

ENABLERS AND INHIBITORS ASSOCIATED WITH THE WILLINGNESS TO PARTICIPATE IN CHILD SAFETY INITIATIVES

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Safety is a priority in South Africa, a country with amongst the highest recorded rates of violence and injury, with children a vulnerable group. The greatest opportunities for reducing the burden of violence and injury amongst children lies in the prevention of harmful environments and situations. Information on the psychosocial inhibitors and enablers of child safety promotion interventions are required to enhance and assure the efficacy of interventions. The determination of context-specific information is expected to be of considerable benefit to community uptake and impact of safety interventions. The primary aim of this study is to determine the factors that enable or inhibit the willingness to participate in child safety interventions. This qualitative study is located in a historically marginalised and under-resourced community consisting of low-cost government housing and backyard dwellings and situated 4km outside of Strand in the Western Cape, South Africa. Eleven interviews were conducted with long standing community members who had either attended, had knowledge on, or experience of child safety initiatives conducted in their community. The study utilised a thematic analysis within a Person-Process-Context-Time theoretical framework. The findings indicate that willingness to participate is influenced by multiple and interconnected enablers and inhibitors. The personal, relational and environmental factors included: muted individual agency (comprised of hopelessness and struggling alone, scepticism, and experiences with daily living struggles); community care provision (limited community connectedness, care and concern for children, and neighbourliness); and structural, physical and social constraints (Catch-22 priorities, unequal power relations, and physical community impediments).

Keywords: *willingness to participate, participation inhibitors, participation enablers child-centred initiatives*

1. Introduction

Safety is a priority in South Africa, a country with amongst the highest recorded rates of violence and injury, with children a particularly vulnerable group (Seedat et al., 2009). The greatest opportunities for reducing the burden of violence and injury amongst children lie in the prevention of harmful environments and situations (Peden et al., 2008; Sleet, 2018). The assurance of safety and health for communities, families and individuals is thus increasingly being pursued. Safety promotion interventions, including those specifically focused on violence and injury prevention, however, remain fraught with complexities and challenges and are also often delayed in their effects (Peden et al., 2008; Van Niekerk et al., 2014). The administration of interventions in real-

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world situations are required to effectively assess the intervention and in turn, improve the condition of a population (Alvidrez et al., 2019). The implementation of an intervention is however by itself not sufficient for positive and sustainable intervention outcomes (Leviton, 2017), with multiple factors accounting for the lack of efficaciousness and sustainability of interventions (Van Niekerk et al., 2014). One of these is the reluctance of prospective participants to engage in interventions, with evaluation research indicating the critical importance of community participation for positive outcomes of interventions (Adams & Sherar, 2018; Madon et al., 2018). However, evaluation studies have shown that participation in health and well-being interventions tends to be problematic, with up to 80% of prospective intervention participants refusing to participate (Hopp et al., 2006; Subramanian et al., 2004). Lochman (2000) and Spoth and Redmond (2000) postulate that such poor rates of participation often threaten the internal validity (that is, demonstrations of the impact of the intervention on the specified outcomes under ‘ideal conditions’) and external validity (that is, generalisability, applicability, transferability and extrapolation of the outcomes) of interventions, especially when their efficacy had previously been established. With the result, the potential benefits of the implemented intervention may be compromised. According to the World Health Organization (WHO), participation is viewed as a key contributor to health and well-being outcomes (WHO, 2001). The concept and measurement of willingness to participate or engagement by individuals and communities in an intervention provides an opportunity for meaningful reflection and possible corrections of intended interventions prior to implementation (Beebe et al., 2001; Edwards et al., 2000; Ogunrin et al., 2018; Stallinga et al., 2014).

An individual’s willingness to participate is however difficult to define and even more difficult to measure; thus the exploration of this construct and the factors that may impact upon it is expected to produce new knowledge and insights that may inform its further development and application (see Ogunrin et al., 2018; Stallinga et al., 2014). The development of more nuanced understandings of the willingness of community members and stakeholders to participate in child-centred safety promotion interventions will facilitate the implementation and utilisation of evidence-based prevention strategies. Moreover, fostering community members’ willingness to participate in interventions will contribute to the mobilisation of efforts within the community to engage with, sustain and support evaluations of the use of evidence-based safety promotion approaches. One challenge, however, is to develop interventions and assessment measures that take into account, local, often adverse contexts. Context-specific information about the psychosocial inhibitors to and enablers of child-centred safety promotion interventions are required to enhance and assure their efficacy (see Stallinga et al., 2014; Swartz et al., 2006). The determination of such locally-sourced information is expected to be of considerable benefit to the implementation of child safety interventions in South Africa and elsewhere.

