

Health, Nutrition, Safety and Security in Early Childhood Development Programmes in Zimbabwe: What are the Implications to Children with Special Education Needs?

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ABSTRACT The aim of the study was to establish whether primary schools attaching ECD classes in Chiredzi district in Zimbabwe were catering for the health, nutrition, safety and protection needs of the children with special education needs. The study was underpinned by the Ecological Systems Theory. It adopted a mixed methods approach. The researchers triangulated the following instruments: interviews, questionnaires, observation, document analysis and focus group discussions. The results show that in many schools, children with special education needs' health and nutrition were, to a very large extent, ignored. Some schools made efforts to provide nutrition to all ECD children, but there were no efforts made to identify specific meals for children with chronic diseases. All the schools did not have legislations to protect such children, resulting in discrimination and abuse. The study recommends more concerted efforts from stakeholders on the health, safety and protection of learners in ECD settings.

INTRODUCTION

Early childhood development (ECD) aims at providing young children (0-8 years) the best beginning in life, ensuring that they have a strong foundation for their growth, development, and education (Siraj-Blatchford and Woodhead 2009; UNESCO 1990). Early childhood development should provide services; education and care to children and their families. These services should be directed towards the child's holistic development providing appropriate health, nutrition, early stimulation education and psychosocial support within the context of the family and the community (Department of Social Development and UNICEF 2006). Literature stresses the importance of provisioning adequate health facilities, nutrition, safety and protection of the young children to have a strong foundation from an early age, a period during which the brain and the biological pathways are at their maximum development (Wall 2011). The overall development of young children is enhanced by the adequacy of good and balanced nutrition, availability of health facilities, including safe water and learning environment to avoid, factors such as (malnutrition, diseases and teratogens). The aim of early

childhood development is to minimise social risk and contextual risk factors that are barriers to childhood development (UNICEF, Basic Education and Social Development and National Planning 2014). The current early childhood development programme witnessed the development of policies and statutes all from the government and non-governmental organisations that support and sustain ECD programmes. The aim being to prevent or reverse the adverse effects of factors that have the potential to affect children's development (World Health Organization 2011).

Literature Review

Comprehensive ECD programmes should offer a broad range of support systems for young children and families, covering health, safety, nutrition and protection of all children in the age range of 0-8 years. According to Britto et al. (2011), such programmes are rooted in early learning and education, including family support social protection and child welfare to enhance children's development. The provisioning of health, nutrition, and safe learning environments is central to the holistic development of young children. Studies across the globe claim most developing nations disregard the provision of a safe and quality learning environment, which, is negative on good health for the early

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learners (Chinhara 2016; Simeonsson 2000). This paper argues that at national levels, education does not consider the high activity level of children aged between 3 and 8, who require balanced nutrients to meet the everyday energy demands of these children.

Health, nutrition, and secure nurturing environments are critical to the welfare needs of children for the overall development and repair of tissues. Ideally, the early childhood development phase must be treasured with intervention programmes and services, integrated across health and nutrition, safety, child protection and welfare (Britto et al. 2011).

In a study in Asia, Yoshikawa and Kabay (2012) note the majority of ECD programmes lacked sound health and nutrition programmes, especially for children with special education needs. The study shows the vulnerability of children with special education needs. In a study in South Africa, Atmore et al. (2012) observed that the government initiated programmes to reduce vulnerability in ECD centres by provisioning food supplements.

A wide range of studies demonstrating that malnourishment causes direct and irreversible structural damage to the brain, impair motor development. They further, say malnourishment cause significant developmental retardation to cognitive development and impairment of exploratory behaviours. Inadequate health facilities and poor nutrition affect learning abilities and long term educational achievements (Duggan et al. 2008; Victoria et al. 2008). The effects of inadequate nutrition contribute to economic stress, affecting the health care expenditures (Wildeman and Mbebetho 2005).

Learners who suffer from general malnourishment do not have the same potential for learning as their adequately nourished counterparts (Chinhara 2016). The effects of malnutrition on ECD children necessitate attention on what children learn. This necessitates later educational achievement (poor performance in school, and less schooling attendances). Such children have a higher risk of chronic diseases (kwashiorkor, loss of concentration in school work and cancer) (Victoria et al. 2008). Therefore, improving nutrition through various interventions can bring about health and educational benefits as well as economic benefits to children.

