Original Article

Childcare Services in the Emerging Daycare Centers of Addis Ababa: Status, Practices, and Lessons

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Abstract

Recent developments are witnessing an emerging expansion of daycare services for children of age 3 and less years. The purpose of this study was to explore the status, practices, and effectiveness of these emerging daycare services in Addis Ababa. The study employed a sample of 10 daycare centers found in KolfeKaranio and Nefas Silk sub-cities. Participants were parents (n=100), caregivers (n=27), daycare center owners (n=4), and early childhood care and education (ECCE) focal persons (n=2). Data were collected using questionnaire, interview, and observation form. Findings indicated that there was an enabling policy framework but without standards, guides and manuals for caregivers. Administrative, coordinating, and supervisory offices were missing as yet and, hence, many of the centers were not licensed, guided, supervised and monitored. They lacked the required texture of a 'professional daycare service' in establishing and sustaining a stimulating, consistent, responsive and caring environment. Hence, the daycare centers seemed to be more of a stay site rather than agents of development for ITs. In fact, further research is needed to examine the impacts of these daycare services particularly on the ITs.

Keywords:Childcare/ Daycare/ ECCE / KG/ Preschool education /Nursing

1. Introduction

Research findings indicate that early childhood experiences are critical for rapid brain (Tierney & Nelson, 2009), cognitive (Korjenevitch & Dunifon, 2010) and language development (Vandell &Wolfe citedin Korjenevitch & Dunifon, 2010). It is at the same time foundational for infants and toddlers (ITs) to develop ability to learn and relate to others (Citizens' Committee for Children, 2004), to acquire general well-being and emotional health (Gunnar & Cheatham, 2003; Citizens' Committee for Children, 2004), to build internal model of representation of the self (Howes, 1998; Lally, 1995), and to achieve resilience among high-risk groups (Elicker & Fortner-Wood, 1995).

There has been a corresponding recognition of the role of early care in the development of children by international agencies and conventions. For example, the UN Convention of the Rights of the Child (CRC) stipulates that every child has the right to

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care and education (CRC, 1992). The world conference on "Education for All" (EFA) that took place in Jomtien, Thailand also underscored the fundamental place of Early Childhood Care and Education (ECCE). The 1999UNICEF World Summit (cited in Dereje, 1994) even stipulated that a society that pays no attention to the early period of childcare and education fails to recognize the high social return or cost in the future.

Ethiopia is one of the countries that accepted these and other related declarations and attempted to take measures to addressing the needs of children in the early years. In fact, recognition for the importance of early years' education in Ethiopia even dates back to the turn of centuries basically rooted into the three religious movements: the introduction of Christianity in the 4th C in the Northern Ethiopia that initiated preschools to teach, among others, basic literacy (Pankhurst, 1955; Wagaw, 1979), the expansion of Islam in 7th C that introduced Quranic schools to teaching early Arabic reading to Muslim children in Eastern Ethiopia (Alidou, Boly, Brock-Utne, Diallo, Heugh, & Ekkehard, 2006), and the evangelical movement initiated in the 1950s that contributed to the expansion of early years schooling particularly in Southern and Western Ethiopia(cited in Tesema, 2013).

Although establishment of early years education in Ethiopia can in no way be regarded delayed even by a European standard (see, for example, Demeke, 2007; Hoot, Szente, & Belete, 2004), its expansion has been, however, very slow (Demeke, 2003; Hoot, Szente, & Belete, 2004) mainly because there was little government involvement in the general outlay, administration, guidance, coordination, and budget allocation (Tirussew et al., 2007). This has led many scholars to voice their concerns in the 1990s (e.g. Habtamu, 1996), early 2000s (e.g. Hoot, Szente, & Belete, 2004), and very recently (UNESCO, 2006b; Demeke, 2007; Szente, Hoot & Selamawit, 2007; Tirusew et al; 2007). However, these voices seemed to heed attention from the Government in more recent years.

The Ethiopian Government seemed to recognize the fundamental importance of early childcare and education as a means to accelerating the attainment of "Education for All" (UNESCO, 1990) and the "Millennium Development Goals" (Demeke, 2007), if not for its own sake, so to speak. To this end, a joint government agency was set up composed of three line ministries (namely Ministry of Education, Ministry of Health, and Ministry of Women, Children, and Youth Affairs) who eventually signed a Memorandum of Understanding to implementing early childcare and education in a multi-sectoral, integrated and holistic manner (MoU, 2010). The Agency then designed a draft National Policy Framework (MoE, MoH & MoWCYA, 2010a), strategic operational plan (MoE, MoH & MoWCYA, 2010b), and guidelines (MoE, MoH&MoWCYA,2010c) to steer up the implementation of ECCE. Commensurate with these changes, lots of developments are underway today: implementation of three modalities of ECCE provisions (Kindergarten, primary school attached '0' classes and Child-to-Child initiative) that raised gross enrollment from about 2 % nearly two decades ago (EMIS, 2000) to about26.1% (with12, 639 teachers and 3,688centers) in more recent years (EMIS, 2014).

These interesting developments were, however, developmentally truncated only to the later phases of early years' care and education (i.e. to 4 to 6/7 years of age); despite the fact that the need for establishing nursery (for children of age 3 years and below)in every kebele was stressed even in studies as early as 1978/9 (MoE, 1971 E.C.). Education and care for children under the age of three years have been left to parents

(UNESCO, 2006) because most available programs are limited to children with ages 4-6 years (Tirussew et al., 2007). In fact, one of the four pillars of the ECCE National Policy framework(MoE, MoH, MoWCYA, 2010a)directly targets 'health and early stimulation program' from Prenatal to 3+ years. According to the policy, main activities include growth and health monitoring, addressing developmental needs and preventive health care, including proper health seeking behaviors, full immunization, nutrition support, early developmental stimulation and parental education and demonstrations. The program is to be realized basically through Health Extension Workers (HEW) and Voluntary Community Health Workers going door-to-door as there are no provisions for center-based services. This being the case, recent developments are, however, witnessing an emerging expansion of center-based/daycare services in Addis Ababa for children of 3 and less years (Martha, 2013) and parents were happy about the services; although such services retain certain challenges (Martha, 2013).