The study was guided by a Process-Person-Context-Time (PPCT) framework to explore community members’ perspectives, experiences and understandings of the factors that impact upon willingness to participate. The selected framework acknowledges that an individual’s behaviour both impacts on and is impacted by multiple spheres of influence; hence, efforts to change behaviour are more likely to be efficacious when examined within these multiple levels of influence, contemporaneously (Gregson et al., 2001). Bronfenbrenner’s PPCT model draws attention to the bi-directional interplay between the individual and the interlocked systems (that is, process, person, context and time) in their immediate environment (Bronfenbrenner & Morris, 2006). The PPCT model purports that, as individuals exert influence over their immediate environments, so do the immediate environments influence these individuals (Bronfenbrenner & Morris, 2006).

Considering the aforementioned, the current study's primary aim is to determine the factors associated with the willingness to participate in interventions in an under-resourced South African community. This aim was actualised through the following research objectives:

- a) to explore community member perceptions of child safety promotion interventions occurring in the community;
- b) to explore community member views on the factors that promote participation in child safety promotion interventions; and
- c) to explore community member views on the inhibitors or barriers to participation in child safety promotion interventions.

2. Method

The current study was part of an initiative to develop a psychosocial assessment tool for determining an individual's willingness to participate in safety promotion interventions specifically targeted at individuals residing in under-resourced and marginalised communities. The broader initiative was guided by a participatory approach and community engagement strategy throughout the instrument development process. The initiative utilised a mixed-methods research design, with a bottom-up approach to instrument development to enable the co-construction of knowledge from multiple sources. The methods used during the construction of the instrument included a literature review as part of the conceptualisation process, and individual interviews, Nominal Group Techniques and Delphi Panel Reviews to inform the formulation of a willingness to participate construct. The current study utilised a qualitative approach through key informant interviews to determine community resident conceptions of the factors associated with the willingness to participate. Whilst his study contributes to the formulation of the construct and the domains needed for a quantitative assessment tool that will measure willingness to participate in impoverished settings, it also specifically contributes to the knowledge of which factors enable or inhibit community members in their decision to participate in interventions. The findings from the larger study are reported elsewhere (see Ismail, 2018; Ismail & Van Niekerk, forthcoming).

2.1. *Study setting and design*

The study was located in an under-resourced community consisting of low-cost government housing and backyard dwellings, situated in the Helderberg Basin about 40km outside the City of Cape Town. The community has been in existence for about 20 years, with community members previously located in nearby informal settlements and backyard shacks (Bulbulia & Van Niekerk, 2012). A South African Science Council and South African University, in a joint venture, have been involved in this community since 2001 and coordinated the implementation of a number of safety initiatives in the area. The current study utilised a qualitative approach to determine the factors associated with the willingness to participate in interventions, and thus contribute to the formulation of concept domains for a quantitative assessment tool to measure willingness to participate in under-resourced settings. The findings from the larger study are reported elsewhere (see Ismail, 2018).

2.2. Informants

Individual interviews with targeted community residents were held in order to provide insights into the everyday realities of residents in their community and to contextualise perceptions of the factors to willingness to participate in interventions in their community. This interview data was utilised to develop the indicators related to the construct willingness to participate to provide an in-depth understanding of perceptions and perspectives of the community. Eleven informants, of whom 10 were females, were purposively recruited to participate in the individual interviews (Table 1). A purposive sampling strategy was utilised to achieve a heterogeneous sample of community residents that represented a broad spectrum of perceptions and experiences concerning willingness to participate in child safety promotion initiatives. Since the interviews were conducted during the week, more females were recruited, with more men in this community tending to be at work. The participants were only eligible to partake in the study if they fulfilled specific inclusion criteria, namely: had either attended, knowledge on, or experience of child safety initiatives conducted in their community (see Van Niekerk & Ismail, 2013). The informants were predominantly Afrikaans speaking and had been long-standing members of this community, living there on average just more than ten years. Prospective informants were invited to participate in the individual interviews depending on the participant's time and availability.

