

#LOVEPLAYTALK
MY CHILD IS A SOMEBODY



ilifa
LABANTWANA

Insights

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Parenting

Lessons for **ECD** from Parenting Interventions in South Africa





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Editor's Letter

“It is easier to build strong children than to repair broken men.”

- FREDERICK DOUGLASS

This building process starts at conception and much of a child's strength is determined by the time she is six years old. This period of development, from conception to six, lays the foundation for lifelong health, wellbeing and education.

South African policy and legislation affords children special care and protection, recognising their vulnerability and their enormous potential. This policy intent translates into a range of essential services, including healthcare, nutrition, social support, and early learning stimulation – with provisioning aimed at the most vulnerable children in society.

While essential, these services form only the very outer circle of support around the child. Within the state's support mechanism is the community the child belongs to and within that band of support is the family unit – the most immediate level of influence during the child's most important development years. At the nucleus of these concentric support circles is the parent – or the primary caregiver – and her child. Sociology defines this relationship as a dyad, from the Greek word for two; it is the smallest possible social group and the first one we belong to upon birth.

Nurturance, security, stimulation and love delivered through the parent-child dyad is where early childhood development begins. At Ilifa, we refer to this as the “ordinary magic” through which parents and primary caregivers impart to their children the gifts of imagination, language, social cohesion, curiosity and understanding of the world.¹

The social structures around the parent-child dyad, however, are of profound importance because the support, or in adverse instances the neglect or hostility they give, will affect the ability of the parent to nurture her child, impacting the quality of the relationship between them, and consequently the development of the child.

In this Ilifa Insights, we explore the relationship between the parent – or the primary caregiver – and the child, within the context of these concentric circles of influence. Our implementing partners each discuss the ways in which their interventions attempt to mitigate the adverse environmental influences directed at the parent and the impact this has on her relationship with her child and the child's development.

Neuroscientist **Barak Morgan** explains the effects of **the adverse external environment on the architecture of the brain**, and the impact of interventions on caregivers' brains, and their consequent behaviour.

One of the clearest applications of Morgan's theory is seen in the article describing **Sinuvuyo's Caring Families Programme** – a direct intervention aimed at changing punishment-based parenting behaviours.

Philani's Mentor Mothers programme, which was implemented in Khayelitsha and other

Cape Town informal settlements, clearly evidences the impact of increased support for the primary caregiver.

In the case of families with children with disabilities, especially those who live in remote and poor areas of the country, the parent-child dyad faces additional stress and, in many cases, outright hostility.

The article describing **Ilifa's inclusion work in KwaZulu Natal** identifies the need for, not only direct caregiver support, but also for advocacy to combat the stigma around disability.

The circles of influence are explored in the article detailing **Ilifa's home visiting programme in the North West**, which relies heavily on community support – through the Family & Community Motivator programme – for its efficacy.

And finally, Ilifa partner **dlananathi** has developed a **First 1 000 Days Relationship Support Tool Ibhayi Lengane**, designed to be implemented in the form of an “add-on” to existing home visiting programmes, and aimed at encouraging activities which strengthen the parent-child relationship in the first 1 000 days of the child's life. Dlananathi's account of the tool is given in the context of the parent's most immediate circles of influence.

We hope you enjoy the read and welcome your input via email to lisa@ilifalabantwana.co.za or svetlana@ilifalabantwana.co.za

Lisa Cohen
Parenting Portfolio Manager

“A parent is a parent to all children”

Sinuvuyo parent skills training programme participant (page 8)



ILIFA LABANTWANA is a national programme, initiated and supported by a donor partnership, that aims to provide implementation evidence, build national capacity and galvanise informed political support for the provision of quality ECD services at scale, focusing on the poorest 40% of children under six. The donor partners include the ELMA Foundation, the DG Murray Trust, the First Rand Foundation and the UBS Optimus Foundation.

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A word on our strategy

Through Phase II (2013-2016), Ilifa Labantwana aims to provide evidence that is based on actual experience of implementation and careful evaluation, to build consensus and mechanisms to scale up appropriate and cost-effective ECD services and support for young children in South Africa.

Phase II	Provide implementation evidence. Put forward mechanisms for scale. Build consensus on what needs to be done and how to do it.		
Focus	ECD information access and use	Systems development and optimisation to support implementation	Engaging the public
Goals	Population-based ECD targets are set and used by government for planning purposes	<ul style="list-style-type: none"> • Delivery models: Evidence of what ECCE implementation models work and how these can be scaled • ECD regulation: Efficient and effective systems • ECD funding: Increase in funding and improvement in funding mechanisms • HR systems: HR capacity and systems to sustain programmes 	Increased public demand for ECD services Increased understanding of the role of caregivers in the first 1 000 days
Focus area	Engagement and capacity-building with government		
Goals	<ul style="list-style-type: none"> • Improved capacity at provincial and district levels for ECD management and oversight • ECD-related laws and policies create a more enabling eco-system 		

The programmes outlined here form part of our work in systems development and optimisation, with the aim of generating evidence of what early childhood care and education (ECCE) models work and how these can be scaled.

Over the past year we have engaged partners in the implementation of five models:

1. A **Relationship Support Tool** to assist home visitors to strengthen maternal-child relationships (page 26).
 2. A **home visiting Family & Community Motivator programme** (FCM) targeting children aged 0-6 years and pregnant women (page 23).
 3. **Playgroups** for children aged 3-4 years, implemented through the Community Work Programme – this model is not highlighted in this publication, visit www.ilifalabantwana.co.za for more information.
 4. **ECD centre** enrichment – this model is not highlighted in this publication, visit www.ilifalabantwana.co.za for more.
 5. Inclusive **ECD hubs** serving local municipalities (page 18).
 6. Philani’s Mentor Mothers **maternal and child health home visiting model** (page 14).
 7. The **Sinovuyo Caring Families Project** (page 8).
- For each of these delivery models, Ilifa aims to document programme outcomes, costs, coverage and systems fit and, where appropriate, to develop implementation manuals to support replication by the end of Phase II.
- In addition to the above, Ilifa has been supporting research to assess child outcomes on two other parenting interventions:
- Ilifa’s work on increasing public understanding around the role of the caregiver in the first 1 000 days is demonstrated by the **#LovePlayTalk** multi-media campaign (page 28).



Too great expectations? Moving beyond the core story of brain development

Recent scientific discoveries in brain development are reshaping our understanding of early childhood development. BARAK MORGAN explains the concepts of behavioural and neural plasticity in the context of parenting interventions.

We now know more about the early childhood development phase than we ever have. What makes recent findings so compelling are the enduring and largely irreversible ways in which adverse social conditions are biologically woven into the brain, with negative consequences for health and socio-economic outcomes in later life. This insight is known as the core story of brain development.

In general, adverse early childhood social environments, such as violence,

poverty and insecurity, steer brain development on trajectories that support “survival” behaviours – behaviours adapted to surviving in these harsh environments. On the other hand, favourable early childhood social environments steer brain development on trajectories that support “thrive” behaviours – behaviours adapted to making the most of favourable conditions. Broadly speaking, to survive in harsh environments depends upon quick automatic reactions: fight, flight and freeze behaviours which stem from

deep in the brain. Harsh environments do not offer the luxury of stopping to think too much. Conversely, survival in favourable, yet far more complex and nuanced social environments, requires reflective thinking and future planning. These functions stem from the neocortex, which also keeps control over the deep, reactive parts of the brain.

Brain development becomes deeply biologically embedded in two contrasting brain architectures. The first is known as top-down, and

is characterised by the neocortex in command; the second is known as bottom-up, and is characterised by the subcortex in command. The process of development of either architecture occurs during early childhood because that is when neuroplasticity is highest (Figure 1).

