CONTEXTUALLY BASED MODEL OF AN EARLY CHILDHOOD HOME-VISITING PROGRAMME FOR VULNERABLE CHILDREN IN THE EASTERN CAPE PROVINCE OF SOUTH AFRICA

BY

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DECLARATION

I, Kim Schmidt (201113886), hereby declare that this thesis titled "**Contextually based model of an early childhood home-visiting programme for vulnerable children in the Eastern Cape province of South Africa"** hereby submitted for the degree of Doctor of Philosophy in Social Work has not previously been submitted by me for this degree at this or any other university. I further declare that this is my work in design and execution, and that all materials contained herein have been duly acknowledged.

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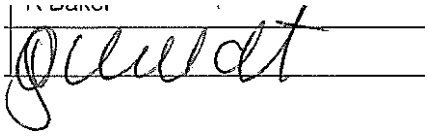

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ABSTRACT

In South Africa, there are many vulnerable children. Vulnerability refers to the child's potential to be harmed either physically or psychologically with multiple exposures to stress resulting in children becoming vulnerable (Matengu, 2018). Factors that place young children at risk of being harmed include poverty, being orphaned, not living with their biological parents or having a disability. In South Africa, more than 50% of children are impacted by these very factors (DSD, 2018). Vulnerable children can be supported through various interventions to overcome the challenges they face, in spite of the stress that they may experience.

This results in a great need for prevention and early intervention services particularly during early childhood when children are most vulnerable because of their complete dependency on caregivers for care and protection. This study adopted an interpretivist, qualitative approach using an intervention research design to develop guidelines for a model of an early childhood home-visiting programme that supports the optimal development of vulnerable children, aged 0–2 years in the Eastern Cape province of South Africa.

Findings confirmed that vulnerable children need responsible caregiving and a nurturing environment yet they are exposed to risk factors such as extreme levels of poverty, ongoing and severe child maltreatment and poor physical health. In addition findings confirmed that there was support available to vulnerable children in the Eastern Cape province but that there were gaps in these services. Furthermore findings indicated that there is a need for an early childhood home-visiting programme, that such a programme should be implemented by a multidisciplinary workforce and that the guidelines for such a programme must include a range of practice principles and processes.

In conclusion the study found that vulnerable children in the Eastern Cape province continue to be exposed to a complex range of risk factors with devastating consequences for their immediate and future well-being and that the gaps in services to vulnerable children further hinders their development. Lastly it was concluded that there is a need for a multidisciplinary team to implement a home-visiting programme and that such a programme would hold many potential benefits for the young and vulnerable child.

Guidelines for a model of an early childhood home visiting programme were developed and refined to include five practice principles which outline processes in relation to the engagement and advocacy with stakeholders and role players, the recruitment and selection of a home-visiting workforce, the content of a training programme for a home-visiting workforce, the implementation of the home-visiting programme and the monitoring and evaluation of the programme. This model draws together the disciplines of health, social work and early childhood education to provide transdisciplinary training to a home-visiting workforce that is then equipped to engage with communities and caregivers in support of ensuring that vulnerable children are able to achieve optimal development.

Key words: early childhood, social work, vulnerable children, home-visiting programme, transdisciplinary, biopsychosocial

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ACCRONYMS AND ABBREVIATIONS

ARV:	Antiretrovial
BCM:	Buffalo City Municipality
BFCI:	Baby Friendly Community Initiative
CSG:	Child Support Grant
DoBE:	Department of Basic Education
DOE:	Department of Education
DoH:	Department of Health
DSD:	Department of Social Development
ECD:	Early Childhood Development
FCM:	Family and Community Motivator
HFA:	Healthy Families America
HCT:	HIV Counselling and Testing
HIV:	Human Immunodeficiency Virus
NCF:	National Curriculum Framework
NDA:	National Development Agency
NGO:	Non-governmental Organisation
NIECDP:	National Integrated Early Childhood Development Policy
NPO:	Non-profit Organisation
OVCs:	Orphans and Vulnerable Children
TB:	Tuberculosis
UNICEF:	United Nations International Children's Emergency Fund
UNCRC:	United Nations Convention on the Rights of the Child
WHO:	World Health Organisation

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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

The need to prioritise quality programmes that support children towards healthy development is acknowledged both internationally and nationally (Schwethelm et al., 2019; Tomlinson et al., 2020). Early childhood programmes are programmes that provide care, support, development and learning opportunities to children from birth to 4 years and can include outreach programmes, playgroups, or can be centre-based, such as a preschool or crèche (Kuhne & Fakie, 2019; Republic of South Africa, 2015). These programmes support families who are ultimately responsible for raising, protecting and caring for children who are the next generation and who will secure the future of South Africa (Sadan, 2018). The draft National Child Care and Protection Policy calls for universally accessible promotive services for all children and highlights, among others, the current gaps of poor nutritional and health care and a lack of quality and affordable early childhood services (Proudlock & Rohrs, 2018). Large numbers of children in poor and rural communities do not benefit from any early childhood programmes. In fact, more than three million vulnerable children do not access any early childhood programmes in South Africa and, of the many children who should receive subsided access to early childhood programmes, only 25% actually do so (Atmore, 2021; Ilifa Labantwana, 2021).

Vulnerability refers to the child's potential to be harmed either physically or psychologically with multiple exposures to stress resulting in children becoming vulnerable (Matengu, 2018). Factors that place young children at risk of being harmed include poverty, being orphaned, not living with their biological parents or having a disability. In South Africa, more than 50% of children are impacted by these very factors (DSD, 2018). Vulnerable children can be supported through various interventions to overcome the challenges they face, in spite of the stress that they may experience.

The United Nations Convention on the Rights of the Child obligates government to provide support services to caregivers in their parenting roles (UNICEF, 2019). The draft National Child Care and Protection Policy calls for targeted prevention and early intervention services noting that 90% of vulnerable children do not receive such services, with a lack of parenting programmes being one of the shortfalls (Ilifa Labantwana, 2021; Proudlock & Rohrs, 2018). The Nurturing Care Framework provides an action plan for

the health sector, outlining the role of various sectors and the five components of nurturing care needed for optimal development within the first 1,000 days (Bamford, 2019). Yet it is noted that 12.8 million children continue to live in poverty (Hall et al., 2019), 27% of children are stunted (National Department of Health et al., 2017) and only 21% of young children access any sort of early childhood programme (Hall et al., 2019). It is clear, however, that although the need for quality early childhood programmes as well as prevention and early intervention child protection and health programmes are acknowledged, in reality the implementation of such programmes remains problematic.

Access to an early childhood programme could serve as a prevention or early intervention service for vulnerable children. This type of access opens an opportunity for both the caregiver and child to receive supportive interventions ranging from nutritional through to opportunities for learning and parental education. Despite the potential value that these programmes hold for vulnerable children, the implementation of these programmes across the sectors of early childhood development (ECD), child protection and health is severely hampered, with numerous authors citing a lack of political will and a consequent lack of funding from government as the culprits (Atmore, 2021; Strydom et al., 2020).

Adding to the challenges around implementation and funding, is the debate around which government department ECD should be located in. While some may argue that early childhood programmes should be located primarily in health or education rather than social development, others argue that a transdisciplinary approach to early childhood programmes is needed (Irvine, 2019; Moodly et al., 2019). A transdisciplinary approach requires knowledge from different professions to come together so that new knowledge can be created; in this case, to support the effectiveness of early childhood programmes so that the complex needs of the young child, especially the vulnerable young child and their family, can be met (Irvine 2019; Moodly et al., 2019).

However, in contexts where multiple vulnerabilities exist and services are needed within the context of the home, social workers may be in a better position to offer such services (Azzi-Lessing, 2013). Social workers are trained to support individuals and communities, empowering them to navigate the vulnerabilities that they face with a specialised focus on rendering child protection services. Social work is one of the only professions that offers such services in the context of the family's home (Ferguson, 2009, 2010). The role

of social work in early childhood services and, in particular early childhood home-visiting programmes, is thus worth exploring in more depth and, as such, forms a part of the research for this social work thesis.

The National Integrated Early Childhood Development (NIECD) policy states that early childhood services can be provided through home-visiting programmes that offer support to caregivers and the child at a household level (Republic of South Africa, 2015). Such programmes may differ in terms of goals, however, all home-visiting programmes share a common focus: firstly, in noting the importance of the development that occurs during early childhood and the important role that caregivers play during this time, and secondly, in believing that the most effective way to engage with caregivers and young children is to do so by taking services to them (Gomby et al., 1999; Schaefer, 2016). Such programmes have the potential to address the often-complex needs of vulnerable families with young children from within the very community and home where they live, supporting the well-being of the caregiver while at the same time reducing the occurrence of child maltreatment and improving future outcomes for the child (Ferguson, 2009). Numerous studies show the impact of home-visiting programmes in reducing risk factors and enhancing protective factors for the young child and, as such, are noted as integral in prevention and early intervention services during early childhood (Azzi-Lessing & Schmidt, 2019; Easterbrooks et al., 2019; ; Le Roux et al., 2010; Nygren et al., 2018; Thurman et al., 2016). In South Africa, such programmes may thus be significant in the implementation of the proposed changes to the draft National Child Care and Protection Policy and the NIECD policy in ensuring a developmental approach to service rendering and in supporting the optimal development of all young and, in particular vulnerable children.

Early childhood is defined by some as stretching from birth until 9 years of age. More recent literature has refined early childhood to refer to the period from birth until the child reaches the age of 5 years, which is when the most significant development occurs (Eremenko & Esposito, 2018; Republic of South Africa, 2015). However, before this operational definition of early childhood lies the time that early childhood experts have termed ‘the first 1,000 days’. The first 1,000 days stretches from the “period between a woman’s pregnancy and her child’s second birthday”, presenting as a time within early childhood where the child is especially responsive to good care or made vulnerable through inadequate care; “it is a unique period of opportunity when the foundations for

optimum health and development across the lifespan are established" (Arabena et al., 2015, p. 5; Department of Social Development [DSD], 2014). Other studies have also supported the conceptualisation of early childhood as beginning from conception, noting the important development that occurs from conception through to birth (DSD, 2014). In this study, the young child is conceptualised according to the definition of the first 1,000 days, and the young child will thus be referred to as the child/children for the purpose of this study.

Early childhood programmes and, in particular, home-visiting programmes, are one of the interventions implemented to support the optimal development of the child and to support children in overcoming the stresses they are exposed to. Various studies agree that home-visiting programmes are effective, yet most of these studies have noted the lack of such programmes in rural areas. There is, therefore, a call for such programmes to be developed and implemented in the rural contexts of South Africa, where children are more vulnerable due to high rates of poverty and a lack of early childhood programmes and resources (Azzi-Lessing & Schmidt, 2019; Cooper et al., 2009; Ilifa Labantwana, 2018; Le Roux et al., 2010; Van Niekerk et al., 2017).

This study aims to develop a model for a contextually based early childhood home-visiting programme to support vulnerable children in the Eastern Cape, a large and predominantly rural province. The study has a particular focus on the first 1,000 days due to the critical development that occurs during this time and the significance of this time for optimal future outcomes.

Chapter 1 introduces the study and the research topic. The problem statement is presented together with the justification for the study. The study's aim, research questions and objectives are outlined, and the significance of the study is argued. Lastly, the study's operational definitions are presented, and the proposed structure of the thesis is outlined.

1.2 Research problem

Early childhood development services have historically belonged to the DSD and although recent developments have indicated that ECD will be moved to the Department of Basic Education (DoBE), this has yet to happen (Du Plessis, 2021; Ramaphosa, 2019). However, over the years, the DSD's involvement has often been limited to the registration of ECD centres and the subsidy of such centres. Less attention has been

given by the DSD to using ECD programmes for the support of vulnerable children in an effort to render prevention and early intervention services outside the realm of centre-based ECD programmes. This is problematic as social workers have, since the dawn of democracy, been mandated by legislation to render home and community-based prevention and early intervention services as a priority in an effort to lower the rates of child maltreatment in South Africa (Patel & Triegaardt, 2005; Republic of South Africa, 1997).

With high rates of child maltreatment occurring during early childhood, it is problematic that these children receive minimal support, which is often only received after maltreatment has been reported on numerous occasions or has resulted in serious injury (Easterbrooks et al., 2019). It seems natural for the DSD and social work to partner with ECD services for more than just the registration of ECD centres or subsidies; such a partnership could reach the vulnerable child and prevent child maltreatment, assisting social work in prioritising prevention and early intervention services. Social work statutory caseloads remain extremely high (Strydom et al., 2020). This may be due to high rates of child maltreatment or possibly because social work has never really been able to make the switch from statutory work to prevention and early intervention services in an effective manner. This research is partly centred around the divide between the DSD, social work, ECD and health, which is seen as problematic as it may make already vulnerable children at high risk for poor future outcomes even more vulnerable.

There is a great need for prevention and early intervention services during early childhood considering that more than a million children are born every year, that many of these children will experience poverty and that many of these children will live in rural areas making access to ECD services problematic and costly to render (Hall et al., 2017). The first 1,000 days set the trajectory for future well-being and early childhood programmes to support development during this period are essential if South Africa is to break intergenerational cycles of poverty (Symington et al., 2018). Despite this knowledge, 62% of South African children do not access any early childhood programmes with the majority of children between 0–2 years of age remaining at home with their caregivers (Van Niekerk et al., 2017). Quality early childhood interventions can significantly reduce poverty and inequality across South Africa, making universal access to ECD programmes an urgent priority for the future of South Africa (Van Niekerk et al., 2017).

There is, therefore, a great need for effective early childhood programmes, in particular non-centre-based programmes, such as home-visiting programmes, that target the most vulnerable children during the first 1,000 days. These children are found in their homes being cared for by their caregivers, and, in a province such as the Eastern Cape, 79% of these children are living below the poverty line (Hall et al., 2017). If South Africa aims to make a full, comprehensive and age appropriate ECD package available to all children by 2030, it remains problematic that in a province with the highest rates of child poverty, only 12% of 0–2-year-olds access any type of early childhood programme thus increasing their vulnerability and putting them at greater risk for poor future health and educational outcomes (Hall et al., 2017, Petersen et al., 2010; Republic of South Africa, 2015). It is thus vital that the DSD and social workers, perhaps in partnership with other state departments and disciplines, continue to address this lack of services to vulnerable children, who are found primarily at home with their caregivers. It is estimated that between 200 and 250 million children in poorer countries are unable to reach their full development potential due to malnutrition and maltreatment related to poverty (Black et al., 2017; Grantham-McGregor et al., 2007; WHO, 2018). This places great strain on these children, holding them back from becoming productive members of society and often trapping them in a cycle of poverty that is then passed to the next generation (Grantham-McGregor et al., 2007).

Malnutrition and maltreatment can be prevented before cognitive abilities are permanently impaired, yet many children in South Africa continue to face exposure to these factors during early childhood. This is problematic as early childhood, more so the first 1,000 days, is the most critical time for brain development. It is the time when a good foundation is laid for future development. Alternatively when children are exposed to ongoing risk factors without protection; this becomes the time when a good foundation is not set, and optimal future development becomes difficult to achieve. This study is centred around the disparities that exist within the Eastern Cape province which continuously expose children to poor developmental outcomes making it increasingly difficult for them to break free from poverty and its associated risk factors. The study examines the lack of equitable and quality early childhood programmes that offer support to vulnerable children within their home setting, which is the context where 88% of children are cared for during the first 1,000 days.

1.3 Research aim and questions

The overall aim of the study was to develop guidelines for a model of an early childhood home-visiting programme that supports the optimal development of vulnerable children, aged 0–2 years, in the Eastern Cape province in South Africa.

The study was guided by the following five research questions that align to the overall aim of the study:

1.3.1 What are the needs of vulnerable children in the Eastern Cape province and the potential outcomes when such needs are met?

1.3.2 What are the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors?

1.3.3 How are vulnerable children in the Eastern Cape province currently being supported?

1.3.4 Which different disciplines are involved in an early childhood home-visiting programme that supports vulnerable children and what are their roles and the extent of their involvement?

1.3.5 What guidelines are needed for a model of an early childhood home-visiting programme that effectively supports the optimal development of vulnerable children in the Eastern Cape province?

1.4 Research objectives

The overall aim of the study was achieved through the following five objectives:

1.4.1 To explore the needs of vulnerable children in the Eastern Cape province and the potential outcomes when such needs are met.

1.4.2 To understand the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors.

1.4.3 To identify the ways in which vulnerable children are currently being supported in the Eastern Cape province.

1.4.4 To determine the various professionals that are involved in an early childhood home-visiting programme and their roles and extent.

1.4.5 To develop guidelines for a model of an early childhood home-visiting programme that supports vulnerable children in the Eastern Cape province.

1.5 Significance of the study

This study hopes to add to the research that has already been done in the field of early childhood, child protection and in particular the role of home-visiting programmes in supporting vulnerable children and their families in the rural communities of South Africa. The findings thus add knowledge to the fields of social work, child protection, early childhood and maternal health and ECD generating knowledge that is transdisciplinary in nature. Secondly, it will have practice importance as it will provide guidelines for a home-visiting programme, which is one of the early childhood programmes that is highlighted in the NIECD policy as being important in supporting the optimal development of vulnerable children. Such guidelines can be shared across the various disciplines that work with vulnerable children in the Eastern Cape province. It will also provide insight into the current and very interesting debate around whether early childhood home-visiting programmes should be facilitated by paraprofessionals or whether it is more beneficial for such programmes to be implemented by professionals and, if so, who these professionals should be.

Lastly, the home-visiting programme, if implemented, may support vulnerable children in the rural context of the Eastern Cape province who may not have any access to early childhood prevention or early intervention programmes within their communities. This is of great significance as although South Africa has the national Children's Act 38 of 2005 and an ECD policy, both of which contain programme priorities, equitable access to quality programmes for vulnerable children remains problematic, particularly in rural communities (Jamieson et al., 2017; Republic of South Africa, 2015; Strydom et al., 2020; Van Niekerk et al., 2017).

It is widely acknowledged that living below the poverty line increases the vulnerability of children, yet this vulnerability could be significantly reduced if these children had access to quality early childhood programmes (Van Niekerk et al., 2017). Social work is a profession that promotes social change and works with structures, communities and families to navigate the challenges that they face and enhance their well-being (International Federation of Social Workers, 2014). Social work should, therefore, be closely involved in programmes that support optimal development during early childhood. This study is significant in supporting caregivers and children in communities that experience factors which render young children vulnerable to poor future outcomes.

In so doing, it hopes to support the fight against poverty and the lifelong implications of poor future outcomes that poverty may have on those who live in and with it.

1.6 Scope of the study

This study takes place within the Eastern Cape province, which is a large and rural province with a population of 7 million, making up 12.6% of the total South African population (Statistics South Africa, 2016). The Eastern Cape province is characterised by high poverty rates with as many as 888,000 people living in poverty (Alexander, 2019; Statistics South Africa, 2016). These high rates of poverty are accompanied by high rates of unemployment and a general scarcity and inadequacy of resources to support high numbers of at risk families (Statistics South Africa, 2016; Azzi- Lessing & Schmidt, 2019). In addition to this, the province has the highest rates of women abuse in South Africa and spends the third largest amount on child protection caused by exposure of children to harmful circumstances (Fang et al., 2017; Statistics South Africa, 2017).

Presently ten percent of South Africa's children live in the Eastern Cape province, equalling around 250,000 children (Statistics South Africa, 2018b). In 2017, 989,318 new births were registered in South Africa, with 115,893 of these in the Eastern Cape province (Statistics South Africa, 2018b). This figure indicates that there are many young children in the Eastern Cape province with a great deal of them falling within the first 1,000 days of development. This study focuses on these young children who are within the first 1,000 days of development, a period stretching from conception until about 2 years of age, for whom there are very little supportive resources.

The importance of the first 1,000 days is widely acknowledged as being the most critical time of development; it is the time when the essential pathways for optimal brain development are laid and when health and environmental factors have the greatest influence on this development (Moore et al., 2017). The high rates of poverty in the rural context of the Eastern Cape province, the high number of young children in the Eastern Cape province and the critical importance of the first 1,000 days of development have all shaped the scope of this study.

1.7 Reflexivity

Qualitative researchers should be aware of their own personal and professional influences and how this might contribute towards bias during the research process. The researcher, as a foster mother, social worker and social work educator, remained aware

that her involvement both in caring for, working with and teaching about vulnerable children may influence the study. The researcher carefully guarded against this by staying in regular contact with the study's supervisor who provided input, guidance and assistance, in ensuring the credibility of the study.

1.8 Operational definitions

The operational definitions for the key terms used in the study are provided below.

1.8.1 The first 1,000 days

"The first 1,000 days of life – from conception until a child's second birthday – is increasingly recognised as a unique period of opportunity when the foundations for optimum health and development across the lifespan are established" (Bamford, 2019, p. 71). This term is used throughout the study to refer to the time from when the child is conceived until the child reaches 2 years 7 months of age.

1.8.2 Child/children

For the purposes of this study, the term child/children refer to the child/children from conception through to about 2 years of age, encompassing the first 1,000 days of development. For this study, the term includes the infancy, toddler and the beginning of the early childhood stage, as defined by Erikson's stages of psychosocial development (Donald et al., 2014).

1.8.3 Vulnerable children

Vulnerable children are children who experience inadequate caregiving, poor health, disabilities or limited access to quality early childhood services due to risk factors in their family or community (Republic of South Africa, 2015). For the purposes of this study, the operational definition of vulnerable children is children who are exposed to risk factors, such as poverty, disrupted caregiving, malnutrition, infectious or chronic diseases or maltreatment, during the first 1,000 days of life.

1.8.4 Early childhood

Early childhood can be regarded as the period from birth until 9 years of age but, in South Africa, it is generally regarded as the period from birth until 4 years of age (Kuhne & Fakie, 2019). For this study, the term early childhood is further refined to refer to the period from conception, extending throughout pregnancy and birth until the child is just over the age of 2 years, encompassing the first 1,000 days of life.

1.8.5 Early childhood development programmes

Early childhood development programmes are programmes that provide care, support and learning opportunities for young children. These programmes include play groups, outreach programmes at a household level, guidance and support for parents and partial care facilities (Republic of South Africa, 2015). Early childhood development programmes can also, at times, be referred to as early childhood programmes. For the purposes of this study, the operational definition of ECD programmes is programmes that support the child and caregiver during early childhood and can include those facilitated by professionals and paraprofessionals either in the home of the family, the community where the family lives or at a centre-based facility. In addition, the terms early childhood programmes and early childhood development programmes are used interchangeably throughout the study.

1.8.6 Child protection services

Child protection services are defined as “formal and informal structures, functions and capacities that have been assembled to prevent and respond to violence, abuse, neglect and exploitation of children” (UNICEF, UNHCR, Save the Children & World Vision, 2012, p. 3, as cited in Strydom et al., 2020). This study adopts this definition.

1.8.7 Prevention and early intervention programmes

Prevention and early intervention programmes are located within child protection services (DSD, 2006). For this study, these programmes are defined as programmes that work with caregivers and children empowering them so that families can be preserved and strengthened to care for and protect their children in an environment that is conducive to optimal and healthy development.

1.8.8 Home-visiting programmes

For this study, the operational definition of a home-visiting programme is a support service offered in the context of the home environment. This service is offered once or twice a week to encourage stimulation, learning and ensure good nutrition as well as linking families to other resources where needed (Republic of South Africa, 2015; National Planning Commission, 2015; Shumba et al., 2019). A home-visiting programme is thus preventative in nature and a form of early intervention where risk factors are identified.

1.9 Structure of the thesis

The following structure guides the writing up of the thesis:

Chapter one: Introduction

The introduction chapter provides an overview of the research study, including the research aim, objectives and research questions. It also outlines the research problem and the significance of the research.

Chapter two: Legislative and theoretical frameworks

Chapter 2 begins by outlining developments in international and national legislation and policies relating to early childhood and child protection. The biopsychosocial model, which is used as the theoretical framework, is then described. Lastly, its relevance to ensuring the optimal development of vulnerable children through a home-visiting programme that supports factors of biology, psychology and social and cultural well-being is presented.

Chapter three: Literature review

Chapter 3 begins with a discussion that explores early childhood as a life stage, and the development that occurs within this life stage. The protective factors that promote optimal development are critically examined as are the concepts of vulnerability during early childhood. Lastly, the chapter identifies and discusses home-visiting programmes that are already being implemented internationally and nationally to support vulnerable children and their caregivers. Throughout this chapter, the importance of investing in ECD to reduce inequality and ensure social justice within South Africa is highlighted.

Chapter four: Research design and methodology

Chapter 4 describes the research plan that was designed and implemented to guide the study, and the methods and procedures that were followed for sampling, data collection and data analysis. Included in Chapter 4 is the biographical data of the participants.

Chapter five: Needs and their outcomes for vulnerable children

Chapter 5 presents and discusses the findings that emerged in relation to the first objective of the study, which was to explore the needs of vulnerable children in the Eastern Cape province, and the potential outcomes when such needs are met. Two major themes emerged in this chapter; the needs of vulnerable children, and the

outcomes when such needs are met. These themes guided the findings that were presented in Chapter 5.

Chapter six: Risk factors and impact on vulnerable children

In Chapter 6 the findings and discussions that emerged in relation to understanding the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors is presented. This is the second objective of this study. Two major themes emerged in this chapter. They are the most common risk factors that vulnerable children are exposed to, and the consequent impact of exposure to such risk factors.

Chapter seven: Support offered to vulnerable children

Chapter 7 presents and discusses the findings that emerged in relation to the third objective of the study. This objective aimed to identify the ways in which vulnerable children are currently being supported in the Eastern Cape province. The themes that emerged in relation to this objective are the current support offered to vulnerable children, and the gaps in support offered to vulnerable children.

Chapter eight: Multidisciplinary workforce

In Chapter 8 a discussion of the findings that emerged in relation to the fourth objective of the study is presented. This objective was to determine the various professionals that are involved in an early childhood home-visiting programme and their roles and extent of involvement. One theme emerged in relation to this objective, which is the necessity of a multidisciplinary workforce to implement such a programme. This theme guides the findings that are presented in Chapter 8.

Chapter nine: Guidelines for an early childhood home-visiting programme

Chapter 9 draws from the literature presented in Chapters 2 and 3 and the findings discussed in Chapters 5, 6, 7 and 8 to present guidelines for an early childhood home-visiting programme that can be implemented to effectively support vulnerable children in the rural Eastern Cape province.

Chapter ten: Summary of findings, conclusions and recommendations

Chapter 10 concludes the study by examining whether the study achieved the overall aim and objectives and contributed to the production of new knowledge as the research

questions were answered. The limitations of the study are stated. Lastly, it makes recommendations drawn from the findings and with regards to future research.

1.10 Conclusion

Chapter 1 has introduced the study, outlined the research problem and presented the study's aim, research questions and research objectives. The significance and scope of the study was discussed, and the operational definitions and structure of the thesis was presented. Chapter 2 presents a critical review of legislation and policies relating to early childhood and child protection and presents the biopsychosocial model as the theoretical framework for the study.

CHAPTER TWO
LEGISLATIVE AND THEORETICAL FRAMEWORKS

2.1 Introduction

Chapter 2 provides both a legislative and theoretical framework for the study. It begins by outlining the developments in international and national legislation and policies that relate to young and vulnerable children. In addition, the challenges facing prevention and early intervention programmes in South Africa, despite having a relatively strong legislative and policy framework, are unpacked. Chapter 2 continues by presenting the biopsychosocial model as the theoretical framework for the study. The biological, psychological and social factors that form the foundation for the biopsychosocial model are critically examined within the context of early childhood, health, optimal development during the first 1,000 days and in relation to early childhood programmes.

2.2 Legislation relating to early childhood development

Early childhood development was recognised as a matter of importance by the South African Government as early as 1994, when the first democratic elections were held. Since then, legislation and policies, such as the United Nations Convention on the Rights of the Child, various white papers on social welfare and education and the Children's Act 38 of 2005 have passed through parliament, all foregrounding the importance of ECD services (Atmore, 2013).

More recently, *Transforming our world: The 2030 Agenda on Sustainable Development* was adopted by South Africa, and the South African National Curriculum Framework (NCF) for children from Birth to Four and the first National Integrated Early Childhood Development Policy (NIECD) was approved by cabinet (Dhlamini, 2016; Dlamini, 2015). Understanding the context of legislation and policy relating to ECD internationally and nationally is important as policy provides plans, actions and a system of governance that are there to ensure the best interests of the country's people (Moodly & Schmidt, 2019). Early childhood development legislation and policy thus influences the way in which ECD programmes are planned, implemented and funded. Some of the more influential legislation and policies that presently shape the programmes provided to children in South Africa are discussed in more detail below.

2.2.1 United Nations Convention on the Rights of the Child

Thirty years ago, South Africa, together with other world leaders, adopted an international agreement on childhood, the United Nations Convention on the Rights of the Child (UNCRC). The UNCRC makes a commitment to the world's children, acknowledging that every child in the world has rights (United Nations Children's Fund [UNICEF], 2019). Such rights are described as "what you should have or be able to do to survive, thrive and meet your full potential" (UNICEF, 2019). The UNCRC has given South Africa a platform from which to work in developing legislation and policies that relate to children and secure their well-being in South Africa. Some policies that acknowledge and flow directly from the UNCRC include the Children's Act 38 of 2005 and the NIECD, both of which protect and support the well-being of children in South Africa. The UNCRC and its "strong and dedicated focus to child rights in the international arena" does influence policy in the South Africa context (Moodly & Schmidt, 2019, p. 66) and may be used to advocate for future policies and programmes that support child well-being.

Despite the UNCRC, government has acknowledged that many children in South Africa lack access to ECD services, which negatively impacts upon the rights of the child as enshrined in the Constitution of the Republic of South Africa 108 of 1996 (the Constitution) and international agreements such as the UNCRC (DSD, 2014). Aligning South Africa to international conventions and laying a strong legislative framework for supporting optimal development of the child is of great importance but, at the same time, such a framework means nothing if there is not a consolidated effort to see early childhood programmes being sustainably funded to reach the most vulnerable of young children. With the high rates of poverty and the associated risk factors for the young child, South Africa has a long way to go in implementing the UNCRC and has acknowledged that inadequate ECD services is one of the challenges facing the country (DSD, 2014).

2.2.2 Global Agenda on Sustainable Development

The 2030 Global Agenda for Sustainable Development, as adopted by all United Nations (UN) member states in 2015, includes five categories that relate to: working in partnerships to prioritise social development, economic development, environmental sustainability and a peaceful and inclusive society (Dhlamini, 2016). These five categories are further refined and aligned to the 17 Sustainable Development Goals

(SDGs) that were set to achieve sustainable development by 2030 (United Nations, 2021). As a response to the SDGs and the pressure to meet the developmental needs of its citizens, South Africa has aligned its National Development Plan 2030: Our future – make it work (NDP) to the 2030 SDGs (Sekwati, 2016).

Resulting from the SDGs and the NDP, strengthening investments in ECD has again emerged as a key priority for the South African Government, particularly in relation to the category of social development (Motshekga, 2015). Targets relating to ECD can be seen throughout the SDGs and the NDP with the time before birth and the first few years of life being noted as the most effective and cost-efficient time to intervene (Motshekga, 2015). Both the SDGs and the NDP call for quality ECD services that support the holistic development of children regardless of who the child is or where the child lives (National Planning Commission [NPC], 2015). The importance of both the SDGs and the NDP for South Africa and early childhood programmes is that there is now both an international and national commitment made by all governments who are part of the UN to prioritise early childhood. This global social and political commitment may be used to advocate for the resources needed to implement early childhood programmes in communities where children continue to be exposed to risk factors associated with poor future outcomes.

2.2.3 White Paper for Social Welfare

The White Paper for Social Welfare, which was introduced in 1997 just after the beginning of democracy in South Africa, sets the scene for service delivery to be developmental and geared towards vulnerable groups, such as women, children and those effected by poverty (Republic of South Africa, 1997). It highlights the strong link between education, or the lack thereof, and poverty, where if the head of the home lacks education there is a strong likelihood that the household may experience poverty (Republic of South Africa, 1997). The policy adopts a life cycle approach and notes that programmes to support women during pregnancy, and children during early childhood, should be made available especially as young children are very vulnerable due to their dependency on care by adults. It is interesting to note that the lack of ECD services to the youngest children was also noted as being problematic some 20 years ago with such services in the rural areas being of particular concern.

This policy calls for a national ECD strategy that supports young children, in particular those from birth to 3 years of age, highlighting that a range of services from home to centre-based programmes initiated through community work interventions are needed. Furthermore, this policy acknowledges that social welfare should be involved in ECD services. Social workers can reach out to caregivers and young children, perhaps through community development initiatives, thus supporting the development of ECD programmes in communities where risk factors expose children to vulnerabilities during early childhood. The White Paper for Social Welfare prepared the way for social workers to work developmentally with communities to support vulnerable groups, such as women and children, and, consequently, has an influence on the ECD landscape in South Africa.

2.2.4 White Paper on Education and Training

Early childhood development is also acknowledged by the Department of Education as being crucial in supporting the future of the country and the development of disadvantaged communities (Republic of South Africa, 1995). The White Paper on Education and Training policy highlights the need for a multi-sectoral approach to ECD, with the Department of Education being responsible for the development of ECD policies and frameworks and the educational aspects of ECD programmes, such as curricula. The White Paper on Education and Training and the White Paper for Social Welfare were adopted and published more than 20 years ago. In both policies, attention is drawn to the vital importance of ECD programmes and the need to work with other disciplines to ensure that all young children receive the best start in life.

A person is then left wondering why quality ECD services and programmes remain inaccessible to the most vulnerable, with infrastructure and funding remaining problematic despite policy calling for such services to be urgently prioritised due to the impact of risk factors on the child during this period. It is, perhaps, worth asking if South Africa might have been facing a different developmental trajectory today had ECD services and programmes been prioritised when the policies were developed. Quality infrastructure and curricula, together with adequate funding for staff and nutritional programmes, should have been a direct consequence of the policies mentioned above, yet sadly, implementation of these policies has been problematic and slow. Perhaps the voices of our most vulnerable citizens, women and children, remain unheard even today after more than 20 years of democracy.

2.2.5 Children's Amendment Act 41 of 2007

The Children's Act 38 of 2005 gives effect to the rights of children and speaks to the care and protection of children in South Africa. In 2007, the Act was amended, and, among others, Chapter 6 was developed and gives responsibility for ECD services and programmes to the Minister of Social Development. The Children's Amendment Act 41 of 2007 states that it is the Minister's responsibility to develop an ECD strategy and to ensure the provision of ECD programmes. The Act highlights that ECD programmes in vulnerable communities should be prioritised for funding as should ECD programmes for children with special needs. The amendment also provides norms and standards for ECD programmes, and the process for registration of all ECD programmes is outlined.

While these norms and standards are necessary, they become problematic for more vulnerable communities as the programmes in such communities may be unable to adhere to such norms and standards, thus making funding challenging to access. For an ECD centre to receive funding from the DSD, the centre must be partially or fully registered, which requires the centre to adhere to the norms and standards as stated in the Act. Many centres in disadvantaged communities remain partially registered or unregistered because they are unable to conform to such norms and standards. In this way, the very Act that mandates the DSD to fund ECD programmes in vulnerable areas, continues to place such centres, and the children who attend their ECD programmes, at a disadvantage as they are unable to receive funding or subsidies. This is primarily due to the poor infrastructure within which they operate. However, it is such programmes, that while they may not meet the norms and standards required by the Act, they continue to provide a safe place for vulnerable children (Ilifa Labantwana, 2021).

From the amended Act, it is clear that it is the responsibility of the DSD to ensure that children access ECD services and programmes and that the funding for such services in vulnerable communities has to be prioritised. In reality, however, funding centres in such communities remains problematic (Ashley-Cooper & Atmore, 2013). More recently, the proposed amendments to ECD in the amended Children's Act 41 of 2007, which in no way resolved issues around accessibility or funding for early childhood programmes, were not accepted by parliament due to a lack of proper consultation with stakeholders and advocacy groups (South African Government News Agency, 2021a). Early childhood development stakeholders have welcomed the decision and have, at the same time, begun advocating for amendments around strategic areas that will make a variety

of early childhood programmes accessible to all young children as well as ensure sustainable funding for these programmes (Ilifa Labantwana, 2021). The proposed amendments will be important for non-centre-based programmes, such as home-visiting programmes, for which there are currently few registration or funding requirements in the Act (Hickman & Mathlape, 2021).

In addition, ECD stakeholders are advocating for an easy and user-friendly process for the registration and funding of all early childhood programmes as this may begin to make subsidised services accessible to the very children who need them (Ilifa Labantwana, 2021). With the amended Children's Act 41 of 2007, the requirements for the registration of programmes are complex and funding for these programmes is extremely difficult to access (Ashley-Cooper & Atmore, 2013; Ilifa Labantwana, 2021). These challenges will initially need to be addressed through legislation, such as the amendments to the Children's Act. Furthermore, once approved, these amendments will then have to be implemented by the DSD for other legislation and policies, such as the UNCRC, the NIECD, the SDGs and the NDP, to be realised, all of which highlight the importance of early childhood programmes to support the optimal development of vulnerable children.

2.2.6 National Integrated Early Childhood Development Policy

The NIECD outlines five priority programmes for development and funding to serve especially vulnerable groups of children (Republic of South Africa, 2015). Each of these is stated below and could be implemented as a part of a home-visiting programme. In addition, it is interesting to note that the programme priorities link to the biological, psychological and social factors of the biopsychosocial framework that support optimal development during early childhood. The five priority programmes are:

- Support for new parents and children under the age of 2 years
- Review and strengthen national food and nutrition strategy for children
- Provision of early learning opportunities for children from birth
- Inclusion and support for children with disabilities
- Public communication about the value of ECD.

Support for new parents and children under the age of 2 years, provision of early learning opportunities for children from birth, inclusion and support for children with disabilities and public communication about the value of ECD are social factors found within the

community of the child and family that support optimal development. According to the biopsychosocial model of health, which is discussed in more detail later in this chapter, if these social factors are strengthened and supported, then they will support the health and development of the vulnerable child (Morgan & Sotuku, 2019). This is confirmed by Prado & Dewy (2014) who state that brain development is heavily reliant on sources of stimulation during the first 1,000 days; a child needs to be taught social skills during this time.

The second programme priority is to review and strengthen a national food and nutrition strategy for children. This programme priority is integral to assisting vulnerable children achieve good health as the cell formation that occurs during the first 1,000 days is heavily reliant on good nutrition (Schmidt et al., 2019, as cited in Moodly et al., 2019). For healthy brain development during the first 1,000 days, good nutrition is thus essential. Programmes to ensure that all children are well nourished will be important if the development of children made vulnerable through poverty is to be optimised. The programme priority highlighting good nutrition speaks to one of the key biological factors that influences both development and good future outcomes.

Another important issue addressed by the NIECD is the funding, infrastructure and human resources needed for ECD services. The policy acknowledges that there needs to be increased funding for ECD programmes; infrastructure needs to be upgraded and an investment in the training of ECD professionals secured (Republic of South Africa, 2015). The financial commitment made by this policy is important as South Africa has one of the highest expenditures on education in the world, yet less than 2% of government spending is in the ECD sector – at a time when investments are most needed (Giese in Meterlerkamp, 2022). Each of these funding avenues is important if vulnerable children are going to be supported to achieve optimal development. Early childhood development programmes will need to be funded in a manner that is sustainable and cost efficient so that programmes can be developed and implemented on an ongoing basis by professionals in communities that have no access to ECD programmes. Infrastructure for centre-based programmes is also important as many ECD centres in disadvantaged communities, where the majority of vulnerable children are found, are in dire need of funds to ensure safe buildings and good sanitation for the children in their care (Atmore, 2013). The NIECD is integral to ECD in South Africa as it is the first ECD policy since democracy (Dlamini, 2015). This policy is important for this

study as it aligns to the theoretical framework of the biopsychosocial model. It recognises the importance of ECD and supports that a range of services are needed to support optimal development and good health during early childhood (Dlamini, 2015).

2.2.7 South African National Curriculum Framework (NCF)

Both the NCF and the NIECD policies are integral to the implementation of ECD services in South Africa. Both policies provide the first framework, since democracy, for the delivery of quality equitable ECD services and programmes to all children and their caregivers (Republic of South Africa, 2015). The South African National Curriculum Framework (NCF) provides a vision for all children in South Africa. It outlines the main areas of development for young children and suggests ways that adults can help children to develop (Department of Basic Education [DoBE], 2015). The NCF identifies three themes that are central to ECD; these are developing competency, recognising the importance of learning and the need for strong connections with adults (DoBE, 2015).

In addition to the themes noted above, the NCF outlines six early learning and development areas, each of which contains specific aims, developmental guidelines for different ages, suggested adult support and assessment opportunities (DoBE, 2015). These three themes, supported by the six early learning and development areas, provide a very practical framework for caregivers and professionals while at the same time are broad enough to allow for the incorporation of indigenous knowledge and culture. This framework is valuable in guiding ECD programmes and, for this study, is particularly useful as it can inform the contents of a home-visiting programme. Essentially, the NCF provides some guidance in terms of how children may be supported and guided throughout childhood towards optimal development and good health. The NCF also supports the interaction of good physical health and a safe social environment, which supports opportunities for learning for the child to develop optimally. The NCF thus aligns with the theoretical framework for the study. The importance of early childhood as one of the most influential development periods is explained in the section that follows as well as Chapter 3 of the study.

2.3 Theoretical framework: Biopsychosocial model

The biopsychosocial model finds its origin some 50 years ago and is noted for its significance in acknowledging the interactions between biology, psychology and the social environment of family and culture in order to better understand health, illness and

development (Cohen & Brown Clark, 2010; Fava & Sonino, 2008; Suls & Rothman, 2004). The biopsychosocial model was developed by George Engel in response to the shortcomings of the biomedical model, which viewed illness as purely biological or physical, ignoring to a greater extent the role of individual, family and community influences on illness or, alternatively, good health and optimal development (Fava & Sonino, 2008). Erikson's theory of development is another well-known theory that that speaks to the development of the child, also acknowledging the role of the caregiver in this development (Orenstein & Lewis, 2022). Again less attention is given to the wider social environment of the child, such as the culture into which they are born or the community and society within which they will be raised. While still of importance, these western theories, are being challenged to broaden their theories to include influences at a cultural, community, and societal level. Today, much research has been done that acknowledges the impact of the environment and, in particular stressful or chronic life events on health and well-being (Cardaso, 2013; Fava & Sonino, 2008; Lehman et al., 2017).

The biopsychosocial model has gained significance since its initial conception and remains relevant with adaptations noting the dynamic and ongoing influence that the environment has on health, illness and development over time (Fava & Sonino, 2008; Lehman et al., 2017; Shonkoff & Garner, 2012). These ongoing adaptations to the model, due to advances in science, support its relevance to health, illness and development in today's society.

The model has also been used to understand the factors that influence and work together so that children can develop optimally during early childhood (Horwitz & Neiderhiser, 2011; Morgan & Sotuku, 2019; Shonkoff & Garner, 2012). Science acknowledges that health in the early years – beginning with the mother even before she becomes pregnant and continuing during pregnancy and after birth – lays the foundation for a lifetime of the physical and mental vitality that is essential for responsible participation in society during adulthood (Shonkoff & Garner, 2012). Healthy development during the early years is thus of paramount importance to the future of the child but also to the future of the country and society.

It is important to state here that in this context, development is primarily understood as brain development as each individual's feelings, thoughts and behaviours are a reflection

of what is happening in that individual's brain (Boyce & Kobor, 2015; Metzinger, 2003; Morgan et al., 2014). Here, the attention given to brain development in early childhood starts to be understood as "you are your brain" and, with the rapid brain development that occurs during early childhood, it is important to do as much as possible to ensure that optimal brain development is understood and then supported (Morgan & Sotuku, 2019, p. 27). Due to the reciprocal relationship between brain development and development, the terms development and brain development are used interchangeably throughout the thesis. The biopsychosocial model proposes that the different biological, psychological and social factors work together, influencing one another from the time of conception to impact upon the development or brain development of the child.

Biology is not, however, always the determining factor (Calkins, 2011). As such, genetics alone will not determine the development of the child, but the child's development will be determined by genetics and, equally important, the environment in which the child is raised (Morgan et al., 2014). The implications of this theory is that the child's future feelings, thoughts and behaviour may be partly genetically predetermined but may, in addition, be shaped by the psychological and social environment in which the child grows. For this reason, it is important for any early childhood programme to address variables within each of these spheres of influence so that health or optimal development can be achieved. An early childhood programme that only supports variables within one of the spheres of influence may not be as effective as one that addresses and strengthens biological, psychological and social factors within the environment of the child. A practical example illustrating this point, is one where an early childhood programme supports early learning and stimulation, which is needed by all children, but offers no assessment or intervention in relation to biological, psychological or additional social factors that may be impacting the child's development.

If the biopsychosocial model is considered in this context, then such a programme may not be as effective as one that addresses factors across areas of biology, psychology and the social environment. Another example of the need for early childhood programmes to use the biopsychosocial model as the theoretical foundation for interventions is noted in a study by Van Niekerk et al. (2017). The study noted the lack of attention given to supporting and ensuring the physical health of young children in non-centre-based ECD programmes and recommends that a concerted effort is made to include health projects in such programmes. Such a recommendation would be

supported by the biopsychosocial model where biological factors, such as low birth weight, illness or disability, are acknowledged as key in determining well-being. Figure 1 outlines the different factors of the biopsychosocial model and the way in which these factors influence each other, ultimately supporting the health and development of the child and, according to this theory, the possible future feelings, thoughts and behaviours of the child.

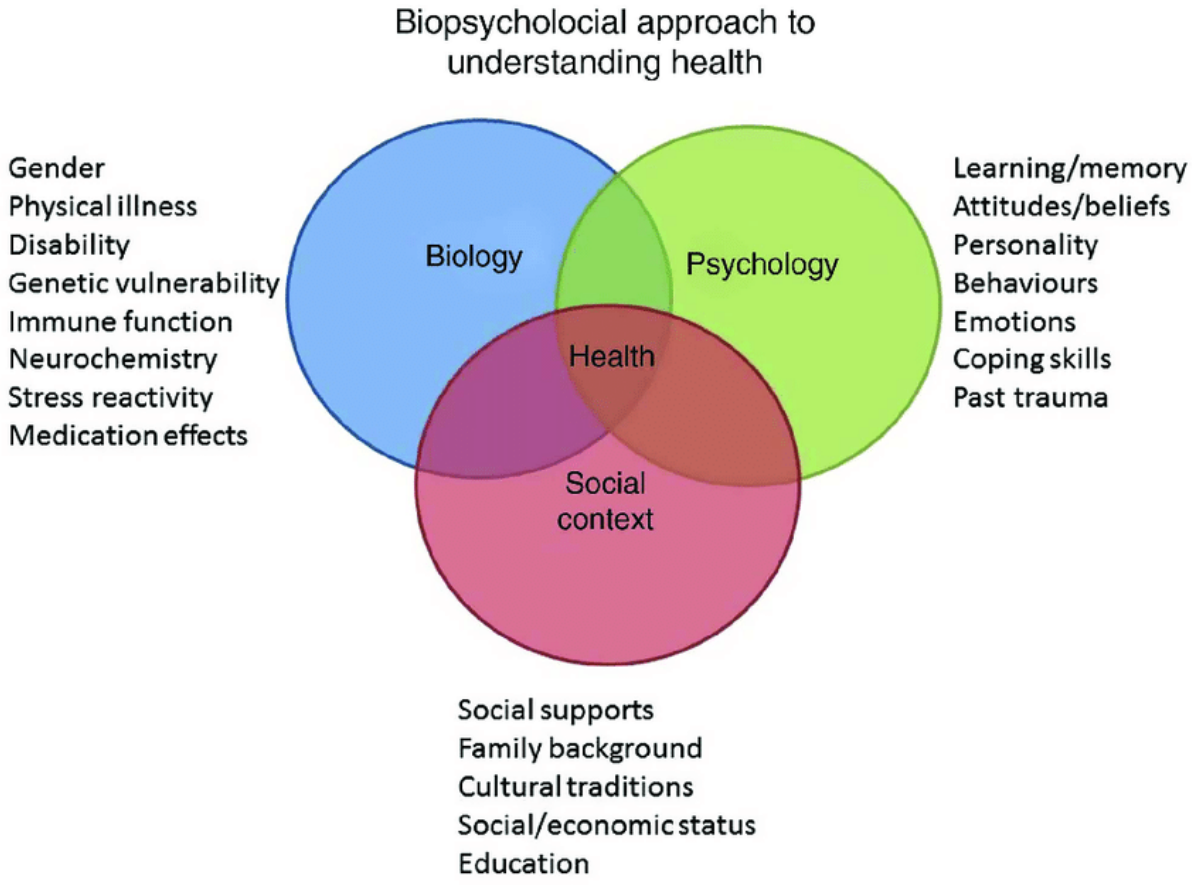

Figure 1: The biopsychosocial model (Perspectives Clinic, n.d.)

Figure 1 shows a clear overlap between the different factors of the model, with health at the centre and connected to each of the factors. Early childhood development programmes should, therefore, incorporate support within each of these developmental areas acknowledging that the interaction between these factors is of great importance if health and optimal development is to be achieved or if illness and poor development is to be understood (Santrock, 2007). The importance of these factors working together are again acknowledged when optimal supportive care during early childhood is outlined as consisting of five components, namely health care, good nutrition, nurturing caregiving and a safe environment with opportunities for learning (WHO, UNICEF & World Bank

[WB], 2018; Bamford, 2019). Each of these components can be closely connected to the biological, psychological and social factors of the biopsychosocial model and are discussed in detail later in the chapter. It is important to state that the level of overall health of young children, especially during the first 1,000 days, may be largely influenced by the biological, psychological and social well-being of their caregivers and that of the community within which they exist (Shonkoff & Garner, 2012). Any early childhood programme would thus need to support the well-being of the child as well as the caregiver and, to a certain extent, that of the surrounding community as it addresses the different factors of the biopsychosocial model.

While the biopsychosocial model holds relevance and is significant in understanding illness and good health during early childhood, there are also critiques of the model. As imagined, the challenge with such a programme and, by implication, the biopsychosocial model, is the vast number of resources that would be required for implementation. In the context of South Africa, a low-middle income country (LMIC), and that of the Eastern Cape, a predominantly rural province characterised by high rates of poverty, unemployment and a lack of resources (Azzi-Lessing & Schmidt, 2019), the challenge becomes even greater. Taukeni (2019) agrees that taking the biopsychosocial model from theory to practice presents some obstacles. Firstly, it may be time-consuming and thus expensive to apply in practice, requiring an in-depth assessment with vulnerable children and their caregivers (Taukeni, 2019). Secondly, the model calls for a multidisciplinary approach for which there may not exist sufficient resources, finances or training opportunities (Taukeni, 2019). In a LMIC, such as South Africa where this study is located, these obstacles may initially be challenging to overcome.

Research has, however, shown that an investment in early childhood is less costly for society in the long run (Bamford, 2019; Britto et al., 2017). In spite of these obstacles, using the biopsychosocial model for early childhood programmes remains especially effective due to the rapid brain development that occurs during this time period of the child's life, often setting the foundation for good future development (Motshekga, 2015). Suls and Rothman (2004, p. 119) acknowledge that the model needs more work to "specify the processes that connect the biological, psychological and social systems". Taukeni (2019) agrees that the cause and effect of interactions between illness, disease and psychosocial factors is complex and difficult to specify and that this may contribute towards the lack of practical guidelines for practice.

The significance of working with the biopsychosocial model for this study lies in the value it holds for developing a prevention and early intervention early childhood programme with specific and detailed guidelines which, according to critique, is one of the shortcomings of the model. Rather than disregarding the model for its shortcomings, the researcher feels that this study can assist in filling some of the gaps because the relevance of the model for optimal development during early childhood cannot be disputed. For optimal development, biological, psychological and social variables have to come together to support the child and caregiver. However, too many early childhood programmes fail to address these variables simultaneously.

Pilgrim (2015) adds to the critique of the model, stating that the model needs to include a more careful examination of the political and economic context at a societal level when considering illness and health. The author draws on the example of depression which may be caused (as per the biopsychosocial model) by psychosocial variables in the life of the individual. Alternatively, Pilgrim (2015) argues that an individual may have depression which, accompanied by its diagnostic symptoms, may then be causing challenges within the psychosocial environment for the individual. Here, Pilgrim dismisses the biopsychosocial model due to the lack of evidence for cause and effect preferring the model to be supported by the general systems theory which allows more flexibility around cause and effect, and which places more value on the political and economic factors and the power held on a macro level, which he feels ultimately influences illness and health.

A similar case can be made for the young child who sees a doctor because of illness. If viewed from the biopsychosocial model, the child's illness may be caused or influenced by psychosocial variables in the environment of the child, the family or community suggesting medical treatment together with other interventions at a family and community level. Pilgrim may, however, suggest that it is the illness itself which is causing trauma or stress for the child or their family and that with a medical diagnosis and treatment, the illness and consequently any psychosocial stress or trauma will be resolved. Pilgrim also adds that there may be insufficient political or economic will to resolve illness due, for example, to the large profits made by pharmaceutical companies who offer treatment without necessarily curing the illness. Both Pilgrim (2015) and Suls and Rothman (2004) agree that the social domain of the biopsychosocial model remains underdeveloped and is the least represented domain of the model in literature.

However, this domain, where interpersonal dynamics with family, work, peers, community resources, politics and economics are located, potentially exerts a great deal of power throughout the lifespan over the well-being and poor development of children, adults, families and communities. Despite critiques of the biopsychosocial model, it remains a dominant theory to understand illness and health, shaping interventions within health, psychology and the social sciences. In addition, it remains a model that is dominant in research and one that is evolving to address critique and shortcomings as they surface so that interventions can be strengthened to support overall good health and optimal development. Each of these factors, and the influence they have during early childhood as they interact with the environment of the child, will now be described in more detail below.

2.3.1 Biological factors

Factors relating to biology that impact upon the development of the child include genetics, immunity, illness and disability (Lehman et al., 2017). Such factors are the physical parts of the body, for example, the cardiovascular system, the lymphatic system and the immune system, each of which is made up of a complex system of cells and structures that affect and determine health (Lehman et al., 2017). Cardaso (2013, p. 1) agrees that biological influences include genetics and disease but adds that it also includes “physical injuries, nutrition, hormones and toxins”. These biological factors will play a role in determining the overall health and, of interest to this study, optimal development of the child. Some of these biological factors are genetically predetermined. For example, a child with a chromosomal abnormality that is inherited from a parent is a factor that is genetically predetermined. Other biological factors are not predetermined and can be influenced by the psychological and social environment from as early as conception. For example, a child who is exposed to alcohol, a toxin that is consumed by the mother during pregnancy, may develop foetal alcohol syndrome (FAS), a disability that results in the child having thought, emotional and behavioural challenges throughout their life. In such cases, the consumption of alcohol, a social factor, has had a biological impact upon the development of the child that was not genetically predetermined.

Considering the impact of the psychological and social factors on the physical health of the child, it becomes of utmost importance that the mother is supported during pregnancy. Such support could include education and guidance regarding nutrition, visits to the clinic for regular check-ups and support in avoiding environmental toxins that may

have a negative impact upon the biological development of the child. This support may optimise the child's biological well-being and overall development. While many may think that the child's formation and growth during pregnancy extending throughout life is primarily genetic, this is not true, as seen in the example used above; even during pregnancy, the environment has an impact upon the biological development and overall health of the child (Morgan & Sotuku, 2019).

Once the child is born, adequate nutrition and health care, such as regular check-ups and immunisations from the local clinic, can continue to support the optimal biological development of the child. It is especially important to ensure that vulnerable children are able to access adequate nutrition and the additional health care they may need to ensure optimal biological development during early childhood. The effects of the environment on the biological development of the child can be seen once again. Good nutrition and access to health care may be difficult to obtain for a child born into a family that experiences poverty within the social environment. This would have a negative impact on the child's biological development. For example, a child is born and at birth is healthy with no signs of a disability. After birth, the child returns home where the family lives in a very poor rural area and does not visit the clinic for his/her immunisations. The child contracts measles and, as a result of not being immunised, their immunity may become compromised. This may result in a disability, such as hearing loss. Here, the biological health of the child is influenced by the social factors in the child's family and community. The reverse may also be true; for a child born into a family that is financially stable, nutrition and health care may be accessible and relatively easy to achieve, thus supporting optimal biological development. The psychological factors of the biopsychosocial model will be explained in the section that follows.

2.3.2 Psychological factors

The different factors of psychology that have an effect on overall health include personality, mood, behaviour and trauma (Lehman et al., 2017). The biopsychosocial model acknowledges these factors and the influence they have in determining the optimal development of the child in the early years of life. For vulnerable children, healthy development may be challenging as they often face circumstances that threaten their psychological well-being. Psychological stress can be caused by abuse, neglect, depression, substance abuse, violence or extreme poverty and, in such circumstances, it is essential to have a good support system in place if the child is to develop optimally

(Republic of South Africa, 2015). The interplay between social factors and psychological factors, and the overall effect this has on the healthy development of the child can again be seen. For example, a child may be more stressed if they live in a home where there is poverty accompanied by child maltreatment. The child then fails to thrive, and the optimal development of the child is threatened (Morgan & Sotuku, 2019).

Situations of poverty are also often accompanied by high rates of child maltreatment. In situations where parents and children experience ongoing distress, their psychological well-being is compromised and can result in poor biological health and poor future outcomes for the child (Republic of South Africa, 2015). For example, a young child who is emotionally abused or neglected and suffers stress as a result may fail to thrive physically despite being given enough food to eat. As such, the psychological factors are impacting upon the health and biological development of the child. Vulnerable children and their caregivers should have a good support system, either through friends, family or professionals, such as nurses or social workers, to ensure their psychological well-being (Simandla, 2014). Once again, the interaction between social factors, such as having a good support system, and psychological factors, such as feeling secure and in control, and the effect this has on the optimal development of the child, are seen. The social factors and the influence that they have on biological and psychological well-being as well as overall development and health are explained in the following section.

2.3.3 Social factors

Social factors influencing health and well-being can include interpersonal, family and community support systems, culture and economic status (Lehman et al., 2017). It is important to acknowledge that the development of the child and their overall health will be influenced by the relationships that they have with caregivers, the culture within which they are raised and the community where they live. Acknowledging this influence is of critical importance if human health and for this study, child health, is to be understood and supported (Cohen & Brown Clark, 2010). The particular or specific social factors that influence health and optimal development is one of the areas of the biopsychosocial model that continues to be researched and defined. Lehman et al., (2017) suggest that the biopsychosocial model draw on Bronfenbrenner's ecological systems perspective to further define social factors as micro-, meso-, and macro level variables influencing and being influenced by illness or good health. Here the role of nurturing and protective

caregiving and the role of family, culture and community is acknowledged and the impact that it has on the health of the child is recognised.

Living in a social environment that is supportive and protects children from vulnerabilities is central to the optimal development of all children. This can be challenging in a country, such as South Africa, where many communities experience poverty, children may be exposed to violence on a regular basis and substance abuse resulting in FAS is on the rise (Hall et al., 2017). In these circumstances, the social environment within the home and the surrounding community may have an effect on the health of children and may not support the optimal development of the child (Republic of South Africa, 2015). The biopsychosocial model supports that the social environment of the family and community where the child lives has an impact on the well-being of the child. For example, if the child and caregiver reside in a community where there is a high rate of substance abuse, and the mother participates in such social activities throughout her pregnancy and after the child is born, this social factor may result in the child having FAS which, as stated before, may result in the child's overall health being compromised.

In the rural Eastern Cape province, where the traditional Xhosa culture dominates, the cultural beliefs and traditions can have an effect, both positively and negatively, on the development of vulnerable children. Nsamenang (2008) describes early child development in an African context as the process of growth within the physical, cognitive, social and emotional developmental areas, resulting in the moral maturity required to participate in society. It is, therefore, clear that from an African perspective, optimal development during early childhood encompasses many different areas of the parent and child's functioning, as described in the biopsychosocial model.

Ultimately, the approach taken to ECD programmes can be shaped around the holistic development of the child, which is based on universal knowledge that there needs to be a healthy interaction between biology and psychology, with ECD programmes responding to the culture of the family and society in which they live (Gatchel & Oordt, 2003). In this way, the biopsychosocial model as a theoretical framework embraces the interacting role that biology, psychology and social factors play in shaping the health of children. Once the factors that influence the development of the young child are understood, the different components that may be needed for a home-visiting programme can be developed. In addition to this, a contextually based home-visiting

programme may need to be shaped in response to the social factors that exist within the particular community where the programme will be implemented. Early childhood home-visiting programmes may thus have to provide support to vulnerable children and their caregivers in the three areas as outlined by the biopsychosocial model in order to effectively support the healthy development of the child.

2.4 Conclusion

Chapter 2 has presented the legislative and theoretical frameworks for the study. It is clear that both international and national legislation supports early childhood as a critical period of development and calls for programmes to support development during this period. It is also clear that despite a strong legislative framework, South Africa has a long way to go in implementing such legislation so that the most vulnerable children are able to access quality ECD programmes. The biopsychosocial model was critically examined and presented as the theoretical framework for the study. This model outlines the impact that biological, psychological and social factors have on the health of the child. However, despite critique, the model is well situated to support optimal development during early childhood and, as such, a home-visiting programme to support vulnerable children. Chapter 3 presents a literature review that takes a close look at issues relating to early childhood. Risk and protective factors for vulnerable children are unpacked and the different ECD programmes that can be offered to support vulnerable children are explored.

CHAPTER THREE
LITERATURE REVIEW

3.1 Introduction

In Chapter 3, a literature review is presented. The literature review as a research methodology has grown in relevance and is explained as the gathering and analysis of research pertaining to the topic of the current topic (Snyder, 2019). For this study the researcher conducted a semi-systematic literature review. This involved searching across data bases and disciplines for empirical evidence in relation to the study's research questions (Davis, et al., 2014). Themes were then identified, logically organised and critically analysed. For this literature review, the importance of early childhood as a critical development stage is argued, protective factors for the optimal development of the child during this stage are highlighted and supported, while the concept of vulnerability during early childhood and its devastating consequences are examined. Lastly, the chapter identifies and examines home-visiting programmes that are already being implemented internationally and nationally to support vulnerable children and their caregivers during early childhood. Throughout the chapter, the importance of investing in early childhood to reduce inequality and ensure social justice within South Africa is highlighted.

