

**EARLY COMMUNICATION DEVELOPMENT: PARENTING BELIEFS AND  
PRACTICES IN A RURAL CONTEXT**

**A RESEARCH PROJECT PRESENTED TO  
THE DISCIPLINE OF SPEECH LANGUAGE PATHOLOGY  
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MASTER OF COMMUNICATION PATHOLOGY**

**BY  
BRONWYN EARL  
REG. NO. 200004841  
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## **DECLARATION**

### **Early Communication Development: Parenting Beliefs and Practices in Rural KwaZulu-Natal.**

I, Bronwyn Earl, declare that this dissertation, submitted to the University of KwaZulu-Natal in partial fulfillment of the requirements for the degree Master of Communication Pathology (Speech-Language Pathology), represents my own original work and not been previously submitted to this or any other university.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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1. My Lord, Jesus Christ, who has carried me through and taught me so much in the process. “The LORD is my strength and my shield; my heart trusts in him, and he helps me. My heart leaps for joy, and with my song I praise him. (Psalm 28:6-8)”
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## ABSTRACT

Many children in the foundation phase in rural schools in KwaZulu-Natal, South Africa struggle to acquire early literacy skills. A review of the literature demonstrates the link between early communication development and academic achievement, including literacy skills (Rossetti, 2001). This study explored the beliefs and practices of caregivers regarding early communication development as a means to providing culturally appropriate early communication intervention. The study drew on phenomenological and interpretive viewpoints to inform the qualitative design. Fifteen caregivers with healthy infants in the age range of 0-12 months were recruited from a post-natal clinic in Inanda, a rural community in KwaZulu-Natal. The study took place in three phases. Phase 1) Nine of the participants were divided between two focus groups. Focus groups used photo elicitation as a method of stimulating discussion on subjects relevant to the topic. Phase 2) Data from the focus groups was used to inform the development of an individual guided interview schedule. One participant took part in a pilot study of an individual interview. Phase 3) The remaining five caregivers participated in individual guided interviews. Data obtained through both focus groups and individual interviews was analyzed for themes using Creswell's Data Analysis Spiral (1998). Five themes were identified as falling within the two study objectives: Parenting beliefs and parenting practices. The themes under parenting beliefs included: the role of the parent; needs and abilities of the infant and communication. Themes included under parenting practices were: daily activities and language stimulation. The results show that caregivers' beliefs are guided by the desire for their infants to be accepted by community members, thus prioritizing issues of respect and observable health as their parenting goals. Caregivers' daily activities facilitate the development of the maternal bond which serves as the foundation for the development of communication and provides language stimulation. These practices are however noted to be intuitive and lack a formal knowledge base. Practice and research implications for these findings are discussed.

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## CHAPTER 1: INTRODUCTION

### 1.1. Introduction

*“Language is the ultimate human achievement - a unique means of communication.”*(Billeaud, 1993, p.7).

Language is deeply interwoven in the fabric of our lives. Every function and action throughout the day is conveyed, explained or assisted by language. Poor language skills are synonymous with poor academic achievement and, frequently, with lower life achievement (Rossetti, 2001). It is therefore not surprising that poor language skills are targeted by a range of professionals and have been subject to a range of theories and treatment methods over the years. Currently speech-language therapists (SLTs) work with other professionals in the remediation of language delays and disorders, in clients of all ages, in order to improve their quality of life. Further, research has demonstrated that the potential for language difficulties can be predicted to a certain degree (Rossetti, 2001; Stanton-Chapman, 2004) and, in many cases, can be reduced or prevented through early intervention. Research into early language development indicates that many of the precursors for language development are formed within the first year of a child’s life when they are in fact non-verbal (Rossetti, 2001). The term early communication intervention (ECI) thus becomes a better description of this type of intervention and it follows that the first year of life is a crucial time for early intervention. Added to this, caregiver-child interaction serves as the foundation for early communication development (ECD) (Gross et al, 1993, cited in Horodynski & Gibbons, 2004). Therefore understanding the parenting beliefs and practices in relation to ECD is a logical starting point for the development of any ECI.

Research in the United States of America, United Kingdom and even in South Africa has found ECI to be of benefit to children considered to be ‘at risk’ within a community (Rossetti, 2001; Van Kleeck, 1992). However, there is also clear evidence that such programmes are not always effective with populations that are culturally and

linguistically diverse from that of the SLT (Alant, 1989; Dunst, 2004; Horton-Ikard, 2006; Van Kleeck, 1992). In this study, culture is defined as “a shared approach to life” that is based on beliefs and practices, social norms and communication patterns that are adopted by individuals who identify with a given culture (Betancourt & Lopez, 1993, cited in, McCollum & McBride, 1997, p.495). Any programme of intervention must be in agreement with the beliefs and cultural practices of the caregiver or family of the child if it is to be effective (Melendez, 2005; Van Kleeck, 1992). Information about the beliefs and practices of a family thus provides valuable information from which more effective, and culturally sensitive ECI may take place.

This dissertation seeks to investigate the beliefs and practices of a small group of primary caregivers regarding ECD. The families are drawn from a rural community in KwaZulu-Natal, a province of South Africa. In this chapter the researcher will motivate for the study and will explore key aspects of the study including: ECD and its importance, parenting beliefs and practices, culture, poverty, and the specific challenges of South Africa, in general, and rural KwaZulu-Natal specifically.

## **1.2. Problem Statement and Background**

As a newly qualified and idealistic speech-language therapist I chose to work for a non-government organization that works to uplift the poor and disadvantaged people of the Valley of a Thousand Hills, from a ‘grassroots’ level. The Valley of a Thousand Hills is a poverty stricken, rural region composed of many steep hills and valleys, as the name suggests, and is set around the Inanda Dam in KwaZulu-Natal. My job allowed me considerable freedom in choosing which needs to prioritize and which projects to support. And the needs are considerable. Poverty is the norm, many households struggle to meet their basic food and clothing needs. The steep geography of the area makes access to government resources such as clinics and schools very difficult as many community members live far from roads and the resources are few and far between. Basic infrastructure such as electricity, running water and phone lines are considered luxuries and poor hygiene is an ongoing challenge due to the lack of access to water and

sewerage systems. Schools in the area are severely under resourced and in many cases run by demoralized teachers who have come from similarly deprived backgrounds. It is not surprising that pass rates are low and drop-out levels high. Statistics indicate 59.3% of the country's poor population lives in rural areas (Armstrong, Lekezwa & Siebrits, 2009).

Under such living conditions, disability and disease progress quickly and as the only speech therapist in the area, I was challenged by the complexity of dealing with the associated communication disorders within an environment that required all the patient's efforts simply to survive. Although I saw many children afflicted by cerebral palsy and cognitive delay, I quickly found I was receiving far more requests for assessments of learning difficulties than any other disorder. A school screening program developed by myself and conducted with community rehabilitation facilitators in numerous schools in the area revealed a startling percentage (sometimes 60%) of the children in grade R (Reception) and grade one were failing to grasp the basic concepts upon which literacy and learning are based. I.e. children had difficulty learning shapes and colour concepts and recognizing letters visually or phonetically. These children either repeated the year numerous times until they dropped out altogether, or were pushed through each year despite their inability to learn to read. The sheer numbers of struggling children were overwhelming and called for far more time and resources than I or the community had available. Training the teachers was only a partial solution as the teachers were already stretched to cope with those children that were showing progress in class. Discouraged and at a loss, I decided it would be more helpful to address the root of the problem. But what is the root of the problem?

Putting the question to the teachers was revealing: In varying degrees the schoolchildren in the area were suffering from prolonged malnutrition, exhaustion from walking as much as 10km to school each day, and "problems" at home, possibly post-traumatic stress when the statistics for domestic abuse and rape in rural areas are taken into account (40% of South African men have been violent with a partner, 25% of men admit to raping a women, AVERT, 2010) and the statistics are reportedly worse in rural regions in the

country. In addition, the Language in Education Policy is flawed in practice (Probyn et al, 2002) with many schools introducing children to learning in English in the early grades. The low quality and quantity of teachers and educational resources create their own difficulties that must be overcome (Chisholm, 2004). Since all or even one of these factors could cause a learner to struggle to learn, there was little I felt I could do as a SLT to rectify these challenges. On researching the subject, I discovered the importance of the home environment in determining whether a child has adequate internal resources for learning in school (NICHD Early Child Care Research Network, 2000, cited in Shonkoff & Phillips, 2000). Reading up on early learning, I found the undeniable link between the language skills a child possesses on entering grade R (the reception year), and future school achievement (Morrison et al., 1995; Stevenson et al., 1976; cited in Shonkoff & Phillips, 2000). Thus I realized that as important as schooling is, it is the groundwork laid before schooling begins that significantly impacts performance. This I felt I could address. Early communication development is the domain of the SLT (Hughlett, Spriestersbach & Tomblin, 2002) and I felt a caregiver-child language stimulation programme could be one means to at least partially address the complex early education difficulties of the area. However, the more I researched the more I discovered I needed to know if the intervention was to be effective. I needed to work with the beliefs of the caregivers if any lasting impact was to be made on the language development of the children.

### **1.3. Theoretical Framework**

Much of current research into the emergence of language supports the sociolinguistic pragmatic approach, which hypothesizes that language is learnt through social interaction and observation of the environment (Conti-Ramsden, 1993). According to the ecological models of Sameroff & Fiese (2000) and Dunst (2004), every factor of the child's environment has the potential to positively or negatively impact development. Amongst the significant influences on a child's development are factors such as: family structure; the mental health of the family; social class (Sameroff & Fiese, 2000); the age of the caregiver; and the level of education of the caregiver (Horodyski & Gibbons, 2004;

Weitzner-Lin, 2004). It also follows that if language is learnt through social interaction and observation, then in order for appropriate interventions to be developed, specific information is needed regarding these factors. Social interactions in the first year of a child's life are largely limited to interactions with the caregiver.

A key factor underpinning language intervention is the significant role of the primary caregiver. Rossetti (2001) credits the mother-child bond as being crucial for the successful development of social interaction skills. These skills in turn lead to a child's willingness to interact with the world through language. The view that mother-child interaction is an indicator of future developmental competence was put forward by Gross et al in 1993 (cited in Horodyski & Gibbons, 2004). This view is supported by numerous research studies which demonstrate that good mother-child interaction correlates with good communication skills (Anderson & Marinac, 2007; Billeaud, 1993; Deutscher, Fewell & Gross, 2006; Nord, Lennon, Liu & Chandler, 1999, cited in Horodyski & Gibbons, 2004; Roseberry-McKibbin, 2001). Thus this study focuses on the primary caregiver as a key contributor to the successful language development of their child.

This study relies heavily on the use of the terms "beliefs" and "practices" as they relate to parents and parenting. Thus there is benefit in understanding the theory upon which the use of these terms and their relationship to each other, is grounded. The relationship between the parent's belief system and the parent's childrearing practices was only noted as being significant to childhood development studies in the last 30 years. In 1974 Levine reviewed 40 years of previous anthropological studies of parents and culture and produced a 'parental goals theory' still widely held today. Levine (1974) proposed that parents' childrearing goals and hence parental behavior were formed from cultural beliefs and values together with environmental pressures. Thus the relationship between beliefs and behaviour was established. Within this study the researcher refers to parenting behaviour as 'parenting practices'. Numerous studies since Levine's work have established the link between beliefs and practices both in the field of parenting and in related fields such as education and health (e.g. New & Richman, 1994; Zhang, 2005;

Harkness & Super, 1). It is upon this theory that this study of both the beliefs and the practices of parents has been based.

Since research demonstrates that parenting practices are closely related to the cultural beliefs and values of the primary caregiver (Bornstein et al, 1996; Keller et al, 2006; Super & Harkness, 1994; cited in Borke, Lamm, Eickhorst & Keller, 2007; Melendez, 2005; McCollum & McBride, 1997), there are thus as many differing child-rearing practices as there are cultures in the world. The majority of these practices were adopted in the belief that ‘our way is better’ (Shonkoff & Phillips, 2000). Where intervention seeks to change the beliefs and practices of the caregiver, the caregiver is likely to reject the intervention, to the detriment of the child’s development (Melendez, 2004, Trivette, Dunst & Hamby, 2004). It is thus crucial that an understanding, of primary caregivers’ beliefs regarding language development is formed prior to developing any early intervention programme.

In this study culture refers to an identifiable group of people sharing a cognitive schema (Betancourt & Lopez, 1993, cited in Garcia Coll & Magnuson, 2000). Yet, perversely culture is also unique to each individual. Pillay (2003) puts it well when he says “culture or ‘lives’ naturally defy scientific organization. Lives intersect, histories intertwine, and languages overlap.” (p. 298). Thus, throughout this study it should be kept in mind that although groups are frequently linked through language, race, ethnic origin and circumstance, nobody can claim to know the unique perceptions and processes of each individual or even family. Nevertheless, there is still worth in learning more about the basic patterns and beliefs surrounding a particular group as a means to understanding individuals within the group better (Dunst, 2004; Van Kleeck, 1992).

## **1.4. Situational Context**

### **1.4.1. The dangers of poverty**

Low socioeconomic status (SES) is repeatedly found to be a leading risk factor for delayed development in young children (e.g. Sameroff & Fiese, 2000; Stanton Chapman,

Chapman, Kaiser, Hancock, 2004). The consequences of low SES are self-perpetuating and an age-old problem for every society and culture. Low SES negatively influences every aspect of a child's development, from conception, when the foetus is more likely to receive poor nutrition and to be exposed to harmful substances and disease (Klerman, 1991, cited in Halpern, 2000), and continues to negatively impact the environment into which they are born, learn and grow. Studies show that poverty results in the presence of numerous risk factors that may not otherwise have been present, including: parental stress, poor mental health (in the caregiver), single parenting, teenage mothers, low parental education levels, exposure to substance abuse, exposure to verbal and physical abuse, caregivers' lack of awareness of appropriate developmental levels in an infant (Sameroff & Fiese, 2000), increased risk of exposure to disease (Stanton-Chapman, Chapman, Kaiser, Hancock, 2004), erratic parenting (Halpern, 1993, cited in Stanton-Chapman, Chapman, Kaiser & Hancock, 2004) and, significantly for the focus of this study, poor mother-infant interaction (Sach, Pietrakowicz, & Hall, 1997, cited in Horodyski & Gibbons, 2007). Further, stress, depression and low education levels result in parents in low SES environments generally speaking less frequently to their children (Stanton-Chapman, Chapman, Kaiser & Hancock, 2004; Bresnitz & Sherman, 1987; Loejoy, Graczyk, O'Hare, & Newman, 2000; Hart & Risley, 1995; Hoff-Ginsberg, 1991, cited in Pan, Rowe, & Snow, 2005) with the consequence that these children generally have a lower vocabulary than that expected and needed for progress upon entry into school. The danger of living in an environment of low SES is the increased number of risk factors that the child is exposed to as a result. Sameroff & Fiese (2000) found it is not which but rather how many risk factors a child is exposed to that result in developmental delays. This finding is reiterated in the study by Stanton-Chapman, Chapman, Kaiser and Hancock (2004), which investigated the detrimental effects of multiple risk factors on language development. Thus the profound negative impact of poverty on early language development and parenting behavior is clear. This study looks at an area in rural KwaZulu-Natal where poverty is rampant and may well be a significant contributor to the poor literacy skills apparent in foundation grades.

### **1.4.2. The challenges of South Africa**

In South Africa statistics indicate that two thirds of children live in poverty (Children's Institute, 2009) and are therefore at risk for communication delays. Approximately 54% of the population live in rural areas (StatsSA midyear estimates, 2005, cited in DHIS, 2008). Rural areas have a higher population of 'at risk' children as there is poor access to health services and a higher occurrence of poverty in these areas (Armstrong, Lekezwa & Siebrits, 2009). Real and apparent risk factors in South Africa include:

- Environmental factors such as; domestic abuse -an average of 80% of women in rural areas are reported to have experienced abuse in the home-(Vetten, 2004); crime; and physical deprivation from a lack of basic necessities.
- Social stress factors, such as mental and physical stress created by the HIV epidemic, unemployment and exposure to crime.
- Low education levels of parents (Christie & Gordon, 1992).
- Broken homes in which the primary caregiver is a grandparent, single parent or sibling to the children. In KwaZulu-Natal, where this study takes place, just 28% of children live with both caregivers, whilst 40.8% live with their mother only and 27.8% live with neither caregiver (Meintjes, 2009). This is a result of a) the barriers created to marriage by cultural traditions such as 'lobola' (South Africa Web, 2009). b) the high number of orphaned children (1.4 million) as a result of the HIV pandemic (AVERT, 2010), c) poverty and the legacy of apartheid which created a tradition of many parents going to work in urban areas and leaving their children in the family homes in rural regions (Children's Institute, 2009).

In the province of KwaZulu-Natal, the predominant culture is that of the Zulu. Zulu tradition requires a potential bridegroom to pay lobola before he can marry (South Africa Web, 2009). This 'lobola', or payment for a bride, is frequently beyond the means of the average man and requires years of saving and paying before the marriage can take place. Thus cultural practices and poverty combine to make marriage impossible for many couples and more casual sexual relationships occur (Children's Institute, 2010). This is demonstrated by the statistics for children living with their parents (Children's Institute, 2010). Single parents rely on the child support grant paid by the government as a means

of survival. The grant is the small amount of R250 per month (South African Government Services, 2010) but in many cases this is a household's sole source of income. When the figures are looked at for who the primary caregivers are in rural areas it becomes apparent that this study can't expect to deal primarily with the biological parents of the children. For ease of reference within this study the researcher therefore refers to the caregiver rather than to the parent as a term that encompasses both the biological caregiver and any other primary caregiver. There are thus many challenges for children living in rural areas in South Africa as single parenting is another risk factor that indicates possible delays in ECD (Rossetti, 2001).

When a child is identified as being 'at risk' for language delay, it is standard practice for SLT's in South Africa to implement a programme of Early Communication Intervention (ECI). It is particularly important for ECI programmes to be effective for caregivers in rural areas, as poor access to resources and inadequate health-provider to child ratios mean that children in need of intervention can frequently only be seen once a month or less by SLT's. Primary caregivers are therefore required to put into practice home programmes provided by the SLT, to supplement the infrequent clinical visits and encourage ongoing communication development. Thus, any intervention needs to be culturally sensitive. Cultural sensitivity is an awareness of, and respect for, the cultural traditions and beliefs that govern a given community (Campinha-Bacote, 2003). The term 'beliefs' refers to the emotional certainty that a doctrine or principle is true (Encarta, 2010). Cultural sensitivity is a skill that must be learnt and developed and not simply a broad attitude of tolerance for other cultures (Campinha-Bacote, 2003). Each individual is exposed to countless 'cultures' in different contexts of living and may adopt parts of several cultures to form their own beliefs and practices (acculturation). Wordnet (2010) defines 'context' as "the set of facts or circumstances that surround a situation or event" (<http://wordnetweb.princeton.edu/perl/webwn?s=context&sub=Search+WordNet&o2=&o0=1&o7=&o5=&o1=1&o6=&o4=&o3=&h=>). Although there may be similarities in race, language and socio-economic status between two individuals there would still be differences to overcome in communicating effectively. Thus any ECI needs to be flexible enough to incorporate the cultural differences within each family.

The early intervention framework described by Dunst (2004) supports the need for the cultural beliefs and practices of caregivers to be acknowledged. He proposes a model that accommodates cultural variations in family dynamics and practices and works to strengthen and enhance parenting skills and daily activities that are already present and benefit the development of the child. This model of intervention (discussed further in section 2.3.2) may thus provide a suitable means through which appropriate ECI may take place in this high risk area, however Dunst (2004) is emphatic that there is a need for specific knowledge about the parenting beliefs and practices in the area within which ECI is to take place. His recommendation is supported in the literature (e.g. Mccollum & McBride, 1997; Melendez, 2005). More information is needed regarding the beliefs and practices of parents who reside in rural contexts

### **1.5. Definition of Terms**

*Early communication development (ECD):* A direct definition could not be found in the literature but drawing on the use of the term in the literature enabled the researcher to form a clearer understanding of the phrase. Like Fenson et al (1994), the researcher has used the term early communication development as a broad term that encompasses early language development and all the verbal and non-verbal behaviours and gestures that develop to convey meaning in this process. The term is used to acknowledge more clearly that language development begins from birth (Patterson, 2009).

*Ecological:* the term ecological indicates that the context of a situation has been taken into consideration (Dubowitz, Black, Starr & Zuravin, 1993; Sameroff & Fiese, 2000)

*Enculturation:* the process by which aspects of one's own culture are adopted, including values, beliefs and behaviour, according to Laughlin, 1989; Little Soldier, 1985; Nanda, 1994, (cited in Trivette, Dunst & Hamby, 2004).

*Infant:* this term is used in this study to refer to babies that are preverbal and any age from birth to 12 months old.

*Poverty:* a situation of deprivation of any of a number of factors and resources, not only financial deprivation (Cuthrell, 2010), defined and discussed further on pg 29.

*Rural:* Balfour, Mitchell & Moletsane (2008) state that rurality is associated with a degree of isolation, poverty, strong community ties and poor health. Thus, for the purposes of this study a rural area refers to an area that is at a distance from most resources (i.e. shops, and government services), is generally accessed by dirt roads, and has homes lacking in basic amenities (e.g. running water).

## **1.6. Summary**

The problem highlighted in this chapter is the poor literacy skills apparent in foundation levels in rural schools in KwaZulu-Natal. There are many contributing factors to this problem, one of these factors may be poor ECD. An ECI would help to address poor ECD, however currently used South African ECI is culturally inappropriate and therefore ineffective (van Kleeck, 1992). One means of addressing the literacy difficulties in foundation levels in rural KwaZulu-Natal, is by enhancing ECD from the home (Dunst, 2004). In South Africa, where resources are limited (Alant, 2007) and risk factors are rampant (Alliance for Children's Entitlement to Social Security, 2002), it is particularly crucial that promotive and preventative practices be successful. There has been little research into the beliefs and practices of primary caregivers regarding communication development in rural communities in South Africa. It is therefore difficult to develop an ECI that will be culturally appropriate and will therefore be adopted by primary caregivers. A careful study of the literature is called for.

## CHAPTER 2. REVIEW OF THE LITERATURE

### 2.1. Introduction

This chapter will present a review of the literature relevant to the problem statement. The literature is used to present the argument that, in order to address high levels of early literacy skill deficiencies in young children's language in rural contexts, an exploration of the parenting beliefs and practices regarding ECD is indicated. The review will encompass the following four areas: 1) the link between literacy skills and ECD; 2) how caregivers' beliefs and practices regarding ECD are formed; 3) the South African context relating to ECD; and 4) the proposed research question.

Early communication development begins at birth and is largely dependent on the mother-infant relationship (Rossetti, 2001; Billeaud, 1993). This relationship is established within the first year of life (Rossetti, 2001), hence this study will focus specifically on parenting beliefs and practices apparent from birth to 12 months, when the child is preverbal. This age was selected as a median age at which speech develops (Darley & Winitz, 1961) although speech may emerge before or after this age the caregiver would still be able to recall their methods of interaction with the infant in the preverbal state. The primary caregiver is identified as a key participant in ECI (e.g. Billeaud, 1993; Rossetti, 2001) and thus factors that influence parenting become relevant in exploring ECI in rural communities.

South Africa is a developing country and thus prone to extremes of circumstances – for example, extreme poverty exists side by side with extreme wealth; and strong African cultural traditions exist alongside western beliefs and practices. The meeting point between these extremes is marked by unique consequences in terms of acculturation of knowledge and beliefs in parenting, and intracultural variation (Harkness & Super, 1996). Trivette, Dunst & Hamby, 2004 cite Birman (1994) as defining acculturation as the adoption of aspects of another culture. With this understanding it is important not to make assumptions about the cultural beliefs and practices of any given community, but

rather seek to explore and understand the parenting beliefs and practices of families living in specific communities.

The review begins by (1) establishing the link between literacy skills and ECD. Early communication development is then briefly explored and the works of Dunst (2004) and Rossetti (2001) and others are drawn on to establish how early communication is developed and to identify the factors that influence it. Understanding how ECD occurs reveals the central role of the primary caregiver and the relationship formed with the infant (Patterson, 2009). The literature is thus reviewed to establish the impact that parenting, and varying beliefs and practices about parenting, have on ECD. To this end, studies by Robinson & Acevedo, (2001), Dunst (2004), and Trivette, Dunst & Hamby, (2004) are reviewed as studies that support the ecological standpoint of the researcher.

The researcher then shifts the focus to (2) primary caregivers and how their beliefs and practices regarding ECD are formed. Understanding the issues that influence and shape the development of beliefs and practices will enable the reader to develop a more informed understanding of the beliefs and practices described in the current study. A review of the literature highlights the issues of cultural beliefs and poverty as significant influences on parenting. Some of the works drawn on include: Mccollum & McBride (1997), Roseberry-McGibbin (2001), Hoff-Ginsburg (1991), and Cuthrell (2010). Several of the studies reviewed indicate the need for an awareness and acknowledgment of context within studies of culture and beliefs. Thus, the literature is reviewed to explore cultural variation and contextual influence regarding ECD in greater depth, drawing on two international studies, Melendez (2004), and Hoff-Ginsburg (1991) and on the South African study by Geiger & Alant's (2006). The literature establishes the need for research into specific intervention contexts, in order to establish ECI that will be relevant and thus effective (Hoff-Ginsburg, 1991).

(3) To contextualize the study in South Africa a brief overview of the socioeconomic context in South Africa is given, and South African literature specific to ECD and parenting is presented. Although comprehensive searches were carried out using a

number of search engines including EBSCO host, SABINET, Google Scholar and a physical search of available South African journals, there were very few studies that addressed parenting in relation to ECD. More specifically there were no published studies conducted within the selected context that were able to provide information about ECD (i.e. Valley of a Thousand Hills in Kwa-Zulu Natal, South Africa). Three South African studies were used: van Kleeck (1992), Seeff & Bortz (1994), and Tomlinson, Cooper & Murray (2005).

4) Finally, the literature review concludes with the researcher's proposal that an exploration of parenting beliefs and practices in rural KwaZulu-Natal regarding ECD, is necessary.