Environmental impact on the brain's development

Figure 2 illustrates how different early environments influence brain development. The developmental

landscape in A and B is identical, but differing environmental influences (not shown) at key time points, illustrated by wherever valleys divide into two, steer development down different trajectories. Once in a valley, the steep walls make it very hard to change course and there is no going back.

Behavioural plasticity means that where valleys divide, there are already neural circuits in the brain capable of going left or right. These circuits are waiting for the environment to steer behaviour one way or the other. Once this decision is made, the circuits supporting the chosen behaviour will strengthen and those in the forsaken valley will weaken. This results from *neuroplasticity*, which means that circuits which are used grow stronger and circuits which are not used grow weaker. The depth of the valley represents the depth to which neuroplasticity has caused "the environment" (that is the behavioural trajectory selected by the environment) to become biologically embedded and difficult to change.

This is how favourable and adverse early social environments guide brain development along contrasting top-down (positive) and bottom-up architectures. The former is adaptive in nurturing environments and the latter is adaptive in threatening environments.

Parental investment strategies

Adverse environments also steer early brain development towards a "quantity over quality" adult reproductive strategy (having more children with less parental investment per child), while favourable environments steer brain development towards a "quality over quantity" adult reproductive strategy (fewer children with more investment per child).

The former strategy makes sense when the chances of losing a child are high and where children who do reach

adulthood will need only basic life-skills to survive. The latter strategy makes sense when almost all children reach adulthood and enter a complex world where far more sophisticated skills, which require significant parental investment to acquire, are needed to succeed.

A paradox

The social significance of the core story of brain development is that caregiver/child relationships have the power to mediate the influence of the greater social environment in steering early brain development in one direction or another. Building adults' capacities to engage children in high quality, nurturing relationships is therefore of decisive importance.

But if the core story is correct, how can adults who experienced early social adversity, which steered their brains along survival and limited parental investment trajectories, establish and maintain quality nurturing relationships with children? At the same time we *know* that psychosocial interventions *can* change adult behaviour in ways which enhance nurturing relationships and increased caregiver investment per child.

Is the core story wrong? Does an intervention, in fact, work by pushing the adult brain up and over into the next valley? Clearly not, even low-intensity interventions change caregiver behaviour far too quickly for such big structural brain changes to occur.

The solution to this paradox lies in *behavioural plasticity*. A change in social environment can unlock nurturing behaviours which were not evident, simply because the environment kept the underlying circuits locked away in the brain. Changing the environment in the right ways can unveil *latent* nurturing behaviours one might not have suspected were there.

But where do these latent nurturing behaviours come from? How does it suddenly seem possible to go back

"There are domains where behavioural plasticity remains high even after brain and behaviour have seemingly become deeply embedded along one valley. Parental investment is one of these domains."

in time up a long, deeply embedded valley to the point where the road forked and behavioural plasticity was once high?

The answer is that there are domains where behavioural plasticity remains high even after brain and behaviour have seemingly become deeply embedded along one valley. Parental investment is one of these domains. Countless psychosocial interventions demonstrate that the neural pathways for both low and high investment remain available. This is because these pathways are easily switched on or off by simple hormonal signals which are very sensitive to social environment. No major brain rewiring or effort is necessary to activate these unused neural pathways. In short, Figure 1 does not apply here.

Beyond the core story of brain development

The core story of brain development emphasises how early social adversity and neuroplasticity conspire to biologically embed brain architectures that result in socially undesirable long-term behaviours, which are very difficult to reverse. In contrast, this article highlights an abundance of behavioural plasticity in the domain of parental investment, which the core story of brain development implies should

not be there.

The good news is that adult investment in nurturing relationships with children can increase much more readily than the core story suggests. The challenging news is that a shift in adult behaviour from a psychosocial intervention is unlikely to endure if psychosocial conditions change back again. This implies that psychosocial interventions must be sustained if behavioural change is to be sustained.

It is tempting to conclude from the core story of brain development that the physical, psychological, social and economic wellbeing of individuals, families, communities and nations all hinges around the quality of adult-child nurturing relationships. But unlocking latent behavioural potential in adults for greater caregiver investment requires a greater social environment that not only unlocks but also *keeps* these highly plastic, readily reversible behaviours unlocked.

This analysis does not in any way question the need for psychosocial interventions with proven efficacy, but rather serves to place caregiver behaviour in its broader biopsychosocial context. Behavioural plasticity challenges any expectations, *that if we can just get parental investment during early childhood right*, neuroplasticity and biological embedding will make everything better, without anything else having to change first. But human behaviour cannot be rigidly programmed during early childhood to change society bottom-up. Society must take steps to reduce social adversity, so that vast stores of latent parental investment can be unlocked from the top-down for the benefit of children of all ages. Overcoming social adversity cannot be put on the shoulders of caregivers, nor can it be our long-term expectations of the children they care for.

Dr Barak Morgan is a post-doctoral fellow in the field of neuroscience at the University of Cape Town.

The Ability to Change Brains and Behaviour Decreases Over Time

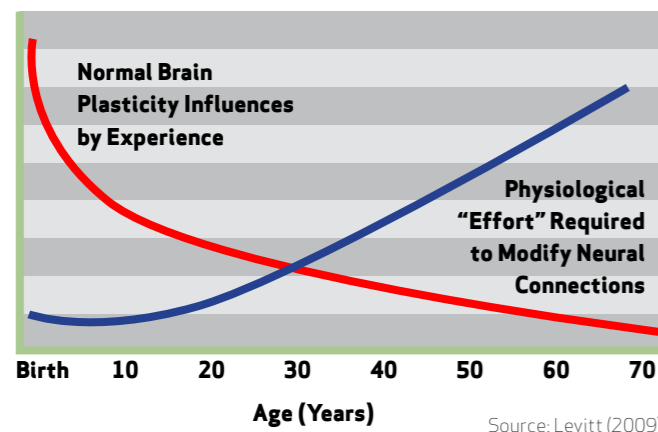


Figure 1. Neuroplasticity, the ability to change brains, decreases over time, while the effort needed to do this increases over time.

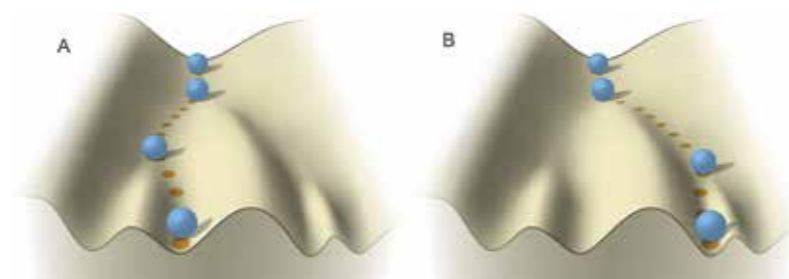


Figure 2. The core story of brain development. Valleys represent different strategic trajectories that brain development (blue ball) can follow. The different trajectories shown in these two identical landscapes are the result of different environmental conditions (not shown) steering development at key decision points in different directions. Once in a valley, even a big change in environment can do little to change the course of development.

Source: Mitchell, Kevin J (2013); Waddington's "Epigenetic Landscape" Figure_1.tif. PLOS Biology. 10.1371/journal.pbio.0050113.g001.