Table 1. Participant characteristics

| <i>Characteristics</i> | | <i>N=11 (%)</i> |
|------------------------|------------|-----------------|
| Gender | Male | 1 (9.1) |
| | Female | 10 (90.9) |
| Age | 21-30 | 3 (27.3) |
| | 31-40 | 2 (18.2) |
| | 41-50 | 4 (36.3) |
| | 51-60 | 2 (18.2) |
| Employment status | Employed | 3 (27.3) |
| | Unemployed | 8 (72.7) |
| Marital status | Single | 1 (9.1) |
| | Married | 8 (72.7) |
| | Divorced | 1 (9.1) |
| | Widower | 1 (9.1) |

Potential participants were identified with the assistance of the Research Unit's community fieldworkers and invited on an individual basis. Community fieldworkers were briefed on the research aims, expectations for involvement, inclusion criteria, and ethical issues pertaining to participation. Subsequently, fieldworkers provided the study with a list of potential participants' names, addresses and contact numbers and we then visited their homes to brief and possibly enroll them into the study. Once information about the study was conveyed to each respondent, and informed consent was obtained, an appointment was arranged to conduct the interview. Respondents were given the option of selecting a suitable venue for the interview. Most of the respondents preferred being interviewed at their homes, while others selected the closest church hall.

2.3. *Data collection procedure*

The study interviews commenced during the initial stages of the broader study (see Ismail, 2018) and took place over a period of four months. Each interview included the principal researcher and a co-interviewer, both coming from a research psychology background. The interview length was influenced by the talkativeness of respondents and their willingness to engage at a deeper level during the interview and ranged from 50 to 80 min. A semi-structured interview schedule focusing on the main research questions was used as a guide, but on most occasions, respondents led in their own conversation. While some participants found it easy to speak about their experiences, others struggled with where to start.

Permission was obtained from participants to audio record the interviews for the purposes of verbatim transcriptions, analysis, and interpretation, and provided respondents with the opportunity to ask questions. At the end of the interview, respondents' feelings about the interview process were explored, which provided an opportunity for debriefing. Interviews were conducted in both English and Afrikaans, with both languages widely used in the Helderberg and its immediate surrounds.

2.4. *Data analysis*

A thematic analysis was employed and was driven both by theoretical interest and the nature of the data. Themes extracted were categorised according to the "explicit or surface meanings of the data" (Braun & Clarke, 2006, p. 84). The interviews were transcribed by a post-graduate psychology research intern. To ensure that the transcripts were representative of the written text, the interviews were transcribed verbatim. Interviews were transcribed verbatim soon after the interviews took place in order to make it easier to remember the context in which the statements were made, and heighten the representativeness of the transcripts to the verbalised dialogue. After the first reading, the principal researcher checked the transcriptions against the tape-recorded material, and notes taken during and immediately after the interview, and changes made when necessary.

For the analysis, the principal researcher started by reading through all the interviews to obtain an overview and thereafter proceeded to read each transcript meticulously. In the subsequent reading, a line-by-line coding was done, ascribing each sentence in the interviews with a code that described the main essence of the sentence. The initial codes were both inductive and deductive since they originated both from the principal researcher's own theoretical understandings and from the respondents themselves, consistent with thematic analytic practice (Braun & Clarke, 2006; Miles & Huberman, 1994). The coding process was guided by the study's primary aim and three research objectives. We were interested in respondents' perceptions and understandings of their and others willingness to participate in child safety promotion interventions in their community. This resulted in the emergence of three themes encompassing a number of sub-themes. The analysis was conducted with the verbatim transcriptions of the interviews and the familiarity and understanding achieved with the data was thus through the manual method (Webb, 1999).

2.5. Ethics

The study was conducted in accordance with the ethical guiding principles stipulated by the University of South Africa, and the ethical code of conduct recommended for social research (Babbie & Mouton, 2001). All the respondents gave their written and oral consent to participate in the interviews. The study was performed according to the Declaration of Helsinki ethical principles for involving human respondents. To maintain the principle of non-maleficence, the respondents were guaranteed confidentiality, which was taken into account when reporting the findings. In accordance with respecting the respondents' autonomy, all the respondents were informed that they had the right to withdraw from the project at any time without suffering any consequences. In the interviews, the researchers were aware of power issues, in that an interview is not a conversation between two equal individuals. The interview time was taken into careful consideration. The respondents were given the opportunity to reflect on what they said in the interviews, and time was also available for the respondents to ask questions.