Because infant daycare practices contrast with traditional cultural conceptions (Lamb, 1998), there were debates in other countries about the appropriateness of out-of-home care or education (Balban, 2006; Belsky, 2003)as well as about the various non-parental forms of daycare and their effects on children's development (Lamb, Bornstein & Douglas, 2002). A number of OECD (Organization for Economic Co-operation and Development) countries pay a stay-at-home child-raising allowances for parents with children up until age 2 or 3 with an understanding that this is a better developmental choice for children (OECD, 2006). Daycare services are often viewed as provisions utilized primarily by single mothers and disadvantaged families (Phillips cited in Lamb, Bornstein & Douglas, 2002, p.45) and have negative effect for children from more advantaged backgrounds (Lamb, Bornstein & Douglas, 2002). Furthermore, at a very young age, daycare is likely to limit breastfeeding, reduce parent-child attachment, expose a child to stressful interactions with other children, and reduce direct child-adult interaction due to higher adult-child ratios (Belsky, 2003). In terms of physical health, evidences indicate that greater time spent by children in center-based care is associated with increased rates of respiratory problems for children aged 12 to 36 months and increased rates of ear infections for children aged 12 to 24 months (Gordon et al., 2007).

Other researchers counter argued that daycare is likely to provide good out-of-home care (Lamb, 1998), relieves employed mothers of full-time childcare responsibilities (Lamb, 1998) and hence improves family income by enabling maternal employment (Petriwskyj & Grieshaber, 2011). It also has positive effect for children whose parents are mentally ill or overly stressed, or have poor parenting skills (Belsky, 2003). Additionally, daycare is said to allow opportunities for children for positive social interactions and learning to socialize and co-operate with peers and strangers right from the beginning (Balban, 2006). In doing so, it improves early cognitive functioning (Belsky, 2003).

The third group of researchers argue that differences in rearing environments had little apparent effect on the way children develop, that daycare and home care have remarkably similar effects on the developing infants (Clarke & Clarke, 2000; Kagan & Klein cited in Lamb, Bornstein & Douglas, 2002, p.27) and children who spend in daycare centers do not differ much in their language achievements from children who are cared for exclusively in the home (NICHD, 2000).

Heeding the debates above, other scholars suggest that we need to move away from asking "if daycare services are bad or good for children" to asking more meaningful questions about the manner in which daycares affect children's development and measures to be taken to optimize the development of infants in out-of-home care environments (Lamb, Bornstein & Douglas, 2002, pp. 46-47). It is important that the effects of a particular daycare experience be viewed in the context of other events and experiences in the infants' lives (Lamb, Bornstein & Douglas, 2002, pp. 47). That is, whether out-of-home childcare is good or bad for ITs depends to a large extent on the quality of services and provisions provided in the centers (Belsky, 2003).

In the light of these ideas, there is, therefore, a need to explore the contexts of daycare centers mushrooming in Addis Ababa at this early stage of expansion so that early corrective measures can be taken to avert a wrong start. A lot has been done researching ECCE in Ethiopia from different perspectives; but, given its novelty, little was done on day care centers and a number of concerns naturally trigger curiosity to learn about them. For example, what policy provisions exist in the first place? What objectives do the daycare centers bear to advance? How are they organized, operate and provide services? What resources (material, human), services, and activities are put in place? How professional are the services and activities? How far the centers entertain the developmental needs of babies and young children? What strengths, challenges, and support are experienced? How can we encourage them move forward? And, what is in general the quality of care rendered in the centers? Endeavoring to address these questions, this research then has the objective of examining the status, practices, and quality of daycare centers in Addis Ababa.

2. Conceptualization of Quality Early Childhood Care

Meanings: Early childhood encompasses all young children from birth to the age of 8 years experiencing the most rapid development as well as establishment of strong emotional attachments with care givers and others (UNCRC, 2005). Early childcare is then the process of scaffolding this development so that young children would ultimately become physically healthy, mentally alert, emotionally secure, socially competent and able to learn (UNCRC, 2005). The dynamic process embracing all activities, interactions, services, protections and provisions along these directions is generally termed 'quality early childcare'(Fenichel, Lurie-Hurvitz, & Griffin, 1999; Lamb, Bornstein & Douglas, 2002;Belsky, 2003;Arnold, 2005). This 'quality early care' is socially-constructed, culturally-bound, context-specific, and dynamic (Arnold, 2005) and, hence, a concise straightforward definition remains elusive. Hence, there is a need to operationalize it preferably in terms of outcomes (Zigler et al., 2009), principles (Gonzalez-Mena &Wismeyer, 1993), components (Zero to Three, 2009), and indicators (Korjenevitch&Dunifon, 2010).

Outcomes: It is commonly said that 'quality early care' is generally found to yield healthy ITs with fewer behavior problems (Vandell & Wolfecited in Korjenevitch & Dunifon, 2010), happier ITs who are ready for kindergarten (Zigler et al., 2009), securely attached ITs who are able to explore, learn, and form wider relationships with others (Tierney & Nelson, 2009), independent and self-confident ITs who engage in

learning (Tierney & Nelson (2009), and ITs who are able to perform on IT-friendly cognitive, linguistic, and social tests (Korjenevitch & Dunifon, 2010).

The question is what principles, processes, and practices are at work to optimize achievement of these developmental outcomes. Here are the major principles, components, and indicators to be used as a guide in our present study.

Principles: quality early care is maintained through (Gonzalez-Mena &Wismeyer, 1993;Fenichel, Lurie-Hurvitz, & Griffin, 1999):

- addressing the diverse needs of infants and toddlers (ITs)
- involving ITs in activities and issues that concern them,
- investing in quality time: setting tasks (such as diapering, feeding, bathing, and dressing) and staying near while Its are engaged in different activities,
- learning each child's unique ways of verbal and non-verbal communication,
- investing time and energy on building the total child,
- honest feelings (getting angry, scared, upset, and nervous now and then) instead of pretensions in front of children,
- modeling the behavior a caregiver wants to teach,
- recognizing problems as learning opportunities,
- letting the ITs solve their own problems,
- building security by teaching trust, and
- ensuring smaller teacher-child ratios and appropriate group sizes.