Learning lessons about positive parenting from a parent skills training programme

By Jamie M Lachman, Catherine L Ward, Inge M Wessels, Lucie D Cluver, Frances Gardner & Judy Hutchings

Child abuse and maltreatment are prevalent in South Africa; and the risks for children are compounded by societal factors such as high levels of poverty, HIV/AIDS, drug and alcohol abuse, and community and interpersonal violence.

Caregivers who are living with HIV/AIDS, who are caring for orphans, who have themselves been victims of child maltreatment or intimate partner violence, are particularly at risk of becoming perpetrators of child maltreatment, simply because of the stressors they face^[1-3].

Children who are abused in early childhood are more likely to develop patterns of behaviour that result in negative outcomes later in life⁴. These outcomes can include behavioural problems, poor educational performance, juvenile delinquency, substance abuse

problems, mental health problems, intimate partner violence, and the inter-generational transfer of abuse to one's own children^[5-8]. Preventing child maltreatment, especially in high-risk contexts, is therefore an imperative for the wellbeing of South African children.

Parenting programmes that empower caregivers with skills for warm, positive parenting have been shown to be effective at reducing risk and allowing children to thrive^[9,10]. However, while a number of effective child abuse prevention programmes for the early childhood stage are available in high-income countries^[11-13], very few have been rigorously evaluated in Sub-Saharan Africa^[14,15]. Compounding the challenge is the fact that many of the programmes that have been shown to work in high-income countries are too costly to transport to low-resource settings, and may also present implementation challenges in different cultural contexts^[16].

Sinovuyo Caring Families project: Addressing the evidence gap

The goal of the Sinovuyo project is to build an evidence base for a low-cost scalable parenting programme that prevents maltreatment and child conduct problems and meets the challenge of feasibility in low-income countries. Ilifa is supporting the development of the project as a collaboration with academic institutions (the Universities of Cape Town, Bangor and Oxford), local NGOs (Clowns Without Borders South Africa, ikamva Labantu and The Parent Centre), and international agencies (the World Health Organisation and UNICEF). In the long term, it may be possible that what is learned from testing the Sinovuyo Caring Families Project can help us integrate parenting support into ECD delivery systems.

Sinovuyo is a 12-week, group-based programme, designed specifically for delivery in low-resource

settings. Each session is delivered by community workers trained to model parenting techniques. These facilitators also conduct home visits to support parents who require extra coaching and to involve other caregivers in the programme. The programme also includes SMS text reminders to support participation and reinforce key parenting principles.

Building a “Rondavel of Support”

The Sinovuyo Caring Families Project uses a model called “Building a Rondavel of Support for You and Your Child”, based on 50 years of research from around the world, which highlights the importance of establishing positive and nurturing relationships with children prior to using authoritative, limit-setting strategies^[17].

By improving the quality of parent-child relationships through the use of positive parenting techniques, children are less likely to misbehave, which in turn reduces parents' need to enforce limits and use disciplinary methods. At the same time, parents learn to regulate their own emotions and replace harsh and inconsistent parenting with non-violent and consistent discipline strategies^[18]. Parents also learn simple, mindfulness-based, stress-reduction techniques to help them cope with stress arising from community violence, illness, poverty and the challenges of child rearing.

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“By improving the quality of parent-child relationships through the use of positive parenting techniques, children are less likely to misbehave...”

The Sinovuyo model

Thatch roof:
Limit setting and discipline

Mud walls:
Positive parenting

Problem solving



Non violent discipline

Instruction giving and household rules

Using praise and rewards

Naming feelings and actions

Special time for you and your child

Establishing parent goals

Building a Rondavel of Support © for you and your child



The social learning approach upon which Sinovuyo is based, strengthens parents' and caregivers' ability to support and learn from each other. Group discussions and collective problem-solving help them to be accountable and practice new parenting skills. Group role-plays are also invaluable in helping parents to learn core principles.

Piloting and testing

Two years ago, we piloted the programme with 68 families of children aged three to eight years, living in Khayelitsha, Cape

Town. Parents who participated were disadvantaged and lived in high-violence communities; yet they participated at high levels of interaction, engaged in the programme and found it culturally acceptable. Community workers implemented the programme with high fidelity to the design. Results indicated promising early signs that the programme improves positive parenting behaviour, thus warranting further testing.

From 2014-2016, the Sinovuyo programme is being evaluated in a large randomised control trial with

“Parenting programmes that empower caregivers with skills to manage their children’s behaviour in a nurturing and consistent manner have been shown to be effective at reducing risk and allowing children to thrive.”

268 families and has extended into Nyanga, Cape Town. Using parent-report and observational assessments, the Sinovuyo team is examining the programme’s impact on child behaviour problems and both harsh parenting and positive parenting. We are also evaluating the programme’s effect on parental mental health and the use of social support.

Integration into ECD programmes

There is great potential for the Sinovuyo Caring Families programme to be integrated into a broader ECD service delivery system, such as the one currently being developed by government, in partnership with

Ilifa, in North West province. Many aspects of the programme’s approach and delivery would complement and strengthen home visiting programmes and early learning playgroups.

Sinovuyo’s collaborative facilitation method empowers parents as the primary caregivers of children. It is client-led and supports parents’ ability to learn through experiential activities, while treating them with respect. As with all community-based ECD interventions, however, this approach requires training, mentorship and ongoing supervision, in order to be delivered effectively

to families living in such challenging circumstances.

Finally, it is important to recognise the communal aspects of parenting in a South African context. One mother from the Sinovuyo programme put it best: “a parent is a parent to all children”. By strengthening the home environment through strong social networks in the community, we can ensure that positive parenting and non-violent discipline becomes the new norm for families in South Africa, thus ensuring that all children are provided with the nurturance and loving support they need to thrive.

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A facilitator's view of the Sinovuyo Caring Families Programme

By Andiswa Mgedle

My name is Andiswa Mgedle and I was born in a rural area near Willowvale in the Eastern Cape. I lived with my mother and my five siblings. My father was working in Cape Town, so we saw him during December holidays.

Growing up in a village, you were expected to respect an older person as if they were your mother or father. Once when I was just five years old, I was involved in a fight on the way home from school. A woman who was passing by just grabbed both of us, gave us a beating and told us not to do it again. I did not tell my mom, because I knew that she would hit me as well. If you did something wrong, you knew that you would get a beating, so you chose to keep quiet. But my mother loved us.

When I was six years old, we moved to Cape Town. The new environment seemed very noisy to me, the shacks were built very close to each other. We stayed with our father more often because our mother began selling clothes to help support the family. She would travel from the Eastern Cape to Durban and to Cape Town. We would only see her three times a year. I missed her.

I now live in Khayelitsha with my child, Olo, who is seven years old. I also live with my two older sisters and my younger brother and my three-year-old niece. Olo's father does not live with us, but he is involved in our lives and supports Olo fully.

This community is so different from where I grew up. People mind

their own business and children have lost respect for their elders. Lots of people are unemployed and they are living in shacks, often badly built ones. It is a stressful place to live and that stress makes it very difficult to be a parent. It can make one short tempered. There are also so many bad role models for our children – crime, alcohol, and drugs are part of our daily life, even in broad daylight.

Before working for Clowns Without Borders South Africa (CWBSA) as a Sinovuyo Caring Families programme facilitator, I was a housekeeper and I was also studying early childhood development. I would practice some of the things that I learned, like reading a book to Olo before bedtime, but if he did something wrong, I would give him a hiding. That's what I was used to from my own childhood.

One day when Olo was three years old, I was bathing him and went to fetch a big towel. When I came back, I noticed that he had spilled bath water on the mat and I became very angry. I hit him. Afterwards, I felt bad, but I didn't say "sorry". I just cuddled him.