3. Results

This study indicates that willingness to participate is a complex, dynamic and multi-dimensional construct that comprise multiple factors that may interact to drive individuals to either engage or more likely not engage in child-centred safety promotion interventions. The key themes which emerged from the individual interviews were: (i) **muted individual agency**; (ii) **community care provision**; and (iii) **structural, physical and social constraints**. Figure 1 provides a visual representation of the themes and sub-themes; the community member experiences are central to the process of engaging with an intervention and this is depicted at the core of the box in red (i.e. personal system); followed by the orange box representing the immediate relational environment of the community members (micro-system); and the grey box representing the wider community context, emphasised as an adverse physical and social environment (macro-system). The themes and their sub themes are described below.

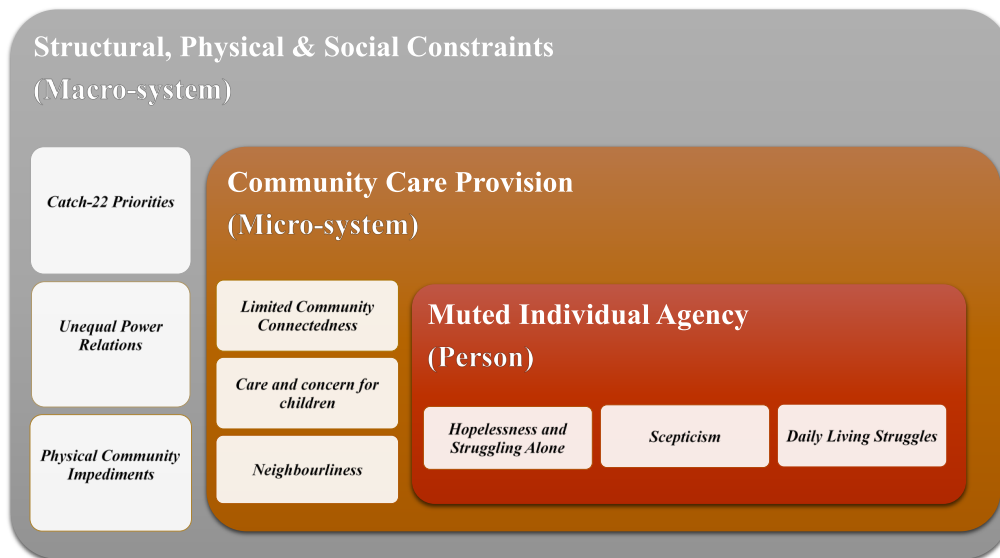


Figure 1. Willingness to Participate Enablers and Inhibitors

Muted individual agency

The theme describes the psychological experience that was specifically reported to inhibit individual engagement with safety actions. The theme illustrates how full expression in naming experiences, speaking out, and working to enhance children's safety are obstructed by often long-standing and daily experiences with hardship and struggle. It describes the ways in which individual agency and 'voice' are muted, on a continuum from restrained voice to one of silence as a result of accumulated individual experience and encounters within adverse community circumstances. Voice is invariably and synonymously linked to verbalisation. However, it is important to be mindful of the near and far reaches of sounded significance that remain 'outside' 'language-as-word' (Ihde, 2007, p.151). While the voice is the nodal point of communication, the metaphorical meaning indicative in muted 'voice' is disenfranchisement and lack of power as a community member, which while occurring at the personal level is situated within the community and meso-levels.

This experience of muted individual agency was represented through three sub-themes, (i) *hopelessness and struggling alone* which was often accompanied by (ii) *scepticism* especially towards community relationships and intervention agencies, with these experiences within (iii) *the daily living struggles* faced in situations of poverty.

Hopelessness and struggling alone

The informants highlighted the hopelessness encountered through their own and others' accumulated experiences of discouragement, at times to the point of despair. Such experiences were reported to be across this community, and manifest across community homes where these were often specifically endured by the maternal figures in families. Sarah and Denise¹ were over time disheartened by the circumstances that they and others faced:

[Mothers] have to struggle alone. This is where [they] wanted to take [their] own life ... they become very discouraged.

and

Look ... [the mothers] are discouraged, one sees it to a large extent. They are discouraged but they simply carry on. They just carry on . . . in nearly all instances you do not want your child to grow up in such an environment. I do not want my children . . .