## **2.2. Establishing the Link between Literacy and Early Communication Development**

Good language skills are clearly linked with academic achievement and good cognitive development (Blank, Rose & Berlin, 1978; Feagons, 1985; Tough, 1977; Wells, 1985, cited in Roberts et al, 1989; Rossetti, 2001; Herbert-Myers, Guttentag, Swank, Smith & Landry, 2006)). The importance of ECD in the formation of future language and life skills cannot be emphasized enough. Lock, Ginsborg & Peers (2002) found that the foundation levels of communication development are closely related to the subsequent development of literacy skills. For example, in the first year of life the infant learns to interpret sounds as having meaning, in the second year the child learns that meaning can be attached to symbols/pictures (Billeaud, 1993). Studies by Rossetti (2001, p.1) support this link between ECD and literacy, stating that "communication skills provide the highest predictive correlation with later intelligence attainment and school performance". Literacy skills are closely linked to our thought processes, ability to access information and interpret the world around us, and to our employment potential (Beard, 1998, cited in Locke, Ginsborg & Peers, 2002). Thus it is apparent that ECI is a field of significant

value particularly in circumstances where a language delay may be prevented through timely intervention.

### **2.3. Early Communication Development**

Understanding the importance of ECI leads to the need for a greater understanding of how early communication develops and what factors influence this development. This section will cover these aspects of ECD.

#### **2.3.1. What is early communication development?**

At birth, the infant has a highly adaptable brain with all the brain cells needed in life already present, however the connections between the cells (synapses) have not yet been formed (Whitehead, 2009). In normal circumstances the natural repetitive interactions of the primary caregiver and the infant that occur in everyday life create the nerve pathways that form the thinking brain (Gerhardt, 2004, cited in Whitehead, 2009). These interactions may include, feeding, changing, bathing, cuddling, singing and talking with the infant and comprise the general stimulation necessary for an infant to develop early communication skills. The infant has a number of instinctive reactions that assist the development of a relationship with the caregiver (Whitehead, 2009). The day-old infant is able to distinguish his mother's voice from other voices and uses this to actively establish emotional attachments (Greenspan, 1988, cited in Prizant & Wetherby, 1990). These include a preference for gazing into the caregiver's eyes, and immense interest in the human face. These behaviours generally result in instinctive responses from the caregiver including, gazing back into the infant's eyes, stroking the infant's face, holding "conversations" with the infant, and smiling. The ability of the infant to imitate facial expressions and movements is present within minutes of being born (Trevvarthen, 1993, cited in Whitehead, 2009) and represents another instinct that assists in the development of a strong caregiver-infant bond. The bond between the primary caregiver and the infant is not purely emotional. Amongst its many psychological purposes it also provides a motivation for, and understanding of, the use of language as a means of connecting with the caregiver and following this, the outside world (Rossetti, 2001). Over the first year

the infant will (all proceeding normally) gradually develop voluntary control over his responses and learn to respond to his mother's (and others) interactions with him (Billeaud, 1993). Thus ECD is a process that begins from birth and is developed through each interaction.

### **2.3.2. What influences early communication development?**

Within an ecological framework the influence of every facet of the environment on the development of communication is acknowledged (Sameroff & Fiese, 2000). The natural progression of this link between daily activities and ECD leads to considerable importance being placed on the role of the mother as the chief influence and contributor to the child's language development (Dunst, 2004; Rossetti, 2001; Sameroff & Fiese, 2000). A paper by Dunst (2004) provides a key reading for developing early intervention that acknowledges the importance of context (as mentioned in section 1.5). In his paper Dunst describes an integrated framework for early intervention that is based on a broad range of research, theory and practice experiences in a range of fields. Dunst visualizes a family-centred practice that includes three areas of input: learning opportunities for the child; the support of the family; and the support of the community and extended family. These areas overlap to form the learning and development a child needs. Dunst bases his intervention and support programme on these basic assumptions. Dunst's figure (below) depicts his understanding of the contributions of the child's experience, the caregiver, and the family/community to the child's development.

This studies focus is on the overlap of the areas of family support with the learning opportunities the child is exposed to, i.e. what Dunst refers to as "parenting styles and instructional practices". It is thus positioned within Dunst's research as a means to the greater intervention aim of developing the child's learning potential. Dunst (2004) places particular emphasis on the learning opportunities presented naturally in the 'activity settings' of daily interactions with both caregiver and community. He uses the term 'activity setting' to refer to the natural environment within which day-to-day activities take place. However, these interactions are dominated by the caregiver in the lives of infants and young children, indicating the importance of the role of the caregiver.

Caregiver-infant interactions form a cycle of positive input and experience for the infant. Studies show that the infant is most interested in the sound range of the human voice (Aslin, Jusczyk, & Pisoni, 1998, cited in Patterson, 2009), and will favour conversation directed at a child over adult conversations (Fernald, 1985, cited in Patterson, 2009). The more the caregiver speaks to the infant the more the infant will respond to and imitate the caregiver. It is not surprising then that studies demonstrate that the more language and interaction an infant is exposed to, the better the language development (Hart & Risley, 1995 cited in Patterson, 2009; Rossetti, 2001). Much research has thus been conducted to identify the characteristics of successful mother-infant interactions (McCollum & McBride, 1997) as it is the mother/primary caregiver who is the main influence on ECD.

#### **2.4. The Need for Early Communication Intervention (ECI)**

Language and developmental delays may be averted by identifying those children who are ‘at risk’, and addressing or compensating for those risk factors before they have a negative impact on the child. Sameroff & Fiese (2000) maintain that within the child’s ecology there are multiple factors influencing development on multiple levels. Dunst (2004) supports this ecological theory in his integrated framework for early intervention. Within ‘risk research’ these factors are organized into two groups: established risk factors (i.e. those conditions that are proven to cause language disorders); and risk factors that may possibly lead to language or general developmental delay. The latter can be broadly divided into risk factors that are biological in nature, and those that are environmental (Rossetti, 2001; Stanton-Chapman, Chapman, Kaiser & Hancock, 2004; Weitzner-Lin, 2004). Biological risk factors are influences on an individual that may have affected his/her nervous system, for example; low birth weight, prematurity, and/or substance abuse of the caregiver while pregnant (Stanton-Chapman et al., 2004; Weitzner-Lin, 2004). Environmental risk factors are external influences on the child that limit the child’s life experiences (Weitzner-Lin, 2004). These would include: maternal-caregiver factors, such as a caregiver with mental illness; and psychosocial factors, such as family crises or social isolation. A comprehensive list of risk factors from Weitzner-Lin (2004)

is included in Appendix A. Research shows that the more risk factors a child is exposed to in early childhood the greater his/her chance of developing a disability or delay in language development (Rossetti, 2001; Sameroff & Fiese, 2000; Stanton-Chapman et al., 2004).

Other contexts that are associated with risk are linguistically and culturally diverse communities (Melendez, 2005; Roseberry-McKibbin, 2001). Frequently, minority status populations, who speak a non-‘mainstream’ language and share a non-‘mainstream’ culture, are found in areas with low SES (Roseberry-McKibbin, 2001). Even without the challenges presented by living in poverty, research confirms that cultural and linguistic diversity create the risk of social isolation, the associated risks of poor access to medical care (due to the language barrier), and maternal depression (due to poverty related stress) [Roseberry-McKibbin, 2001]. In the context of diversity, whether of a linguistic, cultural or economic nature (or all three), there is greater potential for numerous risk factors to impact negatively on a child’s life. South Africa is a country of particular diversity, and acknowledges this with 11 official languages. The Zulu people are the most populous language group with 21% of the total population speaking Zulu in the home (StatSA, 2001). In the community targeted by this study the population is predominantly Zulu speaking. Although the Zulu people are statistically in the majority, and sit in a position of relative power with a Zulu president leading the country, the effects of apartheid, and the continued use of English as the language of learning, mean that the Zulu people still face barriers of poverty, language and culture (UNHCR, 2003). In KwaZulu-Natal, 84.9% of the population is black, with 54% of the total population living in rural areas (Afra, 2010). Thus a large proportion of the Zulu population live in rural areas. Further statistics place 63.4% of children in KwaZulu-Natal in rural areas (Hall, 2009) with the implication of poverty that this carries. Thus in a rural context there is a greater population of children who are at risk for ECD delays and who are thus at risk of developing difficulties in literacy and learning.

## **2.5. The Role of the Caregiver in Early Communication Development**

Horodynski and Gibbons (2004) refer to the work of Gross et al, (1993) in citing mother-child interaction as being a long standing indicator of the child's future developmental competence. Further, good mother-child interaction has been found to correlate with good language skills (Billeaud, 1993; Deutscher, Fewell & Gross, 2006; Nord, Lennon, Liu & Chandler, 1999, cited in Horodynski & Gibbons, 2004; Roseberry-McKibbin, 2001). The mother-child dyad is initially important to establish a bond that enables the child's needs to be met promptly. However, it is the social interaction skills that are taught through this bond that are important, as it is the means through which a child learns to interact positively with the world (Rossetti, 2001, Robinson & Acevedo, 2001). Interactions may primarily take place through daily rituals, as previously stated, which provide opportunities for joint attention, shared enjoyment of an activity and responsiveness (Goldberg, 1977 cited in McCollum, 1997). Responsiveness of the primary caregiver in these interactions appears to have the most influence in promoting good communication development (Horodynski & Gibbons, 2004).

### **2.5.1. The western view of good parenting**

In the view of researchers from western countries, a key feature of good mother-child interaction is the mother's high level of responsiveness to the child's communication attempts (Anderson & Marinac, 2007; Paavola, Kempainen, Kumpulainen, Moilanen and Ebeling, 2007; Billeaud, 1993). Paavola et al (2007) refer to maternal responsiveness as sensitive responsiveness. Sensitive responsiveness is defined as the mother's skill in: (i) recognizing the infant's signals consistently (Meadows, Elias, & Bain, 2000, cited in Paavola et al); (ii) responding appropriately (Meins, Fernyhough, Fradley, & Tuckey, 2001, cited in Paavola et al); (iii) adapting a task to the infant's level of development and thereby maintaining the attention and motivation of the infant (Stevens, Blake, Vitale, & MacDonald, 1998, cited in Paavola et al); and finally, (iv) adapting her own behaviour according to the emotional state of the infant. Good mother-child interaction has thus also been defined as attention to the child's needs (Rossetti, 2001; Billeaud, 1993), and/or the emotional availability of the caregiver (Robinson & Acevedo, 2001). These

definitions of good caregiver-child interaction are widely accepted as good practice in the western world.

Robinson & Acevedo's (2001) quantitative study sought an understanding of the relationship between the reactivity and emotional tie between mother and infant, and the child's language and cognitive development at 2 years old. The study drew on mothers who were part of another study called Home Visitation 2000 and represented a convenience sample of low-income mothers recruited from 21 antenatal clinics in the United States of America. Robinson & Acevedo's study confirms the importance of the mothers' responsiveness. They describe the willingness of the child to engage with others in their environment as 'emotional vitality', and found in their study of 518 low-income, first time mothers, that there is a direct link between the emotional availability of the mother, and the level of emotional vitality displayed by the child. Infants were evaluated at 6-9 months for their responses to emotional challenge tests and then tested at 2 years for language and cognitive skills. The study controlled for birth weight, sensori-motor delay and age differences. Emotional vitality was found to be directly related to the cognitive and language development of the child. Emotional vitality refers to the willingness of the child to engage with the environment. Thus, the study confirmed that the mother's responsiveness to the child, influences the child's motivation to communicate. The caregiver therefore plays a vital role in ECD from the western viewpoint. This indicates a need for more studies of western and non-western cultures to gain an understanding the factors that determine parenting style and responsiveness.

### **2.5.2. Cultures at variance with western views**

Although western media promotes face to face interaction (distal approach) in parenting and influences many families from many cultures, research indicates that this approach is not adopted by all cultures, particularly when it disagrees with the beliefs of the culture (Van Kleeck, 1992; Dunst, 2004). Trivette, Dunst & Hamby (2004) conducted a study of a diverse sample of 203 caregivers and their children from a wide range of: cultures (i.e. African-American, Asian, Middle Eastern, White, American Indian, Hispanic, Hawaiiin) , backgrounds and ages, all in equal numbers. They used an acculturation and

enculturation questionnaire developed for the study to determine the relationship of three factors (i) parenting beliefs, (regarding their role and how children learn), (ii) the level of acculturation and enculturation in the family, and (iii) the level of participation of children in activities both within the family and in the community (these they viewed as learning opportunities). The authors conclude that whether a professional agrees with the parenting beliefs or not, the beliefs of the caregiver must be respected. Numerous studies are cited to support their finding that when attempts are made to change caregivers' beliefs and practices the result is the withdrawal of the caregiver (Janes & Kermani, 2001; Louw & Avenant, 2002; and Windisch, Jenvey, & Drysdale, 2003, cited in Trivette, Dunst & Hamby, 2004). Thus, ECI practices based on western assumptions may not be effective when working with caregivers from diverse cultures.

Dunst's (2004) framework for early intervention practices (discussed in section 2.3.2) acknowledges the need to respect the cultural beliefs and practices of caregivers and is flexible enough to accommodate them. He suggests that interventionists use a capacity-building paradigm in assisting families with children at risk for developmental delay, thus embracing strength building, empowering, and promoting principles. Three of the practice elements proposed include: (i) increasing child learning opportunities; (ii) supporting the caregiver through providing knowledge and skills information, and reinforcing existing parenting skills; and (iii) supporting the family by ensuring that they have resources in the community to assist them. In order for this framework of intervention to become a reality it is necessary to understand two aspects: first, how parenting beliefs and practices are shaped, and second, to review research done thus far with caregivers living in rural contexts in South Africa, - to understand their beliefs and parenting practices regarding ECD.

## **2.6. How are Parenting Beliefs and Practices Shaped?**

In keeping with an ecological perspective, the caregiver should be viewed as an individual who is influenced on many levels by many different factors. A model proposed by Sue & Sue (2003) illustrates the three levels of influence on an individual: i)

universal (i.e. factors common to us all that define us as humans); ii) group (i.e. factors that separate us into smaller groups e.g. race, language, culture); and iii) individual (i.e. factors that make us unique e.g. personal experiences). It is important to remember this individual aspect to parenting even though previous research associates certain groups with certain parenting practices e.g. low socioeconomic status is associated with less responsive parenting (Fish, Amerikaner & Lukas, 2001; Hoff-Ginsburg, 1991). Understanding that the caregiver is an individual enables us to understand that the caregiver has made a decision, based on personal experiences, as to whether or not to embrace their cultural beliefs and practices. It will thus always be necessary to refer to the individual preferences of each caregiver.

### **2.6.1. The impact of culture on parenting beliefs and practices**

Culture is defined by Betancourt & Lopez (1993) as an identifiable group of people sharing a cognitive schema. This schema is passed on through the generations through daily interactions that demonstrate the values and beliefs of the group (Betancourt & Lopez, 1993, cited in Garcia Coll & Magnuson, 2000). Thus parenting, which involves many daily interactions with the next generation, is a primary means through which culture is passed on. Cultural practices influence every aspect of child rearing (Rubin & Chung, 2009; Shonkoff & Phillips, 2000). Parenting practices are uniquely tailored to enable the child to thrive in the environment in which they live. Shonkoff & Phillips (2000), cite LeVine's (1977) theory which considers the context in which parenting occurs and claims that all caregivers have three universal parenting goals that have a hierarchical order, namely: i) the survival and health of their child, ii) the development of the child's capacity to maintain or be maintained financially, and iii) the development of culturally determined personal values and accepted behaviours. However, Greenfield & Cocking (1994) present a differing opinion. They state that cultural competence is the key ambition that every caregiver has for their child. Cultural competence is defined as the ability to follow the cultural norms and 'belong' within one's own culture (Greenfield & Cocking, 1994). Thus, as caregivers in differing cultures seek to build competency in their child in their particular culture, mother-child interactions will support different

values and behaviours and in different ways. The latter is supported by the assertions of McCollum & McBride (1997).

Whichever theory is correct, parenting practices are often divided along a spectrum between two general socialization models: (i) *the independence model* which promotes the child's ability to function alone, and (ii) *the interdependence model* which encourages the child to function as a part of a greater whole/community (Kağıtçıbaşı, 1996, Markus & Kitayama, 1991, cited in Borke, Lamm, Eickhorst & Keller, 2007). The model of *independence* emphasizes the individual as a complete being. The caregiver's focus is on developing qualities that enable the individual to achieve on their own and to grow in independence. Borke, Lamm, Eickhorst & Keller (2007) state that the parenting style that encourages the development of independence is a distal style that emphasizes conversing with the child, and the use of toys in stimulating the child. This model is most commonly associated with caregivers who have achieved a higher level of education (Borke, Lamm, Eickhorst, & Keller, 2007). The model of *interdependence* sees the caregiver encouraging skills that would enable the child to learn to conform to a role, and control "inner attributes" voluntarily so as to find a place as part of a greater whole in society (Markus & Kitayama, 1991, cited in McCollum & McBride, 1997). Parenting in a highly interdependent culture is often more proximal in style (i.e. more physical and less face-face contact) and may, for example, see the caregiver ignoring a child's attention seeking behaviour to demonstrate to them the importance of not drawing attention to themselves. Teaching may take place through physical demonstration rather than verbal explanation. Both social models are said to be present in varying degrees in every culture and individual. Thus, no culture is entirely focused on teaching skills for independence to the exclusion of any interdependence skills, and vice versa. In the same way the parenting styles (proximal and distal) are not used exclusively, but to differing degrees depending on the culture. Primary caregivers in Japan, for example, use a more proximal parenting style with value placed on the interdependent model of parenting (McCollum & McBride, 1997). The western culture emphasizes the individual and their independence, hence a more distal style of parenting is used. However there are areas in which a proximal style of parenting is used e.g. in teaching children manners the

interraction tends to be more instructional and dictatorial (Van Kleeck, 1992). Thus, culture has a significant influence on parenting style but cannot be used exclusively to identify which parenting style is used within each culture.

McCollum & McBride (1997) put forward the theory that the degree to which each model is valued in any culture is specifically determined by: a) the ‘socialization goals’ and characteristics valued in children within the particular culture, and b) beliefs held regarding the capabilities of an infant and how children learn. Rubin & Chung (2006), cite the findings of: Fiske, Kitayama, Markus & Nisbett (1998); Greenfield, Keller, Fuligni & Maynard (2003); and Trommsdorff & Dasen (2001), stating that differences in cultural beliefs will influence every aspect of the child in terms of: self-image, thoughts, emotions, social skills and relationships just as culture previously influenced the caregiver in their childhood. Thus, the culture of each family will impact every part of a child’s development and it is crucial to understand the accepted beliefs and practices of each family when providing intervention. Understanding the generally accepted values and how these values influence parenting styles in a given community will enable interventionists to develop early intervention programmes that are culturally sensitive, and are therefore embraced by the programmes’ participants.

Early communication intervention often seeks to indirectly influence parenting practices as a means of creating ongoing language stimulation in the home, but several studies argue that ‘different’ or non-western parenting practices are not necessarily bad parenting practices (Melendez, 2005; Van Kleeck, 1992). Rather, as stated earlier, a caregiver’s goals and the practices derived from these goals are designed to meet the needs and perceived requirements of particular circumstances and environments (Shonkoff & Phillips, 2000; Schiefelbusch & Pickar, 1984, cited in Seeff & Bortz, 1994). For example, in a culture where the child is expected to be silent in front of their elders, caregivers may discourage the child’s speech attempts in front of the grandparents. Thus, parenting practices may be developed from ‘socialization goals’ valued in the culture, and beliefs about the child’s abilities (McCollum & McBride, 1997).

A sample of studies that have investigated the impact of culture on parenting practices include: Chao, 1990; Harkness & Super, 1996; and Sulzer-Azaroff, 1997. An example of a fairly typical study is an investigation of the cultural beliefs and practices of Nigerian immigrant mothers in Italy (Moscardino, Nwobu & Axia, 2006). The ethnographic study used semi-structured interviews of 29 mothers of infants between 2-12 months to obtain information about all aspects of infant health and development. The mothers indicated that their parenting behaviour placed the physical survival of the infant as the chief priority in parenting. They valued close physical contact and placed a priority on identifying signs of illness and responding to it. The majority of mothers for example, interpreted the infant crying as an indication of a physical problem rather than a call for attention. Thus, a mother might respond to crying by feeding the child or by changing his nappy. The study reported that it was perceived as bad if a child cried once these basic needs had been attended to, as it could indicate an illness. They found that unnecessary crying was discouraged. Hence, although these mothers responded to the child's crying, they discounted the possibility that it might be a call for attention and cared for the child on a purely physical level. This may seem wrong to the western perspective, however considering the poverty stricken context from which it is derived, where the infant mortality rate is particularly high, the prioritization of health over communication, is a logical one. In addition, Moscardino, Nwobu & Axia (2006) cite Babatunde (1992) in identify the key socialization goals in many African countries as: being respectful towards their elders, having obedience, responsibility and being helpful. With these socialization goals it becomes clear that superior speech and language skills or academic achievement might not be the goal of every caregiver in developing their child. Considering the high infant mortality rate within South Africa (43.1 deaths per 1000 births, World Bank, 2009) it becomes possible that a similar prioritization of physical wellbeing may be apparent in the beliefs and practices of caregivers in rural contexts.

### **2.6.2. The impact of poverty on parenting beliefs and practices**

Another significant influence on parenting practice is poverty. Poverty is the cause of many of the environmental risk factors previously listed (e.g. maternal depression, single parenting, low education levels of primary caregivers), and also contributes to many of

the biological risk factors. Socioeconomic status (SES) has been repeatedly linked to the level of education, and academic achievement of an individual (Roseberry-McKibbin, 2001). Children from a low SES context are already found to be lagging behind in development upon entering school (Locke, Ginsborg & Peers, 2002; Roseberry-McKibbin, 2001), and it's easy to understand why when investigated further. Roseberry-McKibbin (2001) found that for a child living in poverty the challenges to develop to full cognitive and physical potential are considerable. Poor access to health care, poor maternal and child nutrition, and low parental education levels work together to prevent adequate language stimulation and the development of the child to his/ her full potential. However, the negative impact on the child is also caused indirectly by the impact of poverty on the caregiver. The caregiver that is struggling to provide the basic necessities for living will have difficulty in providing social and emotional support for the child (Halpern, 2001), or understanding its importance for development.

When chronic poverty is present its impact on mother-child interaction is profound, although not always predictable. Hoff-Ginsburg's (1991) study found that mothers in low SES contexts speak less to their children and spend less time per day playing with their children than mothers from middle class contexts. Other research supports this finding and demonstrates that in conditions of severe deprivation (i.e. poverty) language development is delayed, with little time spent in caregiver-child communication (Stanton-Chapman, Chapman, Kaiser, & Hancock, 2004). Fish, Amerikaner & Lucas, 2007 cite several studies that found a relationship between low SES and parenting interactions. Interactions in a context of chronic poverty are likely to be less positive and more dictatorial (Hart & Risley, 1995). Reasoning may be sidelined in favour of "physical punishment" (Giles-Sim, Straus, & Sugarman, 1995; Hoff, Laursen, & Tardif, 2002; Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000) and maternal sensitivity may be compromised (NICHD Early Child Care Research Network, 1999). The research cited attributes the negative influence of poverty on parenting to increased stress levels in the caregiver and in some cases to lower education levels.

A comprehensive study by Fish, Amerikaner & Lucas (2007) looked at 70 mothers from a low SES rural community in the Appalachian mountains in the United States of America. The study related the mothers' reported attitudes and behaviours in parenting their preschool age children to their children's speech and language skills. The study was able to confirm that in any circumstances greater positive response from the caregiver has a positive influence on language development. The rural Appalachian mothers favoured conformity and obedience over independent thought in their child rearing. However, they were more responsive to crying than middle income mothers in the area and received high ratings for maternal sensitivity. The study established that mothers that were "warmer", more involved in play activities, and used alternative means of discipline to smacking, had children with higher levels of expressive language, and better auditory comprehension. In addition, Hoff-Ginsburg (1991) cites several studies as reporting the attitudes and beliefs of the caregiver are a greater influence on interaction than context (Heath, 1983; Snow et al., 1976; Snow, de Blauw & Van Roosmalen, 1979). Thus, although generalisations can be drawn on the impact of poverty on parenting practices, an investigation into each situation and community is warranted. The study of the parenting beliefs and practices specific to a rural community in South Africa is thus justified.

In Cuthrell's (2010) study of poverty and teaching practices, he ranks poverty in three levels: (i) situational poverty - the result of an event that can be overcome within a period of time e.g. job loss and is thus short term; (ii) generational poverty - where a sustained lack of resources over a few generations has led to a shift in beliefs and values; and (iii) absolute poverty - where the extreme lack of resources has led to a complete focus on survival to the exclusion of other beliefs and values. Chronic poverty includes generational or absolute poverty and is shown to negatively impact parenting (Duncan, Brooks-Gunn, & Klebanov, 1994; NICHD Early Child Care Research Network, 2005, cited in Fish, Amerikaner & Lucas, 2007). It has far reaching consequences. Cuthrell cites Payne (2005) in clarifying the impact of poverty further by noting that poverty is a lack of several resources and not just a lack of financial resources. A lack of resources in terms of "...emotional, mental, spiritual, physical, support systems, relationships and role models, and knowledge of hidden rules" (Payne, 2005, p.105) marks absolute poverty.

Conversely, having few financial resources but, for example, a good support system and strong spiritual resources mitigates the effects of poverty. Thus, an understanding of the entire context becomes necessary before the specific impact of poverty can be understood in any one community, or even family.

### **2.6.3. Summary**

Parenting practices are influenced by the culture to which the family is linked, and by the socioeconomic status of the family and community. The influence that these factors have cannot be predicted or assumed due to the complexity of both cultural impact and poverty. It thus becomes apparent that the general context within which parenting takes place, has relevance in determining culturally appropriate intervention practices in any particular community.

## **2.7. The Relevance of Viewing Culture in Context**

The context within which parenting occurs is argued to have been neglected as a consideration in previous parenting studies by Hoff-Ginsburg (1991). He noted that the majority of mother-child interaction studies take place within a middle class western context. Further, he notes that the participants were generally observed within controlled settings and observed in activities not necessarily common within every household i.e. toy playing or reading a book. He cites several studies in support of his theory that found that mothers' speech in reading books is more complex, uses a larger vocabulary and allowed for more questions and discussion around language topics than other contexts (Goddard, Durkin, & Rutter, 1985; Jones & Adamson, 1987; Lewis & Gregory, 1987; Snow et al, 1976; Wiley, Shore & Dixon, 1989). In his study of 32 upper-middle class and 30 working class mothers and their children, Hoff-Ginsburg (1991) studied the interactions of the dyads in two naturalistic settings (dressing and mealtime), and two previously studied contexts of book reading and toy playing. These sessions were videotaped after a visit to the home and an interview of the caregiver. The study found that observed interactions may not necessarily present an accurate understanding of the actual relationship between mother and child. The settings caused the mothers to

demonstrate a differing number of positive parenting characteristics depending on the setting. For example, there were fewer differences between the middle and working classes when reading tasks were used as opposed to mealtime and dressing tasks. The study was unable to draw further comparisons between the classes as it failed to note the amount of time that the mothers spent during the day in interacting with their children, however the fundamental implication that context affects interactions remained clear. Hoff-Ginsburg (1991) consequently questioned whether the findings of studies conducted in western middle class settings could be generalized to other contexts. The implications are clear - further research into caregiver-child interactions is needed in developing countries in order to establish an understanding of interactions specific to each culture and context. Until this is done intervention will continue to be culturally inappropriate, and thus less effective in the countries in which successful interventions are most needed, such as South Africa.