Children with special education needs are, by nature, vulnerable. Article 11 of the United

Nations Convention on the Rights of Persons with Disabilities (CRPD) state that stakeholders have a responsibility to have programmes that support children's wellbeing (WHO and UNICEF 2012). These responsibilities include the provision of health, nutrition, safe water, proper sanitation and hygiene.

South Africa initiated intervention programmes that offer safe water and nutrition in registered ECD centres. The government collaborates with various service providers, which include non-governmental organisations (NGO) and Non Profit Organisations (NPO). Such intervention programmes includes feeding schemes, provision of deficient micronutrients through fortified sachet powders to homes and community based ECD facilities (Department of Social Development and UNICEF 2006). The Department of Social Development (DoSD) and UNICEF set out minimum standards on issues of health, safety, and nutrition in ECD centres (DoSD and UNICEF 2006).

The guidelines state that "Food must be provided for children at least once a day, either by parents or by the centre" (Department of Social Development and UNICEF 2006: 47) UNICEF (2006: 50) further says, "All meals and snacks should meet the nutritional requirements of the children." (Department of Social Development and UNICEF 2006: 50). It further states "Planning of a menu, whether for babies, toddlers or older children, must be done in consultation with an expert (for example, clinic sister, dietician) ..." (Department of Social Development and UNICEF 2006: 50). There is clear evidence governments follow specific guidelines for health, safety and nutrition programmes for children in ECD centres.

In Zimbabwe most primary schools attaching ECD classes do not have specific meals designed for learners with special education needs. The situation exposes the children to malnutrition and food deficiency as a result of inadequate nutrition provisions (Chinhara 2016). This is despite global policies which dictate inclusive early childhood development programmes should integrate sector programmes of health, nutrition, early stimulation including child protection and welfare programmes to support holistic development of children (Britto et al. 2011). ECD literature also points to the provision of integrated sector programmes for both children and their families (Woodhead 2014) as safety net measures. In addition, Britto et al. (2011) em-

phasise that comprehensive ECD programmes for young children should include: (i) Health and Nutrition and promotion of Integrated Management of Childhood Illness (IMCI). The implication is that ECD programmes should strike a strong balance on care, nutrition supplementation, and expanded programme for immunization, done in health clinics, and through home visits (Britto et al. 2011).

In line with global treaties the Zimbabwean constitution (2013) stresses that young children exposed to poverty and other forms of vulnerability should access social assistance; feeding schemes and government grants as safety nets (Mhongerera and Lombard 2018). Regardless of widespread exposure to poverty and vulnerability amongst early childhood development children, safety nets to support these children's wellbeing are hardly available in ECD centres (Chinhara 2016).

It is the government has offloaded its social service responsibility by instructing parents to provide nutrition for ECD learners enrolled in public ECD centres. The government request parents to fund the construction of ECD health facilities (Moyo et al. 2012). However, parents have financial constraints, and this has resulted in the deterioration of health standards in most ECD centres attached to public primary schools.

Government policies; (statutory Instrument 106 of 2007 and Director's Circular number 12 of 2005) do not explain issues about the diet of children with special education needs in public primary schools. The policy is not explicit on the amount of meals to be provided to ECD children with special education needs. In addition, the policy is not clear about the hygiene requirements of the people that prepare the meals and the general cleanliness of the learning environment. Such issues affect children with special education needs. Hence, they are of paramount importance in the entire ECD programme.

According to the Government of Zimbabwe's Statutory Instrument 106 of 2007, the learning and playing space in ECD classroom should be 2.25m² for each child. The circular goes further to say the sanitation and other health facilities should be adequate and of appropriate size. It directs ECD centres to ensure there is security for the protection of children in ECD centres or in public primary schools attaching ECD classes. However, the policy is not clear as to how ECD centres should ensure health and safety issues. However, in the case of Zimbabwe, the policies in place do not mention how children

with special education needs, should be catered in the ECD settings, yet these learners are part of the inclusive education system.