The reports of especially maternal resignation to the longstanding, daily living struggles faced in their under-resourced community were indicated as common across this community. However, despite the challenges, the informants were reported to have endured these difficulties, even if alone. A source of this resilience was reported to be the desire for a better future for their children. However, despite this centering of the wellbeing and safeguarding of their children, residents indicated that they had stayed away from the child safety activities in their community, doubting that these could have changed the more pressing and dire socio-economic conditions in their lives.

¹ All names of respondents have been changed to protect and conceal identities and maintain the confidentiality of the data provided by the respondents

Scepticism

The residents highlighted this scepticism about what their immediate community environment could offer, doubting and mistrusting specifically the services or interventions offered. The residents doubted that the child safety programmes implemented in their community would be of any use or benefit, and not able to change their local socio-economic conditions, indicated as the source of their local struggles. Denise and Colleen illustrated this:

I feel it is not something good...we should be happy if someone comes out [to give a talk or do a campaign in the community] ... I feel it's not actually good because it does not improve our lives.

and

If one really looks at the world outside today, the world can offer you nothing...you know at the present time what is taking place in the world it is very out of control, but what else can you do.

However, while both Denise and Colleen expounded on this, they but also criticised their scepticism of the safety interventions, indicating that their response did not benefit them in the end. The tension between this and the experience that the '*world can offer you nothing*' suggested a generalised disillusionment that was not countered by supportive external actions, even around the key personal issue of child safety.

Daily living struggles

The daily living struggles faced in this community included the challenge of unemployment or sporadic work, insufficient food to provide for the family, and the unpleasant and dangerous environment children were growing up in. Sarah illustrates her story of these struggles through her fight to protect her child from dangers in the local neighbourhood:

...it is unsafe outside. The world today is chaotic. Children outside ... are actually a big target, a target for ... the drug dealers and the people that perhaps smuggle, drug peddlers start putting major pressure on children there you will find them, where they sit and drink. For example, they [children] do not go there for that but then they become targets. Innocent people always get hurt, wrong time at the wrong place.

The experiences of many in the community was reported around the effect of economic and social challenges on the safety and wellbeing of their children. This appeared to affect their expectations of the future, where life was indicated as not getting better. Lindie, Sarah, Colleen and others reflected on these as constraints to their individual agency, and their consequent experiences of hopelessness and even scepticism of external agencies. These feelings, within their encounters with the daily struggles they faced, were often reported as overwhelming.

3.1. *Community care provision*

While the first theme highlighted individual experiences that inhibited the willingness to participate in interventions, the second theme involved the care and support dynamics in the immediate relational environment and featured both inhibitors and enablers of willingness to participate. This theme illustrates the daily relationships between people in the community, how social problems are engaged with and resolved or not, and who engages with whom. At the meso-level, it is the structure of social network ties between individuals or organisations which impacts children's safety and safety actions in the community. Whilst at the micro-level community connectedness involves the quality and number of connections one has with other people in a social circle of family, friends, neighbours and acquaintances and this, in turn, relates to an individual's feeling of belonging which enhances meaning in life (De Silva et al. , 2005), and which inevitably has an effect on the engagement with collective safety actions in the community (see Hajrasoulih et al., 2018). Thus, community care provision attempts to help us make sense of the positive lived experiences arising from relationships in the community despite the multiple deprivations and inequities experienced by people and localities, across the social fabric. The second theme describes features of the community care provision experienced, which included (i) *limited community connectedness*, (ii) *care and concern for children* and (iii) *neighbourliness*.

Limited community connectedness

The respondents reported a limited sense of connectedness in the community. This lack of connectedness experienced in the community led to many feeling isolated from the rest and alone in the struggle to make the community a safer place. They admitted their frustration and weariness with the situation in their community, reflecting that community residents needed to engage and work together in order to bring about change in the community. Sunnette and Annetjie voiced their frustrations saying that:

...the leaders [of the community] here do not intervene, no one cares. And that is what freaks me out, it makes me sick because no one cares. Like I said everyone is for themselves here...no one will look after each other here.

and

I by myself can do nothing about this [situation in the community] because I stand alone... that's why I just stay in my house. I don't worry about the people around here. If I see them I will talk to them but I will not go sit at their house.

The participants lamented the isolation and lack of care of others by individuals in the community, although in an effort to be safe and stay out of trouble, this was a strategy that they too followed. The lack of connectedness within the community acted as a barrier preventing community members from experiencing a sense of belonging in their community, which in turn hindered participation in community activities and programmes. The lack of leadership from community leaders was hindering such collective actions, a change which was needed to bring about the necessary community transformation.