### **2.7.1. Cultural beliefs**

Numerous other studies advocate the need for research into the specific culture and beliefs of minority communities as a means of providing more effective intervention. An interesting study in the United Kingdom by Marshall, Goldbart & Phillips (2007) demonstrates the need for community-specific not just culturally-specific studies of the beliefs and practices of primary caregivers regarding language development. Their study sought to explore the understanding and beliefs of both caregivers and of SLT's as a means to improving speech therapy effectiveness. The study was conducted in East Manchester in the United Kingdom and consisted of unstructured individual interviews of 15 caregivers of preschool age children who were receiving speech-language therapy, and nine government employed speech-language therapists who worked with preschoolers. The interviews were transcribed and validity was obtained through applying grounded theory and respondent validation. The study found that there were differences in the role that the caregivers believed the SLT should play and the role the SLT believed they themselves should play. Caregivers regarded themselves as "experts" in matters of their child and placed greater significance on factors such as gender and the influence of television on the development of language. Speech-language therapist's place more

significance on environment. Both groups held differing views on what play entailed. Although this study did not address the specific issue of cultural differences i.e. between one group and another, the study nevertheless determined that more studies should be done on caregiver groups to ensure that the speech and language intervention provided could relate to the caregivers' beliefs.

The importance of culture and its impact on parenting is further highlighted by an article discussing infant self regulation and the influence of culture and immigration on parenting (Melendez, 2005). Melendez discusses the possible negative consequences of mismatched beliefs in cross cultural interventions. She cites numerous sources in the assertion that culture is a direct influence on child development and states that it is therefore imperative to understand the culture and context from which a caregiver is coming from in order to understand their practices (Gaskin, 1996). Her viewpoint that “cultural reference group”, the personality of caregiver and individual child, and life experience, interact to form parenting beliefs, is supported by Shonkoff & Phillips (2000) & Geiger & Alant (2005). Her recommendation is for intervention to understand and examine the aims and values of each family and to work with the parenting practices that have resulted from these. Thus there is much support in the literature for a closer examination of the parenting beliefs and practices in this rural community.

### **2.7.2. Contextual influences**

The impact of context upon “caregivers’ cultural belief systems” is further analysed in several studies. Parenting practices that have been adapted to meet the specific needs of the context (as previously discussed) might seem pointless or even damaging if the circumstances are not understood. Zeitlin (1996) discusses several studies which explore the parenting practices and beliefs of the Yoruba, a people group native to Nigeria. The contrast between the cultural belief (which places more value on children than over all things), and their practice of withholding food as a means of training the child to learn respect, is explored. Studies noted that children and even toddlers asking for food or talking about hunger were strongly discouraged in daily interactions, and children were provided with far less food than the caregivers. Although the practice of food restrictions

was given a role in developing cultural beliefs (“moral training”), these practices were relaxed when food was in greater abundance leading to the feeling that the practice was simply an excuse to keep the food for the adults. The context within which these practices took place however, was that of extreme economic deprivation with a scarcity of all foods. The withholding of food is considered to be “for their own good” and indeed helps the child to cope in situations of limited resources. Thus, particularly in ‘developing country’ environments, the context needs to be clearly understood before any conclusions can be drawn regarding whether parenting practices are damaging or in need of interference.

Geiger & Alant’s (2006) observations, of typical parenting interactions and practices in a village in Botswana, provides further support for the need for research into specific cultures and contexts for effective intervention. Drawing on Thorburn & Marfo (1990) and Sawadago (1995) they note that studies of beliefs and values in developing countries add knowledge and new insight into ways of learning that are different from those noted in western studies. From their observations of communications between adults and children in the village, Geiger & Alant (2006) note that many differences in learning are apparent, due to both cultural and socio-contextual reasons e.g. poverty, and conclude that the use of western methods of teaching would be inappropriate. They quote Barrera & Kramer, (1997) who caution against viewing one culture as more ‘normal’ than another - a sentiment shared by Seef & Bortz (1994) who conducted a similar study in South Africa (discussed in section 2.8.2). Thus, there is a demand in the literature for further study into communities in need of intervention.

The ease with which judgment is made by western researchers as to what ‘normal’ is, is indicative of a need for a broader research perspective. A study by Tomlinson & Swartz (2003) appraised articles from 12 international journals and identified that a disproportionate amount of the research available (94%), on the psychological impact of risk factors on infant and children, emerged from Europe and the United States of America. Just 15 of over 1700 articles on research in developing countries actually included a researcher who was a resident in a developing country. They compared this to

the fact that 90% of all infants are born in developing countries, where there are significant social and health challenges. In other words, a disproportionate number of infants are born 'at risk' for developmental delay in contexts other than those most commonly researched. Thus, ECI in communities comprising diverse cultures, is predominantly based on research conducted by western researchers who may not have relevant insight into the everyday context of the participants or the cultural beliefs that underlie observed behaviours. Tomlinson & Swartz (2003) concludes that greater collaboration needs to occur between developing countries and first world countries in research matters. It is therefore important to understand the particular culture and context of each family, and failing this, each community - in order for ECI services to be effective.

### **2.7.3. Summary**

Having established that an understanding of the context and culture of a given community is of worth, it is necessary to explore what is known of the community upon which this study is focused. South Africa in general has been subject to a proliferation of studies of beliefs and practices, however the focus of the majority of these studies has been on HIV and Aids and its impact. The fact that much of the research is focused on issues of HIV and Aids is worth noting as it reflects the considerable impact it has had on South Africa as a country. The impact has been most notable in the poverty stricken rural and urban areas. That it is possible to know of HIV only by hearsay in South Africa tells its own story.

## **2.8. Applying the Context**

### **2.8.1. The South African context**

South Africa is a country of extremes. In the previous chapter the high levels of poverty, and the number of high risk households as a result of single parenting, low education levels, domestic abuse and social stresses such as HIV infection, crime and unemployment, are discussed. In 1998, 50% of the population could be classified as

living on or under the poverty line if the 1US\$ per day measure was used (Nationmaster, 2000). As South Africa is classified as a middle income country (World Bank, 2010) this indicates that a large percentage of the country's wealth is held by a tiny percentage of the population. Statistics show that the country's richest 10% holds 45.9% of the country's total income (Nationmaster, 2002). The economic balance continues to favour White South Africans while poverty is dominated by Black South Africans (OneWorld South Asia, 2010) who comprise 79.4% of the total population (StatsSA, 2010). This imbalance, whereby the majority population is in a position of economic disadvantage, is largely the result of the apartheid era. Poverty can also be delineated by living area - 45% of the country's population is classified as living in rural areas and of these rural dwellers, 71% live on or below the poverty line (Afra, 2010). These statistics are supported by similar findings of the Economic Research Service (USDA, 2006, cited in Fish, Amerikaner & Lucas, 2007). Thus, South Africa is a country in which there is a large population of children from Black/non-mainstream cultures at high risk for ECD difficulties.

### **2.8.2. Parenting in South Africa**

How does living in conditions of poverty affect the mother-child relationship? Tomlinson, Cooper & Murray (2005) investigated the relationship and attachment of 147 mother-infant dyads living in extreme poverty in Khayelitsha, a "peri-urban settlement" near Cape Town, in South Africa. A peri-urban area is loosely defined as an economically disadvantaged area comprised of informal dwellings on the periphery of an urban area (Mbiba, 2002). Tomlinson, Cooper & Murray observed mother-child interactions at 2 months and 18 months through a one way mirror in a building in the settlement. They also interviewed each mother at each meeting. They found that 61.9% of the sample of mother-infant dyads were securely attached. As the rate of maternal depression in this area was found to be over 34% (Cooper et al, 1999), these findings were surprising as depression is known to inhibit the sensitivity of the mother's response to the infant (Cooper et al, 1999, cited in Tomlinson, Cooper & Murray, 2005). However they also found this high level of secure attachment was common to many other developing countries. They hypothesize that despite the high risk conditions, factors such

as the cultural value placed on community (Ubuntu); the close living conditions; and the reliance of mothers upon neighbours and friends for assistance in providing for their children, prevents many of the difficulties and emotional stresses that are found in conditions of poverty in developed countries. The finding is supported by Payne's (2005) definition of poverty as more being than simply financial deprivation (cited in Cuthrell, 2010). In addition, the cultural norm is for mothers to carry their infant on their back as they travel and work, to share a bed at night and to feed on demand (Tomlinson, Cooper & Murray, 2005). Crying is responded to by breastfeeding (True et al, 2001 cited in Tomlinson, Cooper & Murray, 2005), and infants are weaned at around one to two years. This forced, close, continuous contact makes the formation of an attachment far easier than in a western culture. Thus, previously held conceptions, that increased stress and deprivation leads to maternal depression and decreased infant attachment, based on the many studies of poverty in developed countries, may not hold true in South Africa or other developing countries (Tomlinson & Shwartz, 2003).

One of the few published studies of the impact of culture on parenting practices within a South African context was conducted by Seeff & Bortz (1994). The study was entitled 'Caregiver-child interaction in a rural village in South Africa'. The study used a naturalistic, social interactional approach to observe nine mother-child dyads within their daily lives over a period of six days. The study investigated the way in which primary caregivers in a rural setting interacted with their children, and reflects on how these interactions impact language development. Observations of semi-structured play and individual interviews were used to obtain the data. As part of the social interaction approach, the researchers lived within the rural community of a Siswati-speaking village for six days. Seeff & Bortz (1994) found that caregivers believed play was undignified, and interactions and communication centered chiefly around directives and instructions for daily chores, but ultimately concluded that the children still acquired language skills appropriate for their "social and cultural communication context" (Schiefelbusch & Pickar, 1984, cited in Seeff & Bortz, 1994, p. 80), enabling them to become "competent members of their society" (Skinner, 1989, cited in Seeff & Bortz, 1994, p.181). Thus, although it is clear that this rural community held different beliefs from the western-

influenced speech-language therapist regarding language development, it should also be clear that these practices were not wrong for that context. These findings do not argue against the socialization models of Borke, Lamm, Eickhorst & Keller (2007) but rather indicate there is a different perspective from which these findings can be seen. They also support the viewpoint that although language development and parenting methods may differ they are not 'wrong' and present viable alternative intervention approaches of which South African speech language therapists may not be aware. Intervention should again therefore encompass the practices of the culture rather than attempting to replace them with western practices (DeRosa & Kochurka, 2006; Garcia Coll & Magnuson, 2003). It thus becomes important to know the cultural practices of the community in order to accommodate them in early communication intervention.

Van Kleeck (1992) explores the effects of using a culturally biased language intervention within South Africa. She reviews the Hanen Early Language Caregiver Program (The Hanen Centre, 2011) which has been used with some success in South Africa and found it to be based entirely on cultural beliefs. She investigates those families in which the program was not successful and draws a number of conclusions. Her first finding was that the families for which the programme was unsuccessful were not "mainstream" and did not always even use dyadic interactions as is the norm in western cultures, but rather multiparty interactions. In addition she refers to a study by Heath (1983) who found, that working class, black caregiver's did not consider it appropriate to hold conversations with children. She further points out that many cultures believe children should not speak until they are spoken to and thus a quiet child may be seen as a respectful child. In her discussion of many other cultural differences she highlights the use of direct teaching as a method used to teach a child to talk. Although direct teaching is only used in western culture for teaching manners, it is reported in many other cultures as the predominant method by which language is taught to young children (Demuth, 1986). When consideration is given to the western based Hanen program, which encourages the caregiver to do the following: to speak frequently and conversationally with the child; to reward unprompted speech attempts; and to find alternatives to direct teaching methods, to name a few of the culturally determined intervention methods, it is not surprising that

the intervention is not always successful in South Africa. Much of the research referred to in van Kleeck's (1992) paper may now be outdated as a result of post-apartheid paradigm shifts and changes in practice that resulted. However her recommendations continue to hold relevance today as acculturation and circumstances change cultural practices. Van Kleeck (1992) recommends that SLT's should understand their own cultural biases first and then seek to understand the specific beliefs and practices of caregivers in each specific family.

Several unpublished undergraduate studies of local culture have been conducted within KwaZulu-Natal in the past few years (Paideya, 1992; Pillay, 1992). Relevant to the proposed area of study, one undergraduate study investigated the toys and play behaviour of children aged 1-5 within a rural community (Ahmed & Kaliprasad, 1995). This qualitative study used a questionnaire together with observation of 19 caregiver-child dyads at play within a structured environment and observation of the child in solo play. The study found play behaviour to be in agreement with normative data of western play in most aspects. Differences noted included less associative play and more play in isolation, and imaginative play was found to be more limited in subject, frequently centering around adult roles at home and household activities. These differences for the children were attributed to: differing cultural values from those of the SLT, with the premise that African caregivers are more authoritative and require obedience rather than independence, and the socio-cultural factors of working mothers and financial stress within the environment resulting in less time for caregiver-child contact and limited life experiences. These findings support research that indicates that a more proximal style of parenting is associated with the interdependent social model (Borke, Lamm, Eickhorst & Keller, 2007; McCollum & McBride, 1997). It is further supported by research that demonstrates that parenting styles that emphasize interdependence are characteristic of caregivers with lower levels of education, as often found in rural areas (Keller, 2003; Keller et al., 2006; Keller, Lohaus, et al., 2004; Keller, Voelker, & Yovsi, 2005; cited in Borke, Lamm, Eickhorst & Keller, 2007).

A further unpublished study was conducted by Kunene (2002). She investigated the nature of communication between Zulu parents and their children through a naturalistic observation and interview process that occurred in the homes of the seven dyads. The parents who participated in the study were all highly educated females (all postgraduate level except for one tertiary level student) and all but one (the student) were employed. The study identified the nature of language form and use within the interactions and noted that parenting was authoritative and directive, with parents encouraging the child's speech during the observation period. Kunene (2002) notes that the environmental context is of significance in determining the interaction style of the dyad. The study investigated the interactions of Zulu mothers and their children. Differences in terms of socioeconomic status, education and employment prevent further generalization of the findings to a rural context.

#### **2.8.4. Summary**

South Africa has a diverse population with respect to culture and socioeconomic contexts. The current local research that is available identifies the need for intervention to be more culturally appropriate. The latter can be achieved by SLT's demonstrating an understanding of the cultural beliefs and practices of caregivers in each community. There is limited research regarding the beliefs and practices of the caregivers living in rural communities.

#### **2.9. Conclusion**

The literature indicates that poor literacy skills could be addressed in part by facilitating and enhancing infants' ECD. The crucial role of the caregiver in ECD indicates that working with current parenting practices and families' daily routines and activity settings could be an effective means of impacting ECD in rural areas. In order to work with caregivers in providing intervention, it is necessary to first understand the factors that influence primary caregivers' beliefs regarding ECI and practices in stimulating ECD. Factors highlighted in the literature as having considerable influence on parenting

practices were poverty and primary caregivers' cultural beliefs. The importance of viewing these factors within the specific contexts of communities became clear. Research into each community and context was recommended. The literature available on mother-child interactions in South African contexts is inadequate as a foundation for the development of ECI in rural areas. The researcher thus proposes that an exploration of the caregivers' beliefs and parenting practices in rural areas in South Africa is necessary, to facilitate infants' ECD.

## CHAPTER 3: RESEARCH METHODOLOGY

This chapter discusses the research process used to explore parenting beliefs and practices in a rural area of KwaZulu-Natal with regards to ECD. Qualitative research methodologies were used. The chapter discusses the aim, objectives, research approach, and research design. The research site, participant selection, data collection instruments, data collection methods and data analysis will also be discussed. In addition considerations such as researcher bias and ethical considerations will be presented.

### 3.1. Aim

To explore the beliefs and practices of primary caregivers regarding ECD in typically developing preverbal infants (birth to 12 months), in a rural context.

### 3.2. Objectives

- 3.2.1. To explore the **beliefs** of primary caregivers regarding ECD.
  - 3.2.1.1. To explore the beliefs of primary caregivers with reference to communication and how it develops.
  - 3.2.1.2. To explore the beliefs of primary caregivers regarding their role in the development of language in typically developing, preverbal infants.
  - 3.2.1.3. To explore the beliefs of primary caregivers regarding the needs and capabilities of typically developing preverbal infants with regard to early communication.
  
- 3.2.2. To explore the **practices** of primary caregivers in stimulating ECD in their preverbal infants.
  - 3.2.2.1. To explore how and when primary caregivers communicate with their preverbal infants.
  - 3.2.2.2. To explore how and when primary caregivers respond to their preverbal infants' non-verbal communication attempts.

3.2.2.3. To explore the daily activities and routines of primary caregivers and their preverbal infants.

### **3.3. Research Design**

The study explored the beliefs and practices of primary caregivers regarding communication development, while accepting and understanding that individuals are complex. Hence, a qualitative research design was deemed most suitable. Cohen, Manion & Morrison (2007) state that the social world is multi-layered and complex and cannot be converted into numbers without losing its true meaning. The design accommodates the ecological theory that acknowledges the influence of multiple factors in the environment in determining beliefs and practices (Anderson, 1998; Dunst, 2004; Sameroff & Fiese, 2000). Leedy & Ormrod (2005) and Geertz (1973, cited in Cohen, Manion & Morrison, 2007) endorse the need for the entire situation of each participant to be grappled with, resulting in “thick and deep” qualitative research data that can be interpreted more fully (Geertz, 1973). Selecting a quantitative study instead of a qualitative research design would have limited the nature of the information obtained within the study. An understanding of the complexities of the multiple influences of culture, personal experiences and context would not have been communicated.

The study drew on phenomenological traditions as the researcher looked at the primary caregivers understanding of the phenomenon of communication development. A *phenomenological approach* seeks to understand a situation or experience from the point of view of the participant (Leedy & Ormrod, 2005). In this study the experience that the researcher sought to understand was that of a primary caregiver facilitating communication development in a preverbal infant, living in a rural community. The researcher required each participant to relate her own perspective on her parenting in keeping with the phenomenological approach. The perspective of the participants was invaluable in a study that seeks to reach across cultural, socio-economic and language

barriers and gain insight into beliefs and practices that may be unfamiliar to early interventionists with a western background.

In addition, the researcher drew on the *interpretive paradigm* which takes the stance that reality is constructed by the social context and is subjectively based (Leedy & Ormrod, 2005). The influence of culture and history should not be ignored (O'Brien, 2001) and was taken into consideration in interpreting the data. This paradigm was used in the acknowledgement of the uniqueness of the individual and their subjective experiences of the phenomenon of communication development. Thus this study attempted to understand the beliefs and practices of the primary caregivers from the perspective of each individual (Cohen, Manion & Morrison, 2007). The researcher acknowledged the effect of the personal biases and beliefs of the researcher on the participants' responses and the impact of these beliefs on the research (Leedy & Ormrod, 2005).

The research was carried out in *three phases* and is illustrated in Figure 3.1.

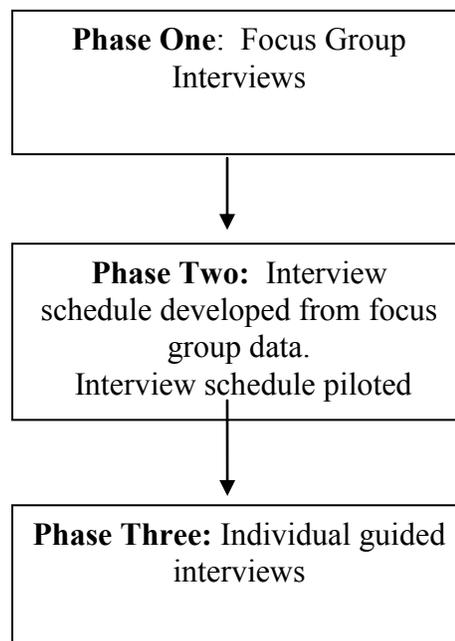


Figure 3.1. The three phases of data collection

**Phase one** used focus groups and a visual methodology (photo elicitation) to develop a conceptual framework of the beliefs and practices of participants regarding ECD in preverbal infants.

**In phase two** focus group discussions were used to assist in developing a data collection tool, in the form of an interview schedule. The use of the interview schedule was piloted.

**Phase three** comprised the **main study**. In-depth information was obtained from participants regarding their beliefs and practices concerning ECD using individual guided interviews of primary caregivers.

### **3.4. The Research Site**

The study was conducted at a government health clinic in eThekweni Unicity, a district of KwaZulu-Natal: one of nine provinces in South Africa. KwaZulu-Natal is situated on the east coast of South Africa (see Appendix B) and has the largest population of Zulu-speaking people in the country. The challenges of this province were discussed in section 2.3. eThekweni Unicity is one of 11 districts within KwaZulu-Natal. The study site was at the Valley of a Thousand Hills in Inanda, a rural region west of the Durban metropolitan area. The site was purposively chosen in order to increase the feasibility of the study. The clinic provides basic health care to a large number of rural communities in KwaZulu-Natal, including; KwaDedangedlale; KwaDabeka; KwaNgcolosi; KwaNyuswa and Fredville. The clinic is accessible by tarred road with a good taxi service, allowing relatively easy access for members of the community. In addition the clinic is situated next to a non-government organisation that has assisted in the initiation of several HIV and Aids treatment and action campaigns. These factors ensure that the clinic is constantly busy. The post-natal clinic in particular is very well attended. The latter was an important factor that influenced the selection of the site, in order to recruit participants. The clinic and staff were also well known to the researcher. The latter was important as the assistance and cooperation of the nursing staff enabled the researcher to establish a trusting relationship with participants, when they noted that the nurses supported the study. Collaborating with the non-government organisation, the researcher

was able to obtain a private setting within the clinic grounds for the focus group and individual interviews. Conducting data collection at the clinic enabled the participants a greater sense of comfort and familiarity, and thus facilitated confidence and openness in communications during interviews.

### **3.5. Participant Selection**

The following criteria were used to select the participants for both the focus groups and the individual interviews:

- Participants had to be the primary caregiver of a typically developing child, who was not more than 14 months old. Recruiting primary caregivers of children slightly older than the 0-12 month target age range widened the pool of possible participants but ensured that the participant still had a clear memory of his/her parenting beliefs and practices in raising the preverbal infant. The study limited the stage of parenting to the preverbal stage (birth to 12 months) as research indicates that many of the markers for age appropriate communication development are developed and encouraged within the first year (Rossetti, 2001). The age of the caregiver and the number of children they had under their care, were not controlled.
- The child had to be in good health and had to meet the developmental milestones in all areas of development (motor, cognitive, communication, and social). The following assessment methods were used to identify good health and typical development: adequate Apgar ratings, normal birth weight and no pregnancy or birth complications (Rossetti, 2001). The judgment regarding the adequacy of Apgar ratings and birth weight was based on accepted levels. Birth weight had to be over 2.5 kgs (Zehnder-Merril, 2001) with a minimum Apgar rating of seven out of ten at 1 and 5 minutes (Odd et al, 2008). In addition, infants should have achieved the developmental milestones of sitting, crawling and babbling within the accepted age ranges. The presence of complications at birth and the development of the infant were ascertained by referring to the immunization chart. The judgement of these criteria was made by the clinic nurse. These

requirements ensured that participants could relate to parenting practices and beliefs that were shaped by their experience with a typically developing infant. On this basis, mothers who believed that there was a health issue with their child (even if it was not identified by doctors), were excluded from the study.

- The participant had to live permanently in a rural area in KwaZulu-Natal to ensure that they represented a caregiver in a rural community with the beliefs and practices shaped by this lifestyle. A participant was judged to be living in a rural area permanently if they had lived in that context for the major part of each year over their lifespan. The clinic services several areas that fitted the definition of rural (as defined in chapter 1 section 1.1.) including: KwaDedangedlale; KwaDabeka; KwaNgcolosi; KwaNyuswa and Fredville.
- The participants were required to be fluent in either isiZulu or English in order for the interpreter or researcher to understand their answers in the interviews. This was due to the researcher's limited skills in the isiZulu language that required the use of an interpreter. This limitation is discussed further under section 5.1.1 pp. 107 in chapter 5.
- The participant needed to be comfortable with sharing his/her beliefs and practices regarding ECD. They were required to be willing to volunteer for the study.

Fifteen primary caregivers were recruited from the post-natal government clinic using two different strategies. Initially participants were selected using two stages however the strategy was adapted through necessity.

### **Recruitment Strategy 1:**

**Stage One:** The infants' immunization chart was initially screened by the clinic nurse who identified mothers and primary caregivers whose infants' charts demonstrated that they were developing typically. Once the criteria for the infants' charts were met the nurse briefly explained the study to the caregiver and referred them to the researcher.

**Stage Two:** The researcher was a qualified SLT. She verified the information received from the immunization chart by questioning the parent. The researcher explained the

study to the caregiver with the help of an interpreter. When the participant demonstrated interest in taking part in the study, the researcher established that the caregiver met the rest of the study requirements.

The researcher recruited nine participants using this recruitment strategy. The researcher was then informed that the clinic nurses would not be available to continue to assist in the recruitment due to time restraints. The recruitment strategy was adapted as follows.

### **Recruitment Strategy 2:**

**Stage One:** The researcher and her interpreter made an announcement in the waiting room of the post-natal clinic explaining the study and asking for participants. The researcher and interpreter approached primary caregivers individually and explained the study when more participants were required.

**Stage Two:** Volunteers were then taken through stage two of recruitment strategy 1. Six participants were recruited using recruitment strategy 2.

Purposive sampling was used, as participants were selected according to their suitability for the study. Selections occurred over a number of days at random times. The randomness of the sample was increased in strategy 1 by the nurses taking the first participants to meet the requirements. In the second strategy the primary caregivers who were first in line at the clinic and thus most likely to be immediately available, were targeted. Fifteen participants were recruited in total. The same selection criteria were applied to both the focus group participants and the individual interview participants.