3.2 Understanding the importance of early childhood

Numerous researchers, globally, and from many different disciplines, such as science, education, social development and health, argue that early childhood is an extremely important life stage as the development that occurs during this period sets the foundation for future and ongoing development and learning. In the last 10 years, neuroscience has, for example, noted how nature and nurture interact during the first 1,000 days to influence long-term brain architecture (Morgan & Sotuku, 2019). The Department of Basic Education has noted that "the first 1000 days (pre-birth, early and late infancy) of life are highly sensitive to environmental effects" (Motshekga, 2015, p. iii). The Department of Social Development has declared that the government is fully committed to ensuring that all children, especially vulnerable children, have access to early learning opportunities as a wide range of research has shown that such opportunities make a real and lasting difference in children's lives (Dlamini, 2015). The Department of Health has improved their provision of public services to all children under 3 years of age in

recognition of the importance of health during the early years (Slemming & Salojee, 2013).

For this reason, almost all South African government departments have some responsibilities towards ECD (Republic of South Africa, 2015). The first 1,000 days, starting from conception and continuing in the first 2 years after birth, offer “a unique and invaluable window of opportunity to secure the optimal development of the child, and by extension, the positive developmental trajectory of a country” (Republic of South Africa, 2015, p. 16).

Good physical and emotional health of the mother and child during pregnancy and the first 2 years of the child’s life supports optimal brain development, setting the foundation for good future cognitive, physical and emotional development throughout the child’s life (Morgan & Sotuku, 2019). Early childhood is a critical time in life when the brain develops at the most rapid pace, exhibiting a high capacity for change and growth and setting the foundation for future development. It encompasses the physical, socio emotional, cognitive and motor development that occurs in a child (WHO, 2018). The literature above reflects and highlights the importance of early childhood as the time where the foundations for future good outcomes are set. However, it should be noted that early childhood is not the only time that children need adequate care and protection. Children require this support in varying forms and degrees up until the age of about 20 years old, when the brain is fully developed (Morgan & Sotuku, 2019).

To understand the importance of early childhood in setting the foundations for good future outcomes is critical. However, understanding that investing in the ongoing development of a better economy and health and education systems in South Africa is just as critical. Motshekga (2015) confirms that during the first 1,000 days, the child is “highly sensitive to environmental effects” (p. iii) and other scientists agree, and warn that such sensitivity extends beyond the first 1,000 days as environmental influences are ongoing (Cameron et al., 2005; Morgan & Sotuku, 2019). To ensure a good future for South Africa, further investments in early childhood have to be made. It must, however, also be acknowledged that for such investments to be sustainable, the environmental influences of poverty and its accompanying social ills have to be addressed or the investment in early childhood will be wasted.

In order to best understand the rapid development that occurs during early childhood and, more specifically, within the first 1,000 days, it is important to understand brain development as it forms the foundation for cognitive, emotional and social development during this developmental stage and all other stages that follow.

Brain development occurs in the early years of life, more so than before birth. The environment in which children live greatly influences their future success in cognitive development which, in turn, ultimately influences their future success in education, employment and life in general (Azzi-Lessing, 2017; Blair & Raver, 2012; Burton & Metcalfe, 2014; Shonkoff et al., 2012; Tomlinson et al., 2020). Here, the biopsychosocial framework and the interconnectedness of experiences and the social environment on the biological development of the child is again highlighted. According to Azzi-Lessing (2017), where a child is raised in an environment that is adequately resourced and the child is well cared for and protected from harm, optimal brain development will be supported. This will then support development in all other areas for the young child right through to adulthood.

Brain development relies on both genetics (biology) and the psychological and social environment that the foetus and young child is exposed to; nurturing and responsive care results, over time, in self-regulation and a child who is cognitively strong and healthy in emotional and behavioural control (Morgan & Sotuku, 2019; Tomlinson et al., 2020). These capacities are foundational for developing the skills needed to be effective in the both the work environment and social contexts that are essential for success in adulthood (Morgan et al., 2014). The opposite is also then true; where children are exposed to toxic environments and inadequate care and nurturing consistently over time, the brain will focus more on survival and less development will occur in the area of self-regulation, ultimately affecting the potential for future healthy cognitive, emotional and behavioural development (Morgan & Sotuku, 2019; Tomlinson, et al., 2020).

Neuroplasticity is a major factor for the extensive development of the brain during early childhood and is thus important to understand. Neuroplasticity, which is the ability to shape, change and develop the brain and behaviour, is extremely high and responsive to the environment during early childhood and becomes difficult to change later in life (Heckman, 2006; Morgan & Sotuku, 2019). Neuroplasticity and the responsiveness of the brain to good care and protection during the early years is one of the main reasons

that the international community and South Africa is determined to ensure a good quality of ECD services to the youngest children and their caregivers.

In a country like South Africa, where poverty rates are high and often accompanied by high rates of child abuse, neglect, maternal distress, family and community violence and crime, good quality equitable ECD services can act as a buffer for young children against the toxic stress they are exposed to within their social environments. The term buffering is used “to describe the nurturing care that an adult gives an infant” (Morgan & Sotuku, 2019, p. 31). When such care is not offered within the home or community where children live, it can be offered by an ECD practitioner within a safe and nurturing ECD programme, thus supporting optimal development and buffering the toxic stress experienced in the family or social environment. Early childhood is thus an important time in any child’s life due to the rapid brain development that occurs. For vulnerable children, quality interventions during early childhood become especially important due to the responsiveness and potential of brain development during this period. Such interventions may be essential in supporting social justice in South Africa so that intergenerational cycles of poverty and poor outcomes can be broken, and each child has, at least, an opportunity to achieve their full potential.

3.3 Protective factors during early childhood

It is important to acknowledge that optimal cognitive, physical and emotional development during early childhood occurs within an environment that promotes strong brain development (Republic of South Africa, 2015). Environmental factors that enhance and support brain development during the first 1,000 days are known as protective factors. The different protective factors, such as good health and nutrition, nurturing and responsive care and access to safe and quality learning opportunities, all of which play a role in supporting optimal development during early childhood, are described in more detail below.

3.3.1 Good health and nutrition

Good health and nutrition during the first 1,000 days begins with good maternal health and nutrition during pregnancy (Hall et al., 2017). As such, ensuring that all pregnant mothers are in good health and adequately nourished is one of the priority actions supported by the government in an effort to support optimal development during early childhood (Symington et al., 2018). If the mother is well nourished and healthy during

her pregnancy, then the foetus is able to develop well in utero and the scene is set for future optimal physical and mental development that continues throughout childhood and into adulthood (Barker, 1997, 2001, 2007; Kaiser & Allen, 2008). Here, the biological factors of the biopsychosocial framework come into play even before the child is born, with the good health and nutrition of the mother playing a role in determining the biological development of the foetus and, to a certain extent, laying the foundation for good future development. Although pregnancy is not the only time that good health and nutrition is important, it is the beginning of the first 1,000 days and, as such, an important time in the development of the child. As a protective factor, good health and nutrition would thus have to be supported during pregnancy and not only once the child is born.

Ensuring good health and nutrition continues once the child is born and remains especially important throughout early childhood. When children are fed when they are hungry and they are eating nutritious food, then they are well nourished and healthy and able to be physically active and to learn (DoBE, 2015; Mkhwanazi et al., 2018). Exclusive breast feeding for the first six months is also promoted as it supports good health and nutrition of the child (Republic of South Africa, 2017).

Good health during early childhood is, therefore, closely related to nutritious food as well as regular visits to the clinic to monitor growth and receive their immunisations and being in a safe and secure environment that is clean and hygienic (DoBE, 2015). The importance of good nutrition, protection from disease and health care for children when they are sick or injured is again highlighted by the new *Road to Health* booklet, issued by South African clinics to each child when they are born (Slemming & Barnford, 2018). This booklet emphasises that for a child to grow and develop, good health and nutrition are important. All children need to have access to nutritious food in order to develop optimally and to remain physically healthy. The reverse is also true, as where a child has good health, their body is able to absorb the nutrients needed to develop optimally and remain healthy.

In this way, good health and nutrition work together as protective factors supporting optimal development during early childhood. Well-being during early childhood is closely related to being well nourished and enjoying good health and when children experience this, they are able to thrive in their development and learning (DoBE, 2015). Lastly, when a child has good health and is well nourished, they become strong and resistant to daily

stresses, developing resilience, which is essential to future well-being (DoBE, 2015). The role good health and nutrition play as protective factors during the first 1,000 days of early childhood is clearly highlighted.

3.3.2 Nurturing and responsive caregiving

Accompanying good health and nutrition, having a healthy attachment with a caregiver is an essential protective factor during early childhood. While good health and nutrition may be dependent on the caregiver's socio-economic status, nurturing and responsive caregiving does not have to be. Regardless of their socio-economic status, a caregiver can be nurturing and responsive, supporting the optimal development of the child during the first 1,000 days. Healthy attachments are built on nurturing and responsive care. A healthy attachment is understood as one where the child has a close and strong relationship with a caring adult who is concerned with the child's well-being (Sotuku & Schmidt, 2019, as cited in Moodly et al., 2019). The extent to which the child experiences this attachment and the associated nurturing and responsive care during the first 1,000 days will have a significant effect on their future overall development and well-being (Mathews & Gould, 2017).

Nurturing caregiving can be described as warm, caring, non-judgemental, empathic parenting where a parent shows understanding and allows the child to express themself, responding appropriately to the emotions expressed by the child (Morgan & Sotuku, 2019). A responsive caregiver engages with the child, implementing a "serve and return" type of interaction (Sotuku & Schmidt, 2019). This serve and return interaction is compared to a tennis game, where the child interacts (serve) and the parent responds (return) appropriately, thus engaging with the child and securing attachment and nurturing and responsive caregiving (Sotuku & Schmidt, 2019). Such parenting supports optimal brain development, resulting over time in a child who is able to remain calm and is well developed cognitively, socially and emotionally (Morgan & Sotuku, 2019). Here the biopsychosocial framework, the interplay between biology and the influences of the social environment in which the child lives, and the impact of this interplay on the psychological development of the child are seen.

The integral importance of nurturing and responsive caregiving during the first 1,000 days is highlighted by the various sources drawn on in this section. It has a biological impact upon the development of the child's brain, which then affects future psychological

well-being. After all, the brain is who we are and every thought, emotion and behaviour reflect a process that is occurring within the brain (Boyce & Kobor, 2015; Metzinger, 2003; Morgan, 2013; Morgan & Sotuku, 2019). A child who is well cared for and loved will be a happy child who is able to develop optimally in all areas. While nurturing and responsive caregiving is not dependent on socio-economic status, it must be acknowledged that a low socio-economic status may be accompanied by environmental stresses that impact upon good caregiving. Caring for children is hard work, both physically and emotionally, and may be stressful especially if the caregiver is faced with additional challenges, such as poverty, violence or health issues (Mkhwanazi, et al., 2018). In such instances, programmes that engage meaningfully with caregivers to support them in the challenges that they face while at the same time promoting nurturing and responsive caregiving may be a real source of support for caregivers.

3.3.3 Access to safe and quality early learning opportunities

Access to safe and quality learning opportunities for children during the first 1,000 days are identified as protective factors as they provide support to caregivers who are faced with the daily hard work of caring for children (Mkhwanazi et al., 2018). Safe and quality learning opportunities can either be offered through non-centre-based ECD programmes or more formal centre-based ECD programmes. Non-centre-based ECD programmes may be more suitable for caregivers who have no formal employment, while centre-based ECD programmes may be more suitable for those who are in formal employment. Either option can become a protective factor for both the caregiver and the child if the programme is of good quality. Rowlands (2010) outlines the following key components for an ECD programme so that it presents a safe and quality learning opportunity to the child and caregiver:

- Working holistically from a strength-based perspective: A successful ECD programme recognises that the child and caregiver live in a community that shapes learning and parenting. Furthermore, a successful ECD programme is able to recognise that all children and caregivers have strengths that enable them to survive in the most challenging circumstances.
- Working to empower families: A successful ECD programme works with the family, respecting their self-determination and individualisation, listening to their stories and supporting them to make good decisions for themselves. To realise

this, a strong relationship should exist between the facilitators of the programme and the child and caregiver.

- Working in the environment of the caregiver and the child: A successful ECD programme reaches out to families in places where they already spend time and is not dependent on a specific site for service rendering.
- Working to build relationships with the broader community: A successful ECD programme knows and understands the resources in the community and is able to refer families or bring these resources to the programme as and when they are needed.

The factors that support the success of ECD programmes are important to acknowledge because a child is highly sensitive to environmental factors during the first 1,000 days (DoBE, 2015). This sensitivity makes access to safe and quality learning opportunities of the utmost importance. As a protective factor, a quality ECD programme should offer the child an environment where they are safe from harm and free to develop and learn. Safe and quality learning opportunities allow children to begin to make meaning of the world. Local and indigenous knowledge and skills must be used to promote learning, while at the same time, enhancing learning through hands-on active experiences should be encouraged (Aubrey, 2017). The opportunity to play in a safe environment supports the child's emotional development and will, in turn, affect the child's physical, cognitive and social competence (Lester & Russell, 2010).

Opportunities for early learning and stimulation are crucial for a child's development and, together with nurturing care, can build on the foundation of good nutrition and health, supporting the child towards optimal future development (Britto et al., 2017; Engle et al., 2011; Walker et al., 2011). Here the authors highlight the critical interplay between the protective factors during early childhood, which also speak to the biological, psychological and social factors of the biopsychosocial framework. Quality and safe learning opportunities within the social environment of the young child will be most effective if the child's physical and attachment needs are being met, resulting in a child who has the energy and enthusiasm needed to engage in learning opportunities. During early childhood, as described by the biopsychosocial framework, good health and nutrition, together with nurturing care and quality and safe opportunities for stimulation and learning, work hand in hand, supporting the overall optimal development of the child.

3.4 Vulnerability during early childhood

While the importance of early childhood and the protective factors needed for optimal development during the first 1,000 days are outlined above, it is important to note that the realisation of this development is dependent on “the quality of the biological, social and economic environment” in which the child exists, especially during the first 1,000 days (Republic of South Africa, 2015). If South Africa is knowledgeable about these protective factors and wishes to ensure that each child gets the best future opportunities that they can, why then do so many young children remain vulnerable to poor future outcomes?

Vulnerability during early childhood results from exposure to risk factors, such as poverty, inadequate care, malnutrition, maltreatment or disease (Tomlinson et al., 2020), with children often experiencing multiple risk factors simultaneously, further compounding the chance of poor future outcomes (Republic of South Africa, 2015). Each of these risk factors can occur within the biological, psychological or social context of the young child and often overlap within these different areas. This ultimately has a negative effect on the health and development of the child, as outlined by the biopsychosocial framework described in Chapter 2 of the study. Despite knowing what is needed to support optimal development in young children in South Africa, an estimated 43% of children under 5 years of age are not achieving their full developmental potential due to exposure to various risk factors during early childhood (Black et al., 2015).

The Adverse Childhood Experiences Study (ACES) outlines the devastating long term consequences of exposure to risk factors, such as maltreatment, during early childhood (Norman, et al., 2012; Stevens, 2012). Such outcomes may include chronic and serious illness, mental health challenges and being predisposed to risky behaviours during adulthood all of which are costly for the government to treat and manage (Anda et al., 2008). The acknowledgement of this study here, is critical, as it recognises the long term and costly effects of exposure to risk factors during early childhood. The exposure to risk factors during early childhood may thus have devastating immediate and long term implications for the child. The different risk factors, and the impact they have on the development of the child, are discussed in more detail in the sections that follow.

3.4.1 Poverty

One of the risk factors that is indicative of poor childhood experiences is identified as poverty (Republic of South Africa, 2015). Poverty is also noted as the main underlying cause of poor development during early childhood, which is alarming as ongoing exposure to poverty and hardship in the first year of life have a devastating and lasting effect on brain development and, consequently, cognitive functioning (Center on the Developing Child, 2007; Republic of South Africa, 2015). Poverty is understood as the lack of resources, and a lack of resources ultimately holds the individual back from developing optimally. Poverty can be absolute, where basic needs, such as food and shelter, are not certain or poverty can be relative, where basic needs are certain, but there is still a lack of resources in comparison to others (Swanepoel & De Beer, 2011).

In South Africa, poverty is classified according to three categories. The food poverty line is measured at R557 per month and indicates the amount of money needed to meet the minimum nutritional intake for one person (Statistics South Africa, 2018a). The lower-bound poverty line is measured at R785 and includes the amount needed for minimum nutritional intake as well as some basic necessities for living (Statistics South Africa, 2018a). The upper-bound poverty line is measured at R1183 per month and, as with the lower-bound poverty line, includes the amount needed for minimal nutritional intake as well as a few more of the basic necessities for living (Statistics South Africa, 2018a). Garcia, Virata and Dunkelberg (2008) highlight that Africa has the highest rates of absolute child poverty in the world, with high percentages of children being deprived of shelter, water, education and health.

Currently 11 million children in South Africa live in poverty (DSD, 2018). Having acknowledged that children are one of the groups most vulnerable to poverty in South Africa, the child support grant (CSG) was introduced as the “flagship poverty reduction programme for children” (Patel et al., 2017). However, if the food poverty line is acknowledged in families where no one is employed, even the CSG of R480 is unable to meet the basic nutritional intake for a child, exposing them to risk factors that may jeopardise optimal development during early childhood. For the 2 million children who are eligible but do not access the CSG, their vulnerability may be even greater as the CSG may help in some ways to mitigate the effects of poverty.

Swanepoel and De Beer (2011) outline the following implications of poverty for the young child:

- Safe and secure shelter is difficult to access, which could affect the health of the young child.
- Nutritious food and health care is difficult to access during pregnancy and after birth; this negatively effects the development of the baby, exposing the young child to malnutrition and disease.
- Accessing clean water and sanitation becomes problematic, resulting in poor health for the young child.
- Poor nutrition makes it difficult for the young child to grow and learn, and this may continue as the child enters primary and secondary schooling.

Poverty is a social risk factor for children. It impacts upon their biological and psychological development with the most significant impact occurring in early childhood. Here the relevance of the biopsychosocial framework for understanding vulnerabilities during early childhood, and the interplay between biology, psychology and social factors upon the healthy development of the child, is seen. Poverty in the social environment of the child can lead to poor biological development caused by malnutrition, which makes children more susceptible to infectious diseases and poor cognitive outcomes.

In the same way, poverty can result in poor psychological development, caused by the stress often experienced by families who face poverty on a daily basis. This stress is the toxic stress that was referred to in Section 3.2. Such stress can have a negative effect on the development of the brain during early childhood. Poverty is often accompanied by other vulnerabilities, with children experiencing multiple vulnerabilities at once. This makes poverty one of the most devastating and complex risk factors that the young child can be exposed to during early childhood; as such, it is a risk factor that will need to be explicitly addressed within any ECD programme, particularly in South Africa and rural provinces, such as the Eastern Cape province, where poverty rates remain alarmingly high.

3.4.2 Disrupted caregiving

Disrupted caregiving is understood as a situation where the parents of a child are absent due to abandonment or illness, resulting in the child being left alone or with non-parent

caregivers (Republic of South Africa, 2015). Abandonment occurs when a parent has been absent and has not had contact with their child for a period longer than 90 days (Republic of South Africa, 2005). Parental absence could be caused by the death of a parent, disease or the abuse of substances which then results in the child being cared for by either extended family, an older child in the family or a foster parent (Schmidt et al., 2019, as cited in Moodly et al., 2019). Between 30% and 40% of South African mothers suffer from depression, a form of mental illness, either during pregnancy or after giving birth (Perinatal Mental Health Project, 2022).

In South Africa, some 3,000 children are abandoned every year (National Adoption Coalition of South Africa, 2017) and 14% of all children are orphaned (Hall et al., 2018), with many others experiencing disrupted caregiving due to the high rates of disease, violence and motor accidents (Mogotlane et al., 2010). Disrupted caregiving during the first 1,000 days is especially concerning due to the vulnerability of the child and the dependence of the child on others for care and protection. If nurturing and responsive caregiving are associated with good future outcomes, and attachment with a warm and responsive adult is associated with good future cognitive and psychosocial development (Nutbrown, 2011), then the implications of disrupted caregiving during early childhood may be detrimental for the young child.

Attachment theory originally proposed that the young child should be attached to one mother figure. However, later research has shown that a child is capable of having multiple motherly attachments with no negative effects provided such attachments are nurturing and caring (Nutbrown, 2011). In the South African context, this is reassuring as many young children spend time away from their biological parents. Currently, 20% of children in South Africa do not live with either biological parent (Hall, 2019). This number increases in the Eastern Cape province where 33% of children do not live with either biological parent (Hall, 2019). The outcome for these children is not necessarily negative as many children in South Africa are raised by extended families. However, it should be noted that in 20% of the poorest South African households, children are not living with either of their biological parents (Hall, 2019). This indicates that there is some correlation between poverty and a child not living with their biological parents. This becomes problematic as severe poverty makes it more challenging for the caregiver to care for the child and to meet all the needs of the child. Disrupted caregiving is not, therefore, where the child is not cared for by their own biological parent – rather it refers

to a situation where the caregiver, whether a parent, an extended family member or an ECD practitioner, is unable to protect, nurture and care for the child for whatever reason that may be. Biersteker and Kvalsvig (2007, p. 181) note that disrupted caregiving "has adverse consequences for the child's survival, health and development" and note that disrupted caregiving could be caused by maternal illness, depression, stress, mood or emotional state, poverty, domestic violence or substance abuse. Disrupted caregiving thus remains a risk factor that can place a child at risk for poor future outcomes. Any ECD programme for vulnerable children should, therefore, support caregivers to provide the best care they can to the child so that the child is not exposed to disrupted caregiving.

3.4.3 Malnutrition, illness, disease and disability

South Africa has high rates of infant mortality with 34 of every 1,000 children dying before their fifth birthday (Dorrington et al., 2018). Over one third of all childhood deaths are related to undernutrition, which could be prevented at a household level (Richter et al., 2018). This is an unacceptable reality for children in South Africa and one that indicates the country has a far way to go in reaching the sustainable development goal of ending hunger by 2030. In 2017, 12.3 million South African children reported sometimes, often or always having experiences of hunger, indicating that 12% of all children have experienced some sort of hunger as part of their daily lives (Hall et al., 2018). While this is a significant number of children, it may not be indicative of nourishment as children may be fed but are malnourished, depending on the quality of food that they are consuming. Of concern is that 820,000 children under the age of 5 have experienced hunger, which places them at risk for undernutrition, making them susceptible to stunting, disease and malnutrition if this occurs over a prolonged period of time (Hall et al., 2018). In South Africa, it is widely known that infant mortality rates are 68/1,000 and the under-five mortality rate is 55/1,000 with between 25% and 33% of all children experiencing stunting due to malnourishment (Garcia et al., 2008; WHO, 2018).

Malnutrition is understood as an imbalance between nutrient requirements and intake and can be caused either by illness or the environment and behaviour (Metha et al., 2013). Indicators of malnutrition in the young child include poor growth, developmental delays, muscle weakness, illness, poor immunity, delayed wound healing and hospital admission (Metha et. al., 2013). While one third of all childhood deaths are due to malnutrition, many more children survive but experience the lifelong negative effects of

malnutrition. This makes children vulnerable to poor future outcomes as the effects of malnutrition, depending on the severity, can be irreversible. The effects of malnutrition include poor brain and physical development, lethargy and a general disinterest in their surroundings, increased infections and, at a later stage, poor school performance and attendance (Fenn, 2016; Prado & Dewey, 2014). These effects are most detrimental during the first 1,000 days when a range of nutrients are needed for healthy brain development (Schmidt et al., 2019, as cited in Moodly et al., 2019). In addition to malnutrition, exposure to illness or disease or being born with or acquiring a disability during early childhood, are factors that may place the young child at risk. Numerous authors and studies confirm that exposure to illness or disease, such as human immunodeficiency virus (HIV) and Aids, tuberculosis (TB), diarrhoea or pneumonia, can be damaging to survival, health and development during early childhood. Furthermore, the number of children under the age of 5 years who die from communicable diseases, birth trauma or nutritional conditions is high when compared to those of other age groups (DoBE, 2015; Morgan & Sotuku, 2019; Statistics South Africa, 2017; Stott, 2017). In 2018, as many as 43,000 children under the age of 5 years died from disease or complications, with many of these having been preventable, and some 14,000 new HIV infections in young children are reported annually with only 63% of these receiving treatment (UNICEF, n.d.).

In addition to many young children being exposed to malnutrition and infectious and chronic diseases, around 200,000 young children live with a disability in South Africa (Motala, 2018). Such disabilities may be physical, sensory or neurodevelopmental and result in an impairment that limits the child's participation in activities (WHO, 2001). Various studies note that having a child who is sick, who is HIV positive or who has a disability, places the child at greater risk for neglect in South African communities (Ali et al., 2012; Gray, 2002; Heeren et al., 2012, as cited in Azzi-Lessing & Schmidt, 2021). For these children, early childhood programmes to support both the child and the caregiver are of great significance (Schmidt et al., 2019, as cited in Moodly et al., 2019; Tomlinson et al., 2020). In such instances, early childhood programmes can prevent illness and disability or assist with early intervention, which is critical in minimising the long-term negative impact of illness and disabilities upon optimal health and well-being.

3.4.5 Maltreatment

Child maltreatment is a term that encompasses all forms of child abuse and neglect and remains a serious concern, both globally and in South Africa (Easterbrooks et al., 2019; Azzi Lessing & Schmidt, 2019). Child abuse occurs in various forms and includes physical abuse, emotional abuse, sexual abuse and family violence. A recent study revealed that by the time children in South Africa have reached 15 years of age 33.3% have experienced physical abuse, 16.1% have experienced emotional abuse, 34.5% have been sexually abused and 31.4% have witnessed family violence (Artz et al., 2016; Burton et al., 2015; Ward, 2017). Child neglect occurs in two forms, physical and psychological, although it may happen that the child experiences both forms at the same time (Schmidt & Azzi-Lessing, 2019).

Statistics relating to child neglect in South Africa are difficult to determine as child neglect often goes undetected or occurs alongside child abuse and its definition is heavily influenced by cultural norms. However, child neglect is thought to be the most prevalent form of child maltreatment in South Africa (Friedman & Billick, 2015; Schmidt & Azzi-Lessing, 2019). The majority of fatal child maltreatment cases occur within the under 1-year-old group in South Africa with cases relating to abandonment, injury with blunt force and strangulation being most prominent (Mathews & Martin, 2016). Child maltreatment may have serious and long-term developmental consequences for the young child resulting in “stunted brain development, poor physical and mental health and social and academic challenges” (Center on the Developing Child, 2012, as cited in Easterbrooks et al., 2019).

The serious and long-term developmental consequences of child abuse may be devastating for South Africa with reports of terrible, violent crimes, such as murder, rape and abuse of children, being reported regularly in the media (Kang’ethe & Manomano, 2016; Orton, 2013; Sky News, 2013). While the effects of child abuse on young children are devastating, it is important to note that neglected children may display even more severe signs of depressions, anxiety and withdrawal and show a higher likelihood of experiencing severe cognitive and academic challenges (Schmidt & Azzi-Lessing, 2019). The abuse and neglect of young children has long-term future implications for the child, families, communities and societies yet these implications could be prevented through programmes that support caregivers to care safely for children, removing perpetrators or removing the child from the dangerous situation (Burton et al., 2015).

3.5 Effects of exposure to vulnerabilities during early childhood

Numerous case records of social workers and research studies show that poor early childhood experiences, where young children are exposed to the very vulnerabilities explained in the section above, lead to poor outcomes, which include a failure to succeed at school, unemployment, mental health challenges, early pregnancies and involvement in crime from a young age (Azzi-Lessing, 2017; Schorr & Schorr, 1998). With more than 50% of South Africa's children being exposed to vulnerabilities (DSD, 2018), it is unthinkable to consider such outcomes for more than half of the country's children; the same children who are tomorrow's adults and who will play an integral role in determining the future of the country and society. For vulnerable children, who may experience compromised caregiving due to one or more risk factors associated with poor early childhood outcomes, early intervention – preferably in the first 1,000 days – is integral to minimise the damage caused by the risk factors, thereby supporting the optimal development of vulnerable children (DoBE, 2015; Republic of South Africa, 2015; UNICEF, 2007).

With this knowledge, it seems obvious that social work, a profession primarily concerned with vulnerable populations, should have prevention and early intervention programmes that support caregivers and children throughout the first 1,000 days in place, especially where caregivers and children are exposed to the risk factors that are associated with poor early childhood outcomes. Research indicates that while investing resources into the first 1,000 days may initially be costly, such investments in the long run may yield a good return for the child, the family, the community and society as a whole (Sayre et.al., 2013). Despite this knowledge, many vulnerable children continue to have no access to services during this period.

3.6 Programmes to support vulnerable children during early childhood

It follows then, that for vulnerable families with risk factors that threaten the healthy development of their children, intervention should begin from as early as conception. Intervention should include strategies that reduce the impact of these risk factors as well as strategies that promote children's optimal development. Nutrition and adequate care are essential during the early years and, through support to caregivers of vulnerable children, new skills can be taught so that risk factors can be minimised, and the optimal development of the child is prioritised.

Programmes that offer support to the child and their caregiver have shown positive outcomes for the parent and the future of the child (Peacock et al., 2013; Sherr et al., 2016; Tomlinson et al., 2020; Ward & Wessels, 2013). Such programmes, if offered with the time and resources needed to do so effectively, can also prevent children from being removed from family homes and placed into foster care or child and youth care centres. Young children are often removed from their families as social workers lack the time and resources needed to offer services and monitor progress within their families. This may result in young children becoming stuck in the foster care system, often experiencing broken placements that further perpetuate the trauma that they may have initially experienced within their own families. This makes healthy development difficult for them to achieve (Azzi-Lessing, 2017). The importance, value and benefit of programmes and interventions offered to young children, their families, communities and society is undisputed and supported universally by many sources of evidence (Atmore, 2013; Morgan, 2013; UNICEF, 2007).

Because of the vital importance of the early years of development, universal access to quality ECD services requires urgent attention and is the main determinant for the sustainable, democratic future of South Africa (Sadan, 2018; Van Niekerk et al., 2017). Caregivers, therefore, need to be given support and such support programmes need to be attuned and respond in coordinated ways to the varied needs of caregivers (Hall et al., 2018) which often extend beyond the mere role of caregiving. It is important that programmes are flexible in accommodating caregiver needs as the overall well-being of the caregiver is closely connected to the well-being of the child. Support for caregiving, can be offered either through centre or non-centre-based programmes. Centre-based programmes are offered through day-care centres for smaller groups of children or ECD centres for larger groups of children (Shumba et al., 2019, as cited in Moodly et al., 2019). Non-centre-based programmes include play groups, support groups, toy libraries and home-visiting programmes, all of which are flexible in responding to the needs of the child and caregiver and offer a broad range of support to meet the child's needs (DSD, 2013).

Both centre and non-centre-based programmes have the potential to become a form of prevention and early intervention for the vulnerable child. While the focus of non-centre-based home-visiting programmes is to provide learning opportunities, stimulation and nutritional guidance (NDA, 2017), such programmes also become an opportunity to

assess risk factors and to work preventatively with the caregiver to reduce the consequences of such risk factors on the development of the child during the first 1,000 days. The importance of home-visiting programmes and examples of international, African and national home-visiting programmes are outlined below.

3.7 Home-visiting programmes

Home-visiting and parenting support programmes that are designed to enrich caregiver engagement with children are extremely important as children learn from birth through the relationships they have with caring adults. The quality of this relationship then impacts future social, emotional and cognitive development (Ebrahim et al., 2013; Hall et al., 2017). Home-visiting and parenting programmes are even more critical for vulnerable children with exposure to risk factors such as those described earlier in this chapter, which are closely associated to high levels of distress and poor parenting (Ebrahim et al., 2013).

Home-visiting programmes would take place in the home of the vulnerable child and caregiver, with visits taking place once or twice a week, or monthly, depending on the needs of the child and caregiver or the specific programme that is being implemented. The home-visiting programme can be shaped around the specific needs of the family with a special focus on the overall healthy development of the child, or such programmes may follow a strict predetermined manualised format (Azzi-Lessing, 2013; Tomlinson et al., 2020;). With many children not accessing centre-based ECD programmes and with early childhood being the most effective and cost-efficient time to intervene, it thus makes sense that government should invest in home-visiting programmes that support the optimal development of the child and their caregivers (DoBE, 2015).

Internationally, home-visiting services are implemented through a variety of different programmes. The Healthy Families America (HFA) programme is one example of this (Gwele & Ebrahim, 2019). This home-visiting programme focuses on encouraging nurturing relationships between children from birth to 5 years in families where children are made vulnerable through risk factors (US Department of Health and Human Services, 2013). Another programme in the United States (US), The Parent Child Home Program (US Department of Health and Human Services, 2015) supports vulnerable children between the ages of 2 and 4 years in preparing for school readiness (Gwele & Ebrahim, 2019). A third home-visiting programme in the US, The Maternal and Infant

Early Childhood Home Visiting Program, targets high risk families of young children with services offered by trained professionals, such as nurses, social workers or educators. The programme has shown proven effectiveness in supporting the optimal development of these children (Schmit et al., 2014). In the US, such programmes have shown positive outcomes in terms of improved parental knowledge, child health and school readiness thereby costing the government less in the long run (Gwele & Ebrahim, 2019; Schmit et al., 2014). The three home-visiting programmes described above have focused on supporting vulnerable children facing risk factors and are good examples of investing in early childhood so that children are able to continue developing optimally as they grow and begin formal schooling.

In Africa, some countries have initiated the use of home-visiting programmes to support young children and their caregivers. In The Gambia, a small country in West Africa, The Baby Friendly Community Initiative (BFCI) was launched due to high poverty rates, high infant mortality rates and the high rate of maternal deaths (Marfo et al., 2008). The programme incorporated traditional and cultural knowledge with good health practices, engaging with caregivers of the child, including fathers and men (Marfo et al., 2008). The importance of recognising and respecting the family and culture within which the child exists as being influential in child development is seen in this initiative. For any home-visiting programme, this would be an important starting point; engaging with caregivers is essential so that both home visitors and the programme is accepted. Working with local knowledge and engaging with caregivers in the context of their homes was seen as one of the programme strengths and contributed towards making the strategy “most successful” (Marfo, et al., 2008 p. 215). However, despite the overall success of the programme, there were some challenges. The greatest challenge is noted as the sustainability of a workforce that was voluntary and served the project without any payment (Marfo et al., 2008).

Here, the debate around the workforce used to implement home-visiting programmes is again raised. Trained, unpaid volunteers were used for the programme and while the programme was successful, the greatest challenge was the retention of these volunteers. Indirectly, the challenge regarding funding of ECD programmes is also seen in South Africa as such programmes may be more sustainable when the workforce is employed and renumerated for the important work that they are doing. It may be that a sincere commitment from Government to fund ECD programmes is needed for such

programmes to be sustainable. Atmore (2021) agrees, sharing that in South Africa, the government has not yet allocated sufficient funding for ECD programmes.

Home-visiting programmes, as an important option for advancing ECD services – in particular to vulnerable children – are beginning to receive attention in South Africa (Azzi-Lessing & Schmidt, 2019; Tomlinson et al., 2020). Future Families, a home-visiting programme implemented in the formal and informal settlements of Tshwane, has shown significant success in supporting orphans and vulnerable children (OVCs), increasing their access to HIV counselling and testing (HCT) as well as providing the family with an individualised care programme based on their unique needs (Thurman et al., 2016). In this programme, a qualified social worker provided supervision and training to a group of caregivers who had completed their secondary education and who then rendered home-visiting services to households with vulnerable children (Thurman et al., 2016). The results of the programme supported the usefulness of community-based home-visiting programmes in assisting OVCs to access critically important health and social support (Thurman et al., 2016). While this programme may not have been specifically aimed at OVCs during early childhood, the benefits of such a programme being offered during early childhood are supported through literature, which confirms that timely diagnosis of vulnerabilities, such as HIV, is essential as more than 50% of young children will die within the first 2 years of life if they are HIV positive but are not receiving antiretroviral treatment (ARVs) (Grinsztejn et al., 2014).

A further two South African studies, both in the Western Cape, confirm the success of utilising home-visiting services to offer support to vulnerable children and their caregivers. The first study showed positive outcomes for improving early mother-infant interactions and attachment, and the second showed positive outcomes for children who were malnourished (Cooper et al., 2009; Le Roux et al., 2010). A third programme implemented in various provinces of South Africa, the Family & Community Motivator (FCM) Home Visiting Programme, offered support to vulnerable households with pregnant women or young children (Ilifa Labantwana, 2018). The FCM Home Visiting Programme succeeded in promoting protective factors through increasing opportunities for early stimulation, supporting caregivers, improving health practices within the home and increasing access to essential childhood services. The programme was received positively both by communities and government (Marfo et al., 2008). Here, the usefulness of home-visiting programmes in supporting vulnerable children can be seen.

The challenges, as with other home-visiting programmes, was in securing sustainable funding to pay volunteers, administrative costs and support. This resulted in some programmes being implemented over 12 months and others over 18 months before they were suspended (Biersteker, 1997; Marfo et al., 2008). These challenges highlight that although government acknowledges early childhood as a critical period of development through both legislation and policy, the acknowledgement is not adequately supported through a sufficient and sustainable allocation of resources. For a country to feel so strongly about children's rights and to acknowledge early childhood as a foundation to good future outcomes, it makes no sense that so few resources are allocated towards programmes that protect and nurture vulnerable children during the first 1,000 days.

In South Africa, home visits are conducted by both paraprofessionals, who could be trained community members, paraprofessionals such as auxiliary social workers, who have two years of training in social work, or community health workers, who are partially trained in health care, as well as professionals, such as social workers or nurses who have degree qualifications (Azzi- Lessing & Schmidt, 2019; Bamford, 2019). Paraprofessionals work alongside professionals, assisting them in service rendering, although they are not permitted to provide the full range of services that a fully qualified professional is able to. The two South African studies mentioned earlier suggest that using paraprofessionals for child and family home-visiting programmes may have advantages (Cooper et al., 2009; Le Roux et al., 2010). A study by Tomlinson et.al., (2020) agreed that where home-visiting programmes were offered, good outcomes for the child were noted when services were offered by paraprofessionals but found that positive outcomes for parents were noted when services were offered by professionals. However, for children and families experiencing a complex array of risk factors, professionals with specialised education, such as social workers, may be better equipped to deliver home-visiting services (Azzi-Lessing, 2013). Peacock et al. (2013, p. 11) noted that "home visiting programmes that utilize paraprofessionals often do not have significant effects on disadvantaged families", perhaps supporting the views of Azzi-Lessing (2013) noted above. When discussing professionalism within the ECD sector, a call is made for professionals who have the required knowledge to act in the best interests of the child (Darling Hammond, 1989). Additionally, it is suggested that this knowledge is not solely gained through personal experience, but it needs to be based on sound educational and clinical knowledge (Moodly & Schmidt, 2019).

Despite the debate on who is best suited to offer home-visiting programmes, the effectiveness of home-visiting services as an extension of centre-based ECD programmes is acknowledged both internationally and nationally in supporting vulnerable children and their caregivers. After considering the effectiveness and shortcomings of some of the home-visiting programmes that already exist, it seems prudent to remain aware that a contextually based early childhood home-visiting programme for vulnerable children in the Eastern Cape province, who often face multiple and complex risk factors, will need to address biological, psychological and social variables – all of which come together to influence the well-being of the child. Furthermore, the issues of funding and staff training and retention will need to be explored in detail so that the programme can be implemented and sustained over a period of time that allows all vulnerable children to be supported during their first 1,000 days. Tomlinson et al. (2020) agrees that key components, such as staff selection, training, supervision, working conditions and funding, all of which relate to the implementation of early childhood programmes, often remain undocumented. This is problematic as such components do have a direct impact on programme effectiveness.

3.8 Challenges in offering services to vulnerable children during early childhood

Ensuring optimal development for children in South Africa remains a daunting task given the high rates of poverty and the challenges poverty brings (Azzi-Lessing & Schmidt, 2019). High rates of unemployment and inequality in wages continue to contribute to more than half of all South Africans living in poverty, with children identified as one of the groups most vulnerable and likely to experience poverty (Aubrey, 2017; Statistics South Africa, 2017). Sixty-two percent of children in South Africa under the age of six experience poverty with 30% of these children experiencing food poverty, making them vulnerable to hunger and malnourishment (Hall et al., 2017). This is extremely problematic given that undernutrition during the early years makes children vulnerable to future chronic diseases, poor educational performance, and behavioural and emotional problems (Victora et al., 2008). In addition to the poverty and malnutrition that some children face, other risk factors, such as low birth weight, infectious diseases, environmental toxins, stress, exposure to violence, maternal depression, disrupted caregiving and disabilities, continue to affect far too many children in South Africa (Republic of South Africa, 2015).

A further challenge facing ECD in South Africa is that only 64% of poor children in the country actually receive the CSG. This leaves the remaining 36% of poor infants even more vulnerable. This increases the chance that they will experience hunger and malnutrition, both of which are detrimental to their development, making them susceptible to poor future outcomes (Victora et al., 2008). More than a million children are born in South Africa every year, with many of these children living in rural areas, making access to ECD services problematic and costly to render (Hall et al., 2017). Other challenges facing ECD in South Africa include the poor infrastructure at ECD facilities, where many community-based centres function without safe buildings or access to running water, electricity and sanitation. Government funding for ECD centres remains difficult to access, particularly for centres with inadequate infrastructure. Moreover, many ECD practitioners lack the educational qualifications and skills necessary to promote optimal development for the children in their care (Atmore, 2013).

While South Africa has made some progress in prioritising ECD policy and programmes, there remains much work to be done if each child is to be ensured the best start in life (Republic of South Africa, 2015). Even with South Africa's commitment to ECD, the majority of children "are still negatively impacted by a range of social and economic equalities including inadequate access to health care, education, social services and nutrition" (Atmore, 2013, p. 52). Equitable and quality ECD services for all children remains an ideal that South Africa has not yet achieved (Atmore 2013; Aubrey, 2017). This is confirmed by the South African Early Childhood Review 2019 where it is suggested that "despite South Africa's many successes and achievements", ECD is not one of these; in fact, "ECD as a sector, lags behind" (Hall et al., 2019, p. 6). It could, therefore, be that the greatest challenge facing ECD in South Africa is the gap that exists between policy and implementation. While South Africa's legislation seems to create a safe place for children to grow and develop, this is not the reality of many young children in the country. While the NIECDP and the NCF have attempted to bridge the gap between legislation and ECD and both are good policies, without adequate funding, the implementation of these policies is problematic and extremely difficult to do, especially in the communities where children are exposed to the risk factors described earlier in this chapter.

These risk factors often co-exist, exposing the young child to multiple risk factors simultaneously further compounding the negative impact on the development of the

young child. In such circumstances of extreme poverty, adequate funding to develop opportunities for good nutrition, health, nurturing care and quality early stimulation and learning will have to be the responsibility of the government. It will thus be up to the South African government to source and secure adequate funding for ECD services, particularly in the more vulnerable communities where a range of risk factors for young children exist and hold them back from developing optimally. While this will be a costly investment to begin with, it may be that the return on investment will be worthwhile as quality ECD services promote optimal development, supporting children towards good future educational, health and social outcomes.

These outcomes may result in less expenses for the government in the long run as good future educational, health and social outcomes translate into citizens who are able to independently contribute to a stable and healthy economy. The challenge of inadequate funding for ECD services, in effect, renders the very legislation and policies that are there to support children, and especially the most vulnerable children, useless. Additional resources are needed if good outcomes for children in South Africa are going to be achieved (Bamford, 2019; Masiteng, 2019; Van Niekerk et al., 2017). Without funding, the very children meant to be protected by legislation and policy continue to be exposed to risk factors as there may very well not be many protective factors within their families or communities that they are able to access.

3.9 Conclusion

Chapter 3 has supported the importance of early childhood as a critical development period that may impact upon the future development of the child, setting the scene for either optimal development or for poor future outcomes. Protective and risk factors during early childhood were unpacked in detail with the outcomes for both being presented. This literature review has confirmed that there is sufficient empirical data that supports early childhood as a critical period of development. There is also sufficient data around the positive outcomes for the child who is well supported and cared for while it is also clear that for a child who does not receive good care during early childhood the outcomes may be less than optimal. In this chapter it was determined that there is sufficient literature to describe early childhood development programmes, with the characteristics of home-visiting programmes and practical examples being given. While these areas are well covered in the literature there is less empirical data available in

relation to early childhood home-visiting programmes within the South African context. There remain gaps in the literature when it comes to the training of a home-visiting workforce and the actual implementation of such programmes in a country such as South Africa where there remains a glaring gap between policy and implementation. Lastly, the challenges facing ECD programmes in South Africa were critically examined. Chapter 4 presents the research design and methodology that has guided the study.

CHAPTER FOUR
RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

Chapter 4 begins by describing, discussing and comparing the different research paradigms, and the philosophies that can guide research studies. The chapter continues by outlining the interpretivist paradigm, which is the research paradigm that has guided this study. The quantitative and qualitative approaches to research are explored, and the qualitative approach is presented as the approach that was used in this study. The advantages and disadvantages of such an approach are debated. Various research designs are identified and explored, and intervention research is introduced as the research design that was best suited for this study. This is followed by a discussion that outlines the study population and sample as well as the procedure that was followed for sampling. The method of data collection, together with the research instruments, is then outlined and the research process is described. Next, the steps followed to analyse the data are explained, and the process of ensuring trustworthiness and upholding ethical considerations is unpacked. Chapter 4 ends with a presentation and discussion of the biographical profile of the research participants who were interviewed for the study.

4.2 Research paradigm

A research paradigm outlines the "assumptions, propositions, thinking and approach to research" that the study will take (Bakkabulindi, 2015, p. 21). A paradigm is a basic set of beliefs about life, the people in the world and the relationships that exist between people and the different systems in the world (Guba & Lincoln, 1994). Kivunja and Kuyini (2017) agree that a paradigm consists of beliefs and a line of thinking that directly impacts and influences the way you view the world and, as a result, the meaning that is attached to the research data. A paradigm is, therefore, the foundation or framework from which the research builds or is shaped as the study's paradigm.

Alternatively, the researcher's beliefs about life and people will guide the subsequent research approach, research design and, ultimately, the interpretation of the data. Research in the social sciences involves the study of people and may follow a number of approaches, with the most common paradigms being "the positivist, the postpositivist, constructivism, interpretive and critical" (De Vos et al., 2011, p. 5). Bakkabulindi (2015) notes that the positivist and interpretivist paradigms are most commonly discussed in

research literature and that the positivist paradigm may also be referred to as the traditional, experimental or empiricist paradigm, while the interpretivist paradigm may also be referred to as anti-positivist, post-positivist or the constructivist paradigm.

Tshabangu (2015, p. 45) goes further to suggest that interpretivism is “heavily influenced” and closely linked to “phenomenology, ethnomethodology, critical approaches and hermeneutics”. Taking all these different paradigms into consideration, it would appear that the two most prominent research paradigms are the positivist paradigm and the interpretivist paradigm. These two paradigms and their distinguishing characteristics will thus be explored in detail with a motivation of the most suited paradigm for this study provided towards the end of this section. In addition to these two research paradigms, it must be noted that there is a third approach to research, the mixed methods approach. This approach draws on both the positivist and interpretivist paradigms, attempting to understand the world from different perspectives while including both paradigms as a means of enhancing validity of the research (Johnson et al., 2007).

The positivist paradigm originates from the world of natural science. It views life and the rules of life as being predictable and observable and, as such, adopts a quantitative approach to research (Bakkabulindi, 2015; Gay et al., 2003). The positivist paradigm thus believes that the world works in a set way that can be clearly measured according to a predetermined set of variables and that research can be done objectively with very little involvement by the researcher. The interpretivist paradigm differs completely in that it opposes the positivist paradigm, stating that life and the world are not predictable but rather are influenced greatly by individual and community perspectives and contexts thus taking on a qualitative approach to research (Bakkabulindi, 2015; Gay et al., 2003). The interpretivist paradigm views the world from a more subjective standpoint, seeking to understand the unique experiences of individuals from within their frame of reference and valuing the depth that this adds to the research process. The positivist and interpretivist research paradigms are characterised by philosophical differences in ontology, epistemology, axiology and methodology (Creswell, 2003).

Openly and clearly stating the research paradigm for the study is essential so that the context from which the study is understood is “clear and unambiguous” (De Vos & Strydom, 2011a, p. 41). For this study, the interpretivist paradigm was used. The

philosophy of ontology, epistemology, axiology and methodology for the interpretivist paradigm that was used in this study is described in the sections that follow.

4.2.1 Ontology

The ontology of a paradigm is understood as the science of being and the matter of existence and reality (Bakkabulindi, 2015). For interpretivists, reality is subjective and cannot be separated from the individual or the meaning that the individual ascribes to it (Neuman, 2000). The interpretivist paradigm is thus guided by the ontology or belief that for reality to be understood, the individual will need to be understood from within the social context of their unique world.

4.2.2 Epistemology

Epistemology is concerned with the process of knowing and how you come to know or what is noted as knowledge in the world (Bakkabulindi, 2015; Cooksey & McDonald, 2011; Kivunja & Kuyini, 2017). The interpretivist paradigm uses a subjectivist epistemology, which assumes that the researcher and participant will interact and engage in dialogue as knowledge is gathered and created (Kivunja & Kuyini, 2017). This approach to epistemology results in the interpretivist paradigm making every effort to engage very closely with participants while knowledge, which is qualitative in nature, is gathered and understood. The epistemology of the interpretivist paradigm emerges and builds from its ontology or belief about life and the world.

4.2.3 Axiology

The third philosophical difference between the two paradigms is linked to axiology. Axiology addresses the question of what is right and what is wrong when conducting research and, as such, addresses the values of the researcher and their beliefs about how the research should be conducted (Kivunja & Kuyini, 2017).

The interpretivist paradigm feels that it is nearly impossible for a researcher to be neutral and impartial when conducting research and, as such, declares these values and biases upfront. In addition, it acknowledges and recognises that other values and biases may emerge during the research process and in the writing of the research report (Bakkabulindi, 2015). The interpretivist paradigm, therefore, suggests that the research report will acknowledge and include the values and biases of the researcher rather than ignoring these thus adopting a balanced axiology (Kivunja & Kuyini, 2017). The interpretivist paradigm thus approaches research ethics from a stance where values and

biases are openly stated, and every effort is made to ensure that these do not negatively impact upon the trustworthiness of the study.

4.2.4 Methodology

In research, methodology represents or is the plan that is developed in order to reach the end destination. The interpretivist paradigm has a methodology that is inductive in nature. An inductive methodology is one where observation occurs and is then followed by conclusions being drawn (Bakkabulindi, 2015). There is, therefore, no manipulation of variables or even a hypothesis that is being tested in inductive methodology; rather areas or themes of interest come about as participants share their stories.

4.2.5 Justification of interpretivist paradigm for the study

Now that each paradigm has been explained, it becomes imperative to justify the use of the interpretivist paradigm for this study. The interpretivist paradigm was used as it values multiple and subjective meanings of individuals and communities rather than that of a single expert (Jansen, 2016). In addition, the interpretivist paradigm is well suited to this study: first, as it supports the research approach and design being used and secondly, as it supports the theoretical framework being used by the study.

The interpretivist paradigm opens up a space for participants to influence the research process and actively participate in all that takes place. It fits well within the qualitative approach, which is flexible in nature (De Vos et al., 2011). In addition, it works well with intervention research, the research design of this study, particularly in cases where a programme or model of intervention is being developed. For the home-visiting programme model being developed by this study to be effective, it should be owned by the community, which, in effect, speaks to the community or participants being deeply involved in developing the programme from the very beginning. This is a principle or philosophy that the interpretivist research paradigm supports. Participation, self-determination and ownership are, in addition, values and principles at the very core of the social work profession (Schenck et al., 2010) and, as such, may be acknowledged and implemented in this case with research participants.

Being a value-laden profession, social work and in particular, this study, may be best suited to the ontology, epistemology and axiology of the interpretivist paradigm, which allows for subjective realities, making room for close interaction and personal values and biases of both the researcher and participants. Using the interpretivist paradigm for this

study has allowed for participation and self-determination in shaping the programme model that was developed, taking into consideration individual and community contexts, thus facilitating ownership and perhaps enhancing the effectiveness of the programme model in the long run. Ultimately, it is the researcher's personal and professional belief that professionals who work (as experts) with vulnerable children and the caregivers of vulnerable children will be more likely to support the implementation of a programme model if they themselves have been involved in the design of the model, thus supporting the use of the interpretivist paradigm.

In Chapter 2, it was noted that for the child to develop optimally, biological, psychological and social factors would have to work together to support overall health and well-being. The literature in Chapter 3 confirmed that both professionals and caregivers of vulnerable children play a large part in supporting the overall well-being of the child within all these areas. A range of professionals may be even more involved as the vulnerable child may need additional support in any one of these areas. Literature confirms that interpretive research values the knowledge and understanding that individuals bring to a phenomenon. Because early childhood is such a complex and important development stage, hearing and understanding the views of the caregivers and different professionals trained to provide support for healthy development during early childhood is essential. This will allow for conclusions to be drawn as participant narratives are shared, assuming an inductive methodology that aligns well to the interpretivist paradigm. In addition, because of its subjectivist epistemology, the interpretivist paradigm supports these multiple views and values the unique understanding and knowledge that each of these individuals brings to the study. The interpretivist paradigm has also shaped the research approach and methodology of the study, which are explained in the sections that follow.

4.3 Research approach

There are two approaches to conducting research. Each approach has its own "purposes, methods of conducting inquiry, strategies for collecting and analysing the data and criteria for judging quality" (Fouche & Delport, 2011a, p.63). The first approach to research is the quantitative approach. The quantitative approach to research "is systematic and objective" and uses "numerical data" from a sample population so that it can be generalised to the larger population (Maree & Pietersen, 2016, p. 162). Quantitative research is generally very structured, making use of large sample groups with the researcher remaining objective throughout the collection of the data (Fouche &

Delport, 2011a). Creswell (1994) adds that quantitative studies are appropriate for testing a theory to determine whether the theory holds true or not. The quantitative approach to research thus aligns well to the positivist paradigm, both of which adopt an experiential methodology, with beliefs that knowledge is created and can be generated with the researcher remaining objective and distanced throughout the process. The quantitative approach thus does not support the interpretivist paradigm and would not be a good approach for this study.

The second approach to research is known as the qualitative approach and is the research approach that has guided this study. Qualitative research fits well within the interpretivist paradigm, is used across disciplines and compromises a range of different insights and methods to generate new and interesting knowledge (Hesse-Biber & Leavy, 2011). Qualitative research explores phenomena from the inside, with a high regard for the perspectives of the participants (Ormston et al., 2014). In addition, the qualitative approach aligns well to the interpretivist paradigm as it supports working closely with participants to build up theory and answer research questions rather than adopting a specific hypothesis or working with variables (Leedy & Ormond, 2013). As such, the qualitative approach adopts a subjective ontology, in the belief that knowledge is personally shaped by individuals and their experiences. Consequently, understanding can only be gained by working closely with participants.

The qualitative approach, which is interpretivist in nature and aims to understand life and complex social circumstances from within the world of the participants rather than bringing the researcher's own understanding or hypotheses to the research, stems from an anti-positivist paradigm (Creswell, 2007; McRoy, 1995). The qualitative approach takes on a subjective approach to axiology and methodology, working closely with smaller groups of participants to collect data, learning from the participant about the phenomena that is being studied and producing data that is dense, detailed and descriptive (Cresswell, 2007; Fouche & Delport, 2011a). In addition to using small rather than large samples, the qualitative approach differs from the quantitative approach as it adopts a methodology that is very flexible in nature and can change as it responds to the different context of the social phenomena that is being studied (Kumar, 2005; Leedy & Ormond, 2013).

The subjective ontology and epistemology of the qualitative approach and the flexible stance that it adopts to methodology have made the qualitative approach a good fit for this study. The theoretical framework for the study proposes that vulnerabilities during early childhood are often complex and shaped by the biological, psychological and social factors of the individual child and caregiver as well as the community within which they exist. This implies that for a home-visiting programme to be developed, a deeper understanding of the needs of vulnerable children and the factors that work together to support the overall well-being of children is needed. This deeper, contextualised understanding can only be sought through an interpretivist and qualitative approach and cannot be tested by a hypothesis or the manipulation of variables.

For this reason, the study has collected data from a relatively small group of participants, which includes a variety of professionals who work with vulnerable young children and the caregivers of vulnerable children. This small sample has allowed the research to seek a deeper understanding of the complexities facing vulnerable children. In addition, these participants were on the 'inside' of early childhood in the Eastern Cape province, either working with or caring for vulnerable young children and may have had particular insight into the needs of vulnerable young children, existing programmes, the role players who should be involved in such a programme, and the guidelines needed for a home-visiting programme. Cresswell and Poth (2017) confirm that a qualitative study is conducted for many reasons with the following three being most applicable to this study: firstly, when a topic needs to be explored; secondly, when an in-depth understanding of the topic is needed; and thirdly, when an understanding of the context from which the participants understand the problem is needed (Cresswell & Poth, 2017). In this way, the qualitative approach is best suited to this study, especially as it seeks to understand the context of vulnerabilities from the very people who work and live with them in the Eastern Cape province.

As with any research approach, qualitative research does have some disadvantages. These had to be carefully considered together with the advantages of such research to determine that the approach was indeed best suited to the study. The first disadvantage of conducting qualitative research is that the sample used is relatively small and purposefully selected, making findings difficult to generalise (Fouche & Delport, 2011a). The quantitative approach would, for example, use a large sample that was randomly selected, and the findings could, therefore, be generalised to the larger population

(Ivankova et al., 2007). Despite this disadvantage, the qualitative approach remained the best choice for this study, as it sought to collect an extensive amount of data from a small number of participants so that in-depth and detailed observations could be made about the vulnerabilities and needs of children during early childhood. Inferences could, therefore, be made around the role and involvement of professionals and the guidelines needed for a home-visiting programme model.

Another disadvantage or critique of the qualitative approach is that it is unstructured and allows for greater flexibility during the research process (Kumar, 2005). This is, once again, different to the quantitative approach, which follows a very structured process allowing for variables to be measured and hypotheses to be either confirmed or disconfirmed through the findings (Leedy & Ormond, 2013). However, a hypothesis was not needed for this study, and the aim was not to measure a relationship between variables; rather, a deeper understanding of the social phenomenon around vulnerabilities was sought so that guidelines for a home-visiting programme model could be developed to support children during early childhood. Kumar (2005) and Creswell (2007) support that a qualitative study is unstructured, which is more appropriate when the nature of a phenomenon is sought. Although qualitative research does have disadvantages, some of which are addressed in this section, the qualitative approach remains appropriate for this study as it supported the aim and objectives of the study, which sought to describe and understand rather than to explain or predict. From within this qualitative approach, the research design was selected and is discussed in the following section.

4.4 Research design

A research design is understood as the broader plan for solving the research problem, thus assisting in meeting the overall aim and objectives of the study (Leedy & Ormond, 2013). There are many different research designs, each of which aligns with either the quantitative or qualitative approach being taken by the study. The research designs that are most commonly used in qualitative research include the narrative biography, ethnography, phenomenology, grounded theory and the case study (Fouche & Schurink, 2011). The narrative biography unpacks and constructs the history of a participant's life (Fourche & Schurink, 2011). As such, the narrative biography seeks to retell the life story of the participant. Ethnography involves the study of participants over time, through observation (Creswell, 2007). Ethnography thus entails spending a considerable amount

of time collecting data as an observer in a group of participants. The phenomenological research design supports the description and understanding of life experiences from a range of participants (Creswell, 2007) thus seeking a deep understanding and description of the experiences of individuals.

Grounded theory seeks to develop theory from the data that is gathered, thus explaining interactions, actions or processes (Creswell, 2007). The case study research design is used when a researcher seeks to understand the particular life experiences of a case or a number of small cases, drawing attention to what can be learned from these case/s (Fouche & Schurink, 2011; Schram, 2006). In addition to these research designs, evaluation research, intervention research and participatory action research have also emerged as relevant to the social sciences and, in particular, social work (De Vos & Strydom, 2011b; Fouche, 2011; Strydom, 2011). These have emerged in relevance due to the need for professions, such as social work, to evaluate the effectiveness of programmes, develop interventions that are effective and have a high impact and to include participants as active partners during the research process (De Vos & Strydom, 2011b; Fouche, 2011; Strydom, 2011).

These research models have become significant in social work as it is a profession driven by facilitating change in partnership with individuals, families and communities. As such, social work is interested in developing interventions that facilitate an effective process of change. These interventions should be developed in partnership with communities because social work values strongly support empowerment and the self determination of the communities that they work with. At a later stage, these interventions need to be evaluated to ensure that they are having the intended impact. With this in mind, intervention research was chosen as the research design for this study. The intervention research design has grown in importance over the last few years and is being used to inform social change, solve real-life challenges and guide programme development, all of which are crucial in current day South Africa (De Vos et.al., 2011). Such research is especially relevant to the fields of humanities and social and health sciences as it seeks to develop or improve strategies that facilitate growth and change in the lives of the clients or communities they serve (De Vos & Strydom, 2011b). Intervention research, an example of applied research, was first conceptualised by Thomas and Rothman and originated from the field of developmental research (Fouche & De Vos, 2011).

Developmental research advocates for the development of technology that supports a profession to achieve its objectives (Thomas, 1981). For this study, the home-visiting programme will be the technology that assists professionals in supporting vulnerable children during early childhood. Intervention research is known to be undertaken by social workers when facilitating a process of change together with families or communities to strengthen and maintain well-being (Govender, 2015). Intervention research is, therefore, most suited to this study as the goal of the study is to develop a home-visiting programme in partnership with professionals who work with vulnerable children and the caregivers of vulnerable children thus making the focus and overall aim of the study 'intervention'. Intervention research is used when a practical solution is needed to support a particular family or community (De Vos & Strydom, 2011b; Rothman & Thomas, 1994). The different vulnerabilities and the high rates of these vulnerabilities facing children during early childhood in South Africa and, in particular, the Eastern Cape province – as discussed in Chapter 3 of this study – have highlighted the need for a practical and contextually relevant solution to support optimal development during this critical life stage.

Presently, five different types of intervention research exist. These are listed and described in Table 4.1 (De Vos & Strydom, 2011b; Fouche & De Vos, 2011; Schilling, 1997).