Components: in a manner similar to Gonzalez-Mena and Wismeyer's principles (1993), 'Zero to Three' (2009), an organization working to promote the optimal development of children from birth to age three and their families, describes quality care in a manner that encompasses primary and secondary components of services to, provisions for and interactions with ITs. 'Primary care giving' (Bernhardt, 2000; Zero to Three, 2009) involves establishing personal assurances that attention will be paid to ITs. The primary caregiver is the one who diapers or toilets, feeds and puts the IT to nap; the IT goes to for special comfort; the family knows to contact for daily information; and is a secure base for ITs to explore more, to engage in productive play, and to interact more and more resourcefully in group settings (Raikes, 1996).Excluding those already mentioned, secondary care for ITs, on the other hand, includes adherence to health and safety policies, well-planned physical environments, and cultural and linguistic competence and continuity (Zero to Three, 2009).

Indicators: capitalizing on the most recent and relevant studies on what elements contribute to quality childcare and development, Korjenevitch and Dunifon (2010)gave the following general indicators:

- Caregiver's sensitivity and responsiveness in interactions with children
- Licensing compliance to ensure the minimal levels of safety and standardsof care
- Minimal staff turnover to establish healthy and secure attachments on the part of the children
- A well organized, developmentally appropriate and culturally sensitive program
- Regular assessment of children's progress and informing parents about the results, and,

- Use of positive discipline

The above principles, components, and criteria are then thematically integrated into an approach that guides assessment of the situation of the interactions, services, care, and support in this research.

3. Methods

Design: The study aimed at investigating the current status, practices, and quality of daycare centers in Addis Ababa. Descriptive method was employed because it is an appropriate technique to collect data on large number of variables related to the situations of daycare centers, practices and performances.

Study sites: The study was conducted in two sub-cities (KolfeKaranio and Nefas-Silk Lafto) of Addis Ababa. These sub cities were selected out of the ten sub-cities through simple random sampling technique. Selection of these two neighboring sub cities was purely a chance outcome. Little information was available before the survey about the situation of the sub cities regarding the daycare centers they have so that it could help in guiding the selection process. The daycare centers were not officially registered in Kebeles/ woredas or other offices and this made it difficult, if not impossible, even to identify and access them let alone to make prior decisions as to which daycare center to include in or exclude from the sample. The researchers had to obtain the list of the centers just by asking the relevant kebele administrative personnel in the respective sub-cities. Daycare centers contacted were also asked about other centers like them operating in their woredas and sub cities as they know each other for various reasons. Accordingly, a total of ten daycare centers were identified from such relevant sources and all of them were used as data sources.

Participants: The population of this study consisted of care givers, parents, daycare center owners, and Early ECCE focal persons from both the Addis Ababa City Administration Health (AACAHB) and Education (AACAEB) Bureaus. Research participants involved **all daycare** center owners (N=10) and caregivers (N=27), 2 early childhood care and education focal persons (one from each bureau), and 100 parents (*see Annex 1 for more information*). Parents of the children attending daycare centers were taken using availability sampling technique for two reasons. First, some parents were not willing to be involved in the study as they were unable to find time due to their office work. They were at rush to offices in the mornings and from office to home in the afternoons. Second, some parents used to send their respective children either with house maids or elder brothers/ sisters. Hence, the researchers were forced to take participants who were able and willing to be involved. Such willing parents were contacted and identified with the help of daycare owners and/ or caregivers.

Tools: The purpose of a descriptive survey is to use questionnaires or interviews to collect data from the participants about their characteristics, experiences and opinions as well as the status and practices of a certain state of affair. Accordingly, interview, questionnaire, and observation form were used to secure data about daycare centers and associated stakeholders.

As regards the interview, two separate guides were developed for ECCE focal persons and daycare owners. The interview guide developed for focal persons was composed of items including responsibilities of the focal persons related to daycare services, engagements so far in daycare-related activities, information about the daycare centers, licensure issues, interventions taken, and future plans for bettering daycare services. The interview guide developed for daycare center owners was comprised of issues pertaining to admission of the ITs, accessibility of the centers, employment, profile and performances (responsibilities and activities) of care givers, positive and negative experiences, and support received in the past and sought in the future.

Field visits and observation: Less structured physical observation was made to get a grasp of the situation of daycare centers. It was made employing a form consisting of items helping to check out within and outside classroom conditions, materials, services, activities and behaviors. The observations were conducted in two randomly selected daycare centers for two working days beginning from drop-off up to pick up time of the ITs.

Questionnaire: Two separate questionnaires were developed in Amharic for care givers and parents. The questionnaires were of a semi-structured type having closed- and semi-closed questions. Contents of the questionnaire for parents included general background questions (sex, education, monthly income, number of family members living together, and occupation), number of children sent to daycare and their age, reasons for sending their ITs to daycare, accessibility of daycare and follow up, perceived quality of the daycare, and satisfaction with the services as a parent. Similarly, the questionnaire for caregivers consisted of general background questions (sex, educational background, and training), caregiver-child ratio, availability of play materials, their daily activities and skills in routine care (feeding, toilet training) as well as in stimulating (physical, intellectual, social, and emotional) ITs and satisfaction with this job.

4. Findings

4.1 Legal, Administrative and Policy Issues

Early childhood program was marginalized in Ethiopia for many years until the existing Government realized its importance around late 1990s in meeting Millennium Development Goals, 'Education for All'. These external factors coupled with some internal needs to regulate the unbridled expansion of private preschools in the major cities of Ethiopia gave an awakening call to the Government that eventually culminated in the issuance of some legislative ground in terms of policy and strategy formulation nearly a decade ago. With the understanding that early childhood care and education requires a multi-sectoral response to addressing the holistic development of children, attempts were made at the outset to pool up some line ministries having stake in ECCE together: Ministry of Education (MoE), Ministry of Health (MoH) and Ministry of Women, Children and Youth Affairs (MoWCYA); nobody tells why the Ministry of Labor and Social Affairs had the first historic presence in ECCE affairs in Ethiopia and yet to disappear from the scene when ECCE is about to take shape now. These three line ministries signed a Memorandum of Understanding of collaboration and then endorsed three important official documents governing the design and implementation of ECCE in Ethiopia: The National ECCE Policy Framework (MoE, MoH & MoWCYA, 2010a),

strategic operational plan of implementation (MoE, MoH&MoWCYA, 2010b), and guidelines of ECCE (MoE, MoH & MoWCYA, 2010c). One of the Government's focus areas is the program for children under three years of age. In the National Policy Framework for ECCE, it is stated that the program for children under three will be approached sector wise such that MoE shall focus on education, MoE on health matters, and MoWCYA on parental and familial issues. Accordingly, it has been agreed that the leading role in programming for children from prenatal to age 3+, and for children of age 4 to 6+ will be the MoH and the MoE respectively. Furthermore, MoWCYAand the Ministry of Justice will shoulder the issue of protection of the children (MoE, MoH & MoWCYA, 2010c). In fact, the approach seems like taking a division of labor rather than get into collaborative and joint ventures to holistically address the needs of ITs. In fact, the policy framework discusses approaches that are believed to promote the holistic development of the ITs in the design of programs.