### **3.6. Methods of Data Collection**

Two types of data collection were used in this study, focus group interviews and individual interviews. The focus group interview method was selected to provide a rapid overview of the beliefs and practices of primary caregivers regarding ECD because of the dearth of information on the topic. The individual interviews provided a means of obtaining in-depth information from an individual perspective thus supporting both the

phenomenological approach and the interpretive paradigm, upon which the study drew. The focus group interview method provided baseline information that enabled the individual interviews to be developed. Overall the two methods helped the researcher to obtain multiple perspectives on the same topic (group and individual perspectives). Thus improving the validity of the findings of the study (Mays & Pope, 2000) and reducing the impact of bias. The use of triangulation is acknowledged to improve the reliability of findings. The methods are discussed below:

### **3.6.1. Focus groups**

Focus groups have been used increasingly as a means to investigate and understand the beliefs and perceptions of groups on medical, social and personal issues (Kitzinger, 1995). They are a means of interviewing a number of individuals at once and thus provide data rapidly. Focus groups have also been identified as an effective means of eliciting information from vulnerable groups, and have previously been used in researching women in rural communities (Wong et al. 1995, Pini, 2002; cited in Liamputtong, 2007). The purpose of using focus groups as the initial data collection method was to:

- Establish a groups' agreement of what comprises common beliefs and practices. Kitzinger (1995) states that an understanding of areas on which there is agreement and those in which there is dissent enables an understanding of "normative" behaviour to be established.
- Obtain information on the study topic from a group perspective
- Provide a less intimidating environment than an individual interview.
- Obtain information in an environment of less pressure, where those who would not be confident about voicing their opinions might gain confidence from hearing others sharing.
- Use the interpersonal communication as a means of deriving deeper meaning behind what is said and thus a greater understanding of the beliefs surrounding the topic (Kitzinger, 1995).
- Use the focus groups as a replacement for the information that might have been obtained through observations.

- Provide a foundation from which an individual interview schedule could be developed.

Formal observations were not a part of the study in acknowledgment of the difficulty in obtaining valid results without long term observation, (Geiger & Alant, 2006). Further Hoff-Ginsburg relates the impact that contextual variations have on observed behaviour, impairing the reliability of the findings (Hoff-Ginsburg, 1994). Data was derived from the interactions of the group members as they discussed the topic of ECD and their beliefs and practices regarding this (Morgan, 1988, cited in Cohen, Manion & Morrison, 2007). Two focus group interviews were conducted (Phase One) following participant selection, with four and five participants in each as recommended by Morgan (1988, cited in Cohen, Manion & Morrison, 2007). More than one focus group ensured that the information obtained was valid as different groups can take very different angles on the same topic or one group may be dominated by a strong personality.

Both focus groups took place in a room in the clinic that was not used by clinic staff. The room was set up with chairs in a circle around a play mat with a few toys for the participants' children. The toys included a home-made rattle, a plastic mobile with a movable ball in it and a soft toy mouse.

The focus groups were requested to reflect on, and respond to, images identified by the researcher - and confirmed by the interpreter- as being related to caregiver-child interaction (see Appendix C for images and related questions).

The transcriptions of the focus groups were used to identify areas that required further investigation and to inform the development of an individual interview schedule (Appendix D)

### **3.6.2. Individual guided interviews**

Individual guided interviews were conducted to obtain in-depth information on the topic from an individual's perspective. In-depth, guided, individual interviews were conducted with six caregivers. A focused or guided interview is a semi-structured interview that

focuses the participant on the themes previously identified in the data obtained in the focus group data, but places no restrictions on the direction and quantity of information the individual chooses to share (Bell, 1999; Cohen, Manion & Morrison, 2007). This is a valuable method of data collection as it enables the researcher to gain in-depth information about the thoughts of individuals regarding the beliefs and practices of caregivers concerning ECD. The individual interview enabled the researcher to obtain a more personal account of the beliefs and practices that the primary caregivers reported. It provided indepth information on the study topic.

### **3.6.3. Informal observation**

Throughout both the focus groups and the individual interviews the researcher used informal observation to gain insight into the information given by the participants. Informal observation is used in this study to describe the researcher using visual clues from the participants to gain a greater understanding of their meaning and to corroborate the accuracy of what they were saying with what they were doing. Thus, for example, the researcher was able to observe from the body language of a few participants that they were possibly nervous or under stress. This information could be used both as a sign to the researcher to adapt her approach to put the participant at ease, and as a consideration when analysing the findings. In addition hearing the participants report breastfeeding and then observing them breastfeeding during the discussion provided an additional level of validity to the data obtained.

## **3.7. Data Collection Instruments**

The following instruments were used in data collection: a focus group interview schedule; a pilot study questionnaire; a guided interview schedule; the researcher; the interpreter; and off-site translators.

### **3.7.1. Focus group interview schedule**

An interview schedule (Appendix C) was developed using seven visual stimuli (photos). The photos related to common interactions between primary primary caregivers and

infants and interactions between infants namely; feeding; playing; carrying; joint attention; and face-to-face interaction. The common nature of these interactions regardless of culture was verified by the literature (Patterson, 2009; Rossetti, 2001). In addition, the photos featured interactions, tasks and objects that were familiar to the participants, this was verified by consulting with the interpreter (a resident of the rural community in this study). The interpreter was asked to comment on the pictures and note any pictures that she felt were not appropriate for the context. When images are used to elicit a reaction or response from the participants it is referred to as photo elicitation (Rose, 2001; Schratz & Walker, 1995). The latter method was proposed by Harrison (2002, cited in Liamputtong, 2007) to examine personal orientations, specifically in in-depth interviews and ethnographic studies. Further, Schratz & Walker (1995) state that pictures “have a power that words often lack”, and “we treat them less defensively” (p. 76). There is also evidence that participants speak with less self-consciousness when talking about images (Harper, 2002). Methods that enabled more natural conversation were of particular importance in this study, as information sharing was already hindered by the cultural and language barrier between researcher and participants. Illustrating an idea, practice, or scenario without previous leading statements allowed the researcher to hear the participants’ interpretations of each image, and their perceptions, with less bias and more honesty. The pictures have a distancing effect that enabled personal topics to be approached with more freedom.

Seven photographs were presented one at a time to the group and discussion was initiated around the content of each image. The images were loosely arranged in order of most common interaction to those the researcher felt were more culturally specific, to enable more culturally specific details to emerge after the details of the more common interactions had emerged. Thus, for example Image A depicted breastfeeding, while Image G depicted a mother carrying her baby on her back (a traditional Zulu method). Five of the photos were selected to illustrate a range of interactions within which language stimulation may occur. These included breastfeeding, joint attention with a caregiver, joint-attention with a peer, independent play, play with a caregiver. The remaining two photos depicted neutral interactions that do not demonstrate active

communication development. These included a child standing with his mother and a child being carried by his/her mother. Questions were developed for each photo to provide an opportunity for the primary caregivers to relate their understanding of these photos and how the interactions depicted relate to communication development. The researcher then used further questions to encourage the participants to relate the image to their own personal practices and beliefs in interacting with their child (see Appendix C).

- Seven photos (Appendix C) were sourced by the researcher from photos on the internet, for use within the focus groups in phase one of the study. The photos were a uniform A5 size and were presented one at a time. The pictures were culturally appropriate to assist the participants' ability to relate to the pictures in the focus groups. This was done by featuring primary caregivers and infants of African origin featured in activities the researcher had observed in the community and (as mentioned) verified by the interpreter. Further the pictures depicted people who were either of undetermined SES or of a similar SES.

### **3.7.2. Pilot study questionnaire**

The pilot study questionnaire form (Appendix E) was developed to obtain feedback from the pilot participant regarding the interview process and the interview content. Thus the questionnaire focused on the following areas: themes, style, interpreter, social skills, and general. The areas were chosen as aspects that could be adapted to improve communication between the researcher and the participant i.e. improving any of these areas would enable the researcher to be more culturally appropriate, easily followed, and relevant to the participant.

The pilot interview was conducted by interviewing one participant using the guided interview schedule (Appendix D). Following the interview the participant was asked to answer a questionnaire (Appendix E) regarding the style and content of the interview process. The feedback received from the participant was used to inform the individual interview process in phase three.

### 3.7.3. Guided interview schedule

The results of the focus group interviews were used to inform the development of the individual interview schedule. The guided interview schedule (see Appendix D) was developed specifically for this study and thus addressed two primary areas, parenting beliefs and parenting practices. The link between the beliefs of caregivers and the practices of caregivers has been clearly established in the previous chapters (e.g. McCollum & McBride, 1997). The schedule was divided into three sections, biographical details, parenting practices, and parenting beliefs. Table 3.1. provides information regarding the motivations for questions developed for the interview schedule.

Table 3.1. Interview schedule questions and motivations

| Interview Schedule Questions  | Motivations  |
|---|--|
| Biographical questions: employment status, education level, number of children etc  | Fish, Amerikaner & Lukas's (2007) demonstrate the possible influence of biographical details such as SES and the education levels of the caregiver. Therefore these factors need to be acknowledged and understood   |
| Beliefs: When do you think the child understands what you say? What do you want your child to learn from you? How does the baby communicate? How does he/she learn? What do you think is bad for your baby? | The need to understand the culturally informed social goals of caregivers regarding the child and the caregivers' beliefs about how a child learns language, is discussed by McCollum & McBride (1998)   |
| Practice: Tell me about a normal day with your baby<br><br>When do you talk to your child? Where? What do you say? Why? How often do you talk to them? How old is the child before you talk to them?        | The International Classification of Functioning, Disability and Health (ICF) supports the need for a clear understanding of the functional daily requirements of any patient to develop appropriate intervention (WHO, 2001)<br><br>Hoff-Ginsburg (1991) concludes that there is a need to know the details of quality and quantity of speech in caregiver-child interactions. |

The results of the focus groups (Appendix F) revealed a number of themes that emerged to address the study objectives. However it also revealed a need for a more coherent understanding of the interaction patterns and routines of primary caregivers and their infants than was provided by the focus group interviews. Thus the development of questions for the individual interview schedule was informed by both the focus group results and the literature.

Studies by Hoff-Ginsburg (1991), Fish, Amerikaner & Lukas (2007) and McCollum & McBride (1998) were drawn on in developing the interview schedule. The researcher also drew on a concept demonstrated in the International Classification of Functioning, Disability and Health (ICF), an international system, developed and accepted by the World Health Organisation, as a common measurement system of the functioning and level of disability of any individual. The ICF takes into account the environmental setting of the individual and thus looks at how the individual's daily activities and functioning abilities work within his/her context (Cieza & Stucki, 2008). It follows that an understanding of the communication requirements placed on both the caregiver and the infant in their particular context, will provide insight into those skills and practices that the caregiver identifies as being necessary for the infant to learn. Although specific areas of enquiry were identified and ordered within specific topics, the interview was allowed to progress in a natural conversation style.

#### **3.7.4. The researcher**

The researcher became a primary research tool within this study. Although the initial intention was to encourage a relationship of rapport between the interpreter and the participants and to take a more observational role, the limitations of the interpreter's experience in facilitating meant that the researcher played a prominent part in every interaction. As the group facilitator and interviewer, the researcher had considerable influence on the nature of information obtained. The level of rapport established and the image that was presented to the participants all served to influence the information that was obtained. Thus the researcher was essentially a 'tool' through which information was obtained (Schratz & Walker, 1995). The researcher had some aspects in common with the participants including, being a mother of young children, having grown up in the same geographic area, and a common political history. However, barriers in the form of language, culture and SES differences, all impacted the level of rapport and affected communication. The researcher needed to compensate and account for these limitations in her data collection and analysis. Thus the researcher was the 'tool' that directed the

data collection process in response to the perceived needs of the participants, to obtain the most comprehensive data possible under the circumstances.

### **3.7.5. The interpreter**

An interpreter was present throughout the study as the first language of the participants was isiZulu, a language which the researcher is not fluent in. The interpreter was female as all of the participants were female. Participants are more likely to share information with somebody of the same gender as they are able to feel in a position of greater control (Thompson & Spacapan, 1991).

The interpreter was trained by the researcher by:

- a) informing her fully about the study,
- b) answering any questions regarding the study and its objectives and,
- c) making the interpreter aware of the need for questions to be repeated as precisely as possible, and of the importance of accurate interpretation back to the researcher.

Despite this the researcher accepts that interpretation is the understanding of the interpreter of what is said, and this was accounted for and limited by gaining an understanding of the perspectives and beliefs of the interpreter and by careful selection of the interpreter. The interpreter was a first language isiZulu speaker who lived within the same community as the participants. She had previous experience in working as an interpreter and is a single mother of two children. For these reasons she was able to facilitate the development of rapport with the participants. She proved to be very helpful in enabling the researcher to understand the reasons for the behaviour of various participants and provided valuable insight into a number of responses obtained in interviews.

The interpreter was trained by the researcher over a period of half an hour prior to the participant recruitment process. The researcher explained the study, the purpose of the study and the type of information that was being sought. The training focussed on the manner in which the researcher wished the interpreter to operate and on ensuring that the interpreter was sensitive to the ethics of research and to the message of the participants. The interpreter was given an opportunity to ask questions after every training and

feedback session. The training continued throughout the data collection process in the form of correction, feedback, and on-going discussion of the research topic.

#### **3.7.6. Off-site translators**

Two off-site translators cross-checked the on-site interpretation of the interpreter by reviewing the audio recording of the focus groups and interviews. The first translator was male, a first language isiZulu speaker with extensive qualifications and experience (community rehabilitation facilitator) in community work. Although he was not of the same gender as the participants he was able to bring considerable experience, in working in the community on primary health issues, to bear on the study. He was able to transcribe the study in part and highlighted some instances in which the personal interpretation of the interpreter obscured or distorted the meaning of a participant. He was not able to provide a comprehensive written transcription of the interviews but instead summarized those areas he felt were inaccurate. The second translator was a male, professional qualified translator who was not first language Zulu speaking but assisted by a first language Zulu speaker. He was able to provide a more accurate written transcription of the individual interviews and highlighted the different interpretations of various words. Having an additional review of the translation improved the validity of the findings.

### **3.8. Equipment/Materials**

The equipment used within this study included the following:

- An Olympus digital voice recorder (VN-2100PC) – this enabled a clear audio record of each phase of the research to be kept digitally, whilst keeping the identities of the participants confidential. It further enabled the translation of each phase to be cross-checked.
- A Sony Handycam DVD recorder (DCR-DVD608) – during the focus group interviews this visual recorder enabled the emotions and context of the discussion to be fully recorded. The video recording was done from a background position

with the consent of all the participants'. It did not intrude upon the discussion and did not appear to create any particular restraint in the interview process. It provided the additional advantage of being able to review the casual interactions of the participants with their infants and older children throughout the interviews.

### **3.9. Research Procedure**

#### **3.9.1. Ethical clearance**

Ethical clearance for the study was sought from the University of KwaZulu-Natal Ethics and Research Committees at School, Faculty and University levels by submitting a research proposal. Once ethical clearance was received, permission to conduct the study was requested from both the provincial Department of Health (KwaZulu-Natal District Health Manager) and the matron of the clinic involved (see Appendices G & H). The researcher met with the district manager and obtained verbal and signed permission for the study. In addition, the district manager arranged a meeting with the clinic matron telephonically. The researcher contacted the government clinic selected for the study to ensure that there were no questions or concerns regarding the study, and arranged a date to discuss the study and its requirements with the staff sister and nurses. It was arranged that staff would be provided with information on the first day of participant recruitment. The researcher obtained permission to use a room in the clinic.

The researcher met with the nurses on the first day of participant recruitment to ensure that they understood the requirements for the selection of study participants and were happy to participate. Written versions of the participant requirements were handed out to the staff to help them to remember the requirements.

The initial sample selection process was plagued by miscommunications, due to the cultural barrier, that the researcher has found to be a part of working in the Valley area. The interpreter initially arranged and trained for the study replaced herself on the first day of participant recruitment. She provided her neighbour, a young, unemployed mother of

two small children, from the Valley of a Thousand Hills. The new interpreter was rapidly trained, she had previously worked as an interpreter for various community outreach projects and proved very useful in establishing a tie with the participants. However secondary translations proved her grasp of the topic was not always accurate and this impeded the interview process.

### 3.9.2. Participant recruitment

Participant recruitment took place over five mornings at the clinic using the procedure described in section 3.5. Two recruitment strategies were used and a total of 15 participants were finally used in the study. The distribution of these participants is shown in Table 3.2.

Table 3.2. Distribution of participants over phases one to three

| Research Phase                            | Preferred no. of participants | Minimum no. of participants required |
|---|-------------------------------|--------------------------------------|
| Phase One: Focus groups                   | 12                            | 8                                    |
| Phase Two: Pilot study                    | 1                             | 1                                    |
| Phase Three: Individual guided interviews | 7                             | 5                                    |
| <b>Total:</b>                             | 20                            | 15                                   |

It should be noted that the researcher needed to conduct participant recruitment twice for the purposes of this study as a result of a nationwide service strike. In the first attempt to recruit participants the researcher recruited 18 participants through recruitment strategy 1. Dates were set for both focus group and individual interviews however the strike forced the clinic to close over the chosen dates. Contacting many of the participants proved very difficult as a result of a lack of phone lines. Although many participants provided cellular phone numbers, many of the numbers proved to be out of service. In addition, those participants who were able to be contacted did not attend the next meeting date despite agreeing to do so. Thus the researcher adapted the recruitment process and started recruitment again.

To ensure good attendance of participants the researcher recruited participants and conducted each focus group interview on the same day. Thus, over two consecutive Mondays (a day on which the clinic was very well attended) a group of five and then four participants were recruited and immediately interviewed in focus groups of that number. Conducting the focus groups immediately after recruitment improved the feasibility of the study by preventing poor attendance and ensuring each focus group was attended by enough participants to form a group. According to Cohen, Manion & Morrison (2007) the minimum requirements for a focus group is four participants. The researcher and interpreter used recruitment strategy 1 in obtaining the participants in the focus group interviews.

Recruitment of the participants for phase two and phase three was conducted using recruitment strategy 2 (see section 3.5.). The pilot study participant and each individual interview participant following this was interviewed immediately following their individual recruitments. The pilot study interview was conducted a week following the second focus group. The individual interviews took place over the one day in the week following the pilot study interview. The researcher made the assumption, based on the fact that the clinic services the local rural community members, that the sample of primary caregivers found at the post-natal government clinic represented a sample of some of the parenting practices and beliefs in a rural community.

In every instance, the researcher screened the immunization cards, with the permission of the matron and the candidates, to ensure no abnormal developmental indicators were present. The candidates were informed about the study and its requirements. Verbal and written information (refer to Appendix I) was given to ensure that candidates were willing to participate and were aware of what was required of them. Consent and information forms were provided in isiZulu (refer to Appendices J & K). An interpreter assisted the researcher in presenting and answering any questions or concerns and assisted in explaining the content of any written forms when needed. The researcher paid transport costs of ten rand for the participant's visit to the clinic and indicated that a developmentally appropriate toy (tactile picture books for the infants, and play-dough for

the older siblings) would be offered for the child of each caregiver in appreciation for participation in the study.

The researcher aimed to obtain data from 20 participants but obtained data from 15 participants as a result of difficulty gathering any number of primary caregivers for the focus group interviews. Participants had to wait for other participants to finish their appointments at the clinic and time constraints made it more feasible to gather smaller groups.

The participants have been described in the following section for easy recall of the details as the data collection process is described in section 3.9.4.

### **3.9.3. Description of participants**

Fifteen participants met the criteria for the study. Of the 15 participants, 13 were the mother of the child, one was the grandmother and one was the full-time, self-described ‘nanny’ who had adopted the child into her home at the age of 3 months. All of the participants were female and spoke isiZulu as their first language.

The Zulu people group is the largest people group in South Africa and has a history of dominating the country prior to the influx of white settlers. Tribal traditions of the culture are still respected in many rural areas and many cultural practices are integrated into modern South Africa e.g. polygamy. Although the influence of western culture has been pervasive there is still a strong belief in the hierarchical structure which places men in a position of power (Rudwick, 2008; von Kapff, 1997). Traditional roles dictated that the women remain at home and care for the children and any crop planting, and maintain the home. The boys were expected to herd the cattle. The men were the owners and leaders of the home, who made any decisions and attended meetings. It was expected that women and children do not speak unless spoken to (von Kapff, 1997). Although these roles have evolved and become less rigid, there is still a significant amount of value placed on having respect or ‘hlonipha’ for elders and men, particularly in the rural context (Rudwick, 2008).

### 3.9.3.1. Description of participants in Focus Groups

The first nine of the fifteen participants recruited took part in the focus groups. The focus group participants fell within the age range of 18 to 72 years although the average age was 28 years. The children's ages ranged from 6 weeks to 12 months. The ages of the participants and the number and ages of their children are depicted in Table 3.3. below. The majority of participants (six out of nine) were from the KwaNyuswa area, an area with some tarred roads and basic services (e.g. some houses have water and/or electricity). Unemployment indicates a dependency on the government child support grant which is drawn on by 2,282,246 primary caregivers in KwaZulu-Natal alone (SASSA, 2009). Although many participants had some English skills all of the participants wanted the interpreter to interpret the researcher's questions.

Table 3.3. Description of participants in focus groups one and two

| Name of participant | Age | Children |   |
|---------------------|-----|----------|---|
|                     |     | No.      | Ages  |
| GP 1                | 23  | 1        | 3months   |
| GP 2                | 26  | 2        | 4 years,<br>3 months                            |
| GP 3                | 19  | 3        | 6 years (her brother),<br>26 months,<br>6 weeks |
| GP 4                | 20  | 2        | 4 years,<br>2 months                            |
| GP 5                | 72  | 2        | 3 years,<br>2 months                            |
| GP 6                | 25  | 2        | 3 years,<br>8 months                            |
| GP 7                | 22  | 1        | 3 months  |
| GP 8                | 30  | 4        | Older boarding children,<br>12 months           |
| GP 9                | 18  | 1        | 3 months  |

Key: GP = group participant

Focus group one had participants with a wide range of life experiences. The first five participants recruited took part in group one. The group included three young, first time mothers with infants of around 6 months. A grandmother with a hearing impairment, who was caring for an infant of 2 months and a toddler of around 2 years, following the death of their mother and a teenage mother of two children (6 weeks and 26 months) who

was caring for her 6 year old sibling following the death of their mother. None of the participants were employed, however three of the young mothers had adequate English indicating that they progressed through school. It was not established to which grade.

Four further participants were used to form focus group two. Group two consisted of three young women each with one child. The infants ranged in age from 6 months to 8 months old. The fourth caregiver was the ‘nanny’ of a child of 1 year who was being paid by the mother to care for the child, the child had lived with the ‘nanny’ from 3 months old as the mother worked “away”. Although the nanny was being paid to care for the child she met the criteria for the study as she was the primary caregiver for the child. The child had boarded with her from 3 months of age. The group spoke almost exclusively in Zulu and there was a lot of discussion and disagreement between the mothers and the ‘nanny’ as to what was good and bad for a child. Again, not including the ‘nanny’, all of the mothers were unemployed and living in poverty.

### 3.9.3.2. Description of participant selected for pilot interview

The pilot study participant was randomly selected by approaching the first person in the queue in the clinic waiting room. An individual interview was used as a pilot for this section of the study. Biographical details of the pilot study participant are shown in Table 3.4. below.

Table 3.4. Description of participant in the pilot study

| Name of participant | Age | Children |          | Lives with                                      | Employment                                  |
|---------------------|-----|----------|----------|---|---|
|                     |     | No.      | Ages     |   |   |
| P                   | 26  | 1        | 4 months | Mother, father, 2 sisters, 2 brothers, 1 nephew | uncompleted office admin course, unemployed |

Participant P proved to be out of the ordinary in comparison to all the other participants in the study as she had recently dropped out of studies in office administration. P was more educated and ‘westernized’ than any other participant. The majority of the interview was conducted in English although Zulu was used when expressing a more complex thought e.g. describing her understanding of how language is learnt. The

interview was thus not a good means of planning and adapting for the interviews that followed.

Although participant P was unusual in her exposure and education levels, she had much in common with the other participants. She was unemployed, a single caregiver, and living in a rural area with her mother and father, two sisters, two brothers and a nephew. She was also isolated during the day as all of her family worked during the week leaving her to care for her baby. P was 26 years old and her baby girl was 4 months old at the time of the interview. The interview schedule remained unchanged following the pilot study and only changes in approach and introduction were made.

### 3.9.3.3. Description of participants selected for individual interviews

Five participants were included in the individual interviews, they ranged in age from 20 to 30 years old. The average age was 25 years old. The details of the participants are shown in Table 3.5. below. Two out of the five participants had more than one child. The age range of the children was 2 months to 13 months with the average age of the children being 7 months. Three of the five primary caregivers were unemployed, all of the participants were living in poverty.

Table 3.5. Description of participants in individual interviews

| Participant Number | Age | Children |                    | Lives with  | Employment                          |
|--------------------|-----|----------|--------------------|---|-------------------------------------|
|                    |     | No.      | Ages               |   |                                     |
| M1                 | 20  | 1        | 13 months          | Mother, 4 sisters, 1 brother                          | Grade 12 No English, unemployed     |
| M2                 | 25  | 1        | 2 months           | Husband, father-in-law, brother-in-law, sister-in-law | Achieved Grade 10. unemployed       |
| M3                 | 25  | 2        | 6 months; 7 years  | Mother  | Part time kitchen staff             |
| M4                 | 30  | 1        | 2 months           | Sister  | Grade 10 full time unskilled labour |
| M5                 | 25  | 2        | 12 months; 4 years | Fiance  | unemployed                          |

### Profiles of individual interview participants

The *first participant* was M1, she was a young single mother of 20 years with a baby of 13 months. She presented as very uncertain and young and constantly looked to the interpreter as though for guidance as to what to say. M1 reported she had reached grade 12 however she struggled to express herself in English. She had never been employed and lived with her mother, four younger sisters and a brother. This interview was particularly difficult for the researcher as she struggled to overcome the language /cultural barrier and could not help M1 feel more relaxed during the interview. Although M1 reported that she reached grade 12 the researcher felt that in many ways M1 appeared the least able to respond to the questions posed.

The *second participant* was the only married participant. At 25 she had been married on the day she had her baby, who was 2 months old at the time of the interview. M2 was confident, pretty and dressed with natural style. She reported she had reached grade 10 at school and had previously worked as a domestic worker. She was living with her husband, and his mother, brother and sister. M2 had relatively good English and the researcher was able to achieve a good level of rapport quickly with her as a result of swapping birth stories. The amount of information shared contrasted sharply with the interview with M1.