Becoming a Sinovuyo facilitator has been a great experience for me. The training was very challenging, as we needed to learn new parenting skills and we had to learn how to teach others. In the beginning, I thought some of the skills, like the **5-Minute Cool Down**, or letting your child take the lead during playtime, wouldn't work. They seemed so different from what I was used to in our culture.

We don't consider that children have feelings and also need to be heard. We raise them the way we were raised. We expect them to behave in a certain

way and, if not, we hit them.

However, when I practised these skills myself, I saw that they worked. I also shared what I learned with Olo's father, and told him we need to work with each other. If I make a rule, that rule must apply to Olo even in his house. I'm happy to say that he is helping a lot and trying his best.

I couldn't wait to deliver the programme to other parents but I was also nervous. The thought of me telling parents who already had children older than I am how to manage their children's or grandchildren's behaviour? I worried they might think I was disrespectful. Thankfully, and to my surprise, they appreciated it.

Of course, we had challenges – parents would sometimes miss sessions because they were out drinking; others told us how their partners beat them every night. Some parents complained that their children lied, stole things, and even hit them back. Many asked us for quick fix solutions to their problems, but that is not how Sinovuyo works. The parents are the experts, even if they don't feel that way. We discuss problems as a group and work together to find solutions. As a facilitator, my job is to help parents identify techniques and to coach them as they practice new skills. We are the guides showing the way, but it is the parents' responsibility to do the work to change their parenting and their children's behaviour.

One day, we were doing a home visit with a participant who used to shout at her child all the time. Her neighbour told us that she didn't hear shouting



“There are also so many bad role models for our children – crime, alcohol, and drugs are part of our daily life, even in broad daylight.”

anymore and wanted to come to the session so she could experience what our participant was learning.

Sinovuyo changes the lives of many families – the programme starts in the home and ends in the community. If we can reduce violence and improve relationships in the home, it will spread throughout the community. Our children will grow up learning that there are other ways to solve problems. They will

raise their children to do the same. And generation-by-generation, our neighbourhoods will become safer and happier places to live.

Looking back at my work with Sinovuyo, I have changed a lot. I make sure I spend lots of time with Olo. We are so close. He tells me almost everything. His behaviour has also changed. Now, when he does something wrong, he tells me – so different from when I was a child!

Andiswa Mgedle is a Clowns Without Borders South Africa (www.cwbsa.org) facilitator who delivered the Sinovuyo Caring Families programme during the Ilifa Labantwana-funded randomised control trial in Khayelitsha and Nyanga, Cape Town.





Home visiting to improve maternal and child health

By Mark Tomlinson, Mary Jane Rotheram-Borus and Ingrid le Roux

Investment in children's early years is critical for improving lifelong well-being, setting the foundations for physical health, interpersonal bonds and attachment, language, and cognitive functioning. But, poverty and the high prevalence of infectious

and non-communicable diseases in low- and middle-income countries (LMIC) often create poor outcomes for children and their caregivers.

Identifying sustainable and effective strategies to improve maternal and child outcomes in LMIC has become a high priority and the

challenge is accompanied by the high rates of violence, maternal depression, and under-nutrition in these regions. Despite the fact that these economic, social and health problems are clearly interconnected, intervention strategies for the most part address health risks one by one – in a silo fashion. Many donor agencies continue to fund programmes to address problems generated by a single risk factor.

For example, HIV funding cannot be spent on programmes for depressed women, while funding allocated to alcohol programmes cannot be spent on HIV programmes. Integrated interventions, which target multiple risks, contribute enormously to improved maternal and child health, as well as promote a more efficient and effective use of resources.

In South Africa, families are challenged with a generalised HIV epidemic, rife inequalities, and, in some areas of the country, the highest documented rate of foetal alcohol syndrome in the world. A serious risk factor for child mortality and morbidity is the country's problem of poor nutrition or malnutrition. Pregnant South African women with histories of abusing alcohol, mistreatment by violent partners, depression, and living with HIV are likely to have their – and their children's – post-birth trajectories significantly influenced by these risks. It has been shown that, where multiple risks exist, they take a cumulative toll on children's development, early learning and readiness to learn. Readiness to learn is affected by poverty, family

structure, and child and parent health. Most importantly, readiness to learn is now understood as an outcome of the child's entire life course. There is evidence that the detrimental cumulative effect of multiple risks can be mitigated through early intervention.

Our intervention strategy: the Philani Mentor Mothers programme

The design of the Philani programme builds on the capacity and cultural values of South Africa, fostering attachment and self-efficacy of mothers with their babies. Mentor Mothers are provided with training, materials and skills to address major community health challenges. They provide support and skills to mothers within their daily lives to implement the recommendations received at clinics. As such, Mentor Mothers potentially offer a sustainable para-professional model for building maternal skills, increasing social support and enhancing health care efficacy.

The Philani+ randomised controlled trial study has been implemented in 24 neighbourhoods in Cape Town townships. Participants in the 12 control neighbourhoods received the Department of Health's clinic-based services. In the 12 intervention neighbourhoods, the Mentor Mothers delivered a generalist intervention during home visits. Each pregnant mother received a minimum of four visits during pregnancy and then between four and eight visits postpartum.

“Children of mothers who received the Philani intervention were significantly less likely to be stunted, to have better vocabularies and were less likely to be hospitalised.”

The mentoring intervention content focuses on the following areas:

- Hazardous alcohol use,
- HIV/Tuberculosis, nutrition,
- Disclosure,
- Preparing and planning for one's baby,
- Reproductive health,
- Reducing HIV transmission through preventative health/feeding choices and acts,
- Early sensitive parenting and
- Promoting caring for one's physical and mental health during pregnancy.

A particular strength of this study is that it evaluated the implementation and delivery of a “real world” programme by an existing non-governmental organisation, rather than a package developed and implemented by researchers. We have, to date, conducted an assessment during pregnancy (baseline), and follow up assessments at two weeks, six months, 18 months and three years after birth.

Intervention results to date

Across the follow-up assessments, at the point to 18 months, intervention mothers were significantly more likely to adhere to the complete protocol for prevention of mother-to-child transmission of HIV; to use condoms; have infants of a healthy size; breastfeed exclusively for six months; take their ARV medication both antenatally and postnatally; have a lower number of recent diarrhoea episodes; and have a longer duration of breastfeeding.

“Pregnancy and infancy are critical developmental phases with lifelong consequences; and small changes that become habits can have a substantial impact over a lifetime.”

They were also less likely to engage in hazardous drinking during pregnancy and have infants with multiple clinic visits and episodes of diarrhoea. In addition, infants of depressed pregnant women, receiving home visits from Philani Mentor Mothers, were significantly taller at six months of age than the infants of pregnant depressed mothers not receiving the intervention. At 36 months post-birth, intervention mothers were significantly less depressed compared to mothers in the control group, but were similar in alcohol use and partner relationships. Children of mothers who received the Philani intervention were significantly less likely to be stunted, were less likely to be hospitalised and these children had better vocabularies.

The lessons of the Philani Mentor Mothers

We have shown, using a gold standard randomised controlled trial methodology, the effectiveness of a community health worker (Mentor

Mother) model for delivering home-based preventive care that addresses multiple health issues. We focused on the issues most salient in pregnancy in South Africa, namely HIV, alcohol use, nutrition and perinatal care. These were concurrently addressed with a model of pragmatic problem-solving with cognitive-behavioural intervention strategies. The relationships among initial and sustained maternal risk behaviours and the buffering impact of home visits and social support have been shown in our study.