UNESCO (2007) argues that policies are silent on special education needs services for vulnerable learners in early childhood development settings. For instance, learners affected by HIV and AIDS, including other disabilities, require special health, safety and social welfare needs (UNICEF 2010; Simpson et al. 2006). In their study World Health Organisation and World Bank (2012) acknowledge that children with special education needs experience insensitive and unresponsive environments that are retrogressive to their development. Under such circumstance, it is not clear how primary schools attaching ECD classes protect and care for children with special education needs. Thus, this article investigated how primary schools offer health and nutrition; safety and protection provisions for ECD "A" and "B" learners with special education needs. The following research question guided this study:

- ♦ What are the health, nutrition, safety and protection provisions in place in primary schools attaching ECD "A and B" classes for learners with special education needs in Chiredzi district in Zimbabwe?

Theoretical Framework

This study was underpinned by Bronfenbrenner's Ecological Systems Theory, which states that the environment is the context of young children's development and hence has strange effects on development. Bronfenbrenner located the child's environment in five different levels: the microsystem, the mesosystem, the exosystem, the macrosystem and the chronosystem, all of which qualitatively impact on the child's development (Bronfenbrenner 2005). In this context, the ecological-systems theory conceptualizes special education needs as associated with multiple ecological strata that include parents, friends and the child's characteristics as determined by the availability of adequate and appropriate health, nutrition and protection mechanisms (Bronfenbrenner 2005).

The ecological systems theory is about relationships as much as it is about discrete programmes and factors, such as the early childhood development programmes, which are tasked to support children with special education needs. The ECD teacher, is faced with the undertaking to develop connections between

these kinds of influences and lead in the creation of a true environmental system, which is responsive and passionate to the needs of all young children. Swick and Williams (2006) summarise the ecological systems theory, saying the framework provides a platform where academics explore the situation of children with special education in relationship to the different socio-economic and cultural factors but also including the role of politics in ensuring children's livelihoods. The ecosystem layers are expected to provide facilities that support all children and not excluding those with special needs, through supplementary feeding, health, safety and protection provisions (United Nations Convention on the Rights of the Child 1986). When these are lacking, the development of children is strangely affected leaving them at risk of diseases and suffers developmental delays. Thus, the study applied the ecological systems theory to investigate the collaboration between the school, the home, the health centres and other eco-systemic zones' efforts to support ECD children with special education needs in selected primary schools.

The ecological systems model ensured the researchers explored inclusive education practices in pre-schools attached to public primary schools in finding out whether or not they support ECD learners with special needs with respect to health and nutrition, safety and protection facilities (Koutrouba et al. 2006). The ecological systems framework stresses the importance of protective and preventive policies and legislations for inclusive learning environments, an area that the study also investigates (Bronfenbrenner 1979). Bronfenbrenner sees protective and preventive processes as mechanisms that keep the child away from physical and psychological harm. In the case of children with special education needs, they need protection from all sorts of environmental harm; for instance, a protective and healthy learning environment is fenced and safe from all forms of harm (Nisreen 2013). The ecological systems theory emphasises that children are not isolated, but are always persons in context (Nelson and Prilleltensky 2005; World Health Organisation 2012). To this end literature says, children's contexts should be studied extensively to find out how these impact on their development (Winter 2010).

The Ecological model was employed because it views the child with special needs' environment as the engine for the child's development (Chan et al. 2009). Bronfenbrenner (1979) notes,

the child's environment, has cultural values and beliefs that have negative but sometimes positive impacts on growth, development and early stimulation opportunities (Chan et al. 2009). Hence, understanding ways in which stakeholders are involved in processes that improve experiences of children with special needs help everyone concerned with children's welfare to become supportive to the needs of ECD children.

METHODOLOGY

A post-positivism paradigm was employed in this study as the researchers wished to maintain an interest in some aspects of quantification (positivism) and incorporating interpretivist concerns around issues of subjectivity and meaning. Specifically, the researchers used a pragmatic combination of qualitative and quantitative methods (Maree 2007). The paradigm opens the door to multiple methods of different worldviews as well as to different forms of data collection and analysis procedures (Mertens 2010). Using multiple sources of information enabled the researchers to solicit views from participants on the ground, who gave insights based on their pragmatic experiences of the phenomenon regarding the provision of health and nutrition facilities to children with special education needs in ECD "A" and "B" classes attached to primary schools.

Design

A concurrent Triangulation Mixed Method design was employed for this study. Both quantitative and qualitative methods of data collection were gathered at the same time and then integrated in the interpretation of the overall results as stated in Creswell (2014). The design provided a broader and deeper picture of how public primary schools provided health and nutrition; safety and protection to early childhood development children with special education needs.