The *third interview* was conducted with M3 who had brought her daughter of 6 months for a check up. M3 was 25 years old and had a 7 year old son in addition to her baby. She lived with her mother. She worked part-time as kitchen staff in a restaurant and left her baby in the care of her mother on these occasions. M3 had some English.

M4 was a mother for the first time at 30, at the time of the interview her daughter was 2 months old. M4 worked full time for a butchery, from 7am to 6pm seven days a week. She was allowed 1 day off a month and had been working for a year prior to having her baby. M4's sister cared for her baby during the day while she worked, M4 only saw her baby at night. As a result her baby was on formula and not breastfed. Although she had very little contact with her baby during the day she slept with her in her bed during the

night. This participant could still provide information in the form of her opinions and beliefs regarding parenting.

The *final interview* was conducted with *M5* a mother of two at 25 years old. *M5* lived with her 12 month old son and her fiancé while her 4 year old daughter lived with her mother. This is a relatively common arrangement in the area, in the researcher's experience, and results when the mother goes to live with a man who is not the father of the previous child. Another common practice experienced in the area is for the partner to wait to see if the mother can produce a male child prior to contracting to marry the mother. *M5* did not relate which grade she had achieved in school however she had never been employed. She was able to add to her answers with information from her experiences in raising her older daughter. This interview was rather strained as her baby had been treated for a burn on his leg at the clinic prior to the interview and he was in considerable pain. The researcher tried to finish the interview as quickly as possible to enable the mother to take her son home.

#### **3.9.4. Data collection**

Data collection took place in three phases as previously described in section 3.3.

**Phase One** used two focus groups with a focus group schedule, that was supported by a visual methodology (photo elicitation), to develop a conceptual framework of the beliefs and practices that are held by participants regarding ECD in preverbal infants.

**In Phase Two** the researcher used the data obtained from the focus groups (see Appendix F) to develop an individual guided interview schedule. A pilot study was conducted using this interview schedule. The pilot study participant provided feedback on the interview process by answering a questionnaire post-interview (Appendix E).

**In Phase Three** the researcher conducted individual guided interviews of primary caregivers to obtain in-depth information from participants regarding their beliefs and practices concerning ECD. (See Figure 3.1 on page 42)

The procedure followed by the researcher in conducting data collection will be described next in chronological order.

#### 3.9.4.1. Phase one: focus groups

- Two group interviews were conducted following the same format with the same interpreter. The focus groups took place at the clinic site, and the researcher paid for the transport costs of the participants.
- The researcher used a comfortable interaction environment to build rapport with participants. Tea and cake were offered before the focus groups began, using a separate room on the clinic property for the gathering. The room was empty except for toys and a mat placed on the floor for the older children and chairs placed in a circle around the mat. The researcher and participants differed with respect to culture, socio-economic status, and language. Thus establishing rapport was of particular importance to encourage the participants to be honest in the sharing of their beliefs and practices regarding ECD.
- Once the participants and their children were all gathered and seated in the focus group room, they were offered tea and cake. The participants were given time to settle their children and converse with each other. The researcher and interpreter then joined the group and conversed on general topics (e.g. children) until the atmosphere was more relaxed. The settling of the participants took around 15 minutes for each group.
- The focus group topic was re-established by formally introducing the study and the researcher and interpreter explained their roles more fully.
- The focus group interview was then conducted using photos to stimulate discussion, and direct questioning (Appendix C).
- Each focus group lasted just over 40 minutes (focus group 1: 42 mins; focus group 2: 40 mins). Both focus groups were video recorded and audio recorded to facilitate informal observation of the mother-infant interactions.
- Once the interview was completed the participants were given developmental toys for their children and thanked for their participation.

#### 3.9.4.2. Data analysis of focus group interviews

- The information obtained in the focus groups interviews was analysed using open coding (Leedy & Ormrod, 2005). The data was transcribed and translated into English for further analysis.
- Data analysis was carried out according to the steps laid out by Creswell (1998, cited in Leedy & Ormrod, 2005). Creswell's (1998) system allowed an overall sense of the data to be formed by organizing, perusing, classifying and synthesizing the information into meaningful data that could be illustrated for the understanding of others.
- Thus, the researcher organized the data into two focus group transcripts that were numbered in order of occurrence.
- Themes were identified by perusing each transcribed interview and noting common focus points within all the scripts that were relevant to the study objectives.
- The researcher used a highlighting system to code the themes by colour. Thus information relevant to each theme was identified by highlighting the reference in that theme's colour. Thus all references to daily activities were coded green; all references to beliefs about parenting were yellow; and beliefs about the role of the infant were blue. Where references were relevant to more than one theme they were underlined with all the colour codes associated with those themes.
- The data within each theme was used by the researcher to inform the development of a guided interview schedule (Appendix D) and to confirm the validity of individual interview findings.

#### 3.9.4.3. Phase two: pilot study

- The main aim of the pilot study was to establish the correct interview style and to verify the questions and topics used in the interview schedule. The aims of the pilot study are reflected in Table 3.6.
- One participant was recruited for the pilot study. She was informed of the purpose of the interview and the information that she could provide once it was completed by answering a questionnaire (Appendix E).

- An in-depth guided interview was conducted with the participant.
- Following the interview the participant was taken through the pilot study questionnaire (Appendix E). The questionnaire was developed to identify any changes that were needed in the interview style or content in relation to the study.

Table 3.6. Purpose of pilot study

| Aim of Pilot Study   | Method used  | Response of participant  | Adaptations   |
|--|--|--|---|
| 1. To validate the identified themes of biographical details; parenting beliefs and parenting practices. | <p>Once the interview was conducted the interviewee was asked to:</p> <ul style="list-style-type: none"> <li>• comment on the relevance of the themes discussed, in relation to the topic,</li> <li>• suggest any themes that should be included that were not (Cohen, Manion &amp; Morrison, 2007). Refer to Appendix D.</li> </ul>           | <ul style="list-style-type: none"> <li>• Provided comprehensive information relating to each theme.</li> <li>• requested more information on communication development.</li> <li>• stated no changes were necessary to the themes</li> </ul> | The purpose of the interviews was explained more clearly to prevent false expectations.   |
| 2. To identify an effective method of introducing each theme.  | <ul style="list-style-type: none"> <li>• A trial interview schedule was developed using the themes identified and the researcher discussed each theme with the participant.</li> <li>• the participant was asked to reflect on how these themes could have been more effectively introduced, after the interview had been conducted</li> </ul> | <ul style="list-style-type: none"> <li>• No changes were needed.</li> </ul>  | The introductions to each theme were established to need comprehensive explanations. A simplistic method of introducing the themes was established. |
| 3. To develop a comfortable method of interaction using the interpreter.                                 | <ul style="list-style-type: none"> <li>• Practising communicating through the interpreter enabled the process to feel more comfortable for everyone.</li> <li>• Feedback was obtained from both the interviewee and the interpreter regarding how the process might be improved.</li> </ul>  | <ul style="list-style-type: none"> <li>• No changes needed.</li> </ul>   | None  |

Table 3.6. Purpose of pilot study continued

|   |   |  |             |
|---|---|--|-------------|
| <p>4. To identify appropriate interaction mannerisms e.g. avoiding speaking about financial difficulties.</p> | <ul style="list-style-type: none"> <li>• Questioning of the interviewee post interview to identify weak points and methods. Obtaining suggestions regarding how this could be improved (Appendix D).</li> <li>• Questioning the interviewee to identify any culturally inappropriate behaviours, comments or opinions demonstrated in the interview.</li> <li>• Analysis of the recorded pilot study interview assisted in identifying an effective interview technique.</li> </ul> | <ul style="list-style-type: none"> <li>• No changes needed.</li> </ul> | <p>None</p> |
|---|---|--|-------------|

- The interview was video recorded and audio recorded and reviewed by the researcher.
- The participant had no recommendations or suggested changes to the themes, style, use of the interpreter, and social skills. Her only comment was a query regarding language development. She indicated that she had expected more information giving and that she would like to know more on the subject.
- The comments of the participant were assimilated with the findings of the researcher and the translator, and adjustments were made to the interview process. These adjustments included: providing a clearer explanation of the study at the outset of the interview, asking participants if they would like further information on language development at the end of the interview, and providing a brief explanation of how best to use the developmental toy given to each child at the end of the study.

The data collected during the pilot study was analyzed in conjunction with the data from the individual interviews. The data was included in the final results as the pilot study participant was felt to have been able to add a level of insight into her beliefs and practices that the other participants were not able to provide. The interview content and process did not alter so that the pilot study interview process was comparable to the additional individual interviews.

#### 3.9.4.4. Phase three: individual interviews

- Individual interviews were conducted with five mothers one week after the pilot interview. All of the interviews occurred on the same day, each interview lasted approximately 40 minutes with 30 minute intervals between each interview. This interval time was needed so that the researcher could briefly assimilate the information and recruit the next participant.
- The researcher and the interpreter recruited each participant from the post-natal clinic just prior to each interview taking place.
- Once the study was explained and the caregiver consented to participate, the researcher interviewed each participant using the individual interview schedule outlined in Appendix D. The researcher tried to maintain a conversational style in conducting the interview and ensured that each question was answered by ticking each question as it was addressed. Variations were noted between each participant in terms of talkativeness and confidence in sharing information. Less depth of information was provided by reticent or uncomfortable participants.
- The interpreter was introduced at the beginning of each interview and the caregiver was invited to use the interpreter whenever she felt she needed to. The researcher tried to maintain a relaxed and friendly atmosphere by dressing down, maintaining ongoing conversation in topics familiar to the primary caregivers, being relaxed herself, and placing the chairs in a loose circle rather than directly facing the participant.
- The interviews were audio-recorded and video-recorded.
- Following the interview the researcher reviewed each recording and took notes of possible interpretations and motivations for the data obtained.
- The audio-recordings were then handed to the off-site translators who transcribed the entire interaction into English and noted any disagreement in translation from that of the interpreter.

### **3.9.5. Data analysis**

- Data were analyzed using Creswell's data analysis spiral (1998, cited in Leedy & Ormrod, 2005). Creswell's (1998) system allowed an overall sense of the data to be formed by organizing, perusing, classifying and synthesizing the information into meaningful data that could be illustrated for the understanding of others.
- Thus, the researcher organized the data into interview transcripts that were numbered in order of occurrence.
- Themes were identified by perusing each transcribed interview and noting common focus points within all the scripts that were relevant to the study objectives.
- The researcher used a highlighting system to code the themes by colour. Thus information relevant to each theme was identified by highlighting the reference in that theme's colour. For example: all references to daily activities were coded green; all references to beliefs about parenting were yellow; and beliefs about the role of the infant were blue. Where references were relevant to more than one theme they were underlined with all the colour codes associated with those themes.
- Once the data within each theme was identified, the researcher was able to synthesize the information into findings that could be discussed in relation to the research question and literature.

Data collection, analysis and interpretation took place concurrently as common themes and ideas emerged in the collection process.

### **3.9.6. Researcher bias**

In any study in which the researcher is investigating a population of a differing culture, it is important for the researcher to be aware of the culturally appropriate behaviours expected of her. Thus it is important to know the culture the researcher is working in. It is far more important however for the researcher to be aware of herself, her own beliefs and the cultural paradigms that she brought with her into the study (Terhune, 2006).

In this study the barriers for interacting openly and honestly were significant. The population under exploration were from a different culture, spoke a different language, came from a different SES, and had a history of subjugation by white people. In addition to these barriers, the nature of this study (a qualitative methodology) placed the researcher as a primary tool in data collection, analysis and interpretation (Schratz & Walker, 1995; Vakkayil, 2007). It was therefore crucial that the researcher made herself aware of her viewpoint, acknowledged her standpoint, and compensated for any bias, whether conscious or otherwise.

The researcher thus kept a reflective field journal for the data collection process (Kessler & Lund, 2006), fieldnotes were made after a brief initial overview of the interviews was made. Various methods (e.g. providing time before the interviews to build rapport, using a local interpreter) were used to attempt to lessen the barriers between the researcher and participants. Previous qualitative studies that faced cultural and language barriers include for example: Moscardino, Nwobu & Axia (2006), and Kessler & Lund (2004). These studies all made use of methods to overcome the difficulties of numerous barriers to fully understanding the participants' contributions to the study. The researcher drew on the use of a journal by Kessler & Lund (2004) and Stuart (2004). The researcher also incorporated the methods of Moscardino, Nwonu & Axia's (2006) study, which placed considerable emphasis on building the trust of the participants by being upfront and open in all interactions, using a trusted mediator from the community to introduce them to the participants and ensured that communication was made as easy as possible for the participants.

- Reflective field journal

This was a written record of the data collection process and the decisions and motivations for these decisions (Kessler & Lund, 2006). Consulting back to this record provided a distancing effect which enabled the researcher to critically analyze her actions and reactions, and provided a more distanced viewpoint from which the participants' interactions and impact of these interactions could be analysed.

- Note taking

These were notes made by the researcher while the interviews were still fresh in her mind following a review of the recorded interviews. The researcher made broad summations of the information provided and noted possible motives and interpretations for the data provided in the interviews (Rossman & Rallis, 2003).

- Ice Breakers

These were methods used by the researcher to lessen the cultural, language and SES barriers between the researcher and the participants (DeSilets, 2008).

- Initially the researcher relied on her previous good relationship with the clinic nursing staff. The initial endorsement of the study by the nurses was intended to overcome distrust surrounding the motives and requirements of the study.
- The use of a venue at the clinic was aimed at providing a neutral ground for interaction.
- The translator used in the study was a mother who was living in the area under study and was able to provide a further sense of the familiar for the participants
- The start of each focus group interview included an informal opportunity for the researcher to build rapport with the participants. By providing tea and cake before each interview, conversation was able to occur naturally as the participants and researcher interacted and exchanged basic information about themselves and their children.
- The researcher tried to highlight the common ground between herself and the participants by focussing on her role and experience as a caregiver in conversations, and using a casual interaction style.

The outcome of the steps taken, to compensate for the biases and differing backgrounds of those involved in the study will be discussed in chapter 4.

### **3.9.7. Validity, rigour and trustworthiness**

The researcher sought to improve the validity and trustworthiness of the research data through several means. These included: triangulation; duplicate focus groups; using visual images, demonstrated to improve validity (Liebenberg, 2009); and referring to the literature. The focus groups served the purpose of triangulating the information obtained with the data collected in the individual interviews in Phase Three (Krueger, 1988; Morgan, 1988, cited in Cohen, Manion & Morrison, 2007). Triangulation is when several sources of data are collected to corroborate and validate the findings (Leedy & Ormrod, 2005). It is envisaged that the data supports the findings from each data source. It is used “in order to produce as full and balanced a study as possible” (Open University course E811, 1988, p. 54, cited in Bell, 1999). The validity of the findings of the study are increased when information from Phase One supports the findings of Phase Three.

### **3.10. Ethical Considerations**

The primary ethical considerations in any study should include the participants’ rights to: protection from harm; informed consent; privacy; and an honest reflection of findings (Leedy & Ormrod, 2005; Cohen, Manion & Morrison, 2007). Further, the participants should not feel compelled to participate but should feel free to take part in or leave the study at will. The general motivation behind this is that a researcher should leave “the field open” for other researchers to come in and conduct further studies (Bell, 1999). This would not be possible if participants’ rights were violated, as further research would not be welcomed. In consideration of these rights the researcher has ensured that:

- 1) Participants were fully informed as to the nature of the study, and of what would be required from them. This was done through giving information verbally and in written form (see Appendix I), in the first language of the participants. The researcher made herself available to participants for questions and concerns by being present in person, and by providing a contact number. The interpreter was constantly present to prevent misunderstandings resulting from a language barrier. Consent forms were written in

isiZulu and read in isiZulu to participants who were unable to read, to ensure participants were able to give their informed consent (see appendices J & K).

2) Although this is not a study in which physical harm was a concern, the researcher ensured that harm was not caused by any violation of privacy rights, by ensuring that participants retained anonymity within the study and report process. Participants were also informed of their freedom to refuse to answer any question if they felt it was too sensitive a topic. Copies of transcripts and recorded data have been retained confidentially to establish the honest report of findings should they be queried.

3) Further, consideration was given to preventing any bias of the researcher from influencing the interpretation of data. Unacknowledged bias in the interpretation of the results would result in an inaccurate portrayal of the data. The most important step in the process of accounting for bias is to 'know thyself' (Terhune, 2006), thus the researcher examined herself thoroughly for entrenched and unconscious bias or prejudice. Limitations in this regard will be stated clearly within the report. A course on ethics in research has been completed by the researcher.

4) It should also be noted that the researcher consulted with Jean Stuart, the Director of the Centre for Visual Methodologies at the University of KwaZulu Natal, with regard to the ethical considerations related to the images used in the study. It was determined that, as the pictures used within the study were obtained from the internet they are considered to be within the public domain and thus are assumed to be open for use (personal communication, April 9, 2010). In addition, as the pictures were used as prompts within the study and the study itself does not have negative associations, no harm was done to the subjects featured in the images. The subjects within the photos are not known to the community and thus they remain anonymous. Thus, no negative association or wrongful representation took place regarding the photos (Karlson, 2008).

5) The data obtained will be stored securely for five years, in collaboration with the researcher's supervisor, thereafter the information will be deleted from the computer disc it is stored on.

### **3.11. Summary**

The researcher explored the beliefs and practises of caregivers with regard to ECD using a qualitative research design. Two approaches were used, the phenomenological approach and the interpretive approach (Leedy & Ormrod, 2005; O'Brien, 2001). Focus group interviews provided information for the development of individual interviews which were used to obtain information from the caregivers' perspective. The information was analysed using the interpretive paradigm (O'Brien, 2001), and due consideration was given to issues of bias and the impact of the context on the data.

In the following chapter the researcher will present the data obtained through this qualitative methodology and discuss the areas identified as being of particular significance to the study.

## CHAPTER 4: RESULTS AND DISCUSSION

### 4.1. Introduction

This chapter reviews and discusses the findings from phase 3, the six individual interviews. The results of the individual interviews have been organized within the two study aims: *Parenting Beliefs*, and *Parenting Practices*. In relation to **Parenting Beliefs**, three themes were identified as relevant to the study aims: 1) *The role of the caregiver*; 2) *the role of the infant*; and 3) *how communication develops*. In relation to **Parenting Practices** the information falls into two themes: 4) *the family's daily activities*; and 5) *primary caregivers' language stimulation*. A discussion of the results takes place under each theme heading. The overall findings of the study are then discussed in relation to the study aims and literature.

The researcher would like to acknowledge that these findings are already limited by the researcher's personal bias's, which undoubtedly influenced the identification of which data was relevant. Further, it should be noted that there are possibly many alternative interpretations of the data from those presented in this chapter.

#### 4.1.1. Developing the themes

The themes for this study were developed both from the objectives of the study and from an analysis of the data collected within the focus groups (phase 1, as seen in Appendix E). The study objectives dictated the need to identify themes within the areas of caregiver beliefs and caregiver practices regarding ECD. The sub-aims of the study objectives guided the identification of themes 1, 2 and 4. The study objectives drew on literature that motivates for an increased understanding of parenting practices (e.g. Greenfield & Cocking, 1994; Van Kleeck, 1992), and demonstrates the impact of parenting beliefs on these practices (e.g. McCollum & McBride, 1997).

## 4.2. Results and Discussion

### 4.2.1. Parenting beliefs

The researcher sought to address the following three sub-aims in exploring parenting beliefs: 1) Caregivers' beliefs regarding their role in developing ECD; 2) caregivers beliefs regarding the capabilities/role of the infant in ECD; 3) caregivers' beliefs regarding communication and how it is developed. The beliefs of the caregiver were explored using individual interviews.

#### 4.2.1.1. THEME 1: Role of the Caregiver

##### i. Participants beliefs regarding the role of the caregiver

Each mother was posed the same question, “What do you think the role of the mother is?”. Some mothers needed this question rephrased, to “what do mothers do?”, or, “what is the job of the mother?”. The general answer was a brief statement to the effect that the mother raises the child. When pressed to elaborate on this statement mothers responded that they: “feed the baby”, “raise a healthy baby”, “comfort the baby”, “play with him”, “teach her”, in various combinations. P provided this example when asked to elaborate:

*R: What is the job of the mother?*

*P: It's to look after the baby, teach her... like when I wake in the morning I take her and say “Hello! How are you?” ...like that kind of thing.*

P added that she felt her role was also to teach her child how important education is as she grows older and to show her how to look after herself. This view that the mothers role is to care for the child and protect him/her, teach the infant, and develop the child's independence is supported by the focus groups participants' descriptions of the mothers in the photographs (as seen in Appendix F).

When asked what they want to teach their infant, and what they think they can teach their infant in the future, mothers gave a very clear answer, six out of the six mothers reported that they wanted to teach their infant to have respect. This was clarified as the desire for the infant to learn to be respectful towards others. It should be noted that the off-site translator explained the meaning of this word (‘respect’) as being unlike the western held

definition but more as the expression of a social competence, as something that allows the child to fit within the community appropriately. Two mothers stated the child needed respect for her elders, and two mothers related this as respect for “adults and also young people”. P went further and stated that she felt that having respect was the best way for her child to learn from others.

Other skills and characteristics that mothers felt they should instil in an infant included: the child being clever, the child being able to speak Zulu and English, the child “*knowing herself*” (a term used to refer to good behaviour according to the translator), the child enjoying school, and being kind and helpful to others. Walking and talking were reported by two mothers as important skills to develop.

#### ii. Discussion: Balance and respect

Two things were made clear in investigating the role caregivers felt they played. The first belief that became apparent was the balanced view of the role of the mother in general. In contrast to previous studies of tribal communities that have suffered deprivation – where a greater focus is seen on the physical needs of the infant (Moscardino, Nwobu & Axia, 2006; Zeitlin, 1996) - participants overall related a more balanced view of the caregivers role. This view included: their responsibility in maintaining the health of the infant, providing the infant with attention, comfort and enjoyment (play), together with the need to teach their infant new skills. These beliefs weren’t contradicted in any way by any of the participants, however each participant had a slightly different emphasis on an aspect of the mother role. This indicates the individual nature of the mother’s perceived role to the researcher. However, the general belief that the mother should teach the infant new skills could be used in motivating caregivers’ participation in an early intervention programme. This will be discussed further under implications (in chapter 5).

The second belief that became clear was that every participant, whether asked directly or not, brought up the need or desire to teach their infant respect. According to the translator, the respect referred to is not the western based trait of holding someone in high

esteem (Wordnet, 2010). Rather respect refers to the ability to cope socially by interacting appropriately with every person of every station within the community. The translator described this as a necessary skill in a highly social culture where community plays a significant role in the development and survival of every child. Thus emphasis on the child learning respect can be seen as an extension of the responsibility related by caregivers to teach their children how to cope in the world. If this interpretation is correct then this is a significant indicator of the importance that is placed on acceptance by the community. Any belief that is so predominantly held and so frequently mentioned should be considered an important clue in understanding the paradigms from which caregivers in the community operate. If caregivers view respect (or social competence) as being of key importance in parenting their infant then it follows that a certain amount of attention will be given to making the infant fit into the community in more than one way. This finding is supported by the various parenting goals that primary caregivers identified. The implications of this finding for early communication intervention will be discussed further in chapter 5.

The third belief follows on from the second belief. Participants referred to the need to have the infant play with others to show that he/she is healthy. The need to teach the infant to walk and talk was also mentioned as being important. If a primary aim is for the infant to successfully merge into the community, as suggested by the second belief, it may then also follow that certain behaviours and practices would be strongly discouraged. An example of this may be the extreme stigma that research indicates is attached to the HIV /Aids epidemic, particularly in rural areas of South Africa (Campbell, Foulis, Maimane, & Sibiyi, 2005). A study conducted by Campbell, Foulis, Maimane, & Sibiyi (2005) found that economic and political factors work to increase the stigma attached to HIV/AIDS and interventions related to the disease. This theory supports the assertion that caregivers place particular emphasis on maintaining the health of their infant to avoid the possibility of their infant being seen as HIV positive. This finding should be considered and explored more fully, as it is possible that mothers may fear taking part in a language intervention program in case it impairs their infant's position within the community by associating intervention of any kind with HIV/AIDS.

#### 4.2.1.2. THEME 2: Needs and abilities of the infant

##### i. Participants' beliefs regarding the needs and abilities of the infant

Mothers in this study believed their children could learn: to show respect for others, to walk, to be helpful to others, to talk both Zulu and English, and to have good behaviour. In addition one mother reported she wanted her infant to be a doctor when she grew up.

The expectations and understanding of the infants' abilities differed between mothers. Five out of six *mothers believed that their child understood them to some degree*. The age at which they thought understanding was present differed according to the age of their infant. For example:

*R: How old was she when you started talking to her?*

*M5: When she was 8 months*

*R: Why did you start to talk to her then?*

*M5: That is when I realized that she is starting to understand things*

*R: How did you know that she was understanding?*

*M5: When I called her name she used to turn her head and look at me*

*R: Does she talk now?*

*M5: Yes, she can say basic things like 'mama'*

*R: Do you think she understand more words than what she can say?*

*M5: Not yet*

M5, whose daughter was 12 months at the time of the interview, related how she realized her infant understood her at eight months because she began to turn towards her name being called. She did not think that she understood more than a few words however at the time of the interview. M4 reported she felt her infant (two months) would start to understand her at four months of age and expected her to start talking at around the age of nine months to a year. She related that she felt that her infant had a certain level of understanding as she smiled when she spoke to her. P was uncertain of the amount her infant understood at two months but predicted that at nine months to a year she would begin to understand what was said to her (this was based on observations of her nephew).

M1 related a belief that her child only had very simplistic thought patterns e.g. thinking about food.

*R: [referring to what the infant thinks about] About what kind of things?*

*M1: She thinks about food and about the mother when she wants to be breastfed*

This belief in the infant's ability to have simplistic thoughts was also related in the focus groups, as seen in Appendix F, when participants endowed the babies in the photos with feelings and thoughts.