Table 4.1: Types of intervention research

Type of intervention research	Description
1. Knowledge development (KD)	Empirical research that seeks to deepen the understanding of behaviour in relation to interventions within health or social service professions.
2. Knowledge utilisation (KU)	The findings from knowledge utilisation are connected to and implemented in practice.
3. Design and development (D&D)	These are studies that specifically design and develop interventions.

4. Longitudinal studies	These studies observe and record what happens with clients during and after contact with health or social science agencies.
5. Full scale experiments	These studies test interventions that facilitate change in various settings.

Extracted from these sources: De Vos & Strydom, 2011; Fouche & De Vos, 2011; Schilling, 1997

This study has developed guidelines for an early childhood home-visiting programme model and thus falls within the third type of intervention research, design and development (D&D), as seen in Table 4.2. This type of intervention research is primarily concerned with the design and development of interventions and involves "the systematic study of purposive change studies" (Fraser & Galinsky, 2010, p. 459). One of the reasons that interventions are designed and developed is so that interactions between the individual and their social environment can be strengthened (Schilling, 2011). These strong and healthy interactions between individuals and the social environment are very important for this study as the biopsychosocial model highlights the influence and importance of the interaction between the biological, psychological and social factors in the child's overall well-being during early childhood.

Fraser and Galinsky (2010) note that the design and development of an intervention usually begins by outlining a social or health problem in which risk factors are present. For this study, as outlined in Chapters 2 and 3, the high exposure rate of young children in the Eastern Cape province to a range of vulnerabilities presents significant risk factors for poor future outcomes. Intervention research remains significant for vulnerable children in the first 1,000 days of life due to the critical importance of this development period, as outlined in Chapter 3 of this study. Fraser and Galinsky (2010, p. 460) draw attention to the creativity that is needed to develop and design an intervention, noting that it creatively blends existing research and knowledge with that of the practice setting, often in partnership with the research participants. This further supports the choice of the intervention research design for this study as the study seeks to draw on existing research and knowledge relating to home-visiting programmes, early childhood and vulnerabilities, while at the same time work creatively with participants and the rural

context of the Eastern Cape province to build a model for intervention that supports vulnerable children during early childhood.

Intervention research generally follows five or six different phases, each consisting of a number of smaller steps or operations (De Vos & Strydom, 2011; Fraser & Galinsky, 2010). These phases provide a general sequence for progression with the research but may also overlap – or it may be that the research loops back to a previous phase as challenges are experienced or new information is received (Rothman & Thomas, 1994). These phases of intervention research are briefly outlined in Table 4.2 that follows.

Table 4.2: Phases of intervention research

PHASE	DESCRIPTION	OUTCOMES
Phase 1	Explanatory research	Identify population at risk, specify risk factors and identify mediating factors.
Phase 2	Conceptualisation	Design the programme, develop guidelines, decide on specific aspects, such as contents, training for facilitators and how the programme will be implemented.
Phase 3	Programme design	Develop first draft, circulate for expert input, refine guidelines and circulate again for expert input.
Phase 4	Efficacy testing	Test the programme on a small scale to determine effectiveness.
Phase 5	Effectiveness testing	Test the programme on a larger scale.
Phase 6	Dissemination	Share the programme and findings relating to effectiveness and impact.

Extracted from these sources: Fraser, 2004; Fraser & Galinsky, 2010, Rothman & Thomas, 1994.

Although intervention research consists of many smaller phases, which are often implemented in a cyclic nature over a long period of time, only the first three phases were implemented in this study due to time and financial constraints. The first three

phases guided the study so that the researcher and the participants could work together to develop and refine the guidelines for a model of an early childhood home-visiting programme. These three phases and the research process that followed are discussed in detail in the sections that follow.

4.4.1 Phase one: Explanatory research

Phase 1 is when the problem or, in this case, the research problem, is clearly defined, the study population is identified and the risk factors are examined (Fraser, 2004). In essence, this phase begins with a literature review that closely examines the problem associated with a specific study population and uses this literature to explore the risk of exposure to the problem for that specific population group. For this study, Phase 1 of the intervention research design began with the development of a research proposal and then continued with the writing of the literature review in Chapter 3. In both the proposal and Chapter 3, the study clearly identified the research problem and presented literature relating to early childhood, in particular, the first 1,000 days, as a critical period of development for all children. The study then continued to explore the vulnerabilities facing many young children in the Eastern Cape province during this period of development. The risk factors associated with exposure to these vulnerabilities during the first 1,000 days of development were also explored in detail in the literature review.

However, for this study, the explanatory stage did not end with the literature review. In addition to the work that was done in this phase for the literature review, for an interpretivist, qualitative study, this phase continues to include the data being collected and participants sharing their own insights into the problem and its associated risk factors. For this study, the first two objectives further supported the explanatory phase of the intervention research design as participant insights were sought into the specific needs of vulnerable children and the risk factors facing vulnerable children in the Eastern Cape province. Although these were identified by the literature, the voices and stories of the participants and their contextually significant experiences relating to the needs of vulnerable children and the risk factors that they face were essential due to the nature of the paradigm and the approach that was used by the study.

Fraser (2004) goes on to say that in the explanatory phase of intervention research, once the problem, the population and the risk factors are identified, it is important to continue by identifying the protective factors that can be built on or strengthened through the

intervention programme. A credible intervention can, in fact, be determined by "the extent to which malleable risk factors are paired with change strategies of sufficient strength to produce positive outcomes" (Fraser & Galinsky, 2010, p. 460). This was initially achieved through the theoretical framework in Chapter 2 of the study. The biopsychosocial framework clearly indicated that for optimal development during early childhood to occur, biological, psychological and social factors would need to work together to support the healthy development of the child. From this theory, the protective factors of good health and nutrition, nurturing and responsive caregiving and access to safe and quality early learning opportunities were then identified and presented in Chapter 3. As with the problem statement and the risk factors, for this study, understanding the protective factors from literature and theory was not sufficient to meet the requirements of an interpretivist and qualitative study.

The protective factors were further explored and understood from the participants' point of view as the first objective of the study aimed to explore the needs of vulnerable children, and the third objective of the study aimed to identify the ways in which vulnerable children are currently being supported during early childhood. This opened a discussion with the participants around the needs of vulnerable children and the support that is or is not being offered to vulnerable children in the Eastern Cape province, thus facilitating a discussion around protective factors. This phase of intervention research, which combined the use of a literature review and participant insights, was essential to the study. Fraser and Galinsky (2010) agree that intervention research combines existing knowledge with knowledge received from participants, and the practice setting. In addition, adhering to this phase ensured that context and the specific needs of vulnerable children in the rural Eastern Cape province could be understood and that the malleable risk factors could be identified and then matched with protective factors. By the end of Phase 1, it was important to have an understanding of the risk factors that can be mitigated and the protective factors that can be strengthened (Ciccheti & Hinshaw, 2002). Fraser (2004, p. 211) confirms that this process of "articulating the mediating/moderating processes that lead from vulnerability-producing conditions to differential outcomes" has great value for the development and design of interventions. Once the outcomes for phase one of the research design were achieved, the researcher was able to move into the second phase of intervention research.

4.4.2 Phase two: Conceptualisation

The conceptualisation phase is described as the time where the knowledge generated in Phase 1 is consolidated “into actions that can be undertaken in practice” (Fraser & Galinsky, 2010, p. 211). Such actions could include education or knowledge sharing, strengthening skills, providing access to support or opportunities for development (Fraser & Galinsky, 2010). Fraser (2004) states that it is often during this phase that practice principles and programme sessions are developed or manuals are written. In addition to the actual development of the programme during Phase 2, the fit between the design of the intervention and the context within which it will be implemented is an important consideration (Fraser & Galinsky, 2010).

For this study, it was important to use the knowledge gained in Phase 1 to ensure a good fit between the home-visiting programme model and the context of the Eastern Cape province. All elements of the model and the home-visiting programme needed to be developed with the context of the Eastern Cape province in mind. In addition, the conceptualisation of the intervention should be designed for implementation by certain people in order to reduce implementation failures (Fraser & Galinsky, 2010). For this study, it would thus be imperative to firstly identify what current support was being offered to vulnerable children. This would prevent the duplication of services ensuring that there was a need for such a programme. Secondly, it would be imperative to identify which professionals would be involved in implementing this home-visiting programme as well as deciding who these professionals would be employed by as this would influence the implementation and impact that the programme would have.

Phase 2 was supported by the third and fourth objectives of this study. These objectives were to identify the current services being offered to vulnerable children and to determine the different disciplines involved in supporting vulnerable children and the roles and extent of their involvement as well as developing guidelines for a model of a home-visiting programme that supports vulnerable children in the rural Eastern Cape province.

4.4.3 Phase three: Programme design

During Phase 3, the first draft of the programme model is developed, circulated for review and refined (Fraser, 2004; Fraser & Galinsky, 2010). After the first draft has been reviewed and refined, essential programme elements are noted, and the measures that will be taken to ensure fidelity should be clearly stated (Fraser & Galinsky, 2010). Fidelity

criteria will specify such aspects of the programme that are essential for ensuring that the programme has a high impact (Fraser & Galinsky, 2010). These criteria can include the length of the programme, minimum number of sessions, content areas to be covered, who the facilitators should be, the training they are required to have before they are able to implement the programme, funding of the programme and supervision and organisational management of the programme (Fraser, 2004; Fraser & Galinsky, 2010).

Phase 3 consisted of two stages. The first stage involved developing the draft guidelines and circulating these to the experts for input. Once input was received, it was incorporated into the draft guidelines. Stage 2 involved a consensus workshop to consolidate the development of guidelines for the programme. A consensus workshop is goal-oriented and aims to bring about "meaningful dialogue" between practitioners and researchers (Sabir et.al., 2006, p. 833). This dialogue, in turn, informs contextually relevant interventions that are more likely to be implemented in practice (Glasgow et al., 1999; Glasgow et al., 2001). For these very reasons, once the individual interviews had been completed and the first four objectives had been achieved, the draft guidelines were circulated to the professionals who participated, essentially a panel of experts, for input and a consensus workshop was facilitated so that professionals working in the field with vulnerable children could give input into the guidelines that were developed in order to achieve Objective 5. This process supported the design of a contextually relevant intervention for use in practice. Phase 3 – programme design – thus formed the last part of the research design used in this study.

4.5 Research population and sample

"A population is a group of persons, objects or items from which samples are taken for measurement" (Lumadi, 2015, p. 226). It is integral to any study that the researcher is able to clearly identify and define the research population. It is impossible to collect data from the entire research population thus a sample is used. Inferences are then tentatively made about the larger population from the sample (Lumadi, 2015). Clearly identifying and defining the research population thus influences the quality of the sample being used and, consequently, the validity of the inferences that are made at a later stage.

With this in mind, the research population for this study was identified and defined as all professionals working with vulnerable children and their caregivers in the Eastern Cape province. The caregivers of vulnerable children in the Eastern Cape province were also

included in the research population. The population was defined in this way for two reasons. First, the biopsychosocial framework that is being used as the theoretical framework for the study highlights the importance of biological, psychological and social factors working together and influencing one another to support the good health and development of the child during early childhood. From this theoretical framework and the literature presented in Chapter 3 of this study, it is clear that a range of different professionals with individual expertise would be providing services to vulnerable children.

A child who may be vulnerable through poverty or abuse and neglect within their social environment may need the services of a social worker, nutritionist or an ECD practitioner, who supports the child through an ECD programme. A child who may be vulnerable through illness or disease – a biological factor – may need the services of a health professional, such as a medical doctor, paediatrician or professional nurse. A child with a developmental delay or a disability may need the services of many different professionals, such as health care professionals, social workers and ECD practitioners. For this reason, the research population was defined to include a range of professionals working with vulnerable children and their caregivers. Secondly, the research population was defined to include the caregivers of vulnerable children as the research paradigm of interpretivism, the qualitative research approach and the intervention research design adopted by the study both supports and values the subjective day-to-day and real insights of participants so that deeper understanding of needs and interventions can be sought.

The caregivers of vulnerable children may not have the individual medical, social, psychological, or educational expertise of the different professionals but they will have the unique and subjective knowledge and understanding of their child that comes from living with and caring for the child daily. They are thus in a position to shape a home-visiting programme model that is contextually suited to the family and community within which the child exists. The population for this study was thus made up of professionals from health, such as medical practitioners, nurses and dieticians, from the social sciences, such as social workers, child and youth care workers and auxiliary social workers as well as professionals from education, such as ECD practitioners and educators. The caregivers of vulnerable young children, who are knowledgeable about

the needs of their own young children and the context within which they can be supported, were also included.

A sample is understood as a “set of respondents or participants selected from a larger population” (Lumadi, 2015, p. 226). Once the research population has been clearly defined and identified, the sample can be selected. A sample is selected as it is almost always impossible to study the entire population (Lumadi, 2015; Maree & Pietersen, 2016). In this study, it would have been impossible to interview all professionals who work with vulnerable children or all the caregivers of vulnerable children as the population is simply too large. Furthermore the total number making up the population would be impossible to determine due to the vastness of the province and many different private and government departments that offer different services to vulnerable children. Determining who the sample would be made up of and the number of participants was thus essential for the study. For sampling, it is essential to clearly define size, who the sample will be made up of and the reason for the specific way in which the sample was selected (Fouche & Delport, 2011, p. 110). In interpretivist, qualitative studies, the sample size cannot be determined without the concept of saturation being unpacked.

Saturation is understood as the point where no new themes or subthemes are emerging or no new data is being generated and is, as such, closely connected to determining the sample size in qualitative research (Nieuwenhuis, 2016). Determining the sample size based on the point of saturation is essential as it indicates that further data collection is unnecessary (Saunders, et al., 2018). Furthermore Nieuwenhuis (2016) states that excellence in a qualitative study is closely linked to saturation. Various suggestions exist with regards to sample size in a qualitative study. For ethnographic studies, 30 to 60 participants are suggested (Bernard, 2000; Morse, 1994). Bertaux (1981) suggests that 15 is the minimum number of participants and Guest et al. (2006) found that by 12 participants the point of saturation had generally been reached.

Other than saturation, it is important to ensure that the amount of data in a qualitative study is not too large so that the extraction of data becomes challenging (Nieuwenhuis, 2016). After taking these factors into account, it was decided that the sample for this study would include 24 professionals made up of eight health care professionals, eight social science professionals and eight early childhood professionals, all of whom have individual expertise in the area of vulnerable children. Eight caregivers of vulnerable

children were also included in the sample. This would ensure that the sample size fell within the requirements for a qualitative study and that both professionals and caregivers were given an opportunity to participate in the study. The sample size was, however, flexible in that saturation would guide the sample size to ensure the production of excellent information. This is supported by Nieuwenhuis (2016, p. 85), who suggests that, in addition to saturation guiding the sample size, a funnelling approach can be used to determine a sample that provides "sound expertise, rich experience, detailed knowledge and an ability to convey these verbally". Table 4.3 shows the intended sample size and the actual sample size, which was eventually informed through willingness to participate in the study and data saturation.

Table 4.3: Sample size

POPULATION	INTENDED SAMPLE SIZE	ACTUAL SAMPLE SIZE
Health care professionals	8	6
Social Sciences	8	6
Education	8	6
Caregivers	8	9
TOTAL	**32**	**27**

The intended sample size for professionals was not achieved as data saturation was reached by the 18th interview. After discussing this during supervision meetings, data collection with the professionals was ceased after 18 interviews were completed. For the caregivers, the actual sample size exceeded the intended sample size. The researcher exceeded the intended sample size as some of the interviews conducted were relatively short and it was thus decided that the sample size could be increased. Although the sample size for the caregivers was exceeded, the researcher had hoped to continue with a few more interviews until data saturation was reached. However, this proved impossible due to the context of Covid-19 and the constant lockdown scenarios enforced by government during this time which stretched from March 2020 until the end of 2021, making access to caregivers difficult to facilitate.

The researcher conducted introductory email or telephonic interviews with the professionals to determine their expertise, knowledge and willingness and ability to participate in the study before in-depth interviews were conducted. The professionals

were subsequently asked to enquire with the caregivers whether they would be willing to participate in the study. The researcher then followed up with each caregiver in an introductory meeting before the interview began to determine their voluntary participation.

4.5.1 Sampling procedure

There are two predominant types of sampling procedures that can be employed when research is conducted. The first is probability sampling and the second is non-probability sampling (Lumadi, 2015). Probability sampling suggests that each member of the population has the same chance of being randomly selected to participate in the study (Maree & Pietersen, 2016). When probability sampling is used, it allows for the generalisation of findings across the population (Maree & Pietersen, 2016). There are three different types of probability sampling: cluster, random and simple random sampling and these are mostly used for doing quantitative research (Lumadi, 2015). The main advantage of probability sampling is that when the entire population is known and each member of the population has an equal chance of being selected to participate in the study, then inferences can be made about the entire population, allowing for generalisations of findings across the population (Lumadi, 2015; Maree & Petersen, 2016; Nieuwenhuis, 2016).

Probability sampling was not feasible for the purposes of this study as it was impossible for the researcher to access or create a list of all the professionals who work with vulnerable children, or the caregivers of vulnerable children in the Eastern Cape province. Such a list does simply not exist and would be very time-consuming and difficult to create. The second type of sampling, non-probability sampling, was used for this study and is described in the paragraph that follows.

Non-probability sampling is not based on randomness or the probability theory. Rather, it collects samples using a process that does not allow each member of the population an equal chance of being chosen to participate in the research (Lumadi, 2015; Maree & Pietersen, 2016). Nieuwenhuis (2016) confirms that qualitative studies generally make use of non-probability, purposive sampling. The disadvantage of non-probability sampling is that generalisations have to be made with caution or not at all as the sample used may not be randomly representative of the population (Maree & Pietersen, 2016). While researchers are urged to use non-probability sampling with caution, there are

times when it can be advantageous. Maree and Pietersen (2016) confirm that non-probability sampling should be considered when results are needed quickly, when the measuring instrument needs to be tested, when preliminary studies need to be done, when finances are limited or when the population may be challenging to access.

Non-probability sampling is used mostly in qualitative studies as it allows the researcher to "seek out individuals, groups and settings where the specific processes being studied are likely to occur" (Denzin & Lincoln, 2000, p. 370). For this study, non-probability sampling was used as firstly, it worked well with the research paradigm and approach that were selected for the study, allowing participants to be directly approached in a setting where they were expected to be working with vulnerable children. Secondly, it allowed the participants to be approached quickly, with little cost and without the challenges of requiring a database or list to be developed and accessed before they could be selected to participate in the study.

Non-probability sampling allows for a rich collection of deep data to be collected from specific participants as these participants are not just individuals, but rather represent "social experiences and processes" that will not be unique to them (Strydom & Delport, 2011, p. 391). In this way, the non-probability sampling of professionals and caregivers from the study population should represent some attributes of the general population, making generalisations possible. There are four different types of non-probability sampling namely: convenience sampling, quota sampling, snowball sampling and purposive sampling (Maree & Pietersen, 2016). Purposive sampling and snowball sampling were used in this study and are discussed in further detail in the sections that follow.

4.5.2 Purposive sampling

"This type of sample is selected based on the knowledge of a population and the purpose of the study" (Lumadi, 2016, p. 235). Purposive sampling is used in unique situations with a specific aim in mind (Maree & Pietersen, 2016). The paediatrician from a state hospital in the Eastern Cape province was purposefully approached to participate in this research as she had shared the work that she does with vulnerable young children at a training session attended by the researcher. During this training, the paediatrician had expressed her dismay at not being able to continue supporting and monitoring vulnerable children once they had left the hospital. The paediatrician was thus selected based on

her knowledge of vulnerable children and her access to both the study population of other professionals working with vulnerable children and caregivers of vulnerable children through her work at a local state hospital. In addition to the paediatrician, the researcher purposefully approached educational professionals who had attended the same training as the researcher. During this training, these professionals had also expressed their knowledge and working experience in relation to ECD and vulnerable children. Lastly, three non-profit organisations (NPOs) that work with vulnerable children and are well known in the local community were purposefully approached to participate in the study. In this way, purposive sampling was used to identify the participants for the study.

4.5.3 Snowball sampling

Snowball sampling is used when "the population is difficult to find or where research interest is in an interconnected group of people" (Maree & Pietersen, 2016, p. 198). Snowball sampling entails approaching a single participant who is a part of the research population and then requesting that participant's assistance in reaching other participants (Strydom & Delport, 2011). Once some of the professionals were purposefully selected to participate in the study, these professionals were asked to identify other professionals and caregivers of vulnerable young children who they may have worked with before or who they thought may be interested in participating in the study. For example, the paediatrician was able to connect the researcher to the nursing manager of the hospital, who then referred the researcher to two senior nursing staff in the paediatric wards. These two nursing professionals were then interviewed and, in turn, introduced the researcher to the hospital dieticians as well as various caregivers who were at the hospital with their vulnerable children. Snowball sampling was thus used to identify some of the professionals for the study, and the second group of participants namely, the caregivers of vulnerable young children.

4.6 Methods of data collection

For Phase 1 and Phase 2 of the study, data was collected through individual interviews. Each individual interview was guided by an interview schedule. For Phase 3 of the study, the guideline document was refined and consolidated through a consensus workshop. Each of these is discussed in more detail below.

4.6.1 Individual interviewing

"An interview is a two-way conversation in which the interviewer asks the participant questions to collect data and to learn about the ideas, beliefs, views, opinions and behaviours of the participants" (Nieuwenhuis, 2016, p. 92). Interviewing is thus used when the study seeks to understand the self of the participant in relation to the particular area being studied. Dakwa (2015) confirms that an interview is a planned face-to-face engagement with answers being sought which can then be analysed in qualitative research. Dakwa (2015) emphasises that interviews should be orderly, rational and planned and that they should only include questions that relate directly to the study's research aim and objectives. The advantages of interviewing include being able to interview participants who may be illiterate, being able to probe if a participant's answer is too short or unclear and it allows the researcher flexibility – often resulting in deeper and more meaningful data (Dakwa, 2015).

Greef (2011) notes that interviewing is the most dominant method of data collection for qualitative studies. Interviewing was chosen as the appropriate method of data collection for this study as it supports the research paradigm, approach and design used by the study. In addition to this, interviewing has allowed the caregivers of vulnerable children to be included in the study, regardless of whether they are literate or not, and it has allowed the researcher the opportunity to ask open-ended questions, leaving participants free to elaborate and share their experiences. Although interviewing was seen as the best method of data collection for this study, various authors have noted the weaknesses of this method of data collection. Interviewing can be costly and time-consuming, requiring the researcher to personally contact each participant and record and transcribe the interview, both of which incur monetary and time costs (Dakwa, 2015).

A further concern with interviews is that the participant may feel intimidated by the researcher, may not open up due to fear of judgement or may deliberately not reveal useful information (Dakwa, 2015). These weaknesses were acknowledged and understood, however, the advantages of this approach were seen to outweigh the weaknesses for this particular study. Even taking the weaknesses of interviews into account, they allow the researcher to acquire rich detailed and dense data that supports understanding the experiences of participants and the way in which they view these (Nieuwenhuis, 2016). Furthermore, if the researcher is able to build a trusting

relationship with the participant, it will result in information that might be difficult to collect using any other method (Nieuwenhuis, 2016).

There are different types of interviews, ranging from unstructured to semi-structured and structured. The unstructured interview does not have any specific format; it is free flowing and conversational. However, the researcher is always aware that such a conversation may result in rich informational data (Dakwa, 2015). The semi-structured interview makes use of some specific open-ended questions that are directly related to the area being studied. This is then followed by probing and clarification from the researcher to elicit a rich set of data (Nieuwenhuis, 2016). For most qualitative studies, either the unstructured or semi-structured interview is used (Greef, 2011). The structured interview contains specific questions that are set out ahead of time and are then asked sequentially by the researcher (Nieuwenhuis, 2016). For this study, the semi-structured interview was chosen as it allowed the researcher to develop some key interview questions that related directly to the research objectives and would assist in ensuring that the overall aim of the study is met. At the same time, it allowed the participant an opportunity to share additional information that could lead to new themes emerging.

4.6.2 Interview schedule

Once a decision was taken that semi-structured interviews would be best suited for the collection of data for this study, the researcher began to develop interview schedules as the research instruments to be used to collect data from the participants. Interview schedules are useful in both individual and focus group interviews as they provide some structure yet allow enough room for participants to share their own perspectives and to give input throughout the phases of the intervention research design (Bryman, 2012). Greef (2011) confirms that the interview schedule is prepared beforehand and guides the interview, supporting the process of engagement with the participant. With this in mind, an interview schedule consisting of nine open-ended questions was developed. Greef (2011) advises that the questions should follow a natural order and that they should be relevant and appropriate to the research topic. With this noted, each of the questions was developed to support the research objectives and questions that have guided the study and that relate directly to the research topic. A sample of the interview schedules that were used for the study are attached as Appendix F and G.

4.6.3 A consensus workshop

A consensus workshop is goal-oriented and aims to bring about “meaningful dialogue” between practitioners and researchers (Sabir, 2006, p. 833). This dialogue, in turn, informs contextually relevant interventions that are more likely to be implemented in practice (Glasgow et al., 1999; Glasgow et al., 2001). For these very reasons, once the individual interviews were completed and the first four objectives had been achieved, a consensus workshop was facilitated so that professionals working in the field with vulnerable children could give input into the guidelines that were developed in order to achieve Objective 5.

A consensus workshop was chosen by the researcher to ensure that the guidelines would be contextually relevant and that there was more likelihood that the guidelines would be accepted by professionals and caregivers for implementation in practice. Stokes (1997) notes that too often intervention research does not reflect the reality of the people who may inevitably need to use it, resulting in challenges with practical implementation and poor outcomes. A consensus workshop thus assists in bridging the gap between research and practice and is especially relevant for this study, where guidelines for a model of a contextually based home-visiting programme were sought to be developed for use in practice to support vulnerable children in the Eastern Cape province.

Before the consensus workshop was facilitated, the draft guidelines were circulated to the professional participants who had been interviewed for the study. Each participant was invited to give input into the draft document. The individual inputs were then worked into the guideline and presented as a part of the consensus workshop. For the consensus workshop, the professional participants were invited to attend a workshop where consensus was reached regarding the guidelines and inputs received during round one. Sabir et al. (2006) strongly supports the involvement of those who work on a day-to-day basis within the area that is being researched. When programmes are being developed, this may especially support effectiveness in practice. A sample of the draft guidelines, with input received and consensus reached, is attached as Appendix H.

4.7 Actual process of data collection

The process of data collection began with a pilot study towards the end of the first quarter of 2021. A pilot study is conducted in order to improve the quality of the study, to support

the credibility of the data collection tools and to ensure that the researcher is better prepared for the collection and analysis of data in the subsequent study (Malmqvist et al., 2019). For these reasons, a pilot study was done before continuing with data collection and analysis on a larger scale. Five professionals were emailed and invited to participate in the pilot study. These professionals all initially agreed to participate with one interviewee postponing their interview, which was then rescheduled to a later stage.

Once all four participants were interviewed, the interviews were transcribed. The semi-structured interview schedules were then critically examined and refined to ensure that they aligned to the research questions and that the data being collected aligned to the overall aim and objectives of the study. Consequently, three sub-questions were added. The first emerged in relation to the context of Covid-19 and its impact on the needs of children and the services being rendered to vulnerable children. The second emerged after the researcher noted that all the professional participants who had been interviewed thus far were female, possibly suggesting that the present workforce in ECD was made up of mostly females. Although the gender of the facilitators of an early childhood home-visiting programme model was not explicitly discussed in any of the pilot study interviews, when the researcher examined the demographics of the participants from the pilot study, she found that all the participants were female. The researcher felt that this demographic may indicate that the early childhood workforce was primarily female. This then led the researcher to consider what the implication of the early childhood workforce being largely female may be for the home-visiting workforce of the programme being developed by this study. The pilot study thus indicated that a sub-question in relation to the gender of the workforce required for such a programme should be included in the interview schedule. The third sub-question emerged in relation to the guidelines for a model of a home-visiting programme with reference to the registration of such a programme. The first and third sub-questions were added after the pilot study indicated that the context of Covid-19 as well as the context of legislation and the registration of programmes were influential in impacting the type of support that could be offered at a household level to vulnerable children and their caregivers.

The pilot study thus supported the quality of the study as it confirmed the credibility of the data collection tools and ensured that the researcher was better prepared for large-scale data collection and analysis in the subsequent study.

The researcher also encountered some challenges in the pilot study. Microsoft Teams (MS Teams) was used to interview many of the participants, which was mainly due to Covid-19 and the need to limited personal interactions. This approach became challenging as participants needed to have data and electricity, which was not always guaranteed with data being costly and load shedding (a period without electricity) being a common occurrence in South Africa. This resulted in some interviews having to be rescheduled. In addition to these challenges, one interview did not download with sound and had to be redone. A second interview did not download completely, resulting in the researcher having to work from the notes that were taken during the interview, which then had to be checked by the participant before being used. While these challenges were disappointing and discouraging, they were overcome and did not occur again during consequent interviews.

Once the pilot study was completed, a further number of professionals were emailed and their participation in the research study was requested. Of the 18 professionals that were interviewed, four were able to identify caregivers who may be interested in participating in the study. These professionals approached the caregivers on behalf of the researcher to determine their willingness to be interviewed. The caregivers were then approached by the researcher, with their prior permission, and the interviews were conducted. At the end of these interviews, the caregivers were asked if they knew of any other caregivers who may want to be interviewed for the study. Three of the participants were able to refer the researcher to other caregivers whom they knew from being at the hospital with their children. In this way, a total of seven caregivers – all within a health care facility – were identified using snowball sampling and were subsequently interviewed for the study. A further two caregivers were approached purposively by the researcher as they were both foster parents working closely with a child protection agency. The researcher knew that they were well respected for the care that they provided for vulnerable children and that they had many years of experience in doing so. Both agreed to participate in the study. A time and date were set up with them at their convenience and the interviews took place.

The context of Covid-19 made the process of data collection quite complicated. At the height of infections during the first, second and third waves of Covid-19, health care facilities became very strict in terms of who they allowed into the facilities. The researcher was also wary in terms of her own exposure risk to Covid-19 and of collecting

data in a hospital setting prior to receiving her Covid-19 immunisation. Covid-19 also made access to participants more complicated, with caregivers being required to stay in locked isolation rooms with their children until their Covid-19 tests came back negative. These caregivers could thus not be interviewed. Although the caregivers who had negative results for Covid-19 could then leave the isolation rooms, they were not allowed to leave the health care facility or have any visitors during their stay.

Literature states that many vulnerabilities experienced during early childhood result in, or are related to, issues of poor health – thus the researcher knew that a good place to find participants may be the hospital setting. Numerous attempts to meet with a third group of caregivers were made. These caregivers were identified by one of the professional participants who informed the researcher that she knew these caregivers through a groupwork programme in a local community. The date was set, and the researcher went ahead and prepared for the interviews with some of these caregivers. Unfortunately, on the weekend before the planned interviews the third wave of Covid-19 reached a point where the government enforced level four lockdown; no social gatherings were allowed, and only essential services continued due to Covid-19 restrictions. The professional participant who had connected the researcher to the caregivers then cancelled the appointment for these interviews due to level four lockdown restrictions. This was most unfortunate, but the researcher had to resign herself to the fact that the circumstances facing our NPOs and communities at that time was out of the ordinary and that the laws of the country regarding lockdown had to be respected and adhered to. Despite these complications, the researcher was able to exceed the intended sample number of caregivers. This process concluded Phase 1 and Phase 2 of the research design.

For Phase 3 of the research design, the draft guidelines were circulated to all 18 of the professional participants, who essentially constituted a panel of experts, for input. Three of the participants gave input and this was incorporated into the draft guidelines document. Several other participants promised to send input but after two weeks, despite follow-up, had not done so. A consensus workshop was then set up and all 18 participants were invited to attend so that a process of agreement could be reached with regards to the guidelines. Six participants attended the workshop consensus. Participants added one practice principle to the guidelines document and recommended some additional detail be added to processes throughout the guidelines document. After

two hours, consensus for each practice principle and the related processes was reached and the workshop was ended.

This entire process of data collection and data analysis took place over a period of one year. The process of data analysis is outlined in more detail in the section that follows.

4.8 Data analysis

Data analysis is intricately intertwined to credibility, dependability and conformability in qualitative research and, as such, should be done systematically and with careful consideration (Macguire & Delahunt, 2017). For qualitative studies, thematic analysis is commonly used as it provides a flexible method for the identification of themes, patterns and meanings (Braun & Clark, 2006; Clark & Braun, 2013; Macguire & Delahunt, 2017; Willig, 2013). Of importance is that thematic analysis should not only summarise the data that is collected; it should move deeper and beyond simply being a summary and should look for the meanings, ideas and beliefs that underlie what participants are sharing (Braun & Clark, 2006). In order for data analysis to begin and be completed with credibility, it should be implemented in an organised, practical and step by step manner that can be explained and applied throughout the process of data analysis (Evans & O'Connor, 2017).

Braun and Clark (2006) present a six-step process that can be followed to ensure that thematic analysis is done authentically and that it moves beyond simply becoming a summary of the data that was collected. The six-step process by Braun and Clark is one of the most influential in the social sciences as it provides a practical method to ensure that thematic analysis is done accurately (Macguire & Delahunt, 2017). These six steps were followed for the thematic analysis of data in this study as they are highly regarded in research, and, in addition, they are detailed and intricate thus supporting the trustworthiness of the study. Each of these steps and the way in which they were used to guide data analysis during this study are outlined below.

4.8.1 Step one: Becoming familiar with the data

Step 1 involves becoming familiar with the data (Braun & Clark, 2006; Maguire & Delahunt, 2017). For this study, the researcher ensured that this was done by firstly, doing the interviews herself and making notes during the interviews. Additional notes were made after the interviews, with the researcher listening to the recordings of the interviews and reading and rereading the transcripts from the interviews until the

researcher felt that she was comfortable with the data that was collected. The researcher consulted the notes taken during the interview and incorporated these with the additional notes made per hand on the transcripts to support familiarisation with the data. Once completed, and, where possible, transcripts were emailed to participants for checking. Three participants responded by adding or making changes to the initial interview, and these changes were then incorporated into the transcripts. Once the researcher had achieved the first step of becoming familiar with each transcribed interview, Step 2 and the process of generating initial codes could begin.

4.8.2 Step two: Generate initial codes

The second step in data analysis involves the arrangement of data in a manageable and systematic way (Braun & Clark, 2006; Maguire & Delahunt, 2017). For this study, the data was arranged according to the research questions that had guided the study with any relevant and interesting data being coded as the researcher progressed. Open coding was used for this study. Open coding involves developing codes as the data is analysed with no pre-set codes being prescribed before data analysis begins (Maguire & Delahunt, 2017). Once the first step of becoming familiar with the data was completed, the researcher set about generating initial codes from the first transcript. An independent coder assisted with the same process and once both the researcher and the independent coder had completed the process of coding, the coding was compared, discussed and modified before moving to the next transcript. Although an independent coder is not essential, it can be useful to support the trustworthiness of the study (Maguire & Delahunt, 2017). The step of generating initial codes was completed for each of the transcripts before moving on to Step 3, which is searching for themes.

4.8.3 Step three: Search for themes

Once the initial coding has been completed, the researcher can move on to Step 3 of the analysis process. Step 3 involves identifying particular themes that represent something significant or of particular interest in the data that were collected and coded (Braun & Clark, 2006; Macguire & Delahunt, 2017). A theme may thus pull together some of the initial codes or it may stand alone if it represents something interesting that emerged in the data. Once the initial coding on the data was completed, it was then possible to begin searching for themes to pull together patterns that had emerged. The researcher worked closely with the independent coder and the supervisor during this step to support trustworthiness.

4.8.4 Step four: Review the themes

Once the themes have been developed in Step 3, they need to be reviewed in Step 4. Reviewing the themes involves checking and rechecking that the themes make sense, that there is no repetition, and that the data does actually support the themes that have been developed (Braun & Clark, 2006; Macguire & Delahunt, 2017). Here the researcher, once again, worked very carefully, using supervision to ensure that this was done with trustworthiness. Step 4 also involved grouping initial codes under each theme into subthemes, where possible (Braun & Clark, 2006; Macguire & Delahunt, 2017). In addition, this step was supported by checking that the themes emerged across data sets with the prevalence of the theme noted.

4.8.5 Step five: Define the themes

Step 5 follows on Step 4 in that it involves the refining of themes (Macguire & Delahunt, 2017). This refinement should ensure that each theme accurately represents the idea or pattern that emerges from the data as well as describe how the subthemes and categories relate to the main theme (Clark & Braun, 2013; Macguire & Delahunt, 2017). This final set of themes, subthemes and categories was carefully reviewed during supervision and was then used to guide the writing up of the themes, as discussed in Step 6 below.

4.8.6 Step six: Write up the themes

The last step in thematic analysis involves the writing up of the themes in the thesis, research report or research paper (Braun & Clark, 2006; Maguire & Delahunt, 2017). Once the first five steps of thematic analysis were completed, the themes, subthemes and categories were then written up in the thesis. In addition, the writing up of each category was supported by verbatim extracts taken from the transcribed interviews. In this way, each theme, subtheme and category were supported. The presentation and discussion of the data can be found in Chapters 5 to 9 of this thesis.

4.9 Trustworthiness of data

Lincoln and Guba (1999) suggest that the four criteria of credibility, transferability, dependability and confirmability are of the utmost importance in maintaining good quality during a qualitative research study. Morse et al. (2002) agree that validity or trustworthiness in a qualitative study is determined by these same four criteria and go on to say that qualitative rigour is shown by openly disclosing the research process that

was followed, ensuring member checks during coding, obtaining participant feedback and checks, and regular debriefing of the researcher. Okeke (2015) notes that while quantitative studies seek to separate themselves as much as possible from participants in order to maintain validity, this is not the same in a qualitative study. Rather, qualitative studies seek to engage with their participants so that personal experiences and beliefs can be shared (Okeke, 2015). For this reason, dependability and transferability are sought in a qualitative study while reliability and generalisability are sought in a quantitative study (Okeke, 2015; Schurink et al., 2011). The criteria that support the trustworthiness of this study as well as the processes that were put in place to maintain trustworthiness are presented in the sections below.

4.9.1 Credibility

Credibility, which is also known as authenticity, has the goal of demonstrating "that the inquiry was conducted in such a manner as to ensure that the subject has been accurately identified and described" (Schurink et al., 2011, p. 419). Credibility is enhanced through the use of well-known research paradigms, and the overall alignment between the research approach and design with the theoretical framework and research aims and objectives (Nieuwenhuis, 2016). For this study, the research paradigm, approach and the research design were clearly described and aligned through the use of multiple theoretical sources. This can be seen at the beginning of Chapter 4. Furthermore, the development of the research instruments was closely guided by the aim and objectives of the study. This ensured that the data collected did indeed fit the overall aim and objectives of the study – resulting in a study that is credible. Moreover, after each semi-structured interview, the researcher sought debriefing with a trusted and experienced colleague in the field, sharing the story of data collection as well as sharing the actual interview schedules and recordings where needed. In addition, after the interviews were transcribed, where possible, they were sent to the participants for verification and comments. The researcher was left with some questions after two of the interviews and these were sent through to the participants by email and permission to use the additional information received was given in writing by the participants. Where participants asked not to be recorded, the notes taken during the interview were shared with them and verified before being used in the study. Nieuwenhuis (2016) confirms that debriefing the researcher through supervision and participant checks of the transcripts and notes supports credibility.

4.9.2 Transferability

Transferability replaces generalisability in a qualitative study and refers to the ability of the study's findings to be transferred from the study to a similar scenario or case (Okeke, 2015; Schurink et al., 2011). To enhance transferability, the study should work closely within already proven theoretical frameworks and bodies of literature to show that the study is guided by these and that findings may then be transferred to other cases that fall within this same theoretical framework and body of literature (Schurink et al., 2011). To support transferability, the researcher has worked closely with the biopsychosocial framework as the theoretical framework for the study, intertwining it closely to the literature that was reviewed, the findings that emerged during data collection and analysis, and the consequent development of guidelines for a model of an early childhood home-visiting programme. Schurink et al. (2011, p. 420) go on to explain that transferability can, in addition, be supported through "triangulating various sources of data" such as multiple cases, participants or different methods of data collection. Transferability was thus further ensured through the sample comprising multiple participants from within the research population.

The first source of data came from a range of professionals working with vulnerable children in different settings. The second source of data came from the caregivers of vulnerable children. Transferability can also be supported by a clear statement outlining the role that the researcher played during the research process and through the inclusion of detailed information relating to participation, the research situation and methodology, and a clear theoretical orientation resulting in a final research report that is descriptive and rich (Smaling, 2003). The researcher has, for this reason, clearly outlined the research process that was followed as well as provided a detailed theoretical description of the research methodology that has guided the study. Transferability was further enhanced throughout the chapters of the study by striking a good balance between the inclusion of theory and a narrative of the research process. This resulted in chapters and a final report that are descriptive and detailed.

4.9.3 Dependability

Dependability refers to the manner in which the entire research process has maintained consistency and is determined by the quality of the research report, which is closely examined from the initial stage of research design through to the methods of data collection, analysis and the presentation and analysis of the findings (Okeke, 2015). For

this reason, the researcher ensured that the research report was well written with careful attention given to explaining and documenting the research process in a manner that would be easily understood by the examiners and readers of the report. This detail is evident throughout this chapter and the chapters that follow; the research paradigm, approach and design are carefully aligned to support one another, the population and sample are clearly defined, and the research process and analysis of data is described in careful and detailed narratives.

4.9.4 Conformability

Conformability refers to “the degree of neutrality or the extent to which the findings of a study are shaped by the participants and not by researcher bias, motivation or interest” (Lincoln & Guba, 1985 as cited in Nieuwenhuis, 2016, p. 125). Schurink et al. (2011) agree stating that conformability captures the ability of the researcher to remain objective throughout the study and, in particular, to present and analyse the research findings without bias. In order to try and maintain objectivity, the researcher has endeavoured to carefully document the steps followed in collecting and analysing the data as well as attach supporting documents to this report in the form of transcripts, initial notes documenting the emerging themes and the final themes and subthemes. In addition, participant quotes are included in the five chapters that present and discuss the findings. These quotes were carefully selected as evidence of the themes that emerged. Furthermore, careful attention was also made to include quotes that were different in order to show that the researcher acknowledged these differences. Nieuwenhuis (2016, p. 125) agrees that conformability is supported when the study creates a good “audit trail” of how the data was collected and analysed and when participants’ quotes are included as support for the themes that emerged.

4.10 Ethical considerations

Conducting research allows researchers certain freedoms in the search for knowledge and with this freedom comes a responsibility “to act responsibly and with integrity” (Sotuku & Duku, 2015, p. 113). When research is conducted, researchers need to maintain research integrity and should be guided by principles, such as honesty, truthfulness and reliability (Sotuku & Duku, 2015). Ethics flow from values and principles, which are beliefs about what is acceptable and what is not acceptable.

To ensure that this study adhered to the research ethics of the University of Fort Hare and the Faculty of Social Sciences and Humanities, approval for the study was sought from the University Research Ethics Committee (UREC) and the Inter Faculty Research Ethics Committee (IFREC). Once the study was approved by these committees, an ethical clearance certificate was granted. The UREC ethical clearance certificate is attached as Appendix A. In addition, ethical clearance was sought from the Cecilia Makhiwane (CMH) and Frere Hospitals Research Ethics Committee, as one of the sites was used to access participants for the study. This ethical clearance certificate is attached as Appendix B. It was also hoped that the DSD would participate in the study and although ethical clearance was requested on numerous occasions, it was never received. Thus, the DSD was unable to participate in the study. The following research ethics and principles, as identified by Sotuku & Duku (2015), have guided this study so as to ensure that research integrity has been maintained.

4.10.1 Informed consent

Informed consent is a principle that ensures that participants are fully informed about personally being researched and are given a choice about whether they wish to participate in the research or not (Sotuku & Duku, 2015). This requires an openness on the part of the researcher who should clearly and articulately communicate the aim of the research, the process that will be followed and any harm that the participant may be exposed to by participating in the research (Creswell & Poth, 2017; Strydom, 2011). Sotuku and Duku (2015) go into even more detail outlining that in addition to the above, the participant should be informed as to how the research findings will be shared and used, who they are able to contact about the study and confirmation that they are free to withdraw from the study at any time with no negative repercussions for such a decision. Informed consent is achieved through a verbal voluntary agreement by the participant to participate in the research which is then followed by informed consent given in writing (Sotuku & Duku, 2015).

For this study, the researcher developed a letter inviting participants to voluntarily participate in the research. This letter is attached as Appendix C. A second more detailed letter that outlines the aim and objectives of the study, the research process that will be followed and outlines the risks that the participant may face by participating in the research was also developed. This is attached as Appendix D. In addition, the letter indicates that the data will be shared in this thesis, academic journals and conferences

and that it will be used to develop guidelines for a model of an early childhood home-visiting programme to support vulnerable children in the Eastern Cape province. Lastly, the letter explains that the participant is free to withdraw from the study at any time and that this will not result in any negative repercussions. This letter was given to each participant before they participated in the research interview. The contents of the letter were clearly explained to each participant and each participant was given an opportunity to ask any questions that they may have before agreeing to voluntarily participate in the research interview.

The agreement of the participant to participate voluntarily in the study was then consolidated through signed consent. The signed consent form was attached as Appendix E. In addition to the participants giving voluntary informed consent, consent was also sought from the Eastern Cape Department of Health, Eastern Cape Department of Social Development and the NGO's who employed the professionals who participated in the study. Such consent is identified as substitute consent and is sought when the person participating in the research may not have the authority to make the decision of informed consent (De Wit, 2013; Sotuku & Duku, 2015).

The consent of an employer is required for many employees before they decide whether they would like to participate in research that relates to the work that they are involved in. The researcher respected this and thus sought substitute consent from employers before approaching participants directly. For the hospital site and the child protection NPOs, substitute consent was given either verbally or in writing as per the policy of the employer before individual participants were approached. Despite numerous follow ups, the Eastern Cape Department of Social Development did not respond to the request for their participation in the study and thus they did not grant consent for participation. This resulted in participants from this government department not being approached to participate in the study.

4.10.2 Beneficence

Beneficence refers to the benefits that the research may have for participants and implies that research should be conducted in such a way that there are benefits for the participants themselves, for other people and for society as a whole (Sotuku & Duku, 2015). The research should thus generate new knowledge that may benefit the participants, other people in the Eastern Cape province and society. The responsibility

of sharing the findings of the study with the public becomes important here as the study remains meaningless if not shared (Strydom, 2011). This ethical consideration was upheld by completing the study and the thesis in a manner that was as accurate as possible. Participants were also given access to their own transcripts and an opportunity to make changes in an effort to enhance validity. Once the guidelines for a model of an early childhood home-visiting programme were developed, these were shared with participants in a focus group. In addition, each of the professionals were given the opportunity to refine the guidelines, all input was anonymised and then recirculated until the professionals were able to reach agreement and no further changes were recommended.

The preliminary findings were disseminated through a book chapter that outlined the neglect of young children in South Africa and made policy and programmatic recommendations. Once the study was completed, the findings were disseminated to all participants and stakeholders in a research report. This report has subsequently been submitted for publication in a South African journal. It is also hoped that the researcher will have an opportunity to present the report at an academic conference in the near future. Cresswell and Poth (2017) agree that once the study is completed, it should be shared with as many audiences as possible in order to ensure that the knowledge generated is able to benefit society as a whole. Lastly, the researcher has sought a partnership with other experts and funders in an effort to implement the home-visiting programme so that vulnerable children in the Eastern Cape province can be further supported towards optimal development.

4.10.3 Non-maleficence

The principle of non-maleficence upholds that there should be no intentional harm done to the participant and that potential harm should be minimised (Sotuku & Duku, 2015). At no point in the research should the participants be harmed or be placed at risk of any physical, psychological, emotional, social or economic harm. The researcher recognised that discussing and sharing the needs of vulnerable children may be upsetting to the participants and, for this reason, the researcher endeavoured to ensure that no participants were pressured into participating in the research. Creswell and Poth (2017) support that participants should not be forced into signing consent forms.

The researcher ensured that at all times there was respect for participants' self-determination in deciding whether or not to be a part of the study. Some participants indicated that they would participate in the study but stated that they did not wish to be recorded. The researcher respected this and renegotiated with these participants who then agreed to the researcher taking notes during the interview. The researcher also ensured that sufficient time was spent debriefing the participants after the interviews and referred them to any support services that were needed so that the principle of non-maleficence was upheld. This was particularly important in this study as participants shared stories of vulnerable children and the risk factors that they were exposed too. In such cases the researcher ensured that participants were able to access the necessary services needed to protect these children.

4.10.4 Respect for anonymity, confidentiality, and privacy

During the analysis and reporting of data, it is important to respect the participants' privacy and to ensure that participants cannot be identified (Creswell & Poth, 2017). Anonymity is a principle that ensures that the identity of each participant is protected both during and after the study, making them unidentifiable (Sotuku & Duku, 2015). Participation in a research study may lead to participants indirectly giving up some of their privacy and, as such, it is important that participants are given an opportunity to decide with the researcher when their identity and private information can be shared with others, how much information can be shared or withheld from others, and the conditions under which their identify and information can be shared (Sotuku & Duku, 2015). Strydom (2011) agrees that in all circumstances, the amount and type of information that will be shared in the research report must be openly negotiated with the participant and that their refusal of consent must be respected and accepted. Evidence of the confidentiality statement that was presented to each participant was attached as Appendix D.

Four of the caregivers who agreed to participate in the study were hesitant to give consent for the interview to be recorded. The researcher respected this and asked if they would prefer the researcher to take notes rather than recording the sessions. The caregivers agreed to the researcher taking notes, and, at the end of the sessions, they checked these notes before giving permission for the notes to be used in the study. In order to ensure anonymity and protect privacy, the researcher assigned pseudonyms to each participant in the order that they were interviewed. This can be seen in Chapters 5

to 9 where professionals and caregivers are identified according to these pseudonyms. In addition to individual anonymity, it is also important to protect the identity of the research sites (Sotuku & Duku, 2015). In order to ensure this, the identifying names of the sites where the research was conducted are not revealed in this study; rather, they are described in general terms to protect their identity.

4.11 Biographical profile of participants

The biographical profiles of the two groups of participants – professionals working with vulnerable children and caregivers of vulnerable children – is presented and discussed in the sections that follow. For the professionals, the biographical profile examines age, gender, qualifications and working experience. For the caregivers, the biographical profile examines age, gender, education, relationship of the caregiver to the child, special needs of the child, number of children in the home and the source/s of household income.

4.11.1 Biographical profile of professionals

The following table introduces the biographical profile of the professionals that participated in the study.

Table 4.4: Biographical profile of professionals

CRITERIA	NUMBER OF PROFESSIONALS (N18)			
AGE OF PROFESSIONALS IN YEARS	20–29 years 1	30–39 years 4	40–49 years 6	50 years and above 7
GENDER	Male 1		Female 17	
QUALIFICATIONS	Matric 1	Diploma/Certificate 9	Honours degree 6	Master's degree 2
PLACE OF EMPLOYMENT	Tertiary state hospital 6	University 2	NGO/NPO 10	
YEARS OF WORKING EXPERIENCE	0–9 years 5	10–19 years 4	20 years and above 9	
EXPERIENCE WORKING IN A HOME-VISITING PROGRAMME	Yes 8		No 10	

Table 4.4 indicates that the majority of professionals who participated in the study were above the age of 40 years. The remaining participants were between the ages of 30 and 39 years while only one was younger than 29 years of age. The age of the participants may indicate that young people are less interested in the fields of health care, social work and ECD. This may be due to the difficult circumstances under which such professionals work or the low salaries often paid in these fields of employment. Various studies confirm that for jobs in health care, social work and ECD, there may be a lack of employment opportunities, such jobs are poorly remunerated, and they are often associated with high stress levels (Delobelle et al., 2011; Jobted, 2021; Kheswa, 2019).

The studies mentioned here could present some of the reasons why fewer young people choose to study in these fields. In the context of the Eastern Cape, a largely rural province, this may also indicate that the younger generation of qualified professionals prefer to work in urban areas. Delobelle et al. (2011) note the tendencies of graduates

to seek work in urban centres with fewer graduating professionals being willing to work in rural areas.

The majority of the professionals interviewed for this study were female with only one male. This did not present as problematic for the study as it was not intended to analyse data relating to gender. However, the female majority of professional participants may indicate that work with vulnerable children in the fields of health, social work and early childhood education is seen as appropriate for females and, as such, are dominated by women. Various South African studies have noted the dominance of females in the fields of health, social work and early childhood education (Khunou et al. 2012; Van den Berg & Ndoda, 2021).

A number of the professionals interviewed for the study had qualifications relating to health care, including one medical doctor who specialised in paediatric neurology, two nurses, two dieticians, one occupational therapist and one home-based carer. Table 4.4 indicates that of those with qualifications relating to health, four had degree qualifications, two had diploma qualifications and one had a certificate qualification. This may indicate that often both health professionals and health paraprofessionals are involved in offering services to vulnerable children. Some of the professionals interviewed for the study had qualifications relating to the social sciences. Three have degrees in social work, one had an auxiliary social work qualification and two had certificates in child and youth care.

Once again, from those participants with qualifications relating to the social sciences, it was seen that both professionals with formal degrees and paraprofessionals with certificate qualifications were involved in rendering services to vulnerable children. Fewer of the professionals interviewed for the study had qualifications relating to education; some were early childhood practitioners who also qualified as ECD trainers, one had an honours degree in education, and another had a master's degree in education. Lastly, few of the participants interviewed for the study had any formal qualifications relating to health, social and psychological well-being or the education of vulnerable children. One had a diploma in business management and the other had completed a matric.

This multidisciplinary approach of various professionals and paraprofessionals working together to support interventions relating to vulnerable children, particularly in the African

context, is supported by various other sources of literature as well as the biopsychosocial framework – the theoretical framework used for the study. Of the professionals interviewed for the study, the majority were employed by either a NGO or a NPO, some were employed by a tertiary state hospital and the minority were employed in education at a university.

Overall, the data presented in this section aligns well to the biopsychosocial model being used as the theoretical framework for the study, which highlights that during early childhood, biological, social and psychological factors should come together to influence the optimal development of the child. For this to occur in the life of a child who is facing risk factors that threaten their optimal well-being, a multidisciplinary team will be needed to support the child and their caregiver. This team will be found working at government institutions and within the non-government sector, both of which are committed to serving vulnerable children. This partnership between various governmental departments and NGOs/NPOs is noted and supported by the DSD, one of the main custodians for vulnerable children (DSD, 2021).

Table 4.4 indicates that most of the professionals who participated in the study had vast experience in working with vulnerable children. One participant had 2 years of experience while all the other participants had 4 or more years of experience with the majority of professionals having 20 or more years of working experience. As with the age of professionals presented in Table 4.4, it is worrisome that there seem to be fewer professionals in the groups of 0–9 and 10–19 years of working experience. It would have been reassuring to see an even spread of professionals across all the categories of working experience as the professionals with less experience would, over time, become those professionals with more experience and be prepared to take the place of those who retire and leave the profession. While this may have become a limitation of the study, the professionals who participated in the study had good working experience and could thus add much value to the study, it is however concerning that this group may leave the field and head toward retirement while younger generations may be less interested in this field.

The majority of participants indicated that they had not heard of or worked in a home-visiting programme in the Eastern Cape province. One participant indicated that she had worked closely with a primary health care facility in a home-visiting programme for

mothers and babies but indicated that she was no longer involved in the programme and did not think the programme still existed. As already discussed in the literature review of this study, non-centre-based programmes, such as home-visiting programmes to support vulnerable children, are notably scarce in rural provinces such as the Eastern Cape (Van Niekerk et al., 2017) and the findings in this study support this view. One participant indicated that she had worked in the Western Cape where home visits were done to follow up on patients, including children, who defaulted in their treatment for TB and HIV. Three participants indicated they had accompanied paraprofessionals to the homes of caregivers who had vulnerable children during a research study or as students, however, these were not in the Eastern Cape province. Very few of the participants indicated that home visits formed a part of the work that they did to support vulnerable children. Where carried out, these home visits were not part of a specific programme as such but formed a part of the services that they rendered and did not focus primarily on early childhood. The following section presents the biographical profile of the caregivers who participated in the study.

4.11.2 Biographical profile of caregivers

The following table introduces the biographical profile of the caregivers that participated in the study.

Table 4.5: Biographical profile of caregivers

CRITERIA	NUMBER OF CAREGIVERS (N9)			
Age of caregivers in years	20–29 years 2	30–39 years 5	40–49 years 2	50 years and above 0
Gender	Male 0		Female 9	
Marital status	Married 3		Unmarried 6	
Highest level of education	Grades 1–7 1	Grades 8–11 5	Certificate/Degree 2	Did not indicate 1
Relationship of caregiver to child	Biological mother 7		Foster mother 2	
Special needs of child	Severe child neglect 3	Disrupted caregiving 1	Infectious disease 1	Combination of malnutrition/disease 4
Number of other children in the home	0–2 other children 5		3–4 other children 4	
Source of household income	Unemployed and receive CSG 5	Unemployed and receive CSG and DG 1	Employed 2	Unemployed but husband receives monthly salary 1
Income sufficient to meet needs	Yes 6		No 3	

Table 4.5. begins by indicating the age and gender of the caregivers who participated in the study. The majority of caregivers were between the ages of 30 and 39 years. Two were in their 20s and two were over the age of 40 years. None were older than 49 years of age. All the caregivers were female. This reflects the overwhelmingly high number of women in South Africa who carry the majority of child rearing responsibilities. This caregiving responsibility, which is mainly fulfilled by women in South Africa, is also noted by other South African studies (Johannes, 2021).

Two of the caregivers were married. The remaining seven were unmarried although three indicated that they had occasional support from their partners, while one indicated

receiving ongoing support from her partner. This data was not surprising as South Africa has a low rate of marriage, with some 47% of all women remaining unmarried, a percentage confirmed by Kamar (2021).

One caregiver had to stop attending school in Grade 5 due to the financial constraints facing her family, and five stopped attending school during high school. Two caregivers had post-school qualifications and one declined to indicate her level of education. More than half of the participants in this study had thus not completed their secondary schooling. This is challenging as education is seen as one of the doors to securing a good future, to securing employment and is key to breaking the cycle of poverty for future generations. Statistics South Africa (2020) notes that 53.2% of individuals who did not complete their schooling are unemployed. The close correlation between level of education and future employment opportunities is thus noted and explored further in the sections that follow.

Table 4.5 indicates that the majority of caregivers who participated in this study were biological mothers, while only two were foster mothers. Statistics in South Africa indicate that 12% of children do not live with either biological parent, however, this number increases in the Eastern Cape province where 33% of children do not live with either biological parent (Hall, 2019). This study supports these statistics, with seven caregivers being the biological parent of the child and two of the children not residing with either biological parent.

The children of the caregivers presented with a range of vulnerabilities with at least four having two vulnerabilities simultaneously. Two of the children were diagnosed with severe and acute malnutrition (SAM), one was hospitalised due to severe neglect, and another was placed in foster care due to her biological mother being arrested and incarcerated. It was interesting to note that two of the children were from a set of twins, perhaps indicating that multiples births present some risks for the child. The researcher then looked for literature relating to the phenomenon of maltreatment with multiples. Literature confirmed that the number of multiples had increased by 10% over the last 20 years and that multiples have a 13% chance of being maltreated compared to a single infant who has a 1 percent chance of being maltreated (Lang et al., 2013; Nelson & Martin, 1985). In addition, research shows that one of the multiples is more likely to be maltreated rather than both of them (Ooki, 2013; Tanimura et al., 1990). This then

caused the researcher to reflect back on the interviews with the caregivers of the two infants who were admitted for SAM. In addition, the researcher reflected on her asking (after the interview in informal conversation) about the health of the other infant, who was not hospitalised. Reflecting on that conversation in which both caregivers said that the other twin was healthy – which at the time made no sense to the researcher as surely if one infant has SAM, both should have SAM as they are living in the same household – the researcher felt that this may support research that shows the possibility of one multiple being more likely to be maltreated or neglected than both.

All of the caregivers indicated having between one and four additional children at home perhaps reflecting that where there are many children in a household, the risk factors facing children become higher, especially in the context of poverty. Increased family size is noted to be related to increased risk of child maltreatment; however, this could also be mitigated when there are more individuals in the household who can assist in caring for young children (Emery et al., 2020; Nelson & Martin, 1985).

Table 4.5 shows that six of the caregivers who participated in the study are unemployed and rely on government grants as their main source of income. This data reflects the high rate of unemployment in the Eastern Cape province, which stands at 51.2% – the highest in South Africa, as well as the large number of women (42%) who rely on the CSG as their main source of income (Spaull et al., 2020; Statistics South Africa, 2020). The correlation between completing schooling and future chances of employment is evident here. The same six caregivers who had not completed their schooling indicated being unemployed and that the CSG was their main source of income. Three of these six caregivers who noted the CSG as their main source of income indicated that they received some additional financial assistance from their partners or families. Two of the participants were employed and received a regular monthly income while another did not work but the monthly salary of her husband ensured that the needs of the household were met.

Six participants felt that the household income was sufficient to meet the needs of their child. Three participants stated that the government grants they received were not enough to adequately meet the needs of their children. This is not surprising as statistics indicate that as many as 47% of households in South Africa run out of money for food during the month (Spaull et al., 2020). For children in the Eastern Cape province, the

harsh reality may be that if the family's only source of income is the CSG, it is nearly impossible to meet all the basic needs of the children in that family. Without additional support, the development and optimal well-being of the child will be challenging to achieve as good nutrition, one of the most important biological factors needed for optimal well-being, is integral yet statistics alert us to the fact that 47% of households run out of money for food monthly. For children in such situations, where nutritional needs are unmet during the early years, the biopsychosocial framework indicates that development socially and psychologically will be challenging to achieve, compromising future optimal development and well-being (Centre on the Developing Child, 2007; Horwitz & Neiderhiser, 2011; Morgan & Sotuku, 2019; Republic of South Africa, 2015; Shonkoff & Garner, 2012).