Data Collection

Semi structured questionnaires were administered to school heads, and ECD teachers and face to face interviews were administered to 10 school heads, 3 members of the District Education Team, and 3 personnel members' from 3 line ministries; the Ministry of Health and Child Welfare and the Ministry of Public Service, La-

bour and Social Welfare as well as the Ministry of Local Government and Housing. The researchers also interviewed 3 members from non-governmental organisations. Data were also collected from parents in 3 focus group discussions comprising 5 members in each group. Furthermore, the researchers used observation schedules to observe suitability and adequacy of health, nutrition and safety facilities in schools that support children with special education needs. Finally, the researchers used document analysis to examine if the practices were in line with government, provincial and local statutes on implementation of ECD programmes.

Data Analysis

The data collected via the questionnaires were coded and entered under SPSS. The analysis took the form of univariate analysis such as frequency counts, percentages, and the calculation of appropriate indicators. Multivariate analysis was used to identify relationship between variables. The qualitative data collected was clustered in common themes, tallying and ranking of responses to uncover the main issues that emerged (Mertens 2010). The issues arising from the interviews, the questionnaires and document analysis were triangulated and put together as findings of the study.

Credibility, Trustworthiness, Validity, Reliability

The issue of credibility, trustworthiness, validity and reliability were enhanced through use of multiple perspectives in data collection and the large sample of respondents and sites which verified the data. This study used three different data sources which gave credibility to the results. The questionnaire and interview instruments were pilot tested to ensure they were clinical to collect the data they were meant to collect (Greene and Hall 2010). Member checking was done to allow participants to confirm the transcribed data and corrections were made where necessary (Onwuegbuzie et al. 2013).

RESULTS

Data were collected in efforts to establish whether or not there were health and nutrition, as well as safety and protection measures targeting young children with special needs in schools. In the first section, the researchers

wanted to know whether or not primary schools had adequate and well-monitored health provisions meant for young children in early childhood classes. Take note of the responses given in Table 1.

Table 1: Adequacy of health facilities in primary schools that cater for ECD “A” and “B” learners with special needs

Adequacy of health facilities in primary schools for ECDSEN learners	Teachers		School heads	
	f	%	f	%
Adequate	14	45	8	42
Not adequate	13	42	7	37
We don't have any	4	13	4	21
Total	31	100	19	100

According to the information, fourteen (45%) teachers and eight (42%) school heads said health facilities were adequate in their primary schools, but went on to express the non-availability of toilets that specifically cater for learners with special education needs. Meanwhile, thirteen (42%) teachers and seven (37%) school heads indicated that schools did not have adequate health facilities for ECD learners in general. For instance, teachers and school heads indicated toilets in schools did not meet government specifications of squat-hole ratios for ECD learners. In addition, four (13%) teachers and four (21%) school heads said their schools did not have any health facilities for ECD learners, and all ECD “A” and “B” learners shared the toilets with junior classes.

From the responses, some primary schools attaching ECD classes did not have health facilities for ECD learners. All early childhood development children used the same health facilities; water sources, toilets, and incinerators that the junior and able students used. This shows lack of adequate and suitable health facilities for ECD learners with special needs. Children with physical disabilities who might have challenges using some health facilities have their lives at risk. Below is qualitative data collected regarding availability and adequacy of health facilities for ECD “A” and “B” learners in primary schools:

HI 9: *The school lacks adequate health facilities, and this is against the Ministry's regulations on institutions enrolling ECD “A” and “B” learners. Currently, there is one Blair toilet with 10 squat holes for girls, and the other 10 squat holes for boys. There are no washing*

facilities, after use of toilets. It's a health hazard to learners.

TR 6: *Sanitation facilities are not adequate and sanitizers are always in short supply. The water and toilet conditions are bad and there is need to improve to protect the young learners' health needs.*

FGD3: *We do not have enough toilets. This sanitation problem is worrisome. As a cholera-manifested area, we are putting the health of learners at risk.*

DEO: *There are health and sanitation challenges in schools. Most schools do not have adequate toilet facilities and classrooms are small and congested, posing a health hazard. It is even worse in resettlement satellite schools where some children are using pit and bush toilet facilities. The donors and the local authority are no longer supporting health programmes in schools. Parents do not have resources to resuscitate the health and sanitation systems in schools. Schools are not fenced and the situation jeopardises the safety of learners. We have had children dying in canals and roads because the schools are not fenced.*

However, participants from other schools said they had appropriate health facilities but raised concerns about their suitability to support learners with special needs.