All of the mothers understood crying to indicate a need in the child, explaining that it may be because the infant needs a nappy change, or has hunger, pain, tiredness, or illness. Two mothers also reported that crying was used as a means of communicating a 'want'. M3 related how she used to bath her infant in the afternoon but if it was too cold then she wouldn't bath him. At the time in the day when she would usually bath him, he began to cry. M3 believed that was because he wanted to bath. She also related how he tried to tell her things by crying and looking towards things that he wanted. M2 also had a very literal interpretation of her infant's movements. She related how her child touched his head if he wanted her to scratch it and touches her mouth if he is hungry. She thus demonstrated a great sensitivity to her child's communication attempts and a high level of expectation in the capabilities of her infant. This understanding that the baby was *able to communicate to a limited degree* was shared with the majority of the focus group participants (see Appendix F).

Mothers expected their babies to learn through copying/modelling i.e. they related an expectation that their children would learn by seeing what the mother does. For example:

*R: How do you think babies learn to talk?*

*M2: I would say if there is the time when he will speak and also he will learn from what I'm saying. If God has created him to talk he will talk. He'll mimic what I'm saying even if he doesn't do so properly and I'll correct him*

The mothers reported they would also teach the child by telling them what was good and bad. However this expectation was spoken of in the future tense by most of the participants who had infants under a year, indicating that they did not expect the infant to

learn at the current age. Only M1, whose child was 12 months old, reported that she taught her child by telling her when she did the wrong thing. She gives a verbal warning first and then a smack if she continues to disobey her. This indicates a high level of expectation in the understanding of a child of 12 months. M1 should be remembered as being the participant with the worst English skills and who was the least comfortable in the interview environment. Other mothers reported that their children weren't old enough to smack yet. P related that:

*P: The best way to raise a child is to talk to it and show it how to do the right things rather than shouting at it and hitting it – as happened when I was growing up.*

#### ii. Discussion: A physical orientation to infants' needs

The researcher suggests that participants portrayed a very *physical orientation* to the needs and abilities of their infants. Although the caregivers know the child is communicating, the majority of participants did not indicate any knowledge of the connection between the child's cries and the development of anything beyond an ability to share an immediate physical need. This is perhaps indicative of a lack of understanding regarding the link between early communication and later language development. Thus although the caregiver may respond to the infant and thereby develop a bond with the infant (Billeaud, 1993; Deutscher, Fewell & Gross, 2006; Nord, Lennon, Liu & Chandler, 1999, cited in Horodyski & Gibbons, 2004; Roseberry-McKibbin, 2001), the response may sometime be inappropriate (e.g. the mother offers the child the breast if the cause for crying is not evident) as participants do not appear to anticipate the infant having a need for attention, or stimulation. Such responses are classified as decreased maternal responsiveness or emotional availability (Meins, Fernyhough, Fradley, & Tuckey, 2001, cited in Paavola et al). According to Robinson & Acevedo (2001) the mother's ability to read the physical or emotional needs of the child accurately (emotional availability) has a direct impact on the development of the child's emotional vitality (the child's willingness to make communication attempts in various environments). Thus participants demonstrated beliefs that support the development of a maternal bond and ensure the health of the infant but that may unwittingly decrease the

infant's willingness to learn to communicate as a result of not being able to interpret the signal correctly (Robinson & Acevedo, 2001). The researcher acknowledges that the beliefs of participants regarding crying were not sufficiently probed during the data collection process and thus much of this discussion is based on the absence of information which the researcher anticipated her questioning would reveal, and speculation as to why participants did not refer to these areas. This limitation is discussed further in chapter 5 (pg 103).

A further point noted in the data collection was the belief in the *infant's ability to learn through copying*. This method of learning is commonly related to a proximal style of interaction (McCullum & McBride, 1997) where less verbal explanation and more demonstration occurs. The previously discussed emphasis on respect (as a tool for social acceptance) supports this finding, as there is a clear link between interdependence and a proximal interaction style. That participants' place great value on the role their child plays in the community is a textbook example of an interdependent socialization model (Borke, Lamm, Eickhorst & Keller, 2007). However, although the predominant interaction style may be proximal and the socialization model may be more overtly interdependent in nature these are not absolutes. The use of face to face play and interaction was noted by participants and is indicative of a more distal style of interaction, thus although current language interventions would be inappropriate given the proximal style reported by participants, it would be possible to incorporate play into the intervention programme. This possibility will be discussed further in chapter 5 under implications.

#### 4.2.1.3. THEME 3: Communication

##### i. Individual interview beliefs regarding communication

Mothers were directly observed to *communicate instinctively* with their children. Mothers for example used physical contact and vocalisations to soothe their babies. They also reported responding to the child's needs appropriately when the child cried or pointed. One mother reported that you should tell your infant what you are doing while you do it. Other mothers revealed that they understood their infant was trying to

communicate with them when the child fussed or indicated an object that they wanted. Three mothers used their infant grabbing at their breast when they were hungry as an example of this communication. However, in direct questioning from the researcher, all of the mothers demonstrated that they did not understand the connection between these actions and language development. For example mothers misunderstood questions about play that followed on from a language development question and presumed the researcher was referring to a new topic. This lack of awareness was also noted in the focus groups with only one or two exceptions (see Appendix F).

Questions directed at learning language (the researcher referred to talking) were met with hesitation and uncertainty. Mothers reported that they did not think about this aspect of parenting much, if at all. More directed questioning enabled mothers to share their understanding of how language is learnt.

*R: how do you think your baby can learn to talk?*

*M2: I would say that if there is the time when he will speak, and also he will learn from me what I am saying. If God has created him to talk he will talk. He will mimic what I am saying even if he doesn't do so properly and I'll correct him [sic].*

Five mothers reported that their baby learnt to talk by copying their speech. The idea that language was learnt through imitation and example was not always clear, as the reason behind mothers talking to their children was not always due to a desire to stimulate language development. Mothers reported that they began talking to their child for a number of reasons (to entertain, or because they think they are now old enough to understand) but showed a lack of understanding of the connection with language development. Some mothers demonstrated that they thought expressive language develops prior to receptive language. For example M1 related:

*M1: No the baby does not understand although she can say them [words].*

#### ii. Discussion: Instinct vs. theory- does it matter?

Caregivers' beliefs regarding language stimulation were *instinctive rather than theorized*. This is to say that participants responded to questions about their beliefs and

understanding of communication and language stimulation with uncertainty and related not having considered these issues prior to having been asked in the interview. The unequal balance of power between the researcher and the uneducated, impoverished women in the study needs to be considered as a possible barrier to the participants communicating their beliefs. However, the strong beliefs that were related regarding issues of play, daily interactions (e.g. carrying the baby on the mother's back) and the physical needs of the infant indicate that this lack of conviction regarding language was not simply a result of the unnatural context of the interviews. The manner in which participants answered questions regarding the motivations for those practices that facilitate ECD, indicated either ignorance or a lack of regard for language development issues. It is unlikely to be a lack of regard for these issues given the importance that participants place on their children learning to talk. Participants did not indicate any knowledge of a link between communication and bonding, and improved ECD. Participants provided many reasons for their practices but the very number of different explanations given for the same practices indicates to the researcher the instinctive nature of those practices. The participants thus demonstrated instinctive or learnt bonding techniques that aided ECD but lacked a formal knowledge base. This leads to the question, does understanding the purpose and benefits of language stimulation practices impact the influence of these practices? This discussion continues once the results for parenting practices have been presented.

#### 4.2.1.3. Summary of parenting beliefs

The beliefs of primary caregivers demonstrated an understanding of the needs of the infant that was instinctive rather than being based on any formal knowledge. Infants were believed to have the ability to communicate basic physical needs through crying and gesture but were not described as having any needs beyond the physical. Primary caregivers' placed particular emphasis on issues of respect and observable good health in their parenting goals. These goals reflect the desire for the infant to be accepted by the community. This finding supports a community orientated culture (i.e. an interdependent socialization model) that is further indicated by the primary caregivers belief in the use of

imitation and modelling as a means to teaching language (Borke, Lamm, Eickhorst & Keller, 2007).

#### **4.2.2. Parenting practices**

Parenting practices refer to the behaviours and methods employed by primary caregivers in raising their children with reference to ECD. This objective was addressed in six individual interviews of primary caregivers.

##### 4.2.2.1. THEME 4: Daily activities

This theme was developed to incorporate those daily practices where the opportunity exists for the caregiver-child relationship to be developed. A strong bond between caregiver and child facilitates the development of early communication skills which lay the foundation for good language development (Billeaud, 1993; Deutscher, Fewell & Gross, 2006; Nord, Lennon, Liu & Chandler, 1999, cited in Horodyski & Gibbons, 2004; Roseberry-McKibbin, 2001). Understanding the daily practices of these primary caregivers in terms of routines, common interaction and teaching styles and language stimulation opportunities also enables more appropriate interventions to be developed. This section provides detailed information related to the practices of caregivers and primary caregivers. As a result of the quantity of information provided by primary caregivers this theme has been divided into sub themes for better clarity.

##### i. Daily activities described in individual interviews

Understanding daily routines and the activities of mothers with their infants is a means of assessing the daily speech requirements and life skills that the child needs to acquire. The individual interviews thus asked focussed questions around this topic. The results were remarkably similar between participants, with variation in the manner in which these activities were carried out rather than in what and when they occurred.

The typical daily routine related by the mothers in the individual interviews was supported by the focus group findings. Although the focus groups did not reveal any information regarding routine, the same daily practices were related. The day involved

the mother waking up, preparing the child's breakfast and feeding her (formula, breastfeeding or porridge). Four out of six mother's then bath the baby before the baby sleeps in the morning. Six out of the six mothers reported doing household chores including, washing, cleaning and cooking during the morning either while the baby sleeps or while the baby plays. Two mothers reported consistent meal times, the remaining four mothers did not specify any times for activities. Two of these mothers had very young infants (two months) and thus fed their infants on demand and did not track the sleep patterns of the infant. One mother did not spend the day with her baby at all (M4) and the remaining mother had a child of a year and was only able to provide an impression of her day through a step by step questioning process that took her through her day. All of the daily routines were noted to include, sleeping, feeding, household chores and play, which is in agreement with the activities related by the focus groups (see Appendix F). In addition to these activities, two of the mother's worked and thus left their children with other caregivers and two of the mothers reported taking trips out of the home, (one mother reported a twice monthly visit to the closest urban shopping district, another mother reported visiting neighbours). Of the four unemployed mothers, one did not refer to leaving the house at all, two worked, and one reported leaving her infant with somebody she trusts when she goes out. The exposure of the infants to a variety of environments thus appears to be infrequent, and limited. Nevertheless the extended families within which many of the mothers lived provide opportunities for interaction and stimulation.

In reference to those aspects of the day previously explored within the focus groups (Appendices C & F):

*Feeding:* five of the six mothers' breastfed their babies. The mother who worked full time used formula. None of the mothers exclusively breastfed however, as four of the five babies that were breastfed had started eating solids, and the remaining mother used both formula and breastfeeding. From the descriptions of the daily routines and from references to their methods of soothing it was apparent that all of the mothers use feeding (either breast or bottle) both to comfort their child when he/she cries and to help him/her to sleep. For example:

*R: How do you get the baby to sleep?*

*M2: I give my baby food and carry him around for while and give him a dummy or give him the breast and he just falls asleep*

*Sleeping:* Sleep routines were noted to be very relaxed. All the mothers referred to the baby “falling asleep” rather than to putting the baby to sleep. For example M3 described her routine:

*S: ...and after that I bath the baby, and the baby falls asleep.*

A few of the mothers reported sleeping in the same bed as the baby, a practice (frequently noted in the past by the researcher) that enables the mother to breastfeed the baby when they wake up in the night, without disturbing their own rest. Reported methods for getting the infant to sleep included: holding and rocking the baby while making a shushing sound (shushuzela), carrying the baby on the mother’s back, feeding the baby with either a bottle or breast, singing, and simply placing the child on a bed when they are tired.

*Carrying* – Three of the mothers were directly observed to carry their babies, western style, in a baby pouch on the front of their bodies. The remaining three mothers were observed to carry their babies in both arms in a cradled position. Carrying on the back was noted as a means of comforting the child and of keeping the mothers’ hands free for household chores. It was also noted as a method of encouraging sleep. These findings support the data obtained in the focus group interviews which referred to the use of carrying the child on the back as a means of comforting, completing household chores and assisting the baby in falling asleep (as seen in Appendix F). The carrying of the baby on the front of the mother’s body was observed to generally be used for the younger infants.

*Play* - Participants were asked directly to clarify the term ‘play’ when they used it. Four of the mothers indicated various methods of playing with their infant, including using ‘baby speak’, making faces or doing things to make the baby laugh, touching the face, making “the baby jump”, and singing and dancing with the baby. These examples of

play are almost identical to the examples of play related in the focus group data (Appendix F), indicating that these are widely held play practices. The remaining two mothers who did not describe play in this way were M5 and M1, who both had older babies. They both clarified play as either allowing the baby to crawl around on the floor or play outside with the older children. M5 later referred to bath-time as a time in which she plays with the baby herself. Thus the only mother not to report playing with her infant directly was M1. Babies that were mobile were perceived to need less individual input from the mother and more input from other children. This was reinforced by the description of play given by the mothers of the more mobile babies. E.g:

*R: How does she play?*

*M5: She just goes out and plays with other kids although she is not yet walking, only crawling.*

The information provided by the focus groups supports this finding in it's acknowledgment that play occurs with other children of all ages (see Appendix F).

Play appeared to hold varying importance for each mother. Two mothers described play as part of their role as a mother, another mother referred to play in the bath as a means to teach her baby to talk.

*M5: When we are bathing I say "the baby's bathing; the mother is bathing her" to teach her words*

From the remaining four mothers' lack of reference to play in response to questions regarding development and learning, it appears that play was viewed by them as a less important part of parenting practice than providing for infants' physical needs. An interesting aspect was raised by M5 regarding play. She stated that it was very important for the child to play well with other children as an indicator to other people that he is healthy. This finding supports the previously discussed finding that the opinion of the community is greatly valued. It is also likely that this is a reference to the stigma that remains attached to the HIV and Aids epidemic in rural areas in South Africa (Campbell, Foulis, Maimane, & Sibiyi, 2005) as previously mentioned in the discussion of theme 1.

Toys were referred to very little by the mothers. M3 remarked that her daughter liked to play with “noisy things”, and M5 responded to a question regarding toys saying that her daughter likes to play with a teddy bear. This lack of interest in toys and seeming absence of any great variety of toys is in sharp contrast with the list of toys given by the focus groups (Appendix F). It is possible that the focus group setting created a need to demonstrate a certain level of living in front of the rest of the group, or perhaps the toys are in fact present but the lack of reference to them indicates their level of usage or how much they are enjoyed in comparison to playing outside with peers. The latter is more likely as three of the mothers were employed in the individual interviews and thus seemingly more able to buy toys for their children, as opposed to the number of focus group participants who were unemployed (eight out of nine participants).

#### ii. Discussion: Daily activities facilitate early communication development

The details of daily routines and interactions were found to be in agreement with parenting practices noted in previous studies of rural communities. True, Pisani & Oumar’s (2001) study of the Mali tribe in West Africa reported very similar daily interactions in terms of the child being carried on the mother’s back, the infant sleeping with the mother and the breast being offered in response to crying. They found that these *practices assisted in developing a secure attachment with the mother*. Participants’ also reported responding to the needs of the infant appropriately, for example understanding that the infant cries to indicate a nappy change is needed. This responsiveness is referred to as maternal sensitivity in the literature and is considered the basis of good interaction between mother and infant. Good mother-infant interaction is put forward in a number of studies as an indicator of future developmental competence (Anderson & Marinac, 2007; Billeaud, 1993; Deutscher, Fewell & Gross, 2006; Nord, Lennon, Liu & Chandler, 1999, cited in Horodynski & Gibbons, 2004; Roseberry-McKibbin, 2001). This indicates that the parenting practices reported in this study should facilitate age appropriate ECD in these children, barring the impact of poverty related risk factors,

Interacting and playing with the child were described by participants as normal daily practice, in seeming contrast with previous studies within this field. Seeff & Bortz's study (1994) related that mother's in a rural village in Eastern Transvaal regarded sitting on the floor and playing with the child as being 'undignified' and inappropriate, while a study by Ahmed & Kaliprasad (1995) found that children played in a western style but with less interaction with the caregiver's and more isolated play than that described in the current study. However both of these studies followed the parenting practices and beliefs of older children (one to five years) and their caregivers, unlike the current study which focused on preverbal infants (birth to 14 months). It is possible that the findings of Seef & Bortz's (1994) study hold true for the community in the current study. The belief that play is beneath the dignity of the mother may account for the differing information provided by participants with older infants (eight months to 13 months) in relation to those with younger infants (birth to eight months). Once the infant became mobile participants, related more formal attempts to "teach" the child to speak but fewer methods of play and communication interactions were related. Although considerably more research is needed to confirm this, the researcher speculates that once the infant reaches a certain point in their development they are perceived as being in less need of close physical nurturing, or perhaps the more directed play of a toddler is perceived as less necessary. Mothers gave the impression that they expected their babies to spend most of their play time in play with other children and in independent (although supervised) exploration of their environment. This theory is supported by the references by several mothers to their desire to teach their child independence and by the mothers of the older infants reporting that their child plays outside with other children. These mothers also reported fewer communicative interactions within their day. Further study is needed regarding the beliefs of caregivers' regarding play and this will be discussed further in chapter 5 under research implications. However, within this study the reported play interactions, between infants and caregivers, were adequate for ECD.

#### 4.2.2.2. THEME 5: Language stimulation

##### i. Language stimulation practices related in individual interviews

Practices that have been demonstrated by the literature to aid in language development were apparent in the reported practices of the mothers in this study. Primarily this involved the mother talking to the child, but many other practices were mentioned that develop the mother-child relationship and motivate the infant's early communication attempts.

Talking to the child was acknowledged by all of the mothers as part of their parenting practice. Six out of six mothers reported talking to their child during the day, and one mother reported singing to her child. Mothers spoke of talking to the child as they woke up and numerous times during the day (“too many times to count”), although the most highly educated participant (P) reported talking to and playing with her infant twice a day. One mother reported talking to the child in the bath, four mothers spoke of speaking, “anytime” and about “anything” as one mother put it.

Closer questioning revealed that most mothers spoke of “anything”.

*M5: Sometimes I say things and she says them back. When we give things to the baby we say 'tate' [means thatha – take] or when she is standing up I say 'ama yedwa' [means ume yedwa – she is standing on her own] and the baby repeats [tate and ama yedwa = babytalk]*

The examples given of what the mothers said to the babies varied according to the age of the baby. Thus M4 reported making sounds to make her baby laugh (her baby was two months), while M5 speaks of teaching her to say “tata” (Zulu for “take”) and ‘ama yedwe’ (Zulu for “she is standing”) and various other directly taught words. P gave an example of saying, “hello, how are you?” as her baby woke up.

Both M5 and M1 stated that they began speaking to their child at eight months of age. The fact that these were mothers of older babies should be noted. This may indicate that they are referring to a more deliberate use of words rather than responsive noises and nonsense talk, given that the mothers of the younger infants also referred to speaking to their babies.

Other practices reported in the interviews that develop language included: playing, singing, dancing with the baby, responding rapidly to the baby's crying (communication attempts), and developing a bond with the baby through close bodily contact in sleeping, feeding and carrying. These practices were confirmed in the focus groups who also reported using all of these practices (see Appendix F). All of the findings indicate a general lack of awareness of the importance and purpose of their actions. Mothers performed these practices for a variety of reasons but the manner in which the information was revealed indicated that the knowledge was instinctive and indistinct, they had not consciously thought out the reasons behind their actions.

ii. Discussion: Instinct provides the foundation for early communication development

The more interaction and language a child is exposed to the better their language development (Hart & Risley, 1995, cited in Patterson, 2009; Rossetti, 2001). If these were the only factors upon which good language development were based, then the children of this rural area would be heading for a bright future. The participants reported performing many of the behaviours noted to assist the development of a bond between mother and infant, including: stroking the infants face; smiling; and gazing into the infant's eyes. These practices were described without any, but two, participants giving any indication of even a limited knowledge of the positive benefits of these behaviours on ECD. It thus seems more than likely that these are real practices that take place, as reported, on a daily basis. These behaviours are considered to indicate a good mother-child bond, which Rossetti (2001) holds to be an important precursor to ECD. Thus participants' daily interactions with their infants provide the foundation for the development of early communication.

Participants related that they speak directly to the child frequently throughout the day, a practice to which infants are instinctively more receptive (Fernald, 1985; Fernald & Simon, 1984, cited in Patterson, 2009). This study sought the perceptions of caregivers regarding their beliefs and practices and thus did not obtain data regarding the actual

amount of time caregivers spend speaking to their infants. Hoff-Ginsburg's (1991) study found that caregivers in situations of low SES (as in this study) and with lower education levels, speak to their children less than caregivers who are employed and have higher education levels. Although participants reported speaking to their infants frequently and in numerous different contexts during the day, the frequency may well be a relative term. Nevertheless, the perception of the participants in this study is that they speak to their infants frequently and future interventionists need to consider this perception in developing and implementing appropriate programmes. Although speaking to the infant was related as accepted practice, participants did not relate their practice of talking to the infant with language stimulation, implying a lack of understanding of the benefits of talking to the infant.

The methods by which participants reported teaching their infants to talk were different from the 'mainstream' intervention methods. A very direct teaching approach was used and this excluded any reference to the contribution that non-verbal practices (e.g. responding to the infants needs when they communicate), and even informal verbal practices (e.g. singing with the infant), have in the development of language. This direct teaching approach is discussed by van Kleeck in her review of a South African intervention programme for cultural bias (1992). She cites a number of non-Western cultures that use this approach extensively in teaching their children to speak. Van Kleeck reports that direct teaching is a relatively common approach (outside of American/western mainstream culture), citing the Samoans (Ochs, 1982; an aboriginal tribe (von Sturmer, 1980) and the Basotho (an African tribe) (Demuth, 1986), as examples. A direct teaching approach is generally only used in western/mainstream culture in teaching the child manners (van Kleeck, 1992), however it appears to be the most common method by which caregivers in this region teach language. Also reported by most of the participants was the use of objects/toys in teaching their infant, and sitting opposite the child to interact, Borke, Lamm, Eickhorst & Keller's study (2007) proposes that these are the indicators of a distal style of interaction. This is surprising, given the association of the Zulu culture with "ubuntu" (togetherness) which values the role of community above that of the individual. Given this association it would seem more

likely that participants would display a more proximal style of teaching, which is associated with a model of interdependence and includes learning by working alongside the caregiver and through observation (Markus & Kitayama, 1991, cited in McCollum & McBride, 1997). This approach did in fact become more apparent in the individual interviews in numerous examples of participants expecting their child to learn speech and other skills by example and by copying. Thus as reported by *McCollum & McBride (1997)* these approaches are not absolute and occur on a spectrum related to the socialization model position.

#### 4.2.1.3. Summary of parenting practices

To sum up the findings on parenting practices, primary caregivers described routines and activities common to households with small children in many cultures, both rural and urban (Moscardino, Nwobu & Axia, 2006; Tomlinson, Cooper & Murray, 2005; Zeitlin, 1996). Findings confirmed that primary caregivers are focused on the physical needs of the infant and instinctively provide the opportunities for bonding and language stimulation necessary for ECD. With regards to the learning of language, primary caregivers described both a direct teaching approach and an expectation that the infant would learn through observation of the caregiver and copying/imitation. The combination of these practices indicates the spectrum nature of socialization models to the researcher and confirms the complex nature of cultural beliefs and practices. The value of this study becomes apparent as a means of understanding the particular beliefs and practices of primary caregivers in this community regarding ECD.

### **4.3. Looking at the Impact of Belief on Practice**

Participants reported using behaviours that, according to Rossetti (2001), promote the bond between the mother and infant and facilitate the infant's natural instincts to attempt to communicate with the world around them. However these behaviours were not supported by the caregivers' beliefs or their related understanding of the benefits of these behaviours, a discussion of this disparity follows.

It is significant for the development of intervention that despite the lack of knowledge behind these caregivers' practices, language stimulation practices are still present. The primary caregivers' beliefs behind the actions must impact the practice at some level. For example, primary caregivers reported playing with their infants, talking to them and showing them things around them but they did not understand why they were doing this. As a result these actions may only take place when the caregiver 'feels like it'. Previous studies show that 'low income' mothers speak less frequently, are less likely to engage in mutual play, use more directives and ask less questions of their children than middle class mothers (Bee, Van Egeren, Streissguth, Nyman, & Leckie, 1969; Farran & Haskins, 1980; Heath, 1983; Hess & Shipman, 1965; Schacter, 1979, cited in Hoff-Ginsburg, 2001). Understanding the benefits of talking to your infant and responding to their communication attempts would presumably provide an added motivation for mothers to implement these practices consistently during the day. An increased motivation to speak seems more likely given the value participants in this study placed on their children learning to speak. If the caregiver believes that these practices are simply a means of entertaining the child (as was related by the participants) they might only use these practices when they feel the infant needs entertaining. When developing intervention programmes it would therefore be beneficial for primary caregivers to be educated regarding the benefits of these practices as a means of motivating for consistent communication and interaction behaviours. Understanding the benefits of language stimulation could thus be a strong motivator for primary caregivers to continue with and build on their current practices that stimulate language development. However if the language interventions are not culturally appropriate, understanding their purpose will have little effect.

The reasons behind the use of a distal style of interaction should be further revealed by examining the findings on the participants' beliefs regarding the role of the infant and the role of the caregiver.

#### 4.4. Summary

Overall the findings of this study are broad and raise a number of questions, many areas of this study need to be investigated further. However three points have emerged from the data as having significance in terms of the study aims.

The purpose of this study was to obtain an understanding of the beliefs and practices of primary caregivers regarding ECD, in order to obtain information for culturally appropriate intervention. Given the purpose of this study, perhaps the finding with the most potential for helping future interventionist to understand the cultural paradigms within this community is the emphasis that was placed on respect. The 'respect' under discussion was described and defined by both the primary caregivers and the off-site translator as being a social skill that enables an individual to fit smoothly into the community. The literature refers to this respect (isiHlonipho) as 'the language of respect' and defines it as a linguistic system through which respect is conveyed (Rudwick & Shange, 2006). Rudwick & Shange (2006) further note that it is predominantly used by women in traditional Zulu and Xhosa culture, specifically those in rural areas. The relevance of this finding to ECD is not immediately apparent but is very real. The prioritization of community opinion influences parenting goals, making skills that help to improve community standing of greater importance to the caregiver. The development of speech and language development is thus of importance from the primary caregivers perspective, and this is supported by the findings of this study. The implications of this finding will be discussed further under practice implications in chapter 5.