4.12 Conclusion

In conclusion, Chapter 4 has outlined the interpretivist research paradigm, the qualitative approach and the intervention research design that has guided the study. Each was critically interrogated, resulting in a clear motivation for their fit to this study. The research population and sample were clearly defined with non-probability, purposive and snowball sampling presented as the most appropriate manner to select participants who have an in-depth knowledge of the research topic. The semi-structured interview was presented as the most suitable method for data collection and the development of the interview schedule that was used as the data collection instrument was described as was the use of the consensus workshop to refine the guidelines for the programme. The research process and the analysis of the data was explained and the ethical considerations that guided the study were carefully discussed. Lastly, Chapter 4 presented and discussed the biographical profiles of the two groups of individuals who participated in the study. Chapters 5 to 9 organise, present, and discuss the findings that emerged in relation to the study's objectives. Each chapter is dedicated to one objective. This format assisted the researcher to efficiently present and discuss a large amount of data. In addition such a format supported a logical and coherent flow from the presentation of the findings through to the related discussion. Chapter 5 presents and discusses the qualitative data that emerged in relation to Objective 1 of the study.

CHAPTER FIVE

NEEDS AND THEIR OUTCOMES FOR VULNERABLE CHILDREN

5.1 Introduction

Chapter 5 presents and discusses the qualitative data that emerged in relation to the first objective of the study. The first objective of the study explored the needs of vulnerable children in the Eastern Cape province and the potential outcomes when such needs were met. Firstly, the data is reduced to themes, subthemes and categories and presented in a table format. Following this, the themes, subthemes and categories are presented and discussed in narrative form. All data is supported by direct quotations from the transcribed interviews. The findings are supported by a literature control and the biopsychosocial model that formed the theoretical framework of the study.

5.2 Needs of vulnerable children and outcomes when such needs are met

Two themes emerged in relation to the first objective of the study. These are: basic primary needs of vulnerable children; and building a foundation for optimal future development. The subthemes that emerged in relation to the first theme are: responsible caregiving; and a nurturing environment. The subthemes that emerged in relation to the second theme are: holistic overall well-being; and prospects for a good future.

Table 5.1 presents an outline of the themes, subthemes and categories in relation to Objective 1. These are then presented and discussed in the section that follows.

Table 5.1: Themes, subthemes and categories representing the needs of vulnerable children and the potential outcomes when such needs are met

Themes	Subthemes	Categories
Basic primary needs of vulnerable children	Responsible caregiving	• Knowledgeable caregiver • Responsive caregiver • Well-supported caregiver
	Nurturing environment	• Adequate nutrition • Regular health care • Protection from harm • Love and care • Opportunities for stimulation and learning
Building a foundation for optimal future development	Holistic well-being	• Age-appropriate development • Healthy self-esteem
	Prospects for a good future	• Educational success • Well-adjusted adults • Positive impact for society

5.2.1 Theme: Basic primary needs of vulnerable children

Two subthemes emerged in relation to the basic primary needs of vulnerable children in the Eastern Cape province. These were responsible caregiving and a nurturing environment.

Subtheme 1: Responsible caregiving

Many of the participants felt that responsible caregiving was needed for vulnerable children to develop optimally. Three different categories emerged under the subtheme of responsible caregiving: a knowledgeable caregiver, a responsive caregiver and a well-supported caregiver. Participants felt that having a responsible caregiver who is knowledgeable in childcare, especially how to care for a child responsibly within an environment of low socio-economic conditions, was needed by vulnerable children in the Eastern Cape province. In the words of one participant, a social worker, who is quoted below, a knowledgeable caregiver is one who knows what her child needs and where to access such support and one who is willing to learn from the mistakes she has made:

> *Giving that mom all the information of what is going to happen when you've got the baby, there are resources that you can go to this, you know, institution and whatever that can help.* (P2)

Another participant, a community health care worker who specialises in offering programmes to mothers and babies, agreed with the social worker above, saying that mothers need to have information because of the many challenges they may face while parenting:

> *I think for the mommies to be given information around all the topics because sometimes other things that cause the problem for mommies, there is a postnatal depression, you see.* (P8)

A third professional, a dietician, shared how important it was for mothers to be well informed because they needed to understand the importance of breastfeeding for the development of their child "*breastfeeding is very important"* (P14). This participant felt that understanding how important breastfeeding was would then help them to be responsible caregivers. The caregivers who participated in this study agreed that it was important to be knowledgeable if you were to provide care for your child. One of the caregivers shared that often the process of becoming knowledgeable is through learning from the first time you become a mother and sometimes through the mistakes you make

"*It is stressful. You don't go to school to be a mommy, if you make mistakes with the first one you learn"* (C6).

Many participants noted the importance of having a caregiver who was responsive to the needs of their child. They explained that having a "nice" parent – one who is reflective, who engages with the child, who is able to listen to input from others and who is responsible in meeting the needs of the child – is important. A responsive caregiver would, therefore, contribute towards responsible caregiving and meeting the needs of the child. One of the participants who has a qualification in education noted that *"Nice parenting"* (P17) is needed. A second participant, also a professional working in education, added that having a caregiver who was responsive in terms of making time for a child was important "*But it's just about creating and it's also about an adult making time for a child"* (P18). Another participant, a social worker, expressed that a mother who was "*Sober minded"* (P9) was needed for a vulnerable child to develop optimally. This participant felt that it was important for a child to have a caregiver who was able to think clearly and make good decisions or to be responsive to the needs of the child. A few of the caregivers also shared how important it was to be a responsive caregiver and how this was an important need for young children. In particular, Caregiver 6 was able to narrate how she loved being a mother and how she was open to learning from her children. She was able to think things through and felt that this helped her to meet the needs of her children. In addition, she shared her story of being HIV positive and how through being responsive to the input and guidance from nurses, her youngest child had recently tested negative for HIV. This was a wonderful example of how her responsiveness as a caregiver had benefitted her child, ultimately supporting good health:

> *You must listen to the nurses, don't question, you must listen they know what they are talking about.* (C6)

> *You learn from your children, sometimes your child teaches you, you learn, and you know how to ask and to listen because the children tell you.* (C6)

Another participant, a social worker, supported what the caregiver above had shared about the importance of responsive caregiving. This participant shared how it was so important for caregivers to be responsive to the health care needs of young children and then went on to note that many parents do not return to the clinic for follow-up appointments:

> *If the parents would be hands-on responsible parents because I've had cases where the parents had to come in for a clinic appointment and they never came back. So, if the parents were to be responsible enough. (*P9)

Another important feature of responsible caregiving is connected to the support that the caregiver receives from family and friends. The majority of participants, both professionals and caregivers, shared how important it is for the caregiver to have a good support system. The participants shared how important it is to have family support when you are caring for a child who may be vulnerable. It was felt that vulnerable children who may be exposed to various risk factors would need a caregiver who was well supported so that she, in turn, could care well for her child. One participant said that "her dad also supports her, he visits and he helps" (C4). In addition, participants felt that if caregivers were supported in caring for their child, it makes it easier for them, resulting in better care of the child. The following excerpts highlight the need for caregivers to have support as they care for their children:

> *Another thing that can help us to observe on growing and developing our children is that family, family strengthening thing.* (P4)
>
> *I have good support at home my husband and nanny and my older children are independent that makes it easy to look after my baby.* (C3)
>
> *I have good support from my family, we are close, my mother gets a pension she was a teacher, even my brothers and sisters we care for each other.* (C4)

Only one of the participants, a caregiver, mentioned the importance of spirituality and tapping into a relationship with God as a source of support in being a responsible caregiver. It was interesting that only one of the participants spoke of spirituality when according to the Statistics South Africa (2014), the majority of South Africans (84.2%) identify themselves as Christians.

> *It's something inside you, we were made by God, no one can tell you, even the doctors can tell you but its God (how to be a good mother) you cannot do it on your own.* (C6)

Studies on parenting have also noted the importance of a responsible caregiver in meeting the needs of the child, especially during the early years or first 1,000 days when the young child is dependent on the caregiver for all their needs. The World Health Organisation (2018), for example, notes that responsive caregiving is critical for the young child and can lower the damaging effects often associated with low socio-economic status. Therefore, in the context of vulnerable children, responsible caregiving

becomes even more important as they are exposed to various risk factors in their environment which, without the support of a responsible caregiver – one who is knowledgeable, responsive and supported – may harm their overall well-being and development.

The biopsychosocial framework notes that the development of a child is greatly impacted by the social factors of interpersonal, family and community support systems (Lehman et al., 2017) thus supporting the need for each child to have a caregiver who is responsible and able to meet the needs of the child despite the vulnerabilities that may exist within their family or community. A responsible caregiver, therefore, has sound childcare knowledge relating to good parenting practices and the needs of a young child. Such a caregiver knows and understands the connection and interaction between the variables or factors of the biopsychosocial framework that influence health during early childhood. In addition, a responsible caregiver is able to use this knowledge to be responsive to the child's needs resulting in a child who is loved, happy and secure. Again, this aligns with the biopsychosocial model which notes the connections between different factors that influence development and brain development during early childhood (Horwitz & Neiderhiser, 2011; Morgan & Sotuku, 2019; Shonkoff & Garner, 2012).

In summary, participants shared that it is essential for vulnerable children to have not only a caregiver but a responsible caregiver who is knowledgeable, responsive and supported by friends, family and community resources. Morgan and Sotuku (2019) note that a caregiver can support optimal health, well-being and the development of the young child, buffering the child from the low socio-economic conditions and the associated stressors that may exist in their family or community. These findings support literature by Sotuku and Schmidt (2019) and Mathews and Gould (2017) who note that knowledgeable, responsive caregiving during early childhood sets the foundation for good future cognitive, social and emotional development.

Responsible caregiving, which according to Mkhwanazi et al. (2018) is hard work both physically and emotionally, may be more challenging to achieve in the context of low socio-economic conditions. With the extremely high rates of poverty in the Eastern Cape province, responsible caregiving may thus be more difficult for caregivers to achieve. However, it becomes essential as it may be the only protective factor that the child has

in the midst of the many risk factors commonly associated with low socio-economic conditions. This study confers with the literature reviewed in Chapter 2 and 3 of this study, highlighting one of the needs of vulnerable children – that of having a responsible caregiver.

Subtheme 2: Nurturing environment

The second subtheme that emerged in relation to the needs of vulnerable children in the Eastern Cape province was that of a nurturing environment. A nurturing environment was described by an overwhelming majority of the participants as one that ensured adequate nutrition, regular health care, protection from harm, love and care and one that provided opportunities for learning and stimulation of the young child. The need for adequate nutrition and the important role that nutrition plays in the development of the young child was noted by most participants in the study. A dietician, who is quoted saying "*Nutrition it is extremely important the most important thing for babies"* (P15), then went on to elaborate and shared that if life was like a story, an appropriate introduction to the story would be one that began with food. This participant felt that the start of any good life begins with food *"The basic story of a good start in life is food"* (P15). Another participant, a medical doctor, when asked to describe good nutrition explained that there was not an exact formula for proper nutrition but rather that a healthy balanced diet was needed during early childhood "*For optimal brain growth, some vitamins are needed but I don't think they know exactly what, it is more about a healthy balanced diet"* (P11). Many participants explained the importance of breastfeeding, and then shared information about nutritious and inexpensive meals that the young child would need, and which could be prepared with a small budget. A professional nurse, quoted below, highlighted that all children need to be breastfed and, thereafter, nutritious meals could be introduced:

> *Exclusive breastfeeding for the first six months and then after six months you introduce mash and rama [mashed potatoes and butter] if the child is to develop well. Or brown bread soaked in sour milk is a meal for the child it is also good.* (P12)

The caregivers who participated in the study also noted the importance of nutrition as one of the most basic needs of their children, although they referred to this in a less formal manner. The caregivers indicated, however, that they would need sufficient income in order to ensure that their child was able to have enough good or proper

(nutritious) food to eat. One caregiver stated that she needed "*Enough money and food for my child"* (C4) while another explained that *"A home environment that is stable with regards to diet"* was important (C9). A nurturing environment was in addition described by participants as being one that ensured the child received regular health care. This is illustrated by a participant, a social worker, who shared the following when asked to identify the needs of vulnerable children in the Eastern Cape province:

> *An environment that would also, even the parent would adhere, when the child is not feeling well, they would attempt to go to the clinic and make sure that the child's health is taken care of, not neglected or just brushed away.* (P10)

Access to regular health care was then noted as a need of each vulnerable child and was closely connected by participants to weight gain and growth. Two of the caregivers whose children were admitted to a state hospital at the time of the interview had themselves accessed health care for their children because they were malnourished, and they shared the following:

> *Good weight to put on weight and to grow.* (C6)
>
> *She must be happy and have good health so she can grow, I am worried because she eats but she is not growing.* (C4)

The need for the child to have access to health care becomes apparent (as indicated in the cases above) where the children were not putting on weight and were not growing. In circumstances such as these, the child would need access to health care or the child may become malnourished, stunted or fail to thrive. Another participant, a child and youth care worker, shared how important it was for the child she was caring for to access regular health care in order to be given the medication that he needed daily as he was HIV positive:

> *He needs to get his treatment and so I give him pills daily and food daily and the medication that he needs for his health is important.* (P3)

Many of the participants also shared that each young child, especially where there are risk factors, needed to have regular access to health care so that they received their immunisations as required and that their weight and growth could be monitored. This will ensure that any problems are identified sooner rather than later. One professional shared how getting caregivers of vulnerable children to go to the clinic was a part of the work

they did as they recognised access to regular health care as a need for each vulnerable child that they worked with:

> *We also do that in Isibindi [Xhosa name of community-based programme meaning courage] because we emphasise the importance of going to the clinic for the children. And following the dates, you know, the appointment.* (P4)

Another category that emerged under the subtheme of a nurturing environment was the need for vulnerable children to be protected from harm. Both caregivers and professionals noted how important it was for vulnerable children, especially during the early years of development, to be protected from harm and how this protection supported an environment that was nurturing for the child. Being safeguarded was noted as a need for each young child and was also connected to overall well-being and optimal development with one participant stating *"I must keep him safe"* C4. Protection from harm and a secure environment was also connected by one participant to the need for a young child to have a clean environment. This category can be seen in the participant quotes that follow:

> *Safeguarding, your brain survives on nutrition and safety and cognitively the ability to explore and learn.* (P17)

> *No stress. Love, security, security and safety, nutrition, I think definitely an environment that is conducive to that.* (P4)

> *I would say a secure environment, an environment that is clean.* (P10)

It was interesting to note how participants connected the different needs of vulnerable children consistently during the individual interviews. Participants often mentioned many of the needs together in one sentence as if they were all of equal importance and dependent on one another. This was again illustrated when the participants spoke of the need for protection from harm and then also referred to nutrition and love and an environment that was supportive of all of these different factors. Love and care were also identified as a category under the subtheme of a nurturing environment. In addition to vulnerable children needing responsible caregivers, adequate nutrition, regular health care and protection from harm, the majority of participants also expressed that vulnerable children in their early years needed much love and care. Participants felt that such love should be unconditional and could be given not only by the mother but by both parents and the family *"I think they need love"* (C4) and *"Love and care for their children"*

(P9). Participants indicated that this love and care was needed so that a foundation for future development was secured:

> *He needs care, someone to care for him.* (P3)
>
> *Where somebody actually cares for the child.* (P2)
>
> *They need love, being able to really love into a child unconditionally. I think if a child feels that I think they, so much more can be built on that foundation.* (P4)

One participant shared that mothers should begin to love their child during pregnancy and others noted how important the bond with a mother could be for a child – essentially being a need for the child. Participants used words, such as crucial and significant, when referring to the love and bond needed from and with the mother. The use of these particular words may represent the importance of the need for each child to be loved by their mother. This is seen in the participant quotes that follow:

> *Because like giving them information that loving your child is not after you've given birth; it's when the child is still in the tummy. So, you have, you need to love the child when it's still in your tummy.* (P8)
>
> *That stage from zero maybe up until 2 years is very crucial. That bond with the mother, it plays a significant role.* (P10)

The last category that emerged under the subtheme of a nurturing environment was in relation to each child needing opportunities for stimulation and learning. Many of the professional participants noted that this was an important need for the young child:

> *The child needs stimulation, it is not just about eating and sleeping and playing.* (P7)
>
> *Because it's good for me to focus on the development, but not only am I feeding my child, or I am providing proper nutrition to my child and I'm not talking about expensive things because whatever you've got you can use for the development of your child.* (P4)

Two of the caregivers also expressed how important it was to play with and teach your children, thereby creating opportunities for stimulation and learning:

> *Engaging with a child, get down on the floor and play with your child on the floor.* (C9)
>
> *Teaching because she does not know anything she is just learning. Just love, support and teach only.* (C6)

One professional participant spoke in detail about the need for each young child to be given an opportunity to play and described how this supported brain development. In addition, the participant described the characteristics of meaningful stimulation that would then support learning during early childhood. The implication of this is that opportunities for stimulation and learning occur within a nurturing environment; one where the child is safe, loved and cared for:

> *The basics of play to grow children's brains, are that activities must be social, must be active, must be meaningful, must be joyful, and must be iterative – we are on a journey of learning, to investigate, discover, learn ask questions, not being afraid of making mistakes and learning from that.* (P17)

A nurturing environment, sometimes also referred to as nurturing care is defined as "a stable environment created by parents and other caregivers that ensures children's good health and nutrition, protects them from threats, and gives young children opportunities for early learning through interactions that are emotionally supportive and responsive" (WHO, UNICEF & World Bank, 2018, p. 3). Throughout this study, participants reflected on the importance of each child, especially vulnerable children, needing a nurturing environment. This need is confirmed by WHO, UNICEF and the World Bank in the definition shared above. The narrative of the participants continuously wove together the need for adequate nutrition, regular health care, protection from harm, love and care and opportunities for stimulation and learning.

All participants expressed the importance of adequate nutrition with many simply stating nutrition as the cornerstone of needs after having a responsible caregiver. The importance of nutrition is highlighted in literature and in Chapter 3 of this study where nutrition is noted as a key protective factor during early childhood and where it is noted that for a child to develop optimally nutrition is of essential importance (Mkhwanazi et al., 2018; Republic of South Africa, 2015).This is a relatively simple need if one considers that most caregivers realise that children need to eat to stay alive. However, in the context of children made vulnerable through poverty or perhaps a chronic illness then adequate nutrition may be more complicated to ensure. Here the findings have confirmed that for any early childhood programme to be effective in supporting vulnerable children, addressing the importance of adequate nutrition will need to be foregrounded together with the first theme of responsible caregiving.

The second category of regular health care under the subtheme of a nurturing environment, as noted by this study as a need for vulnerable children, is also supported explicitly in literature. In fact, literature at times presents good health and nutrition simultaneously. However, literature draws attention to the fact that good health and nutrition should begin from conception and continue throughout the pregnancy. This will have a better long-term effect on the development of the child rather than only beginning once the child is born (Hall et al., 2017). This was not mentioned by any of the participants in the study. However, it is of integral importance because if a child is to develop optimally then nutrition and health care should begin with maternal nutrition and health care from conception.

This means that the ECD programme should begin with nutritional and health support for mothers during pregnancy rather than beginning once the child is born. This is supported by the theoretical framework of the study, with the biopsychosocial model noting that biological factors, such as the health of the mother during pregnancy and the health of the child during early childhood, influence brain development. Moreover, because brain development occurs rapidly during early childhood, health becomes of essential importance for the child (Motshekga, 2015). In addition, it should be said that health during early childhood is closely related to adequate nutrition (DoBE, 2015; Mkhwanazi et al., 2018).

This study has confirmed the importance of both adequate nutrition and regular health care as a need for vulnerable children during early childhood. The third category under the subtheme of a nurturing environment noted the need for vulnerable children to be protected from harm. Azzi-Lessing (2017) confirms that it is an important need of children during early childhood. Being protected from harm becomes more important for vulnerable children simply because of the vulnerabilities they face in addition to being at an age where they are unable to protect themselves. Callahan et al. (2011) agree that children who grow up in the disadvantaged communities of South Africa often face difficult circumstances, such as substance abuse, crime, deviant behaviours and violence in their homes and communities. Exposure to such circumstances may mean that for vulnerable children, being protected from harm is an essential need or they may face circumstances that will impair their well-being.

Literature confirms that such circumstances, as noted above, increase the risk of poor parenting and of the child being abused or neglected (O'Connor, 2002; Taliep et al., 2018). The findings in this study support other findings and literature, confirming that vulnerable children need to be protected from harm and that this is one of the basic primary needs for such children. The biopsychosocial model notes that genetics, together with factors such as the environment in which the child is raised, will impact on brain development and influence future outcomes for the child (Lehman et al., 2017; Morgan et al., 2014). In order to achieve optimal development, each vulnerable child, therefore, needs to be protected from harm and this finding is supported by the theoretical framework being used by this study.

The fourth category noted that each vulnerable child needs love and care in order to achieve overall well-being. Literature as well as the biopsychosocial model notes that social factors, such as the love and care given by caregivers, becomes a protective factor during early childhood and that healthy attachments for the young child are built on a foundation of love and care (Lehman et al., 2017; Sotuku & Schmidt, 2019). This literature as well as the biopsychosocial model, which notes the importance of social factors such as relationships, supports the findings of this study. Participants in this study felt that love and care from the biological mother was an important need of the child. This differs from theory, which acknowledges that each child needs love and a strong bond, but notes that this love and bond is not necessarily needed from the biological mother; rather, it may be given by any caregiver as long as the child receives this love (Nutbrown, 2011).

The last category under the subtheme of a nurturing environment was the need for each vulnerable child to be given opportunities for stimulation and learning. The DoBE (2015) acknowledges that the child is highly sensitive to environmental factors during the first 1,000 days, making opportunities for stimulation and learning of vital importance. Aubrey (2017) agrees that opportunities for stimulation and learning are needed so that the child can begin to make sense of their world and that this then supports future optimal development. Literature thus supports the findings in this study in terms of vulnerable children needing opportunities for stimulation and learning. The participants in this study felt that these opportunities for stimulation and learning together with adequate nutrition, regular health care, protection from harm and love and care were needed by vulnerable children during early childhood so that optimal future outcomes could be achieved, and

the cycles of vulnerability could begin to be broken. The participants also shared that should these needs be met, then a foundation for future optimal development was laid. These future outcomes form a part of the second subtheme that emerged under the first objective of this study and are presented in the section that follows.

5.2.2 Theme: Building a foundation for optimal future development

Under the first objective of the study and in relation to the needs of vulnerable children in the Eastern Cape province, a second theme emerged. This theme noted that when the needs of a vulnerable young child are met, then a process of building a foundation for optimal future development begins. In this study, participants were optimistic that if the needs of vulnerable children could be met during early childhood, then future prospects for the child, their family and their community are optimal. Two subthemes emerged under this theme: firstly, that of holistic well-being and secondly, that of prospects for a good future. These subthemes are presented and discussed below.

Subtheme 1: Holistic well-being

Numerous participants noted that when the needs of a vulnerable child are met, then there is a sense of holistic well-being for the child. Under this subtheme, two categories emerged: age-appropriate development and a healthy self-esteem. Participants began by sharing that when a child's needs are met during early childhood, the child is then enabled to be healthy and strong. One participant, a social worker, shared that you then have "a healthy child" (P2). Another participant, a child and youth care worker, shared that even though a child has a chronic illness, if the child's needs are met, the child is then able to be strong or achieve overall health or well-being *"He's strong now (refers to a child made vulnerable through a chronic illness and being orphaned)"* (P3).

A further participant, an auxiliary social worker, shared that when a child's needs were met, then that child would have the energy to grow and develop and learn within a school setting *"A child that is, you know, has the energy to learn at school"* (P1). In addition to being healthy, strong and able to engage in learning, some of the participants felt that when the needs of a young child were met then the child was able to learn well and generally achieve age-appropriate development. The connection between needs being met during early childhood and resulting holistic well-being and age-appropriate development is noted by the participant who shared "*Then everything can be attended to and the child can develop well"* (P1). The insights that these participants have shared

are important as it is widely known that a healthy and strong child is able to develop and reach their developmental milestones easily. Such children will also engage during opportunities for stimulation and learning and may continue to reach their developmental milestones as they progress through life, setting a foundation for future optimal development. Another participant goes on to describe how a conducive environment, regardless of the socio-economic conditions of the family, is able to secure the child a good foundation. The participant, a social worker, implies that the development of the child may not necessarily be determined by riches but that children can be well raised in low socio-economic conditions. This participant felt that meeting the needs of the child for love and health, regardless of the physical structure within which the child was being raised or the family not having a lot of money, would allow the child to feel that they belonged, thus supporting emotional well-being. In addition, this would support the child's holistic well-being and secure a good foundation for the child:

> *The parent does not need to have a lot of money but just a conducive environment secures the child. They find their sense of belonging. It doesn't matter whether it's a shack that they are staying in or one room, or a big house. If the environment adheres to all their needs, emotional, physical, their health, if all of those are met that secures the child to having a good foundation.* (P10)

Literature and the biopsychosocial model support the statement made by this participant, acknowledging that optimal development is not solely dependent on one factor but that all factors work together influencing one another to impact upon the development of the child. However, Mkhwanazi et al. (2018) note that the pressures of raising a child within an environment where there are risk factors, such as poverty, violence or poor health, does increase the stress on the caregiver. Therefore, while it may be true that age-appropriate development and holistic well-being need not be dependent on the amount of money a family has or the home that they live in, the risk associated with low socio-economic conditions can result in caregivers being more stressed. Shonkoff and Garner (2012) agree that the development of the child will be influenced by the environment within which they are growing and where all the child's needs are met, a foundation will be set for age-appropriate development throughout childhood. Additional support for the caregiver may thus be needed in situations of vulnerability so that the child is supported towards age-appropriate development.

The second category that emerged under holistic well-being was that of self-esteem. Self-esteem is understood as an individual's sense of self-worth that includes the beliefs they hold about themself and their emotional state, which may then also predict behaviours (Smith & Mackie, 2007). A healthy self-esteem is where an individual or child has a good sense of worth, has positive beliefs about themself and consequently presents with good behaviours. Some of the participants in this study felt that where a child's needs were met during early childhood, the child would be able to develop a healthy self-esteem. An ECD specialist indicated that *"You would have a child that is happy"* (P18), and another participant, a social worker, noted that *"Well I believe that a happy child makes a happy adult"* (P9), perhaps signifying that needs that are met during early childhood contribute towards a healthy self-esteem which could then be carried through to adulthood. One participant, a child and youth care worker, who had worked with a specific vulnerable child, emphasised that where the needs of a vulnerable child are met, that child is able to be good, perhaps signifying the relationship between needs being met, consequent physical and emotional well-being and resulting healthy self-esteem where the child then presents with behaviour that is 'good'.

Another participant noted that a healthy child would be accepted, loved and included by the teachers at school and others in the community. This, in turn, would result in a healthy self-esteem for the child who may then feel that she is loved, and that she is wanted and of value:

> *When the healthy child, when he or she goes to school, the teachers loves him or her. The people outside, they love him, so she won't isolate her. Like, she will know that 'I'm useful to the community' and add the value.* (P1)

Other participants added to this, sharing that where the child experiences physical and emotional health, the child would have a sense of identity, belonging and purpose in life, all of which contribute towards a healthy self-esteem "*A child who will have a sense of identity, belonging, purpose in life"* (P6) and "*Children will feel like we can do, we can belong, we can contribute"* (P10). Some participants felt strongly that where a vulnerable child was able to achieve physical and emotional well-being, then the child would be better equipped to cope with the challenges that they may face in life. In addition, such children would be disciplined, would know right from wrong and the consequences of the choices they made and the actions they took. This translates to having a healthy self-

esteem in that these children may experience an intrinsic belief about their worth and their goodness, making good choices as adults in later life:

> *When there is that foundation it's mostly likely that the child, even futuristically, will just progress positively and handle, they will be able to have better coping skills on how to approach any circumstances that they might be facing.* (P10)

> *They also have because the foundation goes with age appropriate discipline because they get to grow up knowing what is right and what is wrong and what are the consequences of these. So that results to the type of adult that they are going to become, or a teenager or an adolescent that they are going to become, or a youth that they are going to become because it is instilled in them.* (P7)

Lastly, some participants shared that the foundation is set for vulnerable children to be responsible when they are supported by responsible caregiving and a nurturing environment. As an example, one participant noted that the child is now able to take responsibility for his own health *"He sets the phone and said mom it is time for pills now"* (P3). This sense of independence and taking responsibility is an important part of age-appropriate development, and, for the child who is supported through responsible caregiving and a nurturing environment, the process of independence and taking responsibility will come gradually and naturally over time. It will also contribute towards the forming of a healthy self-esteem, where the child has positive beliefs about him- or herself and is then able to behave appropriately. In this way, meeting the needs of a vulnerable child during early childhood is of critical importance as it influences a health self-esteem as the child grows. Ultimately, a healthy self-esteem influences the beliefs a child has about themself, their family and the community in which they live. This belief system will then influence the child's thoughts and behaviours. A child who is able to form a healthy self-esteem may carry this through to their future, thus remaining emotionally stable and behaving in a responsible manner.

Subtheme 2: Prospects for a good future

Under this second subtheme, most of the participants shared that when a child's needs are met then the child has prospects for a good future. Such prospects are presented as educational success, developing into well-adjusted adults and generally having a positive impact on society. Each category is presented and discussed in the sections that follow. One participant narrated quite a lengthy story of a child she had assisted through the child protection agency where she had worked. The participant shared this

story to illustrate the future outcomes for a very young child who was initially abused and neglected by her mother and grandmother. This child was then cared for by a responsible neighbour who was able to meet the needs of the child through support from the child protection agency and later, a foster care grant. This story supports the notion that where a child is removed from a situation of abuse and neglect and is then placed in a situation where the child's needs are met, the child is able to build a foundation for optimal future development and one such outcome may be achieving educational success. This particular child had managed to complete matric and was attending college:

> *She kept that child for 4 years without foster care grant. She was only getting food parcels. Then when that child was 4 years she got the foster care grant. And that child is in college now. She is here in TVET. She passed matric. And she still lives with that granny and now she's at college.* (P1)

It is possible that the participant was implying that should the child not have been safeguarded and placed in a family where her needs were met, then the child may not have been able to achieve these educational successes later in life. Azzi-Lessing (2017) agrees that what happens during early childhood in the life of a child will influence their future educational success. Morgan and Sotuku (2019) add that cognitive development, and thus educational success, is influenced not only by genetics but also by the biological, social and psychological factors in the environment of the child and that the brain is highly sensitive to these factors during early childhood. The findings are supported and explained by the biopsychosocial model which notes the connection and interactions between biological, social and psychological factors during early childhood on the overall future optimal development of the child, including their educational success (Shonkoff & Garner, 2012). For this child, being placed in a nurturing environment with a responsible caregiver during early childhood resulted in educational success. This child was able to break free from the story of her biological family, which was one of poverty, substance abuse, disrupted caregiving, abuse and neglect, ultimately overcoming 'genetics' to achieve educational success. The story shared by this participant illustrates how a child is able to continue towards optimal development, despite abuse and neglect, when an intervention is done timeously. In addition, this story illustrates how the child's needs can be met through a non-relative and not necessarily through the biological mother as felt by other participants in this study and noted in the first theme of this chapter.

Another professional participant shared how a vulnerable child who she had cared for and supported in ensuring that his needs were met after his mother died was progressing at school and how he had not had to repeat any grades. For this participant, this represented educational success. These sentiments are expressed in the words the following words "*He's doing Grade 9 now. And every year he's going to study another grade"* (P3). Other participants shared more generally that meeting the needs of vulnerable children will help these children to progress and achieve success at school. Some felt that this may support the child going beyond secondary education and onto tertiary education. Participants also felt that this may change future employment prospects, thereby allowing these children to contribute positively towards society. This is illustrated by the following two statements made by a child and youth care worker and a social worker:

> *That child that will achieve success at school and I think we will see a better society.* (P4)

> *Because that foundation within the first 1000 days, I feel that it plays a very important role because it, because that child gets that primary education from home, then they get the secondary from when they grow up and they go to school. So, it plays a very positive role when the child gets that foundation of being supported in all aspects of their life. That's where you get to find a child progressing well academically at school because they are getting the support at home and at school and they are able to progress even with their grades. That contributes because they don't necessarily end up in primary school or high school. They progress to university.* (P10)

Most of the participants in the study agreed that the foundation for educational success began during early childhood and that a responsible caregiver and a nurturing environment would secure future educational success. Not one participant in this study shared that educational success might be determined by genetics. This is not to say that the participants do not think that genetics play a role in determining educational success, however, they felt strongly that when the needs of the vulnerable child were met during early childhood, then a foundation for future optimal development was built and educational success could be achieved. This finding supports the biopsychosocial model being used for the study. As mentioned throughout Chapter 2 of this study, the biopsychosocial model notes the influential role of various factors – rather than a sole reliance on genetics – in determining brain development and future well-being, including

that of cognitive development and educational success (Cohen & Brown Clark, 2010; Lehman et al., 2017; Morgan et al., 2014).

Most participants agreed that meeting the needs of a child during early childhood contributed towards building a foundation for future optimal development. The participants felt that if a child was raised by a responsible caregiver, in a nurturing environment, then there was a good chance that the child would be a well-adjusted adult. A well-adjusted adult was described as one who was better, who was employed and who had a sustainable future. This participant appeared to be hinting that a well-adjusted adult would be independent and able to sustain themself as they travelled through life without a need to remain dependent on others during adulthood. This is reflected in the statements by the participants, both social workers, shared below:

> *So, if they get the proper care and grounding in the early ages, then I think we will have better adults.* (P9)

> *They find a job a sustainable income all because of the foundation that they got, that primary foundation that they got in the first 1000 days. So it contributes positively, irrespective of the circumstances, whether the child is raised by a single parent, a grandmother, both parents or an aunt. If they receive that, it doesn't matter from who, that plays a significant role to having a sustainable future.* (P10)

Another participant expressed how a good foundation during the early years, where the child's needs were met, also taught them resiliency. This is supported by policy relating to early childhood which notes the resiliency that children are able to develop in response to daily stresses when their needs are met during early childhood (DoBE, 2015). This participant expressed resiliency by acknowledging that the child would face challenges as they went through life but that they would be able to persevere through these challenges because of the responsible caregiver who had provided them with a nurturing environment during childhood. In addition, the participant felt that these children would not adopt dysfunctional coping skills, such as becoming dependent on substances, when faced with challenges. Rather, such children would navigate their way through these challenges becoming more motivated to improve their situations. The participant implied, as other participants did throughout the study, that when responsible caregivers provide vulnerable children with nurturing environments, cycles of vulnerability could be broken, and situations could be changed:

> *In life there are those challenges, so it's part of life that you get challenges. And how you approach them is very fundamental because some might be faced with challenges and they resort to alcohol in order for them to cope, but some might be faced with challenges but that would motivate them to do better for themselves, get a better education so that they are out of that situation.* (P10)

Morgan and Sotuku (2019) support that the outcomes for a vulnerable child, where needs are met during early childhood, will be a child – and later an adult – who remains in control and is well-developed emotionally, cognitively and socially. The last category that emerged under the subthemes of prospects for a good future was noted as when the needs of children are met during early childhood, there is a positive impact for society on the whole. One participant shared that such a "child contributes positively to the community" (P1), implying perhaps that the child would be an asset to the community. Other participants, an ECD specialist and a social worker, shared that society would be healthier if children were nurtured during early childhood, and another shared that the outcomes for vulnerable children whose needs are met would make a contribution towards a better world:

> *So, I think we will have a healthier society if we can nurture our children when they are young.* (P7)
>
> *A better world, yes.* (P9)

There was a general feeling by participants that if it were possible to secure the needs of all children during early childhood, the impact would be felt on a macro level. The community within which the child lives would benefit and the broader society would, in turn, be a better place. In addition, participants noted that the impact on a micro- and meso level for the child, the child's parents and the family of the child could only be positive as it would have their best interest at heart*, "Well, I think it can only be in the child's best interest, and also the parents and the family"* (P7). Another participant, a caregiver, felt that meeting the needs of a child would result in unlimited future outcomes and that on a community and societal level there would be less dysfunctional behaviours, such as crime, abuse and substance abuse. The participant went on to say that ensuring the needs of vulnerable children may even break cycles of dysfunctionality that we currently see in vulnerable or disadvantaged communities and society in general:

> *Outcomes for child who has needs met are unlimited. Less crime less abuse. Less drugs. I think we could break the cycle.* (C8)

A social worker stated quite emphatically that securing the needs of vulnerable children during early childhood would result in *"A good but not perfect future"* (P10). This a simple statement but one that seems particularly challenging and continually out of reach for South Africa to achieve considering the many risk factors facing vulnerable children in the country. Yet, the fight for a healthy society and a better world must begin somewhere. Beginning with early childhood may be a good place to start and although it may not make the future perfect, it may assist in securing a good future, especially for the vulnerable children of South Africa. The legislative frameworks covered in Chapter 2 of this study support that investing in early childhood is an investment that will yield a good return (Motshekga, 2015; Republic of South Africa, 1997, 2015).

The biopsychosocial model covered in Chapter 2 also supports the findings in this subtheme. Acknowledging and understanding the linkages across and between the biological, social and psychological variables in contributing towards good health is critical (Suls & Rothman, 2004). For a vulnerable child, having a caregiver who is able to support the child during the first 1,000 days of development is of critical importance for good health and will influence future outcomes (Motshekga, 2015). This is of particular importance because of the rapid brain development that occurs during this time (Sotuku & Morgan, 2019; WHO, 2018). This category of findings may highlight the importance of early childhood for society. Furthermore, in a manner, it advocates for investments in early childhood. If South Africa focused on creating a better country with citizens who contribute rather than more citizens who drain the economy, then an investment in early childhood is not a wasted investment.

5.3 Conclusion

Chapter 5 has presented and discussed the findings that emerged in relation to the first objective of the study. Two themes emerged under the first objective. The first theme identified the basic primary needs of vulnerable children. This theme was supported by the subthemes of responsible caregiving and a nurturing environment. The second theme emerged in relation to the potential outcomes for vulnerable children when such needs are met and was presented as building a foundation for future optimal development. The two subthemes that supported this theme were those of holistic well-being and prospects for a good future. Chapter 6 presents and discusses the findings in relation to Objective 2 of the study, which was to understand the risk factors facing

vulnerable children in the Eastern Cape province, and the consequent impact of such risk factors.

CHAPTER SIX

RISK FACTORS AND THEIR IMPACT ON VULNERABLE CHILDREN

6.1 Introduction

Chapter six centres around the themes that emerged in relation to understanding the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors.

6.2 Risk factors facing vulnerable children and the consequent impact of such risk factors

Two themes emerged in relation to the second objective of the study. These were: common risk factors that vulnerable children in the Eastern Cape province are exposed to, and the consequences when children are exposed to such risk factors. The subthemes that emerged in relation to the first theme were: extreme levels of poverty, ongoing and severe child maltreatment, poor physical health and unplanned pregnancies. The subthemes that emerged in relation to the second theme were: poor physical health, psychological tension and poor future outcomes. These themes, subthemes and the categories are presented in Table 6.1. This is followed by a presentation and discussion of these themes and subthemes in relation to Objective 2 of the study. All data is supported by direct quotations from the transcribed interviews and a literature control.

Table 6.1: Themes, subthemes and categories representing the risk factors facing vulnerable children and the consequent impact of such risk factors

Themes	Subthemes	Categories
Most common risk factors that vulnerable children are exposed to	Extreme levels of poverty	• Poverty of subsistence • High rates of unemployment • Lack of legal documentation • Poverty of understanding
	Ongoing and severe child maltreatment	• Child neglect • Child abuse • Disrupted caregiving • Exposure to family violence • Exposure to substance abuse
	Poor physical health	• Malnutrition • Illness • Disability • Premature births and/or low birth weight
	Unplanned pregnancies	• Backstreet abortions • Teenage pregnancies • Single parents • Lack of knowledge
Consequences when children are exposed to such risk factors	Poor health physical	• Delayed physical development • Severe acute and chronic malnutrition accompanied by failure to thrive • Chronic and short-term illnesses • Disability
	Psychological tension	• Baby who cries a lot • Unresolved anger • Disengagement from social relationships
	Poor future outcomes	• Death • Unable to progress at school • Crime • Predisposition to alcohol and drug abuse • Challenges with their own adult social and family relationships • Moral disintegration • Cycle that repeats itself • High associated costs for government

6.2.1 Theme: Most common risk factors that vulnerable children are exposed to

Under the theme of the most common risks factors that vulnerable children in the Eastern Cape province are exposed to, the following subthemes emerged: extreme levels of poverty, ongoing and severe child maltreatment, poor physical health and unplanned pregnancies. Each of these subthemes is presented and discussed in the section that follows.

Subtheme 1: Extreme levels of poverty

The majority of participants expressed their concern over the high rates of extreme poverty facing vulnerable children in the Eastern Cape province and noted this as being one of the greatest risk factors facing such children. Under the subtheme of poverty, the categories of poverty of subsistence, high rates of unemployment, a lack of documentation and poverty of understanding are presented and discussed. Many of the professionals shared how they dealt with poverty on a daily basis in the work that they did with vulnerable children and caregivers. This may be indicative of the extreme levels of poverty in the Eastern Cape province as professionals are not dealing with such cases once in a while, but daily. These insights are seen in the excerpts that follow:

> *Based on the communities that we work in, finances is the major issue, is the finances and the old way of doing thing.* (P2)

> *When you are talking about poverty, you know, I say, you know, this is exactly what we are dealing with. We are, you know, we are looking at poverty on a daily basis.* (P7)

An ECD specialist shared that in the context of poverty, 'Ubuntu' was not possible as sharing meant that tomorrow you and your children would be hungry. This participant added that hungry children are a reality in South Africa:

> *We talk of Ubuntu, but Ubuntu, where there is poverty. It's impossible. Children are still going hungry today. That is a fact.* (P16)

Another participant shared how poverty places children at risk and hints that this may cause unintentional neglect. This participant felt that no caregiver would purposefully deny a child the necessary care, but stated that a lack of care may be caused by poverty:

> *It's mostly through poverty. I mean nobody wants to not be able to look after their child, but I think, yes, I think that is one of the issues.* (P13)

When one participant shared her experiences of poverty as a risk factor, she noted with concern that many mothers experienced extreme poverty of subsistence and were admitted into the maternity unit at the hospital and stayed on with their premature babies but had, for example, no toiletries. This participant stated quite simply that these mothers had nothing. A caregiver also shared how she was admitted to hospital and did not have any basic resources to meet her or her child's needs while in hospital, where she had to remain as her child was very sick. In such cases, a person is left wondering how the child will survive once discharged from hospital especially in cases where the baby was

born preterm or with an infectious disease or disability and may have special needs because of this:

> *Mothers experience poverty extreme, no toiletries, they stay in the care of very premature babies at hospital and these mothers have nothing.* (P5)
>
> *My child needs clothes and toiletries, I don't have anything here at the hospital for him.* (C1)
>
> *When we need to phone, we ask the sister here at the ward to help us with airtime.* (C4)

The concerns expressed by participants in this study regarding the high rates of poverty in the Eastern Cape province are supported by various studies throughout literature. Statistics South Africa confirms that as many as 62% of all children in South Africa are multi-dimensionally poor, experiencing different forms of poverty simultaneously, with young children being one of the groups most likely to experience poverty (Statistics South Africa, 2020a). From these studies, it is clear that many children in South Africa do experience extreme poverty and, in particular, poverty of subsistence, which is defined as a lack of basic resources needed to survive (Schenck et al., 2010). Hunger or the lack of food was also noted by many of the participants as a risk factor facing vulnerable children in the Eastern Cape province.

If hunger, or the lack of subsistence, is considered a risk factor according to the biopsychosocial model then poverty, which may cause hunger, is a social factor that influences both social and biological development. A child who lives in a family where there is poverty, a social factor, may experience hunger, which could cause stress and anxiety thus effecting psychological well-being. Moreover, hunger also has an impact upon biological development as continued hunger may cause malnutrition or illness. Here the interconnection between the biological, social and psychological variables are seen as described by the biopsychosocial model (Funderburk et al., 2021).

One of the professionals who participated in the study shared her concern over the high number of children in the Eastern Cape province who live in poverty and, as a result, are without food. This participant also then noted how important nutrition was for brain development during early childhood and how difficult it was for parents to be 'nice' parents when they were worried about not being able to feed their children:

> *Of the 2.9 million children in the province, 2 million are living in multi-dimensional poverty, good parenting is a hard thing to achieve for your*

> *children if you are thinking about where to get the next meal. If you are doing a programme with parents, you have to offer coffee and a sandwich as common good manners and you have got to ask what is in it for them? It is no use thinking that one is 'teaching them' about play or stimulation if their primary need is finding food.* (P17)

Another participant, an ECD professional, expressed her concern that children in the Eastern Cape province do not have basic things, such as food. This finding is supported by various other studies which explain that in South Africa nearly one-third of children under the age of five experience food poverty and more than a quarter (27%) of children under the age of five are identified as having their growth stunted due to malnutrition (Hall et al., 2017). Another professional also expressed this as the reality of vulnerable children and noted that the lack of basics, not only one basic but a variety of basics or poverty indicators, placed children at risk "*For me, it's reality, you know it's not having food and basic things that place children at risk"* (P7). Two of the caregivers expressed that they were unable to ensure that there was enough food to last the family an entire month. Both caregivers simply stated that their income from the CSG was not enough to feed the family and that there were times when they had no food to eat:

> *The grant is not enough, we sometimes have no food to eat.* (C5)

> *Grants do not cover all of his needs at times I don't have money to feed him.* (C7)

Many of the participants, in particular the professionals, noted that there were high rates of unemployment and they felt that this contributed towards poverty, the lack of basic resources and the vulnerability of young children in the Eastern Cape province. One professional participant who was involved in organising and facilitating parenting workshops noted that as many as 90% of the parents who participated in the workshops were unemployed:

> *And, um, and, of course, poverty. Lots of those parents, I mean, we had we workshopped about 546 parents in 2019. And of the 546 parents I think the 90% of that are unemployed parents.* (P7)

A second participant, also an ECD specialist, shared that many mothers attended parenting workshops and she felt that this meant the mothers were not working as these workshops were held during the day. She felt that having a young mother who was unemployment may present as a risk factor for a young child:

> *Workshops are usually during the day, so you will rarely find parents that are working are able to attend those workshops, meaning now those are young mothers that are not working.* (P16)

A health care professional who was working in one of the paediatric wards of the local state hospital noted that high rates of unemployment, together with the abuse of alcohol, were contributing towards the admissions or the 'problems' in the paediatric ward. This statement shows where caregivers are unemployed, it may be one of the risk factors resulting in vulnerability for the young child. In addition, this excerpt notes the correlation between unemployment and the abuse of substances "*High unemployment and alcohol is contributing to the problems in paeds"* (P12).

Only one of the caregivers in the study noted that unemployment was a challenge for her. She was at the local state hospital with her new-born baby who was preterm and struggling with complications due to this as well as having contracted an infectious disease. In addition, she noted that the father of her younger children was not working and that the father of her older children only supports her financially in December:

> *I am unemployed and the father of my younger two children is not working, the father of the older children is working he brings money in December.* (C1)

Two participants noted the impact that Covid-19 has had on the levels of unemployment and on already vulnerable children. One participant noted that many vulnerable children have families who do not work and that these children would then access nutrition through the school system; however, they were unable to do so during Covid-19 when schools were closed. This participant felt that children were vulnerable when caregivers were not working, and that Covid-19 had further complicated this vulnerability:

> *Covid has definitely had a negative effect. I think the negative effect on the vulnerable children is a lot of the families are vulnerable because a lot of them don't have work, so the child's access to nutrition was through the school. Not having access to their school for many, many months caused definitely a hunger to set in and not have the correct nutrition.* (P13)

A few of the participants felt that many parents may have lost their employment and source of income as a result of Covid-19. These participants felt that this situation was a risk for the child. It meant that the child could not be provided for, and that the caregiver may be depressed and both of these factors would then have an impact on the child:

> *Perhaps also seeing the parent that is now extremely depressed because they had lost their job because of Covid, I mean that has a huge impact not only on the parent but on the child and the parents being able to provide for that child.* (P13)

> *With the economy Covid has opened a huge gap in the system, not having food and abuse it is becoming more and more as families are so stressed and you can't put it down to a male or female, but abuse becomes more as people are just more and more stressed. People lose their jobs, and you go home and take it out on the family.* (C9)

A recent study by the University of Witwatersrand (2021) confirmed that Covid-19 has had an effect on employment and that women, as the primary caregivers of children, had been more effected by this than men. In addition, South Africa has experienced high rates of unemployment for many years. Unemployment presently stands at 32.6% (Statistics South Africa, 2021a) with unemployment in the Eastern Cape province being the highest in the country at 45% (Eastern Cape Socio-Economic Consultative Council, 2020).

Where the caregiver of a vulnerable child is unemployed, this becomes a risk factor in the social environment of the child as it may influence, for example, the amount and quality of nutrition that the child is able to receive, thus determining biological development. For the child who was born with HIV, unemployment, poverty and food insecurity will be detrimental to the child's biological development and overall well-being as such a child needs adequate nutrition in order to take their medication. In addition if the caregiver experiences stress as a result of being unemployed this may have an effect on the quality of nurturing care that the caregiver is able to give the child, thus influencing psychological development. The relevance of the biopsychosocial model is seen here where the social variables in the life of the child influence health or illness and poor or optimal development (Taukeni, 2019).

In addition to a lack of basic resources and high rates of unemployment, participants felt that a lack of legal documentation, such as identity (ID) documents and birth certificates, added to the extreme levels of poverty and continued to place vulnerable children at risk in the Eastern Cape province. The majority of professionals who participated in the study noted the great challenge with legal documentation in the Eastern Cape province and how this further exacerbated the poverty that already vulnerable children were facing. One participant noted that there are many cases where the biological mother does not have an identity document, and this then results in the child's birth being unregistered:

> *Because in many cases you will find that, uh, the mother does not even have an ID. So, the child's birth is not registered. The child does not have a birth certificate.* (P12)

A few of the health care professionals expressed their frustration with the Department of Home Affairs where a caregiver might be sent back and forth because she was not the biological mother of the child and was thus struggling to get a birth certificate for the young child in her care. One participant expressed her concern at the long time it takes to resolve matters where biological mothers do not have an identity document. In addition, the participants shared that many caregivers are unable to access the CSG because they themselves have no identity document or simply because they did not go to the Department of Home Affairs to register their baby and obtain a birth certificate.

The two statements from the dieticians who participated in the study also note how important either a multidisciplinary or a transdisciplinary approach to support vulnerable children is needed. In this situation, various role players need to work together to get the matter resolved and the child assisted. Alternatively, if there was one person who had transdisciplinary training then they could assist to resolve the matter quickly without the caregiver having to be sent around to various role players. Delays in service rendering or the lack of an integrated approach in such situations increases vulnerability for the young child and could prevent the child from achieving good health simply because of the length of time it takes to resolve issues relating to legal documentation. These challenges are seen in the excerpts below:

> *Getting birth certificates is a challenge they sent the caregiver back because they wanted an affidavit from the mother, but the mother was missing she was gone, so how was that supposed to happen?* (P14)

> *See a lot of no child support grant, mom has no ID if she is young, or they did not get a birth certificate, and then they don't have the CSG, we always ask and ask why not, we then send to the social worker here and it does generally come right but it takes a long time.* (P15)

Another participant, a hospital social worker, shared how frustrating it was when caregivers did not have identity documents because this then resulted in caregivers having no access to resources to care for their children. The matter was then further complicated when the caregiver and/or child had an infectious disease because without resources the caregiver and child may be unable to access the local clinic and would thus default on their treatment. Here, the biopsychosocial framework shows how interconnected the biological and social factors are. A child with a social network that is

not supportive, for example, a mother who has no identity document and no access to resources to care for her child, may struggle to achieve optimal health. This then has less to do with genetics and more to do with the social factors in the child's environment. The participant below expressed her concern over how one challenge that began with the biological mother having no identity document then led to many other challenges for that young child:

> *And I did mention about if they don't have ID documents. So, they don't have baby clothes, they don't have nappies, they don't even have food for the babies and some of them maybe are sick, maybe they defaulted. I know that when you are also HIV positive you can breastfeed the baby up to a certain time. Then after that what's going to happen; how are you going to feed the baby? If they are struggling then it's not going to be easy for them to go to the clinic, so meaning that they are facing many challenges.* (P9)

Another participant who shared that there was a challenge with children being registered and not having birth certificates noted the long-term future implications of this for the young child. According to this participant, when a child does not have a birth certificate, it becomes difficult for the child to be registered for school and, as a result, these children do not attend school "*We have a challenge of birth certificates. Yes, the child was never registered and also, they are not schooling"* (P4).

In contrast to the professionals, none of the caregivers who participated in the study mentioned that they did not have legal documentation and, where applicable, it appeared that they were able to access the CSG. This supports the biographical data collected for this study which indicated that the caregivers in this study were accessing the CSG. There are, however, many negative consequences for the young child when their parent does not have an identity document or when the biological parent was never registered. In the Eastern Cape province, statistics show that only 81.6% of births are registered within the first 30 days as required by law (Statistics South Africa, 2018). Of the remaining births, 11.6% are registered after 30 days but before 1 year and 6.8% are registered after 1 year but before 14 years (Statistics South Africa, 2018). This translates into many of the most vulnerable children not being registered during early childhood – the most critical period in terms of their development.

The Department of Social Development, the South African Social Security Agency (SASSA) and UNICEF (2012) confirm that a lack of legal documentation in South Africa is problematic and that this then prevents caregivers from applying for the CSG. Births

that are registered when the child is older than 15 years are sent to Pretoria for processing and represent 9.6% of birth registrations in South Africa (Statistics South Africa, 2018). These late registrations are important to note for this study as it implies that for up to 15 years many vulnerable children may not have been able to access the CSG during early childhood; the time when it mattered most. In addition, these children may not have been able to access schooling, which places the child at further risk as education is known to be one of the greatest influencers in breaking the cycle of poverty. Any programme that supports vulnerable children will thus need to provide support to caregivers who have no legal documentation themselves or for their children. Literature confirms that as many as 19% of the poorest and most vulnerable children do not access the CSG (University of Witwatersrand, 2021) with a second study stating that the majority of these cite the reason as being a lack of documentation (DSD, SASSA & UNICEF, 2012).

The findings in this study support that where vulnerable children do not have documentation, perhaps due to the mother herself not being registered or because of disrupted caregiving and the new caregiver not having the child's documentation, this may become a risk factor for the child especially as this may prevent the child from receiving a CSG and, at a later stage, accessing schooling. For a young child who has no legal documentation and is consequently unable to access the CSG or even access schooling at a later stage this then becomes a social factor that may impact biological and psychological well-being. The biopsychosocial model supports that for overall health to be achieved, interventions will need to span across the biological, social and psychological areas of development (Funderburk et al., 2021) with factors in each of these areas coming together to support the child towards well-being.

Should a child in these circumstances then, for example, attend a primary health care facility for immunisations and the health care professionals note that the child is not growing adequately, a biological intervention would not be sufficient to resolve the problem of poor growth. The health care professional may have to spend some time engaging with the caregiver to determine the reasons for the child not growing optimally. A holistic intervention plan may then need to be put into place: the caregiver may need to be referred to a social worker for assistance with an identity document and birth certificate as well as assistance with an application for a CSG, and the child may need to be referred to a dietician at the nearest tertiary health care facility. In addition, working

with a local ECD centre, where an ECD practitioner can assist with growth monitoring and ensure that the child has access to a daily nutritious meal, may assist the child. This finding aligns well to the biopsychosocial model, which according to Funderburk et al. (2021), supports a team-based approach to health challenges both for planning and intervening.

The last category that emerged under the subtheme of extreme levels of poverty was in relation to a poverty of understanding. A poverty of understanding has to do with situations that hold people back from developing optimally because there is a lack of awareness or knowledge (Schenck et al., 2010). A few of the participants in the study felt that there were caregivers who did not have enough information or understanding of what was required to care for children so that they could develop optimally. One of the caregivers expressed how challenging it was for her as she lived in a rural area and had no one to talk to or learn from in terms of raising her child *"It is hard at home in the rural areas I have no one to talk to"* (C1). Another caregiver agreed and felt that parents really do struggle with their children and that they are often afraid to ask when they are struggling with challenges:

> *They struggle with their children because they are not bold enough to go and ask for help, they are afraid to ask for help, then the children do the same because you are a mirror to your child.* (C6)

A professional child and youth care worker felt that when caregivers did not know what to look for or understand age-appropriate development, then they were unable to identify challenges and access resources timeously:

> *I think another thing that we always miss out, the development of the children. That one we always find it late. For example, if I'm observant as a parent in my developmental of my children, I will notice if my child has got a problem or my child cannot crawl or there is some disability area, or my child cannot speak speech, you know, all that. It's one of the biggest challenge.* (P4)

Some of the other participants agreed that a lack of education and the old way of doing things was a real risk for vulnerable children developing optimally. There was a feeling among participants that caregivers really did not understand what it was that they should do so that the child could develop optimally, that they did not understand how to nurture and care for a child and that, at times, caregivers really had no idea how to be caregivers. These insights are seen in the following quotes:

> *Based on the communities that we work in, finances is the major issue, is the finances and the old way of doing things.* (P2)
>
> *Care is one of the biggest challenges facing children in Eastern Cape and I think one of the biggest things as well is also a lack of education, or perhaps even the best way to take care of a child.* (P6)
>
> *Ooh! I think a lot of the time it's the lack of information, of knowledge from the mothers.* (P12)

A South African study conducted in a disadvantaged community in the Western Cape confirms these findings, noting that parents often do not know how to parent effectively (Gould & Ward, 2013). In addition, the study found that many of the parents in the community would welcome guidance with parenting – either in the form of a home-visiting programme or by attending a parenting course. If positive parenting is associated with good outcomes, then it is essential that parents who may not have the knowledge to implement positive parenting are supported so that their children may achieve good outcomes. Poor parenting is often linked to situations of poverty, with children living in poverty more likely to be abused, neglected and left unsupervised (Kaminski et al., 2013; Kotchik & Forehand, 2002). Poor parenting thus presents a real risk factor for the well-being of vulnerable children and is one that was noted by the participants in this study.

If the biopsychosocial model is considered in the context of poor parenting, then a caregiver who does not have parenting knowledge may not feed the child nutritious food. This may then affect biological well-being and a child who does not have sufficient energy may not be able to engage socially and may then too become depressed (psychological well-being) because they are unable to engage meaningfully with others. Here the interconnectedness of variables as per the biopsychosocial model is illustrated (Santrock, 2007) and the strong connection between child and caregiver, especially during early childhood, is highlighted (Shonkoff & Garner, 2012).

Numerous studies have noted the need for the biopsychosocial model to further identify and develop the social domain of the model, calling for the variables within this domain to be further refined so as to reflect the intricateness of these variables on a micro-, meso- and macro level, and the influence these have on development (Lehman et al., 2010; Pilgrim, 2015; Suls & Rothman, 2004). The findings in this theme have identified poverty of subsistence, unemployment and poverty of understanding, which occur within families on a meso level and within the community on a macro level, as variables that place the child at risk of poor developmental outcomes. In addition, the findings have

indicated that a lack of legal documentation occurring on a meso level within the social domain of the family is a variable that continues to place vulnerable children at further risk for poor developmental outcomes.

Subtheme 2: Ongoing and severe child maltreatment

The majority of participants expressed their concern over the many cases of child maltreatment that they saw and worked with in the Eastern Cape province. These participants felt that the ongoing and severe maltreatment of vulnerable children was a great risk factor for optimal future development. Many of the participants raised the issue of neglect as a risk factor for the young child. Some participants felt that the neglect was intentional where mothers simply did not care about or for their children. They made decisions, such as not to breastfeed or to get their child immunised, with a disregard for what was in the best interest of the child. This is seen in the participant quotes shared below:

> *Teenage pregnancy. They neglect their children. There's a big problem there in Duncan Village. They don't care about babies, their children.* (P3)
>
> *And severe neglect.* (P5)
>
> *So, moms tend just not to breastfeed.* (P14)
>
> *They are not getting immunisation.* (P3)

Two other participants, an auxiliary social worker and the director of a place of safety, shared more detailed stories of situations where babies were severely neglected. These two scenarios show that neglect is often accompanied by a host of other risk factors, such as disrupted caregiving or abuse. Another participant, a social worker, noted that, at times, neglect would result in children being hospitalised. These insights are seen in the excerpts that follow:

> *And that day, that child was wet, wet, wet. Then I took that child. I went with her inside the office, I changed the nappy, I put on clean clothes because she was shivering. Yes, then I put those things on. To keep her warm. And I made porridge. To give her, a weak one then to drink it, for her to just so that she can feel warm.* (P1)
>
> *Most of mine are mild neglect if I want to say. I've had a set of twins with extreme neglect. They weren't fed properly, they were abused, they were left alone at three months old, they were a weight younger than a normal birth weight, so at three months old, so there was definitely quite a lot of issues that were not taken care of.* (P6)

> *Sometimes we even get calls from hospitals about babies that have been neglected by their mothers in hospitals.* (P2)

One of the professional nurses noted that when children had disabilities they may be unintentionally neglected as caregivers did not know how to feed them correctly. The child would then become malnourished and hospitalised:

> *One child has cerebral palsy the mother is not coping with the child and does not know how to feed the child and sometimes they will come with SAM [severe acute malnutrition].* (P12)

A hospital social worker noted the dangers caused by the illegal electrical connections in communities which then resulted in children being electrocuted. This may be an example of societal neglect because where communities do not have access to electricity, they use illegal connections which are unsafe and result in serious injuries to young children:

> *There is this izinyoka [illegal live open electrical connection]. The illegal, connections in the townships. We've had children here that are admitted for injuries from those.* (P9)

Various studies have noted that child neglect remains a concern both globally and in South Africa (Easterbrooks et al., 2019; Schmidt & Azzi-Lessing, 2019) and that the effects of child neglect may be severe with long-term implications (Schmidt & Azzi-Lessing, 2019). Child neglect, whether intentional or unintentional, is thus a serious concern and one that was noted by the majority of participants in this study. If considered in the context of the high rates of poverty in the Eastern Cape province, it is not surprising that child neglect was noted as a risk factor for young children by the majority of participants.

Should a caregiver fail to provide nurturing care to a child, in essence, neglecting the child, then the child may fail to thrive. As shared in Chapter 3 of this study, Schmidt and Azzi-Lessing (2019) note that the effects of neglect may result in cognitive and academic challenges, withdrawal from social interactions and depression and anxiety. Here, the interaction of and interconnectedness between the variables as per the biopsychosocial model are again illustrated. A lack of nurturing care, a social variable, influences cognitive abilities (biological development) and results in psychological distress ultimately influencing overall well-being. It should also be noted, as shared by

participants in this study, that societal neglect may have an impact upon the well-being of children.