The gains from our study are significant, but modest. However, small gains often become magnified over time. Pregnancy and infancy are critical developmental phases with lifelong consequences; and small changes that become habits can have a substantial impact over a lifetime. It is important, however, to note that a substantial minority of children are missing key supportive services. For example, even 36 months post birth, 20% of households are not

receiving a child grant, while two of five children get no preschool or crèche experiences. This suggests it may be useful to maintain frequent community health worker visits past the first six months of life. While the importance of early intervention is beyond dispute, it is possible that the benefit of interventions in the first 1 000 days, require functioning preschools, and crèche services, in order for early benefits to be sustained. In communities without such support, it is perhaps important to continue home visits by Mentor Mothers over the 36-60 months post-birth period, which would cover the phases of children’s language development, goal setting, and key processes central to cognitive and socio-emotional development. Children would likely also benefit indirectly by the improved health of their mothers, if visits were extended.

We believe that the Philani intervention is a model for countries facing significant reductions in funding for single health issues and



whose families face multiple health risks. We are continuing to monitor mother and child progress over time and are currently close to completing the follow up of the five-year-old children.

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Mary Jane Rotheram-Borus is a Professor of Clinical Psychology at the University of California, Los Angeles and Director of the Global Center for Children and Families and the Center for HIV Identification, Prevention, and Treatment Services at the Semel Institute for Neuroscience and Human Behavior.

Ingrid le Roux is Medical Director at Philani Nutrition Centres.

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Inclusive ECD for parents of children with disabilities

Over the past year, Ilifa Labantwana, along with its partners on the ground, has worked towards the inclusion of children with disabilities in ECD centres in KwaZulu Natal and the creation of support systems for the parents of these children.

SUE PHILPOTT and BONGI ZUMA discuss the lessons learned from the parents they worked with

The Essential Package of ECD Services has made it possible to identify specific factors that support the learning and healthy development of all young children, from the period of conception until age five.

In South Africa, however, high levels of poverty, particularly in urban informal settlements and rural areas, create environments that threaten children's growth. Conditions associated with low socio-economic status, such as overcrowding, poor sanitation and a greater exposure to environmental hazards, such as fire, increase the vulnerability of

young children and contribute to compromised development.

Conditions of poverty also contribute to higher levels of disability¹, through exposure to hazardous environments, for example, or poor maternal care during pregnancy and childbirth, while the costs associated with disability only serve to deepen poverty.

However, research² shows that although poverty can have a negative impact on a young child's development, this impact can be mediated by the caregiver-child relationship, thus confirming the critical importance of this interaction.

In mid-2014, Ilifa commissioned a

pilot project to develop an approach to inclusion of children with disabilities in ECD services in the remote and mostly rural Ugu district of KwaZulu Natal. In addition to the training of ECD practitioners from nine **inclusive hubs** in the district, a key component of the project was the running of workshops for parents of children with disabilities in each of the six local municipalities.

The aim was to strengthen the role of parents of children with disabilities to support their own child's development and as advocates of the rights of their children. Each workshop was attended by approximately 20 parents and took place over three consecutive days. Day one focused on sharing childcare experiences, as well as learning about disability rights and cultural beliefs about disability; the second day focused on ECD; and the third looked at inclusion in ECD, as well as the advocacy messages of parents regarding the rights of their children.

This article explores the social milieu of parents of children with disabilities, as related by the parents who participated in these workshops, and it reflects on how this social environment serves to undermine and even "poison" the relationship between mothers and their children. Drawing on the parent support programme piloted in Ugu district, this article shares lessons on the actions which can foster an environment in which every parent finds the affirmation they need to provide a nurturing and loving relationship with their child.

The need for intervention

The need for support for parents of children with disabilities is perhaps best described by contrasting a selection of their main shared

5 Components of the Essential Package



Nutritional support



Maternal and child primary health interventions



Stimulation for early learning



Social services



Support for primary caregivers



“The birth of a disabled child is often perceived as a curse or a punishment for the perceived sins of the mother and a source of great shame and disgrace.”

“I am not able to leave my child with my neighbours because they say they are scared of him. How can I leave him with people who are scared of him? So I cannot go out and leave him behind.”

– Grandmother of Kuhle, child with cerebral palsy

experiences with those of parents of able-bodied children. These experiences are based on accounts related by parents during the workshops in Ugu district.

The birth of a baby is usually greeted with joy, with family members talking about it with great pride – a child is seen as a blessing and a gift from God. In contrast, the birth of a disabled child is often perceived as a curse or a punishment for the perceived sins of the mother and a source of great shame and disgrace. In her association with the child, the mother is “disabled by proxy”.

It is common in rural areas for young children to be raised by a number of different family members or adults in the neighbourhood, as per the maxim: “your child is my child”. Even if the father of the child is not involved, other extended family members such as aunts, uncles and grandparents assist with caring for and raising of the child.

In the case of children with disabilities, however, the approach is “your child is your child” and the mother typically receives very



little support from the family or her neighbours. If she takes the child to therapy, for example, there is no one who is willing to go with her. If she asks for support, it is assumed she will have to pay for it.

The attitudes of community members and their actions towards disabled children and their mothers are frequently legitimated by cultural beliefs about disability.

Disabilities associated with behavioural problems, such as autism or Attention Deficit Hyperactivity Disorder, are seen to be manifestations of ancestral spirits, which need to be exorcised. A parent may be pressurised to spend the little money they have on the purchase and sacrificing of animals to appease the ancestors, instead of seeking medical or therapeutic interventions.

What is the impact of this hostile social environment on the mother of a disabled child and how does it undermine her relationship with her young child?

In the first instance, such attitudes contribute to the social isolation of the mother – she is alone, with no one to turn to. Those on whom she would typically rely (mother, mother-in-law) are angry and blame her for the disgrace they believe she has brought to the family. Even where she is trying to respond to the needs of her child, she does not get their support or affirmation. In this situation, is it surprising that a mother would try to hide her child from community scrutiny? Is it surprising that she would be reluctant to acknowledge her concerns about her child or to seek help?

The attitudes of community members contribute to the mother’s feelings of helplessness and uselessness – she is being blamed for something she cannot “undo” and which is beyond her control. She may turn her anger and frustration on to the child, whom she perceives as being the source of the stress in the family dynamic.