Care and concern for children

The experiences of the limited connectedness felt in the community is juxtaposed with the care and concern, about each other, but especially for the children in the community. Despite the general lack of connectedness experienced by individuals, there were others who illustrated their concern and compassion for not only individuals in their community but for their community as a whole. These individual contributions were often gone unnoticed by their community, especially with regards to children, but emanated from a social obligation with altruistic intentions. For example, while Sarah and Denise voiced their concerns about the children in the community, their acts of care are foregrounded:

... sometimes then I say to my children – look how the children are roaming the streets, see how they look. If a child walks in here by me and asks for a piece of bread I give because I am a mother regardless who the child's mother is.

and

They walk around and there is practically no one who is looking after them. I mean a person must also look after other people's children.

Neighbourliness

In contrast, neighbourliness encompassed experiences of strong connections and relational sources of safety in the community. In those micro-spaces in the community where cohesion and connectedness were evident, strong neighbourly ties were reported, with neighbours viewed as a source of support and safety and where for example neighbours would keep an eye on each other's houses when one of them would work night shift or be away from their homes. Sharleen and Marlene describe the kindness and neighbourliness that was displayed amongst each other in their community:

Even during the night, we [neighbours] look after each other...we have to look after each other.

and

Because it is a fact. Many of us, we help each other, if there is maybe one of us in need or so.

The above illustrates that providing support is not always at the most convenient of times but the neighbours were willing to assist each other. Contrary to the experiences of limited community connectedness, other experiences illustrate how community connectedness facilitated and promoted active and meaningful community and intervention participation. Nurturing feelings of social obligation and fostering a cohesive community improved relationships of care between individuals and more broadly within the community. Thus, having resources available (such as caring neighbours) in an under-resourced community can provide opportunities and space for members to participate in interventions hosted in their community.

3.2. *Structural, physical and social constraints*

The final theme reports on the structural, physical and social constraints that restrict willingness to participate in interventions. These constraints encompass both physical and social restrictions that prevent community residents from engaging with interventions implemented in their communities. Respondent conversations highlighted inhibitors, which emerged at three levels namely, at individual, family and societal levels. At the individual level, respondents raised concerns about competing priorities such as employment, social and domestic issues that took precedence over their attendance or engagement of interventions or initiatives in their community. At the family level, concerns were raised about the impact of unequal power relations in the home. At a community level, respondents discussed the physical community impediments which also acted as an inhibitor to participation. Structural, physical and social constraints were therefore typified through three sub-themes: (i) *Catch-22 priorities* faced on a daily basis; (ii) *unequal power relations* in the community and home; and (iii) *physical community impediments*.

Catch-22 priorities

A number of social problems pertaining to structural constraints came to the fore during the interviews. The first sub-theme focused on *competing priorities* (i.e. work, household chores, caring for children etc.) and occurs at the individual level. Respondents reported that many individuals in the community, whether male or female, were affected by precarious employment. Respondents felt that individuals in their community do not always have the luxury to attend interventions. Sharleen and Sarah portray the quandary people in the community face in negotiating time to attend interventions:

Some people's work is very demanding and sometimes they are also only one or two days off in the week, and if you are perhaps off in the week then you maybe want to clean your house or do the washing.

and

Sometimes then they have various events here and so and then parents don't come that much because sometimes then most of them work particularly on a Saturday and on Sundays.

Respondents admitted that they would not abandon the opportunity for employment to attend an intervention since employment is the means of providing for their families. It is evident that financial survival is a priority in this under-resourced setting with many needing to work even if this was on the weekends.

Unequal power relations

There were structural constraints that were more social in nature, such as the unequal power relations that women in the community come up against. Reflections by the respondents illustrate a milieu of unequal patriarchal power relations in the community. This patriarchal milieu is exacerbated by poverty, violence, unemployment, lack of infrastructure, and limited resources,

with these combining to prevent residents from attending safety promotion interventions. Colleen and Denise highlighted the unequal power dynamics between men and women in the community:

Men do not worry here... they do not care if their wife must just go out and work (while they stay home) and that's it [sic].

and

Husbands keep their wives back a lot...that the women must not attend interventions or programmes [sic].