Participants noted that illegal electrical connections in communities impacted upon the social well-being of children as they were unable to move around and explore their environments freely and in safety. In some cases, this resulted in children being fatally electrocuted or being admitted to a tertiary health care facility for burns. Here the variables in the social environment of the child have serious health consequences and may cause additional psychological stress for the child who has to recover from burn wounds. Such trauma may cause a delay in all areas of development for the young child. The relevance of the biopsychosocial model and the interaction of the biological, psychological and social variables are again noted here (Morgan & Sotuku, 2019).

In addition to child neglect, almost every professional who participated in the study shared their concerns over the high rates of young children who were being physically and sexually abused in the Eastern Cape province. The two caregivers in this study who were foster parents also noted that child maltreatment was one of the risk factors threatening the optimal development of children "*A lot of abused and abandoned babies"* (C8) *and "Abuse it is becoming more and more"* (C9). Most participants noted that there were numerous cases of child abuse and that many of these cases were severe with babies and children often being hospitalised as a result thereof. This is illustrated in the excerpts below:

> *There were also those that came in after being sexually abused, some were babies.* (P15)
>
> *Even kids that come for head injury they come in being assaulted by parents maybe parents were fighting.* (P13)
>
> *So, there are children sometimes who do come to our groups, and we've noticed some of them were sexual abused.* (P8)
>
> *There is abuse. Because they don't, some females don't want to talk. If they go to the creche someone will see because the teachers they can see that this child has been abused and hurt and they will quickly call the social worker.* (P7)

One participant felt that you could tell from the community where the child was living whether the abuse would be bad or less severe. This may indicate which of the communities require more support or interventions to support young children and caregivers. This sentiment is seen in the quotation that follows:

And violence, child abuse, is a real problem, it really depends where they are staying, if they come from Amalinda Forest it will normally be very bad, from Duncan it will either be okay or very bad, Cambridge seems a little better, you can't always generalise but it is so that you can tell by the areas that they children are coming from. (P11)

Two of the participants shared their concern over the high rates of physical abuse in situations where caregivers continued to discipline even very young children or children with disabilities by beating them:

So, you know, the kids whenever they go home, they're going to be beaten up. And then some will say 'I don't beat, but I shout. (P7)

Spanking is very common, even for young children, hidings when children are older, also everyone in the family disciplines the child which makes it difficult. (P11)

A further category that emerged under the subtheme of child maltreatment was that of disrupted caregiving. Once again, almost every participant noted that disrupted caregiving was a significant risk factor for young children in the Eastern Cape province. Some babies were abandoned in toilets, rubbish bins or left alone for long periods in a shack (informal housing structure) or the family home. Other babies were abandoned at hospitals or even in public areas. This is seen in the quotations below:

Well, growing up we saw a lot, babies on rubbish dumps, abandoned babies, babies found in the bushes, also new years' was a big one, babies left on the beaches, a lot of children from the hospital and then also kids being removed. (C8)

We used to get those babies abandoned babies from Fort Hare, there is a big container that is close to court for garbage and plastics and they throw them there small babies they are picked by the people in the bins they will hear the child crying. (P12)

The mother of that precious child is gone she is nowhere to be found. (P12)

Many participants narrated different stories of where babies were left alone in a home, or with siblings who were themselves still young children:

They don't care about babies, their children. The other day there was a three-month-old who was left with six years and eight-year-old. Then, the 8-year-old she give the baby cooldrink. She gave the three months old baby that to drink. They were sleeping alone there, from eight o'clock until six o'clock the next morning. She died (the baby). (P1)

Like, if she's going to work, then the child can go to the neighbours to play, and she will lock her shack, the mother. And she will take that child after work. Yes. It's funny, they just send the children. Or the child will go to

> *school in the morning and when she comes back, she knows that the mother is not there, yet there she will go with her friend.* (P10)

Another participant, a professional nurse, also noted that some of the hospital admissions occurred as a result of mothers just leaving babies to cry alone at home:

> *Sometimes, I think they would then actually leave the house completely and those children are left behind. We've received a few children through those circumstances where the mother has completely left the property and neighbours have reported her because they themselves couldn't handle the child crying anymore.* (P13)

As noted in the literature review of this study, the National Adoption Coalition of South Africa (2017) confirms that as many as 3,000 babies are abandoned annually in South Africa. This statistic is supported by the findings of this study where almost every participant noted that being abandoned was a factor that placed young children in the Eastern Cape province at risk. One of the caregivers expressed her own concern that she had left her children alone at home to bring her sick baby to the hospital. This was an interesting finding and one that was not specifically noted in literature. Various studies have noted that disrupted caregiving can occur when the mother herself suffers from depression or illness (Mogotlane et al., 2010; Schmidt et al., 2019, as cited in Moodly et al., 2019) but in this case, disrupted caregiving occurred when a sibling became ill and the caregiver was then required to stay at the hospital for an extended period of time, leaving other young children alone and vulnerable at home. The complexity of this situation is captured in the words of the caregiver below:

> *Even now I am worried about my children, they are alone and I mna [Xhosa word meaning I] am here at the hospital with my sick baby. I phone them every morning to wake them and tell them to get ready for school. My cousin just checks on them for me.* (C2)

At other times, babies were left by mothers with family members, such as grandmothers, who then had to care for them. The participants felt that this was a risk factor for that child. A recent study supports these findings, confirming that as many as 33% of young children in the Eastern Cape province are not cared for by one or both of their biological parents (Hall, 2019). This in itself may not be a risk factor but the participants in this study felt that often parents disappeared with their legal documents without registering the birth of the baby, or they left with the SASSA card. This then often left grandmothers with very few resources to care for the child and then became a risk factor for the optimal development of the child. This is seen in the words of participants below:

Uh, what we found also, we're still finding a situation where grandparents are still looking after kids because the mother have disappeared. And, uh, they've run away with the SASSA cards. (P7)

Or abandoned babies, the baby is just left with the granny and then breastfeeding cannot take place. (P14)

The mother of the child is nowhere to be found but the family they already have so many small children with them but what can be done there is nothing. (P12)

No, the parents are in Johannesburg, or the father is nowhere to be found, you know. (P4)

I think absent parents is one of the risk factors. That children are being left in the care of grandparents and other family members to be taken care of. (P18)

At times, participants noted that disrupted caregiving was because of parents dying from HIV and Aids and now more recently because of Covid-19. A study by Hall et al. (2018) confirms that as many as 14% of children in South Africa are orphaned. The participants felt that children being orphaned became a risk factor that could impact upon them developing optimally:

The parents are dying from Covid, it reminds me the starting of HIV in our country. The parents will die and leave children as orphans. (P4)

And then sometimes we also deal with children who have lost their parents. (P2)

The literature presented in Chapter 3 of this study noted that disrupted caregiving is a risk factor for young children and that many young children in South Africa are impacted as a result of disrupted caregiving (Mogotlane et al., 2010; National Adoption Coalition of South Africa, 2017). If disrupted caregiving is considered in the context of the biopsychosocial model, then this becomes a social factor that may impact the overall well-being of the child. Disrupted caregiving may result in the child being left alone for long periods of time. This, in turn, results in psychological and biological distress as there is no responsible caregiver to soothe the child when the child cries or to feed the child when the child is hungry. Here the interrelatedness of the biological, psychological and social variables on overall health and well-being as noted by the biopsychosocial model are illustrated (Taukeni, 2019). If nurturing and responsive caregiving is a protective factor during early childhood (Sotuku & Schmidt, 2019), then disrupted caregiving may have devastating consequences for the young child. The literature shared above

confirms the findings in this study where the majority of participants felt that disrupted caregiving was a risk factor faced by many young children in the Eastern Cape province.

Some of the participants also shared that family violence resulted in children being maltreated. One of the professional nurses indicated that the ward she worked in admitted many children who had been harmed when their families had been fighting and that such children then often experienced severe physical injuries themselves while another participant agreed stating that *"They always, when mom and dad are fighting involve the children" (P3)*. Another professional, a child and youth care worker expressed her concern over the high rates of domestic violence in communities and noted that this occurs in front of children repeatedly:

> *Mothers, they are abused by their boyfriends and fathers. Yes, there's a lot of domestic violence there. And they hide it. If you say to her you must go to the police station to do protection order, she can go to do it and come with it, put it there under the mattress and then life goes on. The same man beat him again, beat her again. It just carries on and on and on. In front of children.* (P3)

Various studies note the damaging effect of family violence on the young child. Widom and Wilson (2015) go so far as to say that witnessing a family member being abused can be even more traumatic for a child than being abused themself. Majali and Alsrehan (2019) draw attention to the far-reaching effects of violence on the cognitive, emotional and behavioural development of the child. Here the appropriateness of the biopsychosocial model for this study is illustrated. Witnessing violence is a risk factor occurring within the social environment that causes psychological stress for the child. This, in turn, can affect biological development, which determines cognitive and behavioural outcomes, thus placing the child's overall well-being at risk.

Turner et al. (2012) have studied the effect of violence on the development of the brain during early childhood noting that witnessing family violence triggers a stress reaction that is so traumatic that it may lead to permanent changes in the structure of the brain in a young child. This was confirmed by two more studies, one of which noted the effect family violence had on the cognitive, emotional, social and psychological development of the child (Perry, 2001) and the second study, the impact family violence had on brain development if experienced during early childhood (Kaufman et al., 2000). Here the biopsychosocial model is again of relevance. A young child may be physically healthy but social and psychological factors, such as high stress levels caused by the witnessing

of ongoing family violence, may then jeopardise the optimal development and well-being or brain development of the child, resulting in future challenges across all or some areas of functioning. Taukeni (2019) agrees and notes that the biopsychosocial model acknowledges that social, psychological and physical stress in the environment of an individual can have short- and long-term effects on the overall health and well-being of an individual.

With the high levels of violence in South African communities, this is of major concern and a pressing risk factor for young children and their optimal development. According to a national study conducted by Jewkes et al. (2002), one in four women in South Africa has experienced domestic violence; this may make the number of children who witness family violence extremely high. A study by Seedat et al. (2015) confirms the high numbers of children who witness family violence, concluding that as many as 45% of children in South African have witnessed their caregiver being abused by an intimate partner. If this is witnessed when a child is young, then the impact it may have on brain development and future outcomes for the child is devastating. While only some of the participants shared that this was a risk factor impacting upon the development of young children, if statistics from other studies are taken into account, then family violence is a compelling risk factor impacting significantly upon the optimal well-being and development of South African children.

Every professional participant voiced their concern about the high rates of substance abuse by caregivers and identified that where a caregiver was abusing substances, this became a risk factor for the child. The majority of professionals felt that where caregivers abused substances, this resulted in the maltreatment of the child. One of the social workers stated that many of the mothers abused alcohol and did not send their children to school *"They go to the tavern [a local mostly unlicensed bar in South Africa]"* (P3). Another community-based professional noted that many of the removals of children from caregivers were as a result of caregivers abusing substances. She noted too that often babies then had FAS *"A lot of alcohol related removals or babies having FAS"* (P4). An ECD specialist shared that many young mothers were abusing alcohol and she felt that this was a risk factor for the children in their care:

> *But we have cases, we have cases. One of the risk factors which I was going to mention, it was we have parents who are now drinking, especially*

> *when you go to townships, you've got a lot of alcohol abuse from young parents.* (P16)

Many of the caregivers who participated in the study also shared stories of mothers abusing alcohol and drugs causing the young children in their care to be neglected and abused. This is illustrated by the excerpt that follows:

> *He came from family where both parents were using drugs, more than just dagga and it took a long time for him to come out of that, he was inhaling, and he was locked inside.* (C9)

The abuse of substances as a risk factor for young children was also confirmed by the health care professionals who participated in the study. One professional nurse noted that alcohol was contributing to the problems that were being seen in the paediatric ward of the hospital. This could mean that alcohol abuse is one of the driving factors behind the health-related problems being experienced by young children. Both the professional nurse and the social worker cited previously noted that they often see FAS as well as have to treat babies who have withdrawal symptoms as a result of their mothers abusing substances. The health care professionals also felt that these caregivers may never change their behaviour and that they essentially did not care about their children. These inputs are seen in the two quotations below:

> *We have the babies with withdrawal symptoms and foetal alcohol syndrome the features are there, small head and those things you can notice straight away.* (P12)

> *The other one was picked up by police, the parents are drinking, the boyfriend, the boyfriend, there are a lot of parents still drinking out there by the airport, the mothers deliver here in maternity, some deliver before their date.* (P13)

Many participants shared that there are caregivers who drink alcohol and that this has an effect on the children. One participant, an ECD specialist, shared a story where a mother's children were removed from her care because she was abusing alcohol and was not caring for them. This participant quote, and the others given below, highlight the connection between substance abuse and the consequent lack of care or neglect of children with caregivers often being seen in taverns and using resources to purchase alcohol, both of which placed the young child at risk:

> *So, we've noticed that there are some of the moms, they are drinking alcohol. That is affecting their kids. She was like crying, saying that her*

child has been taken from her because she used to drink. As a result of that, her children were taken away from her. (P8)

Because what I've noticed is that the parents do go and give birth and then when they come back, they start smoking, they start drinking and they don't even take care of their children. And then you have all this, all the risk factors the baby is then exposed to at home because of the mom drinking or smoking. (P2)

The issue of alcohol it's a big issue. We try whatever we can. Alcohol doesn't stop. Doesn't stop at all. We had one family one day, we went and do home visit. The mother was drinking with the children. And her excuse was I don't have food, so I want them to get drunk and sleep. (P4)

The participant above felt that substance abuse may have been an excuse for the hunger that the caregiver and children were experiencing yet for that caregiver the real issue of hunger caused by poverty was having a detrimental effect on the well-being of her children. Here the strong influence of a social factor such as poverty on the optimal development of the child is clearly seen. One participant tried to explain that when caregivers experienced poverty and lived in environments that were not conducive for raising a child, they may turn to substance abuse. Here, again the reality of poverty, a social factor detrimental to the well-being of the caregiver and child is seen. In addition, she felt that this occurred frequently and that the abuse of substances by the caregiver then became a risk factor for the young child. The following two excerpts, both from the same participant, illustrate the connection between poverty and substance abuse:

You know, when one is also wanting to deafen the crying of the baby and you are in a space that perhaps isn't conducive to child caring, you will look for other avenues of trying to remove yourself from that and that's possibly where the alcohol and the drugs and all of that comes in. (P5)

A lot of the families find other ways to try and take their pain and hurt and because they are poor, so there is quite a high incident of abuse, whether it is alcohol or drugs. I think that is what we are seeing. (P5)

Another participant shared that alcohol was a big problem and that it simply did not stop, with the situation worsening around payday for social grants *"This week it's the social grant week. It's going to be so, so, so difficult some of them already started drinking on Monday"* (P4). In addition to the connection between substance abuse, poverty and the neglect of young children, one participant noted that substance abuse often caused disabilities for the child. Moreover, despite being warned, the mothers continued with such behaviour. This participant also noted that these mothers then went on to claim and abuse the disability grant they received for their child:

> *Some of them are not going to the prenatal clinic. And they abuse even the disability grant when they have a disabled baby. I talk with them. I always talk to them; if you drink when you are pregnant you can lose or get a disabled baby, but they carry on.* (P3)

A study conducted by Manu et al. (2017) confirms that South Africa has high rates of substance abuse. Kaliszewski (2019) agrees that parental substance abuse impacts the well-being of children and is a risk factor for child maltreatment. Various studies have also shown that children with caregivers who abuse substances have a higher risk of being maltreated, resulting in trauma that will have life-long implications for the child (Staton-Tindall et al., 2013). As such, the concerns noted by the participants in this study, who named substance abuse as inextricably related to child maltreatment and as a risk factor for the development of young children, seem justified. If the biopsychosocial model is considered within this context, then alcohol abuse by a caregiver or even by others who reside within the family home may expose the young child to risks within their social environment. This may cause psychological or biological distress for the child in a very similar way to that caused by maltreatment. If the sensitivity of the brain during early childhood is considered, social and psychological stress caused by a caregiver abusing alcohol could be detrimental to the present and future well-being of the child.

One of the critiques of the biopsychosocial model is that it needs to further define the social factors that influence poor development or illness (Lehman et al., 2010), with the social domain of the biopsychosocial model remaining the most underdeveloped and under-reported in research (Pilgrim, 2015; Suls & Rothman, 2004). The findings in this theme have, however, clearly indicated that exposure to child abuse, neglect and disrupted caregiving, often accompanied by exposure to family violence and substance abuse both on a family and community level, are clearly defined and influential factors within the social environment of the child.

Subtheme 3: Poor physical health

All of the participants expressed that poor physical health presented a great risk for the development of young children in the Eastern Cape province. Malnutrition was noted as a serious concern by most of the participants. The health care professionals indicated that caregivers did not access health care because they did not realise that the child's health was deteriorating or because they did not have the will or resources to access available health care. Some mentioned that the CSG was simply not enough to meet the

nutritional needs of a young child. Most participants noted that they have seen very young children with malnutrition. One of the professional nurses shared a story of a young child who was readmitted for severe and acute malnutrition (SAM) and, in this case, he was brought to the hospital by a neighbour who found him alone. The participant went on to express that this young child was near death. This example shows the severity of the poor physical health that some children face in the Eastern Cape province, and this is, at times, due to poor nutrition which is possibly related to the extreme poverty experienced and discussed in the first section of this chapter. This is an example of how inextricably connected risk factors in the social environment of the child are to the child's biological development. Where a caregiver experiences poverty, she may not be able to provide the child with the nutrition that is needed for optimal development and the child will then experience poor physical health.

Poor physical health then holds the child back from developing optimally during early childhood. It is disheartening and unacceptable that children continue to experience poor physical health from malnutrition in a country that has such a strong legislative framework to support children's rights, one of which is to have access to nutritional food. Some of the participant's quotes in relation to malnutrition are shared below:

> *We are worried about SAM (severe acute malnourishment), we didn't expect them anymore, we used to have many of them maybe about 6 in the ward, they have severe thrush, the history is repeating now, they are coming in drips an drabs now, the grant is not enough.* (P12)

> *Now we have the one where the child is so malnourished, she is back, she was supposed to go to theatre, but it was postponed the child is malnourished.* (P13)

> *He was emancipated he was on feeding tube, and it is not the first time, it is a readmission, he was approaching the grave, he was brought by a neighbour, the child has been in and out for the same and now the child comes back again, and everyone knows that baby and we are worried.* (P12).

One of the auxiliary social workers who has been working in the field for 23 years had a different perspective to the participants above – although she did not disagree. This participant noted that there are babies who are malnourished but that it was not as bad or perhaps that there were not as many cases as in previous years *"With the babies there is malnutrition. But it's better now. But there are those that are malnutritioned" (P1).*

Participants also expressed that there were many cases of young children with chronic and infectious diseases or with disabilities. These factors then contributed towards poor physical health and became a risk factor, threatening the development and overall well-being of the child. In some cases, caregivers seemed unwilling or unable to approach health care facilities for assistance. Neighbours would then report the caregiver to community workers or social workers who would accompany the child to hospital. This is seen in the following excerpts:

> *There was this case in Duncan Village. That baby that was staying with the mom and the father. And she was always sleeping in bed, they didn't even know that that child is sick. They don't know because they see the baby doesn't cry. They see baby is a quiet child. You change her when you want to change her. You feed her when you want to feed her. She doesn't complain. That baby is actually so quiet because she is malnourished and dying, and the parents do not even realise. They don't want to expose themselves, like, to us because that mother doesn't have a grant. She's got an ID book; she doesn't have a grant. She doesn't want to leave her house. Even to go to hospital. We have to force her to go to hospital.* (P1)

> *And sometimes even some community members see it as it happens within the community, then we get reports. Then we follow-up and we try and assist and take them to hospital just to make sure that the children are well taken care of.* (P4)

One participant shared a story of how caregivers who were looking after children with disabilities appeared overwhelmed and that this then resulted in them doing nothing to support or assist the child, placing the child further at risk:

> *I think they get lost. They feel overwhelmed. I think there may be other issues, familial issues, social issues that impacts their ability to help their children. I think sometimes they don't realise that they have it within themselves. They don't know how to unlock it. I think that sometimes the demands are so great on our mothers out there that they kind of, I get the sense of they would they kind of just leave it, you know? I think sometimes they don't feel motivated enough, they don't feel appreciated enough as mothers, and because sometimes it's not just about the vulnerability of the child, it's about their own vulnerability as a mother, as a parent, as a partner. (P18)*

This was, however, not true for all caregivers as many of the caregivers interviewed for this study had themselves accompanied their children to hospital and expressed concern over their children being ill and the effect that this then had on the children's well-being. For example one caregiver shared that "*My baby eats but does not put on weight, I am worried they transferred me here from Butterworth"* (C4) and another shared *"My baby*

was born before his time and now he has meningitis, we were transferred here from hospital" (C1).

One of the professional nurses shared a story of one of the mothers who was at hospital with a very sick baby. According to the nurse, this mother was stressed as her child was not improving and she had other children at home who she felt would not be safe without her being there to protect them. Here the poor physical health of one child seemed to be taking its toll on the caregiver, who was responding with anger and aggression towards the health care professionals. While it is true that a child with poor health may be a stressful situation for a caregiver, it may become even more stressful in a situation where the mother is unsupported, for example, as in this case where the mother felt that being at hospital with her sick baby was endangering the lives of her other children who appeared to be left at home with no one to ensure their safety. This is another example of where the poor health of a young child may become a risk factor not only for the child who is experiencing illness but also for the other children in the home.

Caring for a child with poor health can be a stressful experience for many caregivers. The biopsychosocial framework acknowledges the role that psychological factors play in the well-being of a young child (Lehman et al., 2017) and the NIECD policy notes that where caregivers and young children are continuously exposed to distress, their psychological well-being can be compromised further, thereby impacting upon optimal development (Republic of South Africa, 2015). This interconnectedness of variables is confirmed by the biopsychosocial model (Taukeni, 2019). Additionally, the stress experienced by the caregiver can then have an impact upon the psychological well-being of the child who is already struggling with poor health. For these reasons, it seems important to acknowledge that where a child experiences poor health because of illness or a disability, this presents as a risk factor for the optimal development of the child and, as such, this child and the caregiver may need additional support. The words of a health care professional below capture this sentiment:

> *That baby is very sick she is not improving and that mother is very stressed and burnt out. She says she will rather leave the child here to die because her other children at home will be raped.* (P12)

Another caregiver shared the additional stress she experienced raising her twins as one had cerebral palsy and her other children struggled to understand how much time she needed to spend with him due to his condition. This again illustrated the stress that

parents face when their child has a disability and could highlight that where caregivers are raising children who have a disability, this may be a risk factor and the caregiver may benefit from extra support:

> *At first, she didn't understand, she would hit him, I explained to her that he is not fine and now she knows he is not well, he has brain damage and cerebral palsy.* (C7)

One participant shared that when children have disabilities, mothers struggle to care for these children and are often embarrassed and unable to cope with the medical condition of their child. The same caregiver who shared her experience of raising a twin who had cerebral palsy also shared how difficult it was for her to care for this child and that he was now in hospital because he was malnourished and was struggling to eat. Another participant shared that TB continued to be a challenge and that this really resulted in children becoming very sick. This is seen in the excerpts that follow:

> *And then TB too, TB was a big thing, they would come in and be very sick, very dehydrated, full of sores.* (P4)

> *The mother is young and then she have a child with big head. So sometimes she will be embarrassed about her child. They don't accept those conditions and then they don't cope.* (P13)

> *Everything is difficult. I can't feed him. To bath him is difficult everything is a struggle, he used to cry a lot and thought maybe there is something wrong with his throat. They told me he is struggling they will put a tube in for feeding.I do have support at home, but he doesn't want anyone*. (C7)

The health care professionals added that HIV remains a risk factor for vulnerable children and that where caregivers were diagnosed with HIV during pregnancy, support was needed to ensure that the mother took her medication during the pregnancy and that she gave birth at a hospital so that transmission to the baby could be minimised. In addition, the majority of the health care professionals noted that mothers needed support with babies who were HIV positive as feeding became complicated and regular use of medication was essential to minimise transmission. The quotations that follow illustrate that HIV continues to add to vulnerability for young children:

> *Moms with HIV definitely need support with their young children.* (P14)

> *When there are underlying conditions like HIV that increases the baby's needs.* (P15)

HIV is still a problem, the PMTC (prevention of mother to child infection) has to be done properly. (P11)

Like, you will find that, uh, a mother is only diagnosed during pregnancy that they are HIV-positive. And, a lot of them, they don't do their bookings. They don't go for their bookings, so they are only given treatment once when they are diagnosed. We've had cases where a mother has given birth at home, knowing their status and then they give birth at home exposing the child. (P14)

One of the professionals felt differently to the other participants and shared that HIV was not as problematic or as much of a risk factor as it had been in the past *"With that treatment the mother is taking, it doesn't transfer to the baby and we are seeing less babies dying from HIV now"* (P1).

The last category that emerged under the subtheme of poor physical health was that when babies were born preterm or with low birth weight, the chances of them having future complications or delays in future development were high. Babies born preterm with low birth weight and multiples, who are often born preterm and with low birth weight, were thus identified as being at risk for challenges with their development and health. Many of the professionals noted this as a risk factor for vulnerable children and, in addition, noted that there were many babies, in particular from the rural areas, who were born preterm or with low birth weight. This is seen in the participant quotes below:

We must look out for premature babies, multiples and those with low birth weight. Premature babies very easily prone to infection. (P5)

There are many babies from the rural areas with low birth weight or born before 32 weeks. (P11)

You will find that some of them are ex-premature babies, and this mother is so poor here that she cannot do anything. Dr M is the one taking care of the premature babies. We have another ex-premature baby that is 2 months, he weighs 4 or 3kg only. (P13)

The caregivers themselves also expressed the challenges that they had had when they were pregnant with multiples or because their babies were born preterm or with low birth weight and how this had resulted in additional health problems for their children, who were now admitted to hospital:

I was pregnant with twins. It is hard I can't go anywhere I don't need help though I live alone now in my sister's place in Oxford Street. My girl has got a skin problem we thought it was eczema but hospital says it is another problem (baby admitted for SAM). (C4)

He was born 1.5kg but he was fine then he got meningitis and he was not breathing good. (C1)

I was pregnant with triplets. The one baby died. I had to have an emergency caesarean section, Michael and his sister lived, at six months we found out he had brain damage. (C7)

Literature confirms that poor physical health, such as malnutrition, illness, disability and preterm deliveries or a low birth weight, are risk factors for a young child that may jeopardise optimal future development, particularly due to the sensitivity of the brain during early childhood (DoBE, 2015; Morgan & Sotuku, 2019). Various studies also agree with the findings in this study that having a child with a disability, or a child who is HIV positive, places these children at greater risk for neglect in South African communities (Ali et al., 2012; Gray, 2002; Heeren et al., 2012 as cited in Azzi-Lessing & Schmidt, 2021).

In addition to these studies, the biopsychosocial model confirms that factors relating to biology, such as genetics, immunity, illness and disability, will play a role of particular importance during early childhood – the period in which a child or the brain is most sensitive to such factors. The biopsychological model acknowledges the role that illness will have on optimal development as illness or poor physical health may impact social and psychological well-being (Taukeni, 2019). Children made vulnerable through poor health should thus be supported through interventions, for example, a home-visiting programme, so that the impact of poor health on overall well-being can be minimised. The biopsychosocial model supports that where there is poor health, interventions that enhance psychological and social well-being can reduce readmissions to health care facilities as well as risk behaviours resulting in both better biological and psychological well-being (Taukeni, 2019).

According to the professionals in this study, they worked daily with children experiencing issues related to poor health. All participants expressed their concern about the impact that this would have for the future of the child and identified poor health as one of the risk factors that could negatively impact the optimal development of the child. Caregivers themselves expressed their concern and frustration when their children experienced poor health and then had to be admitted to hospital.

Subtheme 4: Unplanned pregnancies

A few of the participants noted that when pregnancies were unplanned or unwanted, this then places the child at risk. Two of the professional participants, both of whom manage a place of safety for young children, shared stories of their experiences when pregnancies were unwanted. Both participants felt that there was a need for follow up with biological mothers who approached the abortion clinic but, for whatever reason, did not receive an abortion. In addition, one mother, who did not want her baby, was forced by her family to keep the baby and she then later tried to commit suicide. Her baby died from the poisoning, but she survived and is now in a coma. In the excerpts shared below, the two participants bring attention to the risks for the young child when the pregnancy is unwanted, and the mother is presented with no alternative but to keep her child:

> *At the abortion clinic, patients are sitting for days, beyond 20 weeks then they are too late for abortion, what happens to those mums who didn't want their babies in the first place? There is no follow up, it is so busy at the clinic, I am not sure if moms are given alternate options, but it is so busy there*. (P5)
>
> *I have a real fear of illegal abortions, how these kill or don't kill babies. There is a tablet that the mother drinks, it eats away at the foetus but babies can still then be born alive with terrible medical problems. This is a real trauma for the child and mother. How many babies are then born alive but left to die?* (P5)
>
> *There is another case where the family refused to allow mother to have abortion or give baby up for adoption even though she wanted to. That mother later committed suicide after she killed her baby too, she is in a coma now and her baby died, the baby was a few months old*. (P6)

An ECD specialist commented that during parenting training, which they had facilitated with parents at an ECD Centre, it was found that many caregivers were young and had not planned their pregnancies. This participant felt that where parents were young and where the pregnancy was unplanned, this may then present a risk for the child "*It's unplanned pregnancies. In casual conversations with them, you get it from them that they dropped out of school because there was no one to look after the child, so those were unplanned pregnancies" (P16).* Another ECD specialist agreed that young inexperienced parents who did not plan pregnancies presented a risk for the child *"I would say one of the risk factors is young, having young, inexperienced parents, most of the time its an unplanned pregnancy" (P18).*

One of the child and youth care workers expressed that teenage mothers often neglected their babies *"Teenage pregnancy and teenagers who neglect their babies"* (P3). Teenage pregnancies were also noted as presenting a high risk for the child. Health care professionals noted the risks for the child when teenage mothers do not bond with their babies; they do not breastfeed their babies and leave their babies with grandmothers who may be unable to provide adequately for the baby. These sentiments are seen in the following excerpts:

> *Also, the bonding does not happen when the mothers leave their babies.* (P14)

> *Teenage pregnancies are seen a lot, then the child goes back to school and the granny is left with the baby and breast feeding cannot continue.* (P15)

A few participants also shared that young mothers and mothers who have no support, presented a risk for the child. A health care professional noted that currently there was a mother in the ward who was very young and living alone with a set of twins and that her one twin had been admitted with SAM. For this participant, this is an example of a young mother with no support which then presented as a risk for the young child, who had been admitted with SAM *"I don't know if she is a student or what, her child is here as a SAM baby" (P5).* Another auxiliary social worker shared the circumstances of a 2-year-old child whose mother was very young. This young mother had no support from her own mother as the grandmother was abusing alcohol. This participant felt that this was an example of a situation that presented a risk for the child:

> *She was 2 years. And her mother was very young. She could not take care of her, and the grandmother was drinking.* (P1)

A director of a place of safety, a child and youth care worker and an ECD specialist added to this noting that the challenge with young and single parents was that they did not have the knowledge needed to raise a child and that this then presented a risk for the child. These insights are seen in the following quotations:

> *Young mothers with no support.* (P5)

> *Because we are sitting with single parents, we are sitting with young parents who don't know how to raise the child*. (P4)

> *We've got these days more young parents and I mean very young parents.* (P16)

Although not all participants noted unplanned pregnancies as a risk for young children, the biopsychosocial framework highlights the impact of social and psychological factors on the development of the child and, as such, this subtheme is important to explore. Statistics indicate that around 260,000 abortions are performed every year in South Africa and that of these as many as 58% are illegal abortions (South African Government News Agency, 2018). Odeyeni et al. (2018) confirm that teenage pregnancy is a social problem in South Africa and a study by the Human Sciences Research Council (HSRC) and the South African Race Relations Institute (SARRI) suggests that as many as 60% of children grow up without their fathers and that more than 40% of mothers are single parents (IOL, 2021). These statistics, as well as the findings of this study, confirm that unplanned pregnancies, unwanted pregnancies, teenage pregnancies and single parenting are a reality in South Africa.

If nurturing, loving and responsive caregiving in the social environment of the child supports optimal development (Mathews & Gould, 2017; Morgan & Sotuku 2019), then it could be said that children who are unloved, unwanted or ignored may struggle to achieve optimal development. A child who is unwanted may experience rejection by caregivers, which then becomes a psychological variable in the child's development that may affect the child's social well-being and physical health. In this way, the biopsychosocial model supports that an unplanned pregnancy may become a risk factor for the child.

The biopsychosocial model is clear that there is a connection between the mind (psychological variable) and the body (biological variable) (Republic of South Africa, 2015; Taukeni, 2019). If this connection is considered, then where a child is unloved, the child may experience poor physical health thus placing optimal development at risk. In situations where unplanned pregnancies may place children at risk, support for the caregiver and the child through, for example, a home-visiting programme may then act as a protective factor for the child.

6.2.2 Theme: Consequent impact of exposure to risk factors

The second theme that emerged under Objective 2 of the study was the consequent impact of exposure to risk factors for vulnerable children. Under this theme, the following subthemes emerged: poor physical health, psychological tension and poor future

outcomes. Each of these subthemes is presented and discussed in the sections that follow.

Subtheme 1: Poor physical health

Most of the participants felt that the impact of children being exposed to risk factors during early childhood was delayed physical development. Almost all the professionals mentioned their concern about children who do not develop according to their milestones because of exposure to the risk factors that were discussed in the first section of this chapter. The health care professionals shared the following:

> *You are looking at developmental delays, growth delays.* (P15)
>
> *I do see some physical delays.* (P13)
>
> *Many from the rural areas give their babies to their grannies and then the grannies, it depends some are very up to scratch and on board and they come for follow ups, some come and say the child is 1 year and 6 months and he cannot talk yet.* (P11)

The manager of a place of safety expressed that it becomes difficult for such children to develop because they have no strength as a result of malnutrition. She felt that they simply did not have the energy needed to grow and develop and this resulted in a developmental delay:

> *Child who is slow and difficult to manage in terms of behaviour.* (P5)
>
> *Physically very delayed, development becomes difficult, they have no strength because of being malnourished*. (P5)

A social worker shared how stressful it was to see and work with children who could not sit or stand when they should be able to do so. This social worker felt that poor nutrition caused physical developmental delays:

> *It's very stressful. If the child doesn't get the proper nutrition they don't develop. There was a case where a child couldn't sit and couldn't stand because she wasn't given proper attention*. (P2)

Other participants noted that malnutrition was often also a consequence of exposure to risk factors. The participants explained that SAM, chronic malnutrition and a failure to thrive were often seen when children had been exposed to poverty and hunger. In addition, they noted that they were seeing high incidences of malnutrition and that this is detrimental to the child's brain and physical development:

> *Severe malnutrition and then we almost sometimes catch it too late, what damage has been done for these babies who have not been fed for a few months. Neurologically and developmentally it is an absolute disaster, babies just don't thrive.* (P14)

> *We have SAM and chronic malnutrition here with children, for chronic it takes over a long place but for SAM it is severe, and you get bad skin, the extended tummy and they can die. The risk of dying is great. We see both of these all the time. There are seven in the ward right now who are almost SAM they are enough to be that severely starved and now we are seeing it.* (P15)

All of the professionals noted that where a child was exposed to risk factors, they often became sick and then suffered from poor health. The auxiliary social worker felt that children exposed to risk factors were always sick. The same participant then mentioned how the poor health of the child had a further impact on the family who were required to spend time at the hospital with the child, which meant they could not work. This is illustrated in the words of the participant below:

> *And the child is always sick, always sick.* (P1)

> *Because in other families you see that they take turns to go to hospital because they must work.* (P1)

One of the dieticians expressed concern over disease when formula was not mixed properly or if unsafe water was used and how this then resulted in diarrhoea, which worsened malnutrition:

> *Also, other issues with disease, if formula is not mixed properly or unsafe water is used then baby gets diarrhoea and that worsens malnutrition.* (P14)

One of the nurses continued by sharing that children miss out on a nurturing environment when they suffer from SAM and respiratory infections. She felt that they then continued to be at risk as being hospitalised for long periods of time was no replacement for being healthy and happy at home with their family. This is seen in the words that follow:

> *We have SAM and lower respiratory tract infection admissions and I think they miss out. They miss out, I mean, saying you've got a child that is now in the hospital instead of being at home, experiencing the love and care of their parents at home and being exposed to the family environment, now they spend weeks and even months in the hospital. (*P12)

It was interesting to hear from both of the participants who manage a residential care centre for vulnerable children that they had also noticed where children were exposed to

risk factors, such as child maltreatment, they often developed eating habits where they would – from a young age – hide food in their clothing or not know when to stop eating. This is seen in the excerpts that follow:

> *Eating disorders, they come in so hungry and then later you find them hiding food in their clothes.* (P5)

> *I do find that eating becomes a struggle. I often find that the babies that haven't been fed, when they are fed it's almost like their brain doesn't have the switch to say okay, I'm full now. They just keep wanting to feed.* (P6)

One story about a child who was born healthy and then repeatedly physically abused was particularly concerning for the researcher to hear. This little girl was admitted to hospital on several occasions as a result of physical abuse by her mother. The last incident of physical abuse left this child with a severe disability. She is now blind and has severe brain damage. This story was shared by a professional and highlights the impact of exposure to ongoing child maltreatment – with no intervention – on the child:

> *The little girl who was hospitalised on numerous occasions was physically abused by the mother, sent back home from the hospital and then the third time she was beaten so badly by the mother. Now child is blind and has severe and permanent brain damage. There was never any prevention or early prevention with this mother and her baby. Outcomes for this child who was born normal are now a permanent and severe disability.* (P5)

Many of the participants also shared that when children are exposed to risk factors, they may suffer from neurodevelopmental disorders such as FAS or cerebral palsy (CP). The following quotations illustrate this:

> *One little girl has severe FAS with us now and she already has a difficult temperament, tantrums, she is also very small and developmentally delayed, now her four-month-old sister is coming to us and she is going home. I worry how they will cope with her.* (P5)

> *I was going to say and there has been a couple of cases where we've seen foetal alcohol syndrome features.* (P13)

> *And also had one baby that was an abandoned baby that I think had quite a bit of birth trauma and we walked the journey of the possibility of cerebral palsy. So those are sort of outcomes that I'm looking at.* (P6)

The participants in this study felt that one of the consequences of exposure to risk factors during early childhood was poor physical health. This included delayed physical development, malnutrition, illness, eating or neurodevelopmental disorders. Here the

impact of a range of risk factors is seen to have an effect on the biological development of the child. This effect of psychosocial variables on poor physical health is at the core of the biopsychosocial model (Havelka et al., 2009; Suls & Rothman, 2004; Vivian et al., 2010). These children may not have been genetically predisposed to poor health, however, exposure to risk factors has resulted in them becoming developmentally delayed, malnourished or ill.

The greatest of these many challenges, is that when exposure to risk factors occurs during early childhood, the consequences of these can be considerable because of the sensitivity of the brain (Morgan & Sotuku, 2019; Motshekga, 2015). If the biopsychosocial model is considered, then these consequences will span not only across physical health but may affect social and psychological well-being too – thus possibly holding the child back from optimal future development (Azzi-Lessing, 2017). This effect on overall well-being is described by the biopsychosocial model as an interconnectedness and interaction between the different variables of biological, psychological and social development (Taukeni, 2019).

Subtheme 2: Psychological tension

Many of the professionals felt that children exposed to risk factors will experience psychological tension or trauma which may be expressed in the form of crying a lot, anger or by disengaging from social relationships. A few of the professionals stated that the impact of exposure to risk factors during early childhood may be a child who cries or screams a lot or exhibits behaviour that is difficult to manage:

> *A baby who cries a lot, they will be crying.* (P10)
>
> *Clingy baby who struggles to settle and can be demanding. A child who struggles emotionally, screams and cries a lot.* (P5)
>
> *But sometimes we just look at it at face value that this child doesn't listen or is not behaving well, without having to consider as to in terms of their primary education or foundation, what was happening there.* (P4)

One participant noted that this may then result in further maltreatment of the child where the mother either physically abuses the child or leaves the child unattended as she cannot cope with the child who cries continuously:

> *The child is not going to be sustained, so it's going to often be crying. Those children could possibly be smacked because we just need some peace and quiet or the mother will leave the child in the house to cry and go outside.*

> *They are emotional babies and they do cry a lot more because they have this deep-seated hunger that just cannot go away.* (P13)

Two of the professionals, both child and youth care workers, felt that exposure to risk factors during early childhood meant that children were left alone to deal with challenges. The participants shared that such children may be angry or depressed and would have unanswered questions as they navigated their way through life:

> *The children are left alone to face all these challenges. Where are the parents? They were supposed to be dealt with because we would be sitting with young people who would be so angry. The young people who will be bitter. The young people who will never understand why I'm in this situation now*. (P4)

> *He or her maybe got even an anger problem and depression.* (P3)

Under the subtheme of psychological tension, some of the participants, both professionals and caregivers, felt that the impact of exposure to risk factors may be long-lasting and that the work required to help these children was not easy as you first had to undo the damage before you could begin rebuilding. They felt that in a way, the damage to these children caused them to struggle with issues of self-image, resulting in insecurities. This also resulted in struggles with engaging in healthy relationships, both as children and as they grow up. These inputs are seen in the following quotations:

> *Then it also causes self-image issues.* (P4)

> *Child will feel unwanted and unloved and then insecurities come, it is not reversible so quickly.* (C9)

> *Their brains are wired not to trust, and you have to first undo the damage above before you can rebuild.* (P5)

> *There was some sort of passage that I read on attachment that if there's a disconnect of attachment in the early stages of a child, that results to a later maladjustment. (*P10)

> *They battle to have good relationships and it is a ripple effect*. (C8)

Lastly, one participant shared the concept of toxic stress as a consequence for young children who are exposed to ongoing risk factors, such as abuse and neglect. This participant, an ECD specialist, felt that toxic stress was an outcome when risk factors were not addressed:

> *There is the risk of toxic stress. If there are other factors, familial factors, social factors, that may be impacting on the child's risk or ongoing*

> *stressors. In a household where there's abuse or alcoholism or drug abuse there's no release of that stressors and it keeps on building up and so children who are already at risk face an even greater risk of developing that toxic stress. If a child is not getting the right attention, if the problems are not being addressed then those risk factors accumulate.* (P18)

Literature is clear on the effect of stress that young children experience when exposed to risk factors during early childhood. As shared by the participants in this study, a child who is physically abused may cry excessively, exhibiting psychological distress which may then result in social maladjustment where the child is unable to bond with or trust other adults. Here the interconnectedness of psychological and social variables as per the biopsychosocial model are again seen. Children can navigate through stressful experiences or endure risk factors when they have the support of a loving and caring adult who can buffer this stress so that it becomes tolerable rather than toxic (Center on the Developing Child, 2022). The biopsychosocial model acknowledges that some children are able to develop resilience to such risk factors but that prolonged exposure to numerous risk factors, especially during early childhood, may have ongoing adverse effects for the development of the child (Agnafors et al., 2017).

Moreover, for those children who do not have a caregiver to act as a buffer, the impact of exposure to ongoing risk factors becomes toxic and this is what the participants in this study have referred to. As discussed in Chapter 3 of this study, toxic stress during early childhood has a detrimental effect on brain development and can result in poor future health and cognitive delays (Center on the Developing Child, 2022). As shared by the participants in this subtheme, the impact of exposure to ongoing risk factors during early childhood can result in toxic stress for the young child. It thus makes sense that other participants shared that children show signs of psychological distress and tension when exposed to risk factors. When they are babies, it manifests through excessive crying or screaming and, as they get older, they show angry or exhibiting behaviour that is difficult to manage. Eventually they have challenges with both their self-image and in engaging in healthy relationships during adulthood. Here the participants have almost unconsciously, or without naming it 'toxic stress', noted the ongoing or lifelong implications of exposure to risk factors during early childhood.

Subtheme 3: Poor future outcomes

Under the subtheme of poor future outcomes, the majority of participants expressed with dismay that children exposed to risk factors may experience a range of poor outcomes

as they become older, while some may experience death. Some of the participants shared that, sadly, some children may die as a result of exposure to risk factors. The paediatrician shared that death could be as a result of a premature birth or low birth weight as these children are discharged at a very low weight*, "Some died, they are very small when discharged at weight of 1.7kg, maybe 5–10% in the programme died"* (P11). Both nurses shared that eventually some of these children died and that malnutrition was one of the causes of death. In addition, the one nurse shared how painful it was to see children dying from malnutrition; she expressed how close many children came to dying when she spoke of a child who was admitted with SAM, expressing that the child 'was on the grave':

> *Eventually some of them they die.* (P13)
>
> *They die they die it is painful they die and when we are looking at it a severe malnourished child he does not gasp that is the problem he just stop breathing by the time you have reached him he is cold.* (P12)
>
> *That child was on the grave.* (P13)

Another participant shared how a child had died as a result of disrupted caregiving when a mother left her young children unsupervised overnight*, "She died, the baby who was left alone with her siblings at home"* (P3). One of the professionals expressed her fear that some of these children may die without anyone even knowing about their death. A participant then shared a story of a child who was exposed to numerous risk factors and who was eventually murdered and buried by her mother and the mother's boyfriend. These sentiments are seen in the excerpts that follow:

> *Death can also be an outcome and many of these children may die without us even knowing.* (P5)
>
> *Even children's mortality rates increase because of risk factors that are not being addressed. A few years ago, there was a story about a girl, the neighbour saw her sitting on a stone outside the house and she was just by herself and she was this lonely figure. And her mother was in a toxic relationship with a boyfriend and the boyfriend was not her father. And it seemed that these were young parents, and they didn't really care for her and she was neglected. And they killed her and they buried her. It just points to that there was so much vulnerability there and nobody was able to step in and say let's help this family, let's support this Mommy, let's support the child.* (P18)

As discussed in Chapter 3 of this study, 34 out of every 1,000 children in South Africa will die before they turn five (Dorrington et al., 2018). Furthermore, many of these deaths

are related to undernutrition which could have been prevented within the home (Richter et al., 2018).

In addition to death because of undernutrition, child homicide rates in South Africa are extremely high. Imray and Janssen (2020) note that as many as three children a day or 1000 children a year are murdered. Matthews (as cited in Imray & Janssen, 2020) shares that these statistics are likely higher as many cases remain unknown, unreported or are thrown out of the court system due to poor investigation by the South African Police Service (SAPS). The participants in this study agree and have shared their concerns that the impact of exposure to risk factors, such as poor nutrition or child maltreatment, may be death for some of the children in the Eastern Cape province.

Almost all of participants shared their fears over the reality of poor academic performance when children are exposed to risk factors during early childhood. The caregivers in the study felt that these children often have learning disabilities, they do not reach their full potential and that there are many children who are not even attending school. These concerns are seen in the words of the caregivers below:

> *Learning disabilities, they don't reach their full potential at school and they battle.* (C9)

> *There are a lot of children where I live that do not even go to school. Their mothers drink a lot.* (C2)

The social workers, child and youth care workers, auxiliary social workers and ECD professionals agreed that exposure to risk factors during early childhood resulted in many children not schooling, dropping out from school or simply not progressing at school. These inputs are illustrated in the following excerpts:

> *You know if the mommy was drinking then you are creating slow learners. You are creating children who are going to be slow learners and then if they are slow learners there will be a lot of dropouts from school because they will see like they are like left behind all the time.* (P8)

> *Could possibly cause issues with when they get to schooling, they will not to keep up with the rest of the class on an education side.* (P6)

> *The consequences are glaring at us now. You ask yourself why do children drop out? Because school is boring. What is happening at home, if at home I can be sent to the shebeen [name for an illegal bar in the informal settlements of South Africa] to the tavern [name for an illegal bar in the informal settlements of South Africa]), to buy beer and get 5 cents, so why must I go to this teacher who is going to ask me questions.* (P7)

One health care professional noted that as many as 25% of children in the country have learning challenges. In addition, this participant felt that the high rate of learning problems may be a consequence of exposure to a range of risk factors during early childhood:

> *Outcomes show that needs of child not being met in first 1000 days, 20–25% of all SA children has school problems, one in every five children, has a learning disability or a cognitive disability. I am convinced it is from needs not being met when they are little, and they are then unable to reach their full potential.* (P11)

This section speaks loudly to the long-term impact of exposure to risk factors during early childhood. The participants in this study felt that exposure to risk factors continue to place children at risk as they approach school-going age, and it is devastating to think that many of these children then end up with permanent learning or cognitive delays that impact their schooling and perhaps the rest of their lives. What is even more devastating is that this may be as a result of ongoing exposure to risk factors in the environment of the child and not necessarily because of genetics. In other words, this did not have to be so. If these children were supported and protected from these risk factors, then their academic progress and their reality may have been different.

If education is the key to the future, then we are left wondering what future these children have to look forward to, and through no fault of their own. Various other studies have commented on this same finding – that ongoing exposure to risk factors without protection from a caregiver can result in cognitive delays or learning problems for the child (Center for the Developing Child, 2007, 2022; Phang, 2017). In addition, the biopsychosocial model notes this very same impact of social and psychological factors affecting and having possible long-term and permanent effects on the biological development of the child (Taukeni, 2019). Another resulting impact of exposure to risk factors during early childhood spoke to the reality that these children may end up incarcerated or involved in criminal activities. A few of the participants noted their concerns over this:

> *We'll be sitting with young people who'll be raising the number of the prisoners.* (P4)

> *And then, secondly, our crime is up. It's not a mistake. It is because of these very little things. Children that have grown up not motivated, not stimulated, but because there is something in the mind that's need is stimulant.* (P7)

Some participants also felt that eventually children who were not cared for during early childhood may turn to substance abuse themselves:

> *They don't develop into the potential they have to be they eventually turn to alcohol and drugs.* (P7)

> *The problem relates to drugs. The children start at the age of 10. It can cause the child to be not growing. Other children fall into drugs because he knows his or her mom is neglecting them.* (P3)

A few of the caregivers agreed and one shared that it did not even end with substance abuse. This caregiver felt that because of what happened to children when they were young, they then too would abuse substances and, in turn, would never be good to anyone because they quite simply did not know how to be good to anyone:

> *If they don't get love guidance and support they will be abusers when they are grown up they are abusers of alcohol, drugs, and of those things is because of when you were young, what happened to you. When you are grown up it is when the foundation was not built if you didn't get that love and guidance you will never be good to anyone because you don't know how.* (C6)

One of the caregivers felt that children who may have FAS because of being exposed to alcohol during the pregnancy or early childhood then struggled with their own relationships going forward; this then becomes a cycle that repeats itself. This particular caregiver seems to be suggesting that the child, once grown, may then also expose their own offspring to the same risk factors they were exposed too. The following quotations illustrate these insights:

> *A lot of them also have communication problems, made worse by FAS and then they battle to have good relationships and it is a ripple effect. It is a vicious cycle and then they have kids, and it is just the same thing. I have seen that*. (C8)

> *Sometimes we just look at it at face value that this child doesn't listen or is not behaving well, without having to consider as to in terms of their primary education or foundation, what was happening there.* (P4)

Participants also expressed their fears that children who are exposed to risk factors during early childhood will grow up not knowing the difference between right and wrong. This will impact the decisions they make as they go through life. One participant, a child and youth care worker, said that such children may then go and hurt other children or steal because of what they have seen and been exposed to. This is seen in the excerpts below:

> *Because there will be a lot of children who grew up not knowing what's right and what's wrong.* (P1)
>
> *Sometimes they are taking some things.* (P3)
>
> *They know sex. First of all because we are living in shacks (informal type of housing structure). I'm drinking. Sleeping there with my husband in front of him or her. So he can go out and do this with others, hurt others.* (P3)

Another participant, also a child and youth care worker, said that she was worried as these children will not understand how important it is to have an education or a good home because they themselves had never this*, "We'll be sitting with young people who'll never understand the importance of education and the importance of the good home"* (P4). The majority of participants felt that once a child was exposed to ongoing risk factors, without any protection from the impact of such risk, then a cycle began that eventually repeated itself in various areas of the child's life progressing right through to adulthood. In the excerpts below, an auxiliary social worker felt that, even at a young age, when a child is sent to crèche dirty or if she is weak, then even the teachers ignore the child and the message of being unloved or unworthy begins to repeat itself in the school setting:

> *Because if she's dirty, she weak, the teachers will ignore that child, even at crèche.* (P2)
>
> *They take the healthy children. Then she will start from that age to know that 'I am not good.' And she will because she wants to do this thing that the others are doing, what the healthy children are doing, so she will do something else.* (P2)

Another participant expressed how losing children means that we have lost them as adults and that it just becomes a cycle that they then repeat in their own families and with their own children:

> *If you have children that are just not ever making it because their circumstances just never allow for that. Their nutrition is so bad or on the medical side they were neglected and perhaps there was alcohol and drugs that came into the child's system at a young age. Because of their circumstances, they are not going to be working, they are going to be a drain. They are going to be the children that have multiple children, possibly end up in jail, so you know there is quite a vicious cycle if it goes wrong.* (P9)

The same participant expressed how children exposed to risk factors fundamentally miss out on life, their childhood and having a family of their own. This participant felt that there

was not always a good replacement for living with your own family and that a theme of loss seemed to follow these children throughout life:

> *It's a vicious cycle. They are missing out on their early childhood, uh, days. And even when a child has to be removed, I mean, they are missing out on that family.* (P9)

> *They are missing out on life because when they get there, it's all you'll find that the baby was admitted here for, say, malnutrition, and then when we do a background check, it turns out that this child was actually neglected, so then the child has got to be removed. But then it's a repeated cycle because now when they get there, they don't really get that motherly love. And then they come back to the hospital worse because those places are not really giving them the necessary like, motherly care.* (P9)

Many of the participants spoke of risk factors simply becoming a cycle that continued to be repeated in various ways and across generations. This is illustrated in the quote that follows:

> *The fear is that it keeps repeating. It's a cycle that continues and continues. I remember I was placing a child with a foster mother. When I looked at the history, the mother was fostered, the grandmother was a foster child, and everyone has been a foster child. I remember when I placed that child, she said ma'am please help me break this cycle. (P2)*

One participant felt that these children would be lost; she simply stated that we will lose them*, "with the risk factors we'll lose them"* (P12). Many of the participants also shared that children repeated what they themselves had been exposed to and when they were exposed to risk factors, they may then expose others to these risks.

Some of the participants noted how costly the impact of unmet needs became for government and society. One mentioned that this became a strain for the government while another mentioned that even where money was spent to try and intervene or support the child, there was no guarantee that these interventions would be successful:

> *I think that's going to be also a strain to government.* (P10)

> *There's no one who's caring for them, also it's going to cost money from government.* (P16)

> *It costs a lot to fix it.* (C8)

> *You have to look at all of the therapists and things and there is no guarantee it will work, and it costs a lot*. (C9)

Lastly, an ECD specialist shared that for children exposed to risk factors, the impact would result in frightful outcomes, highlighting the inevitable devastating impact on the development of the brain and resilience:

> *The usual frightful outcomes for unmet needs, growing brains, and resilience and all of those things come into play. (P17)*

In a publication on developing brains, Nelson et al. (2012) writes that there is great certainty that experiences play a role in brain development. Should a child be exposed to risk factors during early childhood, which is the time when the brain is highly sensitive to experiences, it will have an adverse effect on the brain development of the child. This, in turn, can impact future psychological, emotional and cognitive development (McCrory et.al., 2012; Nelson et.al, 2012). The biopsychosocial model too notes this interrelatedness of variables and the role of psychosocial factors, such as the risk factors noted in this study in health and well-being (Havelka et al., 2009). Both this literature (McCrory et.al., 2012; Nelson et al., 2012) and the biopsychosocial model support what the participants in this study have shared regarding the devastating impact of risk factors across the areas of biological, psychological and social development during early childhood and possibly throughout life. In addition, this literature supports the biopsychosocial model as it recognises the influence of psychosocial experiences on biological development, which includes the brain development of the child.

6.3 Conclusion

Chapter 6 has presented and discussed the findings that emerged in relation to Objective 2 of the study. This objective was to understand the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors. Four subthemes emerged under the theme of risk factors that vulnerable children in the Eastern Cape province are exposed to. These are: extreme levels of poverty; ongoing and severe child maltreatment; poor physical health; and unplanned pregnancies. Three subthemes emerged under the theme consequences when children are exposed to such risk factors. These are: resulting poor physical health; psychological tension; and poor future outcomes. Chapter 7 presents and discusses the findings that emerged in relation to Objective 3 of the study.

CHAPTER SEVEN

SUPPORT OFFERED TO VULNERABLE CHILDREN

7.1 Introduction

Chapter seven presents and discusses the themes that emerged in relation to the support offered to vulnerable children in the Eastern Cape province. This was the third objective of the study.

7.2 Current support for vulnerable children

Two themes emerged in relation to the third objective of the study. The first theme was identified as the current support available for vulnerable children, and the second theme was identified as the gaps that exist in the support being offered to vulnerable children in the Eastern Cape province. Each of these themes is supported by subthemes and categories. These themes, subthemes and categories are summarised in Table 7.1 and are presented and discussed in the sections that follow.

Table 7.1: Themes, subthemes and categories representing support offered to vulnerable children

Themes	Subthemes	Categories and word counts
Current support available for vulnerable children	Child protection services	• Social work services from child protection agencies • Places of safety for children in need of care • Community-based safe houses and safe parks
	Health care services	• Tertiary health care • Primary health care • Home-based health care
	ECD programmes	• Centre-based ECD programmes • Parenting programmes • Non-centre-based ECD programmes • Technology-based ECD support • Transdisciplinary ECD management team
	Social assistance for vulnerable children	• Child support grant • Food and clothing parcels • Feeding schemes offered within the community
Gaps in support being offered to vulnerable children	Child protection services inadequately resourced	• Lack of follow up by social workers • High caseloads of social workers
	Health care system that is under-resourced	• Lack of planned coordination within system • Primary health care understaffed • Lack of follow up for vulnerable children
	Misuse of social assistance	• Cash assistance used for needs of caregiver • Grant cards given to loan sharks • Children left with caregivers without access to cash assistance • Amount of child support grant insufficient

	Scarcity of home-visiting programmes	• Lack of home-visiting programmes • Potential benefits of such a programme • Success with such programmes in the past • Need for interdisciplinary approach

7.2.1 Theme: Current support available to vulnerable children

The participants in this study were able to identify various sources of support that are currently available for vulnerable children in the Eastern Cape province. Under this theme, four subthemes emerged: child protection services; health care services; ECD services and social assistance. These subthemes are presented and discussed in the sections that follow. Each subtheme is supported by direct quotes from participants as well as a literature control.

Subtheme 1: Child protection services

Many of the participants were able to identify a range of child protection services that are available to support vulnerable children in the Eastern Cape province. These services include those offered by social workers working for child protection agencies in response to reports of child maltreatment, places of safety for children in need of care and community-based safe houses and safe parks. Two of the professional nurses and an ECD professional shared how they worked with and referred cases to social workers, who then supported the children through various interventions ranging from looking for their families, finding a place of safety and assisting with birth certificates. The following are excerpts from some of the participants:

> *The social workers have found his family and they are looking for his birth certificate now, then they will take him to his family.* (P12)

> *Sometimes they are left home to care for each other sometimes if those cases come in the hospital, we call the child protection unit and deal with the social worker they will refer to another social worker for follow up.* (P13)

> *Because we don't have social workers that are working with us here, so we did refer some of those cases to CATCH Project because they've got social workers.* (P8)

One of the ECD professionals shared how she herself was an orphan who had been assisted by social workers many years ago. As she shared her experience, she noted how social workers today are different to those from her past. She felt that social workers are now more able to listen and respond to the needs of children, and she noted as follows:

> *Today I do see a big difference. I do see social workers who are taking steps when there are issues. They are not like social workers from when I was a child.* (P8)

The social workers and an auxiliary social worker – from different work settings – explained the work that they were doing to support vulnerable children. This work begins with risk assessments and continues all the way through to interventions which, at times, included statutory work. Below are excerpts from two of these participants:

> *I'm actually a child protection social worker. Meaning I focus on the well-being of the children. Starting from, we do risk assessments where we get cases that are reported to us, which include neglect, abandonment, child abuse, yes all of those stuff. So, we do risk assessments. If we see a need that's where we do removals and place these children at a place of safety.* (P2)

> *Most of them are child neglect, child abuse, sometimes birth certificate situations, child support grant.* (P1)

Participants also noted that there were places of safety that offered temporary safe care to vulnerable children who were abandoned or exposed to risk factors and could no longer be cared for within their homes or by their families. At times, these places of safety also offered a safe place for babies who were given up for adoption and were waiting to be placed with their adoptive families. Two participants, quoted below, describe the services offered to vulnerable children through a place of safety:

> *Place of safety for abandoned, abused and babies going for adoption.* (P5)

> *I am the Coordinator and the House Mother for a place of safety, which is a temporary safe care facility for babies from birth to 18 months. There are sometimes exceptions to that, and a child does have to stay a little bit longer just depending on their investigative circumstance through the social worker.* (P6)

Another of the participants, quoted below, also shared that she herself was raised in a child and youth care centre. She referred to it as an orphanage, as places of safety were known at the time, confirming that such child protection services have existed for many years *"I was raised in an orphanage, you see"* (P8). A few of the participants elaborated further stating that vulnerable children accessed the services offered through a place of safety either through social workers or the SAPS. A manager of a place of safety explained this as follows:

> *So, we have three types of intakes if I can call it that. One of them is where a social worker removes a child from an environment that where the child*

> *is abused or neglected, or the family sometimes hands the child over to the social worker because they can no longer take care of the child. We see babies that have been abandoned within the community and the social worker or the police drops the child by us and then some of the babies that we receive from social workers are babies that have been placed for adoption from birth.* (P6)

Some of the participants shared that there were community-based child protection programmes, safe houses and safe parks that provided a range of support to various age groups, including support for vulnerable children. These programmes included home visits to at-risk families, work with young people and referrals for further services from social workers. Two of the child and youth care workers explained these services as such:

> *We talk about gender-based violence, we talk about family planning, everything that is affecting this young person.* (P3)

> *We work with children, we work with youth, we work with families. We also run Isibindi [Xhosa name of community-based programme meaning courage]. It's got safe park practice, whereby the children are attending safe park with the siblings or with other community children and what we do at the safe park, it's where most of the programmes we are doing there, things like recreation, sports, art, indoors and outdoors and programmes that will speak with the young people.* (P4)

Many of the participants in this study agreed that one of the current support services available to vulnerable children in the Eastern Cape province is through social work agencies rendering child protection services. Child protection services are understood as both formal and informal programmes that offer prevention and intervention services in response to child maltreatment (UNICEF, UNHCR, Save The Children & World Vision, 2012). This study found that child protection services are offered through social workers within various settings, through places of safety and through community-based safe houses, safe parks and programmes, such as *Isibindi* [Xhosa name of community-based programme meaning courage], in the communities of the Eastern Cape province.