The second point of relevance to the aims of this study is the lack of formal knowledge behind primary caregivers' beliefs and practices regarding ECD. Primary caregivers described (and demonstrated) many parenting practices that are known to facilitate the development of early communication, however these practices were not motivated by any formal knowledge of their benefits for ECD. When placed in the context of this study, this finding elicits the question, if the caregiver did have formal knowledge of how language is learnt, would this enhance parenting practice? It seems likely to the

researcher that parenting would be enhanced given the pattern of more highly educated caregivers providing better language role models (Fish, Amerikaner, & Lucas, 2007; Hoff, 2003). However the influence of external factors such as poverty related stress, the desire to appear 'normal' to the community, and lack of time for interaction with the child (due to work hours) are all potential factors that could negate the benefits of formal knowledge on ECD. The implications of this finding will be discussed further in chapter 5.

The third point of interest in this study is the primary caregivers' reported use of modelling and imitation, together with direct teaching techniques, in teaching the infant to speak. Although these methods are not commonly used in Western parenting practices, and early intervention techniques shy away from direct teaching methods, these methods hold considerable potential for ECD. Van Kleeck (1992) reports these techniques are widely used outside the Western world, and speaks of the how using methods that clash with these teaching methods in interventions will serve to estrange caregivers in the programme. Knowing that primary caregivers in this area use these techniques will enable future interventionists to adapt the programme to agree with those practices with which the infant is already familiar and encourage the family to embrace the programme. These implications are discussed further in chapter 5.

The following chapter will critically review the influences on the data and discuss the implications of this study in greater detail.

## **CHAPTER 5: CONCLUSIONS**

This study sought to address the high number of children demonstrating poor early literacy skills in foundation levels in a rural community in KwaZulu-Natal. The study concluded from the literature that culturally appropriate early communication intervention (ECI) in the homes of infants and children in rural areas would facilitate the development of better language and literacy skills. Since the literature revealed a gap in the knowledge as to what culturally appropriate intervention would be in this particular rural area, the study attempted to explore the beliefs and practices of caregivers regarding ECD. The study was conducted from a qualitative perspective because it enabled the researcher to explore the context around the caregivers' views regarding ECD. This contextual information gave the researcher deeper insight regarding the data provided by the participants. The purpose of this study was to explore parenting beliefs and practices regarding ECD as a first step towards developing culturally appropriate intervention. The context from which these beliefs and practices have emerged has significant influence on the information provided and needs to be understood. This is of particular importance in this study where the information is almost entirely based on the word of the caregiver. Because this approach is also reliant on the ability of the researcher to interpret and facilitate the emerging data it becomes important to provide a comprehensive analysis of the research methods chosen by the researcher, in order for the reader to make their own judgement regarding the study's findings. This chapter will critically discuss the methodological choices and the external influences that shaped this study, prior to the discussion of the implications of the study on future intervention and research.

### **5.1. Critical Review and Limitations of the Research Process**

#### **5.1.1. Participant selection**

The study planned to select the participants for the entire study through one participant selection process using two stages. The first stage used the clinic nurses to assist in

identifying primary caregivers who met the study requirements, and the second stage involved the researcher confirming the suitability of the participant for the study and informing the participant of the study. However although the participants for the first focus group were selected through this process, the recruitment of the 2<sup>nd</sup> focus group was conducted through publicly addressing the waiting group area as the nurses stated they could no longer assist in the study due to work commitments. This recruitment strategy 2 may have influenced which mothers chose to participate. Those who volunteered in this public setting might have been more confident and out-going than a group that has been approached individually and has been given the opportunity to raise any concerns they have prior to agreeing to participate. This was borne out by the second group volunteering more information and discussing and arguing more points than the first focus group. Nevertheless, all of the participants selected for the study met the participant selection requirements and their opinions added valuable insight in developing the individual interview schedule, and validated the beliefs and practices of primary caregivers in that particular community.

This research had a limited number of participants and thus it is difficult to make any broad assumptions regarding the findings of this study. Instead the findings need to be seen as a few examples of beliefs and practices of caregivers within this particular community. These findings should not be over-generalized but seen instead as the first step for early interventionists feeling their way into another culture.

As mentioned in chapter 3 (section 3.5, pg.47) the researcher spoke and understood predominantly English. This meant that the researcher needed to rely on an interpreter in selecting the participants. This limited the language of the participants to isiZulu despite the fact that it is not the only language spoken in the area. This limitation meant that the data obtained can only be said to reflect the beliefs and practices of some isiZulu speakers.

### **5.1.2. Focus group interviews**

A method of photo elicitation was used to promote discussion within the focus groups as a means of reducing the influence of the researcher. Theoretically, fewer words used to introduce each topic results in less influence on the participants as to what stance to take in approaching the topic thus forcing the participants to respond with a perspective based more on their own beliefs and understanding. This was the initial motivation for the use of photos, together with research that demonstrates that the approach is less intimidating for vulnerable populations and minority groups (Wong et al. 1995, Pini, 2002; cited in Liamputtong, 2007). The method did achieve these sub-aims, i.e. it was effective in its purpose of encouraging discussion and provided a neutral discussion point rather than focussing on the individual participants. However, the choice of images was very directive and determined the themes discussed. The researcher chose the photos based on her previous knowledge and understanding of caregivers' practices and beliefs in this community and this was unavoidably incomplete i.e. there may be other activities during which interaction opportunities take place that were not included. The directed images limited the researcher's ability to gain a more general perspective on ECD beliefs and practices within the community and instead provided focussed information on the various themes featured in the images. The themes for the information were essentially determined by the researcher's initial study of the literature and the researcher did not obtain the overview on the study topic that had originally been anticipated. Piloting the focus group interview would have helped the researcher develop a means of obtaining more general data in the focus group interviews in phase one. A pilot would have enabled the researcher to adapt the manner in which the photo's were presented and change the content of the photos to include all reported areas of interaction. Thus not piloting the focus group interview is a limitation to this study. This limitation became apparent to the researcher in studying the focus group data and thus was compensated for in the individual interview process by incorporating more broad based questions based on the literature in the individual interview schedule.

### **5.1.3. Individual interview schedule**

The individual interview schedule was shaped around the two main objectives of the study – caregivers’ beliefs, and caregivers’ practices, regarding ECD. It also included a biographical section addressing basic biographical details such as the names and ages of children, living circumstances and and employment. This section was not comprehensive enough and limited the study as a result. A more in-depth questioning of the background of the participants including the living conditions and basic amenities available in the home, access to schools and other resources, and the use of grants would have allowed more conclusions to have been drawn regarding the data obtained in the study. However the researcher also felt that too many enquiries into personal issues that reiterated the participants’ position of disadvantage would impair communication by establishing an even greater barrier of SES. Nevertheless the lack of more in-depth biographical data is a limitation which should be noted.

### **5.1.4. The translation process**

The undertaking to conduct qualitative research in a language that the researcher is not fluent in was extremely challenging. Three separate translators were used as secondary translators as a result of the difficulty of this undertaking. The researcher was initially not fully aware of the difficulty of transcribing data that has previously been translated i.e. the translator needs to write down what the researcher has said, how this has been interpreted and then assess how accurately this has been done. The researcher sought to solve the predicted difficulties by introducing the off-site translator to verify and transcribe the data collection process. The process was more complex than the selected off-site translator could manage and another translator was sought. These initial translated versions were completed by educated, first language Zulu speakers, and highlighted the difficulty of performing the task accurately. In spite of eventually hiring a professional research translator, there was no way of eliminating each translators own interpretation of the data. Thus the researcher had the difficult task of comparing the various translations of the same data and determining which version was more accurate when viewed in context. In transferring emotive information from one language to

another the essence of what is said is not always easy to capture, this needs to be taken into account when reviewing the results of the study.

#### **5.1.5. The researcher as a tool**

The data collection methods selected for this study were selected in part as a means of decreasing the role of the researcher e.g. using photos instead of words, however the researcher found that this was only partially successful and in practice the researcher needed to facilitate and guide the interview processes to a large extent. The process is thus unavoidably biased as a result of both the interpreter's and the researcher's own paradigms and life experiences impacting how they phrased the questions, responded to answers and interpreted related beliefs. The researcher sought to rationalize her thought process and clarify her own biases and beliefs through the use of a journal and through continuous discussion of the process, however it was unavoidable that prejudices and bias should have an impact on the data obtained. The researcher discovered much in the research process. She must acknowledge particularly the influence of her own culture and beliefs on the data collection. This was noted by the researcher to emerge in her reactions to several answers in the focus groups e.g. the researcher found she presumed the participant who mentioned safety frequently in the focus group was trying to impress the other participants and the researcher. Although the researcher had anticipated the need for her to remain neutral in her reaction to the participants' contributions she was not always successful. This may have then influenced the manner in which participants answered the questions following this. Further, the researcher unconsciously assumed that the participants shared her understanding of basic human behaviours e.g. crying (refer to chapter 4, section 4.2.1.1 pg 85). When these assumptions were revealed as inaccurate, the researcher was not sufficiently skilled to probe the new areas adequately within the interviews. Although the researcher is a valuable tool in reading human emotion and reacting appropriately to a response, and thus can provide insight into data received, it is a flawed tool that needs to be viewed as such.

## 5.2. Implications for Practice

### 5.2.1. Practice implications

- Supporting the language development practices already present in the community, i.e. those practices that develop language skills appropriate for the daily, rural, life requirements (as found by Seef & Bortz's study, 1994) is important (Dunst, 2004). However this incorporation of current culturally acceptable language practices needs to be balanced with the need for children to obtain a greater language development advantage than statistics indicate children in rural areas are given prior to entering school. The researcher proposes that in order for children to overcome the challenges of overcrowded and under-resourced classrooms, it is not enough to simply encourage current positive practices and facilitate ECD as a means of intervention. Early interventionists need to find a balance, in collaboration with caregivers in the community, that acknowledges and compliments current cultural practices but also encourages and develops language stimulation practices. Developing language stimulation practices means introducing new concepts that will enable children to adapt to the western schooling system and go on to succeed academically once they enter the classroom. The researcher thus proposes that an ECI programme could be developed targeting children from 6 months up to the school entry age. The programme could be developed with parents' input and would provide a means for parents and children in the rural community to gain age appropriate language and cognitive skills that prepare the child for the western school system of South Africa.

The importance that caregivers' in this study placed on teaching the child to talk is an indication that the introduction of early intervention programmes that aim to facilitate ECD would be well received. Caregivers would be receptive to learning new, culturally appropriate skills that develop their child's ability to speak and learn. However the acceptance and compliance of any caregiver would be much improved by educating the caregiver regarding language development.

- This study revealed a lack of knowledge regarding language development. Participants had a wide variety of views as to how language is developed but none of these views were entirely accurate or complete. Caregivers that are unaware of the impact of their behaviour on their child's language development or that do not know how non-verbal communication skills lead to spoken language, are unlikely to be motivated to change their practices. Providing information about language development would enable many mothers to adjust their beliefs and thus naturally make their own adjustments to their parenting practices without the need for further intervention. In addition, and significantly, caregivers would be able to identify a communication delay at an early stage and hence seek the appropriate intervention. Topics that might be covered could include: how language is learnt; how language can be developed; language stimulation activities; how language helps learning; and indications of a language development delay. The provision of this information could occur either through mass media methods such as the local radio station, or the local newspaper, or could be provided from the local post natal clinics in regular meetings. Knowing the impact of their own practices on their child's language development could provide a significant motivation for caregivers' to increase the language stimulation activities that occur within the day and to seek out assistance if they feel there is a delay in their child's language development.
- The lack of formal knowledge has further implications for educating the community. Primary caregivers within this study were exclusively female (i.e. nanny, grandmother or mother, which is in line with traditional Zulu culture that places women in the child care role). Directing education programmes at the public in general may create an awareness of positive parenting practices not previously available to men in their traditional roles of decision maker (Rudwick, 2008). Men would not need to necessarily change their role but information, for example through a radio broadcast, would enable a greater understanding of the needs of their children to be formed. Alternatively, it should be considered that

while intervention programs should not exclude the father there should be awareness that early intervention programmes need to appeal to the female family members and that the father may need to be considered as separate from the household, this would be in line with Dunst's suggestion that intervention should be adapted to the dynamics of each family unit (Dunst, 2004).

- It is a difficult line to walk in respecting cultural norms and traditions while introducing new concepts and behaviours. The best course may be to demonstrate respect for the practices reported in this study while presenting the alternative of greater involvement by all family members and citing the benefits of this course. Whether caregivers choose to adapt their practices is ultimately decided by the beliefs they hold and the priority in which they place these beliefs as individuals. A good example of this challenge in balancing culture and need is the need to learn the English language for higher learning. Although some schools in the rural areas introduce learning in English in later years, other rural schools choose to teach in English from the foundation years. Parents may or may not have English language skills to pass on to their children but must decide whether to support the child's learning of another language in the home or not. Studies show the importance of a solid grounding in the mother tongue but this needs to be balanced with the sudden demands that the child will encounter on entering the school system. Teaching English language skills within the proposed ECI programme may be a practical consideration in answering this problem and the benefits should be discussed with the involved parents.
- Having said that caregivers' should seek help for a child's language delay, attention needs to be given to transforming current early intervention practices. It is apparent from this study that the current language intervention practices are not always appropriate for the daily needs, and cultural beliefs and practices, of families living in rural KwaZulu-Natal. Many current intervention programmes in rural areas have focussed on factors that seem relevant on the surface but are not actually based on parental feedback. For example, the practice of teaching

caregivers to make appropriate toys from household items and waste items, although this is an acknowledgment of the poverty in the area, this study shows that toys are bought despite this poverty and that there may be an element of pride in owning ‘proper toys’ rather than using items from the home. It demonstrates that caregivers may not be thinking of the purpose of the toy so much as the ‘fun’ of the toy. These findings suggest that more emphasis needs to be placed on educating the caregiver about language development and on adjusting language stimulation activities to the lifestyle and routines of the household. For example, most of the participants in the study lived in households that included extended family members, no father figure, and sometimes several different generations. When looked at in relation to the *value placed on community* there needs to be greater emphasis on including other family members and making language stimulation acceptable to the household. Family members such as siblings, aunts and grandparents who are living in the same house can all be included in intervention programmes. The challenge of making language stimulation acceptable is a challenge of information sharing and inclusion in the details of implementing the programme in the home.

- Further considerations in developing intervention should be given to the single caregiver status of many of the participants, the work hours that caregivers’ in unskilled jobs are expected to work; the high unemployment figures in rural areas, the language barrier between interventionist and caregiver, and the low standard of education to which caregivers have been exposed (thus limiting their English and Zulu language skills and their knowledge of language development). All of these factors need to be acknowledged and every early intervention programme needs to incorporate these limitations in order for the programme to be accepted and carried out by the caregiver.
- Another consideration is the participants’ extensive use, , of copying and direct teaching methods in teaching their children to talk. Current early intervention programs discourage direct teaching techniques, however these practices were

noted to be commonly used as an effective means of teaching language in many ‘non-mainstream’ cultures (van Kleeck, 1992). The fact that this is the most commonly used method of teaching language in the community indicates that both primary caregivers and children would be more likely to accept interventions in this form. Increasing the role of direct teaching and copying methods in early intervention programmes aimed at this community could prove to be a simple means of making the programme culturally appropriate and hence more effective.

- In building on cultural practices the researcher has suggested: the inclusion of extended family members; respecting and acknowledging the cultural norms; and using the direct teaching methods reported by caregivers. Further acknowledgment of culture could be shown through the use of culturally appropriate materials and activities within the ECI programme. For example a differentiation could be made between male and female daily activities when these are used for including language stimulation exercises, and vocabulary may be used that relates to upcoming community events such as weddings, or for games common to the children in the area.

The framework for intervention suggested by Dunst (2004) would compliment these suggestions for practice and allow for the emphasis that is placed on community opinion and practice. His theory and practice approach uses a supportive stance that allows for the improvement of the knowledge and parenting skills of the caregiver and accounts for issues that are relevant to an area such as the Valley of a Thousand Hills. In this area for example family structures do not often include a caregiver unit, and instead include extended family members living in close proximity. His emphasis on using everyday settings as learning opportunities acknowledges the time constraints and stresses of living in poverty and does not place an extra burden on the caregiver in terms of added responsibilities. Significantly he also emphasises the need for the cultural parenting beliefs to be understood and acknowledged, and plans intervention accordingly. The researcher thus suggests that Dunst’s (2004) framework would be an appropriate foundation upon which ECI in the Valley of a Thousand Hills should be based.

### 5.3. Implications for Research

- This study has provided a glimpse of some beliefs and practices found within this community in rural KwaZulu-Natal, however this is not sufficient as the basis for the development of early intervention programs. There is a need for further research into these reported beliefs and practises that uses a larger sample size to verify the findings. Thus far, the findings are almost entirely a reflection of the understanding and perspectives of primary caregivers in this community. An observation of the reality of these beliefs and practices would be of significant value particularly if the findings were discussed in relation to the participants' perspectives i.e. seeing what participants actually do in practice in relation to what they have reported doing would provide insight into the participants' perspective.
- In addition, the discrepancy that was noted in this study between the reports of play with infants and the reports of play with toddlers, suggests the worth in repeating this study with older children. Using a participant sample that includes children from an older age range, for example 2-4 years, would provide an understanding of the overall parenting beliefs and practices, a child is exposed to prior to entering school. If there are changes in parenting practices with different ages as this study suggests, then it is important to understand these changes when providing intervention for children of different ages.
- There is a need to establish more accurate information on primary caregivers' knowledge regarding language development issues. This could be established through a broad survey of the households in the area where primary caregivers are asked to complete a questionnaire regarding their knowledge of language development issues. Having this information would enable a targeted and accurate education drive to take place that addresses the knowledge levels of the community.

#### **5.4. Conclusion**

This study sought to explore the **beliefs** of primary caregivers regarding their role as a caregiver, the abilities of the infant, and the needs of the infant, in relation to ECD. The study further sought to explore the **daily practices** of primary caregivers with regard to ECD in preverbal infants (0 -14 months). This exploration led to the development of five themes into which the researcher sorted the data. Parenting beliefs include: the role of the caregiver; the role of the infant and communication. Parenting practices included: daily activities; and language stimulation practices.

It is hoped that the information within these themes will enable SLT's and other early intervention professionals to have a greater understanding of these areas and hence provide more effective intervention.

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## APPENDIX A

List of biological and environmental risk factors (Weitzner-Lin, 2004)

|   |
|---|
| <b>Biological factors</b>   |
| Exposure to toxins eg: cocaine and other drugs; fetal alcohol poisoning   |
| Exposure to infectious disease: e.g. HIV/ Aids; Rubella; Syphylis; Toxoplasmosis                                |
| Birth process: e.g. premature birth; brain damage   |
| <b>Environmental Factors</b>  |
| Maternal- caregiver limitations e.g. chronic depression; mental illness; teenage mother with limited experience |
| Psycho-social e.g. poverty; unstable residence; abusive relations within the family                             |

## APPENDIX B

Map 1. Map of South Africa



Map 2. Health Districts in KwaZulu-Natal

[http://ftguonline.org/files/images/FTGU\\_3\\_1\\_09\\_img\\_2.jpg](http://ftguonline.org/files/images/FTGU_3_1_09_img_2.jpg)



Figure 3. KwaZulu-Natal province health districts<sup>14</sup>

## APPENDIX C

### Focus Group Interview Schedule

Biographical Details:

Relationship to the child:

Age:

No. of children:

Ages of children:

Brief description of household:

Employment:

| Photo presented   | Examples of questions asked  | Motivation   |
|---|--|--|
| <p><b>Picture A- breastfeeding</b></p>  <p>Source:<br/><a href="http://www.mothering.com/jenniferjames/category/1910s">www.mothering.com/jenniferjames/category/1910s</a></p> | <p><i>Question :</i> Why do you think the mother is looking at the baby? What do you think she is thinking about?</p> <p><i>Examples of follow up questions:</i></p> <p>When you feed your baby what do you do?</p> <p>Do you ever talk to her?</p> <p>Why do you do that?</p> <p>What does your baby do?</p> <p>Why do you think she does that?</p> <p>Does she do that at any other time</p> | <p>Breastfeeding is a common joint activity between caregiver and infant. It facilitates the bonding process and provides an opportunity for early ‘instinctive’ communication development (Patterson, 2009).</p> <p>Understanding primary caregivers practices and beliefs regarding this activity may provide insight into their understanding of ECD.</p> |
| <p><b>Picture B- teaching/play</b></p>  | <p><i>Question:</i> What do you think the mother is doing? Why?</p> <p><i>Examples of follow-up</i></p>  | <p>This picture provides an opportunity for primary caregivers to discuss how they</p>   |

|  |  |   |
|--|--|---|
|  <p>Source:<br/> <a href="http://www.fpg.unc.edu/ncedl/PAGES/page5.htm">www.fpg.unc.edu/ncedl/PAGES/page5.htm</a><br/> <a href="http://www.calgaryherald.com/.../2068661/story.html">www.calgaryherald.com/.../2068661/story.html</a></p> | <p><i>questions:</i></p> <p>What do you think the baby is thinking?</p> <p>Is she enjoying the activity?</p> <p>Do you ever do anything similar with your baby?</p> <p>How does your baby respond?</p>   | <p>interact with their child on a daily basis.</p> <p>Understanding how primary caregivers teach their children is necessary in providing culturally appropriate intervention (Dunst, 2004).</p>  |
| <p><b>Picture C- curiosity</b></p>  <p>Source:<br/> <a href="http://unambig.files.wordpress.com/2009/09/black-and-white">unambig.files.wordpress.com/2009/09/black-and-white</a></p>  | <p><i>Question:</i> What do you think the babies are doing? Why?</p> <p><i>Example follow-up questions:</i></p> <p>Does your baby ever see babies of a similar age to him/her?</p> <p>Do they ever do anything like this?</p> <p>What do you think the babies are thinking about when they do this?</p> <p>Do you think this is good or bad for your baby? Why?</p> <p>Do you think babies that can't talk can play with other babies?</p> | <p>This picture was used both as a starting point for understanding the exposure infants have to peers and different environments i.e. language stimulation, and to gain insight into primary caregivers' beliefs about the infant's capabilities ( Paavola et al, 2007; Trivette, Dunst &amp; Hamby, 2004) .</p> |
| <p><b>Picture D – neutral</b></p>  <p>Source: <a href="http://www.life.com/image/tlp748123">www.life.com/image/tlp748123</a></p>  | <p><i>Question:</i> What do you think this mother is doing? Why?</p> <p><i>Examples of follow up questions:</i></p> <p>What do you think the baby is thinking?</p> <p>Do you ever do anything like this with your baby?</p> <p>What kind of things make your baby smile?</p>   | <p>A neutral picture of mother- child contact was included to try to allow a broad range of opinions to be obtained from primary caregivers (Prosser, 2010).</p>  |

|   |  |  |
|---|--|--|
|   | Do you do those things more just to get him to smile?  |  |
| <p><b>Picture E- mother-child play</b></p>  <p>Source: <a href="http://www.momlogic.com/images/mother-and-baby-playing/">www.momlogic.com/images/mother-and-baby-playing/</a></p>  | <p><i>Question:</i> What do you think the mother is doing? Why?</p> <p><i>Examples of follow up questions:</i></p> <p>Do you ever do anything like this?<br/>Why?<br/>How does your baby react?<br/>Do you think it's good for them?</p>   | <p>Good mother-infant interaction is a key factor upon which ECD is based (Patterson, 2009). This picture aimed to establish what play interactions the infant is exposed to.</p>  |
| <p><b>Picture F – independent play</b></p>  <p>Source: <a href="http://www.babychums.com/wp-content/uploads/2009/11/...">www.babychums.com/wp-content/uploads/2009/11/...</a></p> | <p><i>Question:</i> What is the baby doing? Why?</p> <p><i>Examples of follow up questions:</i></p> <p>Do you give your baby toys?<br/>What kinds of toys are they?<br/>Does your baby play on his/her own like this baby or do you play with him/her?<br/>Do you talk as you play?<br/>How do you talk?<br/>Do you think toys can help them learn to talk?<br/>How?</p> | <p>Play is the means by which infants learn about the world around them (Patterson, 2009; Rossetti, 2001). Understanding the exposure the infant has to toys, the types of toys and the way in which primary caregivers use them is necessary for planning appropriate intervention (Van Kleeck, 1992)</p> |
| <p><b>Picture G – neutral</b></p>   | <p><i>Question:</i> What are the mother and baby doing?<br/>Why?</p> <p><i>Examples of follow up questions:</i></p> <p>Do you carry our baby like this?</p>  | <p>A neutral picture of mother- child contact was included to try to allow a broad range of opinions to be obtained from primary caregivers (Prosser,</p>  |



Source:

[www.USAID.gov.au/.../images/hivaids\\_image2.jpg](http://www.USAID.gov.au/.../images/hivaids_image2.jpg)

Do you think this is a good way to carry a baby? Why?  
Do you think that carrying a baby like this would help them learn to talk?  
How do you know when your baby wants something?  
What happens when you are carrying your baby and you can't see where he/she is pointing or looking?  
Do you talk to your baby?  
How do you talk to your baby when you are carrying him/her? Do you think he/she understands what you say if he can't see where you are going or what you are doing?

2010). A culturally specific interaction enabled a more focused discussion of culture to take place.

## APPENDIX D

### Individual Guided Interview Schedule

#### 1. Biographical Details

Name: Age: No. of children: Who lives with you?

Education level: Work: Religion:

Language:

How often do you have the baby in the day?

#### 2. Beliefs

##### 2.1. Regarding role of mother

- What do you think mothers are there for? The role?
- What do you think are the most important things for your child to learn?
- Why?
- What do you think is the best way for your child/baby to learn these things?
- What do you find difficult about doing these things for your baby?
- Why do you think a baby cries and what do you do when your baby cries?
- Do you think that the way you look after your baby and teach her is different from other people in your area? From families in other countries/people who speak different languages? How?
- What do you hope for your baby? How will you help her get there?

##### 2.2. Regarding infants and their abilities

- When do you think your baby starts to understand what you are saying to her?
- How much do you think she/he understands?
- What does your baby know about? Think about?
- How does your baby tell you what she needs?
- How do you think he/she learns things?
- What do you hope for your baby to learn from you?
- What do you think is bad for your baby? Why? i.e. what things stop your baby from developing properly? E.g. some mothers have said it is bad for babies to play on their own without the mother there.

#### 3. Parenting Practices

- General (Tell me about a normal day with your baby) What? When? Why?
- Language Development
  - i. When did you start talking to your baby?
  - ii. How often during the day would you say you talk to your baby?
  - iii. What are you doing when you talk to them?
  - iv. What kind of things do you say?