In the Memorandum of Understanding signed between the three ministries (MoU, 2010) as well as the policy framework(MoE, MoH & MoWCYA, 2010a), it is stipulated that ECCE should be built on the four pillars: Parental education, health and early stimulation program (prenatal to 3 years), pre-schools or community-based kindergartens (4 -6+ years), and a community based non-formal schools readiness (p.1). The mission statement stated in the policy framework emphasizes that ECCE in Ethiopia be committed to provide a comprehensive, integrated quality, developmentally appropriate and culturally responsive service for the holistic development of all children; establish a good foundation for children to develop to their fullest potential while respecting and affirming each child's cultural and linguistic heritage, and ensure and safeguard the rights and welfare of all children, including children with special needs (p. 17). For the successful implementation of the ECCE, national policy framework, strategic operational plan and guidelines were set up that underline the need for establishing a good attachment with the child, ensuring that parents/caregivers understand and respond to the signals of the child, providing the child with opportunities to explore the world, stimulating language development through storytelling, poems, rhymes, etc.

We can understand from these then that there is an enabling policy environment for programing daycare services for ITs in Ethiopia. However, despite this enabling policy environment, there are no streamlined programs targeting the early phase of early childhood education. Furthermore, the two focal persons have indicated that standards, curricular materials, textbooks, teacher training colleges and many other activities were non-existent. Focal persons were not assigned at the various administrative echelons of the Government hierarchy to coordinate and monitor services. Manuals that would help caregivers maintain quality interactions with ITs are missing. The respondents from the two bureaus also explained that they are in fact aware of the existence of daycare centers in Addis Ababa but their offices are not doing any substantive work so far. Daycare services for children under three generally appear to be off-focus. MoE (2007) itself has unequivocally admitted that care and education of children in the country is aimed at serving only those with ages 3 to 6 years. This, therefore, shows that there is no government involvement in providing care and education for children of 3 years and below.

4.2 Description of Daycare Centers, Children, and Caregivers

Distinctive Features of daycare centers. All these centers were established between 2001 to 2004 E.C. They were private-based establishments working for profit. While the number of caregivers ranged from a minimum of two to a maximum of four (average being about 3 care giving teachers), that of children ranged from a minimum of seven to a maximum of forty (average being about 17 children). Hence, the caregiver-child ratio was about 1:7. As regards, accessibility of the centers, the majority of parents (N=93) indicated that the fee they were charged was not high, the daycare center was accessible by car (N=100), not physically far (N=91) for non-car users, and had generally no problem of accessibility (N=82).

Infants and Toddlers (ITs) in daycare centers. Age of ITadmission in the majority of daycare centers lies between 6 and 36 months. In order for a child to be accepted in the centers, s/he should complete child vaccination stipulated by the MoH. Children, who have health problems, particularly, sore on their skins, are not accepted. It was said that the reason was to protect other children from being caught with the illness. Although all daycare centers accept children of all sorts, including children with special needs, some respondents believed that such children need to be treated in different daycare centers so that they could get proper care and support from trained caregivers in special needs centers. For example, a respondent said, "*Some parents are not happy to see their children sitting together with those having special needs. Because of this, one child who can't talk and sit down by himself was not accepted into our center*." Another respondent also strongly expressed that her center has not so far accepted such children and will not entertain any child with special needs. Her argument was that these types of children should be treated differently by well-trained caregivers.

Caregivers in daycare centers. **A**ll the caregivers (N=27) were females and nearly half (N= 13) were with high school education while a comparable proportion (a quarter) had educational level below (N=7) and above high school (N=7). Nearly half of them (N=12) were without any training and those indicating to have attended some kind of training (N=15) mentioned that this training was for about less than a year. It was also learned that some of the caregivers (N=3) were the owners of the centers. The caregivers were asked if they were satisfied with their current job. Almost all of the respondents were happy with their current job for the reason that they loved children (N=25) and there was no an alternative job (N=24). These responses seem to contradict one another; satisfied with the job and doing this job because there was no other option. The daycare owners were asked if caregivers had left the center. Half of the interviewees stated that their respective caregivers had indeed left the center. The reasons for leaving included: "*Maltreatment of children (lack of skill in caring for children, lacking of love and affection for the children), access to better job (salary), delivery case, marriage, conflict with parents of the children, being fed up of the work, and health problem"*.

Materials and provisions in daycare centers. Having play materials and other equipment in daycare center in abundance is critical as they can help the ITs to have more developmental experiences. Hence, data were secured on this issue from caregivers, and observations done (see Table 1). The caregivers (N=27) were asked about the extent of provision of materials in the daycare centers. Their responses, summarized in Table 1, shows that materials for serving food (N=22), teaching and learning (N=18), and mattresses (N=26) were fulfilled. However, the level of provisions of the materials was

found to vary among the centers. Particularly, play materials (N=10) and 'teaching and learning materials' (N=9), and materials for serving food (N=5) were partially fulfilled. We asked how adequate these materials are to serve the purpose. The majority of respondents agreed that materials for serving food (N=23) and mattress (N=26) were proportional. While slightly more than half of them considered teaching and learning materials (N=14) to be proportional with the number of children, nearly half (N=13) of them ensured that the materials were partially proportional.

The data secured from observation suggested that play materials were available; though partially fulfilled in few of the centers (N=3); these materials were easily accessible to the children, and the children were playing with the materials. However, the play materials were not arranged age- appropriately.