TR 1: *We are an Estate school, and we have adequate toilets. The water system is accessible and safe to drink. The learning environment is safe for every child, but teacher pupil ratios in the ECD classes are high. We fenced the ECD "A" and "B" classrooms, including the outdoor play centre for children's safety.*

From the data a few schools had adequate health facilities, needed to meet the needs of learners with special education needs. However, other schools were different because ecosystemic layers were supportive, offering good situation and suitable health facilities for ECD children. However, the majority of the schools did not have health facilities specifically designed for learners with special education needs and this posed health risks. Observations showed primary schools attaching ECD "A" and "B" classes, did not have health and safe learning environment to support learners with special education needs. This is regardless of national and international regulations, which direct schools to be child friendly; promoting health and safety for all learners. Evidence showed safety is not provided in school environments as

they lack toilets, safe water and fencing. Schools with Resource Units had appropriate health facilities that supported the needs of children with special education needs. In the next section, results are presented in relation to whether primary schools were safe to promote holistic development of ECD children with special education needs (Table 2).

Table 2: Protection facilities that support the well-being of ECD "A" and "B" learners' with special education needs

Availability of protection facilities to support the well-being of ECD "A" and "B" learners with special education needs	Teachers		School heads	
	f	%	F	%
Yes	8	26	4	21
No	19	74	11	79
Total	31	100	19	100

As indicated, eight (26%) teachers and four (21%) school heads reported that facilities were in place to offer protection for children with special education needs. Meanwhile, nineteen (74%) teachers and eleven (79%) school heads alluded that they lack facilities to protect children with special needs. Teachers and school heads highlighted that they had policies in place that restricted teachers from abusing children. According to the responses, children with special were not protected since their premises were not fenced. They indicated they had unprotected water wells, and this meant all learners, but specifically those with special education needs were more at risk. It emerged that school environments were not safe for ECD learners because some schools were close to running water bodies and it was difficult to ensure safety for the children on inland water ways, which posed safety risks for children. The responses imply inclusive ECD settings did not have mechanism in place to protect learners with special education needs from health risks.

The researchers solicited for qualitative responses on health facilities in schools and these are shown below:

HI 10: *The school does not have rules and regulations that protect learners from abuse. We have had situations when children with special education needs are bullied and teased.*

We do not have safe water for the learners to drink.

TR6: *We are not able to meet the health needs of children with special needs because we do not have adequate accommodation. Toilets are not adequate, and we do not have safe water sources. We have not fenced the learning environment and this puts children at risk.*

From the responses, it is evident few schools have facilities in place to support children with special needs. However, most schools lack health and safety facilities for children. In the next section, the researchers present data in relation to whether or not schools had adequate basic facilities that promoted the safety and wellbeing of young learners. The information on the adequacy of health and safety facilities in ECD institutions is shown below.

Table 3 shows that four (13%) teachers and two (10%) school heads indicated that schools had toilets that were safe to be used by learners with special education needs. Meanwhile, sixteen (52%) teachers and ten (53%) school heads said schools were fenced which was an indication of safety for ECD learners with special education needs. Moreover, thirteen (42%) teachers and eight (42%) signposted they had safe running water for ECD learners from taps or boreholes. Participants that provided qualitative data indicated schools had FIRST AID KITS in place, and were fenced; while teachers taught learners safety precautions. The following are some of the responses on whether there were safe facilities that promote children's wellbeing:

Table 3: Indicating facilities that support children with special education needs' safety

Availability of health facilities that support children's safety in schools	Teachers		School heads	
	f	%	f	%
Toilets	4	13	2	10
Fencing	16	52	10	53
Safe water	13	42	8	42
Another health facility you have for safety of ECDSEN	3	13	2	10

HI 6: *All ECD learners use the same toilets and there are no toilets for children with special education needs. The school has a borehole, which supplies safe water and policies*

are in place. We have not fenced the ECD learning environment which risks learners

HI 7: *We make regular health check-ups for ECD children and we educate them on toilet routines, how to cross roads and not to use sharp objects. We also have water buckets in each class to ensure classes have safe chlorinated water. Sanitation facilities are good and are maintained by the caretaker who is paid by parents.*