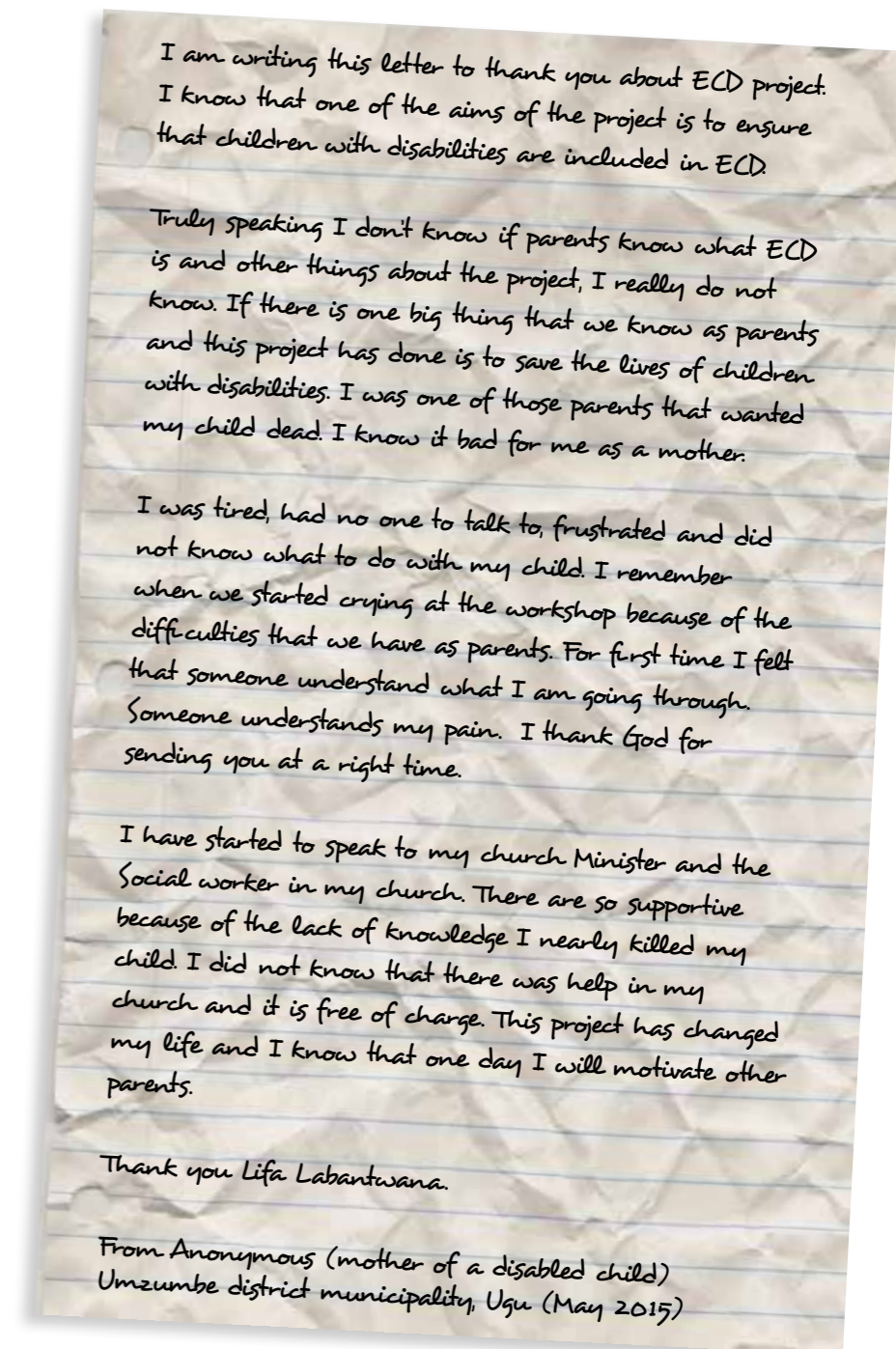
Opportunities and lessons

How can this external environment be challenged and the critical role of mothers of young disabled children be supported? Reflections on the Ugu Inclusive ECD project suggests three levels of intervention:

1. Raising awareness about the causes of disability

There is a need for wide-spread

information about the causes of disability to be disseminated at community level. Traditional healers and leaders need to understand the role of genetics and other medical factors in causing disability. Armed with understanding, healers and leaders would assist parents to get access to the necessary services, rather than exacting from them appeasement for the ancestors.



2. Support groups and collective action of parents

Mothers of disabled children need counselling and psycho-social support, to assist them to accept their children, and to subsequently move from being passive recipients of the disgrace or charity to a position in which they are able to contribute to shaping the future of their child. One mechanism to facilitate collective action is through representation of parents on community structures.

3. Service providers to ensure services are accessible and appropriate for all children

Finally, there is an urgent need for service providers (social workers, therapists, school principals and non-governmental organisations) to identify and remove barriers which prevent access for children with disabilities. These could be physical barriers, attitudinal barriers or barriers to information.

Instead of saying "any child is welcome to use our services", the focus needs to be on "how can we make sure that children with disabilities can benefit from our services?" thus actively addressing factors which may hinder access.

The support programme run for parents in Ugu district has begun to address each of these elements. There has been engagement with community leadership, through municipal structures, on information about causes of disability.

In addition, within each local municipality of the district, parent representatives have been elected to represent the concerns and priorities

of their peers on the local Disability Forums.

Further, the involvement of various service providers, such as social workers, therapists, ECD practitioners, among others, in the parent workshops, has contributed to growing awareness of the need for their services to be more accessible and appropriate for parents of children with disabilities.

Sustainability and expansion will require ongoing support from the Special Programmes manager and Focal Persons throughout the municipality, as well as from government and non-governmental service providers in both the ECD and disability sectors.

In a context of vulnerability deepened not only by poverty but also by disability, the parent-child relationship is one of the most precious and influential elements to the well-being of a child.

Supporting and affirming this relationship is critical for the future of children with disabilities.

Bongi Zuma is Advocacy Officer at CREATE. She is a trained Community Rehabilitation Facilitator, who is disabled herself and is also the mother of a disabled child. Bongi has set up and worked in a number of community projects in KwaZulu Natal and is currently involved in running workshops on the UN Convention on the Rights of Persons with Disabilities.

Sue Philpott is a disability activist, who has been involved in a wide range of disability-related action research studies. She currently co-ordinates the Ugu Inclusive ECD Project.



Implementing ELRU's Family & Community Motivator programme as a key component of Ilifa's partnership with the Department of Social Development in North West over the past four years has been an evolutionary process. FIONA BURTT outlines recent shifts in practice and learning gained from responding to the needs of caregivers through an ECD home visiting programme with a changing focus.

Circles of support for caregivers in North West province

The Early Learning Resource Unit (ELRU) has been working in partnership with Ilifa and the North West Department of Social Development (NWSD) since 2011, demonstrating the importance of home visiting as part of a continuum of approaches to ECD support for young children and their caregivers. ELRU worked

initially in two local municipalities in two North West districts, targeting children under the age of six years from vulnerable families who were not already in an ECD centre. This presented particular challenges. The families frequently reside in remote villages, which are far from services and where poverty is extreme; and there are high incidences of teenage

1. Emmett, T. 2006. Disability, poverty, gender and race in Watermeyer B., Swartz L., Lorenzo T., Schneider M. & Priestly M. (eds). *Disability and social change: a South African agenda*. Cape Town: HSRC.
2. Graham L., Selipsky, L., Moodley J., Maina, J. & Rowland, W. 2006. Understanding poverty and disability in Johannesburg. Centre for Social Development in Africa, University of Johannesburg & UK Department for International Development.
3. Loeb M., Eide, A., Jelsma J., Toni, M., & Maart S. 2008. Poverty and disability in Eastern and Western Cape Provinces, South Africa. *Disability and Society*, 23(4), pp311-321.
4. See for example, Morgan, B. 2013. Biological embedding of early childhood adversity: Toxic stress and the vicious cycle of poverty in South Africa. Ilifa Labantwana Research and Policy.

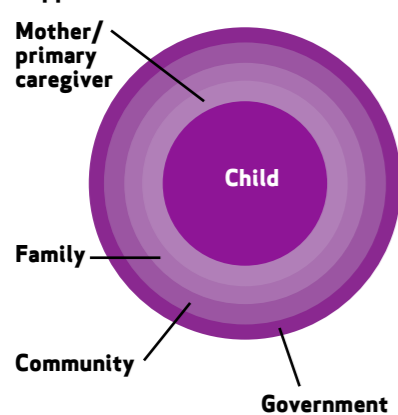
pregnancy and child stunting.

The signing of a new Memorandum of Understanding between Ilifa and NWSD in 2014 determined an expansion of the programme to defined areas in all four districts in the province, doubling the number of home visitors. At the same time, a growing focus globally, and in South Africa¹, on the importance of the first 1 000 days of a child's life and the critical role of the primary caregiver, led Ilifa and ELRU to shift the focus of the North West home visiting programme to offer more explicit support for this period.