Table 1: Provision of Materials and extent of match with the number of ITs (N=27)

	Items	*Not at all*	*Partiallyfulfilled*	*Fulfilled*	*Matching of Materials with the Number of ITs*			
					Items	*Not proportional*	*Partially proportional*	*Proportional*
Caregivers' views about provision of Materials (N=27	*Materials for serving food*		*5*	*22*				
	Teaching materials		*9*	*18*	*Materials for serving food*		*5*	
	Mattresses		*1*	*26*				
	Play materials		*10*	*15*				
Observation of the availability of play materials (N=10)	*Play materials play materials are easily accessible to the children*	*1*	*3*	*7*	*Teaching materials*		*13*	*14*
	Play materials are arranged age-appropriately	*10*			*Mattress*		*1*	*26*
	Children are playing with the materials		*3*	*7*	*Play materials*		*10*	*17*

4.3 Activities in the Daycare Centers

As depicted in Table 2, caregivers and center owners listed a number of services provided and activities of care performed.

Table 2: Services provided by the daycare centers and positive experiences

Daycare owners' mentioning of services (n=10)	*Freq.*	*Daily tasks of caregivers (n=27)*	*No*	*Some times*	*Yes*	*Total*
Feeding	*10*	*Welcome and see of the children*	*0*	*2*	*25*	*27*
Taking care of their personal hygiene	*10*					
Sleeping services	*10*		*0*	*0*	*27*	*27*
Get children play	*10*	*Protecting children from accidents*				
Toilet training	*6*					
Physical and motor exercise	*2*	*Teach numeracy and literacy*	*11*	*10*	*3*	*24*
Oral education such as songs	*4*					
Teaching discipline	*2*		*1*	*1*	*25*	*27*
Introducing alphabets	*2*	*Feeding children*				
Training on shoe lacing, buttoning	*4*	*Diapering*	*1*	*1*	*25*	*27*
TV service	*9*	*Encouraging the children to play*	*0*	*1*	*26*	*27*
Story telling	*3*					
Encouraging children practice language	*1*	*keeping child records*	*13*	*2*	*11*	*26*

Among the major mentioning (either by both or one of them) were feeding the children, encouraging them to play, receiving from and handing over ITs to parents, taking care of personal hygiene, diapering, toilet training, getting children sleep, protecting them from accidents, and providing TV services. On the other hand, only few of the caregivers (N=11) indicated that they keep records about the children.

Furthermore, lesser mentioning were made regarding training the children for independence: *Physical and motor exercise, oral education such as songs, teaching discipline, introducing/ teaching alphabets/ literacy and numeracy, storytelling, encouraging children practice language, encouraging children to be guided by schedule, skill training on shoe lacing and unbuttoning of cloths, social skills etc.*

In addition to the data summarized in Table 2, observation was conducted on two randomly selected daycare centers on Jan. 3rd2012, and Jan. 6th 2012 respectively. Both the centers were found in KolfeKaranio Sub-City, Woreda 7. The purpose of observation was to identify and record physical conditions, materials available, and practices exercised in the daycare centers. The observations were carried out during the working hours, from 7:30 to 11:30 AM (morning) and from 2:00 to 4: 30 PM (afternoon). The time from 11:30 AM to 3:00 PM was bedtime for the children. Hence, no activities were to be identified and recorded. In fact, few small children, who did not stick themselves to bedtime schedule, were observed being embraced by the caregivers. The observer recorded the activities without letting the caregivers know about the act; of course they have already given consent to participate in the research. This was done intentionally so that the natural practices would not be affected, both positively and negatively. In fact, before recording, a good rapport was established between the observer and the caregivers.

The first observation was conducted on January 3rd, 2012. This observation was done in two phases. These phases were pre-classroom activities, done before commenting the actual work, and activities in the classroom. Below are the reports of observations made in each case.

Preparation time for caregivers. The caregivers dressed in their work clothes, apron ('shirit' in Amharic), which could protect their normal clothes from becoming unclean. Then, they made themselves ready to welcome each child from their respective parents.

Receiving children (7:30-9:00 AM). The caregivers welcome the ITs warmly from their respective parents; sometimes kissing the ITs in order to make them feel secure. In some ITs, fear of separation was observed. Some of them were crying and showing unwillingness to detach from their parents. There were situations in which parents of such ITs used 'attention diversion' techniques in which ITs were provided with some play materials so that they could turn their focus from the parting parents to the play materials. In the meantime, the parents sat down on the floor waiting until their respective ITs were fully mixed and started playing with the other children. Lastly, the parents sneaked out from the room, without being noticed by their children. Most of these types of children gave up crying and got back to normal routines. However, one child continued crying even after the attention diversion game. His words were "Mami! Mami!" pointing his finger—out to the door, where he thought his mother was.

Keeping lunch pucks. The caregivers managed to keep each child's lunch puck in a big cupboard. Consequently, the task of arranging child-sized tables and chairs was carried out for the purpose of serving breakfast for the children.

***Feeding* (7:30 A.M-9:00 A.M).** Having breakfast was the first experience of the children as soon as they were brought to the center. This was particularly applicable for those who came to the center without having breakfast at home; some parents were informing the caregivers seriously that the ITs came to the center without having breakfast and, hence, they need to be served right away. One caregiver took out the meal pucks from the cupboard, and put each meal puck in front of each respective child. Consequently, she started feeding the children using different spoons that belonged to each child. The caregiver- child ratio was 1:5. The rest caregivers were engaged in other activities like receiving children and taking them to the classroom where they spend their time playing. Since these children had already had their breakfast at home, there was no need to serve them breakfast as soon as they came to the daycare center; they had to stay until 10:00A.M for the next meal.

The act of feeding was full of fun and happiness. All the children were observed expressing feelings of competition in the course of eating; they were observed competing for the caregiver to mouth them the food saying "for me! For me!" Since one caregiver was serving five children at a time, they were not patient enough to wait for their turn. When the caregiver gave a morsel to a child with his/her respective spoon, the rest were saying "for me", "for me", expressing their desire to eat. In the course of serving the breakfast, an amazing event observed was that each child could identify his/her own meal. So, no child was demanding to have a meal that was not his /hers. During informal discussion with one caregiver, she told the observer:

> *If we unintentionally give a child one morsel from other's meal, he/she spits it out immediately. This may be due to their adaptation to the type of their own meal. In addition, each child could identify what his or her own meal puck is.*

However, the schedule for all the children for breakfast was at 10:00 A.M. At this time, all the children were taken to the dining room. The children were made to take their respective seats, which are arranged in a semi-circle shape. Hereafter, the caregivers made themselves ready to feed the children. The caregiver-child ratio was 1:5/6. The caregivers were very busy in the course of feeding so as to keep the interest of each child to be fed. After breakfast had been served, the ITs were taken back to the classroom where they stay playing until lunch time.