These services are centred around protecting children from harm and securing the psychosocial well-being of vulnerable children, both of which are of particular importance if children are to develop optimally and reach their full developmental potential throughout life. Chapter 3 of this study highlighted that children need nurturing and responsive caregiving and that this was one of the protective factors for a young child during early childhood (Sotuku & Schmidt, 2019). Child protection services, such as the

ones shared by participants in this study, thus remain an important service offered to vulnerable children who may not have access to nurturing and responsive caregiving within their social environment. If children are not cared for and protected from harm, which is a variable in their social environment, then this may cause poor physical and psychological health for the child. This is supported by the biopsychosocial model which emphasises the connection between the different variables of biology, psychology and the social environment, and the impact of these on overall health and well-being – both now and in the future (Taukeni, 2019).

Subtheme 2: Health care services

Under the theme of health care services, most participants were able to identify tertiary health care, primary health care and home-based health care as some of the current services that are available to support vulnerable children in the Eastern Cape province. All of the health care professionals shared the work that they were doing with vulnerable children. This is evidenced below where one of the participants, a medical doctor, shared information about the general care they provide for any child who is admitted into the tertiary hospital:

> *We look after babies here. We see them for consults if admitted at the hospital or seen in other departments and in the postnatal ward and we are here if someone feels that they need a follow from the referral centers.* (P11)

In addition, this same participant shared information about a specialised programme that the hospital has for following up on babies who were born prematurely or with a low birth weight. This programme provides follow-up services and support at the tertiary hospital through an outpatient clinic for these children up until the age of 2 years. This participant explained the programme as follows:

> *We have established a high risk follow up clinic for low birth weight and premature babies, but it has not been going so well with Covid. At the clinic, we work with the physiotherapist, the occupational therapist and dieticians. They (the child and caregiver) come to the clinic after three months of being discharged and they should be followed up until 2 years of age to monitor their well-being.* (P11)

The participant also noted the challenges they had in this programme in getting caregivers to return to the outpatient clinic at the hospital for follow-up visits. Even though there was assistance with transportation and a financial incentive, there were time and cost implications for caregivers. A further concern was that these children were at risk

because of the circumstances surrounding their birth and, therefore, an expectation that they would require specialised services in the future, such as those offered through the clinic, yet many never returned with their caregivers for follow up. The participant felt hopeful on the one hand that this may be because the child did not require further services but doubtful on the other as research indicates that these children would likely have some developmental or health-related problems because of their difficult birth circumstances. This participant also felt that the number of caregivers not participating in the programme seemed to have lessened since Covid-19. These challenges are evident in the two excerpts below:

> *They could also get an ambulance for transport to Frere but they sometimes live even further and that costs them even just to get to the ambulance*. (P11)

> *Covid has really made things difficult, they need a reward, and some will come if they are in town, but many won't come back. Some rightly as their children may not have any problems but research indicates there should be some risks because of the difficult birth.* (P11)

Both the dieticians, the professional nurses, the medical doctor and the hospital social worker shared that the nutritional support provided through the tertiary hospital was of great importance in supporting vulnerable children. These participants shared how they worked together providing health care and nutritional support to children who had special feeding needs or were admitted into the wards to prevent or intervene in cases of malnutrition. They also shared how firm they had to be so that caregivers did not take advantage of the system, how heart-breaking it was to see young children suffering from malnutrition and how time-consuming it was to care for vulnerable children within the hospital setting. The excerpts below describe the services being offered by tertiary health care with regards to nutritional support:

> *Everyone who has been here for long, we know that child. It is heart-breaking to see him come back again. He was so weak but now he is bonding, he is walking around.* (P13)

> *We know when we get an admission for SAM, we know that that room must be warm. That is number one. There must be food if the child is able to eat. You check blood sugar every three hours and then you monitor and weigh every six hours so that you see is gaining or dropping. It is a lot of work, and it needs attention. When they are admitted, often they are not eating, and you have to have patience – you must not be in a hurry.* (P12)

> *In other cases, where there's malnutrition involved, then we refer to the dietetics here.* (P9)

The health care professionals also spoke of how they worked closely with the hospital and community-based social workers in caring for vulnerable children. The social workers assisted with follow ups and supporting caregivers to apply for identity documents, birth certificates and the CSG. The following responses confirm these services:

> *We are working closely with the social workers.* (P12)

> *What we do by the time the child is here we refer to the social worker and the social worker sometimes they will tell you they will do the follow up. It is good to visit and check, it is good.* (P13)

> *So, we try to make sure that the mother does get an ID so that they can register the child*. (P9)

Another health care professional, a professional nurse, shared about the cases in the paediatric ward at the tertiary hospital where she worked. In addition, she shared that there were many cases and that she worked closely with a range of medical professionals. Evidence of this is seen in the excerpt below:

> *We have five rooms here, there are many cases, neuro, cases like hydrocephalus, traumatic brain injury from car accident. We also have an isolation room. Plastic surgeons and maxillofacial they will come for cleft palates.* (P13)

Some of the caregivers were able to confirm the support they received for their children through tertiary health care services. One of the caregivers shared how painful it was to hear of her child's diagnosis and another shared the joy she experienced after working with nurses who were supportive and caring and then hearing that her child was HIV negative. This support is indicated in the words of two of the caregivers quoted below:

> *I went to Frere, and they did all the tests and unfortunately, they told us he won't be able to do anything for himself. I was crying but I got stronger and stronger.* (C7)

> *I have HIV. So, my children when they are doing the tests, they will tell my children everything will be okay. They were kind. They were good. My last born is negative and she tested last month because of the nurses. If you do what they tell you to do no questions asked, you will be okay. It's the truth it is what happened to me.* (C6)

Some of the participants also shared that there were primary health care services offered to support vulnerable children in the Eastern Cape province. Both caregivers and

professionals shared that the clinic staff were caring and helpful but that the clinics were very busy, often resulting in long queues and waiting times for sick children. This is evidenced in the words of the participants that follow:

> *The clinic is good, they try to help, they are about 30min away and it takes R18 taxi fare to get there.* (C1)

> *They are good, the staff at the clinic. They try. But there are long queues. Even if you have a sick baby, you must go early, and you will wait.* (P2)

> *I went to the clinic, and they sent us here.* (C5)

One participant felt that despite help from the local clinics, vulnerable children continued to struggle, possibly indicating that intervention from one service provider was insufficient to resolve the problem. The participant response below notes the support received and the continuous struggle that vulnerable children face:

> *It's difficult for those children. Sometimes I do hear that the clinics help with formula feed and whatever. But those children are struggling. They are struggling.* (P8)

Another participant added that the organisation that she worked for supported mothers at both tertiary and primary health care facilities by providing a starter pack for mothers who had just given birth. While this was not a service provided directly by the tertiary or primary health care facility, it is an example of how different stakeholders can work together to provide services to mothers who may need initial assistance in caring for their child. Evidence of this is seen in the excerpt that follows:

> *You know from my organisation's point of view; we can let and provide to certain hospitals and clinics a new-born starter kit or a new-born pack for the moms that helps them get from the hospital to the house.* (P6)

Some of the participants mentioned that there are home-based health care programmes relating to home-based care for those with chronic illness. Participants shared that these were run-through primary health care facilities, private organisations or NPOs. Participants referred to this programme as the *Izimpilo* [health] programme and referred to the home-based carers as the *Unempilos* [health workers]. One of the nursing professionals explained how she had come across a neighbour who was very ill and how when she referred the matter to the clinic, they sent a social worker to assess the situation. Although this was not an example of a current service being offered to vulnerable children, the participant wondered if the same service may be available to

support vulnerable children. She also mentioned that Hospice (a non-profit organisation) offered such services. Evidence of this is seen in the two quotes below:

> *There are isimpilo [home-based carers] in Vergenoegt [a local community] and I explained to the clinic about a neighbour that needed help, they sent someone the same day to go, the social workers came to that house, and they took that man, it was hardly a week and that man died.* (P12)

> *Hospice has home-based carers for HIV.* (P12)

Another participant, a child and youth care worker, shared how she had worked in a community-based health care programme offering home-based caring in a rural community of the Eastern Cape province. This programme seemed to accommodate both parents and children who needed home-based caring due to chronic illnesses, such as HIV. The participant summarised the work she had done in the following excerpt:

> *I was working with the chronic children because I have HIV certificate and doing home-based caring. I was doing home visiting.* (P3)

The majority of participants were able to identify health care services as one form of current support being offered to vulnerable children in the Eastern Cape province. Chapter 3 describes good health and nutrition as one of the protective factors during early childhood. Having access to health care is thus critical to the support of vulnerable children. Hall et al. (2017) describes how good health begins with maternal health and, as such, health care services during and after pregnancy for both the caregiver and child are vitally important. The DoBE (2015) confirms that good health during early childhood is closely linked to regular visits to a primary health care facility for growth monitoring and immunisations.

The biopsychosocial model highlights the inextricably related variables of good health, biological well-being and the consequent social and psychological well-being and development of the child, thus supporting the importance of access to health care services for the vulnerable child. Participants in this study shared that they were also able to support caregivers through the health care services that caregivers accessed and they shared the effectiveness of these services, which are, at times, rendered in a home setting. Lekganyane and Alpaslan (2019) note the important work being done in South Africa by home-based carers in supporting those who are critically ill, which may, at times, include vulnerable children.

Subtheme 3: Early childhood development programmes

Some of the participants were able to identify different types of ECD programmes as a form of support currently being offered to vulnerable children. A number of these ECD programmes are centre based, offering a daily crèche for children where they are dropped and then collected by caregivers later in the day. Other ECD programmes offer parenting programmes to parents whose children attend ECD centres. Lastly, non-centre-based ECD programmes, technology-based support and a transdisciplinary management team emerged as categories under the subtheme of ECD programmes.

Participants felt that centre-based ECD programmes provided vulnerable children with a nurturing environment where they were able to access adequate nutrition, love and care, some health care, and be protected from harm, all of which are vital for the optimal development of a young child. One of the participants, a manager of an ECD programme, shared that centre-based ECD programmes provided an opportunity for vulnerable children to receive a nutritious meal. This participant felt that caregivers sent their children to ECD centres safe in the knowledge that their child would at least receive some food. This is noted in the words of an ECD professional:

> *Food, basic things that, you know, when they send their children to the ECD centres, the first call is food. My child is going to have something to eat there.* (P7)

One participant felt that having vulnerable children attend a centre-based ECD programme was an important service that supported the safekeeping of vulnerable children. The participant shared that ECD practitioners could intervene when they noticed risk factors and would then call other professionals to intervene if needed. ECD practitioners essentially become advocates for children at risk. The excerpt below highlights the role of ECD practitioners in protecting vulnerable children:

> *And also, of course, our ECD centres we've got children that we, when we see there is something wrong, we will intervene.* (P7)

A few participants highlighted that the ECD centre can become a safe place for vulnerable children firstly, as they may not live in homes that are in a good condition and secondly, because the ECD centre is a place where children are loved. The two excerpts that follow highlight the services offered to vulnerable child through a centre-based ECD programme:

> *We thought they will be better off at the ECD centre than to be kept at the homes because of the condition of their homes.* (P7)
>
> *When they come to the ECD centre, they are loved.* (P7)

This participant also shared that they had employed a social worker to reach out to vulnerable children in the community surrounding the ECD centre to encourage caregivers to access the services offered through the ECD centre so that the child could benefit from the nurturing environment offered within the ECD programme. The participant felt that this was a good programme but mentioned that due to a lack of funding, this specific part of the programme was no longer being implemented. This is reflected in the quote below:

> *We had a programme that was taking care of children who are roaming around our ECD centre. The social worker, unfortunately she has left now but she was visiting those homes where she was seeing children who are not going to ECD centres and wanting to know what the reasons were and then she will send them to our ECD centres and then we will add food because we see what the situation is. And it has been a good programme.* (P7)

Another participant shared how well equipped the ECD practitioners were at monitoring the growth of vulnerable children. This participant felt that ECD practitioners working from the ECD centre were in a better position to monitor the growth of children as there were simply not enough staff at the primary health care facilities to ensure that this was done correctly. These sentiments are evident in the excerpt below:

> *They do growth monitoring, and they are good at it, and they refer to us not the clinics. They do better than the clinic. The clinics are so short staffed that they cannot do it.* (P15)

One of the participants, as evidenced in the excerpt below, noted the importance of centre-based ECD programmes in preparing the young child for future schooling:

> *Knowing what their kids are doing and understanding that their kids whatever is happening at the ECD centre is preparing their children to go to the big school. (*P7)

A few participants shared that a further service, that of parenting programmes, was run through the ECD centres and that these programmes were a form of support for both the parent and the child, ultimately encouraging responsible caregiving. One participant noted that they engaged caregivers of children attending the ECD centre so that even when they were unable to pay fees for their child, the caregiver could offer their time and

services to support the ECD centre. Another shared how they worked with parents of children at the centres, implementing parenting programmes and empowering parents to advocate for their children. Sadly, as seen in the quotes that follow, this participant reflected that these parenting programmes were dependent on funding, which was not always available:

> *We will meet with parents and then we developed a programme a mindful parenting programme. We invite parents to come and then we will have a workshop with them.* (P7)

> *Parenting was a big big success. We saw a need, a great need. We saw the empowerment of parents and for me it was the best thing that we could do for parents. If we were to have money to continue that service.* (P7)

A few of the participants noted that parents would often attend parenting workshops because they knew that they would receive some food. These participants felt that a part of the parent may want to attend the training, but the other reason was because they knew they would receive some food at the training. This is reflected in the following words of the participant:

> *When you go to the centres, when you bring the mothers and the practitioners here, you know that the main thing is that they are sticking in because there is a little bit of food that they're going to get. When they come to the training, you know that they hadn't had anything at home. So, training, part of them want to be trained, but the other part is that there's a little bit of food that they're going to get. So, poverty is a reality.* (P7)

Although some of the current services offered to vulnerable children in the Eastern Cape province are offered through ECD centres, there are some ECD programmes that reach out to caregivers and are not centre based. These programmes, which are no longer run, were aimed at supporting responsible caregiving and were offered through group work programmes that engaged caregivers in parenting skills. One participant noted that many families were reached through the DSD's ECD employees, sharing that it may have been the UNICEF parenting programme:

> *DSD ECD people they are running crazy good with parenting programmes they reached 19,000 families last year. May be through the 12-week UNICEF programme.* (P17)

Another participant shared that the organisation where she worked offered a group work programme for caregivers with young children. During the group work, programme caregivers were taught about topics that relate to caring for a baby during the first 1,000

days. This programme was run once a week over an eight-week period and caregivers received some donations for their babies and food parcels upon completion of the programme. The participant explained this programme in the following quote:

> *Also, if you are talking about the zero to two years, we do run a group that is called Moms and Tots, or 1,000 days programme that is caring for a mom from pregnancy up to childbirth.* (P8)

Another type of ECD programme run by an NGO in the Eastern Cape province was mentioned by a few of the participants. This NGO seemed to combine education for the caregiver with practical support in the form of food or clothing, and a centre-based ECD programme for the child. One participant, who is quoted below, noted that what was useful about this programme was that they would check the child's clinic card, implying that there was also some form of monitoring on the health of the child:

> *Salem, on the way next to Khayalethu School. Where they teach the parents how to bath the child, how to massage the child, what food that you must feed, the importance of breastfeeding. If you cannot breastfeed, what formula that you must use so that your child can grow properly. So those are the two organisations that I know that used to help the parents or the mammas on raising their babies. Also, a nice thing that they used to check, their clinic card.* (P18)

Another participant, an education specialist who is currently managing an ECD NGO, shared that there are two non-centre-based ECD programmes in the rural Eastern Cape province. The participant was unable to elaborate much on the programmes but shared that the first is the Bhulungula Incubator which, according to the participant, is clinic- and health-based. The same participant noted that the second non-centre-based programme she had heard of is facilitated by an ECD training institution, also in a rural community, and was set up through the local traditional leader. Evidence of this is seen in the excerpts below and confirms the existence of non-centre-based ECD programmes:

> *The Bulungula Incubator [xhosa name of an ECD project] at Xhora is a clinic-based programme focusing also on ECD.* (P17)

> *ITEC runs a programme in Jingqi, a rural area in the Idutywa area, through the traditional leader.* (P17)

Another participant shared that through the *Isibindi* [Xhosa name of community-based programme meaning courage] programme, child and youth care workers were able to offer an ECD programme within the home of the caregiver. This programme was offered if the family was identified as at risk and there were young children in the home. The

programme was facilitated within the family home, teaching caregivers the value of play and spending time with their children. The participant explained this part of the programme in the quote below:

> *Our ECD is totally different from other ECD. We do therapeutic work with the families. We teach them the importance of playing. We teach them the importance of spending time with their families.* (P4)

Only one of the participants in this study identified the use of technology based ECD programmes as a current service offered to vulnerable children and their caregivers. This participant, as evidenced in the excerpt that follows, explained that there were some data-free apps that allowed caregivers to access information relating to ECD through their mobile phones:

> *There are also several digitally based programmes supported by civil society and government together for example, Side by Side, run through pre- and post-natal clinics, Messages for Mothers, Mothers2Mothers. They depend on zero-rated platforms. DGMT is working on enabling this with each of the South African digital data companies*. (P17)

One participant shared that there was a mandated transdisciplinary approach to ECD within local government, set up in the Buffalo City Municipality (BCM) through the mayor. This participant shared that BCM was one of the few municipalities in South Africa with such an approach and that there were regular meetings with key stakeholders. This approach is described in the words of the participant below and while this may not be a current service offered directly to vulnerable children, such a set up in local government may be integral in accessing support for ECD programmes:

> *We have had advocacy people here for meetings, social development and education. They are very pro ECD and environmental health. The mayor has to set up an ECD integrated transdisciplinary approach in local government, so BCM has one of the only ones.* (P17)

The literature presented in Chapter 3 of this study notes that early childhood remains one of the most critical periods of development and, as such, services that support the development of vulnerable children during this time are essential (Symington et al., 2018). Some of the participants in this study were able to confirm that ECD programmes are one of the services currently available to support vulnerable children during early childhood. Some of these ECD programmes are centre-based while others are non-centre-based. In addition, participants confirmed that ECD programmes included educational programmes for parents and that these were facilitated through group work

programmes or digital platforms. Only one participant shared that they offered an ECD programme in the home of the vulnerable child and the caregiver. It was interesting to note that none of the caregivers identified ECD programmes as one of the current services available to support vulnerable children. Moreover, the majority of professionals who identified these services were working in the field of ECD. Only one health care professional and one child and youth care worker noted the availability of ECD programmes as a current service available to support vulnerable children.

Allie (2021) notes the critical role of ECD programmes in supporting young children to thrive. As noted in Chapter 1 of this study, ECD programmes do provide a nurturing environment where children can be cared for, supported and where they can access opportunities for learning and development (Republic of South Africa, 2015). While some of the participants in this study agreed that ECD programmes are one of the services available to support vulnerable children, none of the caregivers noted this as a form of support. This is not surprising as literature notes that only 12% of children between the ages of 0–2 years access any form of ECD programme. In addition, literature notes the lack of access to ECD programmes in rural communities, such as those in the Eastern Cape province. Having access to an ECD programme could enhance the overall development and health of the young child as, according to the biopsychosocial model, this is a social variable that impacts psychological and biological well-being because of the nurturing environment, nutrition and health care that the child may receive through the programme.

Subtheme 4: Social assistance

Under the subtheme of social assistance, the majority of participants noted the availability of the CSG, food and clothing parcels, and feeding schemes offered to vulnerable children and caregivers within the community. All of the participants in this study were aware of the CSG, confirmed that the current value is R460, and identified this form of cash assistance as a current support service available to assist vulnerable children. This is confirmed in the participant quotes below:

> *Like you'll see now, the mothers are getting this grant, this R460.* (P16)
>
> *There is also the grant which poorer families are able to access.* (P6)
>
> *We've got the child support grant.* (P12)

> *Even if that money is a small amount of money, but it's helping some of the families*. (P8)

> *It helps a lot the child support grant.* (C1)

During Covid-19, the CSG was automatically topped up by R500 per caregiver and if caregivers were not working, they were able to apply for an additional unemployment grant worth R350. Many of the participants noted the usefulness of the increase in the social grant support available to vulnerable children during this time. Two of the caregivers shared below how this change in the amount of the cash assistance grant they received during Covid-19 was enough to meet all their needs and to ensure that everyone had enough to eat:

> *The grant is not enough, it was good during Covid when we got more. Then there was enough for all of us to eat. Now we are struggling again. The government will never make this change forever though.* (C1)

> *It was enough during Covid with the extra money.* (C2)

Another two participants, both professionals working in a state hospital, agreed with the caregivers and expressed that the CSG made a difference for vulnerable children and that the additional cash assistance during Covid-19 seemed to have made a real difference to the number of SAM admissions at the tertiary hospital where they worked. After expecting an increase in admissions due to lockdown and Covid-19, they experienced the opposite and had fewer admissions. They felt that this may have been as a result of the ban on alcohol and the additional cash assistance grants that had been provided. Evidence of this is seen in the two excerpts that follow:

> *Due to an expected change to many social situations during Covid, we expected a huge increase in SAM admissions. However this was not the case. We don't currently have statistics for this but there was a significant drop in SAM admissions.* (P15)

> *The very vulnerable children at risk of SAM were from families that possibly benefited from relief funding during Covid such as an increase in child support grants, unemployment grants and also the ban on alcohol sales.* (P14)

This finding is supported by another study cited in Azzi-Lessing and Schmidt (2021, p. 20) that found that the care of vulnerable children improved with the additional grant funds provided to families in response to the pandemic (Fouche et al., 2020). Here the importance of the amount of the cash assistance is noted. When the amount is sufficient, it may have an even greater impact on the well-being of the vulnerable child and their

caregiver. One of the participants, an ECD professional, shared how the CSG made a visible impact on the nutritional value of the food that children would bring to school in their lunch boxes. This participant shared, as evidenced in the quote below, that where parents worked responsibly with the CSG, you could clearly see when they had received their CSGs because the lunch boxes of their children would contain nutritious food:

> *In cases where it is working you can see a difference even when you visit the school after the pay day. Let me say a week after pay day you so in those few days you'll find that there are parents who care enough that their children are supposed to be carrying lunch boxes which look this way in terms of the nutritious value. You'll find that they have a fruit, they have yoghurt, they have sandwich.* (P16)

A few of the participants noted other forms of social assistance, such as food parcels and feeding schemes that are offered to support vulnerable children. The *Isibindi* [Xhosa name of community-based programme meaning courage] programme shared that they provided food, toiletries and clothing to families with vulnerable children who needed assistance. This is seen in an excerpt where one of these participants, a child and youth care worker, shared the following:

> *We also supply food parcels to the families. We supply toiletries, we supply clothes, you know, we are support system now to these families for the best interest of the children. We make sure those who don't have school uniform, we provide school uniform because the children they do want to go to school.* (P4)

Another participant, an auxiliary social worker employed by a child protection agency, reflected that in the past, she would access formula from the clinic for vulnerable children and that she would then monitor that the formula was being used responsibly. This is evidenced in the following excerpt:

> *So, that's why I was monitoring them. Just to use that milk for the babies. And then if they know there's no milk, then I report to the clinic.* (P1)

A few participants explained that there were feeding schemes that provided food for vulnerable children and their families. Two of the participants confirmed this:

> *The churches. Because in Duncan Village there are feeding schemes. Even now you can see a young child carrying a tin then they are going to get food, every day.* (P3)

> *I know that there are some feeding schemes that help with young children, moms, some churches and stuff, but I don't really know much.* (P6)

Social assistance for vulnerable children and their caregivers is a critical factor in buffering the risk factors that they may be exposed too. Considering the biopsychosocial model, social assistance becomes a social variable in the life of the child that may impact biological and psychological health and thus support optimal development. When a caregiver can access some financial support for a child, it is likely that the child will have access to nutrition. Furthermore, the caregiver may be less stressed, resulting in the child being more settled and secure. In this way, social assistance is a service that can support the optimal development of the child.

The CSG is currently accessed by beneficiaries and is meant to be a form of cash assistance that empowers caregivers to care for their families and to mitigate the harsh effects of poverty and unemployment. As explained by Azzi-Lessing and Schmidt (2021), any caregiver with an income of R4,000 or less per month or, if married, a combined income of R8,000 or less per month, can access cash assistance through the CSG (South African Government News Agency, 2021). Presently, the CSG, which is R460 per month per child beneficiary, can be claimed for a maximum of six children (South African Government, 2021). Liziwe and Kongolo (2011), in a study conducted in the Western Cape, found that the CSG was useful and that caregivers mainly used the cash assistance to purchase food or to pay towards school fees for their children. Mpike et.al. (2016) confirm that the cash assistance provided through the CSG is effective in supporting caregivers to care for their children. These studies agree with the participants in this study that social grants are one of the current services offered to support vulnerable children.

Although not mentioned as often as the CSG, it does appear as if there is some practical support with material goods, such as food parcels, toiletries, clothing, infant formula and feeding schemes, for vulnerable children and their caregivers. Warshawsky (2014) agrees that, because of the high rates of food insecurity in South Africa, the social assistance offered through feeding schemes and soup kitchens plays a critical role in the survival of vulnerable groups. Most of the participants thus felt that there was some form of social assistance available to support vulnerable children in the Eastern Cape province. Of these, the CSG seemed to be the most accessible as well as the availability of material support and feeding schemes in some communities.

7.2.2 Theme: Gaps in support offered to vulnerable children

In addition to identifying the current services that are available to support vulnerable children in the Eastern Cape province, participants also identified gaps in the support that was offered to vulnerable children. Under this theme, four subthemes emerged. The first was that child protection services are inadequate and poorly resourced, the second was that the health care system is under-resourced, the third was the misuse of social assistance and the last subtheme that emerged was the scarcity of home-visiting programmes. Each of these subthemes is presented and discussed in the sections that follow and is supported by a literature control and direct quotations from participants.

Subtheme 1: Child protection services are inadequate and under-resourced

Although most of the participants identified child protection services as one of the current services being offered to vulnerable children in the Eastern Cape province, many of the participants also noted the challenges with such services. Findings revealed that they are, at times, inadequate and under-resourced. These challenges ranged from a lack of follow-up services to high caseloads, resulting in problematic service rendering.

About half of the participants in this study expressed their dismay at the lack of follow up for cases and support involving vulnerable children. One of the ECD practitioners shared how they had followed up on the well-being of young children placed in foster care with a foster parent who they felt was unsuitable to care for vulnerable children. The social worker then investigated and, according to this participant, as noted in the excerpt that follows, did not intervene effectively leaving those children in the same circumstances that were felt to be unsuitable:

> *This lady has decided as part of her job of earning actually, to foster children. We complained bitterly about it because the conditions were really not conducive. I think we went up to report the matter to up to Bhisho that was in 2019. And to tell you the honest truth, those children are still living in that condition. The lady who came from Bhisho her attitude was those kids have bonded with that lady to such an extent that she doesn't see how they'll be taken and put in a safer place.* (P7)

In the excerpt below a caregiver shared that in the past she received no support from the government or social workers in caring for vulnerable children:

> *We got no support none from the government and none from the social workers really, there were some community members that helped, as a family we just did it.* (C8)

The same participant elaborated in more detail that social workers would place children and would then never follow up or check on the well-being of those vulnerable children. This caregiver felt that child protection services, in particular those rendered by the social workers from the DSD, were not sufficient and stated that it would have been beneficial if there had been a working relationship with social workers monitoring the well-being of vulnerable children:

> *It would have been good to have the department working with them and following up on their cases because they would just leave the children and you would not hear from them again. So, there would be no follow up and no check up and coming to see if they could help*. (C8)

Another participant, a professional, agreed with the caregiver above and felt that social workers did not effectively communicate feedback. In this case, the participant felt that feedback was required regarding the progress of vulnerable children once they had moved out of the place of safety. This participant felt that social workers may be too busy to do the follow up or to give feedback, which is evidenced in the quote below:

> *So, in my mind that would be the social worker who would do a follow up and because they are so busy, they don't always let us know that the child is okay. I will maybe contact the social worker especially if it was a baby that came to us extremely neglected or abused and I know that the child's gone back to biological family and I will try and say, you know, how is that child doing. Sometimes I get info or updates; sometimes I don't.* (P6)

The concerns raised by participants are well documented in child protection studies. According to the DSD (2014), social workers are struggling to manage caseloads. Richter and Dawes (2008) state that social workers are not managing caseloads because of a lack of resources, and this often leaves children at risk. Proudlock et al. (2014) found that child protection cases were often left for long waiting periods before being attended too and Jamieson and Sambu (2017) noted that in as many as 26% of child abuse cases, the children had experienced multiple incidents of abuse. These studies illustrate the harsh realities facing vulnerable children in South Africa, and it is not surprising that participants felt that child protection services in the Eastern Cape province are inadequate and under-resourced.

All the social workers who participated in this study also reflected on the challenges they faced in rendering child protection services. One social worker felt that having a high caseload as well as an administrative burden prevented her from working as effectively

as she would like to. She expressed how difficult it was to really get to know children and build a trusting relationship with them because of the demands of high caseloads and the high volume of administrative work that was required for each case. These reflections, from the same participant, are captured in the excerpts that follow:

> *You have to attend to all of them. And you have to make sure everything is up to date here, to make sure you do your home visits, supervision, so it's very difficult to juggle.* (P10)

> *I am not saying the administration is not important, but having to predominantly focus on the administration, I just feel like we are not really doing what we actually should be doing.* (P10)

Findings in this study have highlighted the inadequacies in child protection services in the Eastern Cape province. These inadequacies are well documented in South African research studies, some of which were shared in the section above. Inadequacies in child protection services are detrimental to the well-being of the young child and may result in the continued maltreatment of children. This is extremely concerning due to the sensitivity of the brain during early childhood (Kaufman et.al., 2000) and because of the effect that maltreatment may have on the future social, emotional and cognitive functioning of the child (Perry, 2001). Such long-terms effects may be poor school performance, aggression and difficulty in parenting later on in life (Jamieson & Sambu, 2017; Schwartz & Gorman, 2003).

These studies concur with the biopsychosocial framework which notes that challenges in the social environment of the young child, for example, maltreatment, may influence psychological and biological well-being such as behaviour, cognition and health (Morgan & Sotuku, 2019). Inadequacies in child protection services are of concern because of the long-term effects of these on health and overall well-being but also because of the complexity of risk factors that vulnerable children in the Eastern Cape province are exposed too as confirmed by participants in Chapter 6 of this study.

Subtheme 2: Health care system is under-resourced

Although most participants were able to identify that a range of health care services were available to support vulnerable children in the Eastern Cape province, most participants also felt that there were some challenges and gaps within these services. These gaps were particularly related to a lack of planned coordination of services between the different disciplines and departments, understaffing in the primary health care system

and the lack of follow-up services for vulnerable children. Essentially, participants felt that while vulnerable children did have access to health care services, the quality of this service alone was not enough to make a substantial change or difference to the life and family of the vulnerable child.

One of the health care professionals, who had already shared that there were tertiary health care services on offer in support of vulnerable children, noted later that these services alone were not enough. The brief statement below highlights the complexities facing vulnerable children in the Eastern Cape province, and the need for different disciplines with sufficient resources to collaborate in supporting these children. As seen in the quote that follows, this participant felt that although they were able to offer health care services for the vulnerable child as well as assist with medical conditions, this alone was not enough to make a change for the family of the child:

> *What we do at hospital is not enough to make a change for the family.* (P11)

The majority of health care professionals who participated in this study expressed their dismay at not being aware of how other professionals worked, at the lack of feedback and communication between the different professional disciplines and the lack of coordination between tertiary and primary health care facilities. Their concerns regarding the gaps in the current services offered to support vulnerable children are seen in the excerpts that follow:

> *We have social workers here, but we also don't know how they work.* (P14)

> *We have a large catchment area here, so they refer back to neighbourhood clinics and we never hear what happens to them. I have to let it go I can't worry about every child but there is no follow up and no communication between different catchment areas, there is no communication.* (P15)

> *The clinic does give milk but not a lot because their supply is not sustainable yet there is a lot of milk at the district office, but they are not collecting and then the milk expires because there is no communication. Everyone is just working sort of isolated, and no one is really working together.* (P14)

Some participants felt that although mothers or caregivers who seemed vulnerable were clearly identified within health care settings, there was no real intervention or referral system in place to monitor the well-being of their children once they left the health care facility. One participant noted with concern that that you could identify the mothers in the

hospital wards who came from difficult circumstances or who were abusing substances but that nothing was done at that level to intervene. This participant also explained the need for follow up when mothers did not return for medical appointments. She also suggested that mandatory testing for substance abuse be implemented. The affected mother and child should then immediately be linked to additional services. These concerns are seen in the excerpts below:

> *Need to follow up when they don't come back to hospital for check-ups. You can see the mums in hospital who come from poverty, abuse, alcohol and drugs yet nothing is done.* (P5)

> *Testing for mum on percentage of alcohol in mom and baby's blood should be mandatory and from there mother and baby should be linked to service. (*P5)

These gaps in the current services being offered through the primary health care system are important to note in the context of the biopsychosocial framework. The biopsychosocial model emphasises the need for different role players to work collaboratively with each other and the caregiver to plan, intervene, support and monitor well-being especially where risk factors are noted (Funderburk et al., 2021). In addition, the model emphasises the impact of lifestyle choices made by an individual on well-being and optimal development (Taukeni, 2019). In this case, the lifestyle choices made by a caregiver, for example, to abuse substances during and after pregnancy, may have a direct impact on their own well-being but it will also impact on the well-being and development of their child.

It becomes crucial for health professionals working with vulnerable children to link caregivers who may be making poor lifestyle choices, such as abusing alcohol or drugs, to disciplines such as social work where the well-being of the child within the home can be monitored. A concerning gap occurs in current services offered to vulnerable children when risk factors are observed at a health care service provider, but the caregiver is not linked to further services. This is of critical importance especially when the child is young as this is such a developmentally sensitive period to all variables noted by the biopsychosocial framework.

Some participants noted the shortage of staff at tertiary and primary health care facilities and confirmed that this affected home-based health care programmes, with delayed salary payments further complicating matters:

> *The problem is the shortage of staff – we are very short staffed in the clinic and the hospitals. If there is enough staff in the clinic, they can work hand in hand with the Unempilo's [community health care workers] and the social worker and they get a stipend but you find they work 6 months and they get nothing.* (P13)

A few participants felt that the large number of patients requiring assistance at primary health care facilities made it very challenging for health care professionals to offer specialised services and to effectively support vulnerable children and their caregivers. One participant, in the following two excerpts, shared the following:

> *Yes, I think 70% yes, they should be able to pick up when a child is vulnerable. I think they will see through the general medical and health check-ups that there's definitely an issue. It depends on what they are looking for and I think it depends on how busy they are. Sometimes it's a little bit like a conveyer belt at some of these clinics. It really is quite hectic.* (P6)

> *I think those working at the clinic that really want to take note will but I also think that sometimes some people can be in very severe poverty, but they have an outward appearance of trying to not be because of their ego basically. Some people like to portray something that isn't there because perhaps they have a dependency issue, and they don't want people to interfere in their lives either.* (P6)

Some participants felt that caregivers may not openly share information with staff at a local clinic as staff are busy and there are many people around, which makes it difficult for caregivers to build trusting relationships with staff at the clinics. This sentiment is expressed in the words of one participant below:

> *Some of them, they are open when they are at the clinics. Then they will open up to the nurse that they are struggling. Some of them even, though they have spoken to the nurse, maybe they are not going to be referred somewhere because of the burden. There are a lot of people who are sitting outside, waiting to come to that consultation room, so it is not easy for the nurse to have an ear for all these people.* (P8)

While many of the participants explained that they received good support from staff at the clinics, some participants noted that clinic staff could be disrespectful when addressing caregivers, making caregivers feel as if they should not ask questions. Participants added that, at times, a caregiver's concerns may be brushed away by clinic staff and that this causes a delay in diagnosis and intervention for the child. These participants felt that that responses by clinic staff at a primary health care level may

prevent caregivers from reaching out for support, even if they needed it. This is seen in the two excerpts that follow:

> *Medical professionals brush it off and say, 'Don't worry, Mama, your child will get better.' 'Don't worry, Mama, your child will grow out of it.' And then the child doesn't actually grow out of it. All children are not diagnosed early enough. If I think of children with autism, for example it's so challenging having that proper medical diagnosis right from the start.* (P18)

> *I think one of the biggest things that I find and I see is if a lady goes to a clinic or a hospital, they are very intimidated and often when they ask questions, they sort of berated for that, why don't you know that, or they are spoken to in a very domineering and angry manner, which then themselves make them say well I am not going to ask again because that's the response I get.* (P6)

The biopsychosocial approach supports that patients – in this case, vulnerable children and their caregivers – should be treated holistically and that they should be engaged in a number of services if health and well-being is to be supported (Funderburk et al., 2021). To be realistic, however, this approach will need a considerable commitment from health care professionals in terms of their time, which may not always be possible in the public health care facilities of South Africa (Maillacheruvu & McDuff, 2014). If caregivers of vulnerable children are to be engaged, then they need to be listened to, counselled and educated which, according to the participants in this study, is not always taking place. A few participants also noted that there was no follow up at primary health care facilities when mothers did not attend follow-up dates after giving birth or when they did not bring their babies for scheduled immunisations. These participants added that this situation seems to have worsened since Covid-19. The reflections of two participants, captured below, confirm this:

> *I do know that when a baby is born in South Africa, specifically within the government hospital, on their clinic books each mom is requested to go to their local clinic three days after giving birth in order to, for her and the baby to have a check-up. I think that is perhaps an area where they try and see what's happening, but I don't think there's any follow-up and I doubt whether they would really realise the person's not ever been there after that, but I don't know of anything else.* (P6)

> *The clinic will not even know if babies do not come for immunisations, there is no follow up, or if they do come, they don't even see that the child missed the six-week immunisation*. (P14)

One participant also noted with concern that the primary health care facilities were unable to access a regular and sufficient supply of formula for vulnerable children. This

means that, at times, vulnerable children are not given the nutritional support that they need to develop optimally, which then results in them being admitted to hospital for malnutrition. This participant's concerns are seen in the excerpt that follows:

> *Once a week you should be able to take a list of abandoned babies and sign the stock out you know where the safe houses are, and you should be able to go and get the tins ready for them. The clinic will not ever give you that, it is also a theft thing, so they don't want a lot of stock at the clinics.* (P15)

> *Clinics struggle with supply for milk, and it is irregular, they will give two tins which is not enough and then the child ends up here with us in hospital, here at the hospital we will give 6–8 tins which comes from our budget.* (P15)

The same participant felt that the *Road to Health* charts were not being used effectively by clinic staff and that when growth was not monitored properly, the child may die. The participant felt that better training was needed for clinic staff so that children's growth was monitored with care. These sentiments are expressed in the words of the participant below:

> *Clinics are not trained properly. They get given this fancy Road to Health chart. You have to make them do it, like I don't want to be lectured, make me do it and then I will understand. And they must know the consequences of not doing their job properly. If you don't do it properly a child could die because you did not monitor their growth properly.* (P15)

While many of the participants spoke highly of the home-based health care programmes, the findings in this study indicated that there appeared to be a lot of doubt as to whether these programmes (to support the development of young children) were still being run through primary health care facilities. The two participants quoted below mentioned the programme, the impact it had and expressed their doubt as to whether the programme was currently being implemented:

> *There was that programme in the primary health care usually they do weights, and they monitor, and they gave milk. I don't know if it is still there.* (P13)

> *The said it was good as these health workers already knew the community and they knew the families already and so they were focused and has a good standing. And they didn't see any malnourished children for a while anymore. They were community members who got training and the worked with children at home. They checked clinic cards and were linked to the clinics.* (P11)

Another participant noted that in the past, schools would have a nurse who would pick up on problems and refer the child for assistance if needed. This participant expressed her concern that this programme was also no longer being implemented. This concern is captured in the words quoted below:

> *Long ago the school nurses would pick up and see and then refer if there was a problem. That was good but now we don't have it.* (P13)

The participants in this study thus felt that one of the gaps in current service delivery to vulnerable children in the Eastern Cape province is the under-resourced health care system. Willcox et al. (2015) confirm that there is a shortage of staff in health care facilities, most notably in primary health care facilities and in the rural areas. The experiences of the participants in this study support this, noting that staff in clinics are often very busy and may not have the time needed to work carefully with each caregiver and child. Another study notes the rise in the number of patients at primary health care facilities. This is mainly due to poverty, which causes the primary health care system to be overburdened (Maillacheruvu & McDuff, 2014), yet the allocation of resources to these facilities has not increased accordingly. It is problematic for a primary health care facility to be under-resourced in infant formula in the context of the Eastern Cape province, where there are high levels of poverty and unemployment. Effectively this means the child's family may not be able to access other nutrition for their child, which results in the child becoming malnourished, failing to thrive psychologically and socially and possibly facing outcomes such as those mentioned by participants in Chapter 6 of this study.

The interconnectedness of variables and resulting health or illness is clearly illustrated by the biopsychosocial framework (Taukeni, 2019). In the past, there were prevention and early intervention health care programmes offered to vulnerable children within the home or school setting, and participants felt that these had been effective. Unfortunately, according to the participants in this study, these are no longer being implemented by health care facilities. Maillacheruvu and McDuff (2014) too noted that health care professionals were unable to keep up with prevention and counselling services due to the high numbers of chronic patients they are required to serve; this inevitably left very little time for other services. With increased workloads and a shortage of human resources in health care facilities, it is no wonder that participants in this study felt that there were gaps in the health care system.

In such a situation, the biopsychosocial model may be lacking in terms of the depth needed to support the optimal health and well-being of vulnerable children. In both this and the first subtheme, which identified that child protection services are inadequate and under-resourced, there is a definite sense that there is an element of societal neglect which increases the risk factors facing vulnerable young children in South Africa. One cannot expect child protection and health care services, or the professionals within these services, to offer a comprehensive biopsychosocial intervention to vulnerable children when both services are struggling with a lack of financial and human resources. Even if existing resources were harnessed to support vulnerable children, the element of societal neglect would be extremely difficult to overcome as the financial resources that impact service delivery across all disciplines are ultimately controlled by the government and impacted by the current landscape of poverty and unemployment in the country.

While the biopsychosocial model acknowledges the role that social factors play in well-being and optimal development, it does not offer any substantial knowledge, theory or evidence-based practice as to how to bring about change on a macro or societal level, which may require a deeper understanding of advocacy, policy and legislation. Two studies hint at this shortcoming of the biopsychosocial model (Keefe et al., 2002; Suls & Rothman, 2004). Rothman (2000) notes that while use of the biopsychosocial model may initially stimulate behaviour change and result in good health, this behaviour may not necessarily be enough to sustain a lasting change. Keefe et al. (2002) reflects that the biopsychosocial model has yet to bridge the gap between research, practice and policy as research is often left unimplemented and consequently unable to influence policy. For example, while the biopsychosocial model may initially support caregivers in adopting healthy lifestyle choices for the vulnerable child, it is unclear how this will be sustained within a climate of societal neglect, which is characterised in the Eastern Cape province by high levels of poverty, unemployment, child maltreatment and very few resources. To expect individual professionals or caregivers to change the present climate in the country may be unrealistic. For the biopsychosocial model to be effective in supporting vulnerable children in the Eastern Cape province towards sustained well-being and good health, the model will need to push onwards towards implementation, evidence-based impact studies and even further towards influencing policy.

Subtheme 3: Misuse of social assistance

While some participants acknowledged the usefulness of social assistance in supporting vulnerable children, most of the participants also felt that there was a risk that this social assistance may be misused by irresponsible caregivers. The majority of participants, both professionals and caregivers, told stories of the cash assistance received through the CSG being misused. Four participants, quoted below, shared examples of such misuse. This included some of the caregivers using the cash assistance to care for their own needs rather than the needs of the child:

> *For the kids to develop further because even the child support grant from SASSA it's used mostly for the parents than the children.* (P8)

> *This grant is used for the mother she wants to look good too, but the grant is for the baby and the mother does not know how to use it for the baby.* (P12)

> *Another thing they do to the kids because the grant the mothers don't use it, they use it for themselves. Most of the time the kids are malnourished and not taken care* of. (P13)

> *So do you feel like even in a family where there are resources, like for example the child support grants, our families don't always know how to allocate those resources so that the child develops well.* (P4)

As seen by the excerpts from five participants, the cash assistance grants were often used by caregivers to purchase alcohol or drugs:

> *They just care about social grant. They go to the tavern*. (P1)

> *They misuse social grant to alcohol most of the time.* (P3)

> *And I'm only talking about the mothers that are not drinking. They buy liquor* you know. *They exchange alcohol with the social grants.* (P1)

> *She uses the money to buy drugs and go drinking and do her braids.* (P15)

Another concern noted by both professionals and caregivers was that the grant cards that the CSGs were paid into were often not in the ownership of the caregivers. These cards remained with *loan sharks* [name used to refer to informal/illegal cash lenders in the informal settlements of the Eastern Cape province] who loaned caregivers cash and, in return, would then keep the grant cards. It became difficult for caregivers to reclaim these due to the loans and interest that they would need to repay to the loan sharks. This is evidenced in the three participant quotes that follow:

> *Because you'll find that a lot of the time in the townships, the SASSA [name of card that the cash assistance grant is paid into] card is with the loan shark instead of being with the mother. That is one of the greatest challenges that we have it is difficult for the child to benefit from the child support grant.* (P8)

> *They don't know how to use it Kim. For example, I will give you the biggest challenge that we are facing in Isibindi [Xhosa name of community-based programme meaning courage]. All the social grant cards are with loan sharks.* (P4)

> *The SASSA cards are with the loan sharks.* (C2)

One participant shared how the child and youth care workers in the community would negotiate with the loan sharks so that caregivers could have their grant cards returned to them only to have the caregiver loan cash from another loan shark as soon as the card was returned. As the participant shared, it felt as if the situation was quite hopeless and that some caregivers were struggling to be responsible with the CSGs they received, falling into the same situation of misuse repeatedly. The implications of misusing the CSG in this way are severe as illustrated by a participant, quoted below, who shared that this then resulted in the caregivers and children defaulting from their HIV and TB treatment as they are unable to take this treatment without eating:

> *They are defaulting so much because there is no food. We have to go and advocate for those families to get those social grants. The following month they change that person (loan shark) they go to another person (loan shark). So, it's the biggest challenge.* (P4)

Another concern raised by a few of the participants was that there were times when caregivers would receive CSGs for children even though they were not living with these children or using the money to care for these children. In such a situation, one participant mentioned that they were then able to divert the grant to the caregiver who was living with and caring for the children. Another participant expressed her concern that there was mother who had with seven children and was receiving seven CSGs, but who did not live with her children. The responses from two participants quoted below highlight the gravity of the concerns raised around the misuse of the CSG:

> *We're still finding a situation where grandparents are looking after kids because the mother have disappeared. They've run away with the SASSA cards, but fortunately, we were able to divert the SASSA card to the person who is looking after the child.* (P10)

> *There is a mom who has seven kids with seven child support grants and she does not even live with her children.* (P14)

Some of the participants felt so strongly about the misuse of the CSG that they added that the government should replace the cash assistance with material assistance, such as food. These suggestions are seen in the quotes from two participants below:

> *As a result, if I can be asked by DSD what is it that we can do we need to go back to the system of food parcel rather than money.* (P4)

> *If the government can provide with food, this will be better than the money.* (P13)

Social assistance is intended to reduce poverty, ensure that basic needs are met and, in so doing, support vulnerable children towards health and development. It thus seems unjust that this assistance is unmonitored and misused by some caregivers. The participants in this study felt that there were many instances where caregivers abused the cash assistance that they received in the form of the CSG. Participants felt that many caregivers did not know how to spend the cash assistance to meet the child's needs and often spent the money on themselves or used it to purchase alcohol. In addition, participants shared that in many instances the grant cards were not with the caregivers but were kept by loan sharks, making it very difficult for the child to benefit from the cash assistance.

Some studies have noted the frustration that social and health care workers and adults experience as they witness, in particular, young caregivers misusing the CSG (Gutura & Tanga, 2016; Hodes et al., 2016; Mpike et al., 2016). However, as shared in the beginning of this chapter, numerous other studies have found that the majority of caregivers do not misuse the CSG and that it offers great assistance towards caring for children when families face socio-economic hardships. Both international and national research supports that, while the minority of caregivers may misuse the CSG, these cases are the exception (Evans & Popova, 2014; Mpike et al., 2016).

However, taking into consideration that the professionals who participated in this study work with vulnerable children and caregivers daily, it may be that much of their work is with the minority of caregivers who are misusing the CSG. This may give this finding some context and suggest that there is a need to monitor situations where cash assistance is being misused. While some participants felt that the misuse of social assistance was problematic, other participants felt that amount of R460 was not sufficient

to meet the very basic needs of the vulnerable child. One of the dieticians stated that this amount was not even enough to buy sufficient milk for a child. This concern is seen in the following excerpts:

> *With the grant of R460 it is just completely not enough to buy a sufficient amount of formula, not even nearly enough.* (P15)
>
> *Which is not really enough to give them like, the care that they need.* (P8)

One of the caregivers who has a young child with cerebral palsy unpacked with much emotion that even though she received the CSG and a care dependency grant, this was not enough to cover the special nutrition that her child needed and, as a result, her son was admitted to hospital with SAM. This caregiver, quoted below, also noted that she was unable to seek work to supplement her income because of the special care that her child needed.

> *At times I do not have enough money to feed him, my other children get cross because he needs so much. Now he is in hospital, he is underweight and I cannot work because I am the only one who can look after him.* (C7)

These participants felt that it was unjust that the amount of cash assistance given to vulnerable children was insufficient to meet the basic needs of the child. According to Statistics South Africa (2019a), the minimum amount needed to meet the nutritional needs of an individual stands at R561 which is R101 more than the SCG. This confirms the perceptions shared by these participants that the amount of cash assistance given through the CSG is too little to meet the basic needs of a vulnerable child. This is of particular concern in the context of the Eastern Cape province and the risk factors that were identified by participants in Chapter 6 of this study. Studies confirm that 60% of children in South Africa are born into families that earn less than R544 per month and in half of these families both parents are unemployed (Statistics South Africa, 2019). In such instances, the CSG may be the only source of income that the family has and with the caregiver and child relying solely on that cash assistance, it is unlikely that the basic nutritional needs of the child can be met.

This narrative illustrates the impact of social variables, such as unemployment and poverty, on the health and optimal development of the young child. The biopsychosocial framework recognises that the well-being and health or illness of a young child, who is very much dependent on their caregiver, will be determined and impacted by the psychosocial factors in the family, home and community of the child (Taukeni, 2019).

Not having sufficient income to meet the nutritional needs of a child – perhaps because the cash assistance is an insufficient amount, and the caregiver is unemployed – may then make it challenging for the child to experience good health. This, in turn, may impact their psychosocial well-being inevitably making optimal development difficult to achieve.

Participants in this study felt that it is thus of critical importance that the cash assistance provided by the government to vulnerable children is of a sufficient amount to meet the basic needs of the child. This is supported by the relief expressed by caregivers in this study (discussed earlier in this chapter) who shared that the top-up on their cash assistance during Covid-19 assisted them greatly and ensured that there was enough food until month end. Many studies have called for and support an increase in the amount of the CSG. For example, Budlender (2016) outlined a proposal to increase the CSG and Webb and Vally (2020) called for the top-up in cash assistance during Covid-19 to be made permanent. These studies and others support the sentiments of the professionals and caregivers in this study who note that a gap in the current services offered to vulnerable children is the insufficient amount of the CSG to meet the basic needs of the child.

Once again, the element of societal neglect is seen in the findings. It may be problematic on a societal level that the amount of the CSG is unable to meet the basic needs of the vulnerable child as the current climate of unemployment, which has worsened, especially for women, during Covid-19 (Statistics South Africa, 2021b), may not allow caregivers the opportunity of supplementing the income they receive from the CSG. In such a situation, the biopsychosocial model may need a stronger focus and influence on policy that speaks to social assistance than it currently holds.

Subtheme 4: Scarcity of home-visiting programmes

The final gap that was identified in terms of the current services being offered to vulnerable children in the Eastern Cape province was that of a home-visiting programme. The majority of participants stated that there was no such programme currently being implemented to support vulnerable children. In addition, participants felt that there was a need for home-visiting programmes and that such a programme would have many benefits for vulnerable children. These views are seen in the excerpts below:

> *No, I don't know of any home-visiting programme here in the Eastern Cape.* (P8)

> *I don't know of anything like that in East London. I think in the interview before I did mention that my oldest daughter was born in the UK and there, they had the home visitor, the nurse visitor that normally came a week or within two weeks to make sure that everything was fine with you and with the child.* (P6)

> *I don't know of any other home-visiting programmes here in the Eastern Cape, I once did a research programme with Tygerberg Hospital (state tertiary hospital in the Western Cape), with social workers, just to observe, it was support for TB (tuberculosis) patients that involved home visiting but nothing here in the Eastern Cape.* (P11)

One participant reflected that she had not seen an ECD programme that focused on the first 1,000 days in the communities where she worked. This participant added that the only programme available to children aged 0–2 years was the care offered by the ECD centre if the mother chose to send the child as she was working. This participant, quoted below, added that many of these children were at home with their mothers and the care that they were getting at home was unknown:

> *You know, it's very difficult to see. I haven't seen it, a programme for the first 1,000 days. Actually, except, you know, you will find in some of our centres that parents who are working will drop their babies, you know. A week-old baby, you know. Hence, you know, our centres they start from 0 to 5. But there are very few ECD centres that, you know, that have little babies. They (these babies) are probably at home. I would say that these babies they are at home with their mothers, so, what they are getting there is unknown*. (P7)

The majority of participants, both professionals and caregivers, felt that there was a need for a home-visiting programme that supports vulnerable children in the Eastern Cape province. This is reflected in the sentiments that follow:

> *A home-visiting programme is needed there are too many contexts and communities where things are not good, and they are not right.* (C3)

> *I would like someone to talk to at home.* (C1)

> *So, with the lack of resources and all of that, so there's only so much that we can do. So, I think that would be, uh, a good initiative. It would really help*. (P10)

> *We have to try this we have to try.* (P12)

Two of the caregivers mentioned their reservations about a home-visiting programme. The one caregiver felt that it was needed, however, she felt that she could not really say this as community members would accuse her of reporting them and this may result in her life and her home being in danger. The second felt that such a programme would

need to be implemented carefully so that confidentiality was respected, and neighbours would not gossip about these home visits. These reservations are captured in the following excerpts taken from two interviews:

> *We need them but I can't say that. They will call me Impimpi [Xhosa word for a "snitch" or someone who tells tales on others] and they will beat me they will even burn my house down there where I live, they will chase you away.* (C2)

> *Mommies will not want that because even to you it is overwhelming you don't want to open up to talk about it unless you go to the clinic on your date to talk about it, you get ready for it then. People will see and say who is that and talk. At home you want to focus on your family and telling them. It's okay if you just come to see the baby.* (C6)

Another participant felt that while a home-visiting programme was needed, it would have to be implemented with caution. She noted that while home visits were easy, they were also difficult because of the stigma attached to being visited in your home by either a government or NGO 'official'. This is seen in the quote below:

> *But when you do home visit, home visit is not, it's easy because we are walking, but it is not easy, you see, because there are a lot of things, there are a lot of stigmas around you know seeing people who are from government facilities, sometimes NGOs because they are associated with the HIV work and someone who is sick, you know. So, home visit is easy, but it is not easy.* (P8)

Many participants noted that even with the current services in the Eastern Cape province, there may be families, women and children who needed services within their homes. These participants felt that a home-visiting programme could assist where children were not attending clinics for immunisations, where they had not returned to hospitals for follow-up visits or where caregivers may be afraid to seek assistance. Participants felt that such a programme may support these caregivers and facilitate a process of empowerment. The following excerpts highlight the role that a home-visiting programme can play in supporting caregivers and vulnerable children:

> *So, I think having this home visit in all other areas that can help a lot of women to know if they are struggling, then there are resources, you can run away from this situation, I think that can help a lot of women.* (C3)

> *We don't know if caregivers are coping. They are at home.* (P8)

> *You can see the mums in hospital who come from poverty, abuse, alcohol and drugs – nothing is done*. (P5)

One of the ECD specialists shared that they had employed a social worker to do home visits to follow up on children who were not attending the local ECD centre. This participant commented that she had also wanted to send this social worker on some training relating to a home-visiting programme and had been unable to find any sort of training for a non-centre-based ECD programme. These reflections are seen in the quote that follows:

> *I wouldn't say it's not happening, but I remember we were looking we were even looking when we employed our social worker, we employed her specifically for home-based. Uh, and with the hope that we were going to send her for training. And we could not find anyone doing that. We could not find anyone doing that in the Eastern Cape, you know. And then we were directed in Cape Town, to ELRIN in Cape Town. But they didn't help us as well.* (P7)

A few participants felt that a home-visiting programme would assist caregivers, through support, education and training, to become responsible caregivers. These participants added that a home-visiting programme offered within the first 1,000 days would assist the child to be better prepared when they began attending an ECD centre or even when they started attending school. Two quotes from the same participant testify to this process of empowerment for the child and caregiver:

> *You will have a stronger parent that has been supported from childbirth up to when the child moves from her to the school. And that parent will be protective of that child. It will not be just sending the child, you know, because that parent will have been developed already. So, home-based is not just the assistance that the child is given; you are empowering that woman.* (P7)

> *That individual child, firstly, is being prepared to go to ECD. You know. By the time that child goes to ECD, already you've got a supportive mother.* (P7)

One participant noted that the benefits of such a programme would have the most impact on those caregivers who did not attend clinic and who were stuck in a cycle of poverty that they seemed unable to break free of. This participant felt that if those caregivers could be worked with at home, gently, then this may begin a process of change and empowerment for the caregiver and their child:

> *We are going to lose them. I mean, we see quite a lot of parents who don't take their children to the clinic. Just to have a check-up. Because, when they get there, they are going to be shouted at. If you've been, you've grown up in poverty, it just repeats itself. It just repeats itself if you don't*

have a positive person who comes and says, let us start us. Let's just see how it'll work out. You know, in a very soft way. (P7)

Participants agreed that visiting caregivers in the home setting presented a different opportunity to engage with and support the caregiver and that such a programme was different to seeing caregivers, for example, at the clinic or in an office setting. One participant, an auxiliary social worker, offer an explanation about the work that had been done reaching out to children at home from birth until the mandatory six-week clinic appointment. Although this programme was no longer being implemented, this participant felt that the programme had been very effective as she had assisted with practical support that would not have been possible in a setting other than the caregiver's home. Another professional shared that information about the child gained from working within the home setting was immense and that a sense of what was happening within the home over and above what the parent was telling you, could be ascertained. These insights regarding the benefits of a home-visiting programme are shared below:

So, when doing the visits, you see other things than what is always seen at the clinic. To see the house and the mother and how is she coping with the baby, then I will do five visits until the sixth week when the baby is going back to the clinic for the weighing. (P1)

It's time-consuming, but there is such a wealth of information that you can get going into a child's house, you know, that the parents won't tell you. Because immediately, you walk into somebody's house, the first thing you pick up is that vibe. You pick up a sense of the vibration of this house, what's going on there, and it's not something that somebody will easily tell you. You just have a sense of what is going on. (P18)

A social worker shared that a further benefit of a home-visiting programme is that it would assist greatly with the high caseloads that social workers faced in child protection agencies. Another social worker added that such a programme would have an impact on community well-being in that there would be a person available who cared about the well-being of caregivers and their children. A third participant, also a social worker, felt that such a programme could work as it would assist in spreading education and connecting caregivers to resources. The participant also noted that this programme was needed as it was not something their context of work necessarily allowed them to do:

As a social worker, I think it will help with the huge caseloads. If we have people out there that are part of the visiting, those who plan, that are doing some of the admin that we could be doing, it would mean that our internal arrangements would actually make a huge different. (P2)

> *It could work because, honestly, we need all the help that we can get in terms of spreading information because that is the greatest challenge. The lack of information. People don't know where to go, who to talk to and in terms of our department here our boundaries are very limited.* (P9)

Another participant felt that such a programme would be useful in following up on the caregivers who dropped out of parenting or group work programmes:

> *Then I will have 20 caregivers in the first session. Then, on the second session, they will be less, less, maybe up to 12 or 10. Then, after that, then I will follow on that eight that didn't come so a home-visiting programme would be good for those that don't come.* (P8)

Many participants felt strongly that such a programme could be the connection that begins to draw different disciplines together as they work to support caregivers and their children. The words of two participants testify to this:

> *The importance, it's the connection. I don't see a relationship within the departments. So, during this period, this is what you need to do. And then, and ask the right questions about are you intending to look after this child? Or are you intending to send this child to an ECD centre? And you look at the conditions and have the Department of Health have a relationship with social workers.* (P7)

> *It is a very important programme and vital that we change things and I really also think that making a multidisciplinary team would be wonderful and we would refer some children that we wanted in such a programme.* (P11)

In addition, in noting the lack of home-visiting programmes and the need for these, the sentiments of the participants in this study were that a home-visiting programme could support the disciplines of ECD, social work and health to work together in ensuring the optimal biological and psychosocial development of vulnerable children in the Eastern Cape province. Literature supports the need for more non-centre-based ECD programmes to be implemented in the rural areas of South Africa (Van Niekerk et al., 2017). Literature also supports the need for more prevention and early services, such as home-visiting programmes, if child protection services are to be effective and poverty and child maltreatment are to be adequately addressed (Strydom et al., 2020). In addition to this, literature supports the importance of health care during the first 1,000 days as regular antenatal check-ups, immunisations and attending follow-up appointments can prevent future illnesses and disease (Republic of South Africa, 2017).