Circles of support

ELRU's programme is founded on the understanding that the caring environment around a vulnerable young child and parent or caregiver is critical to the child's development and wellbeing. The environment can be seen as a series of concentric circles of support, with the child at the centre, from conception onwards. Direct care for that child is provided by the mother/primary caregiver, who becomes the child's immediate support. Providing support for that caregiver and child is a family/household. That household is based in a community, which provides the next layer of support and, even in the most impoverished or remote communities, many means of support may be found, such as a church, community groups and structures

Support around the child



or just by neighbours helping neighbours.

The last circle of support is provided by government services – local, provincial and national. So, for this model to be effective, government services should support the community to support the household to support the caregiver to support the child.

The importance of encouraging every circle to work is the major impetus behind the original naming of ELRU's home visitors as Family & Community Motivators (FCMs) and lies at the heart of ELRU's recognition of such programmes being not just about early childhood development, but a process of community and, ultimately, systemic development.

From doing to encouraging

At the core of the FCM intervention is a year-long programme of fortnightly home visits and monthly cluster workshops for caregivers, the latter providing both education and information and an invaluable opportunity to share with other caregivers. While the programme places a strong focus on early stimulation and nurturing parenting, caregivers and children are also linked through referrals and support to health and social services, such as grants.

In ELRU's 0-5 home visiting programme, the FCM would spend a major part of each visit undertaking play activities with young children and demonstrating these to the caregiver. A stronger spotlight on pregnancy and babyhood, since the commencement of the third phase of the North West FCM intervention, in April 2015, has, however, led to a subtle shift in the training and practice of FCMs. It has also resulted in new understanding about the support required by pregnant women and caregivers of very young children.

FCMs are now trained to work more alongside the caregiver, to encourage her to engage with her child and observe and check her child's

progressive development, during pregnancy and beyond. But, according to ELRU's FCM programme manager, Bernie Dawood, in some households, the mother may have no idea how to do that, so it may be necessary for the FCM to model and invite the mother to practice while the FCM is present.

Recognising that the relationship between mother or caregiver and child is the critical factor in all aspects of a young child's development and well-being (as discussed elsewhere in this issue of *Ilifa Insights*), FCMs have discovered that the support they need to offer can be as basic as showing a caregiver how to hold, talk to or smile at her baby. As Bernie Dawood explains, "some mothers immediately respond, but others take time. We encountered a very young mother, who looked very depressed, unkempt, absolutely absent, not relating to her baby. The FCM had to show her how to smile and laugh with her baby and, eventually, she was able to do it. But, if there had been no home visitor offering support, it would have been terrible for that mother and child."

It's all about relationship

As ELRU staff always affirm, the key to the success of any home visiting programme is the positive relationship built between the home visitor and the caregiver. Simply stated: "For good outcomes, the relationship between participant and programme staff needs to be stable, warm, supportive and uncritical."² How the perhaps intangible notion of relationship and support for the caregiver translates into positive outcomes for the child can be difficult to quantify, but Bernie



“The key to the success of any home visiting programme is the positive relationship built between the home visitor and the caregiver. For good outcomes, the relationship between participant and programme staff needs to be stable, warm, supportive and uncritical.”

significant community resources, this would emphasise the role of FCMs as part of the outer circle of support described above. The qualitative learning about the needs of young children and their caregivers, and the best approaches developed by FCMs for responding to these needs, informs the deepening of FCM's practice and the increasing impact of the programme.

Of concern, therefore, is that the current, multi-layered DSD reporting structure – from the ground via NWSD to national DSD – is entirely about numbers. As systemic change gradually happens and home visiting becomes more embedded in DSD ECD programmes, where will all this learning go?

Fiona Burt is a development consultant, who has been researching aspects of ELRU's FCM programme in North West province for Ilifa.

Dawood is clear that it does make a real difference: "Especially for an isolated, vulnerable caregiver, when someone visits, it's really important. Home visits lift your spirit. You're sitting bottled with all this hardship, now there's someone to share it with and immediately it's released. As soon as it's released, there's a space for something better to come in. Home visits bring trust, motivation, encouragement, moral support. Women naturally learn from each other and sharing helps."

ELRU has often seen this as a very female space, but, since April, has welcomed four men into the programme as FCMs, recruited by NWSD. All are fathers and are proving to have a positive effect

in demonstrating the role of men as caregivers of young children. And in one area, the male FCM has successfully enrolled pregnant women and gained the trust of their families, thus challenging the commonly-held assumption that men in South Africa cannot undertake home-based work with pregnant women or new mothers.

Sharing learning with the outer circle

A major goal of the North West FCM programme has been not only to model the intervention on the ground, but to see it scaled up and sustained over the long term by integrating it into NWSD systems. Ultimately, while still acknowledged as

1. As highlighted in the 2012 *Diagnostic Review of Early Childhood Development in South Africa*, commissioned by the Department of Performance Monitoring and Evaluation in the Presidency and the Inter-Departmental Steering Committee on Early Childhood Development, and the draft South African National ECD Policy, awaiting adoption.

2. Dawes, A., Biersteker, L. & Hendricks, L. 2012. *Home visiting for households with children not in formal ECD: Evidence from the Sobambisana Initiative*. Ilifa Labantwana Learning Brief 5.



Supporting a child starts with supporting a mother

By Rachel Rozentals-Thresher

The First 1000 days Relationship Support Tool “Ibhayi Lengane” was developed by dlalanathi as an add-on to existing home visiting programmes with the purpose of enhancing the mother-child relationship during the first 1000 days. CEO RACHEL ROZENTALS-THRESHER shares lessons learnt through the process.

“We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit,” says the poet e e cummings. Research and practice emphasises what e e cummings expresses so beautifully. We all come to know who we are through our experience of nurturing relationships with significant others. Nowhere is this more important than in the first 1000

days of a child’s life. At present in South Africa, young children and their mothers face a myriad of risks as a result of poverty, violence and disease, all of which present very challenging conditions for development over this crucial time.

A young woman, living in a rural community in KwaZulu Natal province, told us the story of the decisions and actions which changed the course of her life. She described her shame at falling pregnant in her last year of school, her uncertainty in her relationship with her boyfriend, and her fear for the future. The moment that had the most profound impact on her, however, was when she received her mother’s forgiveness and help

in supporting and caring for both herself and her baby.

There is overwhelming scientific evidence that the parent-child relationship, in particular responsive sensitive care in the early years of a child’s life, is critical to children’s development. The benefits of responsive caregiving are seen across the domains of childhood including in the development of secure attachments critical to healthy relationships later in life, and in attentional and language skills key to school achievement and economic productivity in the adult years.

Unplanned pregnancy, particularly when the mother is young and unemployed, often draws a lot of very negative attention, with the effect of isolating the mother at the very time both she and the baby need support the most.

The first 1000 days

Ilifa is committed to developing and supporting programming which is responsive to the early development needs of children in these adverse conditions. Towards this goal, Ilifa is seeking to develop creative ways to strengthen existing partner and government programmes with strategic inputs that influence early child development and increase access to the Essential Package of services by all mothers and children – particularly those most vulnerable.

One of these inputs is the First 1000 Days Relationship Support Tool “Ibhayi Lengane” for home visitors, developed by dlalanathi, Ilifa’s parenting portfolio manager Lisa Cohen, and a number of consulting experts and practitioners in the field. The vision for the tool is for it to become a scalable “add-on”, complementing existing programmes with a specific focus on strengthening the quality of mother and child interaction over the first 1000 days of a child’s life.