HI 9: *The school lacks adequate health facilities, and this is against the Ministry's regulations on safety for learners. There are no safe water facilities and that poses a health hazard to children. We ask children to each bring a bottle of water from homes but this is not enough because it's hot in this region.*

From the above responses, a few schools in Chiredzi District provided adequate health programmes and are safe for ECD learners. Although primary schools indicated that they do work directly with health personnel in cases of child illness, some schools stated that they had FIRST AID KITS, which had basic medication facilities for children. However, in a situation where ECD settings do not have safe health facilities, children with special needs are at risk of diseases given their already poor health conditions to carry out some rigorous activities, which requires energy.

The next section is concerned with results related to whether or not primary schools were offering a special supplementary feeding to children with special needs. The results are presented in Table 4.

Table 4: Whether schools provided nutrition for ECD children with special education needs

Availability of supplementary feeding	Teachers		School heads	
	f	%	f	%
Provided	4	13	4	21
Not provided	27	87	15	79
Total	31	100	19	100

The information shows, four (13%) teachers and four (21%) school heads indicated that their schools provided supplementary feeding to all ECD "A" and "B" children. Further, twenty-seven (87%) teachers and fifteen (79%) said their schools were not providing supplementary feeding to ECD "A" and "B" learners. From the in-

formation, the majority of ECD teachers and school heads concurred that few schools provided supplementary feeding to ECD “A” and “B” classes. Some respondents indicated that parents who were tasked to provide supplementary feeding for ECD “A” and “B” learners were not affording. However, in some schools, respondents said there was local non-governmental organisation which provided porridge for the learners. However, one of the response was that parents and the business community provided funds for children’s supplementary feeding. Some observations were that some children with special education needs, suffering from HIV and other chronic diseases that require regular feeding were deprived of specific food nutrients necessary to boost their immune systems. Qualitative data from interviews on whether schools provided nutrition to ECD “A” and “B” is shown below:

HI 3: *We do not have special nutrition arrangements for ECD “A” and “B” learners. The responsible authority refused to provide supplementary feeding to ECD learners. We encourage each parent/guardian to provide food for his/her ECD child. However, some parents cannot provide owing to poverty, leaving learners with nothing to eat the whole day. This affects children’s attendance and performance.*

FGD 2: *The school does not provide supplementary feeding to ECD children. The parents who are supposed to assist have financial hardships, and do not afford to offer food to the children.*

H2: *Malilangwe Conservation Trust provides porridge as supplementary food for ECD “A” and “B” children including children enrolled in community-based programmes. Parents prepare and supervise the feeding programme for ECD learners.*

HI 4: *Parents are paying for the supplementary food. Well-wishers donate cash to buy supplementary feeding for children.*

According to the results, few schools provided supplementary nutrition and those that provided was through the support of non-governmental organisations. In few schools, parents brought their money together and paid for supplementary feeding for their ECD children. The majority of schools were not providing supplementary feeding, and it emerged that attendance was erratic and performance of children was poor, with very high drop outs. For instance,

in one school, document analysis (school register) showed that in January, the ECD class enrolment was 120 pupils, but before the end of the first term, enrolment had dropped to 90. The reason given was that ECD learners had dropped out because of hunger as they lacked supplementary feeding at school. School heads reported that in schools that were not offering supplementary feeding, children dropped out in large numbers.

In conclusion, data on health programmes in primary schools indicated that many schools did not have adequate health facilities and nutrition programmes. However, the most affected were children with special education needs as existing facilities in the schools were not user friendly and distances to schools were too long. However, children with special education needs were better catered for in schools with resource units, although existing facilities were limited and did not suffice the large enrolments. Emerging from the results was that in those schools that provided feeding schemes for ECD children, it “was a one size fit all” which impact on the health and safety of learners with chronic diseases. Furthermore, facilities in all considered primary schools were limited and did not suffice the large enrolments of children with special needs. Responses showed that some schools developed policies that protected children against abuse from teachers, other children and the school communities at large. The study revealed that the role of NGOs and other private partners was critical in supporting the health, nutrition and safety needs of young children in primary schools generally.