Participants noted that there was a lack of programmes that drew together the services required for vulnerable children in the Eastern Cape province and that this was one of

the gaps in current services. This is supported by literature, which notes the lack of non-centre-based ECD programmes (Van Niekerk et al., 2017) as well as prevention and early intervention child protection programmes (Strydom et al., 2020) in provinces other than the Western Cape and, in particular, in the rural areas where as many as 44% of South Africa's children reside (Van Niekerk et al., 2017). Participants also felt that where such programmes had been implemented in the past, they had worked effectively to support vulnerable children. Most participants felt that a home-visiting programme to support vulnerable children would strengthen current services as many caregivers experienced vulnerability and did not know where to seek assistance. These feelings are noted below in the words of a caregiver and professional:

> *Moms in rural areas can get help, they don't know where to go and they don't even know when things are wrong, they think abuse is normal.* (C3)

> *I definitely think it would strengthen it. I think when there were so many people isolated, they actually didn't have anyone to turn to. They didn't have anyone checking up on them and to have not the checking up on them is maybe not the right term, but they also perhaps – a vulnerable person doesn't have the resources to find out what resources are available to them.* (P10)

Lastly, participants expressed that such a programme had the potential to be individually shaped to work with caregivers and children. The programme would be an investment in the future of the family, the community and society, reaching the most vulnerable who, at times, may not even have the resources needed to travel to seek assistance. These hopes are captured in the words of the three participants quoted below:

> *I think it will come with a positive impact we would be investing to young people who will be better people in life, young people who will be more focussed and children that will know what is wrong and what is right and what is it that they can do to be better citizens from babies because wrong and right starts from babies.* (P7)

> *And another issue is that most of our clients don't have taxi fare. Most of our clients don't have airtime, it's easy to say when you to communicate something to me, go to her and then she'll send the message to me.* (P10)

> *By the time she has a second child, you know that woman is strong enough, she knows what to do.* (P2)

The value of home-visiting programmes is noted by various studies, both internationally and nationally. Gwele and Ebrahim (2019) note that internationally, such programmes have shown good outcomes by improving caregiver knowledge and preparedness for

schooling. Marfo et al. (2008) agree that similar programmes implemented in Africa have yielded good results. In South Africa, such programmes have shown improved health and psychosocial well-being for both children and caregivers (Cooper et al., 2009; Ilifa Labantwana, 2018; Le Roux et al., 2010; Thurman et al., 2016).

The participants in this study concurred with these findings. They felt that there was a great need for such programmes to support vulnerable children as these programmes would facilitate the empowerment of caregivers through the imparting of knowledge, skills and confidence within the context of their own home and community. Participants also felt that the majority of children aged 0–2 years were at home with caregivers and, as such, a home-visiting programme was needed so that they could engage in opportunities for learning and stimulation in preparation for attendance at an ECD centre and future schooling. In addition, participants felt that such a programme would ensure early intervention where risks were identified and support with prevention services by ensuring that children were accessing resources as needed. A further benefit of such a programme is that it has the potential to connect different disciplines and service providers as they worked together to support caregivers and vulnerable children.

This is an important consideration as the biopsychosocial framework notes the importance of the contribution of the different biological, psychological and social variables. Furthermore, it highlights the interconnectedness of these variables and the synergy needed among these variables so that health and optimal development can be achieved (Engel, 1980; Funderburk, 2021; Suls & Rothman, 2004). In South Africa, the biopsychosocial approach to health and well-being is of particular importance due to the vast socio-economic inequalities experienced by the majority of the population (Vivian et al., 2010). For example, you cannot treat a child for malnutrition in hospital and then send them home where there is no income and expect the problem to be resolved. Malnutrition is not just a medical or biological problem and can thus not be addressed solely through a biomedical approach. For the intervention to be effective, the health professionals would need to treat the malnutrition. Moreover, they may also need to work with a social worker who could assist with the problem of poverty that the family is experiencing or an ECD practitioner who could provide the child with a nutritious meal daily through an ECD programme. In the example given above, the importance of the biopsychosocial variables and their interaction to support health and optimal development is illustrated.

A home-visiting programme has the potential to follow up on the child after discharge and work with the caregiver and family, taking into account their unique circumstances to address the social and psychological factors that may be impacting the biological health of the child. If this is not done, the child may return to the hospital with the same diagnosis of malnutrition in the future. Lastly, participants felt that such a programme would assist in getting services to those caregivers who may not have access to the funds needed to get to and from the different service providers who, especially in the rural areas, may be far away and costly to access. Various studies confirm that in the Eastern Cape province, getting to and from services is a real challenge for caregivers. For example, Hall et al. (2016) and Hall and Wright (2011) share that in the Eastern Cape province, 37% of caregivers live more than 30 minutes away from a primary health care facility and add that, in addition to services in rural areas being far away from caregivers, such services remain hindered by poor infrastructure and unreliable service delivery. Schmidt and Azzi-Lessing (2021) agree that in the Eastern Cape, a large and rural province, caregivers do not often have the resources to cover the costs associated with the services that a child may require. In such circumstances, a home-visiting programme can assist in ensuring that the child's overall health and well-being is monitored, and that the child has access to services through the home visitor.

7.3 Conclusion

Chapter 7 has presented the themes that emerged in relation to the third objective of the study, which sought to identify the ways in which vulnerable children are being supported in the Eastern Cape province. Two themes emerged in relation to this study: the current support being offered to vulnerable children, and the gaps in support being offered to vulnerable children. Chapter 8 presents the findings that emerged in relation to Objective 4 of the study, which sought to determine the professionals involved in a home-visiting programme, their roles and the extent of their involvement.

CHAPTER EIGHT

THE ROLES AND INVOLVEMENT OF VARIOUS DISCIPLINES IN AN EARLY CHILDHOOD HOME-VISITING PROGRAMME

8.1 Introduction

Chapter eight presents and discusses the qualitative data that emerged in relation to the various disciplines involved in a home-visiting programme, and the role and extent of their involvement. These findings align to objective four of the study.

8.2 Roles and extent of involvement of various disciplines

A theme that emerged in relation to Objective 4 of the study was that a multidisciplinary workforce was needed to support the implementation of the home-visiting programme. The subthemes that emerged in relation to the theme are that the programme will need a workforce consisting of home visitors, trainers and supervisors. Table 8.1 presents an outline of the theme, subthemes and categories in relation to Objective 4. These are presented and discussed in the sections that follow.

Table 8.1: Theme, subthemes and categories representing the various disciplines involved in an early childhood home-visiting programme and their roles and extent of involvement

Theme	Subthemes	Categories
Multidisciplinary workforce to implement home-visiting programme	Home visitors	• Community members as home visitors • Paraprofessionals as home visitors • Professionals as home visitors • Multidisciplinary team of home visitors • Duration and frequency of home visits • Role of home visitors to include engaging with caregivers and the community • Home visitors to facilitate thorough assessments followed by intervention • Home visitors should be knowledgeable
	Trainers	• Benefits of using professionals as trainers • Training should be ongoing • Training should be transdisciplinary
	Supervisors	• Benefits of using professionals as supervisors • Functions of supervisors • Facilitation of a forum for stakeholders • Nature and frequency of supervision

8.2.1 Theme: Multidisciplinary workforce

The overarching theme that emerged in relation to Objective 4 was that the most effective workforce for such a programme would be a multidisciplinary workforce which brings together local community-based knowledge and professional expertise from across a range of disciplines that already specialise in offering services to vulnerable children. Bringing this multidisciplinary team together for home visits, training and supervision can result in a programme which has the potential to generate a transdisciplinary workforce. This theme is supported by the biopsychosocial model which calls for the use of team-based activities and interventions with professionals working together rather than alongside one another, especially when risk factors threaten health and well-being (Funderburk et al., 2021). The participants in this study agreed that a home-visiting programme would need a workforce made up of home visitors, trainers and supervisors with each of these then forming the subthemes for this chapter. Each subtheme is presented and discussed in the sections that follow and is supported by direct quotes from participants as well as a literature control.

Subtheme 1: Home visitors

All of the participants agreed that as a part of the workforce, a home-visiting programme would need to have home visitors. There were varied opinions on which disciplines would be best suited to the role of home visitors. Many of the participants felt that reputable community members, rather than professionals from a specific discipline, should be recruited and trained as home visitors within a home-visiting programme. Some participants argued that community members are a good resource in terms of local knowledge and felt that for this reason, they would be best suited as home visitors within the programme.

A social worker shared that community members who knew what was happening within their community and who understood the community and the way things worked, would be important in this programme and in influencing a process of change. This participant also highlighted how important it would be for supervisors or trainers to work with and listen to community members because of the indigenous knowledge, understanding and influence they had. Another participant, a medical doctor, noted that home visitors needed to be culturally appropriate so that they had some influence over culture and the traditional way of doing things, which may not always be safe or in the best interests of

the child. The following three excerpts note the influence of community members on caregivers:

> *The caregivers, even if it's from the clinic, the people that actually go in the communities and see what's happening out there. They spend every day with those children, and they know how their mind works. So, the important people are actually the people that stay with them.* (P2)

> *And culturally appropriate community-based home visitors who can influence the grannies and how they do things. They were community members who got training and working with children at home, they checked clinic cards and were linked to the clinics, but it was gone before I started working here at the hospital.* (P11)

> *You should identify the moms who are good already. I think just ordinary people who have a passion and a desire to help and are not scared to get their hands dirty.* (P6)

Another participant, a trainer and ECD coordinator, noted, as seen in the quotes shown below, how community members would be best as they knew what was happening around them. However, she added that such community members would need to work cleverly and strategically so that the home visits did not add to the challenges already being experienced by caregivers:

> *So, it must be people who are also I think know of what is happening around them.* (P8)

> *So, whoever is doing the home visit has to be clever and have to be strategic, they have to know the community and how the community thinks so that the home-visiting programme doesn't create more problems for the families.* (P8)

A few of the other participants agreed that community members should be used as home visitors. These participants felt that community members were knowledgeable and had, most likely, already reported cases of vulnerable children to professionals. They also often knew about the family circumstances, making them suitable as home visitors in such a programme. One participant added that communities may know about the systems in place to protect the misuse of resources and that, in such cases, a community member who was knowledgeable would be helpful. These insights are seen in the two excerpts that follow:

> *Yes, they are always reporting. The community will know the people that can be home visitors because it must be a person that stays in that area.* (P2)

Sometimes I feel the communities know a lot more than we do about how things work. (P14)

Some participants added that using community members as home visitors would be beneficial as the community had access to such persons at all hours and this would influence the effectiveness and usefulness of the programme. It meant that work could continue even if the supervisors or trainers were not available at that time. This is seen in the three participant quotes shared below:

Because for the one who doesn't reside in that community, if something happens maybe after hours and those people need assistance and that one is not there, so I think people who are from that community can help a lot and also that can build a good community in future. (P8)

Yes, so that they can learn how to do it on their own when the professional is not there. (P9)

So that, when the professional worker is not there, then the community can do it themselves. (P10)

Other participants, such as the social worker quoted below, felt that community members would work well in the role of home visitors as they had established and good relationships with community members. This is seen in the excerpt that follows:

Honestly, most of the community members have that one person that they know they can always run to. Whenever they need. Our communities are filled with that. Even when we do removals, we know there's a person that will say I took care of the children because there was no one who was looking after this child. So those people that are involved and even it's, it's so unfortunate that some would be benefitting. Even those councillors, political people that are involved in improving people's lives, they also should take part because the councillor is supposed to be involved in working for the community. (P2)

Some participants agreed that community members should fill the role of home visitors but added that such community members would need to be role models and of sober habits as they would be closely watched by others in the community. One participant, an auxiliary social worker, added that initially the home visitors may be viewed with suspicion but that when their integrity is recognised, they would be respected. Examples of this input are shared below:

And also, the one who are working with people, they must know that they are role models. (P8)

Mistrust will start first, but at the end they will come to you. They will use you as a resource in the community. (P1)

A few participants felt that in the South African context, using community members in the role of home visitors would work well as this may ease the burden on professionals. This sentiment is seen in the excerpt that follows:

> *In South Africa, we do need people who are professionals in facilities, you see. So, if you are going to take them out of the facilities that are also overburdened, so we are going to kill them, we are going to overload them more but if we can train people who have hearts for that.* (P8)

The majority of participants who felt that community members should be used in the role of home visitors added that these community members would need to either have had some prior training or would need to receive training. One participant, seen in the quote below, felt that using community workers who already had a heart for serving the community and adding some training with good supervision would be effective. Another participant stated simply that educating community members was best as it was easy for them to take the learning to the community. These different perspectives are seen in the following quotes:

> *Because if you educate them, it's easier for them to take it out to the community.* (P2)

> *So, they don't know that. So, that's why I say if they can be trained.* (P9)

> *They have to be trained because it's not a matter of doing it just to get it done, they have to be more equipped. They have to be educated properly.* (P2)

> *There are a lot of these moms in the community. Women who work at the church or soup kitchens are doing something for the community already will be good. Give them some training and then supervise.* (P15)

These findings are corroborated by those of Azzi-Lessing (2013; 2017), who found that home visitors should be well trained as this impacts the effectiveness of the home-visiting programme. Wagner et al. (2003) agree that home visitors require adequate training because the families of vulnerable children need a home visitor who is knowledgeable and able to assist with the complex challenges they may face. In the following excerpt, one participant felt that there should be home visitors with training but for cases that were less complex, home visitors could just be caregivers themselves reaching out to other caregivers:

> *Some home visitors with training: health, how to refer, play and teach, others may not need any formal training, could just be mother reaching out to another mother, depends on complexity of case.* (P5)

This may, however, not be appropriate for a home-visiting programme that supports vulnerable children as even this study has noted the complexity of risk factors facing vulnerable children in South Africa and, as such, the majority of cases may be complex. Some participants mentioned that there may be risks in using community members but that if community members respected the community, then this could still work. The three quotes given below illustrate this:

> *The only thing that the community doesn't want is someone who will go and talk. Gossiping.* (P1)

> *Community members obviously will not be happy with some of the decisions that are taken regarding their families or anything, so it's a matter of why did you report me, you are turning on someone, I'm a community member, you are supposed to protect me.* (P2)

> *Because community members do have that sort of belief that we are a community, you cover my back. If I'm selling drugs, you need to cover me. [Laughing.] Because if you don't, I will not protect you. So those are the risk factors.* (P2)

Although many participants felt that community members with training were well suited to the role of home visitors, one of the caregivers felt that both community members and professionals would work in the role of home visitors if they were easy to talk too. However, two participants disagreed and felt community members should not be used in the role of home visitors. These insights are presented in the quotes that follow:

> *Someone who is friendly someone you can talk to it doesn't matter if it is a community member or a professional.* (C7)

> *I do not want community member because they might gossip.* (C1)

> *No, not the community members, I'm very sorry. They must participate, not doing the programme.* (P3)

Some participants felt that paraprofessionals would be better suited as home visitors in the home-visiting programme. Suggestions varied from paraprofessional health care workers to child and youth care workers and home-based carers, all of whom have some training and are thus qualified as paraprofessionals within their field of training. These suggestions are noted in the quotes below:

> *We use already trained home-based carers who have 2–3 years' experience and then we as managers and supervisors are trained nurses with degrees and it works well.* (C3)

So, it is uncomfortable for me to go to someone's home, and it is uncomfortable for someone to have me in their home telling them what to do. But those community health workers were amazing everyone loved them, and they were very well respected in their communities. (P15)

A home visitor in my knowledge, it's child and youth care workers because they stay in that community. They know better those families. They know the background and the history of that family. So, child and youth care workers can do a better job, especially with the background of the community and the communication and the language that they can put in those homes. (P4)

Some participants felt that ECD practitioners, who were community members who had a passion for young children, would be well suited as home visitors. These participants felt that it was important for home visitors to be well trained as a home-visiting programme should essentially replace the care and stimulation that a child would receive through a centre-based ECD programme. This is seen in the quotes below:

I mean, if you're looking at practitioners. Practitioners are more your community members that are interested in this, you know? You need a community member who's going to do rounds, you know, checking those mothers have got babies. (P7)

We need home-visiting programmes that are going to be implemented by qualified ECD practitioners that know what they are looking for when they are visiting those homes. (P16)

Several of the professional participants felt that social workers should be involved as home visitors in such a programme and this sentiment was supported by many of the caregivers.

In Germany they have social workers, and they are in charge of a few families, they visit and help with all kinds of things, they do it for the at-risk children or moms, for big families or a preterm. I never heard anyone saying that a social worker is annoying, they are thankful that someone is there to help. (P11)

Social worker must do the follow up. (P13)

I think the social workers because they've got that confidentiality. They, the nurses don't have confidentiality. They're supposed to have, but they don't have. Community members trust social workers more. (P1)

I think if you are going into the villages or home you would need a social worker if a child has to be removed. (C8)

I will like someone like a social worker. (C2)

One participant felt that the clinic sisters should do the home visits to follow up on pregnant caregivers and on caregivers who have recently given birth:

> *I think clinic sisters from the clinics actually go out. They usually do it for sick people, like people with chronic illnesses and everything. I think that they should go out also for people who are pregnant and have tiny babies to see how they are doing and give them education about everything.* (P13)

Although there were varied insights into the different disciplines that should be involved as home visitors for such a home-visiting programme, many participants felt that a team effort was needed. This team should include community members, paraprofessionals and professionals from a range of disciplines, including those of child and youth care workers, ECD practitioners, social workers and health care workers. Participants also felt that this team effort would ensure a holistic approach to the needs of children and would thus ensure the support and safety of the home visitors. The following quotes illustrate these insights:

> *The community member will link up with the clinic, will link up with the social workers or psychologists, if need be, and then when there is a need for that particular parent who's not coping, that community member can immediately know that this is happening.* (P12)

> *I really felt that it's not just one type of profession or one individual: it's definitely a team effort. Perhaps you have a community person, and you have a professional person. It's safety in numbers as well.* (P6)

> *I still say it is the nurses with the social worker and the izimpilo and they must hold hands.* (P12)

> *And I do believe that there needs to be more than one home visitor per case so that that one person doesn't have to deal with the burden of doing this work.* (P2)

One of the same participants noted that it would make sense to use both professionals, who were bound by a code of conduct, and community members, who had the context and specific knowledge needed for such a programme:

> *I think, I think the advantage of using a qualified person is often they have to conform to certain rules and regulations and in terms of like the Councils that they have to belong to. I think the community members not having that, there could be scope for issues coming up. I think if they have a team, so it's not just one person, then I think it would be okay.* (P6)

It was also interesting to note that a few participants, when asked about the gender of home visitors, felt that male visitors could form a part of the team. Participants felt that

some families may relate well to male home visitors and that they could bring a different approach to the home visits, which may be good for the caregiver and child. An example of this is captured in the quotes below:

> *Men do bring something different when they interact with young children, and it is good for children to experience this.* (P5)

> *You should include male home visitors they too may be more easily accepted by other male caregivers*. (P6)

Nsamenang (2008) notes the complexities of vulnerabilities facing young children and their families in Africa. In addition, the findings in Chapter 6 of this study confirmed the often multiple and complex risk factors that young children and their families face in the Eastern Cape province. Within this context, home-visiting programmes face the challenge of supporting vulnerable children and their families who may face multiple and complex risk factors. Furthermore, there is a requirement to incorporate local cultural and indigenous knowledge, which is essential for the success of a home-visiting programme (Gwele & Ebrahim, 2019). Keilty (2008) agrees that for a home-visiting model to have an impact on the optimal development of the child, the model would have to be implemented within the context of the family where the child is cared for. This again emphasises the need for a home-visiting programme to incorporate indigenous knowledge that is culturally appropriate.

The findings in this study indicate that one way in which this can be done is to include community members, who have good indigenous and cultural knowledge, as home visitors within a home-visiting programme. Participants in this study felt that if such community members are teamed with professionals, who can then share their knowledge around vulnerabilities, risk factors and the intervention needed to support such children towards optimal development, this team approach could work well.

A multidisciplinary team approach consisting of paraprofessionals and professionals as home-visitors is noted for its effectiveness, and this approach is recommended for use more often within the field of early childhood and home-visiting programmes (Azzi-Lessing, 2013). The majority of participants in this study agreed that a multidisciplinary team of home visitors may be best suited to a home-visiting programme for vulnerable children in the Eastern Cape province. Such a team may support bridging the gap between policy, practice and local cultural knowledge and practices – in essence, supporting the home-visiting programme towards success. The need for a partnership

between community members and professionals was acknowledged by the participants in this study.

Here the findings may differ to the biopsychosocial model, which calls for professionals to come together with the caregiver and child to support optimal well-being and health as the model does not have a strong focus on community involvement. In South Africa, working with community leaders and influential community members in the neighbourhood of the vulnerable child is essential for any home-visiting programme (Evans et al., 2008; Gwele & Ebrahim, 2019). In this respect, the biopsychosocial model may insufficiently note the impact of working with community leaders and members and, as such, may be a gap or unspecified variable within the social factors of the model that contribute towards the optimal development and health of vulnerable children.

The majority of participants agreed that a further role of the home visitors would be to facilitate a helping process with caregivers who have vulnerable children. The first step to facilitating this process would be to engage with caregivers and the community so that the programme can be implemented. This process is important if caregivers and the community are to trust and accept the home visitors and the programme they offer. Participants felt that home visitors would need to have good relationship building skills and that these included being able to listen to caregivers, have empathy and show integrity in the work that was being done. Other participants shared how risky it was for a caregiver to open up and be honest about their circumstances, which might imply and highlight the need for the home visitor to be someone who can be trusted and who is not judgemental. These insights are seen in the participant excerpts that follow:

> *Relationship building skills. If I can almost say invading someone's space. You can't come with your own hyphenating ideas and agendas and with an aggressive manner. You have to put a person; you have to put a person at ease.* (P6)

> *Sometimes other people when they are talking to you they don't want you to answer they only want someone who is going to be there, listening to them.* (P4)

> *Have integrity.* (P1)

> *So, we need to go and visit them and build that relationship, you know, and that trust between us or the family so that if there are other issues then it can be easy for them to tell what is happening.* (P4)

> *Be assertive.* (P1)

It is a stigma for a mother to be able to say I can't feed my child. (P17)

Literature confirms that one of the aspects influencing the success of a home-visiting programme relates to family engagement and the quality of the relationship that the home visitor has with the caregiver (Head Start Early Childhood Knowledge & Learning Center, 2021; Nygren et al., 2018; Schaefer, 2016). One of the very first roles of the home visitor would thus be to build a good relationship with the caregiver and child. Such a relationship would need to be built on values of respect and would include the effective use of relationship building skills to engage with the caregiver and child (Azzi-Lessing & Schmidt, 2019; Schaefer, 2016). A few participants also added that the role of home visitors would be to engage with the community within which the caregiver and child resided. These participants explained that the community was influential in the behaviour of the caregiver and, as such, would need to be engaged by the home visitor. The following excerpts serve to illustrate this:

> *You can work with, sensitise the community because not all communities are doing this, you can maybe work with the councillor and tell them that if the child is malnourished this is what happens but if you work together that can be prevented. You have to try.* (P12)
>
> *But now the problem is with the community. When they go back there that's when they start.* (P2)
>
> *You find out who they are and not a top-down approach, what are the needs of your children, a mapping thing, only working with the community who came to the meeting you don't offer solutions all you do is facilitate. They decide what they need and who should assist, a strong community development approach.* (P17)

The need to work with community stakeholders rather than only specific caregivers in the community is essential and can become influential in supporting the well-being of vulnerable children (Evans et al., 2008; Gwele & Ebrahim, 2019). The findings in this study agree with the studies mentioned above; that for the programme to achieve success, the role of the home visitor needs to extend beyond engaging with the caregiver and child towards engaging with the local community and neighbourhood. Schaefer (2016) concurs that an effective home visitor is able to acknowledge that the caregiver and child are a part of a community, recognising the influence that the community and society has on the well-being of both the caregiver and child. The biopsychosocial model too notes that social factors will have an influence on determining the well-being and development of the child (Cohen & Brown Clark, 2010). The findings here note that the

power held by local community leaders and gatekeepers will be a social factor that home visitors need to understand and draw on if they are to facilitate the programme towards success.

In addition to engaging with caregivers and the community, participants noted that an important part of the role of the home visitor is to facilitate a thorough assessment with the caregiver as this would then inform the services and support rendered going forward. Participants mentioned that the home visitor would need to be skilled enough in assessment to determine whether the caregiver has the knowledge and resources to meet the needs of the child and to support their well-being within the home environment. Home visitors would also need to be able to determine whether caregivers were being honest as they may hide the truth from home visitors. Furthermore, they should be able to explain the consequences to caregivers should they not care for their children adequately. In addition, good writing skills would be important in order to record information received during assessment. The need for home visitors to be skilled in assessment and reporting skills are seen in the quotes below:

> *You need to understand the capacity of the person who's looking after children. Will they really be able to do home-based? What do they understand about home-based services and assessment?* (P16)

> *I think always there should be individual assessment. It's important when you are working with people's lives it's not as easy, you are dealing with people, so you won't have the same answer and you won't be able to handle the case the same way that you did with the other ones.* (P2)

> *Because we cannot take for granted that, because you choose to keep your child here, your child will be stimulated. The child might not.* (P7)

> *So, I think not only good communication skills, but I think good reporting skills because what you write down and then pass on to other different organisations.* (P6)

One participant mentioned that home visitors should have guidelines for facilitating a thorough assessment with caregivers and that such guidelines should assist in determining the child's safety within the home. As such, the role of home visitors would be to assess the safety of the child within the home and to determine when and how the caregiver can be supported but also where the child may be exposed to situations of extreme danger and may need to be removed. Literature confirms that a thorough assessment which is strengths based and planning that is done with the caregiver is

essential for the success of a home-visiting programme that serves high risk families (Head Start Early Childhood Knowledge & Learning Center, 2021; Schaefer, 2016).

In addition, some participants shared that such circumstances may need the home visitor to take on the role of broker and, in so doing, be skilled in terms of doing a professional referral and linking caregivers and vulnerable children to other resources. It was interesting that participants focused on engaging with caregivers, children and communities and assessment as the two key roles of home visitors in the home-visiting programme. Not one participant identified the need for a set programme or curriculum to be followed during the home-visiting programme; rather, participants felt that once the assessment was completed, the programme should be shaped to meet the needs of the child and caregiver. The following excerpt highlights this:

> *We can do them weekly or let's say twice a week and whenever there's a need. It depends on the case and the requirements of actually going out there. It should be an unstructured programme.* (P2)

This unstructured approach to a home-visiting programme may hold great promise as it ensures that each child and caregiver receives a programme aligned to their individual and unique needs. While it may seem easy and be tempting to adopt a structured programme or curriculum that is already proven to be effective in other home-visiting programmes, the participants in this study felt that this may not be as effective as a thorough assessment, followed by the development of a programme suited to meet the unique needs of the child and caregiver. Azzi-Lessing (2017) agrees that the complexities of risk factors facing vulnerable children cannot be resolved through a "one fits all" approach. Daro (2006) adds that while home-visiting programmes are effective, this needs to be complemented by deeper and more focused support to the caregiver and child so that contextual change for issues affecting families on a community and societal level can begin to change.

To illustrate the need for deeper and more focused individualised support, two participants – both ECD professionals – shared how families themselves may be a danger to vulnerable children with relatives often being responsible for the abuse of children. Another two participants, both social workers, shared how checklists may be needed to ensure a thorough assessment that paid attention to the safety of the child. They added that the role of the home visitor would also be to understand how and when a referral to another service provider was needed. This view of a home-visiting

programme and the role of the home visitor is shared by numerous other studies which draw attention to the need for vulnerable children to be supported by a comprehensive system of functional health and psychosocial services that a home-visiting programme that focuses on improving one outcome alone will not be able to accomplish (Azzi-Lessing, 2013; Rotheram-Borus et al., 2014). It would thus be critical for all home visitors to be skilled in the referral of vulnerable children and caregivers to additional services where they can access further quality support. The following excerpts highlight the role of home visitors in facilitating thorough assessments and referrals:

> *Have good guidelines because the challenges that one has with the homes,is that children are abused by uncles. They're not abused by somebody who is not known. They are sexually abused by people who are related to them. So when we're talking about home-based you've got those challenges.* (P7)

> *And you must know when to refer or when to call for a removal and when to work with family. Also, to identify what is dangerous.* (C8)

> *I think it all needs to be part of the training because a referral they need to be educated about forms, which proper way to make referrals.* (P2)

> *They must know when to refer.* (P1)

Some participants shared that home visitors would need to be professional enough to see through the challenges that vulnerable children and their caregivers may be facing so as to facilitate a thorough assessment and work with caregivers – who loved their children – as they offered an intervention. Participants also felt that it would be important for the home visitor to empower the caregiver during the entire helping process. In the words of one of the caregivers, home visitors would need to be emotionally strong and able to motivate caregivers:

> *You must get stuck in there and get things done. Don't be scared. You have to be strong enough to see that and say how can we help this mother because she does love her child.* (C8)

> *There will be times when you need to supply food or clothing but to make the programme work, they must use what they have and the finances they have. Make her feel like she can do it with what she has got.* (C8)

These findings are corroborated by Grobler et al. (2013) who note that facilitators should work from a strength-based approach to identify strengths in even the most difficult of circumstances so that families are empowered to identify and address their needs and work towards well-being. Schaefer (2016) agrees that working from a strength-based

and empowerment approach is of great importance in home-visiting programmes and can significantly impact the motivation of caregivers to participate as well as the overall effectiveness of the programme. The participants in this study agreed that the role of the home visitor will thus be to adopt a strength-based approach as they work with caregivers and families who show a desire to support their children towards optimal development. At times this will need the home visitor to be resilient and strong as the process of empowerment is facilitated.

If considered through the lens of the biopsychosocial model, where various professionals from different areas of specialisation are called to work together to support the optimal development of the vulnerable child (Taukeni, 2019), then professionals, such as social workers who work primarily with the social factors that may be influencing the caregiver and vulnerable child, would be well-equipped to work from a strength-based approach as they receive comprehensive training in such approaches. However, community members, paraprofessionals or professionals from health and education may not receive as much training in such an approach and, if they are to be a part of the home-visiting workforce, they may need additional training in such areas.

Subtheme 2: Trainers

The majority of participants stated that professionals were needed to train the workforce required for a home-visiting programme and that such training would need to be of good quality and ongoing. Participants felt that if a team of different professionals could be brought in to offer training to the home visitors and supervisors within a home-visiting programme then the knowledge generated would be transdisciplinary, which is exactly what is needed. In addition, it was felt that such a training team could link the workforce to various networking opportunities and resources and perhaps even facilitate a forum that met regularly to advocate for vulnerable children.

One of the health care professionals, a dietician from the tertiary state hospital, shared that getting professionals in to facilitate the training may be tough but well worth the effort as there is a credible need for such training so that a workforce can be empowered to implement such a home-visiting programme:

> *The training will be tough. To train ordinary people you don't need a massive team of professionals. But if there is a need it will be great to have these. The hospital is also limited although they have the professionals. Parents can learn from the professionals and do the work themselves.* (C8)

Another participant added that when she was a student, the home visits were done by community health workers and that this would work well provided they were trained by professionals. This sentiment was supported by many of the participants who felt that professionals would be needed to offer quality training to the workforce of a home-visiting programme for vulnerable children. The excerpt shared below highlights that the need for professionals to offer training and that the quality of training in a home-visiting programme is of great importance:

> *When we studied, it was led by dieticians, but community workers did home visits, they did screening on those children, it should be run by professionals and as long as you have professionals doing training then I feel like moms are more receptive to community health workers.* (P15)

Numerous studies have noted the importance of the training that home visitors receive as being integral to the success of a home-visiting programme. Shultz et al. (2018) note that the training of home visitors and supervisors is critical to programme success while Wagner et al. (2003) support that a well-trained home visitor is essential to a home-visiting programme. Participants in this study agreed that the training of home visitors would need to be ongoing and of good quality. The participant quoted below, a social worker, also noted the usefulness of the experiential learning cycle for home visitors, which encourages learning by doing. This participant explained that if home visitors were supported by regular and quality training, their learning and consequently their development, would be ongoing, impacting the quality of work that they were able to do within the programme:

> *They have to have good training and it has to be continuous and it has to be ongoing because things don't stay the same. So that you can come back and re-develop the plan so that it could help the community.* (P2)

This finding is corroborated by Schultz et al. (2018) who state that an effective training programme allows for knowledge building, practicing of skills and reflection and the transference of this knowledge to the work environment. Participants also explained that a range of different professionals would be needed to offer training to home visitors and supervisors. Participants felt that such an approach worked well within ECD as it was a stage of development that was dependent on many variables working together to support optimal development. Some participants gave input with regard to the different professionals and departments they felt should offer training to home visitors. These are seen in the quotes that follow:

And I really also think that making a multidisciplinary team for the training would be wonderful. (P11)

And, I think, in partnership with our Home Affairs because Home Affairs is one of the people that I think are needed in terms of information providing. (P9)

Experienced team of different professionals – social workers, health care workers, hospice who already trains home-based carers for supervision and training. (P5)

Participants went on to describe the benefits that a multidisciplinary team of trainers could have for vulnerable children. One participant explained, on two different occasions, that if she had trained home visitors to work with, then she would trust them to work with the resources that she had access to thus making it easier for vulnerable children to have the nutritional support they needed without having to travel long distances:

Where are the ones that do not end up here at hospital? They get two tins from the clinic but that is not enough, and they don't end up with us at hospital? That is why I am saying I will go and get the stock at district and give it to the community health workers and they can give it to the children. And they can distribute it as they see fit because I know that I have trained them. (P15)

I would like to work with the people at these NGOs almost give them the supplements and then get them to give it out instead of making people come here and spend money on transport and then we could reach more people. (P15)

Other participants agreed that such an approach to training would have many benefits. One participant, as seen in the quote below, felt that this would be an opportunity for professionals to network among themselves so that the problems within the different systems that offer services to vulnerable children could be put on the table and resolved *"We can talk to role players and sort things out and do the correct things according to requirements, we need better networking among professionals"* (P14).

Some participants stated that a multidisciplinary approach to training had the potential to influence transdisciplinary knowledge, which was greatly needed in ECD because currently very few people had this range of knowledge or training. An auxiliary social worker and ECD specialist shared the following:

Transdisciplinary training but a multidisciplinary team. (P1)

> *There are so few people qualified who know the social development side and the neuroscience side of play – we need more of the transdisciplinary training.* (P17)

Lastly, one participant reflected that there was a great need for a forum in the Eastern Cape province. This participant felt that such a programme, which had access to professionals through training, could begin to facilitate a forum where stakeholders could come together and advocate for vulnerable children. This participant felt that it could possibly be the role of the trainers to facilitate such a forum:

> *Need a forum to come together, learn, care, become a voice for our children as the different people who are working with vulnerable children*. (P5)

There was agreement from participants in this study that a home-visiting programme that serves vulnerable children and caregivers who face multiple and often complex risk factors would require a well-trained workforce. Knowledgeable and expert trainers from different disciplines would, therefore, be needed because there is no one single discipline that seems able to fully equip a workforce to implement a programme that can meet the diverse needs of vulnerable children and their families (Azzi-Lessing, 2013). This is supported by Taukeni (2019), who notes that the biopsychosocial model calls for a multidisciplinary approach to support well-being, implying that a range of disciplines will be needed to effectively train a home-visiting workforce.

Internationally, there are existing training programmes that offer training to both paraprofessionals and professionals with such programmes drawing on early childhood mental health to cover core competencies relating to child development, community and family work and the coordination of services (Azzi-Lessing, 2013). Nationally, there are also some home-visiting programmes that have trained paraprofessional home visitors in multiple areas relating to optimal health and development during early childhood. While it is unclear who the trainers for these programmes are, such training programmes have shown success as they equipped home visitors to provide a comprehensive service to the caregivers they were working with (Le Roux, et al., 2010, 2013; Rotheram-Borus et al., 2014).

Taking the biopsychosocial model into consideration in the context of which disciplines are needed for the training of home visitors is essential as the model has serious implications for the time and resources needed to support the optimal development of

vulnerable children. If a multidisciplinary team of professionals can be recruited to train both professionals and paraprofessionals – resulting in a transdisciplinary knowledge base, then there is a possibility that many of the preventative and early intervention services could be offered by the home visitors. This would become a useful support for professionals who are stretched in terms of the resources needed to effectively implement the biopsychosocial model in supporting the optimal development of vulnerable children.

If the role of home visitors outlined in the previous subtheme is considered, then such a training programme, offered to both professionals and paraprofessionals by a multidisciplinary training team and resulting in transdisciplinary training, may align well to what is needed within a training programme for home visitors in the Eastern Cape province. In addition, such a training team has the potential to become an extension of the biopsychosocial model, calling for the different professional disciplines to not only work together but to also work together to train a workforce who can then support the optimal development of vulnerable children at a community level.

Subtheme 3: Supervisors

There was general agreement among participants that there was a need for supervisors within the home-visiting programme and that these supervisors would need to be professionals with specialised knowledge relating to supervision and vulnerable children. The role of supervisors within the home-visiting programme was also defined as one that is both supportive and educational in ensuring that the programme was effectively implemented and that regular and planned programme evaluations were conducted. Participants also shared that the role of the supervisor would be to provide frequent supervision as was required by the home visitors.

One participant, an auxiliary social worker who had previously worked in a home-visiting programme, shared that she had been supervised by a clinic sister from the local clinic and that this had been helpful. Another participant shared that the DSD should supervise the home-visiting programme and explained that it could not be the DoH's responsibility as they supervised health care professionals within a health care setting. The majority of participants, however, felt that social workers should be supervisors in a home-visiting programme. These sentiments are seen in the following excerpts:

> *Like, the clinic was also supportive. Because I talked to the sister in charge. And I had my time for supervision. It was good.* (P2)
>
> *Definitely social workers.* (P10)
>
> *Social workers.* (P9)
>
> *I think the Department of Social Development because social workers work under them. They go into the communities. They are the people that get contacted when something is not working in a family. So, my automatic thought is to that.* (P6)

Participants agreed that the supervisor for a home-visiting programme would need to be a professional and have adequate experience. One participant, a caregiver, shared that these supervisors should be well qualified and professional. This participant explained that such an approach works well within a home-based palliative care setting and, as such, could be duplicated in a home-visiting programme for vulnerable children *"Supervisors should be professional and qualified; this works well with palliative care"* (C3). Participants unpacked the role of the supervisor as one who is there to provide ongoing educational support to the home visitors, and to provide guidance where cases were complicated and needed to be referred. Participants felt that a high level of involvement from the supervisor is needed to ensure that the programme was effectively implemented and monitored. In addition, the supervisor would need to be of sound and strong character and provide the home visitor with ongoing emotional support. This is seen in the three excerpts below:

> *Then working hand-in-hand with the social workers as supervisors, you see, because going, visiting homes and keep the information to yourself is not going to help you do need someone to refer to.* (P1)
>
> *The supervisor is someone who is going to listen to you, and also keeping this information can also affect you as the one who is visiting homes. That is why we do need a social worker to work hand-in-hand with the ones who are visiting homes.*

Participants also noted that the frequency of supervision required would be determined by the experience of the individual home visitor and the complexity of the case, with some requiring more supervision and others requiring less. This is seen in the two excerpts that follow:

> *Some of the home-based carers need more support from supervisors and others are fine doing most things on their own.* (C3)

> *And if something is not going well, she the supervisor must be there more often.* (P1)

Lastly, participants felt that the programme would need to be evaluated so that its impact could be measured. This is a task that could be monitored or facilitated by the supervisor and, as such, forms a part of the role that the supervisor would play in the programme. Participants shared that evaluation could be based on statistics, such as reducing the number of underweight or stunted children, the number of hospital admissions, monitoring growth using the *Road to Health* booklet or in the number of cases reported to child protection agencies. This is seen in the quotes that follow:

> *Impact could be measured by reducing underweight and stunting in children, which is how WHO monitors how well a country is doing in caring for their children*. (P11)

> *For evaluation you could use clinic books to see if they are thriving or still failing to thrive, you could at if their clinic visits become more frequent, you could look at if they were previously admitted if there are readmissions, how long it takes to take them off the nutrition programme.* (P15)

Some participants felt that there was a need for a long-term impact study. One participant shared that this could be monitored by admissions of children from the home-visiting programmes into local ECD centres as caregivers begin to understand the importance of their children accessing a programme that supports early learning and stimulation. Other participants suggested that the child's development be monitored over time as well as future schooling progress. These insights are seen in the following excerpts:

> *And the number of children actually going to school because after those programmes they need to go to day-care. So, if their parents care to take them to day-care, it means that there's something that was done right.* (P17)

> *It will be interesting to see if they do better in school, but that may be difficult to assess but interesting because of all the other factors that influence performance at school*. (P11)

The effective supervision of home visitors is an important factor for the success of a home-visiting programme and is noted as such by numerous studies, both nationally and internationally (Azzi-Lessing, 2013; Ebrahim et al., 2013; Le Roux et al., 2010, 2013; Rotheram-Borus, 2014). Participants in this study agreed that the supervisors would be an important part of the work force needed for a home-visiting programme. Participants also agreed that supervisors would need to be professionals with good training and experience in the fields relating to the care of vulnerable children. The majority of

participants indicated that social workers would be best qualified to occupy this role. Participants felt that the role of the supervisor would be to provide ongoing support to the home visitors in the work that they were doing and to ensure the evaluation of services.

These findings are corroborated by other international studies that note the importance of the supervisor in a home-visiting programme and confirm that the roles of a supervisor include those of providing support, teaching and ensuring that the programme is of a high quality through ongoing monitoring and evaluation (Adirim & Supplee, 2013; Head Start Early Childhood Knowledge & Learning Center, 2021; Jones Harden et al., 2012). These same studies note that programme effectiveness is related to optimal cognitive development, compliance with immunisations, regular contact with health care providers and an increased likelihood that the child will attend a preschool at a later stage. This aligns to the input of the participants in this study who suggested that programme success could be measured through the ongoing monitoring of both short- and long-term markers, such as health, cognitive development and access to ECD centres at a later stage.

Literature adds that is it important for supervisors to be culturally competent so that the support and guidance they offer the home visitors is relevant to the context of the caregivers with whom they are working and the community within which they live. In addition, supervisors should be readily available to home visitors in the case of emergencies (Azzi-Lessing, 2013). While participants felt that these same considerations were important to note in the context of the home visitors in this study, they were not identified in relation to the supervisory workforce. Cultural competence and being readily available to the home visitors may thus be two important considerations in terms of the supervisory workforce and the role of the supervisor in a home-visiting programme that were not specifically noted by the participants in this study.

8.3 Conclusion

Chapter 8 presented and discussed the findings that emerged in relation to Objective 4 of the study, which was to determine the various disciplines involved in a home-visiting programme and the role and extent of their involvement. Chapter 9 presents and discusses the findings that emerged in relation to Objective 5 of the study, which sought

to develop guidelines for a model of an early childhood home-visiting programme that supports vulnerable children in the Eastern Cape province.

CHAPTER NINE
GUIDELINES FOR A MODEL OF AN EARLY CHILDHOOD HOME VISITING PROGRAMME

9.1 Introduction

Chapter nine presents and discusses the findings that emerged in relation to developing guidelines for a model of an early childhood home-visiting programme that supports vulnerable children in the Eastern Cape province. The researcher developed the first draft guidelines from Phase 1 and 2 of the study, which consisted of a literature review and findings from semi-structured interviews. Phase 3 of the study consisted of two stages. In Stage 1, once the guidelines were developed, they were circulated to a panel of experts for input and refinement. Stage 2 of this process then consisted of a workshop with the panel of experts to reach consensus regarding the developed guidelines. Once a final consensus was reached, the researcher was able to finalise the guidelines. The guidelines are presented in the section that follows.

9.2 Guidelines for an early childhood home visiting programme model

The guidelines have essentially emerged as a number of practice principles (or activities) supported by processes (or well-defined steps) that may be followed to develop a model of an early childhood home-visiting programme. The following practice principles were agreed upon in the consensus workshop: engagement and advocacy with stakeholders and role players; the selection and recruitment of a multidisciplinary workforce; training of the home-visiting workforce; implementation of the programme; and monitoring and evaluation of the programme. Table 9.1 presents these practice principles as well as the supporting processes and some of the supporting comments from the consensus workshop. Each practice principle and process are presented and discussed in the section that follows.

Table 9.1: Guidelines for an early childhood home-visiting programme

Practice principles	Processes
Engagement and advocacy	Engagement of stakeholders and role players
	Advocacy for implementation of home-visiting programme
Recruitment and selection of a home-visiting workforce	Recruitment of multidisciplinary team to attend home-visiting programme training
	Training and selection of home visitors and supervisors
Content of a training programme for the home-visiting programme workforce	Values and relationship building skills
	Assessment of protective and risk factors
	Planning for intervention
	Knowledge of community resources
	Safety measures and self-care
Implementation of the home-visiting programme	Programme funding should be intersectoral and sustainable
	Setting up of a comprehensive multidisciplinary referral system from all stakeholders to the home-visiting programme so that the programme can focus on prevention and early intervention services
	Duration and frequency of home visits
	Implementing the programme: From engagement and assessment through to intervention and evaluation
	Supervisors provide supervisory support to home visitors and are responsible for continued networking and advocacy with stakeholders and role players locally and at a societal level
	Multidisciplinary team of trainers providing comprehensive and ongoing training
	Development of a forum
Monitoring and evaluation of the home-visiting programme	Qualitative evaluation consisting of caregiver, community and home visitor feedback, both written and verbal
	Quantitative impact evaluation monitoring hospital readmissions, reports to child protection agencies, weight and growth, access to ECD centres and age-appropriate development

9.2.1 Engagement and advocacy

The first practice principle was added to the draft guidelines by participants during the consensus workshop. This practice principle outlines the processes that should be followed to engage with stakeholders and role players before the programme can be implemented. It aligns well to the biopsychosocial model, which calls for stakeholders and role players to adopt a team-based approach in the services being offered to vulnerable children. Engagement and advocacy with a range of existing stakeholders and role players would thus support the initial implementation of the biopsychosocial

model as it works towards building a multidisciplinary approach to the support offered to vulnerable children and their caregivers.

- **Engagement with stakeholders and role players**

Participants agreed that it would be important to reach out to both stakeholders, such as the DSD, DoBE, DoH, Buffalo City Municipality (BCM), and role players, such as NGOs and NPOs, so that the dissemination of the research findings can be facilitated. This process of engagement should include sharing the aim, objectives and findings of the study so that support can be harnessed for the implementation of the programme. Participants recommended that this would form a part of the advocacy that was needed to harness support before the programme could begin. Participants noted that this practice principle was critically important due to the inconsistencies and poor management within the different systems of health, social development and education. It was felt that, if adequately coordinated, this programme had the potential to bring these systems together and to effect necessary change for the vulnerable child.

- **Advocacy for implementation of the home visiting programme**

Once the relevant stakeholders and role players (as identified above) had been engaged, participants felt that the guidelines, practice principles and processes for the early childhood home-visiting programme should be shared together with a synopsis that outlines a time frame for the implementation of the home-visiting programme. Participants noted that such a process was an important form of advocacy which was integral if stakeholders and role players were to support the implementation of the home-visiting programme. In addition, it was noted that such a practice principle may assist with the recruitment of a home-visiting workforce from those who are already qualified in related fields and who may be interested in getting involved through existing stakeholders or role players.

9.2.2 Recruitment and selection of a home-visiting workforce

The second practice principle unpacks the processes that can be implemented for the recruitment of a multidisciplinary team to attend training for the home-visiting programme and secondly, the processes that can be followed for the training and selection of home visitors and supervisors. During the consensus workshop, participants felt that more detail should be added to the disciplines that would be required to participate in the training and who would then make up the home-visiting workforce. This detail would

ensure that the team was representative of professionals who were able to support optimal development across biological, psychological and social functioning, in alignment with the biopsychosocial model.

- **Recruitment of multidisciplinary team to attend training**

For a home-visiting programme to be effective, a multidisciplinary workforce will need to be recruited to attend a training programme. Such a workforce should include potential home visitors who are community members with community knowledge and life experience as well as paraprofessionals and professionals who already have advanced training in the fields of health care, social work or education and are experienced in working with vulnerable children. This partnership between community members and professionals was seen as a potential strength of the home-visiting programme because of the support they could provide to caregivers and each other as the programme was implemented. It was unanimously agreed that supervisors should be included as part of the workforce and that they would be required to provide regular supervision of the home visitors. It is preferable that supervision is undertaken by trained professionals, such as professional nurses, social workers or ECD educators, who have experience in working with vulnerable children, in rendering home visits and in the supervision of a workforce.

- **Training and selection of home visitors and supervisors**

The findings show that trainers from a range of professional disciplines should be recruited to work together to provide the initial and, at a later stage, regular and ongoing training to the home-visiting and supervisory workforce. It was suggested that a multidisciplinary approach to the training of a home-visiting workforce would facilitate the transfer of knowledge and skill that is transdisciplinary is nature. It was felt that this is essential if the optimal development of vulnerable children is to be supported. Once a multidisciplinary workforce was recruited to attend the training, it was put forward that both the home visitors and supervisors attend the training programme and that their level of knowledge and skill is assessed at the end of the training.

It was then recommended that the final selection of home visitors and supervisors is made from the group of attendees who participate in both the training and the formal assessment. This would then comprise the home-visiting workforce. The careful selection of paraprofessional and professional home visitors to work in partnership with community members would need to ensure representation from across the disciplines of

health, social work and ECD. This is important as these disciplines represent the biological, psychological and social spheres of influence for the vulnerable child. Findings indicate that the selection of the home visitors should be guided by the need for a large team of trained home visitors, some of whom should reside in the community where the programme will be offered as well as those who have paraprofessional or professional qualifications and will work alongside these community members. A training certificate could be given to those who attended the training but were not a part of the final selection to join the programme. This could assist them as they seek alternate employment or enrich the work that they may already be doing.

9.2.3 Content of a training programme for a home visiting workforce

The following practice principle provides suggestions for the content of a training programme for a home-visiting workforce. Participants reached consensus around this practice principle but added a more detailed description to some of the processes. Participants agreed that such a training programme would need to facilitate a process where the following content is covered: values and relationship building skills; assessment of protective and risk factors; planning for intervention; knowledge of community resources; safety measures and self-care. Participants also felt that such content would need to extend beyond a particular discipline due to the needs of the vulnerable child. This aligns to the biopsychosocial model which calls for a multidisciplinary and team based approach to health and development. Yet it also extends beyond what the model calls for. Essentially these processes create a platform for a range of professionals from different disciplines to come together and train a home visiting workforce. This results in a training programme that is transdisciplinary in nature and a transdisciplinary workforce, moving beyond the multidisciplinary approach of the biopsychosocial model. Each of these processes is described in the sections that follow:

- **Values and relationship building skills**

Findings suggest that the first part of a training programme for a home-visiting workforce should equip home visitors with the professional values and relationship building skills needed to facilitate effective and quality engagement and a strength-based assessment with caregivers, families and communities. A strength-based assessment values both the caregiver and the child and acknowledges that they have potential to develop and grow despite the hardships they may be facing. It was agreed that values, such as

respect, individualisation, confidentiality and self-determination, will need to be taught as these are essential if strong relationships are to be built. In addition, these values form the foundation of, and are implemented through, relationship building skills such as listening, attentiveness, questioning and basic and advanced empathy. The implementation of these values through the use of relationship building skills will, therefore, need to be taught, practiced and evaluated during the training programme. There was agreement that these values and skills can be used by home visitors to facilitate effective engagement and a strength-based assessment.

- **Assessment of protective and risk factors**

Once there is an understanding of the values and skills that are needed to effectively engage with children and caregivers, then the content of a home-visiting training programme should begin to build knowledge around the factors that offer protection and build resilience during early childhood. These include responsible caregiving and a nurturing environment. Careful attention should be given to first building a comprehensive understanding of these protective factors within the biological, psychological and social domains of the child and secondly, of the interrelatedness of these factors. It was suggested that such knowledge may inform a strength-based assessment. The home-visiting workforce will need to be trained to identify context-specific risk factors that may prevent children from achieving optimal development and well-being.

In the Eastern Cape province, this study found that the most common risk factors vulnerable children were exposed to were: extreme levels of poverty, including poverty of subsistence, unemployment, lack of legal documentation and understanding; ongoing and severe maltreatment including neglect, abuse, disrupted caregiving, family violence and substance abuse; poor physical health, including premature births, low birth weight, malnutrition, illness and disability; and unplanned pregnancies, backstreet abortions, teenage pregnancy, single parents and a lack of knowledge.

As with protective factors, such risk factors may present across the biological, psychological and social domains of the child and, if persistent, may hold the child back from achieving optimal development. Findings indicated that the early identification of risk factors can minimise the impact of these risk factors on the development and well-being of the child. Furthermore, it was suggested that early identification may reduce the

consequences that long-term exposure to such risk factors has for the future outcomes of the child. This knowledge and understanding will assist the home visitors in conducting a thorough assessment. The protective and most common risk factors guided by the biopsychosocial model, which acknowledges the influence of variables on each of the biological, psychological and social domains of the child, may, it was felt, be built into an easy-to-use assessment tool or checklist that can assist home visitors in completing a thorough assessment.

- **Planning for intervention**

The content of a training programme will need to cover the skills and knowledge needed for the home-visiting workforce to develop and plan an intervention that works towards strengthening the protective factors and minimising the risk factors within the biological, psychological and social domains of the child. It was agreed that such an intervention plan would need to be uniquely shaped to meet the needs of each child and caregiver. Rather than developing a set intervention tool as part of the guidelines for vulnerable children, who often face a complex array of risk factors, an individual developmental plan and intervention is suggested. This will allow home visitors to work with the child and caregiver in addressing their unique risk factors while building capacity around protective factors. Such an approach may be more effective than a set intervention tool that is unable to accommodate the individual needs of a child and caregiver.

There are a variety of early childhood intervention programmes and resources available online. These are focused on different aspects of building protective factors during early childhood. Some, for example, focus on early learning and stimulation while others focus on parenting skills. Rather than reproducing these programmes and resources, it is recommended that a home-visiting workforce work from existing tools and intervention programmes to develop a specific set of interventions that will assist in meeting the unique needs of the child and caregiver. The interventions will then be delivered within the home of the child and caregiver. It was felt that this individualised approach, combined with the delivery of services within the home of the child and caregiver, makes this programme significant in its ability to reach the most vulnerable of children, some of whom may simply not have access to any other resources.

- **Knowledge of community resources**

It was agreed that the home-visiting workforce will need to be equipped with knowledge relating to community resources so that vulnerable children and their caregivers may be linked to such resources when required. This should only be done in situations where the home-visiting programme is unable to offer such services, where the caregiver is unresponsive to change or where the safety and well-being of the child is at risk. Findings suggest that these community resources could include informal networks of support, such as community leaders or gatekeepers within the community, or formal networks of support offered by paraprofessionals or professionals in the field of health, social work and education. Knowledge of community resources and the manner in which such resources can be accessed may support the optimal development of vulnerable children and their caregivers.

If the practice guidelines regarding the recruitment of a multidisciplinary team of trainers is followed, then much of the knowledge around current services and how to effectively access such services can be shared as part of the content of a training programme. Ideally, it was felt that the multidisciplinary team of trainers would represent the various community resources that can be accessed to support vulnerable children. For example, an official from the Department of Home Affairs may facilitate some of the training to equip the home-visiting workforce with knowledge about the registration and late registration of births. This may support the transferring of transdisciplinary knowledge which can empower the home-visiting workforce to support vulnerable children, caregivers, family and the community to effectively access such community resources. Participants felt that the development of a comprehensive resource list (presently unavailable) for distribution among the home-visiting workforce, stakeholders and role players would be beneficial in developing a knowledge base of local resources.

- **Safety measures and self-care**

It was agreed that an important part of the training programme for home visitors would need to include information in relation to safety measures and self-care. The very nature of home visits and a home-visiting programme, where the home visitors might step from an office into a community where violence and crime is rife and then into the home of a caregiver and a child who is vulnerable, in itself presents various risks to the physical and emotional well-being of the home visitor. At times, these risks may be easily

noticeable. For example, the caregiver may refuse to allow the home visitor into the home or threaten the home visitor with violence. However, these risks may be less noticeable at other times. For example, the caregiver may allow the home-visiting to take place but may conceal the risk factors that the child is exposed to, making intervention challenging and difficult to negotiate.

Findings in this study suggest that creating awareness of the physical dangers and the emotional risks of burnout when working in a home-visiting programme will need to be addressed as part of the training programme as well as strategies to prevent them. It is suggested that the organisation that employees the home visitor workforce have a safety plan, that the workforce receives training in this safety plan and that supervisors support home visitors in the implementation of such a plan. In addition to a safety plan, findings suggest that the role of the supervisor in providing regular supervision that is both educational and supportive is critical to preventing burnout among home visitors.

9.2.4 Implementation of the home visiting programme

The following practice principle presents processes that relate to the implementation of the home-visiting programme. Such processes refer to: programme funding; the setting up of a referral system; the duration and frequency of home visits; programme implementation by the home-visiting workforce; supervisory support; comprehensive and ongoing training and the development of a forum. These are essentially structural processes within the social domain of society which if the biopsychosocial model is to be considered need to be strengthened as they are influential in supporting caregivers and the optimal development of vulnerable children. Participants reached consensus regarding this practice principle although they felt that more detail needed to be added to some of the processes. This detail has been added and each of these processes is presented in the sections that follow.

- **Programme funding**

Findings noted that for the implementation of the home-visiting programme to be effective, sufficient and sustainable, intersectoral funding should be sourced on both a national and international level. Both national and international policy and legislation within the sectors of health, social development and education prioritise early childhood programmes and, as such, could be approached to fund an early childhood home-visiting programme. It was suggested that programme funding would need to ensure that the

salaries of the multidisciplinary workforce are paid. The payment of salaries will assist with the retention of the workforce needed to implement the programme. There was unanimous agreement that programme funding would also need to ensure that the programme is well resourced with practical resources needed to monitor and support the optimal development of the child. Such practical resources should include nutritional support, material support, transport costs and early learning materials. A partnership with an academic or research institution may assist such a programme to access sustainable and substantial funding.

- **Setting up of a referral system**

Findings confirmed that there was a lack of follow-up and intersectoral collaboration even though vulnerabilities or risk factors were identified. For this reason, the home-visiting programme would need to have an effective and efficient referral system in place. The referral system should ensure that vulnerable children are referred by a range of stakeholders to the programme immediately risk factors are suspected. This will assist the programme in offering services at a prevention and early intervention level. It was suggested that this is critical if vulnerable children are to be supported towards optimal development before the consequences of exposure to risk factors result in poor outcomes, which are challenging to undo at a later stage. Such a referral system will require that a range of professionals across disciplines that offer services to vulnerable children are informed of the programme and of the process for referral so that as many vulnerable children as possible can be assisted through the programme. Participants felt that a strong marketing campaign, with a WhatsApp number for referrals by professionals and self-referrals by caregivers, would assist in ensuring that the referral system is effective and efficient.

- **Duration and frequency of home visits**

The programme should ideally be offered from conception through to when the child is over the age of 2 years. Such long-term programmes have shown good outcomes for both the child and caregiver. Once risk factors have been reduced and protective factors have been put in place, caregivers can be referred to other ECD programmes, such as play groups, parenting groups, toy libraries or an ECD centre, to replace or supplement the home-visiting programme. Findings have indicated that the frequency of home visits will be determined by the complexity of the risk factors identified from either the referral

or during the assessment. As such, home visits may be as often as twice daily or once a week and should be of sufficient length to engage and intervene with the caregiver and child. In addition to the frequency of home visits, it was suggested that the duration of the programme should extend over enough time so that progress can be monitored and evaluated.

- **Implementing the programme**

Essentially, the role of the home visitors would be to implement the home-visiting programme from engagement and assessment through to intervention and evaluation with vulnerable children and their caregivers. Each home visitor can work with 20–30 referrals, depending on the complexity of the referrals that are received. The complexity of the referrals will guide the home visitor in planning for the frequency of home visits. It was agreed that the implementation of the programme would begin through engagement with the community and then the family and caregiver of the child.

Findings also suggested that the role of the home visitor would extend through to conducting a thorough strength-based assessment and developing an intervention plan to support the well-being of the child and caregiver. The home visitor would then continue to monitor the growth and development of the child. If the intervention is successful, then the home-visiting programme can be supplemented with less intensive services such as play groups, toy libraries, parenting groups or an ECD centre. If the intervention is unsuccessful and the child remains at risk, it was suggested that the role of the home visitor would then be to work with the supervisor to refer the case for further intervention.

- **Supervisors provide supervisory and networking support**

The role of the supervisor would be to assist with the implementation of the home-visiting programme through managing the referral system and matching home visitors to vulnerable children and caregivers. Findings supported that supervisors would be required to provide ongoing educational, administrative and emotional support to home visitors as they monitor and evaluate the effectiveness of both the programme and the home visitors. It will be important to have a variety of supervisors, ranging from health care professionals, social workers and ECD educators, so that they can support the home visitors with the discipline-specific knowledge that is needed to implement the programme effectively. Each supervisor may be required to take responsibility for 4–5 home visitors, ensuring that adequate supervision and case management is possible. It

was suggested that supervisors would be required to network among stakeholders to ensure that the home-visiting programme is accessible to all who work with vulnerable children. Where vulnerabilities are identified by professionals in the field, they would then be able to refer the child and caregiver to the programme at an early stage so that prevention and early intervention services are possible.

If the gaps in support being offered to vulnerable children are to be considered, then it is suggested that an additional role of the supervisor would be to advocate for vulnerable children and families on a societal level. For risk factors such as poverty and unemployment to change, society will have to accept that it has neglected to support the most vulnerable in society. If changes are to be made, then such changes will have to be effected an a societal, political and community level and not only at an individual or family level.

- **Multidisciplinary team of trainers providing ongoing training**

There was agreement in the findings that the role of the trainers in the home-visiting programme would be to provide comprehensive and ongoing training to both the home visitors and supervisors. It was felt that trainers should be recruited from the various fields of practice that offer services to vulnerable children during early childhood. This will ensure that both home visitors and supervisors clearly understand the different variables within the biological, psychological and social domains of the child that either support or threaten optimal development. Some examples of trainers who may be invited to provide training to the home-visiting workforce include doctors, nurses, dieticians and occupational therapists from the health sector. Social workers, psychologists, child and youth care workers, and officials from the Department of Home Affairs, the Department of Agriculture (to assist with poverty alleviation through gardening) as well as ECD educators and practitioners will be included in the training team as they have expert knowledge that supports the psychological and social well-being of the child, family and community.