At 11:30-12:30 A.M., lunch was served. The practices observed during the lunch time were similar to the practices observed during the breakfast time.

Keeping personal hygiene of the children. Once the process of feeding is over, the caregivers engaged themselves in cleaning the children. This involved wiping the mouth and its area using clean towels. Then, the act of putting off the neck clothes from the children followed.

Language used. Most of the time, the caregivers did not call on the children by their names. They use a common affectionate name "Enat", and "Abat" which roughly means you my 'mom' and my 'dad'. Only few children were being called on by their names.

Activities in the classroom. The children were made to enter into the classroom where they spent most of their time. Consequently, the door of the classroom was closed not to allow them go out. If they go out, they will face physical damages. Hereafter, they were provided with different materials to play with. The materials were at different corners of the classroom but within the reach of the ITs. Each child moved and picked up a play material of one's choice. The children were seen freely playing with the materials in group as well as individually. During this process, the role of the caregivers was to closely and keenly watch out that the children may not fall down, or do something wrong with the play materials or take care of the ITs from any physical damage. They were busy running from corner to corner to follow up, particularly the smaller ones.

Most of the time, the initiative for play was taken up by the ITs themselves; not by the caregivers; play was not purposeful. Each IT used to pick up one or two play materials he/she seemed interested in. While this was taking place, it was observed that ITs were entering into conflicts. As one child picked up a play material, another child was observed crying, saying "ImbiYene!" ImbiYene", which means "no, it is mine; don't take it away!" This happened because some play materials were not insufficient number. One caregiver was noticed trying to settle the conflicts through the 'attention diversion' technique (commonly seen practiced in the daycare centers)—showing another play material to the child who was crying.

It was also observed that few ITs were seen playing together in their spontaneous initiatives. The caregivers were not sensitive to the social interaction of the children unless conflicts arise. They were not making efforts to encourage the children to play together, to use the materials turn by turn, and borrow play materials from one another. Most of the time, the worries and concerns of the caregivers were to look after the children so that each child would be physically secured. Hence, equal weight was not given to the activities which could enhance all the developmental domains.

TV service.TV and videos were turned on for the children so that any child who was interested in could watch. This program continued without any mediation of the

caregivers until bed time. ITs were left to themselves to make sense of what they see. In the meantime, changing diapers and cleaning the children were done by the caregivers. Smaller ITs were observed being fed with nipples within certain time intervals. No specific IT was assigned to a particular caregiver. All the caregivers were responsible for the wellbeing of all the ITs. Hence, childcare was a common responsibility. During informal discussion with the daycare center owners, the data collector asked "why does each caregiver care for all the children at the same time?" Below were the replies from the two centers:

> *Our system with respect to this is not self-contained. We do not appreciate this method because in case a caregiver becomes absent for personal reasons, the ITs cared for by her may feel insecure; they may cry and be unwilling to be cared for by another caregiver for she is unfamiliar.*
>
> *If we assign specific ITs to each caregiver, a caregiver may not take care of the one not assigned to her in case of accidents; such as, for example, falling down. They only take care of their respective ITs.*

Bedtime. Almost all the children were scheduled to sleep from 12:00 A. M to 3:00.P.M. They were taken to their bedrooms. However, some children, the small ones, did not follow the schedule seriously. They remained in the arms of the caregivers until they fall asleep. The sizes of the mattresses were arranged on the basis of the age of the children.

The second observation was held on Jan. 6th 2012 in another daycare center. Almost all the activities observed in this daycare center were similar to that of the practices observed in the first daycare center. The caregivers were more sensitive to the physical security of the children. They made themselves very busy taking care of the ITs so that they may not to fall down, changing diapers, washing potties, arranging the play materials in their place and order, and pacifying those who cry. Caregivers were rarely seen engaging in activities (such as asking different questions; telling stories; mediating during play, interacting, watching movies, provoking curiosity, and organizing plays…) that promote social interaction, cognitive and language development, and physical and motor skills. Either they did not have time for these activities, or knowledge about their importance or else the skills as how to do initiate and sustain them individually and in groups.

The caring process was not formally arranged; no particular IT was assigned to one particular caregiver. All the caregivers were taking care of all the children; each child belonged to all caregivers or vice versa. During an informal discussion with the daycare center owner, the researcher raised the question "why the caregivers care all the children at the same time?" She replied that,

> *If we assign certain children to the caregivers each, they will not take care of the other children in case of danger such as falling down. They only could take care of their respective assigned children. So, we don't appreciate to assign some children to some caregivers. Rather we give a responsibility to each caregiver to take care of every child in common.*

In this center, breakfast was not necessarily the first experience for the children. It was served only for those who did not have it at home. It was noticed that some parents were informing the caregivers that their children came to the center without having their breakfast so that they could be served at the center.

The daily schedule of activities in this second observation site is presented in Table 3.

Table 3: Daily Activity Schedule of Daycare Center Two

Activities	*Time*
1. Receiving children from parents	*7:00 A.M.-8:00A.M.*
2. Arranging potty, play materials, chairs…	
3. Serving breakfast	*8:30A.M. -9:00A.M.*
4. Taking out the children to play	*9:00 A.M.-10: 00A.M.*
5. Taking children back to the classroom, where they also play with different materials	*10:00A.M.-11:30A.M.*
6. Lunch time	*11: 30A.M. -12:30 A.M*
7. Bedtime	*12:30A.M--2:30P.M.*
8. Recreation time using different songs and films	*2: 00 P.M.-2: 30 P.M.*
9.'Mekses', or 'Maqueya' time –meal served after lunch	*2:30 P.M.-3:00 P.M.*
10.Play time in the classroom	*3:00 P.M.-4: 30 P.M.*
11. Preparation for handing over the ITs to their parents	*4:30 P.M.-5: 00 P.M.*

4.4 Problems, Support and Measures to be Taken

Problems noted. The observer had noted the following problems during observation of the first and second daycare centers:

- *The caregivers did not give equal weight to all developmental domains. They seem unaware about the cognitive, social and emotional development of the children. They were fully concerned with the physical well-being of the children, the act of feeding and cleaning.*
- *The children were confined only to the classroom environment. They were not allowed to go out. There was no adequate outdoor play.*
- *Most of the time, the caregivers did not call the children by individual names. They used to call them using the pampering words such as 'enateye, abateye'.*
- *All the activities were done spontaneously. No written schedule which could guide the practices of the center. During informal discussion with one caregiver, the observer asked if there are planned daily sessions. The caregiver replied, "Why guide! These are very small children and shouldn't be confined with a guide! This is not a formal school!"*
- *No records showing the scenario, developmental history, of each child.*
- *Some play materials were not in reasonable proportion to the number of children.*
- *The compound is not wide enough to promote children's free movement.*
- *Caregivers were less sensitive when the ITs were inserting the same materials into their mouths.*

Support. **A**ll the daycare owners agreed that they had never secured any support so far; be it from the government or non- government organizations. The respondents from the two bureaus, too, didn't mention about support provided except the one from the health bureau mentioning some initiatives to control and supervise. Even then, no support was given to empower or strengthen the centers technically and professionally.

Measures to be taken. The respondents were presented with the question "what measure do you think should be taken to make the daycare centers more effective?" The respondents suggested measures that would enable the existing daycare centers function more effectively: *Support from professionals, training for caregivers and daycare center owners, supervision from government authorities to ensure proper practices, organizational government structure to support and coordinate daycare centers, standard to govern the daycare centers, guideline on how to care for children, access for indigenous play materials in abundance (the imported materials are too expensive), appropriate and relevant land for construction, awareness of parents about the importance of daycare services, hiring trained caregivers, hiring caregivers who are patient, and who have children themselves.*

5. Discussions

Alike the expansion of ECCE centers that dictated policy formulation around the 1990s, there has been an expansion of daycare centers in Addis Ababa since 2009. This is an alternative avenue of childcare and, therefore, can be good news particularly for those whose circumstances may not allow a home-based care for their ITs. This discussion section attempts to delineate the defining features in a broader sense and then looks into the concerns that accompany these centers. With the hope to learning lessons and appropriating practices in the centers right at this early stage of expansion, attention is paid only to the concerns. The concerns are presented from an overall professional zeal noted in the centers. Then the core aspects of quality care are discussed.

5.1 Defining Features

Early childhood care that is being currently underway in a form of daycare center retains certain distinctive features. There is, on the one hand, daycare centers mushrooming in Addis Ababa on the ground and an empowering policy environment at the top but a missing administrative layout to connect the two in terms of policy implementation. It is like a house having a ceiling and a floor but without walls. The ceiling appears relevant but as far as it is not sheltering the floor, its existence is of little use. On the other hand, the daycare centers retain certain features that make them distinct operationally, demographically (composition of parents' educational, occupational, financial, and family size composition) and rationally (different parental reasons for preference of the daycare centers). The impact of absence of the wall unfolds itself in compromising the professional integrity of the centers, on the one hand, and the quality of service delivery, on the other. However, it has at the same time certain interesting features of hope for the future. We discuss these issues in a better detail beginning with the positives.

5.2 Professionalism in Daycare Services

The daycare services obviously experience lots of concerns that would challenge their professional integrity. We may begin with the objectives of the daycare services. Although the services are beneficial in so many ways, the objectives were, however, not articulated other than that of working primarily for profit. It is not known if they are meant to enable ITs acquire academic skills (mastering numeracy and literacy) or simply meant to provide a safe and protective stay space for ITs until parents come and collect them, or to enable ITs develop KG readiness…Lack of guides and manuals for caregivers is another challenge in the caring process. If caregivers are not directed what to do and how in caring for ITs, they are likely to resort at best to their experiences or at worst to trial-and-error. This is particularly challenging because many of the caregivers are not trained in IT care**.** More importantly, many of the centers were noted working without license. Obviously, licensing compliance helps to make sure that a daycare center is meeting the minimal levels of safety, teaching standards, and proper curricula for quality care (Scarretal. cited in Korjenevitch & Dunifon, 2010). Licensure is an important mechanism of ensuring that service delivery is meeting professional standards.

When it comes to the children, two major issues stand conspicuously: problem of access for ITs with special needs and problem of breastfeeding because of early entrance into the centers. As regards the former, professionals underscore that provision of equal opportunities for all ITs is an important indicator of quality (Jennie & Lindon, 1994). Furthermore, ITs have, from the legal perspective, a constitutional right for equal services and their right can't be denied simply because of lack of caregivers with skills in special needs. The centers need to be inclusive by empowering the caregivers technically rather than shutting the doors in the name of lack of trained personnel. As regards the second concern, it was noted that there were institutional differences in the minimum age of admission but accepting children before six months was also noted. This obviously denies the ITs from the opportunity for breastfeeding as well as other psychological benefits that accompany mother-child interaction during breastfeeding.

When it comes to play and other materials, provisions were in fact encouraging but selection of play materials needs to be guided by specific purposes for which the materials are sought. They need to be developmentally appropriate to the ITs. Furthermore, materials need to be culturally relevant so that they can meaningfully stimulate learning and interaction. Putting all sorts of materials in the playground and make them accessible to children of all ages can only make children busy but without a learning business. We can, as a final remark, raise issues of assessment of children's progress. Development in the early years is rapid and it has to be assessed at regular intervals. Assessment outcomes have to be well recorded, regularly consulted, and willingly shared with parents and other support providers, if any. However, there was no assessment of and record keeping about the developmental progression of the ITs.

5.3 Quality of Care Services

If daycare services are not professionally rendered, we would barely expect them to be effective. Additionally, we can also examine quality from other perspectives as well: how well the child-caregiver interaction was stimulating and enriching; how

sensitive, consistent, rewarding and trusting was the caring environment, and how interactive, engaging, and personal was the caring relationship?

One important principle of quality care is the need for investing in quality time. This involves two things. The first one, which the caregivers were in fact noted doing, was setting tasks such as diapering, feeding, bathing, and dressing. The caregivers were seen initiating and directing these activities during visits. In fact, setting tasks was seen to dominantly embrace the physical aspects of child needs alone. Less evident were efforts that stimulate such important domains of development as language and communication, feelings, social behavior, and cognitive development. Caregivers were near the children while the babies were engaged in different activities. They were available physically with little involvement in the process unless problems arise urging them to fix.

