible to water-borne diseases such as cholera and typhoid which negatively impact on their physical health.

Contrary to parents' view, there was consensus between children and teachers that there was limited support in hygiene aspects such as tooth brushing, ironing children clothes, cutting nails, cleaning hair and changing clothes. Not brushing teeth, ironing children's clothes, cutting nails, cleaning hair and changing children clothes regularly may have been viewed as trivial by parents. However, issues that appear 'small' may have significant negative impact on the children's health. Children's bodies in the age range 0-5 years have less resistance to infection (Omolayo, 2018). It must also be appreciated that as per government policy (Circulars 14 of 2004, 12 of 2005 and 48 of 2007) for the first time, 3-5 year are enrolled at the ECD centre were they come across many children with different infections. Their bodies take time to develop resistance to these 'new' infections. They might be vulnerable to diseases/illnesses like dandruff, ring worms and diarrhoea among others. Contraction of such diseases/illnesses is detrimental to the children's development in all domains (Bicaba, Z., Brixiová, Z., & Ncube, M., 2015).

Nutrition support

It was noted that nutrition support was satisfactory and dominated by NGOs in terms of provision for nutritious food. This researcher raises concern because support services by NGOs are not sustainable since NGOs give out what they have, not necessarily as per need. Support can also be terminated when the NGOs relocate or focus on completely different activities. Amos (2013) and Parenting in Africa Network (2014) suggest that to achieve sustained support for children 0-5 years, communities should be engaged in capacity building endeavours. These draw upon resources for parents' own well- being and well-being of their children. Such activities target parents as primary caregivers of children, and provide them skills that while not directly related to parenting, will enhance their ability to support children in areas of need. Consequently, considering that rural communities are impoverished and survive on subsistence farming, families and ECD centres should be supported financially so that they purchase seed, fertilizer and pesticides. Parents can assist with manure. Schools and

families without nutrition gardens have to be encouraged to make an initiative to establish nutrition gardens to generate income and complement feeding programmes already in place.

The study also found that nutrition support was relatively limited in aspects such as balanced diet, food preservation and nutrition gardens. Parents were however, of the view that children were supported in all aspects. This view of parents can be explained by food aid and agricultural inputs they receive from government and its partners such as NGOs. Parents could have overlooked the fact that aid in the form of food and agricultural inputs are not a permanent arrangement, once terminated would expose children to malnutrition. Ortiz, Daniels & Engilbertsdóttir (2012) posits that what is required for under-fives to realise their full potential is consistent provision of nutritious food and balanced diet. As per results only parents said that children received support in the aspect of balanced diet. Parents may have considered nutritious food and balanced diet as synonymous basing on feeding programmes their children are beneficiaries. However, as teachers and administrators relatively obtain a higher literacy level than parents, they were clear that the porridge and barley wheat children received as food aid from government and NGOs were nutritious but did not constitute a balanced diet by themselves.

Education support

The study found that children got support in education in the form of encouragement to do sport and supervision of their homework. It was also noted that there was lack of education support in aspects such as provision of learning materials and lunch box for the child, access to ECD centre, access to birth certificates and human resource provision. Aspects of education in which children got support are important for the children's optimum development but do not adequately cover all domains. Lack of support in provision of learning materials, lunch box and birth certificates deprives children of learning comfortably so that they have a decent education, as these are part of the requirements of ECD centres (Statutory Instrument 106 of 2005). Considering that under-fives are within a phase whereby they experience optimum development which Montessori in Morrisson (2018) refers to as the 'sensitive period", it is imperative that they get necessary knowledge, skills, and attitudes through access to ECD centres and home-based programmes with qualified personnel competent in laying the foundation for later life.

Through observation, it was noted that all primary schools had an established ECD class B for 4-5 year olds but had yet to establish ECD class A for 3-4 year olds. In view of this

observation, there is access to ECD as per establishment of class B, but limited because 3-4 year olds are still kept out of school. Education programmes of 0-3 year old in the communities were hard to come by. This is due to government policy that preschool education starts at 3 years (Statutory Instrument 106 of 2005). While some parents might not view provision of some learning materials like text books as their responsibility, the majority would have provided if they had necessary resources given the fact that parents strive to provide the best for their children (Omolayo, 2018). Essentially, the districts in question are rural and there is likelihood that lack of provision of learning materials is due to poverty.

Child protection

It was found that all protection aspects that include reporting child abuse, preventing child abuse, gender discrimination and road safety were considered as provided except for first aid. However, efforts by service providers were undermined by cultural practices like "spare the rod and spoil the child", "what was good for parents is good for their children" and practices like consulting magicians, faith healers and village herbalists when children fell ill. This calls for conscietisation of parents on children's rights, ECD national policy and effects of some cultural practices on learning and development of children during the early years. However, in the process, it is important to begin with the assumption that those raising children have best interests of children at heart. All the same, in working with parents, it is important to know that there are things they are doing right, despite the limiting factors in the situation they exist. Thus child support programmes should respect and build on what families are able to provide. If there are practices in the culture that appear detrimental to the child's development, then new information can be presented with respect. This may influence the parents to reflect and change their own care practices than look down their authority by prohibiting them certain practices.

More so, government implicitly supports corporal punishment in schools, though it is only supposed to be employed by the school head. However, it is the child's right to be protected (CRC, 1989; African Charter on the Rights and Welfare of Children, 1990; and Child Protection and Adoption Act, 2001). Scolding and corporal punishment were observed as on the rise and there is cause for concern because abuse is criminal in terms of Zimbabwean Law. Caregivers need to be educated that though scolding and corporal punishment may help children stop undesirable behaviour, they also result in negative developmental outcomes among children in the formative years (Omolayo, 2018; Locke in Crain, 2010). These

negative developmental outcomes include sense of insecurity, withdrawal and inability to relate well to others later in life (Erikson in Slavin, 2015).

Conclusion

Trends on child care change. There is need therefore, for continuous training for service providers like parents, teachers, social workers, health workers, and local administrators on the needs and rights of children. This would keep a cohort of caregivers, whether at family, ECD centre, community, district or national level; informed of current trends in the provision of support for children, 0-5 years. It is important to encourage networking among various service providers. The division of support services along sectoral lines such as health, hygiene, nutrition, education and protection as found in this study may create competition and narrow intervention and hence compromise children's development. Furthermore, because many sectors are involved, networking may be poor leading to lack of awareness of what others are doing. Lack of awareness of what others are doing may create duplication of activities and omission of some critical support services. As such lack of certain services such as first aid may have been a product of lack of networking. Essentially collaborative work among service providers is encouraged because in our African context, "it takes a village to parent a child".

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