If literature is to be considered, then the training of the home visitors and supervisors should be done through the sharing and application of knowledge so as to ensure optimal learning. The application of knowledge should be facilitated by the trainers and can be done through the use of case studies, role plays, simulations and feedback. In addition

to this, the trainers – as experts in their field of knowledge – may support supervisors with advocacy on a societal, political and community level.

- **Development of a forum**

Due to the scarcity of resources in the Eastern Cape province, and the need for a platform that draws professionals together, findings suggest that programme implementation include the development of a forum. Such a forum can facilitate the sharing of knowledge, resources and support in building a network in the Eastern Cape province that supports vulnerable children as well as the professionals who currently offer services to such children. Findings confirm that no such forum currently exists in the Eastern Cape province, and this may perpetuate a disconnect between the different departments, disciplines, organisations and individuals that work with vulnerable children and caregivers. Participants felt that such a forum could begin in the local municipal area and then move out to other municipal areas in the Eastern Cape province.

9.2.5 Monitoring and evaluation of the home-visiting programme

The following practice principle suggests processes in relation to the monitoring and evaluation of the home-visiting programme. Participants were in agreement that such a principle was vitally important to the programme, both in terms of securing sustainable funding and to the sustainability of the programme. This practice principle should include processes relating to both qualitative and quantitative methods of evaluating the outcome of the programme for both the caregiver and the vulnerable child. Each of these processes is presented in the sections that follow.

- **Qualitative evaluation**

While there are many early childhood programmes offered in the Eastern Cape province, very few are able to explain how the rendering of services or outcomes for the programme are evaluated. Evidence of impact and effectiveness is thus lacking. It is suggested that the monitoring and evaluation of the programme, with its associated outcomes for the child and caregiver, will need to be carefully planned, implemented and documented. Participants in this study felt that such evaluations should include formal and informal feedback from caregivers, home visitors and community stakeholders in relation to the impact that the programme has on reducing risk factors, building protective factors and in supporting good future outcomes for the child. Once evaluations are conducted, data should be analysed and shared with stakeholders. This may assist in

securing sustainable funding for the programme and may support evidence-based practice.

- **Quantitative evaluation**

In addition to the qualitative programme evaluation, some forms of quantitative evaluations that rely on statistics (which may, or may not show reduced risk factors, improved protective factors and improved outcomes for vulnerable children) are also recommended. Findings suggest that such an evaluation could monitor the number of readmissions to hospitals or cases reported to child protection agencies. In addition, it was suggested that the growth and weight of children and immunisation compliance could also be monitored and recorded at each home visit. Monitoring the access that children in the programme have to ECD centres as they grow as well as tracking their overall progress until school-going age could also form a part of the long-term quantitative evaluations. Each of these evaluations should be diligently planned, implemented and documented, possibly through a digital platform, so that a long-term impact evaluation is possible. In essence, such evaluations, as with those mentioned in in the previous section, can assist with securing sustainable funding and may support evidence-based practice.

9.3 Conclusion

Chapter 9 presented the guidelines that emerged in relation to Objective 5 of the study, which was to develop guidelines for a model of an early childhood home-visiting programme that supports vulnerable children in the Eastern Cape province. These guidelines were drafted within Phase 2 of the study, which consisted of a literature review and the findings from semi-structured interviews. The guidelines were refined in a consensus workshop in Phase 3 of the study and were consequently presented in Chapter 9. Chapter 10 provides a conclusion to the study by examining whether the study achieved its overall aim and objectives and, in so doing, contributes to the generation of new knowledge. The limitations of the study are outlined and recommendations are made for practice and future research.

CHAPTER TEN

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

10.1 Introduction

The aim of this study was to develop guidelines for a model of an early childhood home-visiting programme that supports the optimal development of vulnerable children, aged 0–2 years, in the Eastern Cape province of South Africa. Without a clear understanding of the context facing vulnerable children and their caregivers, there is little hope of informing social change and developing a programme that can solve real-life challenges. This study has occurred at a crucial time. President Ramaphosa has announced that ECD services will move from the DSD to DoE. The amendments to the Children's Act, which provides for ECD services, were rejected as they failed to address issues of accessibility and funding of ECD services. There is an increased call for the development of early childhood programmes that offer comprehensive, preventative and early intervention support for the optimal development of the young and vulnerable child. In essence, the South African Government is being challenged by the social work and early childhood sectors to take responsibility for the implementation of legislation and policies that prioritise support services to young and, in particular, vulnerable children before they are exposed to ongoing risk factors that have detrimental consequences for their development.

The study adopted a qualitative approach and an intervention research design located within an interpretivist paradigm so as to facilitate the development of contextually relevant guidelines for a model of an early childhood home-visiting programme. Semi-structured individual interviews were conducted with 18 professionals and nine caregivers in Phase 1 and 2 of the study, which involved explanatory research and conceptualisation. Phase 3 of the study was conducted in two stages. In Stage 1, the draft practice guidelines were circulated per email to a panel of experts for written input and in Stage 2, a consensus workshop was held to reach agreement regarding the guidelines, it's practice principles and related processes as well as the written input that was received. This chapter summarises the key findings in relation to the study's objectives which were:

- To explore the needs of vulnerable children in the Eastern Cape province and the potential outcomes when such needs are met.

- To understand the risk factors facing vulnerable children in the Eastern Cape province and the consequent impact of such risk factors.
- To identify the ways in which vulnerable children are currently being supported in the Eastern Cape province.
- To determine the various disciplines that are involved in an early childhood home-visiting programme model and their roles and extent of involvement.
- To develop guidelines for a model of an early childhood home-visiting programme that supports vulnerable children in the Eastern Cape province.

These objectives were achieved and discussed in Chapters 5, 6, 7 8 and 9. In addition to summarising the key findings, Chapter 10 draws conclusions and makes recommendations for practice and future research. Lastly, the limitations of the study are presented and concluding remarks are made.

10.2 Summary of findings

The sections that follow present a summary of the findings in relation to each of the study's five objectives.

10.2.1 Needs and their outcomes for vulnerable children

The primary needs of vulnerable children were understood as those of responsible caregiving and a nurturing environment. All children, and especially vulnerable children, are in need of caregivers who are knowledgeable, responsive and well supported. These factors ensure responsible caregiving so that they can, in turn, support the optimal development of the vulnerable child. Knowledgeable caregivers were described as those who understood the needs of a young child and who were knowledgeable in terms of community resources. Responsible caregiving also embraced learning from mistakes, which enables a process of empowerment. Responsive caregivers were described as those who were able to engage with and make time for the vulnerable child and respond to input and guidance from professionals who had experience in working with these vulnerabilities. Caregivers need a good support system which could come from family, friends or spiritual beliefs. It was felt that a caregiver who was well supported may be better able to care for a vulnerable child.

Responsible caregiving goes hand in hand with a nurturing environment, which was described as one in which the child receives adequate nutrition, regular health care, protection from harm, receives love and care and the child has opportunities for

stimulation and learning. Adequate nutrition was described as the basic foundation for a good start in life and was thus seen – with regular health care – as a critical need for vulnerable children. Accessing regular health care ensured that the weight and growth of vulnerable children could be monitored, and interventions could occur before malnutrition, illness, disease or disabilities became life-threatening.

There was also a great need for vulnerable children to be protected from harm, especially in the early years where they were solely dependent on their caregiver to ensure that this was provided. A safe physical and psychological environment where the child is protected from harm is thus needed for optimal development during the early years. Love and care were identified as a need for the vulnerable child and, in addition, such love should begin from conception with the mother's love being seen as important. However, love and care from others within the family was also noted as being important.

The outcome for vulnerable children where needs were met was that a foundation for future optimal development could be built with the child achieving holistic well-being and prospects for a good future. Holistic well-being was described as an outcome where the child achieves age-appropriate development. This included good physical and cognitive health and a child who was strong, happy, healthy and able to learn and progress within a school setting. Holistic well-being was further described as a situation where the child has a healthy self-esteem which included a sense of identity, belonging and purpose. Achieving holistic well-being would, in turn, lay the foundation for good future prospects. Such prospects were noted as continuing through to adulthood and included being able to achieve academic success.

The study also found that where needs were met during early childhood, children can become better adults; adults who were responsible, independent and able to contribute towards a sustainable future on an individual, community and societal level. Good future prospects can, in addition, include a life free from the abuse of substances and crime for the adult – who is now able to make responsible choices rather than perpetuate cycles of abuse, dependency, poverty or crime, resulting in a positive impact for society on the whole.

10.2.2 Risk factors and their impact on vulnerable children

The most common risk factors that vulnerable children in the Eastern Cape province are exposed to include extreme levels of poverty, ongoing and severe child maltreatment, poor physical health and unplanned pregnancies.

Professionals described how extreme levels of poverty were seen daily, rendering caregivers unable to provide basic necessities, such as food and toiletries, for their children. The Covid-19 pandemic also impacted the access that children had to food through school nutrition programmes during lockdown and on the days children did not attend school. Both professionals and caregivers voiced that unemployment remains a harsh reality in the Eastern Cape province and that these high rates of unemployment contribute significantly towards the extreme levels of poverty in the province. Participants shared that the high levels of unemployment had worsened due to Covid-19.

Another factor contributing towards extreme levels of poverty in the province is the lack of legal documentation. The births of many caregivers remain unregistered and, as such, these caregivers are unable to register the birth of their own children. This results in a lengthy and complicated process of registering a 'late birth' for the caregiver before the birth of the child can be registered. At other times, caregivers simply refrain from registering the birth of their child and this results in numerous challenges for the child, inevitably perpetuating the cycle of poverty being experienced by the caregiver and child.

A second risk factor facing vulnerable children was the exposure to ongoing and severe child maltreatment. This included child neglect, which could be intentional where caregivers purposely refrained from breastfeeding, taking children for vaccinations or left children unattended for long periods of time. Child neglect could also be unintentional, especially where children had disabilities or illnesses and caregivers did not know how to care for them. There was a lack of awareness and knowledge when it came to parenting and caring for a young child. Some caregivers felt isolated and unable to reach out for support or information due to the rural communities that they resided in. Professionals felt that a lack of knowledge or the poverty of understanding around healthy child rearing practices was consistently placing young children at risk.

In addition to child neglect by caregivers, child neglect was also seen on a community and societal level, for example, where illegal live electrical connections within communities caused children to suffer burn injuries, some of which may even result in

death. Child abuse, both physical and sexual, which resulted in serious injury for the child was noted as being common and on the increase. There was a correlation between poverty and child abuse with some participants confirming that the harsh circumstances of poverty facing a caregiver increased the likelihood of the child being abused.

Disrupted caregiving, which resulted in babies being abandoned or left alone and/or unsupervised for long periods of time, was described as a serious risk factor for children. Another form of disrupted caregiving occurred when biological mothers abandoned their children with family members who were then expected to care for these children with little or no resources. The biological fathers of children were often unknown or missing. While professionals noted that they were able to intervene in such cases, assisting family members to access resources for the child, there was still a sense of frustration that biological mothers and fathers essentially abandoned their children and their child-rearing responsibilities. At other times, disrupted caregiving was caused by the death of parents, with Covid-19 related deaths adding to the immensity of this challenge.

Exposure to family violence and substance abuse was another factor identified as contributing to the severe and ongoing maltreatment of children. In particular, substance abuse by caregivers was noted as a common and serious concern in the Eastern Cape province. This exposure was strongly associated to high levels of neglect and abuse of the child.

The third risk factor identified by this study was that of poor physical health. Participants expressed concern about the many health-related challenges that children face from as early as birth, which then places them at risk and renders then vulnerable both to other associated risk factors and to poor future outcomes. Participants noted the high number of babies born prematurely – or with a low birth weight – in the Eastern Cape province. These babies then often faced other challenges, which emerged either in their biological, psychological or social areas of functioning. Both premature births and a low birth weight were consistently associated with conditions of poverty and substance abuse during pregnancy. The birth of multiples presented as a risk factor, with these babies often born prematurely and with low birth weight. Health professionals, in particular, shared that, those children who were identified as malnourished, suffering from an infectious disease or who had a disability, were at risk for poor developmental outcomes. Hospital readmissions for such children was very common, with very young babies being admitted

for severe and acute malnutrition. Exposure to HIV remained a concern for participants as caregivers had to be responsible for their own health care during and after pregnancy so as to minimise the risk of transmission to the child. Disabilities, such as cerebral palsy and hydrocephalus, were identified as other common risk factors for the child as caregivers were often unable or unwilling to care for these children adequately. In general, it was found that poor health in young children increased the stress that caregivers were already facing, essentially rendering the child more vulnerable to poor future outcomes.

The fourth most common risk factor that emerged was unplanned pregnancies. Where pregnancies were unplanned, participants expressed that this became a risk factor for the child due mainly to the fact that planned pregnancies may result in unwanted babies. Where pregnancies were unplanned and babies unwanted, not all caregivers were able to access a legal abortion due to the demand on abortion clinics in the Eastern Cape province. In such circumstances, backstreet abortions were common with babies either being aborted or born with the most challenging medical conditions. Some unwanted babies were also left to die either through abandonment or child neglect. Teenage mothers and single parents presented additional risks for the child as young or unsupported mothers who had unplanned pregnancies were often seen to neglect their children. Unplanned pregnancies were often associated with low levels of parenting knowledge and skill thus increasing the likelihood of the child being exposed to maltreatment.

This study confirmed that where young children are continuously exposed to risk factors, the consequences included poor physical health, psychological tension and poor future outcomes. Poor physical health was seen in delayed physical development, severe and acute malnutrition or a failure to thrive, all of which were noted as detrimental to the child's future well-being and development. The continuous exposure to risk factors was often also connected to the child becoming ill, either with a chronic or short-term illness or with a disability which then contributed further to delayed physical development, malnutrition and a failure to thrive.

Participants also expressed that a further common consequence of unmet needs was the impact that it had on the child's psychological well-being. Unmet needs, whether biological, psychological or social, often caused psychological tension for the child

resulting in a child who cried a lot, who was angry or who was withdrawn from social relationships.

In addition, the consequences of unmet needs during early childhood were connected to poor future outcomes that extended beyond the early years of development. For some children, the consequence of unmet needs is death. Participants explained how traumatic it was for them to see children dying because of poverty, maltreatment, poor health and unplanned pregnancies. Where children survived these risk factors during early childhood, participants shared that these children may face challenges with schooling – either not attending school or experiencing cognitive or learning problems. Participants also felt that exposure to risk factors during early childhood increased the likelihood of the child's involvement in crime and substance abuse.

There was a general feeling that where needs were not met during early childhood, the child may be lost to the family, community and society with a moral disintegration that could then be repeated during adulthood. This moral disintegration, which may include perpetuating cycles of poverty and unemployment, inevitably becomes costly for the government, which then must support such an individual rather than the individual supporting themself, their family and contributing towards the economy of the country.

10.2.3 Support offered to vulnerable children

The two main themes that emerged under the support offered to vulnerable children were that of firstly, current support and secondly, the gaps in the support being offered to vulnerable children.

Current support included support from child protection services with much of this being offered through social workers at child protection agencies when reports of child maltreatment were received for investigation. Another important source of support offered through child protection services is the residential care offered through places of safety for the temporary safe care of children. There were some community-based programmes in specific geographical areas offered to vulnerable children through child protection programmes, such as *Isibindi* [Xhosa name of community-based programme meaning courage]. For children exposed to risk factors within their family or community, these child protection services were deemed critical.

Health-care services were another form of current support identified in this study as being critical in supporting vulnerable children. Participants shared information about the services being offered through tertiary health-care facilities, which included medical and nutritional care for sick and malnourished babies and an after-care programme for babies born prematurely or with a low-birth weight. It was interesting to note the impact that Covid-19 had on these current services with participants sharing that the need for nutritional support with admissions for SAM had dropped during Covid-19. Participants attributed this to the increase in the CSG, and the ban on alcohol sales during this time.

Another important form of support noted by participants in this study is provided to vulnerable children through primary health care facilities. These services were noted as important in accessing primary health care services, such as immunisations, and for the referral of vulnerable children to tertiary health care facilities for further medical intervention. In addition, it was shared that some primary health-care facilities connected those in need to home-based caring services. While these services were not specifically linked to support for vulnerable children, it was felt that the service may be valuable in supporting vulnerable children.

In addition to child protection and health-care services, ECD programmes were identified as a part of the current support being offered to vulnerable children in the Eastern Cape province. This support was seen as critical as it offered access to nutritional support, growth and weight monitoring, intervention in cases of child maltreatment and preparation for formal schooling. In addition to services for the child, some ECD programmes offered parenting programmes, support groups and digital support platforms for parents. One participant shared that local government had established an ECD working group for stakeholders, and it was felt that this too was a current service that indirectly supported vulnerable children in the Eastern Cape province.

The last theme that emerged under current support to vulnerable children was that of social assistance. The CSG was seen as an important form of cash assistance that families were able to access. In particular, it was felt that the top-up of R500, which caregivers received during Covid-19 over and above the CSG, was helpful in supporting families to meet their needs. Assistance with food and clothing was also provided to some families through local community-based programmes, NGOs or churches and this was seen as a valuable form of social assistance in supporting vulnerable children.

While current support was available to vulnerable children, gaps were also found in the support being offered. Such gaps existed within child protection services, where it was felt that these services were under-resourced. This often made it challenging for social workers, who faced the daily realities of high caseloads and numerous administrative demands. In other situations, social workers appeared to render no follow-up services, leaving vulnerable children and alternative caregivers, such as foster parents and places of safety, unsupported.

Health-care services too appeared to be functioning in a system that was under-resourced and health-care professionals felt that the work they did was not sufficient to bring about a change for the family. In addition to this, a lack of coordination and communication between the different subsystems within the health-care system was seen as problematic. The referral of caregivers to services outside of the health-care system was often overlooked by health-care professionals. Where referrals or further health-care appointments were made, there appeared to be a lack of monitoring and follow-up. Health-care professionals often felt that they were unaware of the outcomes of referrals and acknowledged that they were unable to monitor whether caregivers followed through with scheduled appointments either at primary or tertiary health-care facilities or with external service providers.

Staff shortages at both tertiary and primary health-care facilities were identified as a serious problem for health-care workers. The approach of staff at primary health-care facilities was at times noted as harsh and unengaging, which made it impossible for caregivers to reach out for assistance even though they desperately needed this support. Access to nutritional support and regular growth monitoring, which in the past had been done through community health-care workers in the home of the family or at the school the child was attending, appeared to no longer be a service that was offered and was noted as a gap in current services.

In addition to the gaps in child protection and health-care services, there were glaring challenges reported over the misuse of social assistance by caregivers, who were seen to be using the CSG for their own needs – and often for the misuse of substances. There appeared to be no system in place that monitored the use of the CSG to prevent misuse and ensure that the CSG did, in fact, assist the child towards achieving healthy development. For those who were not misusing the CSG, the monetary value of the CSG

was noted as problematic as it was seen as insufficient to meet the basic needs of the child.

The last gap in current services being offered to vulnerable children was noted as the scarcity of home-visiting programmes. Participants explained that there was no home-visiting programmes currently being offered through service providers and stated that they were not aware of any non-centre-based ECD programmes being offered to young children within the first 1,000 days of development. The need for such a programme and the potential benefits that such a programme holds for the optimal development of vulnerable children and the empowerment of caregivers, particularly those in rural areas who often did not know who or where to turn to for support, was determined as being significant. In addition, such a programme was seen to have the potential for connecting the different disciplines and service providers that work with vulnerable children, which appeared to be a challenge with current services.

10.2.4 Determining the roles and involvement of various disciplines

It was determined that a multidisciplinary workforce was needed to implement a home-visiting programme model and that such a workforce would need to be made up of home visitors, trainers and supervisors.

Some participants felt that community members with training could function well in the role as home visitors while some participants felt that trained paraprofessionals, such as community health care workers, child and youth care workers or ECD practitioners, would work better in the role as home visitors. A few participants felt that professionals, such as social workers or clinic sisters, should do the home visits. Many participants felt that a team of home visitors made up of community members, paraprofessionals and professionals may then be the most effective in implementing a home-visiting programme that supports vulnerable children. Community members generally have existing knowledge and relationships with the community, which may assist in engaging with the community and caregivers. Community members may also have the knowledge needed to work alongside professionals in developing contextually appropriate plans and interventions to support optimal development, which can then continue after hours or when professionals are not available. Paraprofessionals and professionals ~~may will~~ have the additional expert knowledge needed to assess, plan and intervene effectively,

especially in contexts of multiple vulnerabilities which children in the Eastern Cape province seem to face within their families and communities.

The role of the home visitors would be to facilitate a helping process at a community, family and individual level through the use of relationship building skills and based on the values of confidentiality and respect. The helping process should include a thorough assessment, an individualised intervention plan and referrals for specialised assistance if needed. Furthermore, the characteristics of a good home visitor would be that of a good role model to the community, being able to motivate and empower caregivers and being willing to work with caregivers as they navigate through the risk factors that they face in caring for their vulnerable child.

All of the participants agreed that a range of professionals from the disciplines of health, social work and education should form a part of a multidisciplinary team that is responsible for training home visitors. In addition to coming from a range of different disciplines, such professionals should have existing experience and knowledge in working with vulnerable children. Training the home visitors was seen as integral to ensuring that both the home visitors and supervisors were equipped with the transdisciplinary knowledge needed to support vulnerable children and their caregivers to achieve optimal development. While this training may be challenging to arrange and facilitate, it was felt that it would benefit both the home visitors and the trainers. The home visitors would benefit by receiving ongoing and quality training from experts in the field. The multidisciplinary team of trainers will benefit as they would then have an already established relationship with the home-visiting workforce and may be able to reach out to them for support in the work that they themselves are doing with vulnerable children, which may not extend to home-visiting services.

The supervision of the home visitors was identified as key to the success of a home-visiting programme. Supervisors would need to be qualified and experienced professionals so that they can provide supportive and educational supervision to the home visitors on a regular basis. Some of the professionals that could be considered for such a role include health-care professionals, such as paediatric nurses and social workers, or ECD educators. The role of the supervisor would also include initiating a forum, which is currently non-existent in the Eastern Cape province but which participants felt was needed. Such a forum could bring together stakeholders and role

players from the different sectors of health, social work and ECD so that an integrated approach to services is supported.

The role of the supervisor would also include the setting up and management of a referral system so that vulnerable children could be referred to the programme. In addition to providing supervision, supervisors would need to ensure the regular monitoring and evaluation of the programme. Such evaluations could be short term and qualitative in nature, for example, feedback from the stakeholders, role players and caregivers on the effectiveness of the programme. Evaluations could also be impact-based so as to determine effectiveness and long-term outcomes for the children who are supported through the programme.

10.2.5 Guidelines for a model of an early childhood home visiting programme

The guidelines for a model of an early childhood home-visiting programme were developed and refined to include a range of practice principles and related processes. The first of these outlined the need for advocacy with stakeholders and role players so that the study and its findings could be shared and support for the implementation of the programme could be sought. Once this practice principle had been implemented, it was agreed that a multidisciplinary team would need to be recruited to attend training, which would empower them with the knowledge and skills needed to implement the home-visiting programme. The team should be made up of respected community members who could then work alongside paraprofessionals and professionals from the disciplines of health, social work and ECD.

In addition to recruiting a home-visiting workforce, a multidisciplinary team of trainers would need to be recruited to train the home-visiting workforce so that they are able to offer assessment and interventions across the areas of biological, psychological and social development. The content of a home-visiting programme should cover the teaching of processes relating to values and relationship building skills, the assessment of protective and risk factors, planning for intervention, knowledge of community resources and safety measures and safe care. For the implementation of the home-visiting programme, it would be essential to source intersectoral and sustainable funding and to set up a comprehensive referral system. Such a system should be digital and, if efficient, would essentially ensure that vulnerable children are referred to the programme

as early as possible either through stakeholders or role players or through self-referral by the caregiver.

The programme could, therefore, be implemented preventatively or as an early intervention service before long-term exposure to risk factors occurs. It was agreed that the duration and frequency of the home visits would be guided by the severity of risk factors that the vulnerable child was exposed to. Home visitors would facilitate a helping process from engagement and assessment through to intervention, evaluation and eventually termination of services. Supervisors would be required to provide ongoing supervisory support to the home-visiting workforce. Participants also felt that supervisors should ensure ongoing advocacy with stakeholders and role players so that adequate resources are accessed and provided for the implementation of policies through services that are required to protect and support children – especially vulnerable children – towards optimal development.

A further process that forms part of the implementation of the programme should include the development of a forum where stakeholders and role players can connect to support one another and share resources.

The last practice principle relates to the monitoring and evaluation of the programme. Participants felt that it was essential to include this practice principal in the guidelines as the ongoing monitoring and evaluation of the programme would provide valuable data on both the short- and long-term impact that the programme has for vulnerable children and their caregivers.

10.3 Conclusions

The following section draws conclusions in relation to each of the study's five objectives.

10.3.1 Needs and their outcomes for vulnerable children

This study has confirmed the need for responsible caregiving and a nurturing environment if vulnerable children are to achieve optimal development. Caregivers should be knowledgeable, responsive and well supported if they are to provide young children with a nurturing environment. This study has confirmed that a nurturing environment is one in which a child receives adequate nutrition, regular health care, protection from harm, love and care and opportunities for stimulation and learning, and that each of these is of equal importance. These needs are influenced by biological,

psychological and social factors within the family and community of the child and align to the biopsychosocial model.

The meeting of these different needs, especially during early childhood, is ultimately dependent on whether or not the child has a responsible caregiver. In essence, it is this dependency that makes the child particularly vulnerable during early childhood. Recognising this dependency and the interaction of variables across the areas of biopsychosocial functioning is important to note as a home-visiting programme will need to work with the child and caregiver. The caregiver is an important influencer in the social environment of the child – either supporting the child towards optimal development or influencing and contributing towards poor outcomes for the child. The findings in this study agree with literature that notes when a child's needs are met, then the child is able to achieve physical health, emotional well-being and there are prospects for a good future. A home-visiting programme will need to work towards strengthening protective factors through supporting the caregiver to meet the needs of the vulnerable child.

10.3.2 Risk factors and their impact on vulnerable children

The risk factors emerged as very real, very complex and often inextricably connected with serious consequences for vulnerable children. A home-visiting programme cannot and should not risk glancing over these risk factors to focus on the needs of the child as these risk factors have a direct impact on the needs of the child not being met. For this reason, a home-visiting programme will need to begin with a thorough assessment followed by a tailor-made intervention plan that is shaped to address and reduce the risk factors of the family. As the specific risk factors are addressed, the needs of the child may begin to be met or a secondary intervention plan will begin to assist caregivers in working towards meeting the needs of the child.

This study differs to other home-visiting programmes, which suggest limited attendance to risk factors but then draw the child and caregiver back to the planned programme for the visit with a specific focus on parent-child engagement. At the same time, it remains unrealistic to expect a home-visiting programme, or any other programme aimed at an individual, family or even community level, to eliminate such real, complex and intricately connected risk factors. To eliminate risk factors, such as extreme levels of poverty or ongoing and severe child maltreatment, interventions would need to occur at a societal level. It would require a consolidated effort from society and government to address

these issues simultaneously and consistently, spanning across generations through the distribution of efficient and sufficient resources.

Sadly, the findings in this study have found that vulnerable children continue to be exposed to devastating risk factors, resulting in poor physical health, psychological tension and poor future outcomes. Furthermore, this cycle is often then being repeated as adults with their own children.

10.3.3 Support offered to vulnerable children

Current services are available to support vulnerable children. There are, however, also gaps in these services, which mainly relate to a lack of resources, including an ever-dwindling source of sustainable funding that results in few workers and high volumes of work. This is problematic in a province where many children remain vulnerable and face complex risk factors which have dire consequences for future well-being and development. Professionals within their own disciplines are aware of the services that they offer to support vulnerable children, however, there appears to be less awareness of what other disciplines are doing to support vulnerable children and little interconnectedness between different services and across disciplines. There appears to be ~~may be~~ a lack of an interdisciplinary and team approach to cases of vulnerable children, which is not ideal when the biopsychosocial framework and the importance of biological, psychological and social variables working together to support optimal development and overall well-being during early childhood is considered. After all, the biopsychosocial model notes the importance of each variable as well as the interconnectedness of the variables. They are not needed as much separately and individually; rather, it is the influence that each variable has on the other that influences either well-being and optimal development or illness and poor development.

The findings in relation to current services have again highlighted that there is an element of societal neglect which contributes towards the gaps in the current services that are offered to support vulnerable children. Implementing the biopsychosocial model may be problematic in the context of a lack of financial and human resources within the sectors of health, child protection and ECD. This is then made even more difficult in the context of high rates of unemployment and poverty which currently exist within South Africa and the Eastern Cape province. This element of societal neglect has a great influence on the development of vulnerable children if you are born into a family where despite trying, no

one is employed, and the only income is the CSG – your chances of optimal development are not great.

Here, the reality of unemployment, the low amount of the CSG and the few resources available to assist – factors determined at a societal level – will negatively influence the development of the vulnerable child. As one of the gaps in current services, the findings in this study have confirmed the lack of early childhood home-visiting programmes being implemented in the Eastern Cape province despite there being a great need for such programmes.

10.3.4 The roles and involvement of various disciplines

A multidisciplinary workforce is needed for the implementation of an early childhood home-visiting programme as the need of the vulnerable child and the risk factors that the child faces stem from across the biological, psychological and social spheres of influence. While it may be too costly to employ a fully qualified workforce of home visitors, supervisors and trainers, it may be possible to employ community members with experience in caring for vulnerable children or paraprofessionals, such as child and youth care workers, ECD practitioners, auxiliary social workers or community health workers, to work alongside professionals. Alternatively, it may be possible to work alongside stakeholders and role players who are already working with children or within communities.

These stakeholders or role players could be supported with training and may then decide to accommodate a home-visiting programme as part of the services they are able to offer to vulnerable children. Either way, before the home-visiting workforce is selected and the home-visiting programme implemented, the home-visiting workforce will need to receive training, which should be transdisciplinary in nature due to the risk factors they will need to assess and develop intervention plans for. While it may be too costly to employ a permanent multidisciplinary team for training the workforce, it may be possible to recruit an ad hoc multidisciplinary training team from those currently working with vulnerable children to train the home visitors on specific topics. This will ensure that the home-visiting workforce is well equipped with transdisciplinary knowledge to support vulnerable children towards optimal development. This builds on and extends beyond the multidisciplinary and team based approach adopted by the biopsychosocial model.

10.3.5 Guidelines for an early childhood home visiting programme

In light of the risk factors and gaps in current services, a home-visiting programme is needed and has many potential benefits for the young and vulnerable child. Such a programme will need to be well resourced in terms of support from stakeholders and role players, a well-trained workforce and sustainable funding to support a home-visiting workforce as well as to provide practical resources for vulnerable children and their caregivers. Rather than developing a detailed weekly programme or curriculum, the guidelines have developed practice principles for processes suggesting that a thorough assessment should be conducted with each child and caregiver, followed by an individual intervention plan due to the unique and complex risk factors faced by vulnerable children in the Eastern Cape province. Such an intervention plan may then include working with the community, extended family and caregiver to reduce risk factors while simultaneously building protective factors rather than following a specific ECD curriculum or weekly plan.

The guidelines that have been developed for the model of this home-visiting programme present have the potential to translate the biopsychosocial model from theory into practice principles and processes. These practice principles and processes facilitate both a multidisciplinary approach to the support offered to vulnerable children and a transdisciplinary approach to the training of the home-visiting workforce, through which the effective support of vulnerable children and their caregivers is made possible.

Additionally, the guidelines present practice principles that outline the processes needed for the development of a comprehensive resource list, an effective and efficient referral system and a local forum. These are all additional platforms that, if established, support the implementation of the biopsychosocial model, drawing service providers together through the work that they are doing with vulnerable children. The guidelines present processes for the monitoring and evaluation of the programme. There is currently a shortage of impact evaluations in the field of health, child protection and ECD. This programme model has the potential to contribute to this research and knowledge gap. The contribution of knowledge and research will, in addition, be transdisciplinary due to the nature of the work being done by the home-visiting workforce, which is compelled to stretch across the disciplines of health, social work and ECD if it is to effectively support vulnerable children towards optimal development.

10.4 Recommendations

This study has noted the scarcity of programmes that support the optimal development of vulnerable, young children in the Eastern Cape province, a largely rural and under-resourced province in South Africa. The study adopted an intervention research methodology to develop guidelines for a model of an early childhood home-visiting programme that supports vulnerable children, aged 0–2 years, in the Eastern Cape province. It is envisioned that this model will be of practical relevance to the fields of health, social work and ECD, strengthening the current services being offered. The following recommendations are made for social work practice, policy and legislation, the research process and future research.

10.4.1 Recommendations for social work practice

- There is a need for home-based programmes spanning from conception to 2 years of age to support responsible caregiving and a nurturing environment. These programmes are essential because of the brain development that occurs during this time. When risk factors are present, especially during (but not limited to) the first 1,000 days, intervention should be immediate. Specialised intervention plans should be developed, by social workers, in partnership with caregivers to simultaneously reduce risk factors and incorporate protective factors that then support the optimal development of the child. Such programmes will be more effective in supporting the vulnerable child than a set curriculum or 'one-size-fits-all' programme model.
- It is recommended that service providers work closely with one another and across disciplines to provide an integrated service to vulnerable children as soon as risk factors are suspected. Together with other service providers, social workers, have to make the shift to prevention and early intervention as damage done by ongoing exposure to risk factors during early childhood is difficult and costly to undo at a later stage. Home-visiting programmes, if structured to meet the unique needs of the vulnerable child and their family, offer an opportunity for social workers, to work with caregivers preventatively and as an early intervention. They should not be viewed as a last resort once the child has been exposed to ongoing risk factors over a prolonged period of time.
- Current service providers that offer services to support vulnerable children should be encouraged to meet, learn and work together. It is recommended that a

workforce made up of community members, paraprofessionals and professionals across the disciplines of health, social sciences and education should be harnessed to provide services to vulnerable children aged 0–2 years. Furthermore, it is recommended that the training of such a workforce should be transdisciplinary due to the interconnectedness of the biological, psychological and social variables during early childhood. Transdisciplinary training will equip the workforce to support caregivers and vulnerable children in achieving optimal development and good future outcomes. As a profession, social work is well positioned to initiate an interdisciplinary approach to such services and to initiate the training of a home-visiting aworkforce.

- Advocacy for a sustainable source of funding for prevention and early intervention programmes that support vulnerable children towards optimal development is needed. More resources are needed to implement such programmes effectively, and a diminishing source of funding from the government cannot be accepted. It is, therefore, recommended that stakeholders and role players, including social workers, be supported and encouraged to use advocacy, social action and litigation to hold government responsible for the implementation of its own legislation and policies that relate to children, and especially vulnerable children.

10.4.2 Recommendations for policy and legislation

The following recommendations are made with regards to policy and legislation:

- Government needs to allocate sufficient and sustainable funding for the implementation of policies and legislation that offer protection and support for vulnerable children. Gaps in the current services for vulnerable children can be addressed if the government begins to close the gap between policies and the funding needed to implement these policies. It remains government's responsibility to adequately fund a range of quality programmes across disciplines so that all vulnerable children can access such support. It is thus recommended that government take this responsibility seriously.
- It is recommended that government consider an increase in the CSG as the value of the CSG, currently R480 is below the amount needed to meet the basic nutritional needs of an individual. The temporary increase in the CSG during lockdown and Covid-19 proved valuable to caregivers in meeting the needs of

their children. In addition, SASSA should develop a mechanism for monitoring the use of the CSG so that abuse of the grant is minimised.

10.4.3 Recommendations relating to research process

- An intervention research design within an interpretivist paradigm and a qualitative approach has worked well in supporting the study towards achieving its overall aim and objectives. Such an approach is recommended for use in other studies that strive to inform social change and develop interventions that are contextually relevant.
- The biopsychosocial model proved relevant and significant as the theoretical framework for the study. It is recommended that this model be used in practice to firstly guide a multidisciplinary approach to services and, secondly, to enrich the theoretical knowledge base of programmes.
- Furthermore, it is recommended that the social domain of the biopsychosocial model be further developed to specify variables, such as the gap between policy and practice in terms of funding and resources, high rates of unemployment and poverty in the Eastern Cape province and the low monetary value of the CSG in South Africa, at a government and societal level. These variables within the social domain of the vulnerable child indicate a form of societal neglect that consistently prevents vulnerable children from achieving optimal development. As such, these variables should be specified within the biopsychosocial model.

10.4.4 Future research

It is recommended that future research be conducted on:

- Preventative and early intervention parenting programmes targeting the caregivers of vulnerable children. This will provide insight into other programmes that are effective in building protective factors and reducing the risk factors that vulnerable children are exposed to. These programmes may then be considered for implementation in the Eastern Cape province. Such research should seek the input of male caregivers whose participation in this study was challenging to elicit.
- Understanding the concept of societal neglect and the consequences thereof for the vulnerable child in South Africa.
- Using the biopsychosocial model to strengthen a multidisciplinary approach for implementation by professionals when offering services to vulnerable children.

- Increasing the cash amount of the CSG so that it is able to meet the basic needs of vulnerable children.
- Developing a system to manage the misuse of the CSG.
- Home-visiting programmes in other provinces of South Africa and the Southern African Development Community (SADC) region as this may provide valuable insight into how these programmes are implemented, the workforce that is used and the training that is provided to the workforce.
- The impact of non-centre-based early childhood programmes on outcomes for vulnerable children. Such studies may assist in monitoring and evaluation, securing sustainable funding as well as advocacy for the importance of early childhood programmes that are preventative in nature.
- The role of advocacy and litigation in securing sustainable funding from government for quality early childhood programmes that support vulnerable children.

10.5 Limitations of the study

The following limitations were encountered in this study:

- The study was conducted in the Eastern Cape province, with a limited number of participants. Although purposive sampling allowed for rich and diverse narratives from participants, the geographical location of the study and the small number of participants indicate that findings should be generalised with caution.
- A larger sample of caregivers, may have given caregivers a stronger voice in the study. In addition the participation of male caregivers in the study was a challenge. However, due to the complexities of Covid-19 and numerous lockdown levels prohibiting more than one caregiver to access essential services and prohibiting group gatherings, it was not possible to increase the number of caregiver participants or to access male caregivers. While this does not undermine the study, again findings should be generalised with caution.

10.6 Conclusion

This aim of this study was to develop guidelines for a model of an early childhood home-visiting programme that supports the optimal development of vulnerable children aged 0–2 years in the Eastern Cape province of South Africa. This was done using an intervention research design that comprised of three phases: explanatory research,

conceptualisation and programme design. The findings support that the biopsychosocial model is of critical importance for optimal development during early childhood and that it is influential in shaping a multidisciplinary approach to services, and a transdisciplinary approach to the training of a home-visiting workforce. The interpretivist paradigm and qualitative approach adopted by the study assisted in answering the study's research questions and, consequently, in the development of guidelines for a model of an early childhood home-visiting programme that can be implemented to support vulnerable children.

The study has broadened the understanding of the risk factors that vulnerable children continue to be exposed to as well as the current gaps in support offered to vulnerable children, both of which continue to have detrimental consequences for these children. In addition, the study holds promise for practice in health, social work and ECD, presenting guidelines for a model of an early childhood home-visiting programme that is preventative, focused on early intervention and both multidisciplinary and transdisciplinary in nature.

Chapter 10 has summarised the major findings of the study and drawn conclusions in relation to each of the study's five objectives. The chapter has made recommendations for practice and for future research. Lastly, the chapter presented the limitations of the study and concluded, bringing the study to an end.

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APPENDIX A: UREC ETHICAL CLEARANCE

University of Fort Hare
Together in Excellence

ETHICS CLEARANCE
REC-270710-028-RA Level 01

Project Number:	TAN011SSCH01
Project title:	**Contextually - based early childhood home visiting programme model for vulnerable children in the rural Eastern Cape of South Africa.**
Qualification:	PhD in Social Work
Student name:	Kim Schmidt
Registration number	201113886
Supervisor:	Prof P.T Tanga
Department:	Social Work
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby grant ethics approval for TAN011SSCH01. This approval is valid for 12 months from the date of approval. Renewal of approval must be applied for BEFORE termination of this approval period. Renewal is subject to receipt of a satisfactory progress report. The approval covers the undertakings contained in the above- mentioned project and research instrument(s). The research may commence as from the 25/03/21, using the reference number indicated above.

Note that should any other instruments be required or amendments become necessary, these require separate authorisation.

Please note that UREC must be informed immediately of

- Any material changes in the conditions or undertakings mentioned in the document;
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The student must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

UREC retains the right to

- Withdraw or amend this approval if
    - Any unethical principal or practices are revealed or suspected;
    - Relevant information has been withheld or misrepresented;
    - Regulatory changes of whatsoever nature so require;
    - The conditions contained in the Certificate have not been adhered to.

Request access to any information or data at any time during the course or after completion of the project.

Your compliance with Department of Health 2015 guidelines and any other applicable regulatory instruments and with UREC ethics requirements as contained in UREC policies and standard operating procedures, is implied.

UREC wishes you well in your research.

Yours sincerely

Professor Renuka Vithal
Chairperson: University Research Ethics Committee
08 April 2021

APPENDIX B: CMH/FRERE ETHICAL CLEARANCE

EASTERN CAPE PROVINCE

DEPARTMENT OF HEALTH ISEBE LEZEMPILO

CECILIA MAKIWANE AND FRERE HOSPITALS RESCARCH ETHICS COMMITTEE

DEPARTMENT OF INTERNAL MEDICINE

PRIVATE BAG X 9047

EAST LONDON

5200

Enquiries:

Assoc Prof AG Parrish

Cell: 082 5765930

E-mail: andygp@mweb.co.za

30 March 2023

Protocol Title: Contextually - based early childhood home visiting programme model for vulnerable children in the rural Eastern Cape of South Africa.

Protocol Reference Number: FCMHREC/A081/2021

Protocol Status: Approved

To Ms K Schmidt

Dear Kim

The FCMHREC has reviewed the above amended application. The proposed study takes the form of series of structured interviews, and as such does not entail substantial clinical risk. Compliance with standards of Good Clinical Practice in terms of anonymizing information and data security are still essential in terms of collection, storage and publication of results.

Explanation of protocol status: 'approved' – the study may proceed with the conditions listed below; 'amendments required' – the suggested amendments are needed before the study will be approved and in the interim the study may not proceed; 'study not approved' – the study protocol was felt to contain substantive issues which will be spelt out below and the study may not proceed.

Period of approval: one year from the date of this letter. At the end of the approval period, please notify the committee of the status of the project (completed, discontinued or need for a further approval period). Also notify the committee at completion of the project on how you intend to feedback results to the local clinical and/or patient community.

Conditions of approval: Please inform the FCMREC if any of the following occurs: proposed protocol changes; serious or unexpected adverse events; unforeseen events that may affect the continuing ethical acceptability of the project.

Please note that the clinical governance structure of the institution(s) in which you intend to perform this study still need to be contacted both for permission to work within their clinical domain, and also so that they are aware of your activity on site.

Yours sincerely

Assoc Prof AG Parrish

MBChB, DA(SA), MMed(Med), MMedSci, FCP(SA)

Chair, CMH and Frere Ethics Committee

APPENDIX C: INTRODUCTORY LETTER TO PARTICIPANTS

Request for Permission to Conduct Research[1]

Dear

My name is Kim Schmidt, a Social Work PHD student at the University of Fort Hare. The research I wish to conduct for my Doctoral thesis involves the development of a contextually based early childhood home visiting programme model for vulnerable children in the Eastern Cape.

I am hereby seeking your consent to participate in a semi-structured interview. Your participation will provide valuable insight into the needs of vulnerable children, the support they currently receive, the different disciplines that are involved in service rendering and the guidelines needed for an early childhood home visiting programme model that supports vulnerable children in the Eastern Cape. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the University of Fort Hare Research Ethics Committee (UREC).

If you require any further information, please do not hesitate to contact me at 082 494 8780 (cellular number) or kschmidt@ufh.ac.za (email address) and/or supervisor, Prof P.Tanga at 0**67 388 7599** or ptanga@ufh.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

Kim Schmidt

University of Fort Hare

APPENDIX D: LETTER TO PARTICIPANTS

INDIVIDUAL INFORMATION SHEET AND INFORMED CONSENT FORM[1]

(AGES 18 YEARS AND ABOVE)

Title of Study: CONTEXTUALLY BASED EARLY CHILDHOOD HOME VISITING PROGRAMME MODEL FOR VULNERABLE CHILDREN IN THE EASTERN CAPE OF SOUTH AFRICA

Dear participant,

My name is Kim Schmidt and I am studying and working at the University of Fort Hare. I am conducting social work research that aims to understand the needs of vulnerable children, aged 0-2 years, who reside in the Eastern Cape of South Africa in order to develop a model of an early childhood home visiting programme that supports optimal development. Such research will add knowledge to the fields of social work, vulnerable children and early childhood, perhaps generating knowledge that is transdisciplinary in nature. Secondly this research will have practice importance as it will provide guidelines for a home visiting programme model, one of the ECD programmes that is highlighted in the NIECD policy and the Children's Act as being important in supporting the optimal development of vulnerable children.

We would like you to allow us to conduct a brief semi-structured interview, of about 45 minutes, with you about the work that you do with vulnerable children and the guidelines that you think are needed for an early childhood home visiting programme model that will support vulnerable children to achieve optimal development. This study has adopted an approach that values multiple and subjective perspectives of individuals and community participants in developing a model that is suited to the specific needs of the community. Intervention research which is the research design that has guided the study has grown in importance over the last few years and is being

used to inform social change, solve real-life challenges and to guide programme development all of which are crucial in current day South Africa.

Some questions may be of a personal and/or sensitive nature and I may be asking some questions that you may not have thought about before. We know that you cannot be absolutely certain about the answers to these questions, but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers.

Please understand that **your participation is voluntary,** that you are not being forced to take part in this study. The choice of whether to participate or not, is yours. However, we would really appreciate it if you do share your thoughts with us. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

The information will remain confidential. This means that your name and address will not be linked in any way to the answers you give. We study and report on the answers given by all the people we interview and not on an individual basis. The research data will be anonymous – with all personal respondent information removed and will be archived at the University.

At the present time, we do not see any risks in your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

There are no immediate benefits to you from participating in this study. However, this study will be helpful in finding out more about the needs of vulnerable children, the services currently being offerred to support vulnerable children and in developing a home visiting programme model suited to support vulnerable children in the Eastern Cape during early childhood.

Who to contact if you have been harmed or have any concerns

This research has been approved by the Inter-Faculties Research Ethics Committee (IFREC) as per delegated authority of the University Research Ethics Committee (UREC). If you have any complaints about ethical aspects of the research or feel that

you have been harmed in any way by participating in this study, please call the IFREC Administrator, Uviwe

Reporting and Complaints

If you have questions at any time about this study, or if you have concerns/questions you may contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the researcher/project leader, please contact the IFREC Chairperson, Prof. Simatele on msimatele@ufh.ac.za or the UREC Chairperson, Prof. Renuka Vithal on rvithal@ufh.ac.za.

If you have concerns or questions about this study please feel free to contact the project coordinators:

Researcher:

Name: Ms Kim Schmidt

Department: Social Work and Social Development

Address: 50 Church Street, East London

Phone: 082 494 8780

Email: kschmidt@ufh.ac.za

Supervisor:

Name: Prof Tanga

Department: Social Work and Social Development

Address: 5o Church Street, East London

Phone: 078 448 9611

Email: ptanga@ufh.ac.za

APPENDIX E: SIGNED CONSENT

I *(name of participant)* ……. have been informed about the study by *Kim Schmidt.*

I understand the purpose, procedures, and risk-benefit ratio of the study.

I have been given opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any procedurals that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as result of study-related procedures

I understand that I will be given a copy of this informed consent.

I understand that if I have any questions or complaints about my rights as a study participant, or if I may have concerns about any aspect of the study or the researcher/s then I may contact the Chairperson of the Inter-Faculty Research Ethics Committee, Prof. Pumla Gqola or Chairperson of University Research Ethics Committee, Prof Renuka Vithal (details available from the Researcher or by contacting the University of Fort Hare or Website www.ufh.ac.za)

Participant **signature**:
……

Consenting for Audio Recording– when necessary

YES / OR

Participant **signature**:
……

Data curation – I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage.

Participant **signature**:
……

Date: ……

APPENDIX F: DEMOGRAPHIC DATA AND INTERVIEW SCHEDULES FOR PROFESSIONALS

Thank participants for participating.

Discuss letter informing participants of the study.

Discuss informed consent and confidentiality and participants to sign form.

Overall goal of the study:

The overall aim of the study is to understand the needs of vulnerable children, aged 0-2 years, who reside in the rural Eastern Cape of South Africa in order to develop a model of an early childhood home visiting programme that supports optimal development.

Biographical data of professionals

Age of participant: _____
Gender of participant: _____
Qualifications: _____
Place of employment: _____
Number of years in current employment: _____
Years of working experience with young children: _____
Any experience in working with young children and their caregivers through a home visiting programme model? _____
_____

Semi – structured interview questions

Section one: Needs of vulnerable children in the EC

1) Please tell me about the work that you do with vulnerable children.
2) In your opinion what is needed for children 0-2 years to develop optimally?
3) In your opinion, if these needs are met what impact will this have for the child?
   Probe for information relating to the impact for:
   10.1) the child's biological development
   10.2) the child's psychological development
   10.3) the child's social development
11) In your opinion, if these needs are met what impact will this have for:
   11.1) The child's family
   11.2) The community
   11.3) The government/ the country/ society
12) Could you describe some of the most common vulnerabilities that you identify when working with these children and their caregivers? Please explain.
   Probe for vulnerabilities relating to:
   12.1) poverty
   12.2) disrupted caregiving
   12.3) nutrition
   12.4) chronic or infectious diseases
   12.5) maltreatment
13) What do you think are some of the consequences for the child when they are exposed to risk factors and their needs are not met during early childhood?
   Probe for information relating to effect on the child's:
   13.1) biological development
   13.2) psychological development
   13.3) social development
14) What do you think are some of the consequences for others when the child is exposed to these risk factors and their needs are not met during early childhood?
Probe for information relating to consequences for the:
   14.1) family
   14.2) community
   14.3) country, government and society

Section two: Current support being offered to vulnerable children in the EC

15) Could you share any of the ways in which these vulnerable children are currently being supported by you/ your place of employment in the rural EC?
Probe for support offered at/by:
15.1) Individual level
15.2) Family level
15.3) Community level
16) How does this support ensure optimal development of the young child?
Probe for information relating to
16.1) biological factors
16.2) psychological factors
16.3) social factors

17) Have you ever heard of or been a part of other programmes outside of your place of employment that supports vulnerable children in the EC?
Probe for information relating too:
17.1) Who was running the programme?
17.2) How was the programme delivered to vulnerable children (centre or non-centre based)?
17.3) What content was covered in the programme?
Probe for:

- content relating to providing nurturing and responsive care for the child
- ensuring good health and nutrition for the child
- accessing safe and quality learning opportunities for the child you are caring for

17.4) How was the programme funded?
17.5) How was the programme monitored and evaluated?
17.6) What were some of the challenges experienced?
17.7) What were some of the successes?

Section three: Involvement and role of other professionals, para professionals or non professionals in a home visiting programme for vulnerable children

18) Could you share about some of the other professionals that you work with as you support vulnerable children?
19) Who are some of the professionals you feel should be more involved in programmes for vulnerable children and what would the extent of their involvement need to be?
20) In your opinion who are some of the professionals you feel should be more involved in a home visiting programme for vulnerable children and what would the extent of their involvement be?
Probe for information about:

- Professionals or paraprofessionals? Why? Pros and cons?
- If paraprofessionals how would they be recruited and selected?
- If paraprofessionals what training would they need to be given or have?
- If professionals who should these professionals be?
- Who should supervise the programme?
- How will facilitators of the programme be supported and supervised?
- How will facilitators once recruited and trained be retained?
- Who should fund the process of recruitment, selection, training and supervision of the facilitators?

Section four: Guidelines for a home visiting programme model

21) What are your thoughts around a home visiting programme that supports vulnerable children?
22) Do you have any suggestions/ ideas for a home visiting programme that supports vulnerable children here in the Eastern Cape?
23) What services should be delivered? (content to be covered, length and duration of programme)
24) How should these services be delivered? (individual, family, group based, combination)
25) How should funding work? (Who should pay and how do we make funding sustainable)
26) What principles do you think will support success of the programme?
27) What could be the risk factors for the programme not being successful?
28) How should the programme be evaluated?
29) How could the impact of the programme be monitored?

Thank you for taking the time to participate in this study. It is truly appreciated.

APPENDIX G: DEMOGRAPHIC DATA AND INTERVIEW SCHEDULES FOR CAREGIVERS

Thank participants for participating.

Discuss letter informing participants of the study.

Discuss informed consent and confidentiality and participants to sign form.

Overall goal of the study:

The overall aim of the study is to understand the needs of vulnerable children, aged 0-2 years, who reside in the rural Eastern Cape of South Africa in order to develop a model of an early childhood home visiting programme that supports optimal development.

Biographical data of caregivers

Gender of caregiver: _____
Age of caregiver: _____
Education level of caregiver: _____
Years of experience in caring for young children: _____
Relationship of caregiver to child: _____
Age of child: _____
Special needs of child: _____
Number of children in the home: _____
Ages of these children: _____
Source of household income and amount: _____
Does household income meet basic needs of child? _____

Semi – structured interview questions

Section one: Needs of vulnerable children in the EC

12) Please describe your experience of caring for your young child?

13) What are some of the challenges that you have faced in caring for your young child?

Probe for:
Have you had any challenges relating to poverty? Please explain
Have you had any challenges relating to disrupted caregiving? Please explain
Have you had any challenges relating to nutrition? Please explain
Have you had any challenges relating to chronic or infectious diseases? Please explain
Have you had any challenges relating to maltreatment? Please explain.
14) As a caregiver please describe the support you need with regards to the following:
14.1) providing nurturing and responsive care for the child you are caring for
14.2) ensuring good health and nutrition for the child you are caring for
14.3) accessing safe and quality learning opportunities for the child you are caring for

Section two: Current support being offered to vulnerable children in the EC

15) Could you describe any support you have received since you became a caregiver to your young child?
15.1) How have you been supported by your family?
15.2) How have you been supported by the community?
15.3) How have you been supported by NGOs or the government?
16) Do other young children in the community presently receive any type of family, community, NGO or government support? Please elaborate
17) Have you ever heard of or been a part of a home visiting programme that supports children and their caregivers here in your community? Please explain.

Section three: Involvement and role of other professionals, para professionals or non professionals in a home visiting programme for vulnerable children

18) If you think of the needs of your child and your own as a caregiver, who are the different people that you think would be able to provide you will the support that you need?
18.1) How would you feel about receiving support from someone within your family?
18.2) How would you feel about receiving support from another community member? Would you want this community member to have any training? If yes, what sort of training? If no, why not?
18.3) How would you feel about receiving support from an ECD practitioner, social worker, nurse or another professional employed by a NGO or the government and trained to work with vulnerable children?
19) What kind of support would you like to receive from the different groups identified above?
20) What are your thoughts around a home visiting programme that supports vulnerable children?
21) In your opinion who out of the groups identified above would be best to offer such a programme to you and your child in your home?

Section four: Guidelines for a home visiting programme model

22) What sort of programme do you think you and other caregivers with young children would like to receive or would find helpful as you care for your children?
23) What areas of content should be covered in such a programme in relation to:
24) How often do you think caregivers should have access to such a programme? Please explain.
25) Do you have any suggestions/ ideas for a home visiting programme that supports vulnerable children here in your community? Please explain.
26) Who do you think should manage this programme? An NGO or the government? Please explain.
27) What do you think might be some of the challenges with a home visiting programme?
28) What do you think some of the benefits of such a home visiting programme may be?

Thank you for participating in this interview and for sharing your views and opinions. It is truly appreciated.

APPENDIX H: DRAFT GUIDELINES WITH COMMENTS FROM CONSENSUS WORKSHOP

Table with input from panel of experts on draft guidelines for an early childhood home visiting programme model

Practice principle	**Process**	**Sample of comments from consensus workshop**
Advocacy with stakeholders and role players	Engagement of stakeholders and role players for the dissemination of findings	Stakeholders and role players should be informed of findings and proposed guidelines (P16). Stakeholders are people who have a stake in the thing and they need to give their blessing, like Home Affairs, DoBE, DSD, Local Economic Development, the municipalities and environmental health people (P17) If advocacy is going to be something which is an actual practice that advocatcy need to happen then maybe it would be good to put it in from the outset as a separate thing (P17). I agree (P5).
	Social marketing of programme before implementation	There needs to be a an introduction before you recruit for the training, explaining what the programme is and the purpose of the home visiting programme (P17) I agree. It does make sense (P16). Role players are the organisations who are actually going to do something with this, whoever is in the programme, and then you need to have role players who are going to do the training (P17).
Recruitment and selection of home visiting workforce	Recruitment of multidisciplinary team to attend home visiting training	Agreed and utilising of existing organisations to curb the duplication of services (P8). Name the team and where they will be recruited from (P11). I think that is a good idea (P17). Can we add child and youth care workers? (P4). That is super I think moms themselves are very powerful, mothers and fathers actually (P17). Another place which might be quite useful, I am just thinking of people who qualified, ECD practitioners with an NQF level 4 and 5 is maybe somebody to add in there as well (P17). To add to the list I was thinking foster care mothers, usually there are mothers where social workers usually place vulnerable children (P16). How are we going to choose these home visitors, I think the issue of values and how they behave when they are in the community, they cannot visit the homes when they are drunk (P8).

	Training of home visitors and supervisors	The protocol needs more detail in who and how it will run (P11). We may invite agriculture to train the home visitors and to attend the training (P16). We may invite home affairs to train the home visitors (P16) If we can invite the DOBE to explain how they work (P4). There are so many midwives around that are doing nothing, they would make excellent teams (P5). I totally agree with this (P4).
Contents of training programme for the home visiting workforce	Values and relationship building skills	Excellent ideas especially around our values and approaches to children and their upbringing (our roles and their roles) (P17). We cannot do without confidentiality (P4). I am happy with this as everything starts with communication (P5).
	Assessment of protective and risk factors	I agree. You can list them (P5). Add more detail regarding the protective and risk factors that are of relevance in the context of the Eastern Cape so we really need to add substance abuse (P4) Develop a checklist as an assessment tool (P5) Things are very hard for people and its useful to have these things in detail (P17)
	Planning for intervention	Very good, really no story will be the same and I like the home context of the programme (P11) I think it is very wise to do that. Every household is so unique you have to be able to apply and make a plan (P17). Drawing from a Wikipedia that each person would have of what is possible (P17). (vs set rigid programme for intervention) Very nice to do that and that we are flexible about and focused on the family, unique and individual (P17). I am fine with this strategy because really when you speak of programme the programmes tend to take a blanket approach this one has accommodated children's vulnerability, the interventions are also going to be suitable because the context is not the same, it is different, needing now a tailor made approach and intervention. I think I like the strategy (P16). With the tailor made intervention, I think that goes a long way in building rapport with the mommy and the child and the whole family because it is focused on them, it will build their confidence (P5).
	Knowledge of community resources	This may be a problem. In my experience there are just not enough of those reasources or some are really not good (P11).

		Need to develop a list of resources for home visiting workforce to work from and to share with local networks as one simply does not exist presently (P6). Eastern Cape is completely different (when it comes to recources) (P17). Wouldn't it be important to have an asset register then write down all of the community resources and how to access them so they are readily available for the various home visitors (P5). I am thinking that maybe BCM will have wom knowledge of that because you have to register all ECD programmes (P17).
	Safety measures and self-care	Great, very important (P11). I am happy from my side (P4). I am also happy (P16). SO the home visitor doesn't go on their own, if that makes sense in terms of the security and safety as well (P6).
Implementation of the programme	Programme funding should be intersectoral and sustainable	Agreed. Will cost a lot so a very good fundraising team will be needed (P17). Wise to focus or say this is BCM (P17). I agree (p17). Get the course accredited so that a certificate is a real draw card, as well as food parcels if you have volunteers (P17). I think that's a really good idea, having a combination of volunteers and sort of employed people (P6). I would suggest that you really have a dedicated person to this (P5). It is a good idea to see if you can get the programme through Fort Hare at least for further research (P17). I think it would be great (P17).
	Setting up of an comprehensive multidisciplinary referral system from all stakeholders to the home visiting programme, so that programme can be focused on prevention and early intervention services	More detail needed here (P11). A wottsapp referral system may work (P17). Say for example a mom gives birth and they go hoem and they feel like they need, you know nobody is referring the home visitor to them but they really feel they need it, is ther a platform for them to get hold of or apply? (P6). You know in the clinics or the birthing centres having posters and forms that moms can almost sign up immediately (P6).
	Duration and frequency of home visits	Yes it makes sense (P5). Its okay (P4).

	Home visitors implementing programme from engagement and assessment through to intervention and evaluation	We are in agreement (P5).
	Supervisors provide supervisory support to home visitors and are responsible for continued networking and advocacy with stakeholders and role players locally and at a societal level	More detail needed in terms of who the stakeholders and role players are and will be and advocacy and engagement should be first practice principle and then should be continued by supervisors (P17).
	Multidisciplinary team of trainers providing comprehensive and ongoing training	I am happy with this Kim, I am happy (P4) Agreed (P17). This would also help with self-care and debriefing (P6).
	Development of a forum	Such an important point (P11). I am happy kim because also that's what we are doing in the site in GOnubie area. We'v got the CPF wherby all NPOs that are working in the community we do meet and discuss so yes that would be great (p8).
Monitoring and evaluation of the programme	Qualitative evaluation consisting of caregiver, community and home visitor feedback, both written and verbal	What funders like to know is the reach. SO that means having a system of registers, you know attendance so that forms a part of the quantitative (P17). Yes agreed (P6). Yes I agree (P4).
	Quantitative impact evaluation monitoring hospital readmissions, reports to child protection agencies, weight and growth, access to ECD centres and age appropriate development	I immediately get excited to do a study about how many children are malnourished, TB exposed and not worked-up for infection, properly immunised, dewormed and how that hopefully changed after a year of the program running (P11). This is the next big thing that would be very useful from a fundraising as well as a societal point of view to be able to speak to the impact on the systems with which the child is engaged (P17). Monitoring and evaluation is digital now, can use cell phones to link into a big data base that is the best way forward including photographs where the POPI Act allows it (P17).