This in a way means that the routine cares observed in the centers were a bit mechanical. The routine care services (feeding, TV show, diapering etc.) were provided in mechanical ways as if the caregiver was dealing with objects. However, these activities were supposed to serve as sites of communication in which the caregiver uses them to initiate mediation of meaning about activities involved and implications. In the same way, caregivers were supposed to mediate during TV shows to direct children's focus and to understand salient issues. They are also expected to serve as partners during play to stimulate and regulate children's play behavior.

The caring process also appears less varied and less diverse. Young children need exposure to a wide variety of experiences, interactions, materials, settings…to deepen their observations and click on the development of the total person. Or else young children may develop stereotyped and erratic behaviors that tend to reject any new encounter even in the feeding act. Furthermore, there is a need for investing time and energy to building a total person rather than a baby who is content physically with, for example, diapering. Although providing children with different materials may help them develop cognitively, this alone isn't enough. The day to day living, the relationships, the experiences, the diaperings, the feedings, the toilet training, and the playing need to be integrated and organized so that they may enable ITs grow physically, intellectually, socially, and emotionally (Gonzalez-Mena, &Wismeyer, 1993).

It was also noted that there was a problem in personalizing caring. An important principle of quality IT care is the need to make it personal or individual. There is a need for learning each child's unique ways of communication and teach them one's own. Each child has a built-in timetable that dictates when she/he will crawl, sit up, and start to walk. Caregivers need to encourage each baby to do development in one's idiosyncratic ways. This principle requires identifying each child's style of verbal and non-verbal means of communication. In this regard, it was, however, noted during observations that such personalized approaches were less practiced. Caregivers were not even using personal names when addressing the children. They were using common names. A tendency was observed to treat all the children in a similar way, having similar expectation from all, and encouraging them to fit into similar schedules, rhythms, and rules. From the perspective of children, we would also note a lot more passivity. Much of the time was spent in TV shows, sleeping, and feeding. These are routines that leave young children in a state of passivity or inactivity (Gordon et al., 2007).

The researchers may also share a concern that the caring experience may fall short of being consistent, responsive and trustworthy. A number of studies shows that this experience enables young children to be securely attached to the caregiver and this security serves as a foundation for an independent, resourceful, self-confident, and learning child. Such infants explore more, have more productive play, and interact more and more resourcefully with adults in group settings when their attachments to teachers are secured (Raikes, 1996). This being the case, there are practices in the daycare centers that would cast doubt on the capacity of the daycare centers to avail sensitive, responsive, and consistent care. First and foremost, a high child-caregiver ratio (1:7) was observed. This ratio appears to exceed the recommended ratios of adult caregivers (see Kontos & Wilcox-Herzogcitedin Santrock, 2002). Findings show that the smaller the caregiver-child ratio, the more the interaction between the two parties (Vandele & Wolfe cited in Korjenevitch & Dunifon, 2010). Higher ratio would hardly allow the caregiver to maintain a consistent care with each child (Bernhardt,2000).

Techniques and contents of care were also found to have some problems. For example, using common names while calling the children (enatiye, abateye) rather than using the actual individual names of the children wouldn't allow individuation. Such pampering names would also belittle the children and act as a barrier for them not to move forward. Introducing literacy and numeracy at this stage is too early, by any standard. Caregivers are supposed to realize that learning happens when the baby is ready-not when the adults decide it's time (Gonzalez-Mena, &Wismeyer, 1993). It is preferable to convince parents to wait rather than trying to please them by showing that their ITs are catching something in response to what they pay for the center. [Note that many parents take ITs wanting them to learn].

Attention diversion was commonly employed to regulate unwanted behavior and this is commonsensical, inappropriate, and less effectual. Trying to divert the attention of the children, caregivers deprive children from learning opportunities by going through the problems, rather than around the problem. Children, even babies, should be allowed to handle their own problems to the extent that they can. "Very young children can solve more problems than many people give them credit. The caregiver's role is to give them time and freedom to work on the problems. That means not responding to every frustration immediately. Sometimes a bit of facilitating will move a child forward when he or she gets stuck on a problem, but the facilitating should be the least help necessary, leaving the child free to work toward his own solution" (Gonzalez-Mena, & Wismeyer, 1993). Furthermore, attention diversion is a temporary solution as children would experience a comeback to the unresolved problem because incomplete tasks capture attention. This technique still lacks honesty in solving problems. Caregivers need to be real persons in regard to their feelings, instead of pretending in front of children. "Children in daycare need to be around real people; not warm empty role players (Gonzalez-Mena&Wismeyer, 1993).

6. Conclusions

In the light of the analysis and discussion above, it can be concluded that:

- There is an enabling policy framework but without standards, guides and manuals for caregivers;
- Administrative, coordinating, and supervisory offices are missing as yet and, hence, many of the centers are not licensed, guided, supported, monitored, and supervised;
- Daycare centers have a number of strengths, though young and without experience;
- Lack of professional rigor was, however, noted in many ways;
- This lack of professionalism had affected the quality of care rendered in the centers. Serious problems were observed in terms of establishing and sustaining a stimulating, consistent, and responsive caring environment with the children;
- This suggested that the daycare centers are serving at the moment more as a place of stay for the ITs rather than agents of development. One may wonder if they are any different from home-based care except for opportunities to peer interaction, and
- Daycare centers can obviously serve as an alternative care for those who may not provide home-based care for their children.

This research is the first undertaking in the area and it is hoped that subsequent research are required to augment many of the claims. It is specifically suggested that future research is particularly needed to assess the impact of the daycare services on the young children's experience and development.

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Annex1: Participants of the study by study site

Daycare center (names abbreviated)		Location	Sample care givers	Sample parents
1	KDC	Nefas Silk LaftoSub-City	2	9
2	MBDC	KolfeKaranio Sub-City	3	17
3	FDC	KolfeKaranio Sub-City	2	8
4	BSDC	KolfeKaranio Sub-City	4	12
5	SBDC	KolfeKaranio Sub-City	2	7
6	ADC	KolfeKaranio Sub-City	2	7
7	HDC	Nefas SilkLaftoSub-City	2	10
8	EDC	KolfeKaranio Sub-City	3	10
9	PDC	KolfeKaranio Sub-City	3	11
10	SDC	KolfeKaranio Sub-City	4	10
Total			27	100