## APPENDIX E

### Pilot Study Review Questions

#### Themes

1. After taking part in the interview what do you think this study is about?
2. From what you understand of the study do you think that the themes discussed were appropriate?
3. Are there any areas that you feel were left out of the study that should be added? Why?

#### Style

4. Did you understand each area of discussion easily?
5. Did you feel that the topic changed smoothly and comfortably?
6. Could you suggest ways in which this could be improved?

#### Translator

7. In using a translator during the interview did you feel as though it prevented you from sharing your opinion in any way?
8. What could the researcher and/or translator have done to make the translation process more comfortable?

#### Social skills

9. Did you feel comfortable with the interview process?
10. How could the researcher help you to feel more comfortable? E.g. video recording stopped, less people present, more respect shown.
11. Was there anything that the researcher or translator said or did that was inappropriate or made you uncomfortable?
12. Was there anything that was asked or discussed that you did not fully understand?

#### General

13. Did you understand the purpose of the interview when it was explained? How could the explanation have been improved?
14. Is there anything you would like to comment about relating to the interview? The study? The participants?

## APPENDIX F

The results of the focus groups reflect comments that primary caregivers made in response to photographs presented to them in the focus groups. The researcher made the assumption that the comments that were made on the photos demonstrate how the participants perceive themselves, or how they wish to be perceived with regard to the topic areas.

### **Theme One: Role of the Caregiver**

#### **i. Focus groups: Participants' beliefs regarding the role of the caregiver**

Comments that were made by participants in response to the photos and the questions that accompanied them were taken as a projection of the social and cultural beliefs of the participants themselves. This is in line with Prosser (2010) who states that images can be used as tools to help the viewer to express his/her own thoughts and beliefs. Thus, even though the participants often referred to the subjects within the photos as carrying out an action or having a particular motivation, these actions and motivations can be presumed to demonstrate the participants' projection of actions and motivations they would use themselves. It was also then not necessary or possible to differentiate between a response made about the participants own beliefs and practices, and a response made in relation to the photographs, as all of the responses were made after viewing a photo (as a method to stimulate conversation) i.e. even though the questions related to the beliefs and practices of the participants, their answers would have been influenced by the exposure to the photograph.

The beliefs of the primary caregivers regarding their role as a caregiver were revealed by a number of questions posed to the participants. The results are presented in Table 1.

Table 1. Participants' responses regarding the role of the caregiver

| Photo   | Questions asked   | Participants response relating to the theme  |
|---|---|--|
| A – picture of mother looking down at her baby while breastfeeding. | Why is the mother looking at her baby?  | <ul style="list-style-type: none"> <li>• Ensuring the baby is growing</li> <li>• Checking her health</li> </ul>  |
| B – picture of mother showing an object to a baby                   | <ul style="list-style-type: none"> <li>• What is the mother doing?</li> </ul>     | <ul style="list-style-type: none"> <li>• Teaching the child about objects</li> <li>• Teaching the child about HIV</li> <li>• Ensuring the infant does not play with beads so she does not get hurt – mother needs to supervise.</li> </ul> |
| C – Photo of babies sitting together looking at a toy               | No question   | <ul style="list-style-type: none"> <li>• Important to supervise the infant so she doesn't get hurt</li> </ul>  |
| D - baby standing with support from mother                          | <ul style="list-style-type: none"> <li>• What is the mother doing?</li> </ul>     | <ul style="list-style-type: none"> <li>• Helping the baby to stand</li> </ul>  |
| E – baby being thrown in the air by mother                          | <ul style="list-style-type: none"> <li>• Why is the mother doing this?</li> </ul> | <ul style="list-style-type: none"> <li>• Teaching the infant not to be “afraid and make her strong”</li> </ul>   |
| F- baby   | No question   | <ul style="list-style-type: none"> <li>• Babies should be supervised</li> </ul>  |

## Theme Two: The Needs and Abilities of the Infant.

### i. Focus Groups: Participants' beliefs regarding the needs and abilities of the infant

The needs and abilities of infants change rapidly over the first year of life and yet many of the basic needs remain constant (Rossetti, 2001). That these *basic needs should be met* was clearly understood by the participants, who indicated that they fed, protected, comforted, and taught their infants, as part of their daily practices. In addition to the basic needs of the infants, participants demonstrated the belief that the infant was capable of developing a relationship and communicating to a certain extent. Therefore all of the participants saw the infants' role as one of *need* and some saw the potential for *relationship*. Participants demonstrated the belief that infants of all ages had wants and could express them. Table 2 shows the varying responses of the participants.

Table 2. Participants' responses regarding the needs and abilities of the infant

| Photo   | Questions Asked   | Participants' responses relating to the theme   |
|---|---|---|
| Introduction prior to the start of focus groups       | No question – mother describing her best and worst aspects of being a mother.   | <ul style="list-style-type: none"> <li>• Infant “unable to express her feelings”</li> </ul>   |
| A – mother looking down at infant while breastfeeding | <ul style="list-style-type: none"> <li>• Why is the mother looking at her child?</li> </ul>                           | <ul style="list-style-type: none"> <li>• “trying to communicate”</li> <li>• “wanting to bond”</li> <li>• They look into the infants' eyes to “see if they are hurting”</li> <li>• “she is checking she is attached properly”</li> </ul> |
| B – mother showing object to baby                     | <ul style="list-style-type: none"> <li>• What do you think the baby is thinking?</li> </ul>                           | <ul style="list-style-type: none"> <li>• The infant wants the object being shown</li> </ul>   |
| C – two babies sitting next to each other             | <ul style="list-style-type: none"> <li>• What is happening in this picture?</li> </ul>                                | <ul style="list-style-type: none"> <li>• The infant wants the other infant's toy</li> <li>• The infants are angry with each other</li> </ul>  |
| F – infant playing alone with a drum                  | <ul style="list-style-type: none"> <li>• Is playing with toys good for a baby?</li> </ul>                             | <ul style="list-style-type: none"> <li>• Infants play with toys and their desire for the toy can be used to teach them to speak</li> </ul>  |
| G- mother carrying infant on her back                 | <ul style="list-style-type: none"> <li>• How do you know what your baby needs when they are one your back?</li> </ul> | <ul style="list-style-type: none"> <li>• Infants point and wriggle when they want a toy</li> </ul>  |

Participants demonstrated that primary caregivers' beliefs regarding the role of the infant mostly related to the basic physical needs of the infant.

### Theme Three: Communication Development

#### i. Focus groups: Participants' reported beliefs on communication development

Participants reported many stimulating activities within their daily practices and demonstrated an awareness of the infant's ability to feel and think, but very few participants demonstrated a conscious effort to develop language in their children. One participant in group one reported looking at her child in order to communicate during feeding but all other participants in both groups demonstrated very practical motivations for such an action (e.g. checking the baby). When participants were given an opportunity

to relate how they encouraged their baby to learn to talk, no general stimulation activities were mentioned, and only direct teaching and copying methods were related e.g. a participant related how she said a word (tata) while withholding a toy until she said the word. This was true of every action featured in the photos. Opportunities to relate the potential of interactions as language stimulation activities were not taken up and practical physical benefits were noted instead. It thus became clear that participants did not believe there was a connection between communication development and their day-to-day actions. Table 3. demonstrates the responses of participants regarding communication development.

Table 3. Participants’ responses regarding communication development

| <b>Photos</b>  | <b>Questions asked</b>                               | <b>Participants responses related to the theme</b>  |
|--|--|---|
| A – picture of mother looking down at infant while breastfeeding | “Why is the mother looking at the baby?”             | <ul style="list-style-type: none"> <li>• “to communicate” (only one participant)</li> <li>• To check physical well being</li> </ul>   |
| B- mother showing object to infant                               | “How do you think your baby learns to talk?”         | <ul style="list-style-type: none"> <li>• Talking toys are used for the child to copy sounds</li> <li>• Favourite toys are used as motivators to encourage speech attempts</li> <li>• Primary caregivers prefer to sit in front of the child for teaching</li> </ul> |
| E – mother throwing infant in the air                            | “Why is she doing that (throwing infant up)?”        | <ul style="list-style-type: none"> <li>• To make the infant laugh</li> <li>• To teach the infant to be strong</li> <li>• “To teach the child to not be afraid”</li> </ul>   |
| G – mother carrying infant on her back                           | How do you show your baby things while on your back? | <ul style="list-style-type: none"> <li>• The infant must not make noise</li> <li>• “Be quiet we trying to work!” [laughing]</li> </ul>  |

Certain times were viewed as being appropriate for learning to speak and this included bath time and playtime. Participants viewed it as inappropriate or inconvenient for the infant to make speech attempts at other times. For example when discussing the possibility of talking to the infant while carrying them on their backs the participants in both groups demonstrated disapproval of the idea of talking with the infant. Participants

thus viewed the development of language as a skill that is developed through direct teaching and modelling and should not intrude on other daily activities such as chores.

#### **Theme Four: Daily Activities**

##### **i. Focus groups: Participants reported daily activities**

The focus group interviews did not require the participants to report on their daily routine, however many of the activities of daily living emerged through the discussion of the photos. Daily activities highlighted as being part of each day by the participants, included: breastfeeding, sleeping, playing, and physical interaction such as carrying and holding the infant. Table 4. provides details regarding the daily activities reported by the focus group participants.

Table 4. Participants reported daily activities

| <b>Photos</b>                                    | <b>Questions asked</b>  | <b>Participants' responses relating to the theme</b>  |
|--|---|---|
| A – mother looking at infant while breastfeeding | <ul style="list-style-type: none"> <li>• “Do you do this?”</li> <li>• “Why do you do this?”</li> </ul>                | <ul style="list-style-type: none"> <li>• “everybody does this”</li> <li>• Don’t look at the baby, look around instead.</li> <li>• Talk to the baby to get her to feed nicely</li> <li>• “just thinking”</li> <li>• “looking in the eyes to see if they are hurting”</li> <li>• Breastfeed if the baby is upset</li> </ul> |
| B – mother showing object to baby                | <ul style="list-style-type: none"> <li>• What is happening in this photo?</li> </ul>                                  | <ul style="list-style-type: none"> <li>• A mother playing with her child</li> <li>• Mother keeping her child busy</li> <li>• Play distracts the baby when not feeding nicely</li> <li>• Keeping the baby happy</li> </ul>   |
| C – two babies sitting next to each other        | <ul style="list-style-type: none"> <li>• “Does your baby ever see other children of a similar age to him?”</li> </ul> | <ul style="list-style-type: none"> <li>• All participants had experience of this.</li> <li>• Need to have enough toys</li> <li>• Need to be supervised so they don’t fight</li> <li>• Not sure if is good for them to play together at such a young age</li> </ul>  |
| D – mother helping infant to stand               | <ul style="list-style-type: none"> <li>• “What is happening in this photo?”</li> </ul>                                | <ul style="list-style-type: none"> <li>• The mother is playing with her baby to help him stand</li> </ul>   |

Table 4. Participants reported daily activities continued..

| Photos                                 | Questions asked  | Participants' responses relating to the theme  |
|--|--|--|
| E – mother throwing infant in the air  | <ul style="list-style-type: none"> <li>• “What is happening in this picture?”</li> </ul>                                       | <ul style="list-style-type: none"> <li>• The mother is making the child laugh</li> </ul>   |
| F – baby playing alone on a drum       | <ul style="list-style-type: none"> <li>• “Does your child ever play alone?”</li> </ul>   | <ul style="list-style-type: none"> <li>• Toys mentioned: dolls; balls; “ones that make noise”; bears; shape toys and rattles.</li> <li>• Don't like the child to play with household items</li> <li>• Infants also play with their hands</li> <li>• Bathtime is a good time for playing</li> </ul> |
| G – mother carrying infant on her back | <ul style="list-style-type: none"> <li>• “What is happening in this photo?”</li> <li>• “Is this good for the baby?”</li> </ul> | <ul style="list-style-type: none"> <li>• Mother is carrying baby to get her to sleep</li> <li>• She is travelling with her baby</li> <li>• Allows mother to have hands free to do the housework</li> <li>• Gets the baby to sleep</li> <li>• Restricts interaction with the baby</li> </ul>        |

*Breastfeeding-* breastfeeding was accepted without question by participants in the two focus groups as being common practice. Both groups noted that talking to the baby or playing with the baby while feeding helped the baby to feed better. Although no information was given as to feeding schedules or where the feeding takes place, reference was made to using breastfeeding as a means of comforting the child. A group two mother reported:

*GP 7: If there is something I am doing and the baby cries, I leave everything and breastfeed my baby.*

This response indicates a high level of responsiveness to the needs of the infant. Breastfeeding provides an excellent natural means through which the maternal bond is encouraged (Patterson, 2009), which in turn stimulates ECD.

*Sleeping*- sleeping was referred to briefly by both groups. The first reference was an unprompted reference made in the introductions in group one, the participant referred to using the amount the baby slept as an indication that the baby is ill as the baby could not tell her. The second reference to sleep was made in response to photo G (mother carrying a baby on her back), a caregiver described this photo as a mother carrying her baby on her back to help the baby sleep.

*Carrying*- The traditional Zulu method of carrying a small child or infant is to tie them to the mother's back using a blanket. This was confirmed by the mothers in both groups. Both groups reported that carrying the child on the back restricted their ability to interact with the child. When they wished to talk to the child or play they would carry the child in the front or they would sit behind the child. It was directly observed that several of the mothers in these groups carried their young infants heavily swathed in blankets in a cradling position (despite the hot weather). Some carried them on their backs and a few carried the baby at the front in 'baby pouches'. While carrying the baby on the back allows for more close contact time with the caregiver, movement, range of sight and the ability of the caregiver to respond to the infant's communication attempts are all limited.

*Play* – Play was referred to frequently by both groups and in relation to each picture. It became clear that play is considered normal practice with infants. It was used to describe many of the actions in the photos, participants in both groups described play with their infant as: "*making crazy faces*", with demonstrations of cheek touching, throwing up the baby into the air, showing them things, and with 'baby talk'. Participants reported playing with the child with toys on occasion. Play was also reported to occur without the caregiver. Reports of children playing alone (group one), "*playing with their hands*" (group one), and playing with other children, both of contemporary age and older (both groups), came through. Table 4. demonstrates the references participants made to play in relation to photos B, C, D, E, and F. The manner in which the groups answered the questions about toys in the home indicated that toys were seen as something of an indication of parenting status or success, as some of the participants were eager to list the toys their child had.

As is apparent from the length and depth of the information on this sub-aim, primary caregivers were interested in play and had strong opinions on how, where and when it should take place. This data provides insight into the stimulation that infants in this area receive from peers, caregiver-child play and individual play with toys, valuable in developing appropriate intervention.

### **Theme Five: Language Stimulation**

#### **i. Focus groups: Language stimulation practices related by participants**

Many of the daily activities reported by participants promote ECD, including: play, looking into the infants eyes while breastfeeding, talking to the infant, responding to the infants cries, providing close physical contact, and responding to communication attempts. However these were not perceived by the participants as being beneficial for language learning.

Only a few deliberate attempts at developing language were spoken of within the focus groups. Both focus groups reported that they talk to the child to encourage them to copy words. An example was given by a participant in group two of how she plays with her child and teaches her to say “tata” [take] by withholding the toy. Another participant in the same group responded:

*R: What do you do to help your child to speak?*

*GP 4: Play with the baby and talk to the baby. If the baby wants something you must tell the baby what it is.*

Questions about what helps infants to talk also elicited the information that participants used toys that spoke or made sounds to help their children learn by copying the sounds, this was reported by both groups. Talking to the infant was mentioned as occurring during feeding, and while they are playing. Participants in group two were asked if they thought toys helped children to learn how to talk. The response was a confident “no” from the majority of participants. One participant amended this to exclude toys that

make a noise or talked. The nature of the questions directed at the participants did not require every instance and method that they use in developing their child's language to be described. Nevertheless a direct teaching method was the most common reported method of teaching language, with some mention being made of learning by copying.

## APPENDIX G

### Letter to the District Health Manager (KwaDabheka Clinic)

Department of Health  
Private Bag X828  
Pretoria  
0001

Dear Dr Hoque

Re: Permission to conduct research at (name of clinic)

I am a speech language therapist currently registered for the degree Master of Communication Pathology with the University of KwaZulu-Natal, Discipline of Speech-Language Pathology. I am conducting research on primary caregivers' beliefs and practices regarding Early Language Development. I require permission to use the (name of clinic) situated in (name of area) as a base for this research.

The research project explores the beliefs and practices of primary caregivers regarding ECD in infants. This project will specifically focus on caregivers/primary caregivers in rural areas in KwaZulu-Natal and will look at caregivers' interactions with their infants from birth to 14 months (first word stage). I hope to obtain information that will enable speech therapists to provide treatment that is more appropriate and acceptable to primary caregivers in the rural areas and thereby improve the outcomes of treatment in these areas.

The study will require me to ask the nurses at the clinic to identify primary caregivers who meet the participant selection criteria so that I may inform them of the study and request their permission to include them in group and individual interviews. The nurses will be able to identify suitable caregivers by viewing the inoculation cards of infants brought in to the postnatal clinic. No information of a sensitive nature needs to be revealed to me by the nurse. Primary caregivers that participate in the study are required to:

- be the primary caregiver of an infant 0-12 months
- be fluent in either isiZulu or English
- have the care of an infant that is in good general health, that was born without complication and with an apgar rating of 7 or above, further the infant should have achieved his/her developmental milestones appropriately (this is to ensure that the participants experience is with a typically developing infant)
- volunteer and be willing to share their views and practices with the researcher

Nurses at the clinic will be required to participate as follows:

1. Agree to assist in the study

2. Identify suitable primary caregivers as they come through the clinic with their children by looking at the immunization card.
3. Indicate to the primary caregivers that they meet the requirements to participate in a study and direct them to speak with the researcher in the next room.

I hope to conduct this study in March 2010 but should the study be delayed it will be conducted before the end of 2010.

Should you require further details of the study and the participant requirements I will be happy to provide this information and answer any concerns and queries. I can be reached at [brongearl@gmail.com](mailto:brongearl@gmail.com) or on 0728692326.

Sincerely,

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Mrs B. Earl  
(researcher)

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Mrs L. Moodley  
(supervisor)

Permission to conduct study:

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Dr Hoque (District Health Manager)

## APPENDIX H

### Letter to the Clinic Matron

To Sister (name)

**Re: Permission to conduct research at (name of clinic)**

I am a speech therapist currently conducting masters research through the University of KwaZulu-Natal. I would like to use the (name of clinic) as a base for this research and have obtained the necessary permission from the Department of Health to do so. I understand that you are currently overseeing the clinic in the absence of the matron and I need your written permission to conduct this study.

The research project will seek to explore the beliefs and practices of caregivers regarding ECD in infants. This project will be specifically focused on caregivers/primary caregivers in rural areas in KwaZulu-Natal and will look at caregivers input to their infants from birth to 12 months (first word stage). I am hoping to obtain information through this study that will help speech therapists to provide treatment that is more appropriate and acceptable to caregivers in the rural areas and thereby achieve greater parental involvement in treatment.

The study will require me to ask the nurses at the clinic to notify me when a caregiver meets the subject criteria so that I may inform them of the study and request their permission to include them in group and individual interviews. The nurses will be able to identify suitable caregivers by viewing the inoculation cards of infants brought in to the postnatal clinic. No information of a sensitive nature needs to be revealed to me by the nurse.

I hope to conduct this study in March 2010 but should the time change I will inform you.

Should you require further details of the study and the participant requirements I will be happy to provide this information. I can be reached at [brongearl@gmail.com](mailto:brongearl@gmail.com) or on 0728692326.

Sincerely,

---

Mrs B. Earl  
(researcher)

---

Mrs L. Moodley  
(supervisor)

## APPENDIX I

### Explanation letter for subjects

Dear Caregiver

Re: Research study participation

I am doing research on what caregivers and primary caregivers in rural areas do during the day that helps their children to learn language. I am also looking at caregivers beliefs about how children learn to speak. This study will be done by talking to groups of caregivers and by interviewing caregivers on their own.

I would like you to join this study and share your information with me by answering questions. This can be done in a group or on your own. The questions will not be of a sensitive nature but will be about your daily routine and about what you think about communication with your baby. The questions will take no more than an hour. You will need to come in to the (name of clinic) clinic, but the cost of your transport will be paid to you. The questions will be arranged for a clinic day where possible so that you are can attend the clinic at the same time if needed. The individual interviews can be done on any day that suits you.

All that is required of you is your time, and joining the study may help you to be a better caregiver as it will help you to think about how your child learns. The results of the study will be made available to you once the study is finished, should you wish to see them. You are welcome to ask questions at any time in the study. Your participation in this study is voluntary so you are free to leave the study at any stage without penalties. There are no hidden costs or risks involved in joining this study. I will also provide the child of each participant with a small toy in appreciation of your contribution to the study.

Your personal information will be treated as private and your answers to the questions will be anonymous.

Should you have any questions or worries regarding this study please feel free to phone me (Bronwyn Earl) on 0728692326 or contact me through the University of KwaZulu-Natal, Department of Speech Therapy and Audiology on 0312607438.

Sincerely,

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B. Earl  
(Researcher)

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L. Moodley  
(Supervisor)

## **Zulu translation**

Siyakubingelela Mzali

### **Hlanganyela Ocwaningweni lokufunda**

Ngenza ucwaningo ekutheni abazali nabanakekeli bezingane ezindaweni ezisemaphandleni ikuphi abangakwenza phakathi nosuku okusiza izingane zabo ekufundeni ulimi. Kanjalo futhi ngibheka izinkolelo zabazali ekutheni izingane zifunda kanjani ukukhuluma. Lokufundiswa kuzokwenziwa ngendlela yokubuza imibuzo. Kwihlanganisela noma iqoqo labazali.

Ngizocela ukuthi nihlanganyele kulokufunda ngokuphendula imibuzo ngamunye noma ngamaqoqo. Lemibuzo ngeke ibe mayelana nobucayi bempilo, kodwa kumayelana nendlela yansuku zonke yakho yokuphila nanokuthi unamicabango mini ngokukhuluma kwakho wena nengane yakho. Lemibuzo angeke ithathe isikhathi esingaphezu kwehora . Odinga ukukwenza ukuba ufike emtholampilo i (name of clinic) Clinic, izindleko zokugibela uyokhokhelwa uma usufikile. Imibuzo iyoqhubeka ngesikhathi usemtholampilo .Imibuzo yomzali ngamunye iyoqhubeka noma ingabe iluphi usuku oluvumelana nawe mzali.

Esikucelayo kuwena isikhathi sakho kuphela , kanti ukuhlanganyela kulesifundo kuyokusiza ekutheni ube ngumzali ongcono kubuye kukusize ekutheni wazi ukuthi ingane yakho ifunda kanjani. Imiphumela yalokufunda iyotholakala uma sekuqediwe ukufundiswa uma nifisa ukuyibona. Nivumelekile ukubuza noma ngabe inini nesikhathi sokufundiswa. Ubukhona bakho kulokufundiswa kungokuzikhethela kwakho, futhi uvumelekile ukuyeka ukufundiswa noma ngabe inini ngaphandle kokuhlawuliswa. Akunazindleko ezifihlekile uma ujoyina lokufunda futhi ngiyobe sengipha ingane yomzali ngayinye ithoyizi ukukhombisa ukubonga ngokuhlanganyela nathi kulokufundisa.

Imininingwane yakho iyobe iyimfihlo nemibuzo iyobe ingavezi gama lamuntu.

Uma unenkinga noma imibuzo mayelana nalesifundo wamukelekile ukungithinta kule nombolo 0728692326 noma ungithinte ngokuxhumana nenyuvesi yakwaZulu Natali , noma emnyangweni we Speech Therapy and Audiology ku 031 2607438.

Ozithobayo

B. Earl  
( umcwaningi)

L .Moodley  
( obhekele ucwaningo)

## APPENDIX J

### Focus Group Consent Form

Research into the beliefs and practices of primary caregivers regarding communication development in infants 0-12 months in rural KwaZulu-Natal.

This study will require you as the primary caregiver of a typically developing child to share your opinions and information on your beliefs and practices in parenting your child. This information will be obtained through focus group interviews.

Participation in this study is voluntary and the information collected will be treated as private.

I agree to participate in a focus group for this study.

\_\_\_\_\_  
Caregivers/primary caregivers signature

\_\_\_\_\_  
Researcher's signature

### Zulu Translation

#### Ifomu lemvume yokubuzwa kwamaqoqo

Ucwaningo kwinkoleloze nezenzo abazenzayo abazali mayelana nokwakhayo uma bekhuluma nezingane zabo kusukela zizelwe zize zibe nezinyanga eziyishuminane emaphandleni akwaZulu Natali.

Lesisifundo sizodinga imibono nolwazi lomnakekeli wengane ekhuliswayo . Lolwazi luzotholakala ngokuhlangenyela kufundiswe bese kubuzwa nemibuzo uma ikhona.

Akuphoqiwe muntu ukuba ahlanganyele kulesifundo nolwazi oluyotholakala luyoba imfihlo.

Ngiyavuma ukuba yinxenye yalesisifundo

Umzali noma umnakekeli uyasayina

Umcubunguli uyasayina

## APPENDIX K

### Individual Interview Consent Form

Research into the beliefs and practices of primary caregivers regarding communication development in infants 0-12 months in rural KwaZulu-Natal.

This study will require you as the primary caregiver of a typically developing child to share your opinions and information on your beliefs and practices in parenting your child. This information will be obtained through focus group interviews.

Participation in this study is voluntary and the information collected will be treated as private.

I agree to be interviewed for this study.

\_\_\_\_\_  
Caregivers/primary caregivers signature

\_\_\_\_\_  
Researcher's signature

### Zulu Translation

#### Ifomu lemvume yokubuzwa

Ucwaningo kwinkoleloze nezenzo abazenzayo abazali mayelana nokwakhayo uma bekhuluma nezingane zabo kusukelwa zizelwe zize zibe nezinyanga eziyishuminane emaphandleni akwaZulu Natal.

Lesisifundo sizodinga imibono nolwazi lomnakekeli wengane ekhuliswayo. Lolwazi luzotholakala ngokuhlanganyela kufundiswe bese kubuzwa nemibuzo uma ikhona.

Akuphoqiwe muntu ukuba ahlanganyele kulesifundo nolwazi oluyotholakala luyoba ifihlo.

Ngiyavuma ukubuzwa ngalesisifundo

Umzali / umnakekeli uyasayina