Physical community impediments

Physical community impediments are aspects in the environment that, through their absence or presence, limit movement and functioning, and create disability. These include a physical environment that is not accessible, the lack of relevant assistive equipment, and services and systems that are either non-existent or that hinder the involvement of people. The respondents highlighted a lack of childcare options as an inhibitor to participation in campaigns, meetings or interventions. Craig raised concerns about the children:

...if you as the parent is not going to take care of your child, who is going to take care of them.

Childcare facilities are only a good option in this context if you have a job with little flexibility either in hours or the ability to work from home. In an already under-resourced community with high levels of poverty and unemployment, having to pay for childcare facilities is often not possible, as indicated by Lindie:

Everyone does not possess the money to put their children into a crèche [sic].

There are no free subsidised childcare facilities in this community. Thus, when parents cannot afford to pay for childcare facilities they attend to their children at home and are thus not being able to engage or participate in interventions.

Respondents also raised concerns about the limited facilities and services for elderly residents in the community. Many direct caregivers of young children within the community are grandmothers, and with the extensive burden of illness in the South African population many of them are frail and have physical limitations. Sarah illustrates how there are no measures put in place in the community that would assist ailing aged individuals if they needed to leave the home:

...there are two pensioners... we have to care for them...their legs are perhaps sore, they cannot come to our events. Then we are under the impression they are not interested, but they wanted to be there [sic].

The above example illustrates the lack of relevant assistive equipment such as wheelchairs or crutches, and services such as a pick-up and drop-off transport.

4. Discussion

The study identified muted individual agency; community care provision; and structural, physical and social constraints as key inhibitors or conversely enablers of individual willingness to participate in interventions, especially in impoverished or marginalised circumstances. Barriers and enablers to willingness to participate in interventions have been documented at different levels of interaction (Kafaar, 2015; Lesch et al., 2006). Bronfenbrenner's PPCT model therefore provided a means to understand the factors that impacted upon willingness and guided the exploration of these factors at different levels of interaction.

The restricted individual agency was driven by feelings of hopelessness and scepticism within daily living struggles and hardship, which collectively were reported to impair the willingness to participate. These experiences suggest that the pathways in which realistic imagined positive possibilities for an individual's future are constrained, mostly by the external demands that require complex negotiations by individuals with spaces, places, bodies and other people (Bronfenbrenner & Morris, 2006; Tudge et al., 2009). These findings align with other studies that have emphasised the interactions between socio-contextual and personal factors, with the latter including limited appropriate coping mechanisms and pessimistic psychological sense of community that impede participation (Ayoub et al., 2018; Polizzi & Gottfredson, 2003; Van Niekerk & Ismail, 2013). This study draws attention to the interconnections between internal individual resources and the social and environmental contexts and settings.

The study highlighted community care provision, with community support and connectedness represented as a catalyst or impetus for participation in interventions. Research corroborates this finding, recognising the instrumental role connectedness plays in facilitating an individual's access to opportunities, as well as nurturing his or her well-being, and participatory abilities (Zavaleta et al., 2016). Participation in a range of activities, whether it be in household, community, or broader social and political structures, is regarded as crucial for a sense of belonging, and for building trust and reciprocity in communities (Samuel & Uwizeyimana, 2017).

Despite recognition of the vulnerability of children, this study highlighted the multiple and co-existing inhibitors to participation in local child safety promotion interventions. Community residents stress the far-reaching impact of adverse community circumstances on their individual and family well-being, with psychological and social responses primarily constructed to deal with everyday challenges. In this context, the importance of community support and connectedness enabled the ability to prioritise daily family and safety decisions, and to individually and collectively manage, if not overcome, social and daily living hardship (Mosavel et al., 2015). However, despite this recognition, there was a general lack of connectedness and cohesion in this community, which exacerbated both the vulnerability of children in their community and, the unwillingness to participate in community safety promotion initiatives. It has been indicated that communities and their members are at an increased risk of social exclusion and marginalisation when faced with poverty (Swartz et al., 2012). Even though studies conducted in various contexts have identified safety as a ubiquitous concern for children across South Africa (see Adams & Savahl, 2015; Isaacs & Savahl, 2014; Parkes, 2007; Savahl et al., 2015), this study reported that on the whole their community failed to stand together, whether it be in the interest of children's safety and well-being or not. Such social fragmentation holds true especially in under-resourced socio-economic contexts, where social isolation may serve, for example, as a defense mechanism against crime occurring in their community (Emmet, 2003).