This concept acknowledges that many programmes have been scientifically and sensitively

developed to effectively deliver either comprehensive and integrated interventions (such as maternal and child health, nutrition, parenting, play, and structural support through grants) or very specific interventions for mothers and children over the first 1000 days (such as child health, nutrition, or early child development through stimulation and play). Some early childhood programmes focus on the older child. Other organisations deliver support to households which include pregnant women, young mothers and their children, without any particular programme focus on the needs of these target groups.

Ilifa partners openly shared their home visitor programme materials to assist the team in scoping what exists and identifying key opportunities to strengthen existing programmes through an “add-on”. Given that many exemplar early child development programmes already exist, the conclusion of the team was that this could have significant impact on strengthening home visiting programming.

Nurturing the mother

The tool has been developed with a central principle in mind: Care for the baby in the first 1000 days can only be achieved through nurturing relationships around mothers or primary caregivers and children.

The First 1000 Days Relationship Support Tool contains:

- Relationship-based training for home visitors;
- A set of three structured home visits: one with the family and two with the mother and baby, over four phases (pregnancy, birth to six months, six to 12 months, and 12 to 24 months);
- Materials to guide facilitation and some leave-at-home materials for the mother to support sustaining the activities at home.

The principles are as follows:

- The mother is the key to positive care and relationship for her baby.

- Helping the mother first and foremost is the path to supporting her baby’s development.
- Within a caring and supportive relationship, we explore the relationship between the mother and her baby.
- Activities give the knowledge, feeling and action appropriate to strengthen the mother’s relationship with her baby.

The home visitor brings with her:

- **Attitude and approach:** A sensitive, caring view of the mother’s capacity to care.
- **Knowledge:** An understanding of the significance of a responsive relationship in the development of the baby.
- **Activity:** A set of activities to do in the home to build a relationship and connect with the mother.

A trained home visitor brings an empathic, sensitive and strength-based approach to build a relationship with the mother which, in turn, helps her prioritise her own health at this important time and plan to take a small strategic step towards actions which strengthen her self-care.

The home visitor also identifies relationship support and assists the mother in taking a small, strategic step towards attaining that support.

Finally, through her interaction with the home visitor, the mother begins to think about her own relationship with her baby and works towards strengthening that relationship.

The family-focused sessions have the dual aims of encouraging family in their nurturing relationship towards mom and supporting mom and her relationship with her baby; thereby addressing both the inner and outer circles of influence of the child’s early development.

Rachel Rozentals-Thresher is CEO of dlalanathi, an NGO that works, within the South African context, to provide psychosocial support for children through play, by training and supporting caregivers.

'I'M NOT TOO OLD TO PLAY'

#LOVEPLAYTALK

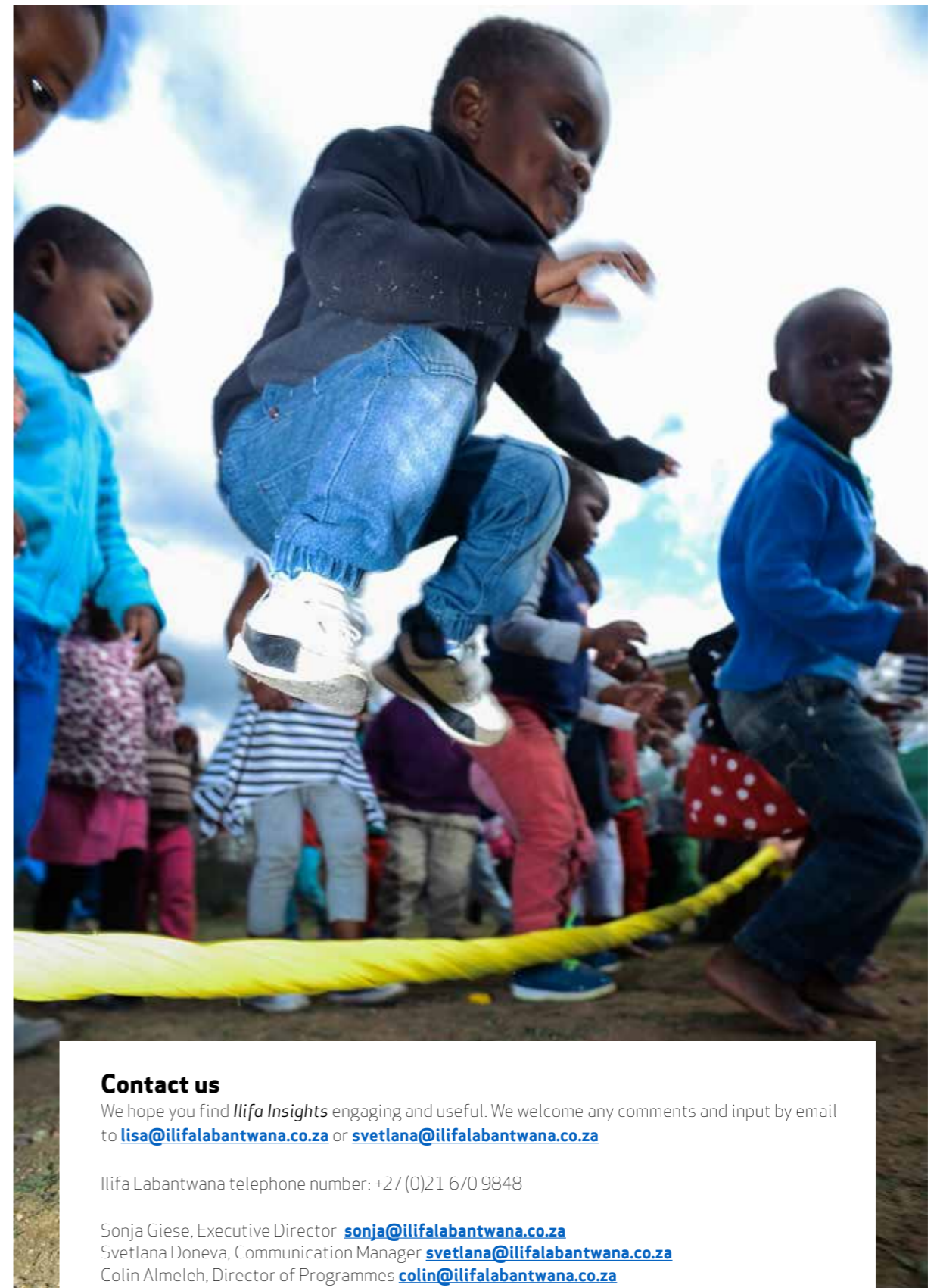
MY CHILD IS A SOMEBODY

All parents have the power to instil magic into their children's lives and it never needs to involve expensive presents or grand gestures. At Ilifa, we believe that it's the ordinary day-to-day interactions between a child and a caregiver that build bright minds, compassionate hearts

and healthy bodies. We launched the #LovePlayTalk national multi-media campaign in June 2015, along these principles, with the goal of encouraging South African parents to spend more quality time loving, playing and talking with their children. #LovePlayTalk's first phase

focused on raising awareness via billboards and public radio service announcements, both of which directed the public to an information-filled mobi-site (**MyChildSA.mobi**). We are currently in the process of defining the phase of the campaign for 2016.

Visit MyChildSA.mobi



Contact us

We hope you find *Ilifa Insights* engaging and useful. We welcome any comments and input by email to lisa@ilifalabantwana.co.za or svetlana@ilifalabantwana.co.za

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**“Life affords
no greater
responsibility,
no greater
privilege, than
the raising
of the next
generation.”**

- C Everett Koop



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