DISCUSSION

The paper examined the provision of health, safety and nutrition as critical components in ECD programmes in Chiredzi District-Zimbabwe. The findings reveal that to a large extent schools lacked the standard health, safety, nutrition and protection facilities to expedite holistic development of all learners including those with special education needs. This was in spite of school heads’ knowledge of the policies from the government on the provision of health and safety for ECD learners. It is evident from the findings that some learners were not provided with appropriate health, nutrition, safety and protection.

Hygiene Concerns

The study reveals that most schools had serious health challenges; ranging from inadequate toilet facilities, lack of safe water, non-hygienic learning environments and poor supply of sanitary materials. This was worsened by the fact that most schools did not have institutional policies to protect children with special needs. According to Yoshikawa and Kabay (2015) health, nutrition, safety and protection in early childhood development settings, require home grown policies to guide stakeholders on how they care for learners. In Zimbabwe similar results reflecting non-availability of health facilities, were noted by Gunhu et al. (2012) where schools lacked adequate and responsive health facilities: water, sanitation and hygiene (WASH). These situations naturally compromised health delivery systems in schools and their inadequacy impact on the health and psychological well-being of the young children as they become prone to childhood diseases (diarrhoea, typhoid, cholera). This is regardless that the Ministry of Health and Child Care's Department of Environmental Health is mandated to inspect the functionality of school health facilities. However, most schools were unhygienic, overcrowding and not well-ventilated classrooms. Under these circumstances, the ECD learning environments might be a health risk to children.

Lack of Commitment of Stakeholders

The study reveals that policies are in place but the implementation requires agency. The government and inter-sectoral departments on ECD worked as separate entities and this did not improve the situation of children with special education needs in schools either. Such observations were noted by Karlsson (2017) in Sweden whose observations were that ECD children with special needs had deteriorating health facilities, because of non-commitment of the government departments and stakeholders. Effective collaborative efforts from stakeholders to support ECD health and nutrition programmes benefit children with special needs especially if these include their families (Duggan et al. 2008; WHO and UNICEF 2012).

Provisioning of Supplementary Nutrition

Supplementary feeding was provided for in few schools but in the majority of schools, it

was the responsibility of parents to provide food when learners were going to school. As noted by Woodhead (2014) the provision of nutrition is a deserved right for every child which when offered adequately can break the poverty circle. The majority of stakeholders made little efforts to support children from poor socio-economic backgrounds, with balanced diet. Learners with special needs were denied their right to supplementary nutrition, yet provisions of such facilities are enshrined in the constitution and in several national policies (Zimbabwe Constitution 2013). Neuro-science put it clear that one reason for poor brain growth is malnutrition (Department of Health 2016). Hence, it should be mandatory for the government to provide fortified foods to ECD learners that have vitamins and/or minerals that are recommended through research (Department of Health 2016).

Even ECD learners living with HIV and AIDS including other chronic diseases were not provided with complimentary feeding as is the case in other counties (). For instance, in South Africa there are deliberate nutritional programmes to support ECD learners, including those with chronic illnesses (Department of Social Development and UNICEF 2016; UNICEF 2017). Relying solely on parental provisions for ECD supplementary nutrition is discriminatory as some families do not have the capacity. The food parents provide to children when going to school may lack proper nutritional values that boost immune system, and this can affect their brain development.

Very High School Dropout Rates

In the study participants argued that lack of supplementary feeding in schools, was leading to high dropout and fluctuating schools attendance of learner especially in rural schools. In similar studies Richter and Chandan (2008) found that children who are offered supplementary feeding often participate actively in learning, and are less likely to drop out of school. The dilemma of children who are under nourished is that they are weak and their ability to participate in learning activities is minimal, and often are negative towards school activities.

Safety Concerns

The study establishes that schools lack safe learning environments, especially for the vulnerable children with disabilities. Most school

environments were inauspicious for learners with special education needs. School environments that do not offer safe learning experiences affect the psychological wellbeing of the children (UNICEF and WHO 2016).