This study indicated simultaneous accounts of cohesion and disconnectedness; whilst this is a contradictory mixture of juxtaposed elements, it is important to note that in this study inhibitors and enablers did not emerge as dual factor concepts that are independent of one another, and can coexist (Cenfetelli, 2004). Rather, inhibiting factors appeared to be the counterpart of the enabling factors. This apparent contradiction, which emerged between connectedness and lack of connectedness, may be attributed to community members' aspirations to achieve cohesion in their community. Feeling connected to one's community represents an extension of the basic human desire for interpersonal relationships with others and the need to belong (Baumeister & Leary, 1995). It is postulated that if communities intentionally build social networks and foster social connectedness, the likelihood is higher that these individuals will develop a greater sense of shared responsibility for each other and for their community. In other words, by encouraging pro-social, altruistic behaviour, individuals can be motivated to act in collective, supportive ways.

In this study, the small pockets within this community that manifested networks and notable relationships could be viewed as indicative of the resiliency in this community, despite its history of adversity and violence (Henández, 2002). Community resiliency is regarded as a positive, adaptive response of community members living in adverse environments (Ahmed et al., 2004, Tchombe et al., 2012). These networks and relationships reinforce positive social behaviour, which in turn increases community connectedness (Durlauf & Fafchamps, 2005). Informal support networks, which include neighbours and close friends in the community, have been associated with resiliency (Ahmed, et al., 2004). This study recognised the importance of the aforementioned informal networks, which, beyond individual and group well-being, are also vital in the planning, implementation and utilisation of interventions (Ismail, 2018; Taliep et al., 2020).

Interestingly, personal safety was never raised in this study as an inhibitor or enabler to participation. Yet, the literature indicates that safety (both in the context of taking part in the intervention, as well as in the context of travelling to the intervention), particularly for women and the elderly, is widely regarded as an inhibitor to participation (see NI Assembly, 2010). The focus on children's safety and recognition of the overall impact of gangsterism, drugs, alcohol and violence on the children, may have indicated a degree of desensitisation or deflection, as the target community has reported daily concerns with drug peddlers, taverns, gang shoot outs and gang-related threats (Van Niekerk & Ismail, 2013).

5. Conclusion

The current study indicates that the willingness to participate in safety promotion interventions are impacted by a number of factors: hopelessness and struggling alone; scepticism about what the world can offer; daily living struggles; limited community connectedness; care and concern for children; neighbourliness; Catch-22 priorities; unequal power relations; and physical community impediments. In this study the construct of willingness to participate was based on a number of assumptions. Firstly, inhibitors and enablers were suggested to coexist and even be dependent on one another. For example, community cohesion was considered an important aspect of willingness to participate. The lack of community cohesion in marginalised communities may therefore result in community members not wanting to engage or participate in community safety interventions. The opposite also holds true, where increased cohesion in communities may result in community members being more 'willing' to participate in interventions. Secondly, in addition, when there is a lack of connectedness in communities, which may subsequently affect the willingness of community members to participate in initiatives in their communities, there is a cost to the success

and efficaciousness of interventions, as the expected outcomes are compromised. Community members, therefore, may not contribute despite having the necessary skills and knowledge to make valuable contributions. There may also be the costs of exhausting community resources in already under-resourced communities that could have been prevented. In South Africa, where there is extensive poverty and inequality, it is imperative that child safety promotion initiatives be utilised effectively to promote healthy and safe communities. The impact of community members not participating in interventions, therefore, extends beyond the individual to families, communities and the broader society.

The development and successful implementation of prevention responses targeting risk factors specific to violence and injury, particularly those factors related to priority child injuries and violence in South Africa are needed. Successful implementation demands the prioritisation of evidence-based prevention initiatives, monitoring systems, improved human resources and administrative capacity (Mayosi et al., 2012), as well as initiatives to foster willingness to participate. Taking this into account, the enablers and inhibitors that emerged in this study should be considered during the intervention planning phase, prior to implementation of interventions in local communities.

6. Limitations

Whilst the selection of respondents were well-informed about child-centred initiatives and therefore able to provide rich information on the barriers to, and enablers of willingness to participate in child-centred safety promotion interventions, respondents may not necessarily reflect the scope of experiences of the average community member in this community, who may not have had access to the same quantity and quality of information on safety promotion interventions. Further, while an equal gender distribution in the study sample was pursued, due to recruitment and attrition challenges a gender balance was not possible. However, the study does recognise that there is rich variation across South Africa's marginalised communities and different historical experiences.

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