Early childhood development phase requires safe and Child Friendly Spaces (UNICEF 2016), where every other person is a secure base (Marotz 2008). Growth and development are enhanced through positive nurturing, responsive and protective caregiving environments. For this study, school environments were not fenced, which left children at risk, especially in schools that were close to roads and water ways, and there were reports that some children had lost lives. One of the earliest philosophers of early childhood development Montessori made it abundantly clear that safety in ECD centres should be at the centre of the programme. Results showed that, ECD learning environments were littered with harmful objects, ranging from nails to sharp objects. Such conditions are not only dangerous to the wellbeing of the vulnerable learners but they risk young learners who, by their very nature, can pick harmful objects and possibly hurt each other (Underwood and Frankel 2012). ECD learning environments should be safe sanctuaries for children's learning and development; free from sharp objects, drugs, dust, and empty chemical containers (Underwood and Frankel 2012). The majority of primary schools did not have safe learning and protective learning environments, particularly those targeting children with special education needs, and this is a cause of concern. Careful considerations must be given to all aspects of children's learning environments, ensuring that there is nothing that potentially puts children's lives in danger.

Lack of Collaboration of the Systems

Overall, the health and nutrition sector should include issues of safety and protection. Although the implementation of ECD programmes calls for an integrated approach, evidence shows that there were some inconsistencies because each entity worked separately; not relating its functions and intentions to solve existing challenges presumed to be the function of the other. Bronfenbrenner's theoretical framework calls for integrated support from all the ecosystemic layers in ECD programmes, partic-

ularly those working with children with special education needs (Bronfenbrenner 2005). The theoretical framework calls for such stakeholders; the Ministry of Primary and Secondary Education, line ministries, NGOs to partner with private organisations to implement comprehensive and responsive learning programmes for ECD learners with special education needs. Effective early childhood development programmes are those that provide access to healthy foods, augmented with nutrition education for both learners and families. Programmes that do not support the general wellbeing of young learners through improved safety practices risk the lives of the children (Underwood and Frankel 2012). ECD centres must have enforcing regulations that promote child health, safety and nutrition programmes to promote holistic development of the learners (Hard et al. 2015).

Good Practices Observed

Childhood Protection Policies

Some schools had regulations to promote safety and to protect the children from abuse. Issues of bullying, and discrimination by teachers and other learners, were reported, as minimal because policies were in place to protect children. This is a critical engagement of stakeholders as reported by World Health Organization and World Bank (2012) saying policies must be in place to protect learners with special education needs from abuse and hurtful environments that may affect the psychological wellbeing as these children are more vulnerable. Thus, this paper argues that child abuse cases in schools may be instigated by lack of protective policies for children with special needs. Save the Children (2009) also supports this saying; children with vulnerabilities often are at risk because of adult actions, inadequate policies and procedures including failures to act when such issues occur. In the case of this study these were in place, and it offered learners some form of safety nets.

The Issue of Agency

The study noted agency was demonstrated by non-governmental organisations' training of health teachers; to be in charge of hygiene stan-

dards in schools as well as ensure that the First Aid Kits were functional. In a broader sense, there were community committees, of children that reported on forms of abuse perpetrated on young children. Notwithstanding, empowering personnel working to improve early childhood development programme to double as teachers and health workers is critical in enhancing the psychological well-being of the learners (Goodwin and Ferrer 2013). Contributing to the critical role of health personnel, Woodhead (2014) acknowledges the role of health teachers in ECD settings, especially when they implement health, nutrition and WASH interventions in schools and homes, crucial to child survival and development.

CONCLUSION

The findings concluded that schools were not providing safety learning environments to learners with special education needs. There was no support to meet the rights, of learners with special education needs as stipulated in the CRC. In many cases schools offering ECD classes were barriers as they offered inadequate legislation and policies that anchor health, nutrition, and the safety needs of all learners. Primary schools with policies had teachers and other learners that had positive attitudes towards children with disabilities. However, this was the opposite in schools that did not have local policies to promote health, nutrition, and safe learning environments; and these fell short of protecting children from psychological and physical harm. It should be understood that holistic development for ECD learners with special education needs cannot be granted in conditions where learning environments are not safe from harm, poor ablution facilities and inadequate general hygiene standards.

RECOMMENDATIONS

Following the findings, the researchers recommend that there should be well monitored policies that support ECD health, nutrition, safety and protection programmes necessary for holistic development of all learners in inclusive settings. The government should offer ECD learners supplementary feeding especially for those living with HIV and AIDS, and those living with chronic diseases including those from poor so-

cio-economic backgrounds to boost immune system.

Areas for Further Research

The researchers recommend that further studies be done on ways schools can meaningful engage private public partnership to support health, nutrition and safety for ECD learners, but especially those with special needs.

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